London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

Wednesday 20 September 2023 at 6.00 pm

Main Hall (1st Floor) - 3 Shortlands, Hammersmith, W6 8DA

Watch live on YouTube: youtube.com/hammersmithandfulham

MEMBERSHIP

Councillor Ben Coleman (Chair) - Deputy Leader and Cabinet Member for Health and Social Care
Councillor Alex Sanderson – Cabinet Member for Children and Education
Dr James Cavanagh – H&F GP
Carleen Duffy – Healthwatch H&F
Phillipa Johnson – Director, Integrated Care Partnership, and Director of Operations for Central London Community Health Trust
Linda Jackson – Strategic Director of Independent Living (DASS)
Jacqui McShannon – Strategic Director of Children's Services
Dr Nicola Lang – Director of Public Health, LBHF
Sue Roostan – Borough Director, H&F, Borough Based Partnership
Sue Spiller – Chief Executive Officer, SOBUS
Detective Inspector David Nicolls – Met Police

Nominated Deputy Members
Councillor Natalia Perez – Chair of Health and Adult Social Care Policy and Accountability Committee
Councillor Helen Rowbottom – Chair of Children and Education Policy and Accountability Committee
Nadia Taylor – Healthwatch, H&F

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Members of the public and press are welcome, but spaces are limited so please contact David.Abbott@lbhf.gov.uk if you'd like to attend. The building has disabled access.

Date Issued: 12 September 2023

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

Item		Pages
1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST**	

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Standards Committee.

3. **MINUTES AND ACTIONS** 4 - 11

To approve the minutes of the previous meeting as an accurate record and note any outstanding actions.

4. **SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) JOINT STRATEGIC NEEDS ASSESSMENT AND SEND STRATEGY** 12 - 56

The Joint Strategic Needs Assessment draws together data and evidence from a range of sources, including the views of parents and professionals working in the field, to describe a picture of need and service provision across Hammersmith & Fulham. The needs assessment has provided the evidence base to inform the Local Area SEND Strategy and is brought to the Health and Wellbeing Board to note.

5. BETTER CARE FUND 2023/25 57 - 108

This item presents the Better Care Fund 2023/25 proposal for the London Borough of Hammersmith & Fulham and the H&F Integrated Care Board.

6. WORK PROGRAMME

To discuss the Board's work programme.

7. DATES OF FUTURE MEETINGS

To note the following dates of future meetings:

- 13 Dec 2023
- 12 Mar 2024

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Wednesday 28 June 2023

PRESENT

Members
Councillor Ben Coleman (Chair, Deputy Leader, and Cabinet Member for Health and Social Care)
Carleen Duffy (Healthwatch H&F)
Dr Nicola Lang (Director of Public Health)
Phillipa Johnson (Director, Integrated Care Partnership, and Director of Operations for Central London Community Health Trust)
Jacqui McShannon (Strategic Director of Children's Services)
Linda Jackson (Strategic Director of Independent Living (DASS))
Sue Roostan (NHS Northwest London ICB)
Detective Inspector David Nicolls (Met Police)

Nominated Deputy Members
Councillor Natalia Perez (Chair of Health and Adult Social Care Policy and Accountability Committee)
Nadia Taylor (Healthwatch, H&F)

Guests, officers, and other attendees
Toby Lambert (NHS Northwest London ICB)
Dr Julia Renton (West London NHS Trust)
Michelle Dixon (Imperial College Healthcare NHS Trust)
Merril Hammer (Hammersmith & Fulham Save Our NHS)
Jim Grealy (Hammersmith & Fulham Save Our NHS)
Sharon Tomlin (SOBUS)
Jo Baty (Assistant Director, Specialist Support, and Independent Living)
Julius Olu (Assistant Director for Public Health and Social Care Commissioning)
Councillor Lucy Richardson
Councillor Ann Rosenberg
David Abbott (Head of Governance)

1. APOLOGIES FOR ABSENCE

Apologies were received from Dr Christopher Hilton (Dr Julia Renton attended in his place) and Janet Cree.

Councillor Lucy Richardson, Dr Nicola Lang (Director of Public Health), and Michelle Dixon (Imperial College Healthcare NHS Trust) attended the meeting remotely.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES AND ACTIONS

The Board agreed the minutes of the meeting held on 28 March 2023 as an accurate record.

The Board agreed to change the order of the agenda as follows – 6, 5, 4, 7, 8.

4. ICS HEALTH AND CARE STRATEGY FOR NORTH WEST LONDON

Toby Lambert (Northwest London ICB) introduced the item which presented the Integrated Care System (ICS) Health and Care Strategy for Northwest London for challenge and comment. He noted that the strategy built off the existing work of the JSNA and Health & Wellbeing Strategies. They were gathering feedback from all Health & Wellbeing Boards and would incorporate them into the final strategy.

Toby Lambert noted that the engagement period would run to the end of July. There was a form on their website for residents to provide feedback. Councils could provide feedback through Health & Wellbeing Board meetings and could also provide longer written responses. The Chair noted H&F may share the minutes of the meeting or provide a written submission at the right time.

ACTION: Linda Jackson / David Abbott

Councillor Natalia Perez asked if there were groups that the ICS wanted more engagement from. Toby Lambert said each section of the strategy had its own engagement process, but engagement had taken place with partners, the residents forum, and colleagues in communications had been working to build links with each group and community.

Merril Hammer commented that the strategy presented was not specific enough. She said the strategy should clearly articulate the current position, have baseline figures to measure progress against, and outline the plan to get to the desired end point. She highlighted the maternity and children and young people sections as a good example. But she felt it was wrong to put palliative care as something that was being done well, noting they were 10 months late to report. She also felt the mental health section was seriously lacking, with little or no detail about baseline provision, need, demand, measures of inequality, productivity, or staffing.

Toby Lambert said he agreed some sections were more detailed than others, explaining that it was partly an artefact of how the document was produced. He

noted there was supporting data available in the needs assessment on their website, but it was not as comprehensive as he would like.

Jim Grealy discussed the need for a clear articulation of what success and failure in each area. He also said there needed to be a realistic look at what could be staffed with the expected resources. Toby Lambert said the strategy would feed into a joint forward plan, which would have more detail about finances and workforce. He noted that while there were shortages in some key professions, overall, they had more staff than ever before. The challenge was how best to deploy that workforce.

The Chair asked if the joint forward plan would contain detailed targets and outcomes. Toby Lambert said it would.

Jacqui McShannon highlighted transitions from Children's Services into Adult Social Care, mental health, and autism as areas that needed more focus. She warned there was a growing cohort of people whose needs were not being met. The Chair also said the strategy did not include enough on autism. Toby Lambert said there had been similar feedback from others and he would feed it back to the ICP.

Jacqui McShannon said she would also like more focus on the group of children and young people that were considerable risk but low incidence. The Chair suggested it would be more impactful if all the Children's Services Directors from across Northwest London coordinated and produced a joint response to the strategy.

ACTION: Jacqui McShannon

Nadia Taylor asked if there was scope to extend the engagement period to ensure a wide range of responses. She also noted the strategy covered a lengthy period and asked if artificial intelligence (AI) and its application in healthcare part of the discussion had been. Toby Lambert said he was personally keen to move from the strategy phase to hard targets and actions. Regarding AI, he said it was part of their research and innovation strategy – and in some areas like population health around hypertension it was already being used to identify people at risk.

Councillor Natalia Perez, regarding mental health services, asked if there would be more investment in alternatives to A&E. she also asked if there would be what plans there were to incorporate the feedback and incorporate it in a meaningful way. Toby Lambert said, regarding A&E, there was a new crisis service which took people out of A&E and into an assessment bed where they could be stabilised and moved back into the community with support. They were looking at the most impactful investments. Regarding the feedback he said they would produce a response to the engagement document, summarising the feedback received and report back to the ICP with recommendations about what to include in the final strategy.

Linda Jackson said one of the key issues was that people needed to be able to see the resources that will enable these outcomes to happen. She said the overarching plans needed to be shown to residents. She also asked if there was a public risk register.
Toby Lambert assured the Board that details plans would follow the strategy in the form of the joint forward plan which would bring together estates, the workforce, and

finances. He added that a risk register was also being put together and it included capital funding as a risk.

The Chair asked if the Board should have a meeting on the joint forward plan. Toby Lambert said there was a decision to be made about whether to try and do it all in one piece or have more detailed discussions about each section i.e., mental health.

The Chair asked what was meant by an 'integrated approach to housing' in the strategy and asked if that would entail the ICP putting money into housing to tackle mould and damp. Toby Lambert said it was unlikely that the NHS could put money directly into housing repairs, but he said they could release land for new housing.

The Chair said children with asthma were costing the NHS a lot of money across their lifetime and suggested that it would be a better use of funding to collaborate with the Council to fix the problem at an early stage. Toby Lambert said there were things the NHS could do, and they would think about innovative approaches, but could not make a commitment at the meeting.

Jacqui McShannon said there was some anxiety in Children's Services about the joint forward plan imposing services for local authorities to deliver but without any additional funding. She also raised an issue about engagement on boards, noting that there should be more representation from staff working directly with children, rather than it always being Director-level. She said it would be useful to see a list of all boards and who was represented on them. The Chair agreed and asked Toby Lambert to provide a list. He added that it would be a good step in helping improve understanding and noted the importance of having a constructive relationship.

ACTION: Toby Lambert

Jo Baty raised the importance of having a scalable core offer, noting that a lot of children and young people move across boroughs. Previously there were reciprocal agreements in place but those had been lost. She said an integrated early help service and reciprocal arrangements would be welcomed.

Jim Grealy objected to phrasing in the document suggesting that ethnicity was one of the main social determinants of health. Toby Lambert said he would ask for it to be rewritten.

ACTION: Toby Lambert

Merril Hammer asked if the joint forward plan was amendable. She also asked if the engagement phase for the strategy could be extended beyond the end of July. Toby Lambert said he would prefer to move on to the planning stage but if groups wanted to come back after the end of July with further input, they would take that on board. Regarding the joint forward plan, he said it would be amendable.

The Chair thanked Toby Lambert for attending.

RESOLVED

1. The report was noted.

5. DELAYED REFURBISHMENT AND REBUILDING OF CHARING CROSS, HAMMERSMITH AND ST MARY'S HOSPITALS

Michelle Dixon (Director of Engagement and Experience at Imperial College Healthcare NHS Trust) presented the item about the delayed refurbishment and rebuilding of Charing Cross, Hammersmith, and St Mary's Hospitals.

The Chair asked for clarification that the planned rebuild of St Mary's Hospital in Paddington, and extensive refurbishment and some new build at both Charing Cross Hospital and Hammersmith Hospital had been pushed back beyond the original commitment of 2030. Michelle Dixon said the hospitals were still in the programme and would receive funding for a business case and enabling works (e.g., upgrading a building's power supply), but the bulk of capital funding would not be committed until after 2030.

The Chair asked if the Trust had received any response to their bid for enabling works made in August 2022. Michelle Dixon said they had not received a response yet.

The Chair asked how much money the Trust was having to spend each year on backlog maintenance. Michelle Dixon said they spent between £7-8m every year on each of the main sites.

The Chair asked for confirmation that if residents saw building works it was maintenance. Michelle Dixon said they could receive money for some enabling works before 2030, but not expansion or refurbishment.

The Chair asked if other hospitals in the core group of forty were slower to complete their business plans, was there scope for the Trust to jump the queue? Michelle Dixon said she anticipated that to be the case. She noted that Charing Cross and Hammersmith could do phased works rather than a complete rebuild. The Trust was hoping to be able to use its land as leverage to get upfront funding before 2030. The Chair asked if there was support from the Government for that. Michelle Dixon said they were speaking to the New Hospitals Programme about it.

Jim Grealy said that residents expected new hospitals to be completed by 2030, but now we learn there is no money guaranteed until 2030 and rebuilds take a long time. He asked when the hospitals would be finished. Michelle Dixon said they were hopeful that the land strategy would enable works to be done before 2030 but if that did not work it would be the late 2030s. She was concerned that the buildings at St Mary's would not last that long though.

Merril Hammer asked if the Trust were planning to use money from land sales to help pay for the rebuild, would the Trust be refunded for that. And if not, what might that money have been used for if not spent on the rebuild. Michelle Dixon said the money would always be used to offset building costs.

Nadia Taylor asked what the impact on patient services would be during the planned rebuild. Michelle Dixon said the state of the buildings impacted on patients every day. She highlighted the ingenuity of the estates teams in keeping services running.

Councillor Natalia Perez asked about contingencies in case of extreme scenarios like flooding. She also asked if the Trust was exploring land deals for Charing Cross and Hammersmith. Michelle Dixon said they were only looking at a land deal for St Mary's because it required a complete rebuild. Regarding contingency plans, Michelle Dixon said there were multiple contingency plans in place. If certain areas are offline then they can move things around, or move to a different site, but if there was a critical mass of problems then it could become challenging to manage.

The Chair noted that experts had advised that if the buildings were not upgraded in the next five years, they would become impossible to fix. Residents have complained about the awful condition of the corridors and other spaces at St. Mary's. He asked for clarification that the Trust would only be getting money for St. Mary's before 2030 if they raised it themselves and not from the Government. Michelle Dixon said she did not expect any capital from the central funding pot if they could not leverage the land.

The Chair asked what happens to the hospitals and patients in Northwest London if the Trust cannot raise the money. Michelle Dixon said they were hopeful they can get the deal done. They would also continue with contingency planning, but they would have to start thinking about moving services off the site. Building experts have told them that parts of the estate will not be viable much further into the future. It would impact care to the hundreds of thousands of people that are treated at St. Marys.

Toby Lambert said 'plan B' was the continued ingenuity of the estates team, but there were limits. They were looking at how to mitigate the problems collectively with the three other nearby hospital trusts. He added that the impact would be sub-optimal and there would be negative impacts on patients and fewer people would be treated if capacity were constrained.

The Chair asked how many people were treated at St. Marys annually. Michelle Dixon said there were around one million contacts across the Trusts, with around 350k at St. Mary's.

Linda Jackson asked how much the backlog maintenance budget was. Michelle Dixon said it would cost around £105m to get on top of the backlog, but they did not have the full amount, so they prioritised the most essential works each year.

Linda Jackson asked what the St Mary's rebuild would cost. Michelle Dixon said it would cost between £1.5bn and £1.7bn, taking land sales into account. Linda Jackson noted that at present, the hospital was not receiving either the rebuild cost or the full maintenance costs required.

Merril Hammer asked what the chances were of the programme falling through if the Government changed at the next election. Michelle Dixon said the £20bn for the New Hospitals Programme was already committed in the spending round.

The Chair noted that a floor-by-floor refurbishment of Charing Cross had been announced in 2018 and asked why the Trust was only working on the business case

now. Michelle Dixon said there had been other priorities like St. Marys, and business cases took a long time to produce and required additional funding.

The Chair thanked Michelle Dixon for attending.

RESOLVED

1. The briefing note was noted.

6. BETTER CARE FUND

Toby Lambert (NHS Northwest London ICB) introduced the item.

The Chair raised concerns about the most recent Better Care Fund (BCF). He explained that the BCF was normally agreed locally with the Council and the NHS, with the aim of getting people out of hospital as quickly and safely as possible. However, this year the Finance Department of the ICP was not acting in an appropriate way and was refusing to approve the budget. This had led to people being stuck in hospital for weeks and weeks.

Toby Lambert said the ICP was not happy about the current situation and conceded there were better ways to manage it. He noted that while the amounts had not been fully signed off as of the date of the meeting, the overall quantum remained. Any money committed would be paid.

He understood the unhappiness around how it was communicated and the transparency, but the ICP had to follow the national guidance and ensure the money was being used effectively as they were accountable for it. He said he would feed the Board's comments back to the ICP.

Linda Jackson commented that the BCF had been worked on jointly since 2015. It funded a lot of contractual services. She suggested the ICP should sign off the funding stream for 2023-24 with a condition saying there would be a joint review of next year's spend.

Linda Jackson added that in terms of outcomes Northwest London had reported consistently reliable performance on discharge and had been leading in London for months. She said holding back discharge money put the area's performance on discharges at risk and had done damage to a lot of challenging work by colleagues at the ICS. The situation had challenged local partnerships and damaged trust and relationships with the ICP. She urged the ICB to sign off the funds for 2023-24 and agree to work together on 2024-25.

Sue Roostan (NHS Northwest London ICB) said she understood the comments from the Council, but they were looking for a level of consistency around the minimum level of contribution. She noted that it was not a cost saving exercise, it was about consistency across the boroughs.

The Chair said this approach had done more damage than anything since the start of the ICS arrangements. They had not engaged early and showed no understanding of how local authorities worked. He said it needed to stop this year. The Council committed to do everything it could to work with and inform their finance team about how we work and the differences between the local authorities in the area. He asked the representatives from the ICB to take the Board's comments back and work with colleagues to rebuild the trust that has been lost.

Toby Lambert said took the points made on board and would take them back.

The Chair thanked Toby Lambert for attending.

7. WORK PROGRAMME

The Chair asked members to send any work programme suggestions to the clerk.

8. DATES OF FUTURE MEETINGS

The following dates of future meetings were noted:

- 20 Sept 2023
- 13 Dec 2024
- 12 Mar 2024

Meeting started: 6.25 pm
Meeting ended: 8.36 pm

Chair ....

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Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Wellbeing Board

Date: 20/09/2023

Subject: Special Educational Needs and Disabilities (SEND) Joint Strategic Needs Assessment and SEND Strategy

Report author: Joe Gunning, Programme Lead, Children's Commissioning

Responsible Director: Peter Haylock, Operational Director, Education and SEND

RECOMMENDATIONS

The Health and Wellbeing Board

1. Notes the SEND Joint Strategic Needs Assessment (Appendix 1) and the Local Area SEND Strategy (Appendix 2)

Wards Affected: All

Our Values	**Summary of how this report aligns to the H&F Values**
Building shared prosperity	Ensuring a person-centred approach that delivers the right level of support to meet presenting needs of children, young people and their families – and in so doing provide them with the best opportunities to thrive.
Creating a compassionate council	Listening and responding to feedback from professionals, young people, parents, carers, education settings and wider partners regarding what was working well, what needed improvement and where the gaps were with regards to current support available.
Doing things with local residents, not to them	The documents were developed following engagement with families. They have been further updated in response to feedback received through consultation with wider stakeholders.
Being ruthlessly financially efficient	This strategy will support local partners to meet the needs of children and young people in H&F and increase the confidence or parents and carers.
Taking pride in H&F	Support H&F to be the best place to grow up, live and work. These

	documents will ensure our support to children and young people with SEND enables them to lead happy, healthy, and fulfilling lives and achieve their life goals.
Rising to the challenge of the climate and ecological emergency	There are no anticipated climate and ecological implications as a result of the publication of these documents.

Background Papers Used in Preparing This Report

None

SEND JOINT STRATEGIC NEEDS ASSESSMENT

1. The Joint Strategic Needs Assessment draws together data and evidence from a range of sources, including the views of parents and professionals working in the field, to describe a picture of need and service provision across Hammersmith & Fulham.

2. The needs assessment has provided the evidence base to inform the Local Area SEND Strategy and is brought to the Health and Wellbeing Board to note.

SEND STRATEGY

3. The Special Educational Needs and Disabilities (SEND) Strategy sets out Hammersmith and Fulham’s local area commitment to improve the educational, health and emotional wellbeing and life outcomes for all young people in the borough aged 0-25 years who have SEND while promoting inclusion.

4. The strategy provides a shared local area vision, principles, and priorities to ensure that partners across the local area are working together effectively to identify, assess and meet the needs of children and young people with Special Educational Needs and Disabilities (SEND) from birth to the age of 25 in H&F.

5. The strategy was developed in partnership and extensively coproduced across the local area in consultation with families, reflecting the H&F value of doing things with residents not to them. Following public consultation, the strategy was further reviewed, and amendments made prior to approval at Cabinet in June 2023.

6. The strategy is presented to the Health and Wellbeing Board to note.

LIST OF APPENDICES

Appendix 1 – Joint Strategic Needs Assessment
Appendix 2 – Special Education Needs and Disabilities (SEND Strategy)

Hammersmith & Fulham's Special Education Needs and Disabilities

SEND Needs Assessment

May 23

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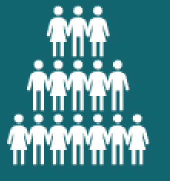


The total population in H&F in 2021 was

183,157 [1]

52,067 children and young people **aged 0 to 25** account for **28%** of the total population in the Borough [1]

+0.4% population **increase** since the 2011 Census

+15.9% increase in population of residents aged between 10 to 15 years since 2011. [1] [2]

27,061

pupils are in H&F schools [3]

3,221

pupils are receiving **SEN Support** [4]

or

12%

of H&F's **0 to 25 population**

England average was 13%

1,511

Children/ young people with a **EHC plan** in the Borough [5]

or

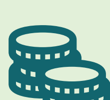
2.9%

of H&F's **0 to 25 population**

England average was 2.8%

H&F Schools

4	Maintained Nursery Schools
36	Primary Schools
11	Secondary Schools
1	Alternative Provision Establishments
2	Resourced Provisions
4	Special Schools
3	Hybrid Special School Satellite Provisions
4	Post 16/College providers



68%

of pupils with an EHC plan live in areas that are 0-30% most deprived in the Borough [3]

5,526

Children and young people have a long term health condition [6]

12,144 children and young people (15%) in **NHS North West London Integrated Care Board (NHS NWL ICB)** who have a diagnosis on their GP records that could be classified as SEN [7]

- There are 52,067 children and young people from birth to 25 in Hammersmith & Fulham (H&F). This accounts for 28% of the total population. [1]
- Life expectancy in Hammersmith & Fulham is 77 for males and 83 for females compared to the national average of 79 for males and 83 for females. [8]
- In 2021/22, there were 1,381 pupils who are EHC Plan holders in H&F. This is 5% of all pupils in H&F. This is higher than the national average of 4%. H&F has seen a consistent rising trend in EHCP numbers in recent years, broadly reflecting the national trend. [4]
- While, over the past 7 years, there has been a higher rate of EHCP growth in H&F compared to the regional and national average, as of January 2023, the rate of EHCP growth in H&F is now below the regional national average and the trend appears to be levelling out. This could be showing an early effect of the Council's early intervention programme having a positive impact on reducing needs escalating to a statutory process. [4]
- The largest primary need groups for children with SEND are Autism Spectrum Condition (ASC) and Speech, Language and Communication Needs (SLCN). [5]
- Our children perform above the London and National trend at Early Years foundation stage in relation to the number of early learning goals at the expected level for the age of the child. [9]
- The percentage of pupils meeting the expected standard in reading, writing and maths at the end of key stage 2 for pupils in H&F with SEND is above London and National averages. [10]

- Key Stage 4 pupils receiving SEN Support progress better in H&F compared to London and England. The attainment 8 score is slightly lower than the London average for pupils with an EHCP but is comparable with the national average. [10]

- The proportion of pupils in maintained schools with an EHCP is above the national average. 468 EHC plans (31%) are placed out of borough. [5]

- There are concerns around some waiting times across some health services due to workforce shortages. There has been investment to support with the waiting list of ASD diagnosis. There are still staff shortages with Health Visitors, Occupational Therapists and Speech and Language therapists both locally and nationally. Staff continue to work collaboratively with families and settings to ensure equity of provision. [11] [12]

- The H&F 2021 SEND Tribunal Appeal Rate was 0.9% compared to 1.4% regionally and 1.8% nationally. [13]

- There are fewer than 10 children and young people with an EHC plan are young offenders, and fewer than 10 children and young people who receive SEN Support are young offenders. [5] [14] [15]

- 9.5% of children with an EHC Plan receive Social Care and 2.2% of children who receive SEN Support receive Social Care. [5] [14] [16]

- There are 60 H&F residents with Special Educational Needs and Disabilities (SEND) who are known to Adult Social Care. [5] [17]

Our population - Borough context

- Hammersmith and Fulham is one of the 13 inner London boroughs situated in the central western part of London. H&F's estimated population has seen a small **0.4%** increase over the past decade, from 182,493 in 2011 to **183,200** in March 2021; this is **4th lowest population** growth in London. [1] [2]

- H&F is the country's **6th most densely populated area** with a density of 11,168 people per square kilometre. In general, the borough's central and southern areas are more densely populated than the northern area, although densities vary greatly between individual wards. [1]

- The age profile of H&F continues to be typical of an **affluent urban population**; there are fewer people near the retirement age and a corresponding lower level of children than in London and England. H&F has seen a **23.5% decline in the under 5-year-old population** between the 2011 and 2021 Census. [1] [2]

- There are **more females (53.1%) than males** (46.9%) in the borough. The male population decreased by 3.4%, from 88,914 to 85,900 (-3,014 people) with a particular decrease in 25 – 44 age range. Whereas the female population grew by 3.9% (+3,621), with particular increases in the 50+ age range. [1]

- Deprivation is a known association with SEN. The majority of pupils attending schools in H&F live in deprived areas, with 60% of Pupils attending mainstream and academies in London Borough of Hammersmith and Fulham lives in areas that are in 0 – 30% **most deprived decile**. Pupils with SEN are more likely to live in more deprived areas, **68% of Pupils with an EHC plan lives in areas that are 0-30% most deprived compared to 65% of pupils receiving SEN Support and 59% pupils with no support or plan.** [3]

- **Pupils with an EHC plan are twice as likely to live in the most deprived area** compared to the least deprived area. This is a rate of 67 pupils with an EHC plan per 1,000 pupils in the most deprived area, almost double the rate of pupils living in the least deprived area, a rate of 34 pupil with an EHC plan per 1,000 pupils. [3]

Our population aged 0-25: Headlines

- There are 52,067 children and young people from birth to 25 in H&F. This accounts for 28% of the total population. [1]

Our population: Gender

- There are significantly more males than females with EHC Plan and SEN support in H&F (Figure 1), as is also seen across London and England ($p<0.05$).
- Of residents who have an EHC Plan, 73% (n=844) are male. This is the same as the national average of 73%. [5]
- Of residents who receive SEN support, 59% (n=1,321) are male. This is lower than the national average of 64%. [14]

Our population: Ethnicity

- The highest proportion of children with SEN are from a white ethnic group (35%). [5] [14] [15] [16] [17]
- There are proportionally more children with SEN from 'black, black British, Caribbean or African' ethnic groups and 'mixed or multiple' ethnic groups (Figure 2).
- There are proportionally fewer children with SEN from 'white' ethnic groups and 'other' ethnic groups (Figure 2).

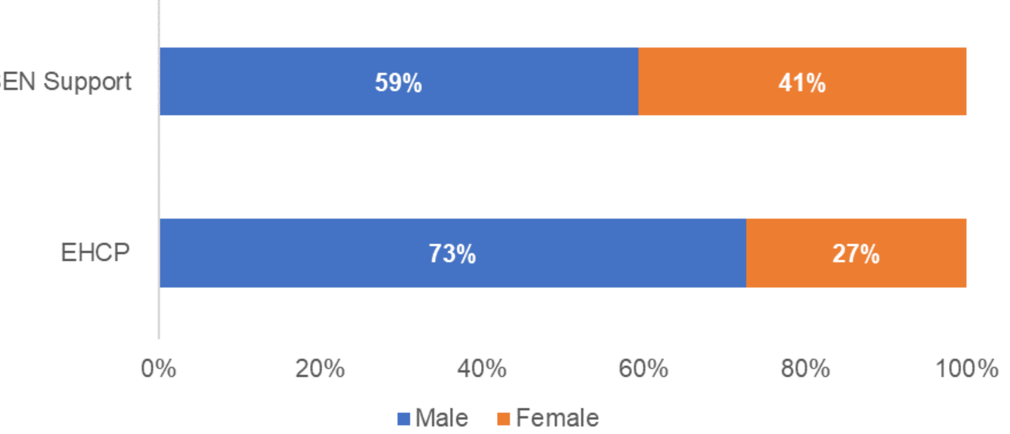


Figure 1: Gender of Children with Special Educational Needs. *Education, Health and Care Plans and Special Educational Needs Support by gender, in Hammersmith & Fulham 2022.*

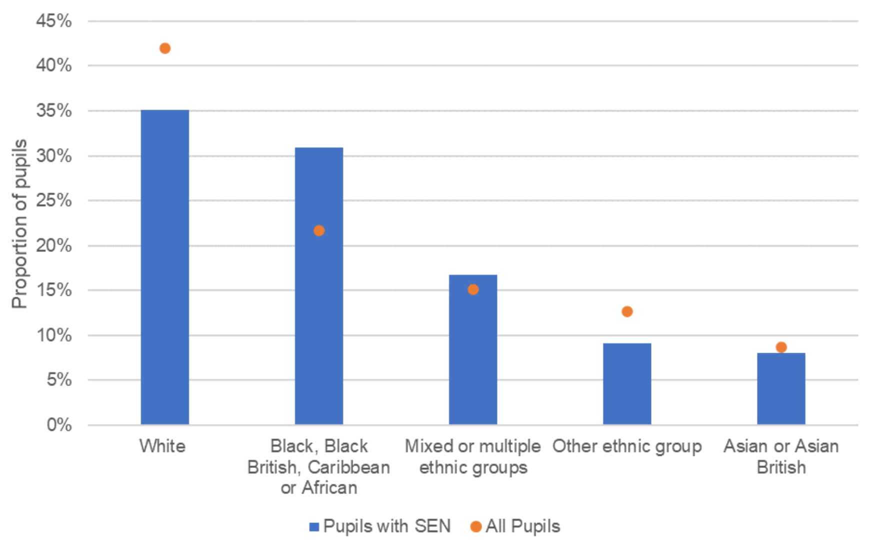


Figure 2: Ethnicity of Special Educational Needs Population. *The proportion of residents and pupils with Special Educational Needs by ethnicity, compared to the proportion of all pupils by ethnicity.*

Our population aged 0-25 - Health Needs

- There are 79,636 children and young people registered with a Hammersmith & Fulham GP.
- There are 12,144 children and young people (15%) in NHS North West London Integrated Care Board (NHS NWL ICB) Hammersmith & Fulham borough who have a diagnosis on their GP records that could be classified as SEN. [7]

Our population aged 0-25 Long Term Health Conditions

Poor health and wellbeing during childhood and adolescence can have a substantial impact on quality of life throughout the life course. It can also have a large impact on education, general health and wellbeing.

- In H&F, there are 57,875 residents under the age of 25 who are registered with a General Practitioner (GP).
- Of those who are registered, 10% (5,526) have one or more Long Term Health Condition. [11]
- Mental Health, Asthma, and Obesity are the three most common long term health conditions among residents aged under the age of 25 (Figure 3). [6]

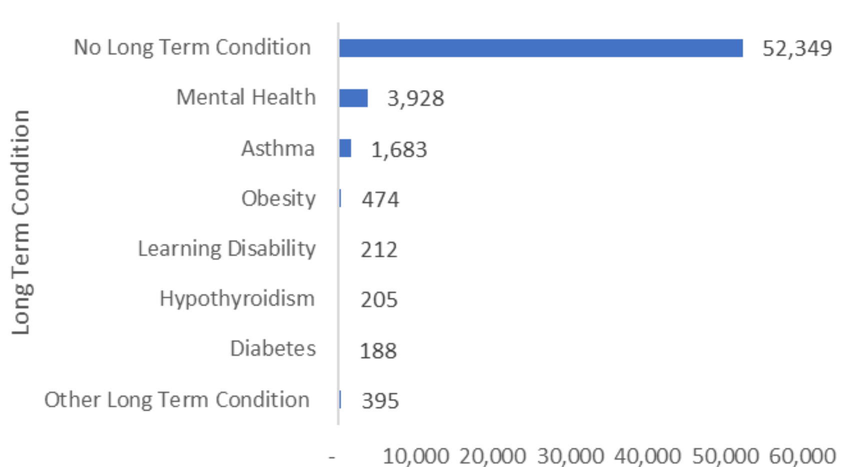


Figure 3: Long Term health Conditions among children and young people in Hammersmith & Fulham. The Number of Hammersmith & Fulham residents, registered with a GP, aged under 25 by Long Term Health Condition.

Deprivation is associated with an increased risk of poorer health and disability.

- In H&F, 27% (n=1286) of children and young people with Mental Health Conditions, Asthma and/or Obesity live in the 20% most deprived areas.
- In contrast, 2% (n=82) of children and young people with Mental Health Conditions, Asthma and/or Obesity live in the 20% least deprived areas.
- By ward, the highest proportion of children and young people with Mental Health Conditions, Asthma and/or Obesity live in Wormholt and White City (10%, n=2467), followed by Askew (9%, n=407).
- The lowest proportion children and young people with Mental Health Conditions, Asthma and/or Obesity live in Palace Riverside (3%, n=142). [6]

The SEND Landscape

- In 2021/22, there were 1,381 pupils who are EHC Plan holders in H&F. This is 5% of all pupils in H&F. This is higher than the national average of 4%. H&F has seen a consistent rising trend in EHCP numbers in recent years, broadly reflecting the national trend. [5]

- In 2021/22, there were 3,221 pupils receiving SEN support in H&F. This accounts for 12% of all pupils. This is the same proportion as the London average, but slightly lower than the national average of 13%. [4]

- Between 2015/16 and 2021/22, H&F has had a consistently higher proportion of pupils with an EHC Plan or Statement of SEN than London and England (Figure 4). H&F has a higher average percentage of pupils with an EHC Plan or Statement of SEN by 0.9 percentage points compared to London and 1.0 percentage points compared with England. [5]

- Overall, the proportion of pupils receiving SEN support has remained relatively stable between 2015/16 and 2021/22. In 2015/16 12.3% of all pupils in H&F received SEN support, and in 2021/22 11.9% of pupils received SEN support. [4]

- The proportion of pupils receiving SEN support in London and England has also remained stable between 2015/16 and 2021/22 and has remained at a similar proportion to the proportion in H&F (Figure 5) [4].

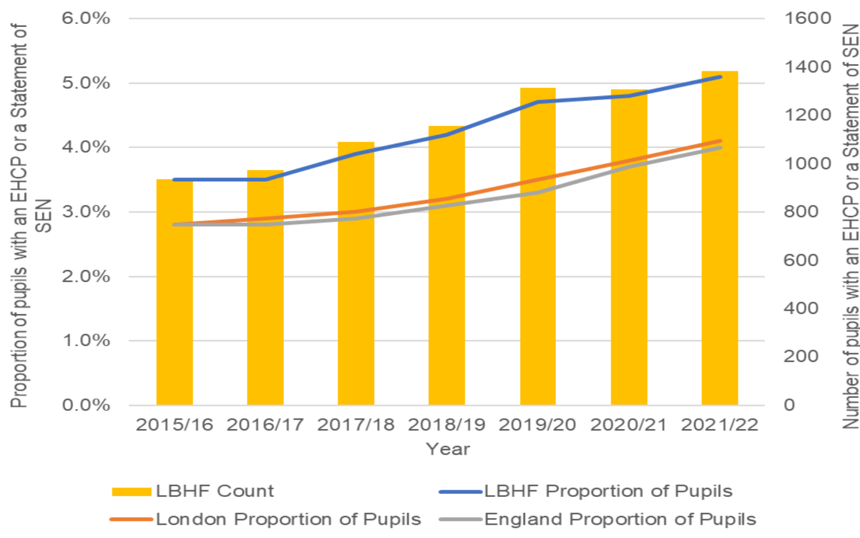


Figure 4: The number of pupils with an Education, Health and Care Plan (EHC Plan) or a Statement of Special Educational Needs (SEN) in Hammersmith & Fulham, and the proportion of pupils in Hammersmith & Fulham, London and England. *The data covers the years 2015/16 to 2021/22, and includes pupils in all schools including independent schools and general hospital schools.*

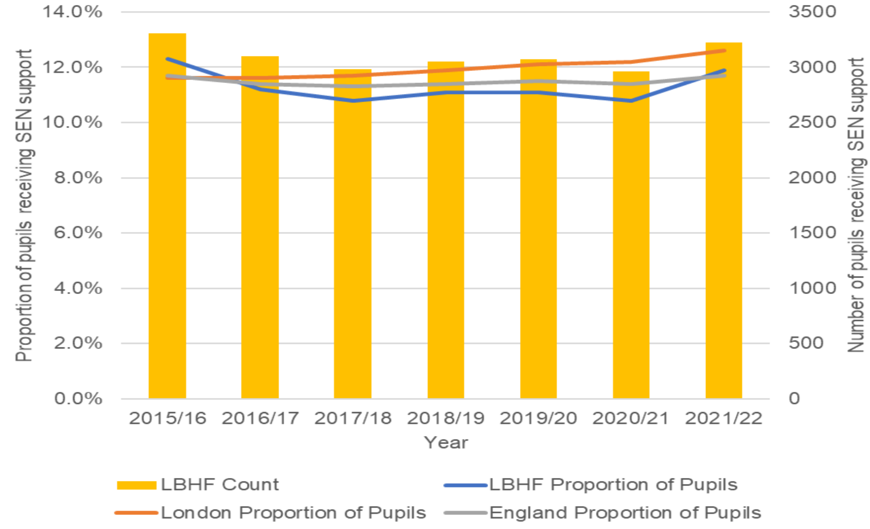


Figure 5: The number of pupils receiving Special Educational Need (SEN) support in Hammersmith & Fulham, and the proportion of pupils in Hammersmith & Fulham, London and England. *The data covers the years 2015/16 to 2021/22, and includes pupils in all schools including independent schools and general hospital schools.*

SEND and EHCP rates

Primary Needs

2220
children and young people receiving SEN Support [4]

- Speech, Language and Communication Needs: 34.6%
- Social, Emotional and Mental Health Needs: 17.5%
- Specific Learning Difficulty: 16.4%
- Moderate Learning Difficulty: 10%
- SEN Support but no specialist assessment of type of need: 6.4%
- Autism Spectrum Disorder: 5.7%
- Other Difficulty/ Disability: 4.7%
- Physical Disability: 2.0%
- Hearing Impairment: 1.4%
- Visual Impairment: 0.8%
- Severe Learning Difficulty: 0.4%
- Profound and Multiple Learning Difficulty: 0.1%

1511
children and young people with an Education, Health and Care Plan [5]

- Autism Spectrum Disorder: 44.6%
- Speech, Language and Communication Needs: 22.0%
- Social, Emotional and Mental Health Needs: 13.6%
- Moderate Learning Difficulty: 7.1%
- Physical Disability: 3.0%
- Specific Learning Difficulty: 2.9%
- Profound and Multiple Learning Difficulty: 2.0%
- Severe Learning Difficulty: 1.9%
- Hearing Impairment: 1.1%
- Visual Impairment: 0.9%
- Multi Sensory Impairment: 0.7%
- Other Difficulty/ Disability: 0.1%

The Local Authority have made substantial investment in creating Tier 2 SEN Support services with the intention to support school partners to meet a higher level of need particularly in relation to Speech, Language and Communication Needs and Autism.

Rates of SEND by Ward [3]

- The wards with the highest number of SEND can be found in the North of the Borough (Figure 6). 28% of pupils with SEN live in White City (279), College Park (200) and Wormholt (185). Wormholt and College Park both have the highest prevalence of SEND, both at 20%.

- The wards with the lowest number of SEND are in Parsons Green (44), Brook Green (51) and Fulham Town (55), this makes up 6% of where pupils with SEN reside in H&F. Brook Green has the lowest prevalence of SEND at 12%.

- A higher proportion of pupils with SEN live in more deprived areas, 68% of pupils with an EHC plan live in 0-30% most deprived areas compared to 65% of pupils receiving SEN Support and 59% of pupils with no support or plan.

- The rate of pupils with EHC plans living in the most deprived areas is 67 plans per 1,000 pupils, this is almost double the rate of pupils with EHC plans who lives in the least deprived area, 34 plans per 1,000 pupils.

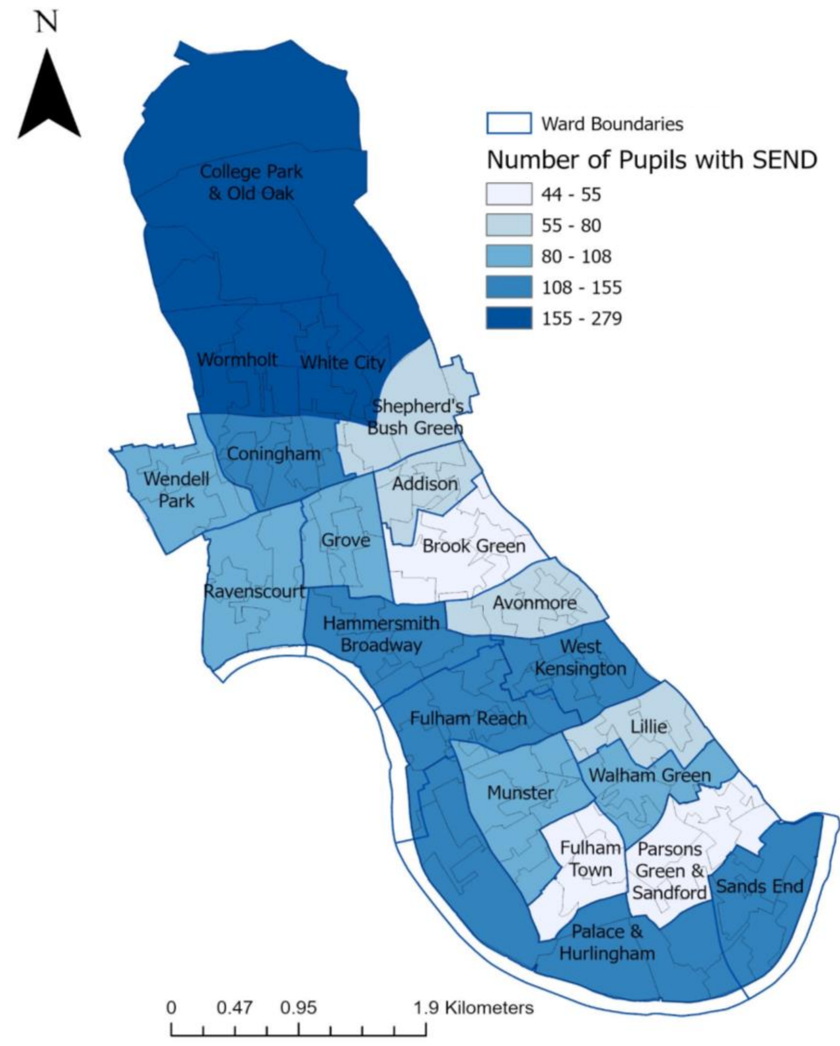


Figure 6. *The number of pupils with SEND by residence ward in London Borough of Hammersmith and Fulham.*

Rates of SEND by Placement Type [18]

- In making placement decisions, the local authority is required to give due regard to parental preference when naming a setting, as such this can result in placements outside of the local area and in some cases in the independent sector.

- Figure 7 shows where H&F resident pupils with EHCP's are educated in 2022 as a percentage of the total EHCP cohort compared with both the London region and England.

- At summer 2022, 280 resident H&F pupils with EHCPs (20%) were educated outside of the local area at a total cost of approximately £8.5million. This was compared to total in borough cost of approximately £6 million. Frequently these out of borough placements are expensive.

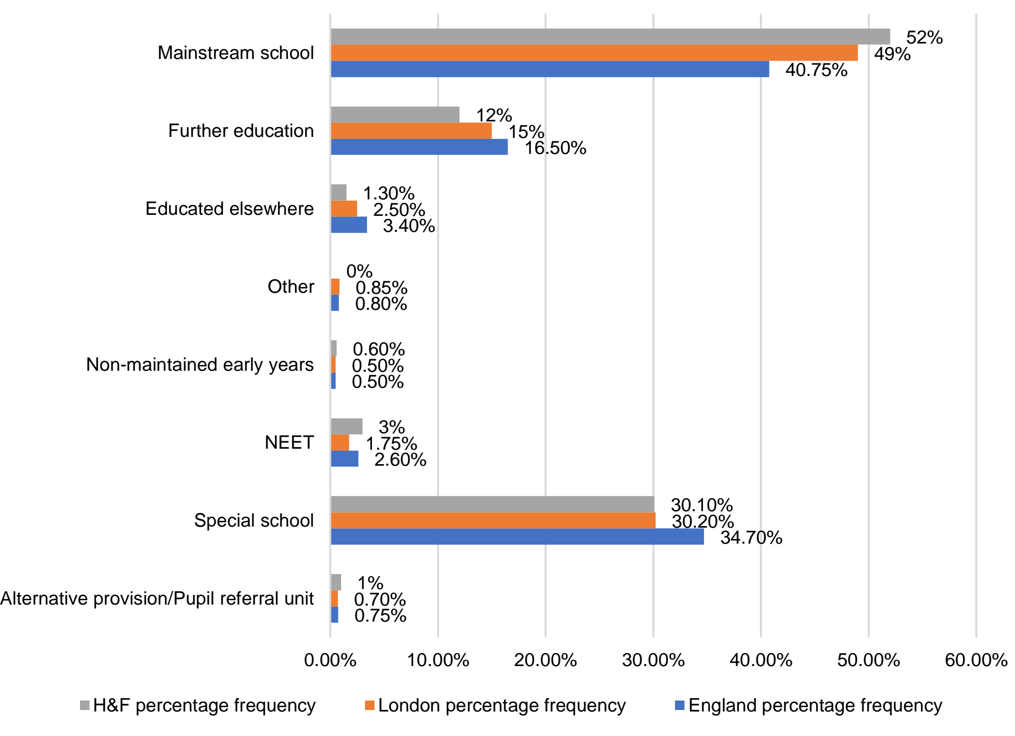


Figure 7. *The number of EHC plans by Establishment Type in London Borough of Hammersmith and Fulham, London and in England in 2022.*

Request for EHCP's

- 316 requests for an Education, Health and Care Needs Assessment (EHCNA) were received in H&F in 2022. [19]
- 30% of initial requests did not proceed to an assessment. This is a higher proportion than London average of 22% and England average of 22% (Figure 8). [19] [20]
- 209 EHCNA were assessed in 2022, of which 5% of assessment's outcome was not to issue an EHC Plan. This is higher than London average of 4% and lower than England average of 6%.
- The rate of EHC Plans issued within 20 weeks is 82.1% for both including and excluding exceptions in 2022. H&F's timeliness performance is better compared to London (64% excluding, 59% including) and England (60% excluding, 60% including). [19] [20]

Age range

- The highest number of children and young people with SEN are in Key Stage 2 (364) and Key Stage 3 (306) (Figure 9). [3]

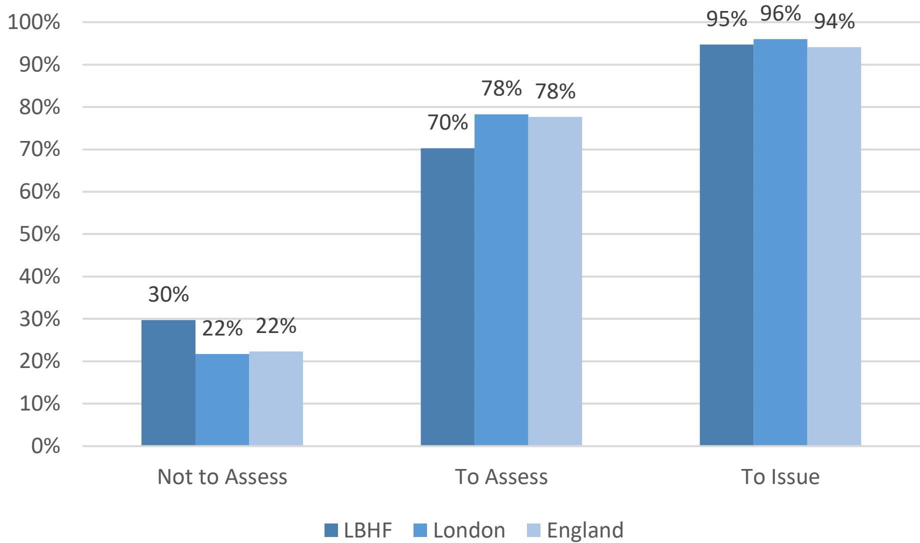


Figure 8: The proportion of initial assessment request in 2022 which outcome was not to assess and to assess and the proportion of assessments that took place in 2022 which outcome was not to issue and plan to issue in 2022 in H&F, London and England.

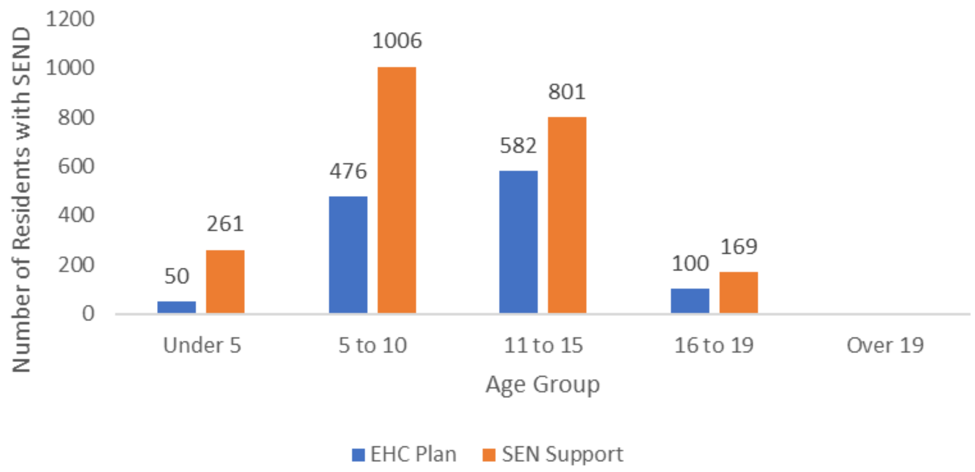


***Figure 9: Key Stage or Age Group of Children and Young People with Special Educational Needs.** Where the individual is no longer part of the educational system their age is shown.*

Alternative Provision (AP) [21]

- The number of pupils attending alternative provision in H&F has been increasing steadily, a trend shared similarly regionally and nationally (Figure 10).
- There are 132 pupils attending alternative provisions in 2023, majority of pupils are males (62.9%).
- 99.2% of pupils identified as having SEN. Autistic Spectrum Disorder is the most common primary need, 34.8% of pupils are diagnosed with ASD. This is followed by Social, Emotional and Mental Health at 19.7%.
- Pupils in alternative provision have a lower proportion of free school meal eligibility at 20.5% compared to the normal school population of 28.9%.

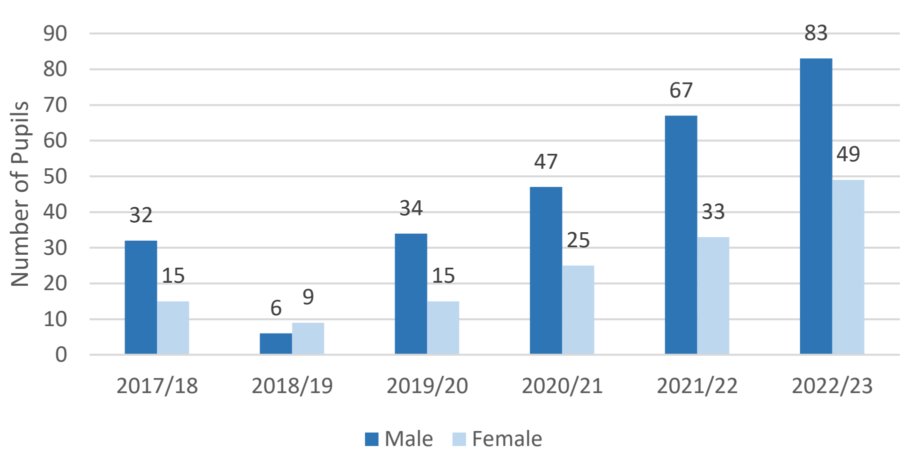


Figure 10. *The number of pupils attending alternative provision in London Borough of Hammersmith and Fulham from 2017 to 2022.*

Community Health Service headlines [22]

- Hammersmith & Fulham Local Area Partnership are committed to ensuring that children and young people have access to high quality support and are at the forefront of decision making. A range of universal, targeted and specialist health services are in place for children and young people with SEND. These services, as well as future plans, are outlined in the Hammersmith & Fulham Local Area SEND Self-Evaluation and included in the SEND Local Offer.

- The National Institute for Health and Care Excellence (NICE) guidelines state that an autism diagnosis should start within three months (~13 weeks) of the referral to the autism team. As of the fourth quarter of 2022/23, the average number of weeks from referral to diagnosis for under 5-year-olds was 91.3. A new one-appointment pathway was implemented for over 5-year-olds, with an average of 212 weeks from referral to diagnosis (Table 1). The Cheyne Child Development Service has received additional funding to outsource 400 assessments from February 2023, as well as an additional £1.6 million funding for Child Development Services (CDS) and Central London Community Healthcare (CLCH) to increase capacity. The impact of the additional funding will be monitored closely. In the meantime, support for children on the waiting list include therapy provision and pre-diagnostic workshops.

- H&F does not meet the target for the proportion of children and young people who receive occupational therapy within 12 weeks of referral (Table 1). In common with occupational therapy services across London and the country, CLCH have faced difficulties with recruitment and this has had an impact on the timeliness of assessments. A number of initiatives have been put in place to increase capacity

Community Health Service headlines continued [22]

- H&F does not meet the target for the proportion of children looked after who has their initial health checks on time (Table 1). Meetings have been put in place to address and improve the statutory timeliness of the health assessments. There will be two standardised Service Specifications across Northwest London for the Looked After Children Nursing Service and Medical Advisor roles, currently in draft and out for final consultation to ensure equity of service across Northwest London.

TABLE 1: PERFORMANCE INDICATORS FOR HEALTH WAITING TIMES FOR SEND SERVICES

PERFORMANCE INDICATOR		2022/23	TARGET
Autism Waiting Times	Under 5s: Average number of weeks to diagnosis	91.3	~ 13
	Under 5s: Number of children waiting	156	
	Over 5s: Average number of weeks to diagnosis	212	~13
	Over 5s: Number of children waiting	170	
Speech and Language Therapy	Proportion of children in treatment within 12 weeks of referral	95%	95%
	Proportion of children and young people who meet their goals	100%	90%
Occupational Therapy	Proportion of children in treatment within 12 weeks of referral	29%	95%
	Proportion of children and young people who meet their goals	100%	90%
CAMHS	Proportion of referrals to treatment under 18 weeks	81%	
	Eating Disorders referrals within 4 weeks	100%	85%
Physiotherapy	Weeks waiting time to assessment	6.8	6
Wheelchair Services	Proportion of children seen within 18 weeks referral to treatment	93% (2022/23)	
Children Looked After	Proportion of children looked after who had initial health checks on time	19%	100%

Health Notifications

In line with the SEND Code of Practice, where health services anticipate a child under school age has, or is likely to have SEND when they start school they are required to have a discussion with the parents and then make a notification to the local authority. This duty is Section 23 of the Children and Family Act 2014.

- Between July 2017 and December 2022, 89 early notifications were received by Hammersmith & Fulham SEND services.
- In 2022, 51 early notifications were received by Hammersmith & Fulham SEND services. [23]

Learning Disabilities and Autism

Children and young people who have a diagnosis of ASC and/or learning disabilities and who may be at risk of admission to mental health inpatient services or residential settings are included on the Dynamic Support Register (DSR), subject to consent. The multi-agency DSR panel explores opportunities for alternative care and treatment within the community to reduce inpatient activity unless it is in the young person's best interest.

CYP (under 18) on the Dynamic Support Register	March 22	March 23
Red	0	1
Amber	10	5
Green	9	3
Total	19	9

Admissions to Inpatient Mental Health Units (under 18)		
	2021/22	**2022/23**
ASC	1	1
Eating Disorder	5	1
Children's unit	1	0
Readmissions within year	0	1
Total patients admitted	**12**	**4**

- There were 148 young people aged 14-25 included on GP Learning Disability Registers at the end of March 2023. 75% received an annual health check in line with the national target. [24]

SEN Support
[5] [14] [16]

Children in Need (CIN)

30
children are on child in need plan accounting for 11% of all children on CIN

Child Protection (CP)

19
children are subject to a CP plan accounting for 13% of all children on CP

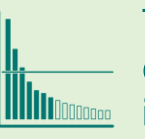
Cared for Children

21
children are looked after accounting for 9% of all children who are cared for in H&F

Cared experienced children

<10
less than 10 children are care leavers

64% of children are from ethnic minority backgrounds



The median age of children on SEN support is **8**

57% | **43%**

EHC Plans
[5] [14] [16]

Children in Need (CIN)

57
children are on child in need plan accounting for 21% of all children on CIN

Child Protection (CP)

15
children are subject to a CP plan accounting for 11% of all children on CP

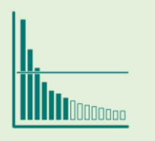
Cared for Children

39
children are looked after accounting for 17% of all children who are cared for in H&F

Cared experienced children

32
care experienced children accounting for 6% of all care leavers in H&F

68% of children are from ethnic minority backgrounds



The median age of children on EHC Plans is **12**

69% | **31%**

Note that assessments of pupils were not undertaken during 2020 and 2021 due to the pandemic. The following data is from 2022.

Early Years Foundation Stage

- Pupils with an EHC plan reached an average of 3.7 number of early learning goals at expected level, exceeding 2.8 in Inner London and 2.4 across England (Figure 11).
- Pupils at SEN Support reached an average of 9.1 early learning goals at expected level compared with 8.4 Inner London and 8.3 across England. [9]

Key Stage 1

- 49% of pupils with an EHC Plan met the expected standard of Phonic Decoding in Year 1 compared to London (25%) and England (17%).
- 56% of pupils with SEN Support met the expected standard of Phonic Decoding in Year 1 compared to London (53%) and England (41%). [10]

Key Stage 2

- 13% of H&F pupils with an EHC Plan met the expected standard in RWM. This is a higher proportion compared to London (9%) and England (7%) (Figure 12). 36% of H&F pupils receiving SEN Support met the expected standard in RWM. This is a higher proportion compared to London (31%) and England (21%).
- 82% of H&F pupils with no identified SEN met the expected standard in RWM. This is a higher proportion compared to London (76%) and England (69%). [10]

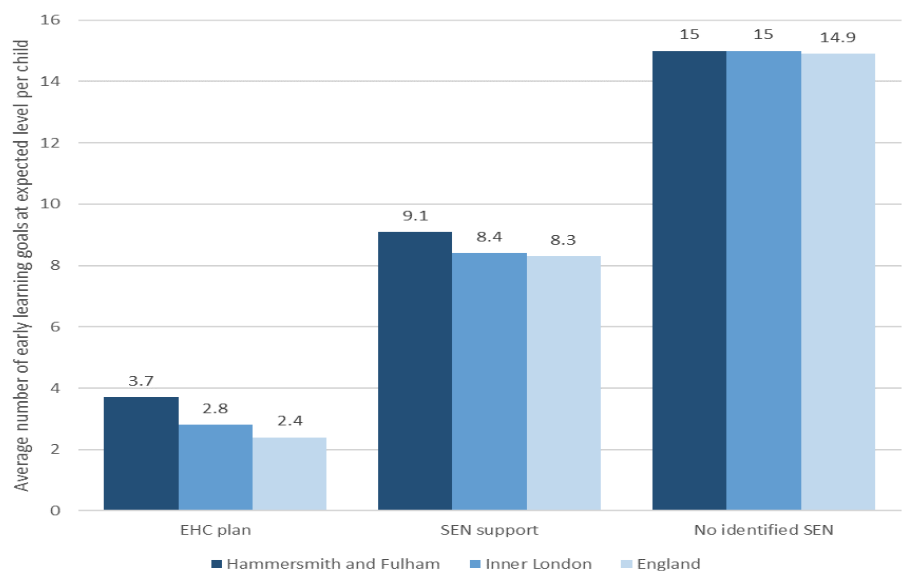


Figure 11: The average number of early learning goals at expected level per pupils at the Early Years Foundation Stage at the end of reception year based on 17 early learning goals in London Borough of Hammersmith and Fulham compared to Inner London and England.

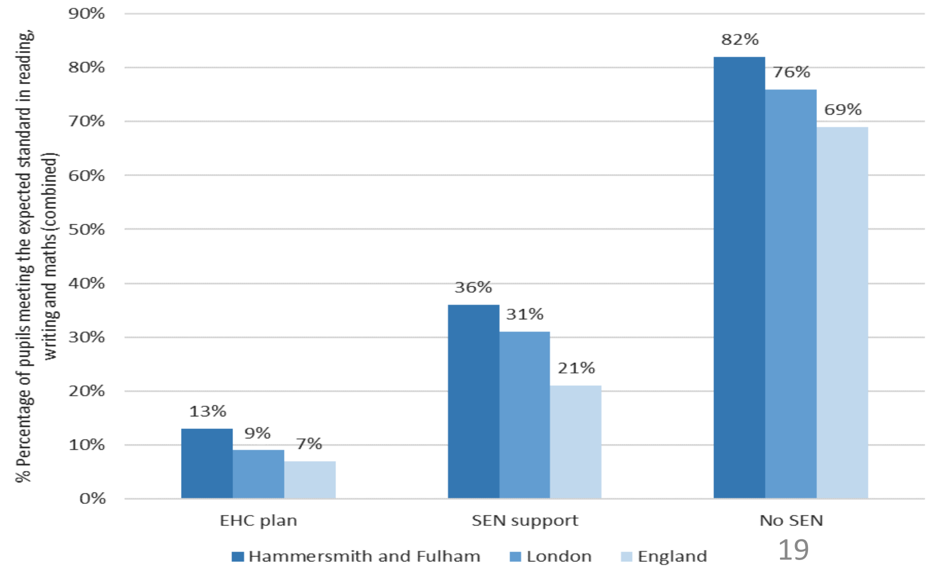


Figure 12: The percentage of pupils meeting the expected standard in reading, writing and maths at the end of key stage 2 for pupils in London Borough of Hammersmith and Fulham, London and England by SEN provision in 2022.

Key Stage 4 Progress Data [10]

- Pupils receiving SEN Support progress significantly better in H&F compared to London and England with a progress score of -0.11 compared to the England average of -0.47 (Figure 13). However, the progress 8 score of pupils with an EHC plan in H&F is lower than London's score (-1.07) but is similar to England's score (-1.33).
- Pupils with no identified SEND have a progress 8 score of 0.58 in H&F. This suggest pupils are expected to make better progress in H&F compared to London (0.37) and England (0.10).
- The average attainment 8 score per pupil with EHC Plan is 15. This is lower than London's average (17) but is similar to England's average (14) (Figure 28) (Figure 14).
- Pupils receiving SEN Support in H&F have a higher average attainment 8 score (46) compared to London (39) and England's average (35).
- Pupils with no identified SEN are expected to have a higher attainment 8 score in H&F (62) compared to London (57) and England (53).

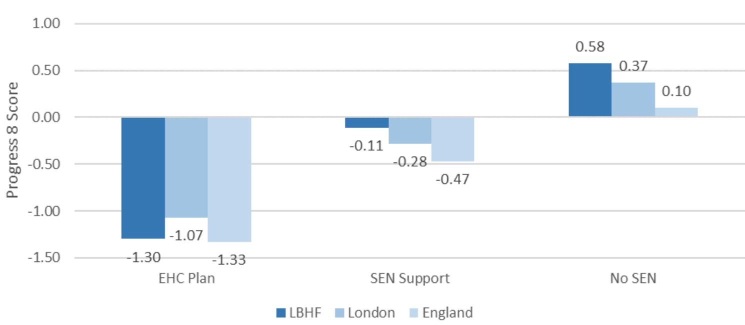


Figure 13: The Progress 8 score at the end of key stage 4 for pupils in London Borough of Hammersmith and Fulham, London and England by SEN provision in 2022. Progress 8 score is a relative measure that measures progress made by a student across 8 qualifications between 11 and 16 years old. A score of zero suggest pupils performed similarly to the national average of pupils starting at a similar level.

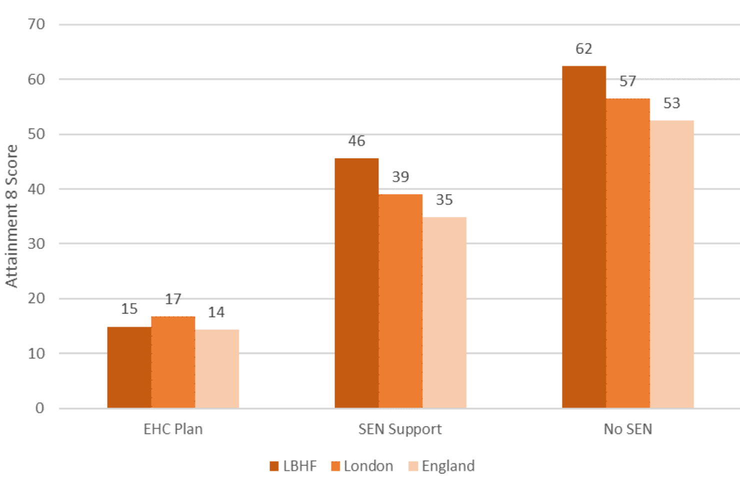


Figure 14: The average attainment 8 score of Pupils in London Borough of Hammersmith and Fulham, London, and England in 2022. Attainment 8 score measures the results of pupils at state-funded mainstream schools in England in 8 GCSE-level qualifications at the end of Key Stage 4.

Qualified to a Level 2 at age 19

- A higher proportion of pupils receiving SEN Support and have no identified SEN in H&F qualify to Level 2 at age 19 compared to London and England average (Figure 15).
- 76.2% of 19 year olds receiving SEN Support qualified to a level 2 in H&F. This is a higher proportion compared to London (72.6%) and England (63.0%).
- 90.9% of 19 year olds with no identified SEND qualified to a level 2 in H&F. This is a higher proportion compared to London (90.5%) and England (86.3%).
- 22.9% of 19 year olds with an EHC Plan qualified to a level 2 in H&F. This is a lower proportion compared to London (35.0%) and England (28.9%). [25]

Adults 18-65

- 71.7% of adults with a Learning Disability live in their own home or with their family compared to London (77.7%) and England (80.4%). [26]

Participation in education and training, ages 16 and 17

- The percentage of aged 16-17 residents participated in education and training is aligned with England average but lower than London average (Figure 16).
- 90.5% of 16-17 years old receiving SEN Support participated in education and training. This is lower than London (93.1%), but higher than England (86.9%).
- 93.9% of 16-17 years old with no identified SEND participated in education and training. This is lower than London (96.6%), but aligned with England (93.7%).
- 87.7% of 16-17 years old with an EHC plan participated in education and training. This is lower than London (93.9%) and slightly lower than England (88.7%).[27]

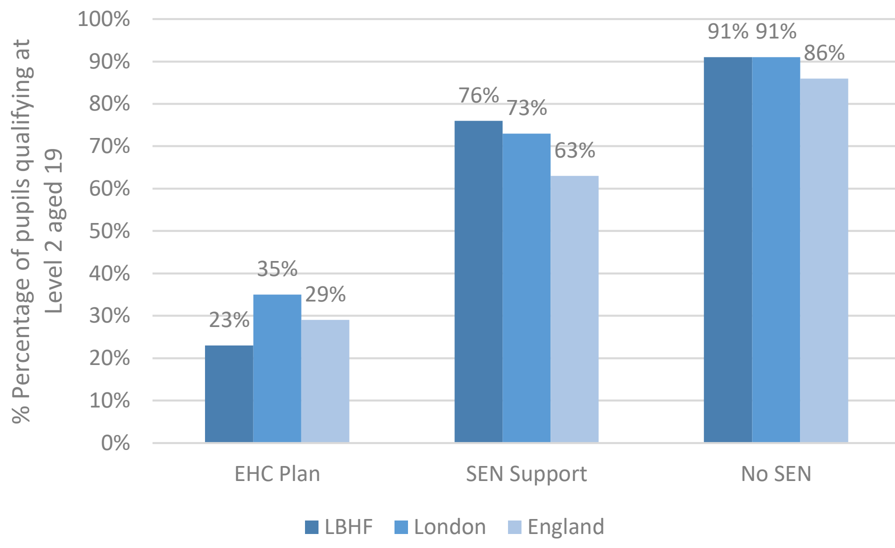


Figure 15 : The percentage of pupils qualified to level 2 at aged 19 in London Borough of Hammersmith and Fulham, London and England by SEN provision in 2021/2022 Academic Year. Level 2 attainment is 5 GCSEs 9-4 or equivalent.

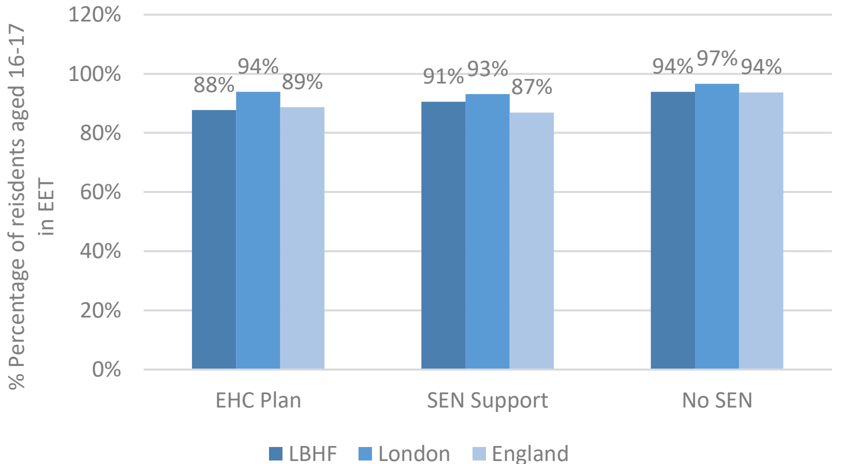


Figure 16: The percentage of residents aged 16-17 in Education, Employment or Training (EET) in London Borough of Hammersmith and Fulham, London and England by SEN provision in 2021/22 Academic Year.

Child poverty is both a cause and an effect of SEND and children and young people with SEND are more likely to have lower levels of educational outcomes. Pupils from ethnic minority backgrounds are disproportionately affected by poverty in H&F and are significantly more likely to be eligible for Free School Meals (FSM). Pupils with SEN are twice as likely to be eligible for free school meals compared to pupils with no SEN ($p<0.05$).

- The percentage of pupils with an EHC plan or statement and eligible for free school meals (FSM) has increased steadily in the last 7 years. This is an increase by 19% in Hammersmith and Fulham, an increase of 16% in London and 26% in England since 2015/16 (Figure 17).
- In 2022, 48% of Pupils with an EHC plan are eligible for FSM. This is a higher percentage of pupils eligible for FSM than the London average of 41% and the England's average of 40%.
- 54% of H&F pupils with an EHC plan are from black or black British background and eligible for FSM in 2022. This is 12 percentage points higher than the percentage of pupils with EHC plan also eligible for FSM from white backgrounds (Figure 19).
- In 2022, 40% of Pupils receiving SEN Support were eligible for FSM. This is a higher percentage of pupils eligible for FSM than London's and England's average of 36% (Figure 18).
- 54% of H&F pupils receiving SEN Support from mixed/dual background are eligible for FSM in 2022. This is 25 percentage points higher than the percentage of pupils with EHC plan also eligible for FSM from white backgrounds (Figure 19). [3]

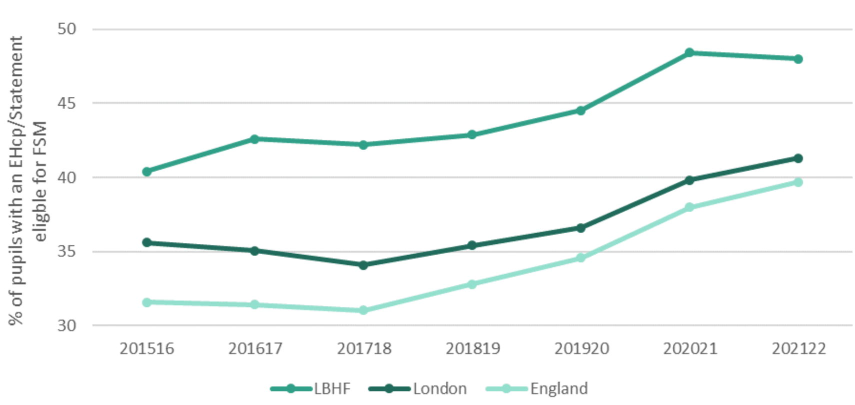


Figure 17: The percentage of pupils with an Education, Health and Care Plan or Statement and are eligible for free school meal in Hammersmith and Fulham, London, and England, from 2015/16 to 2021/22.

Figure 18: The percentage of pupils receiving SEN Support are eligible for free school meal in Hammersmith and Fulham, London, and England, from 2015/16 to 2021/22.

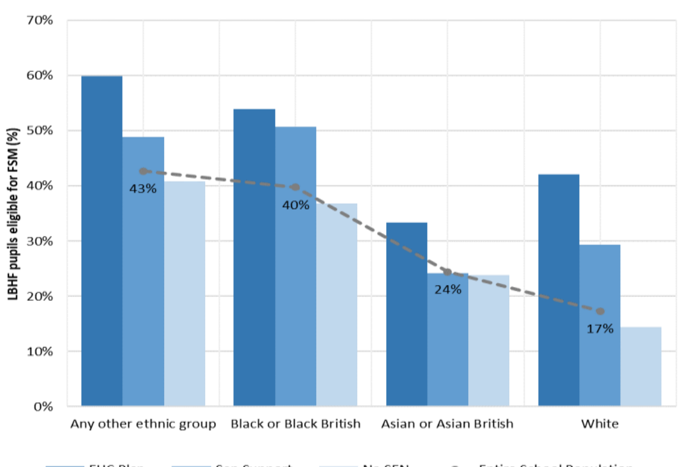


Figure 19: The percentage of pupils in the London Borough of Hammersmith and Fulham who are eligible for free school meals by SEN provision type and ethnicity in 2022.

A recent survey was conducted to understand the experience of parents/carers of Special Education Needs support services in Hammersmith and Fulham

- There were 133 responses to the SEND survey which determined views of parents/carers with a young person with SEND (Figure 20).
- The greatest proportion of young people (46%) were aged 12-16 years old followed by 17-25 years old at 43%. [11] [12]

Parent/Carer Views on Educational Support at School

- Over 75% of parent/carers feel confident discussing their child's/young person's needs and the support available with their school or setting (Figure 21).
- 57% of parents agree or strongly agree that they are familiar with how their child's needs are assessed.
- 60% of parents/carers feel that their child's education setting appropriately supports their SEND.
- 55% of parent/carers feel they have been involved in planning services. [11] [12]

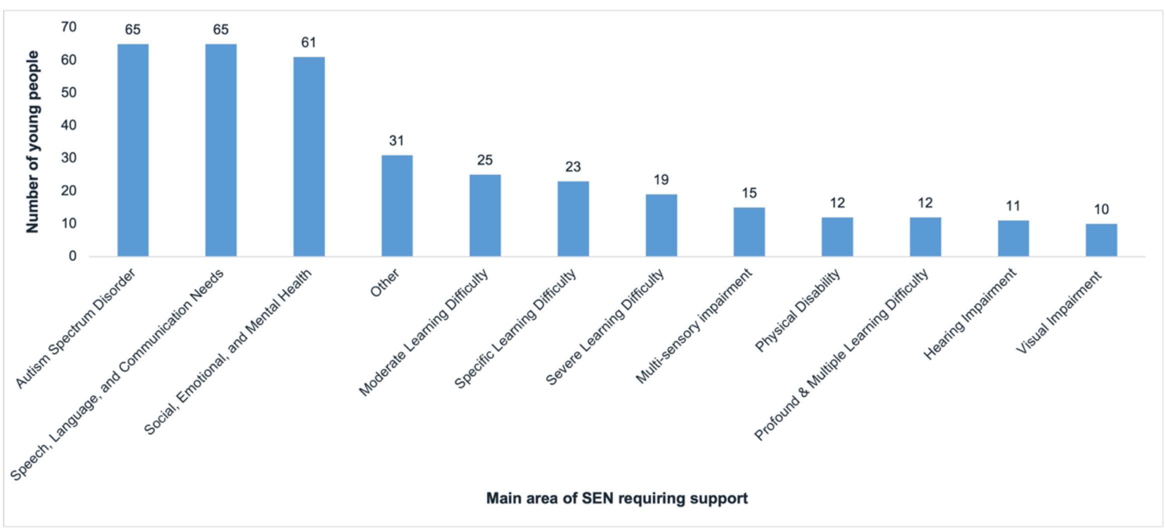


Figure 20: The total number of young people across both the SEND survey and SEND support questionnaire and their main area of SEN requiring support.

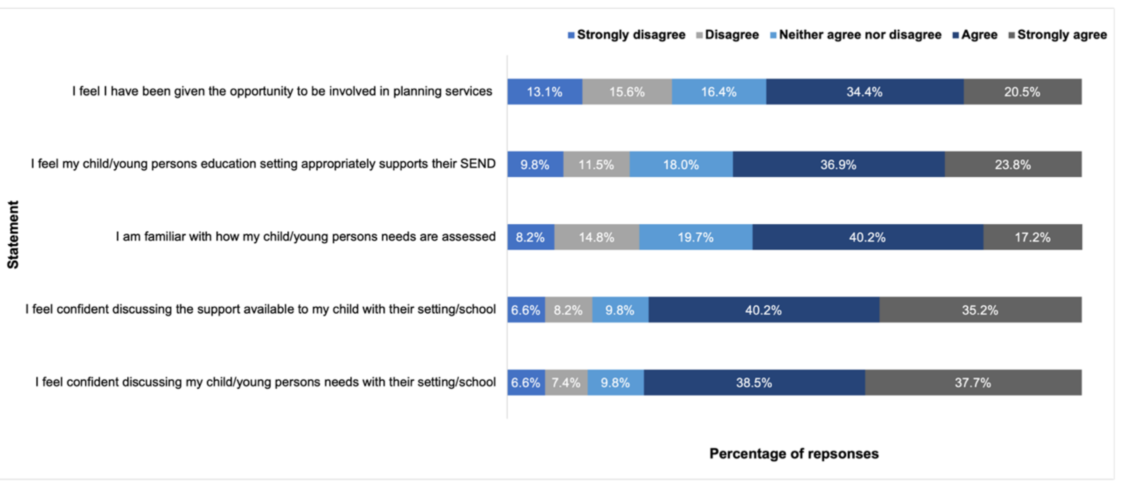


Figure 21: The percentage of parents/carers who responded accordingly regarding statements from the SEND survey about SEN support at school.

EHC Plans

- 75% of parents feel their views were taken into account during the EHC Assessment/annual review process.
- 61% of parents/carers feel their child's views were taken into account during EHC Assessment/annual review process.
- 62% feel their child is making progress towards their outcomes.
- 48% feel the outcomes could be more ambitious for their child/young person.
- 58% agree that their child's EHCP reflects their views, interests, and aspirations. [11] [12]

Parent/Carer Support Groups and Forums

- 72% of parents/carers were unaware of ParentsActive, the H&F Parent/Carer Forum.
- Parents/Carers referred to other various groups they belong to, including We are Family (WAF), Full of Life, Adopt London-South, Make it Happen, and school-created groups. They also mentioned participating in fetal alcohol syndrome disorder (FASD) online support groups, mental health groups, adopters groups, and child development centre groups.
- A local offer is a source of information for children and young people with SEND and their families, to help them find the right support and opportunities in their area. Most parents/carers (71%) had not heard of the Local Offer. 21% had heard of the Local Offer but never used it. Only 8% had heard of the Local offer and used its service. [11] [12]

SEND Tribunals [13]

- The 2021 SEND Tribunal appeal rate was 0.9%, compared to 1.4% regionally and 1.8% nationally. The 0.9% represents 11 appeals registered out of 1251 appealable decisions.
- The provisional appeal rate for 2022 is 1.4% with more appeals registered, measured against a larger cohort. Factors in limiting the number of cases where a Tribunal appeal is registered, or which progress to a Tribunal include:
  - The offer of Next Step meetings to families to discuss the outcome of EHCNAs and EHCP Annual Reviews. This informal dispute resolution process allows supports a shared understanding of the evidence that supported the LA decision, the views of parents/carers and agreement on the use of the ordinarily available provision to meet presenting needs, resulting in a reduction in the escalation to the formal dispute resolution process – mediation and SEND Tribunals.
  - the contribution of the Mediation Service from Kids,
  - the continued dialogue between the EHC Casework Service and families which resulted in 12 cases being resolved without a hearing.
- In 3 cases the Tribunal noted parties maintained a dialogue about the issues in the appeal up to the date of the hearing resulting in fewer issues remaining for the Tribunal to determine. One comment noted that the Tribunal "were pleased that the parties had constructively worked together in child's best interests".
- Whilst the local authority can resolve most issues relating to identification of the child's needs and the provision to meet need in advance of the tribunal (sections B&F), issues relating to the named placement or type of placement are more challenging to resolve. In 5 cases the Tribunal raised concerns about the lack of detailed, incomplete, or insufficient evidence submitted by the local authority. Our focus remains on improving the quality of EHCPs, learning from our SEND QA programme.
- 26 appeals were registered to the First Tier Tribunal in 2022. Of these:
  - 8 appeals proceeded to a First Tier Tribunal hearing
  - 12 appeals were resolved without a hearing
  - 6 appeals registered in 2022 are not yet finalised and will complete in 2023
  - 1 appeal, submitted to the Upper Tier Tribunal in 2022, was an appeal against a Tribunal decision in 2021, and was dismissed.
- Themes included requests for specialist input, increases in packages of support, specificity of named provision and requests for EHCP's.
- The outcomes of the 8 cases that progressed to a Tribunal hearing were:

Outcome	Allowed	Agreed in part	Dismissed
Number of cases	3	4	1

Local Authority - Complaints and Ombudsman [28]

- The service actively uses complaints, tribunals, mediations and next steps meetings to drive service improvements and strives for first point of contact resolution.
- The general themes of stage 1 and stage 2 complaints are parental concerns on EHC Casework and provision, this includes poor communication from caseworkers, delay in decision-making on EHCNA and EHCP annual reviews, missed SaLT assessment and occupational therapy provision leading to compensation.
- During Q1-Q3 of the 2022/23 financial year, 14 Stage 1 complaints were completed in relation to SEND. During the same period 7 Stage 2 complaints were completed.
- In the 2022/23 financial year 21 compliments were received in relation to SEND. Themes include excellent communication, robust EHC planning which has positively impacted the child / young person and the positive impact of the SEND leadership team.

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Hammersmith & Fulham Local Area **Special Educational Needs and Disability (SEND) Strategy**

2023-2028

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Acronyms used in this document

Acronym	Stands for
AP	Alternative Provision
AR	Annual Review
CSDPA	Chronically Sick and Disabled Persons Act 1970
CYP	Children and Young People
DfE	Department for Education
EHCNA	Education, Health and Care Needs Assessment
EHCP	Education, Health and Care Plan
EWMH	Emotional Wellbeing and Mental Health
FE	Further Education

Acronym	Stands for
H&F	Hammersmith & Fulham Council
ICB	Integrated Care Board
JSNA	Joint Strategic Needs Assessment
Ofsted	Office for Standards in Education
PFA	Preparation For Adulthood
SEMH	Social, Emotional and Mental Health
SEN	Special Educational Needs
SENDIASS	Special Educational Needs and Disabilities Information Advice and Support Services
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound

Introduction

Our Hammersmith & Fulham SEND Strategy 2023-2028 sets out our local area vision and priorities for supporting children and young people with special educational needs and disabilities (SEND) and their families, and how we will work together to deliver these over the next five years.

This strategy, co-produced with children and their families, involves all partner agencies in Hammersmith & Fulham who have responsibilities for commissioning and providing services for children and young people with SEND including local authority services, education settings, health providers and the voluntary and community sector.

The strategy applies to all children and young people with SEND aged 0 to 25 who have an Education, Health and Care Plan or receive SEND Support. It is set within the challenging context outlined in the Department for Education's (DfE) SEND Green Paper: Right Support; Right Place; Right Time, published in March 2022 following a national SEND Review. We are committed to supporting all our children and young people to have the best possible outcomes so that they go on to have fulfilling lives, living healthily and as independently as possible.

This strategy will sit alongside our Early Intervention Strategy and SEND Sufficiency Strategy and will align with other strategies as they are refreshed and developed including our Joint Commissioning, Co-production, and Autism strategies.

Vision

Children and young people lead happy, healthy, and fulfilling lives and achieve their life goals.

Shared principles

Underpinning our vision is a set of jointly agreed principles. We want Hammersmith & Fulham to be a place where all children and young people with SEND and their families:

- Feel welcomed, included and valued.
- Have a voice, are listened to, have choice and control and are equal partners in decision-making about their own lives.
- Have their needs identified early and accurately, with effective support put in place quickly.
- Benefit from joined up support from staff who have the right knowledge and skills.
- Have access to high-quality education locally.
- Are clear about what they can ordinarily expect from their local services and education setting.
- Have high aspirations for their future with a clear focus on life outcomes across education, health and care.
- Have access to the right information at the right time.

Co-production

Our vision for co-production is that it becomes the way of working in our local area, transforms culture and practice and delivers positive life outcomes.

We've used an active and flexible approach to co-production in the development of this strategy informed and shaped by residents to reflect the diversity of our local population.

We reached out to children, young people and their families in a number of different ways as shown below.

An overview of this is provided on page 11 in Appendix A: Local area co-production framework

Rethink Champions

Parent Reference Groups

Parent/Carer voice

You said, we will

Youth Voice

Resident-led

Hundreds of conversations

Coffee mornings

Surgeries

Parentsactive

SENDIASS

Youth Council

Surveys

Annual Reviews

Peer researchers

Youth-led

Hammersmith & Fulham context

Supporting children with SEND in H&F

4 maintained nurseries

36 primary schools

11 secondary schools

1 dedicated Sixth Form and 1 FE College

4 special schools

2 resourced provisions

Stephen Wiltshire Centre

1 Commissioned AP provider

Snapshot of children and young people with an EHCP open to Children's Social Care

39 are children looked after

15 have a child protection plan

57 have a child in need plan

32 are care leavers

(Additional children receive support under CSDPA legislation)

60 young people are supported by Adult Social Care

Health providers

NHS North West London

Central London Community Healthcare

Chelsea and Westminster Hospital

Imperial NHS Trust

West London Mental Health NHS Trust

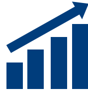
28 GP practices

Snapshot of children and young people with EHCPs

1,511 children and young people with an EHCP resident in H&F

This is 3% of the residents aged 0-25 in H&F

(Snapshot 30 September 2022)



Percentage of pupils with an EHCP increase

The percentage of pupils in H&F with an EHCP increased from 3.5% in 2015/16 to 5.1% in 2021/22

This is higher than London and national averages

EHCP placements in mainstream provision

52% children and young people with an EHCP are placed in mainstream provision

Compared with national average of 40.8%

(DfE SEN2 2022)

Primary needs

Two-thirds of EHCPs in H&F identify Autistic Spectrum Condition and Speech, Language and Communication Needs as the primary need

There is a rising trend in the identification of Social, Emotional and Mental Health (SEMH) as a primary need

Snapshot of children and young people receiving SEN Support

2,195 children and young people with SEN Support in H&F schools – 10.8% of the school population

1,625 (74%) are H&F residents

(DfE Autumn School Census 2022)

Schools

100% of schools rated good or outstanding by Ofsted

West London College rated good

Data correct Autumn 2022

Impact of Covid pandemic

Whilst there was a strong partnership response to the Covid-19 pandemic locally, the impact on children and young people with SEND is continuing to emerge. We know from national research, *Ofsted – SEND: old issues, new issues, next steps June 2021*, that the lost months of education, the narrowing of access to services and community resources, and the financial and emotional impact on families has had a disproportionate impact on disabled children and those with SEN and their families. Local feedback resonates with this and is informing our priorities.

Key priorities

We have identified the following key priorities:

- Robust identification, assessment and early intervention of children and young people's needs.
- Development of sufficient inclusive and effective local provision.
- Successful preparation for adulthood including person-centred pathways through education, health, and care.

Underpinning these priorities is our commitment to:

- Strengthening our outcomes-focussed quality assurance framework.
- Continuing to embed co-production as our way of working.
- A system wide approach at all levels in which SEND is everyone's business.
- Multi-agency workforce development.

Priority 1 – Robust identification, assessment, and early intervention

What we plan to do:

- Strengthen and embed the universal and targeted offer through evidence-based interventions and use of the graduated approach to SEND.
- Develop an early intervention approach to meeting Speech Language and Communication Needs including the expansion and embedding of the Joint Communication Team.
- Pioneer inclusive technology to support independence as young people grow up.
- Develop a whole system approach to support early identification pre diagnosis for those awaiting a formal assessment of Social Communication Difficulties.
- Ensure that Education, Health and Care Needs Assessments are undertaken within statutory timescales and that EHCPs are of a consistent quality and standard.
- Increase the uptake of 2.5-year-old Healthy Child programme development checks.

How will we know we are making progress?

- Improved educational outcomes for children with an EHCP or SEN support.
- Increased uptake in 2.5-year-old checks with Health Visitors.
- The number of children achieving a good level of development on the foundation stage profile increases in line or above the national average.
- Improved waiting times for assessment.
- Schools are confident about meeting children's SEND when they arrive in school reception classes and use the graduated approach to SEN well.
- SEN Early Years Inclusion Funding (SENIF) is used effectively to address emerging needs for children in Private, Voluntary and Independent Early Years Providers.

Priority 2 – Development of sufficient inclusive and effective local provision

What we plan to do:

- Deliver a single strategy and plan for SEN Sufficiency that is inclusive of outreach provision and Alternative Provision arrangements.
- Development of provision to meet Social Emotional and Mental Health Needs in the local school system.
- Develop and implement an Inclusion Charter.
- Support our school network to ensure they have the right skills to identify needs quickly and put in place appropriate provision at SEN support.
- Co-produce refreshed annual review guidance, including toolkit, ensuring children are at the centre of what we do.
- Support and empower our children and young people to be co-producers, so they can actively participate to ensure outcomes are wide ranging and across a broad range of cultural pursuits.

How will we know we are making progress?

- More staff will have accessed training to develop the right skills to identify needs quickly and put in place appropriate provision at SEN support.
- More children placed in local schools.
- The number of suspensions of young people on SEN support in secondary schools decreases.
- The number and timeliness of children reintegrated into mainstream school from Alternative Provision will improve.
- Parents will have more confidence in mainstream schools' capacity to meet needs and include children successfully.
- Increased confidence of settings to effectively support positive outcomes for children and young people with SEND.

Priority 3 – Successful preparation for adulthood (PFA)

What we plan to do:

- Strengthen the young person's voice in their own transition planning.
- Implement the new 16-25 young people's mental health service.
- Expand inclusive employment locally.
- Develop a local area protocol and approach for managing transitions with the care plan at the core of provision and pathway planning.
- Develop robust processes for joint planning current and future cohorts to inform commissioning intentions and appropriate individual pathways.
- Produce a local area PFA pathways document for professionals, parents and young people to ensure routes are clear and defined across Education, Health and Care.
- Develop a local area PFA toolkit to support a shared understanding of pathways and agency/collective responsibilities in delivering robust PFA outcomes for children and young people.
- Review of unit costs and approach to funding post 16 places jointly with Commissioning Alliance partners.

How will we know we are making progress?

- Pathways for children and young people with SEND will be clear and show the different options and access arrangements. Children, young people and their families will experience greater choice and control over decisions and their journey will be in line with their aspirations.
- Young people will have been actively involved in their holistic plans.
- With greater parental confidence in mainstream schools, more children transfer to mainstream secondary and further education colleges.

- Careers information, advice and guidance is inclusive, positive about aspirations and leads more young people with SEND into jobs they want to do, with more young people taking up supported internships and/or moving into paid employment when they are work ready.
- More young people with SEND living and travelling independently with opportunities to join in local community activities.

Measuring success

As part of this five-year strategy, we have identified performance areas against each priority for which SMART targets will be set and reviewed at least annually. We are co-producing our SEND Outcomes Framework with key stakeholders.

SEND systems can be complex and make it difficult to see whether the changes in the system are making a difference for children and young people. We will be using a range of information including audit, data and stakeholder feedback to tell us how well we are performing, what's working well and where we need to act to achieve change.

We will refine our baseline data which is made up of information from: our Joint Strategic Needs Assessment, our local area SEND self-evaluation (SEF); stakeholder feedback; co-production activities; relevant H&F datasets; and regional and national benchmarking and work is underway across the partnership to build on our existing datasets and develop a set of agreed success measures for our SEND Data Dashboard.

Governance

The Children's Education, Health, and Social Care Partnership Board spans the range of local area partners involved in working with children and young people. It is chaired by the Strategic Director for Children's Services and the Borough Director for H&F in the NHS North West London Integrated Care Board. The Partnership Board holds the local area to account on the progress of actions and priorities in this strategy.

Following creation of the Children's Education, Health and Social Care Partnership Board, the SEND Delivery Group will provide oversight of the SEND Strategy and Self Evaluation and subsequent programmes of work; responsible for monitoring the roadmap for SEND for children and young people (0-25).

SEND governance structure

Health and Wellbeing Board

H&F Health and Care Partnership

Frailty Campaign

Diabetes Campaign

Mental Health Campaign

Health and Wellbeing Campaign

Children's Education, Health and Social Care Partnership Board

High Needs Block Performance Board

SEND Delivery Group

Early Intervention and Support Group

CYP Mental Health subgroup

CYP EWMH Partnership Group

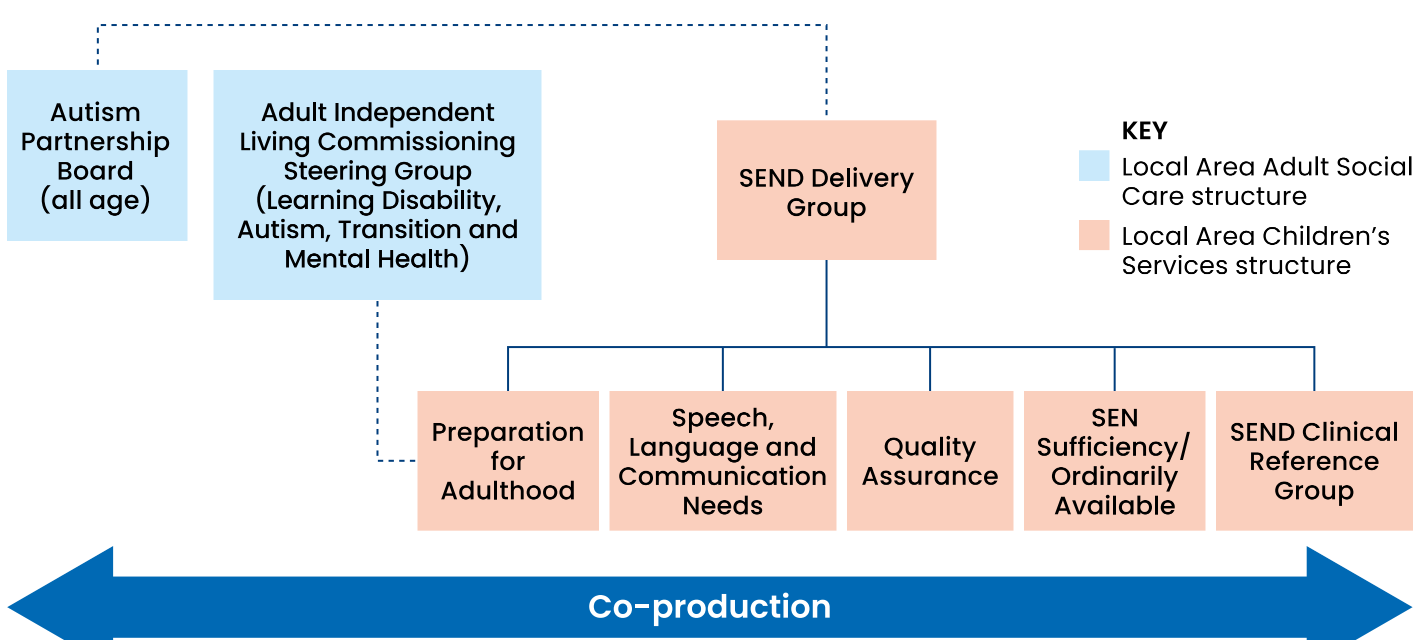
SEMH Steering Group

KEY

Local Area Corporate structures

Local Area Children's Services structure

SEND Delivery Group governance structure



Appendix A: **Local area co-production framework**

Our vision for co-production is that it becomes our way of doing things with residents not to them, that it transforms culture and practice and delivers positive life outcomes

Our shared approach

- We value the voices and lived experiences of our young residents, parents and carers to shape a happier, healthier, and safer borough.
- Young people as influencers, co-producers and agents of change.
- Decisions about children and young people are made together.
- Diversification of approaches so that voices fully reflect our local population.
- Person-centred and inclusive.
- Challenge exclusion and remove barriers.
- Building positive relationships.
- Use co-designed success measures to track progress.
- Honest about quality, value and what's possible.

How we are doing it

- Joint calendar of events and roadshows, reference groups.
- Youth Voice Network & Youth Council, actively participating in 'local offer'.
- Parent-led focus groups alongside multi-agency professionals.
- Surgeries to understand and respond to individual issues.
- Joint Training sessions.
- Digital tools to capture different voices.
- Parent Carer representatives on executive boards & forums.
- Log of issues & regular catching up sessions to co-produce solutions.
- Peer researchers & young champions driving mental health co-production work.

What this means for stakeholders

Children and Young People

- Feel welcome, safe, happy and learning.
- A feeling of independence and control.
- Feeling welcome and valued.
- Being fully involved in planning and decisions that affect me so I know what you're doing and why.
- Feeling safe to talk about my own life goals and what I need to achieve them.
- Activities designed around what I want and not someone else's idea of what I need.

Parents and carers

- My voice and my child's voice are valued and things are done with me.
- Feel supported by professionals and have a peer support network.
- I can become/understand how I can be an 'ally' for my child and support their life plans.

Professionals

- Value children and young people with SEND and their families.
- See young people, children and families as assets and welcome them as equal partners.
- Work with children and young people with SEND to co-produce SEN support and EHCPs built on individual strengths, capabilities and life plans.
- Are prepared to compromise, to change culture and practice.

Appendix B: **Glossary**

Additional Needs
Additional needs describes a group of children or young people who require additional support to help them make improved progress or catch up, which may be a short-term intervention or a longer-term strategy.

Alternative Provision (AP)
Education in a setting that is not a mainstream or special school. The education should be based on the needs of the child and can be provided through a variety of routes, including pupil referral units (PRUs).

Annual Review (AR)
An annual meeting, or every 6 months for under 5s, to review the Education Health and Care Plan. At this meeting parents/carers, the child/young person and professionals review the needs of the child/young person and what support they require. After this meeting, the LA then decides whether an EHCP it is still needed and whether any changes should be made to the Plan.

Co-production
Co-production is a collaborative approach to decision-making and service design that recognises for organisations to deliver successful services, they must understand the needs of their users and engage them closely in the design and delivery of those services.

CSDPA
Chronically Sick and Disabled Persons Act 1970. An Act to make further provision with respect to the welfare of chronically sick and disabled persons; and for connected purposes.

DfE
Department for Education. The Department for Education is responsible for children's services and education, including early years, schools, higher and further education policy, apprenticeships and wider skills in England.

Education, Health and Care Needs Assessment (EHCNA)
A process of assessment referred to as an education, health and care needs assessment carried out by the Local Authority for a child or young person 0-25. An EHC needs assessment is a detailed look at a child's special educational needs (SEN) and the support her or she may need in order to learn.

Education, Health and Care Plan (EHCP)
An EHCP details the education, health and social care support that is to be provided to a child or young person who has SEN or a disability. It is drawn up by the local authority after an EHC needs assessment of the child or young person has determined that an EHCP is necessary, and after consultation with relevant partner agencies.

EWMH
Emotional Wellbeing and Mental Health – this is a partnership group within the SEND Governance landscape.

FE
Further education includes any study after secondary education that's not part of higher education (that is, not taken as part of an undergraduate or graduate degree).

Graduated Approach
The SEND Code of Practice says that schools should follow a graduated approach when providing SEN Support. This is based on a cycle of: Assess, Plan, Do, Review.

H&F
Hammersmith & Fulham Council, the local authority.

ICB
Integrated Care Board – the local NHS organisation responsible for the planning and delivery of services to meet the health needs of the population.

Glossary continued

Joint Strategic Needs Assessment (JSNA)
Joint strategic needs assessments analyse the health needs of populations to inform and guide commissioning of health, wellbeing, and social care services within local authority areas. The JSNA provides an evidence base for health and wellbeing boards to decide on key local health priorities.

Ofsted
Ofsted is the Office for Standards in Education, Children's Services and Skills. Ofsted inspect services providing education and skills for learners of all ages.

Outcome
An outcome can be defined as the benefit or difference made to an individual as a result of an intervention. It should be specific, measurable, achievable, realistic and time bound (SMART).

PFA
Preparation for Adulthood – The term "Preparing for Adulthood" is used to describe the process of moving from childhood into adult life. It is used by professionals to describe the changes in services when a child becomes an adult. However, this transition can happen at different times for different families.

School SEN Support
A category for young people who need extra specialist support but not an EHCP. This may take the form of additional support from within the school or require the involvement of specialist staff or support services. The purpose of SEN support is to help children achieve the outcomes or learning objectives that have been set for them by the school.

SEMH
Children and young people may experience a wide range of social and emotional difficulties which manifest themselves in many ways. These may include becoming withdrawn or isolated, as well as displaying challenging, disruptive, or disturbing behaviour. These behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse eating disorders or physical symptoms that are medically unexplained. Other children and young people may have disorders such as attention deficit disorder, attention deficit hyperactive disorder or attachment disorder.

SENDIASS
Special Educational Needs and Disabilities Information Advice and Support Services. SENDIASS offer information, advice and support for parents and carers of children and young people with special educational needs and disabilities (SEND). This service is also offered directly to young people.

SMART
SMART stands for specific, measurable, achievable, relevant, and time-bound.

- **Specific** – Objective clearly states, so anyone reading it can understand, what will be done and who will do it.
- **Measurable** – Objective includes how the action will be measured. Measuring your objectives helps you determine if you are making progress. It keeps you on track and on schedule.
- **Achievable** – Objective is realistic. Setting reasonable objectives helps ensure success.
- **Relevant** – A relevant objective makes sense and addresses the vision of the project.
- **Time-bound** – Every objective has a specific timeline for completion.

Glossary continued

Special Educational Needs (SEN)
A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she has a significantly greater difficulty in learning than the majority of others of the same age or has a disability which prevents or hinders him or her from making use of educational facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

Transition
The process of moving from one school phase or another or from school to adult life.

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LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Wellbeing Board

Date: 20/09/2023

Subject: Better Care Fund 2023/25

Report author: Julius Olu, Assistant Director – Commissioning and Partnerships

Responsible Director: Linda Jackson, Strategic Director of Independent Living (DASS)
Sue Roostan, Borough Director, H&F CCG

SUMMARY

The Better Care Fund paper setting out the proposal for the London Borough of Hammersmith & Fulham (H&F) and the H&F Integrated Care Board (ICB).
This will form part of the submission to NHS England following this Health and Wellbeing Board.

RECOMMENDATIONS

1. That the Chair, on behalf of the Health and Wellbeing Board, agrees the planned total expenditure and the proposed schemes for 2023-25.

2. That the Health and Wellbeing Board receive an end of year report outlining the outcomes of each scheme and the difference it has made for residents of H&F.

Wards Affected: All

Our Values	**Summary of how this report aligns to the H&F Values**
Creating a compassionate council	The Better Care Fund supports community health and social care resources to reduce the number of people who need to be admitted to hospital and supporting people to get home as soon as they are well.

Background Papers Used in Preparing This Report
None.

DETAILED ANALYSIS

1. In accordance with the statutory duties and powers given to the Health and Wellbeing Board (HWB) by the Health and Social Care Act 2012, the Board's Terms of Reference in Hammersmith & Fulham Council's constitution include overseeing the development and use of the Better Care Fund (BCF) by the Council and the H&F Integrated Care System (ICS).

2. For clarity, the Better Care Fund supports community health and social care resources to reduce the number of people who need to be admitted to hospital. Residents that do require admission to hospital are supported to get home as soon as they are well.

3. The original date set by NHS England for submission of the BCF narrative plan and BCF planning template for 2023 – 2025 was 28 June 2023 which coincided with the sitting of the H&F HWB in that month.

4. H&F were prepared to make a submission on 28 June 2023 but additional reporting requirements from North West London ICB close to the submission date meant the submission date had to be changed to 4 August 2023 when it was submitted following sign off by the chair of HWB.

5. The HWB is asked to retrospectively sign off the memorandum of understanding (MOU) between H&F and NHS North West London, the BCF narrative plan and the BCF planning template for 2023 – 2025.

6. This paper supports the development of the submission to NHS England on how we plan to pool our monies to support joint working over the forthcoming year. The submission is a template submission that has mandated fields for completion by both the ICB and Council. The paper below sets out our approach, areas where we will work jointly, and the governance arrangements to monitor the delivery of the plan in year.

7. Both H&F Council and H&F ICB have committed to completing the template in accordance with the Better Care Fund planning guidance.[1]

Finance Comments

8. The Better Care Fund (BCF) proposed plan for 2023-24 is £41,932,973. The breakdown of this is shown in Table A.

9. There is £10.6m less in the 2023-24 BCF than was approved for 2022-23. As part of the BCF review, the Integrated Care Board (ICB), have advised that there are several schemes which from this year, now part of a new Section 75 agreement, (outside of the BCF pool budget). These amounts to a total £1.4m which the lead commissioner of these services is the LA.

[1] Better Care Fund policy framework can be found at Better Care Fund policy framework 2023 to 2025 - GOV.UK (www.gov.uk)

10. The ICB have confirmed that if they over perform, they will reimburse the Council for the overspend. Over performance would mean actual outturn costs and activity for 2023-24 have been above the level of budget set. The reimbursed in full by the ICB will be within the year end accounting timeframe. The same arrangements will apply to the additional ICB contribution of £4.282m to the pooled fund, as the LA is the lead commissioner for these services.

Table A - Analysis of 2023-24 Better Care Fund Pooled Budgets

Lead Commissioner	**Budget Description**	**Amount £**	**Sub Total £**
ICB	Integrated Care Board (ICB) Minimum Contribution to BCF Pooled Budget 2023-24	9,718,099	
ICB	ICB Minimum Contribution to the LA to protect Social Care	7,445,824	
ICB	ICB Additional Contribution	4,282,523	
ICB	ICB Hospital Discharge Contribution	855,083	
Sub total			22,301,529
LA	Agreed value of Local Authority (LA) contribution to BCF Pooled Budget 2023-24	6,702,808	
LA	Improved Better Care Fund (IBCF)	10,027,236	
LA	Hospital Discharge Allocation	1,405,803	
LA	Disabled Facilities (DFG)	1,495,597	
Sub Total			19,631,444
Grand Total			**41,932,973**

<u>**Sign-off template which will be used for NHS England submission**</u>

Local Authority	**London Borough of Hammersmith & Fulham**
Clinical Commissioning Groups Hammersmith and Fulham Clinical	**Hammersmith and Fulham Clinical Commissioning Group**
Date to be agreed at Councillors Members Board:	**20 September 2023**
Date submitted:	**4 September 2023**
Minimum required value of ICB contribution to BCF pooled budget: **2023-24**	£17,163,923
Agreed value of NHS contribution to BCF pooled budget **2023-24**	£5,137,606
Agreed value of LA contribution to BCF pooled budget **2023-24**	19,631,444
Total proposed value of pooled budget **2023/24**	**£41,932,973**
Minimum required value of ICB contribution to BCF pooled budget: **2024-25** Agreed value of NHS contribution to BCF pooled budget **2024-25**	£18,135,401 £5,137,606
Agreed value of LA contribution to BCF pooled budget **2024-25** Total indicative value of pooled budget **2024/25**	£20,827,386 **£44,100,393**

List of Appendices
Appendix 1 – Memorandum of Understanding – Between NHS North West London and London Borough of Hammersmith & Fulham
Appendix 2 – Better Care Fund Narrative Plan 2023-2025
Appendix 3 – Better Care Fund Planning Template 2023-2025

MEMORANDUM OF UNDERSTANDING

BETWEEN NHS North West London

AND

London Borough of Hammersmith & Fulham

1. Introduction

This memorandum of understanding is between NHS North West London Integrated Care Board (NWL ICB) and the London Borough of Hammersmith & Fulham (LBHF).
It covers the agreement between both parties on the re-classification of some of the schemes in the 2023-24 BCF as well as explaining the approach to undertaking a review of BCF schemes across North West London in 2023-24 to inform planning for 2024-25.

2. Background

The purpose of the BCF lies in supporting people to live healthy, independent and dignified lives, through joined up health, social care and housing seamlessly around the person. The vision is underpinned by two core objectives:

- Enable people to stay well, safe and independent at home for longer; and
- Provide people with the right care, at the right place, at the right time.

The BCF aims to achieve this by requiring ICBs and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under section 75 of the NHS Act (2006).
The delivery of the BCF will support two key priorities for the health and care system that align with the two existing BCF objectives:

- Improving overall quality of life for people and reducing pressure on urgent and emergency care services, acute (hospital based) care and social care through investing in preventative services;

- Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

There are four funding sources that are required to be included within the BCF:

1) NHS Minimum Contribution – made by the ICB;
2) Improved Better Care Fund (iBCF) – grant funding to local government;
3) Disabled Funding Grant (DFG) – grant funding to local government; and
4) Additional Discharge Funding –monies from Department of Health and Social Care to both Local Authorities (LAs) and ICBs.

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Both ICBs and LAs can make additional contributions to the BCF.

To support consistency in the service lines contained in the health minimum contribution, the NWL ICB requested that amendments to both minimum contributions and additional spend were made for the 23-24 submission. This led to a review of the schemes within the BCF by the NWL CFO.

3. The agreement

For the 2023-24 BCF planning submission, ICB colleagues have been working with Borough teams and Local Authorities to create consistency in language, reporting and classification, to ensure that activity is planned and reported in line with BCF guidance, and agree discharge funding that is based on need and improves flow. The following commitments have been made as part of this work:

- The quantum of funding will not change in 23/24;
- We will work on an equal basis to create a clearer understanding and review schemes in detail in Q2/Q3 of 2023-24 to inform our collective planning for 2024-25 and ensure that we are achieving the aims of the BCF; and
- We will work on an equal basis to create a more consistent approach within each fund in 2023-24, which creates a clearer baseline for the above review.

It has also been agreed that as part of the reclassification the quantum of funding will not reduce and we will not decommission committed schemes in 2023-24.

The following changes have been proposed:

1. In order to bring the quantum of schemes within the adult social care element of the BCF back to the minimum level of £7.446m, NHS NWL ICB are proposing to re-classify the following schemes from the Local Authority minimum contribution to the health minimum contribution:

    a) Community Equipment variable contract of £1.148m
    b) Safeguarding contribution of £0.045m

2. Move the 7 day Hospital Social Work contribution of £0.447 from minimum LA contribution to additional LA spend.

3. Move a range of services covering jointly-funded placements and home care, funded nursing care and carer personal health budgets as an addendum to the Section 75 schedule. The ICB will be providing the inflationary uplifts on the budget figures but will not adjust for the expected full year effect. The payments will be based on actual costs incurred with valid backing documents and there will be quarterly meetings in place to agree these recharges.

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On this basis, the movement of these service lines does not change any Lead Commissioning arrangements or control that LBHF currently has in place for 2023-24. The invoicing, monitoring and reporting of the budgets will continue to be quarterly via the meetings already in place to manage reconciliation of actual costs.

These schemes will form part of a joint review process for 2024-25.

The Terms of Reference will be drawn up by the local authorities and the ICB to ensure that they are sufficient for both sets of internal governance and processes.

4. Variations

NWL ICB and Hammersmith & Fulham Council agree to inform each other of any situation that could materially affect the terms of this memorandum of understanding including those of staffing, statutory regulations and service provision. Both parties will discuss and agree any proposed action.

Any extension to this agreement under the same or similar terms must be agreed by all parties and there is no automatic right to extension.

5. Arbitration

Both parties agree to implement and abide by this memorandum of understanding. It will be the aim of all parties to work together to resolve any difficulties and define a solution to problems that may arise. In instances where agreement cannot be reached, a mutually acceptable third party may be asked to arbitrate, or the parties may agree to alternative dispute resolution.

6. Service agreement value and payment

NWL ICB to ensure BCF funding continues to flow through for 2023-24 for all current schemes.

FINAL

7. Signatories by appropriate senior representation of North West London ICB and the London Borough of Hammersmith & Fulham:

On behalf of NHS North West London

Name: Rob Hurd
Title: Chief Executive
Organisation: North West London ICB

Signature:

Date : 4 August 2023

On behalf of the London Borough of Hammersmith & Fulham:

Name: Linda Jackson
Title: Strategic Director Independent Living (DASS)
Organisation: London Borough of Hammersmith & Fulham
Signature:

Date : 4th August 2023

FINAL

BCF narrative plan

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

London Borough of Hammersmith & Fulham

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

We have worked with partners within Hammersmith & Fulham Health and Care Partnership HFHCP (our borough-based partnership) to develop a plan built on shared outcomes and a commitment to build on learning from the last year. Pooled budgets have ensured that we work together not only to improve hospital discharge but to address health inequalities across the health and care system.

In Hammersmith & Fulham we have seen an increase in demand around discharges, particularly with increased demand for health and care services to enable residents to remain at home. Acuity of needs also means that we will need to seek further capacity to meet demand. Our Home Care and Independent Living service that went out to tender last year will be awarded this year with the new service starting in October 2023. It will focus on improve the quality of care for our residents by increasing the number of geographical patches from three to six smaller patches to improve punctuality and carer consistency. We have also explored the geographical patched aligning with the Primary Care Network boundaries as best as possible. Health-related tasks carried out by home care independent living workers with remain a key feature within the new service. The health-related tasks play a key role in helping to maintain our residents & patients' baseline, helping them to live longer in the community as well as prevent higher levels of hospital re-admissions. This is an area we think will require further investment

How have you gone about involving these stakeholders?

The planning templates have been completed with input from the NWL local care team.

NWL Local care team has engaged with system partners for completion of relevant sections of the template. For H&F, local system partners are: Imperial College NHS Trust (ICHT), Chelsea & Westminster NHS Trust (ChelWest), Central London Community Healthcare NHS Trust (CLCH), West London Trust (WLT), Central and North West London NHS Foundation Trusts (CNWL) and LBHF. DFG and Housing leads have been involved in the BCF planning; the discussions around this has been at the H&F Adult Independent Living Steering group.

This submission has been discussed at the H&F BCF Review meeting

Agreed by the Adult Social Care Leadership Team

Signed off by the Chair of the H&F Health and Wellbeing Board on xxx.

Will be retrospectively signed-off at the next Health and Wellbeing Board in September 2023

The H&F HCP (executive leadership group) has reviewed and signed off the BCF plan. H&F HCP Executive group members include: CLCH NHS Trust Director, West London NHS Trust Director, LBHF Strategic Director, Primary Care Lead, PCN representative, NWL ICB Inner London cluster COO, NWL ICB H&F Borough Director.

The Plan has also been shared with HFHCP Operational Delivery Group whose representatives include:

NHS Trusts: CLCH, ICHT, ChelWest, WLT

Primary Care: PCN CDs

Social care- adults and children's

Voluntary sector and patient reps- SOBUS, lay reps, HealthWatch

NWL ICB: H&F Primary care team and H&F Integration & Delivery team

Operational and/or BI teams from Imperial College NHS Trust (ICHT), Chelsea & Westminster NHS Trust (ChelWest), Central London Community Healthcare NHS Trust (CLCH), West London Trust (WLT), Central and North West London NHS Foundation Trusts (CNWL) have supported with completion of metrics tab, capacity and demand tab and the scheme outputs on the expenditure tab of the BCF Planning template.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Plan discussed and jointly agreed by the ICB and LA at monthly BCF review meetings.

Plan presented to the Health and Care Partnership Operational Group for review and comments.

Plan signed off by the Health and Care Partnership Executive Group.

Delegated sign off by the chair of the Health and Wellbeing Board prior to plan submission.

Formal sign off at the next Health and Wellbeing Board on 20th September 2023.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

- "Doing with residents not to them" remains a key priority for H&F. This will mean local people are fully involved in the service design, delivery and evaluation, using a

"strength based" approach to health and social care. (Our Homecare and Independent Living Service tender involved a resident evaluator to ensure that resident voice was consistent through the evaluation process).

- Working with our housing department and Registered Providers to ensure that our vision for Independent Living is achieved across systems. We have developed a Housing for Independent Living Board, led by housing to ensure that there is governance around a systems approach to improving outcomes for residents. Workstream membership includes carer, parent carers, colleagues from health, employment, transitions to adulthood and social care.

- We remain committed to preventative and reablement services. We will ensure that people have improved outcomes and independence and are empowered to meet their own health and care needs through the use of a therapeutic model. We will maintain our investment in the Community Independence Service Model.

- Reduction in length of stay in hospital for residents who no longer require clinical support. Continued investment in step down facilities that support hospital discharge. Review of mental health community provision with health partners to assess what the are barriers to discharge from acute mental health beds and how community provision can support.

- Market sustainability. We have developed a Market Sustainability Plan which will ensure that the acute and primary healthcare sectors are adequately supported by the care market place. The key priorities of this plan are: improving the quality of care provision, ensuring an adequate supply of care, workforce development, strategic partnering and managing the rising demands of inflation.

- We support and value our local carers, including young carers. We have a commissioned Carers Hub for adult carers and a new young carers offer has been launched with a universal and enhanced offer to support varying need levels. We are coproducing a joint Carers Strategy that will align with our vision for Independent Living in Hammersmith and Fulham to ensure that there is parity and consistency across our services.

- Bedding in our new joint equipment service which has only recently transitioned over to a new service provider remains a priority for us given the key role equipment has to play in enabling swift but safe hospital discharges and helping residents to live independently for as long as possible in the community whilst reducing the risk of re-admission.

Metrics

- No residents discharged from Hospital into residential care permanently
- Reduction in the number of residents in out-of-borough placements
- Reduction in number of people requiring home support following reablement

- Reduced length of stays of 14 days and 21 days
- Discharge to P3 bed within 48hours of EDD
- Reducing avoidable admissions via A&E
- Increase in number of carers identified and receiving support

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

All partners in our H&F Health and Care Partnership are committed to a collaborative approach to improving the health and wellbeing of residents in Hammersmith and Fulham. We have agreed six overarching, long-term priorities that we are working on as a partnership:

1. Supporting people to stay well as long as possible
2. Supporting people with mental health needs
3. Developing the partnership (including PCNs)
4. Supporting people who are living with an illness
5. Supporting people suffering with or recovering from Covid-19
6. Identifying and addressing health inequalities across our borough

As a partnership we have agreed to a set sub-priorities that will support delivery of the 6 overarching priorities:

- Frailty - improving our dementia diagnosis rates in Hammersmith & Fulham as part of a shared (health, local authority and third sector) Dementia Partnership Board (DPB) which oversees the delivery of the co-produced Dementia Strategy. The formation of the joint Dementia Diagnosis Working Group which reports into the DPB will improve awareness across the system of the pathways to diagnosis and improve rates.

- Tackling inequalities and using a Population Health Management (PHM) approach to underpin all decisions. A listening exercise in 2022 identified the following specific priority areas to address health inequalities: improving life expectancy for the 20% most deprived; increasing hypertension case finding; supporting mental health and wellbeing, post lockdown; reducing dental decay and improving oral health; ensuring fair access to services by equalities groups, refugees etc.

- Reducing variation between PCNs.

- Mental Health – delivering a new community model and NWL access standards. We have launched a join Mental Health Campaign that focusses on addressing the shared commitments set out in the NHS Long Term Plan.

- Keeping people out of hospital, including through a standardisation of services.

- Community-based specialist palliative care that aims to make sure people get the right care at the right time, by the right team in the right place. It also aims to ensure that patients with a life limiting illness, their families, carers and those important to them have equal access to high quality community-based specialist palliative and end of life care and support that is sustainable and coordinated, and which from diagnosis through to bereavement reflects their individual needs.

Additional areas of focus include:

In response to the Fuller report we have worked collaboratively with partners to strengthen multi-disciplinary teams (MDT) within PCNs for frailty with dedicated geriatricians and senior social workers now aligned to each PCN. Working with acute colleagues we meet weekly to reduce length of stay and overcome any blockages for discharge.

Working with acute colleagues we meet weekly to reduce length of stay and overcome any blockages for discharge.

We have joint commissioning plans for step up and step-down beds to support hospital admission avoidance and reduce length of stay.

In H&F, through a revamp Adult Independent Living steering group we continue to develop and oversee the improvements in the range of services and support available for young adults transitioning from Children's Services and for all adults with learning disabilities, with mental health issues and for those with autism. There are a number of key work stream that feed into this steering group, housing being a very important work stream. Work stream membership includes carer, parent carers, colleagues from health, employment, transitions to adulthood and social care.

The HCP has identified 3 key new priorities for 23-25:

- Access to health and care services – improve patient experience and satisfaction of access to health and care, support PCNs to develop at scale solutions to meet demand for same day care and manage patients with low complexity.

- Integrated Neighbourhood Teams –in response to the Fuller Report to support our complex patients, through proactive planning and delivery, enabling early intervention and prevention and reduction in escalation of need.

- Tackling health inequalities and implementing a population health management approach – identify priorities and campaigns, ensuring that reducing inequalities is at the centre of all we do, monitor the various inequalities initiatives within the borough, ensure use of data intelligence and PHM approach is embedded.

Approach to Joint/Collaborative Commissioning

H&F has commenced the re-procurement of our Home Care and Independent Living Services and the plan is for the new service to be mobilised by June 2024. As the new service will address joint objectives and help to relieve pressures on hospital discharge we plan to continue using the BCF to support this area. BCF funding ensures we maintain sufficient supply of home care with H&F to sustain rapid discharge from hospital back into the community. Our health colleagues also have a bridging service in place. Our Independent Living Workers are expected to carry out a range of health-related tasks, these include:

- Immunisation reminders and support to book these if necessary – Supporting Public Health messages around recommended vaccinations and support residents to engage with these.
- Assistance with eye drops / ear drops - Supporting self-administration and some assistance with administration, if needed and appropriate equipment is available.
- Support with taking Temperature and blood pressure
- Medication assistance
- Topical application of medication - Supporting self-administration and some assistance with administration
- Pressure ulcer care (grade 1) and pressure area monitoring - Monitor skin integrity and escalate to relevant professionals as required
- Simple stoma care - Only with support from District Nursing
- Simple wound care - Only with support from District Nursing
- Eating and drinking therapy - As part of self-care programmes
- Blood glucose monitoring - Only with support from District Nursing
- Domiciliary foot care - As instructed by clinical teams

We have a range of Section 75 schemes that the local authority and ICB are collaboratively commissioning to support the health and care needs of the population of Hammersmith and Fulham:

- Jointly commissioned nursing and social care beds in two nursing homes
- Homelessness support services
- Mental health hospital liaison service
- Community Independence Service

- Stroke early supported discharge service
- Open Age “Steady & Stable” – Falls Prevention Service.
- British Red Cross Service supporting both discharge and prevention of admission

In addition to these schemes, we have the following jointly commissioned schemes that promote the health and wellbeing of our residents, promote independence and support them to remain in their normal place of residence; thereby reducing the hospital attendances and length of stay in acute settings:

- Jointly funded care package and placements for LD clients
- Jointly funded PFI care home beds
- Jointly funded PFI extra care scheme
- Jointly funded mental health placements
- Jointly funded direct payments and personalised health budget clients
- Jointly funded community equipment contract
- Jointly funded Carer’s advice and support services
- Jointly funded safeguarding services

Ageing well

Ageing well funding was provided to deliver the broad objectives of the national programme, which related to improving and investing in NHS community services. The specific priorities below align to the objectives of the BCF providing admissions avoidance support and support to discharge. Systems also had flexibility to utilise funding beyond these categories in support of aligned services/priorities specific to individual boroughs

Safeguarding :

Safeguarding Children: Contribution to the BCF and is intended to protect the health, wellbeing and human rights of children and young people subject to, or at risk of, abuse.

Safeguarding Adult: Contributes to the BCF supports and is intended to protect adults at risk of abuse or neglect

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Integrating Care Around the Person

H&F vision for health and care integration is to create a strong, sustainable, person-centred, and integrated health and care system, which improves outcomes for our residents. Our model of care is designed to:

- Deliver more care outside of hospital using a therapeutic approach, wrap-a-round care which reables residents helps to avoid hospital re-admissions.
- Develop an independent living service, which gives people real choice through direct payments. Independent Living Worker are being encouraged to think in a reabling way.
- Provide integrated, personalised, and holistic services.
- Help residents, carers, and professionals work hand in hand to maintain health, wellbeing and independence, for as long as possible.
- Person Centred Approaches: Promoting Choice, Maximising Independence
- Integrated approaches

- H&F integrated reablement working alongside the rapid response service enables a joint holistic person-centred assessment which informs joint care planning and delivery across community nursing and adult social care.

- H&F's model of integrated health and care is designed to offer more choice and personalised care planning via:

  - Improving access to information and advice to all our diverse communities
  - The delivery of improved person-centred care planning in neighbourhood teams,
  - Being supported by a strong platform of social prescribing, including face to face support from local teams
  - The home first philosophy, promoting maximum reablement opportunity at home
  - The development of a Carers Strategy which acknowledges and values the role of informal carers
  - Creation of step up and step-down opportunities as an alternative to hospital admissions
  - Support to residents and their families at end of life
  - Increased capacity for AMHP at A&E to speed up access when needed
  - The use of Disabled Facilities Grant to promote independence and allow people to maintain family links where possible.
  - Creative use of technology to enable people to remain at home and feel safe.
  - Working with acute colleagues we meet weekly to reduce length of stay and overcome any blockages for discharge.

Delivery of joint Health and Care:

We have a Frailty Campaign in place which has the following key priorities:

1. Review and strengthen MDT Models
2. Integration of End of Life & Palliative Care Services
3. Further integration of mental health /social/physical interface in frailty
4. Data/Metrics (exploration of WSIC frailty dashboard and how it can inform areas of focus to improve patient care)

The expected impact from this campaign will be improved care of frail elderly in the community through improving integration between NHS Services & Local Authority services. There is particular focus on reducing duplication where there may be social care and health care visits to the same patient. In addition we are developing a service directory to improve

signposting to health, social care and voluntary sector services. There is a focus on dementia- , improving the awareness across the system of the pathways to dementia diagnosis and improve diagnosis rates and use data to inform areas of focus to improve patient care.

Building on what was done last year the Frailty Campaign has:

- Transitioned frailty campaign to an operational group to ensure sustainability and embed the MDT way of working as BAU across all PCNs.
- Transferred geriatrician resource to all PCNs.
- Strengthened connections with adult social care.
- Used intelligence gathered from the palliative care public engagement work to identify areas for improvement and agree priorities for delivery at borough level.
- Co-produced the EoL/ palliative care engagement strategy with lay partners & HAFSON representatives.
- Completed phase one of the engagement exercise and gathered public views on what good looks like; what is currently working; where are the gaps area and how we can improve the current service.
- Established a subgroup to improve the dementia diagnosis rate across H&F.
- Engaged with all H&F GPs to correct the dementia coding on their system.
- Created a Dementia WSIC dashboard.
- Improved the Dementia diagnosis rate from 60.4% to 61.9% (pre change of methodology).

Personalised Care and Asset-Based Approaches

Enabling resident to live well, safe and independently within the community requires close working with them to understand what their individual and community strengths are and in some cases linking them up to these. All frontline staff are training and have adapted the culture of working with residents in a strength-based way, understanding that what outcome resident are trying to achieve in order for them to live fulfilled lives free to make wishes and choices that as we do.

Vision for Independent Living

Here in Hammersmith & Fulham we want everyone to have the best possible life. We want everyone to be included. No one should be left behind. Our vision for independent living is for Disabled people of all ages to have the same rights as everyone else to live in the community how they choose. Everyone should be able to be part of and contribute to their communities. We all gain when this happens. We are committed to doing things with residents not to residents. This way we find the best solutions together. Disabled people

should be involved in all the decisions that affect their lives. With this in mind, co-production of services and local care strategies is what we do, involving residents, provider and our vibrant voluntary organisation in service development and monitoring. We remain on a journey to keep building on this.

Delivery of joint Health and Care:

- We have multiagency joint MDT with PCN's already in place for frailty, providing a valuable communication route for all partners and shared learning of each other's ways of working.

- We have reviewed discharge pathways together with PCN, Social Care, Trust and community health colleagues including commissioned providers of care. This has enabled safer quicker transfer of care for patients.

- Working with acute colleagues (Imperial & Chelwest) we meet x3 per week to reduce length of stay and overcome any blockages for discharge.

- We have joint commissioning plans for step up and step-down beds to support hospital admission avoidance and reduce LOS.

- We are also looking at opportunities to co-commission services for people with LD and MH patients support in a shared care environment, to enable people to be re-abled, and gain stability in their lives.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
  - where number of referrals did and did not meet expectations
  - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
  - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Avoidable Admission 22/23 Q1-Q4 plan was calculated by reducing 21/22 Q1-Q4 Actual Observed values by 1% and recalculating the Indicator Value based on this reduced

Observed value. Please note the 21/22 Q1-Q4 Actual Observed values and Indicator methodology was produced by the BCF Team.

We are continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, though this remains our longer-term plan.

There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows:

- The development of our virtual wards programme
- Continued roll out of post covid syndrome clinics
- Go live of respiratory hub-lets
- Continued work roll out of virtual monitoring
- 111/999 Push pilots with urgent community response continue

The local schemes/initiatives supporting this metric are:

- HFHCP Diabetes campaign across primary, community and secondary care for timely monitoring, management and prevention of complications.

- Promotion of vaccination programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.

- HFHCP Frailty campaign with focus on frailty pathway to better support frail adults with chronic conditions in the community

- Integrated Rapid response service in the community to reduce conveyances to hospitals

- Multiagency prevention of admission team at front end of local hospitals to support safe transfer into community

- Expansion of acute SDEC pathways supported by successful recruitment (Imperial)

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions

- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Where possible most people should continue to live in their own home with the clinical wraparound they need and the social care support. Only when this is not possible, should nursing and residential care be offered. However, stepdown care in homes can be invaluable before discharging someone home.

We're continuing to redesign the social care front door so that most people have a period of reablement to prevent unnecessary admission into hospital and to facilitate a speedy discharge home. We have a health and social care - strategic sub-group - Support at Home, which reports into the Frailty campaign group of the ICP.

Several local schemes contribute to reducing unplanned admissions to hospital for chronic ambulatory care sensitive conditions and include:

- HFHCP Diabetes campaign across primary, community and secondary care for timely monitoring, management and prevention of complications.
- Promotion of vaccination programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.
- HFHCP Frailty campaign with focus on frailty pathway to better support frail adults with chronic conditions in the community
- Integrated rapid response service in the community to reduce conveyances to hospitals
- Multiagency prevention of admission team at front end of local hospitals to support safe transfer into community
- Expansion of acute SDEC pathways supported by successful recruitment (Imperial)

In addition there are centrally led NWL programmes which give increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions locally:

- The development of our virtual wards programme
- Continued roll out of post covid syndrome clinics
- Go live of respiratory hub-lets
- Continued work roll out of virtual monitoring
- 111/999 Push pilots with urgent community response continue

Included within BCF is the 52 week falls prevention pathway provided by CLCH and a third sector provider (Open age steady & stable). The service provides early falls prevention through provision of exercise classes, which are clinically proven to reduce the risk of falls. Through the open age steady & stable service there is an offer of further exercise / mobility classes after the falls prevention programme which includes tai chi; zumba; yoga; chair exercises and a specific men’s exercise group.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

In H&F, we have put in place Rapid Response services that support patients and our local acute Trusts to implement the home first approach. People are visited by health care professionals at short notice and receive an assessment by a MDT, made up of nurses, therapists and care and support workers. The care plan will include rehabilitation goals, support for carers, and any equipment which may be needed along with self-help advice. Some people have complex needs and may require longer-term care. The team carries out robust assessments, before coming to a decision, with the person and their families, to determine their long term plan of care.

Additional discharge funding will be used to increase community capacity to support discharges. We will continue investment in the following areas:

- Additional domiciliary care
- Additional step down beds
- Additional assistive care technologies and equipment in the community
- Additional resources to increase capacity of reablement service by increasing operational hours of service
- Workforce recruitment and retention including therapy staff and social workers

Please see High Impact Changes assessment and summary for details on our progress with tackling delayed discharges from hospital. In addition, our investments in reablement services and intermediate care services are aimed at supporting people to regain independence and remain longer in the community following discharge (reducing re-admissions).

Through the above broader approach, we are tackling the mix of causes of delays throughout the system. This includes improving patient flow in hospitals by identifying and

tackling process issues within hospitals that may contribute to delays, and expanding the range of NHS and social care services available to support patients outside hospitals.

Mental Health

A Mental Health working together project which is focusing on the better understanding the mental health discharge pathway and the barriers that affect the swift discharge from mental health inpatient units across northwest London. In H&F we are working through gathering and analysing the mental health data before going on to compare it with other northwest London boroughs. The view is that once we have a regional and local picture we can then begin to improve the mental health discharge pathway.

The additional discharge funding is being used to fund additional homecare and reablement capacity Interim / stepdown placements, Equipment including Telecare, Hospital and community based staffing including Advanced Mental Health Practitioner, Occupational Therapists and Social workers. Care related costs, homecare and placements are only funded from the discharge funding for limited period before social care then picks up the cost. The breakdown of the spend demonstrates we are investing the discharge funding in supporting hospital discharges.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person’s own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Data available to us at the time of completing the BCF plan indicates that for most of the intermediate care services in H&F, overall we have the right capacity to meet the demand. This is supported with the evidence that system partners have not flagged issues regarding patients waiting excessively for access to bedded or community based intermediate care services. Resources have been allocated to cater for the seasonal variation in demand for intermediate care services.

One of the key areas identified has been the lack of social care input to assess and facilitate step up into intermediate care in the community. We have remedied this, by allocating additional fund towards additional social workers.

The expectation is that this additional resource along with the development of Integrated Neighbourhood Teams will enhance the seamless access to intermediate care in the community; thereby reducing urgent & emergency care presentations.

The plan is that further work on intermediate care capacity, demand and access will be carried out as part of the North West London BCF review and standardisation of BCF across North West London.

The BCF review will take into consideration where consistency with other boroughs within North West London is appropriate whilst ensuring that the specific needs of H&F's residents are addressed.

Intermediate Care Services

Please see attached Capacity & Demand template for details on H&F's intermediate care capacity and demand plans. A significant proportion of H&F's Intermediate Care spend is on the Community Independence Service (CIS) which is an intermediate care service providing advanced short- term nursing care, occupational therapy, physiotherapy, and social care to people with immediate health or functional needs, who would otherwise require an admission to hospital. The service aims to offer safe care at home which enables people to avoid unplanned hospital admissions.

CIS consists of four teams:

Rapid Response: For urgent same day response within 0-2 hours for people with immediate health or functional needs who would otherwise require an admission to hospital (input for up to five days).

Home First: Working with acute hospitals to facilitate supported discharge for medically stable patients into the community. People can be assessed in their own home on the same day. (Input for up to 72 hours)

Rehabilitation: The rehab pathway helps people maintain or regain their independence at home to enable people to live well in their own homes, completing roles and tasks that are important to them with as much independence as possible. Most people will be seen within 48hours, with non-urgent referrals assessed within 14 days. (Input for up to six weeks)

Reablement: Services are provided in the home to help a person gain confidence and re-learn skills to carry out daily activities and practical tasks. (Input for up to six weeks)

The other intermediate care services that we commission are:

- Community Neuro rehabilitation
- Intermediate care beds at two units (Alexandra and Athlone)
- Beds in Nursing home with funded nursing care contribution and reablement support
- Intermediate care spot placements

Extra Care

We are also exploring the use of extra care services to support stepdown from hospital into community settings.

Reablement

Reablement as a therapeutic approach to meeting needs and preventing the escalation of needs means we remain compliant with Care Act 2014. The interface between this service and our Home Care and Independent Living service ensures that the right residents end up with the right size care package after their time in reablement.

Community Equipment

Our joint community equipment service ensures that discharge form hospital is not delayed and that residents have the right equipment in place as they are discharge to an appropriate setting.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Reablement

Continued BCF funding for our community independence service (reablement) will ensure that we are able to offer a reabling service to every resident who is discharged from hospital with a view supporting to live independently back at their usual place of residence. Where this is not possible a right-sized homecare package is put in place to support residents and avoid hospital re-admissions.

Community provision

Where return or admission to a care home become necessary we work as one system to ensure efficient discharge back to usual place of resident with a package of care that supports residents and aims to prevent readmission to hospital. Commissioned provider as

seen as a critical part of the system, so we continue to work with providers with a few to steering the market towards supporting safe but rapid discharges from hospital setting.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

High Impact Change Model self-assessment:

- Early discharge planning: Established

Local acute trusts have implemented choice policy of which step 1 includes all patients to have EDD on admission, recorded on patient record system and information provided to patient/carer. Discharge hubs in place to support discharge planning and facilitate timely transfers out of acute settings.

- Systems to monitor patient flow: Established

A&E Delivery board framework and urgent care working group well established. H&F LA are developing AI and dashboards which will further enhance the local ability to monitor patient flow in real time. A new digital solution – Optica is being rolled out at Local Acute trust to introduce new digital solution to monitor daily discharge tasks across organisations. This will be accessible to local authority, community teams etc. to provide a live position of discharge status across the Local Acute trust.

- Multi-disciplinary/Multi-agency discharge teams: Mature

This has remained a multi borough approach within inner London cluster through well-established discharge hubs. The discharge hubs include VCS (British Red Cross, Hospital to Home Service), Social Care, Acute and community services. Hospital social work services work 7 days a week which contribute to the MDT discharge processes. H&F commission British Red Cross to support discharge of patients from hospital to home.

There is a monthly Tri borough discharge steering group which identifies and tackles specific pathway issues and workflows

At a North West London level, a NWL Discharge Steering Group with membership from all trusts, Local Authorities and wider partners meets fortnightly to review progress against plans, with a monthly focus on operational performance including LoS, delays etc.

Ageing Well funding has been allocated to bolster the staffing levels and leadership of the integrated discharge hubs (one per acute site), including working 7 day working. These discharge hubs include clinicians which provide the "check and challenge" around discharge pathways - ensuring the patient is on the right discharge pathway.

There are also weekly DASS meetings and NWL meetings to look at all matters relating to hospital discharges.

- Discharge: Mature

Pathways for discharging residents are mature and business as usual and where possible, patients are discharged home, with support, for assessment of their long-term needs. The expectation is that discharges home will be the default for the majority of patients and there will be less reliance on interim placements and a reduction in residential placements. Continuing Healthcare checklists and decision support tools are no longer completed in hospital.

There is a Home First service in place that covers the three inner London boroughs (Hammersmith & Fulham, RBKC and Westminster). Home First teams communicate daily on capacity with the acute teams and work is underway to try to make the coordination of home first

We are participating in NWL wide Discharge system peer reviews to establish consistent sets of standards and expectations across NWL - we expect recommendations on Discharge Hub workflows and discharge to assess to be a product of this.

Discharge peer reviews are underway and run to July 2023 across the 9 NW London hospital sites to undertake a holistic review of how discharge services are delivered.

In preparation for the surge in demand for hospital beds this winter, we have commenced work on developing the local operational model for a **Bridging Service**. This service will be set up on the following principles:

Timeframe: The goal is to deliver up to 5 days of care to patients ready for discharge, with a maximum of 12 hours from the point of readiness.

Care Capacity: Each day, a predetermined amount of care capacity will be available to accommodate patients ready for discharge, streamlining the process.

Assessment at Home: Patients will be assessed at home post-discharge to determine the most suitable care plan, which may include reablement, longer-term care packages, or care home placement if required.

Integration with Existing Services: The Bridging Service will seamlessly integrate with existing reablement home first services and local authority teams, promoting collaboration and coordination between care providers.

Same Day Clinical Assessment: Clinical assessments will be conducted on the same day as discharge to address patients' therapy needs promptly.

Coordination and Leadership: Effective coordination, overseen by dedicated therapy leadership, will ensure smooth transitions and continuity of care. Daily multidisciplinary team (MDT) calls have already begun to discuss patient progress and make collaborative decisions.

This bridging service would impact on pathway 1 but also avoid patients deteriorating in hospital, having complications and becoming pathway 3 patients needing complex care in care home settings later down the line.

- Seven-day service: Established

All organisations involved in discharge run a 7-day discharge service. However, we continue to see a significant drop off of weekend discharges as a NWL system.

- Trusted Assessors: Established

Trusted assessor within block contract interim beds rolled out to reduce LoS. More work required with OT's/ acute and community and residential and nursing homes to continue to look for way of reducing LoS.

- Focus on choice: Established

Local system acknowledges that D2A must be resident/ patient led for it to be successful. Principles of coproduction embedded within all service developments in H&F at both design and delivery phases. Direct payments and home care are a major focus. NWL framework form discharge and choice is in final stages of sign off. Acute trusts have been implementing choice policies as per national guidance

- Intermediate Care Services

Please see attached Capacity & Demand template for details on H&F's intermediate care capacity and demand plans. In summary, we have invested significant amount in 23/24 on intermediate care services in H&F.

More than half of this funds the Community Independence Service (CIS) which is an intermediate care service providing advanced short- term nursing care, occupational therapy, physiotherapy, and social care to people with immediate health or functional needs, who would otherwise require an admission to hospital. The service aims to offer safe care at home which enables people to avoid unplanned hospital admissions.

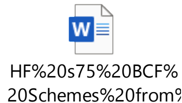
National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The BCF support the running of a variety of jointly commissioned services that ensures H&F continues to deliver its duties under the Care Act 2014. Notable services that supported by the better care fund are:

- Reablement
- Homecare
- Equipment
- Carers Hub – planning and support post discharge
- Care home beds
- LD placement-

Attached is a detailed table of BCF schemes that support the delivery of our duties under the Care Act 2014.



Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

H&F has a statutory obligation to offer a Care Act 2014 Carers Assessment to any adult carer with needs that arise as a consequence of providing necessary care to an adult, which result in deterioration in the carers physical or mental health, where the carer is ‘unable’ to achieve any of the key outcome defined the care act and as a consequence, there is or is likely to be a significant impact on the carer’s wellbeing.

H&F commissions the Carers Network (a third sector organisations) to provide a Carers Hub offer, to ensure we provide carers assessment to all identified unpaid carers and provide them with financial support to prevent carer breakdown.

Hammersmith and Fulham Carers Network provides the following services to adult carers caring for another adult:

- Carers assessments, support plans and indicative personal budgets
- Information, advice and guidance on a range of topics
- Signposting to other services where appropriate.
- Forging partnerships with local charities and businesses to enhance the offer to carers (including support groups and coffee mornings)
- Support grants, when applicable
- Education, employment and training advice (including workshops and activities)
- Raising awareness & outreach to maximise the number of carers identified
- Support Carers to take action and improve their wellbeing (running a quarterly Carers Forum)

We are coproducing a joint Carers Strategy that will align with our vision for Independent Living in Hammersmith and Fulham to ensure that there is parity and consistency across our services. We will work closely with third sector partners and residents to deliver this, including those not currently in the scope for adult carers services, for example those who care for children with physical disabilities, learning disabilities and/or autism. The delivery of the recommendations will benefit from our improved joint working with housing, as early engagement has shown that this is an area of focus for carers particularly for those in social housing.

We are implementing the Dementia Strategy and activities that support people who care for people with dementia. There are four key priorities areas which we will work jointly with health to achieve:

Priority 1: To obtain early and accurate diagnosis within clearly understood timeframes

Priority 2: Clear and accessible information about how to get services and support

Priority 3 :Services must meet the evidenced needs of people with dementia and their carers and families as opposed to assumed needs

Priority 4: Hammersmith and Fulham to be a Dementia Friendly Community

Day centres in the borough provide support for unpaid carers not only providing day respite for carers but also through distinct projects for carers. The newly launched 'Time Out for Carers' is an online and in person self-care programme for carers. This is in partnership with Dementia Action Alliance, H&F and Nubian Life

A new young carers offer has been launched with a universal and enhanced offer to support varying need levels. There is an extensive respite offer for young carers.

H&F's commitment to free homecare offer supports with allowing carers to take breaks in addition to the offer of respite provided through the Carers Hub.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

DFG will continue to support adaptations in a timely manner to support residents' discharge. Significant work continues across the Council to secure Occupational Therapists to work in aids and adaptations.

There is an ongoing programme to log all adapted properties and ensure that they are used to their maximum potential.

Development of extra care Housing scheme in white city in 2023 will release units for step down reablement flats, this will support people with complex needs to be assessed in an out of hospital provision, before decisions are made as to their next move. In addition, these flats will have digital equipment to support residents in maintaining their Health & wellbeing.

For residents pending discharge who require micro living arrangements and equipment we have used the DGF to be able to put in place temporary solutions including smart tech to facilitate the discharge.

We continue to work with housing colleagues to identify opportunities to develop step down facilities, an example of this is voids in extra care have been adapted with DFG and technology to support people to step down from Hospital. These are available for this winter

We have a specialist Housing board which has nominated partners attending to identify the needs and demands of adapted properties and plans for whole lifetime housing options for people 16 years and above.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Click or tap here to enter text.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Click or tap here to enter text.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

We have made progress to improve the way we commission service to reduce health inequalities. The Core20PLUS which focuses on the most deprived 20% of a population, the ICS-identified group in each area that experience poorer than average access and five additional areas of focus. This includes:

- Proportionally targeting our resources to match the needs of individuals and communities to reduce the gap in life expectancy and to increase the quality of life, ensuring resources and delivery are in line with need, which may result for example in increasing resources for providers in more deprived areas in comparison to less deprived areas.
- Having robust mechanisms to reach, hear from and better understand people and communities' experiences.

Working with individuals and communities to reduce the effect of the cost-of-living crisis, especially on people who are already have physical and mental health needs

- Ensuring services are informed by both peoples' and communities' needs and assets.
- Connecting our knowledge of local health inequalities with front-line service delivery,
- Acting for people from pre-conception to after-death. Starting well and ageing well.
- Building trust with BAME communities to understand their lived experiences.

To address these priority areas we have set up the following campaigns:

- Mental Health Campaign
- Diabetes Campaign
- Frailty Campaign
- Dementia Partnership Board
- Building Trust Project – tackling health inequalities through a series of community led listening projects. The projects this summer are being led by the following: Nubian Life (Older People), Age UK (Older People), Eritrean Community, MACWO (Somali)AFND/ H&F Young People, Sobus (Third Sector Infrastructure Organisation), Ase, Sickle Cell Society, Faith Group, AFND/ H&F Young People, Homeless People / Mental Health (TBC).

As a Health Care Partnership in H&F, we have agreed the following as areas of focus to address inequalities:

1) Variation in access, experience of and quality of existing health and care services; Core 20 plus 5
2) Variable support provided to improve health behaviours and enable people to live healthier lives, including effective care and support for people with long term conditions
3) Variation in wider social determinants of health and wellbeing

For all existing and newly identified relevant BCF schemes, we have adopted the following methodology to address health inequalities:

- Improvement methodology combining co-creation with our communities and continuous improvement approach
- Find areas of inequalities using quantitative data (Population Health analytics). At a minimum explore disparities in constitutional standards based on deprivation, sex, age & ethnicity.
- Qualitative data to enhance our knowledge about the problems & its causes. Open conversations with those communities & cohorts that are experiencing those inequalities.
- Collaborate with a mix of stakeholders to generate ideas about potential problems identified.
- Unite a co-design group around small subset of ideas.

Study the impact of tested ideas – both quantitative and qualitative

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	Hammersmith and Fulham	Yes
Completed by:	Cheryl Anglin-Thompson, Carol Lambe	Yes
E-mail:	cheryl.anglin-thompson@lbhf.gov.uk; carol.lambe@nhs.net	Yes
Contact number:	0208 753 4022	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
*Area Assurance Contact Details:	Health and Wellbeing Board Chair	Cllr	Ben	Coleman	Ben.Coleman@lbhf.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Rob	Hurd	rob.hurd@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Carol	Lambe	carol.lambe@nhs.net	Yes
	Local Authority Chief Executive		Sharon	Lea	Sharon.Lea@lbhf.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Linda	Jackson	Linda.Jackson@lbhf.gov.uk	Yes
	Better Care Fund Lead Official		Julius	Olu	Julius.Olu@lbhf.gov.uk	Yes
	LA Section 151 Officer		Sukvinder	Kalsi	Sukvinder.Kalsi@lbhf.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	NWL ICB (HF Borough) Director		Sue	Roostan	susanroostan@nhs.net	
	NWL ICB Head of Finance		Pooja	Maniar	poojamaniar@nhs.net	

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Hammersmith and Fulham

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,495,597	£1,495,597	£1,495,597	£1,495,597	£0
Minimum NHS Contribution	£17,163,923	£18,135,401	£17,163,923	£18,135,401	£0
iBCF	£10,027,236	£10,027,236	£10,027,236	£10,027,236	£0
Additional LA Contribution	£6,702,808	£6,970,920	£6,702,808	£6,970,920	£0
Additional ICB Contribution	£4,282,523	£4,282,523	£4,282,523	£4,282,523	£0
Local Authority Discharge Funding	£1,405,803	£2,016,000	£1,405,803	£2,016,000	£0
ICB Discharge Funding	£855,083	£855,083	£855,083	£855,083	£0
Total	**£41,932,973**	**£43,782,760**	**£41,932,973**	**£43,782,760**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£4,877,501	£5,153,567
Planned spend	£9,718,099	£10,268,143

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,445,824	£7,867,257
Planned spend	£7,445,824	£7,867,257

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	41.3	29.9	39.2	34.2

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,341.1	2,317.7
	Count	440	436
	Population	19101	19101

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.3%	96.7%	97.1%	96.7%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	483	316

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.5%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Hammersmith and Fulham

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. **Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.**	• SUS discharge data used to obtain overall discharges at our main acute trusts, as that is the only borough split we have currently • SUS does not split the data by discharge pathway (P0-3), therefore we have applied the proportions from the national discharge data submission to SAPIT to give us the split • No breakdown avaliable for reablement in a bedded setting - After reviewing our figures for pathway 0, we have discovered an error in the way we calculated our data. We included all discharges instead of focusing solely on the discharges that are supported by commissioned services. As a result, the information we presented was incorrect. Please see the updated figures below: (based on

Complete:	
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! (Select as many as you need)

Demand - Hospital Discharge

Trust Referral Source	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	10	10	10	10	10	10	10	10	10	10	10	10
HUMBER TEACHING NHS FOUNDATION TRUST													
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		20	20	20	20	20	20	20	20	20	20	20	20
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Reablement at home (pathway 1)	47	47	47	47	47	47	47	47	47	47	47	47
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		71	71	71	71	71	71	71	71	71	71	71	71
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		4	4	4	4	4	4	4	4	4	4	4	4
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	47	47	47	47	47	47	47	47	47	47	47	47
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		71	71	71	71	71	71	71	71	71	71	71	71
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		4	4	4	4	4	4	4	4	4	4	4	4
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	47	47	47	47	47	47	47	47	47	47	47	47
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		71	71	71	71	71	71	71	71	71	71	71	71
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		4	4	4	4	4	4	4	4	4	4	4	4
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	10	10	11	10	10	10	11	12	12	11	10	12
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		13	14	15	14	14	14	14	14	14	14	14	15
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		2	1	1	1	2	1	1	1	1	1	1	1
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	14	15	15	14	14	15	16	17	17	15	14	16
IMPERIAL COLLEGE HEALTHCARE NHS TRUST		18	20	21	20	20	20	20	20	21	20	20	21
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST		2	2	2	2	2	2	2	2	2	2	2	2
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	66	72	60	41	46	79	82	74	90	92	96	87
Urgent Community Response	89	89	90	91	92	89	89	90	91	92	92	91
Reablement at home	280	411	406	462	444	420	425	390	364	525	386	474
Rehabilitation at home	317	399	420	480	512	574	501	435	375	443	519	509
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	308	308	308	308	308	308	308	308	308	308	308	308
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	2427	2427	2427	2427	2427	2427	2427	2427	2427	2427	2427	2427
Reablement at Home	Monthly capacity. Number of new clients.	125	125	125	125	125	125	125	125	125	125	125	125
Rehabilitation at home	Monthly capacity. Number of new clients.	125	125	125	125	125	125	125	125	125	125	125	125
Short term domiciliary care	Monthly capacity. Number of new clients.	125	125	125	125	125	125	125	125	125	125	125	125
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	52	52	52	52	52	52	52	52	52	52	52	52
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	75	75	75	75	75	75	75	75	75	75	75	75

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Social support (including VCS)	Monthly capacity. Number of new clients.	66	72	60	41	46	79	82	74	90	92	96	87	34%	66%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	89	89	90	91	92	89	89	90	91	92	92	91	100%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	280	411	406	462	444	420	425	390	364	525	386	474	85%	15%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	317	399	420	480	512	574	501	435	375	443	519	509	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	308	308	308	308	308	308	308	308	308	308	308	308	100%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Hammersmith and Fulham

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Hammersmith and Fulham	£1,495,597	£1,495,597
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£1,495,597**	**£1,495,597**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Hammersmith and Fulham	£1,405,803	£2,016,000

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North West London ICB	£855,083	£855,083
Total ICB Discharge Fund Contribution	£855,083	£855,083

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Hammersmith and Fulham	£10,027,236	£10,027,236
Total iBCF Contribution	**£10,027,236**	**£10,027,236**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Hammersmith and Fulham	£6,702,808	£6,970,920	At this stage of the budget cycle for 24/25, the LA has assumed 4%
Total Additional Local Authority Contribution	**£6,702,808**	**£6,970,920**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North West London ICB	£17,163,923	£18,135,401
Total NHS Minimum Contribution	**£17,163,923**	**£18,135,401**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS North West London ICB	£4,282,523	£4,282,523	ICB have assumed same as 23/24
Total Additional NHS Contribution	**£4,282,523**	**£4,282,523**	
Total NHS Contribution	**£21,446,446**	**£22,417,924**	

	2023-24	2024-25
Total BCF Pooled Budget	**£41,932,973**	**£43,782,760**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

This version of the BCF plan has been updated to show the provisional allocation of the increased Adult Social Care Discharge Grant in 24/25 which is announced at £1bn nationally. The LA grant for Hammersmith & Fulham has been forecast to increase by 66% (formula advised in the BCF guidance). Final allocations have yet to be determined. The total NWL ICB discharge grant will also increase, but allocations per borough will not be confirmed until completion of a jointly agreed finance & performance review. As such the ICB discharge allocation for Hammersmith & Fulham is provisionally forecast at the same level for 24/25, but is subject to change.

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Hammersmith and Fulham

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£1,495,597	£1,495,597	£0	£1,495,597	£1,495,597	£0
Minimum NHS Contribution	£17,163,923	£17,163,923	£0	£18,135,401	£18,135,401	£0
iBCF	£10,027,236	£10,027,236	£0	£10,027,236	£10,027,236	£0
Additional LA Contribution	£6,702,808	£6,702,808	£0	£6,970,920	£6,970,920	£0
Additional NHS Contribution	£4,282,523	£4,282,523	£0	£4,282,523	£4,282,523	£0
Local Authority Discharge Funding	£1,405,803	£1,405,803	£0	£2,016,000	£2,016,000	£0
ICB Discharge Funding	£855,083	£855,083		£855,083	£855,083	£0
Total	**£41,932,973**	**£41,932,973**	**£0**	**£43,782,760**	**£43,782,760**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,877,501	£9,718,099	£0	£5,153,567	£10,268,143	£0
Adult Social Care services spend from the minimum ICB allocations	£7,445,824	£7,445,824	£0	£7,867,257	£7,867,257	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):
60, 61,

									Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
001	NHS Community Service - Anticipatory Care	Anticipatory care planning and delivery	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£414,310	£437,760	6%
002	Community Independence Service (ICB)	Community Independence Service - Health Element	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£3,672,034	£3,879,871	51%
003	Community Neuro	Community Neuro	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£917,865	£969,817	13%
004	Falls Prevention	Commmunity based Falls Prevention service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£219,334	£231,749	3%
005	Original 256 (Stroke Pathway & Open Age)	Original 256 (Stroke Pathway & Open Age)	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£47,670	£50,368	100%
006	NHS Community Service - Ageing Well Rapid Response	Ageing Well Rapid Response	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£359,552	£379,903	5%
007	Red Cross	Red Cross	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£67,922	£71,766	0%
008	Safeguarding	Safeguarding	Care Act Implementation Related Duties	Safeguarding					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£44,549	£47,070	7%
009	Community Equipment	Community Equipment	Assistive Technologies and Equipment	Community based equipment		13568	13568	Number of beneficiaries	Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£1,148,100	£1,213,082	59%
010	Night Nursing	Community night nursing service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New	£70,257	£74,234	1%
011	Community Matrons	Community matrons	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New	£438,703	£463,534	6%
012	Intermediate care Beds (Alexandra Ward) – CLCH	Bed based intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		154	154	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New	£526,638	£556,446	40%
013	Intermediate care Beds (Athlone Ward) – CLCH	Bed based intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		154	154	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New	£779,479	£823,598	60%

014	Tissue Viability	Community tissue viability service	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New	£180,045	£190,236	3%
015	District Nursing	District nursing care in community	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	New	£831,641	£878,712	12%
016	Community Independence Service - Joint Element	Community Independence Service - Joint Element	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,113,163	£1,176,168	7%
017	S256 Transfer to Social Care	Reablement & Packages of Care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£5,692,469	£6,014,663	35%
018	Care Act	Care Act Implementation Services	Care Act Implementation Related Duties	Other	Care Act				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£640,192	£676,427	93%
019	Farm Lane PFI	Contract Beds - Care UK	Residential Placements	Nursing home		18	18	Number of beds/Placements	Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£1,507,590	£1,507,590	21%
020	St Vincent PFI	Contract Beds - Care UK	Residential Placements	Nursing home		13	13	Number of beds/Placements	Continuing Care		NHS			Local Authority	Additional NHS Contribution	Existing	£1,726,344	£1,726,344	24%
021	PFI Contract Monitoring	Contract Monitoring	Enablers for Integration	Programme management					Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£26,349	£26,349	17%
022	Direct Payment	Direct Payment/ (Personal Budget)	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£42,938	£42,938	49%
023	Joint Equipment Contract Monitoring	Contract Monitoring	Enablers for Integration	Programme management					Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£16,194	£16,194	10%
024	LD Placement Reviewing Officer Dual Diagnosis Worker	LD Placement Reviewing Officer	Workforce recruitment and retention						Mental Health		NHS			Local Authority	Additional NHS Contribution	Existing	£28,407	£28,407	39%
025	Carer's Advice, Info & Support	Carer's Advice, info and support service	Workforce recruitment and retention	Carer advice and support related to Care Act duties					Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£44,989	£44,989	61%
026	Look Ahead North East Cluster	Look Ahead North East Cluster	Housing Related Schemes						Mental Health		NHS			Local Authority	Additional NHS Contribution	Existing	£68,600	£68,600	6%
027	London Cyrenians North West Cluster	London Cyrenians North West Cluster	Housing Related Schemes						Mental Health		NHS			Local Authority	Additional NHS Contribution	Existing	£23,627	£23,627	2%
028	Housing Support (PATHS)	Housing Support (PATHS)/ Hospital Liaison Scheme	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Mental Health		NHS			Local Authority	Additional NHS Contribution	Existing	£23,659	£23,659	0%
029	Dual Diagnosis Worker	Dual Diagnosis Worker	Personalised Care at Home	Mental health /wellbeing					Mental Health		NHS			Local Authority	Additional NHS Contribution	Existing	£28,408	£28,408	32%
030	Groundswell Peer Support	Groundswell Peer Support	Personalised Care at Home	Mental health /wellbeing					Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£16,160	£16,160	18%
031	Contract Monitoring for Support Housing Projects	Contract Monitoring for Supporting Housing Projects	Enablers for Integration	Programme management					Mental Health		NHS			Local Authority	Additional NHS Contribution	Existing	£14,696	£14,696	9%
032	S256 Recurrent Reablement	Enhanced Bolstering	Home-based intermediate care services	Reablement at home (to support discharge)		347	347	Packages	Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£267,755	£267,755	100%
33	7 Day Social Work Service (Formerly System Resilience)	7 Day Social Work Hospital Discharge Service	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			Local Authority	Additional NHS Contribution	Existing	£446,807	£446,807	3%
34	ICB Discharge Funding - Bridging care	Bridging service to support patients on P1 pathway to be discharged home sooner	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs							NHS			Local Authority	ICB Discharge Funding	New	£545,083	£545,083	3%
35	ICB Discharge Funding -	Minterm Development	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs							NHS			Local Authority	ICB Discharge Funding	New	£200,000	£200,000	1%
36	ICB Discharge Funding	Reviewing Officers x 2	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs							NHS			Local Authority	ICB Discharge Funding	New	£110,000	£110,000	1%
37	LA Discharge Funding	Hospital Discharge Programme	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs							LA			Local Authority	Local Authority Discharge	Existing	£1,405,803	£2,016,000	10%
38	Contract Beds Older People (Farm Lane)	Contract Beds	Residential Placements	Nursing home		18	18	Number of beds/Placements	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,493,728	£1,553,477	21%
39	Contract Beds Older People (St Vincent)	Contract Beds	Residential Placements	Nursing home		17	17	Number of beds/Placements	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£2,424,086	£2,521,049	34%
40	Direct Payment	Direct Payment/ (Personal Budget)	Personalised Budgeting and Commissioning						Continuing Care		LA			Private Sector	Additional LA Contribution	Existing	£111,844	£116,318	100%

41	Joint Equipment Budget	Community Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		6188	6188	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£793,200	£824,928	41%
42	Look Ahead North East Cluster	Look Ahead North East Cluster	Housing Related Schemes						Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£451,525	£469,586	41%
43	London Cyrenians North West Cluster	London Cyrenians North West Cluster	Housing Related Schemes						Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£561,496	£583,956	51%
44	Housing Support/ PATHS	Supporting Discharges related to Homelessness	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Mental Health		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£24,513	£25,494	0%
45	Dual Diagnosis Worker	Dual Diagnosis Worker	Prevention / Early Intervention	Other	Frontline clinical post				Mental Health		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£28,778	£29,929	100%
46	Groundswell Peer Service	Groundswell Peer Support	Community Based Schemes	Other	Frontline post				Mental Health		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£42,590	£44,294	1%
47	Safeguarding	Safeguarding Board Costs	Enablers for Integration	New governance arrangements					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£95,808	£99,640	63%
48	Community Independence Service (LA)	Community Independence Service - Joint Element	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£675,240	£702,250	4%
49	Disabled Facilities Grant	Adaptations made to homes to promote community independent living	DFG Related Schemes	Adaptations, including statutory DFG grants		160	160	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,495,597	£1,495,597	100%
50	IBCF	Home Care or Domiciliary Care to support discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		356011	356011		Social Care		LA			Private Sector	iBCF	Existing	£5,808,036	£5,808,036	35%
51	IBCF	Residential Placements	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		69	69		Social Care		LA			Private Sector	iBCF	Existing	£4,219,200	£4,219,200	25%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Hammersmith and Fulham

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	41.6	29.4	39.4	20.0	Avoidable Admissions 23/24 plan set using the data published by BCF National Team on the BCF Portal. The plan is derived by taking the 22/23 actual number of admissions and reducing this by 1% and then using this to calculate the Indicator Value. Please note Q4 has been updated since the last submission and is now based on the Q4	There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could
	Number of Admissions	58	41	55	-		
	Population	185,143	185,143	185,143	185,143		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	41.32	29.92	39.18	34.19		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,417.7	2,341.1	2,317.7	Falls 22/23 estimate was calculated using a combination of the Public Health Outcome Framework Data and the Falls Standardisation Tool Shared by the BCF team. The 23/24 plan was set by reducing the 22/23 actual by 1% and re-calculated the indicator value.	In H&F, we have a falls prevention service. The service provides assessment, advice, exercise and strength and balance groups for older people who are at risk of falling. The service aims to prevent falls and unnecessary admission to hospital by seeing a patient before an injurious fall occurs or after a fall to rebuild strength, balance and confidence. This assessment will identify
	Count	440	440.0	436.0		
	Population	19,101	19,101.0	19,101.0		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	94.8%	95.2%	95.6%	95.0%	Discharge to Usual Place of Residence 23/24 plan was set by using hisoircal data to forecast a 23/24 position and then apply a 1% improvement to this forecasted position to obtain a 23/24 plan. The forecasted (do nothing) estimate was Q1 96.1%, Q2 96.5%, Q3 96.9% and Q4 96.4%.	We are continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, though this remains our longer term plan
	Numerator	2,991	2,964	3,134	2,857		
	Denominator	3,154	3,112	3,277	3,006		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	96.3%	96.7%	97.1%	96.7%		
	Numerator	2,875	2,849	3,009	2,645		
	Denominator	2,984	2,945	3,098	2,736		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	483.4	326.1	285.3	316.1	Ambitions set from targets from the implemented a short term directive not to place in residential to allow us review interim residential placement what were drifting. This directive has since been lifted	Where possible most people should continue to live in their own home with the clinical wraparound they need and the social care support. Only when this is not possible, should nursing and residential care be offered. However, stepdown care in
	Numerator	100	72	63	72		
	Denominator	20,687	22,081	22,081	22,780		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	94.1%	93.8%	92.1%	93.5%	Ambition set from targets from the previous years. In 2022-2023 we	We're continuing to redesign the social care front door so that most people have a period of reablement to prevent unnecessary admission into hospital and to facilitate a speedy discharge home. We have a health and social care - strategic sub-
	Numerator	48	45	140	145		
	Denominator	51	48	152	155		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	PR6	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	PR7	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan