**London Borough of Hammersmith & Fulham**

# Health & Wellbeing Board

## Agenda

**Monday 23 June 2025 at 6.30 pm**

**145 King Street (Ground Floor), Hammersmith, W6 9XY**

**Watch live on YouTube: youtube.com/hammersmithandfulham**

### MEMBERSHIP

Councillor Bora Kwon (Chair) - Cabinet Member for Adult Social Care and Health
Councillor Alex Sanderson – Deputy Leader (with responsibility for Children and Education)
Dr James Cavanagh – H&F GP
Carleen Duffy – Healthwatch H&F
Caroline Farrar – HCP Managing Director
Dr Nicola Lang – Director of Public Health
Katharine Willmette – Interim Director of Adult Social Care
Jacqui McShannon – Executive Director of People's Services
Sarah Bright - Director of People's Commissioning, Transformation and Partnerships
Susan Roostan – H&F ICB Borough Director
Sue Spiller – Chief Executive Officer, SOBUS
Detective Chief Inspector Mark Staples – Metropolitan 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

**CONTACT OFFICER:** David Abbott
Governance and Scrutiny
Tel: 07776 672877
Email: David.Abbott@lbhf.gov.uk
Web: www.lbhf.gov.uk/committees

**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: 13 June 2025

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 - 9

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

**4. BETTER CARE FUND (BCF) QUARTER 4 REPORT 2024-2025** 10 - 42

**5. CHILD DEATH OVERVIEW PANEL NORTH WEST LONDON 2023-24 ANNUAL REPORT** 43 - 54

**6. PHARMACEUTICAL NEEDS ASSESSMENT 2025-28** 55 - 59

**7. WORK PROGRAMME**

To discuss the Board's work programme and suggest items for future meetings.

## 8. DATES OF FUTURE MEETINGS

The following dates of future meetings were noted:

- 10 September 2025
- 3 December 2025
- 18 March 2026
- 22 June 2026

**London Borough of Hammersmith & Fulham**

# Health & Wellbeing Board

## Minutes

**Wednesday 19 March 2025**

**PRESENT**

**Committee members**
Councillor Alex Sanderson (Deputy Leader with responsibility for Children and Education)
Dr James Cavanagh (H&F GP)
Carleen Duffy (Healthwatch H&F)
Dr Nicola Lang (Director of Public Health)
Jacqui McShannon (Executive Director – People)
Susan Roostan (H&F ICB Borough Director)
Sue Spiller (Chief Executive Officer, SOBUS)
Detective Inspector Shakila Khan (Metropolitan Police)

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

**Officers**
Peter Haylock (Operational Director for Education and SEND)
David Abbott (Head of Governance)

**Also attending**
Toby Lambert (H&F ICB Executive Director of Strategy & Population Health)
Peggy Coles (H&F Dementia Partnership Board)

*NOTE: Councillor Alex Sanderson took the Chair for this meeting as she was covering the role of Cabinet Member for Adult Social Care and Health while Councillor Bora Kwon was on medical leave.*

## 1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Bora Kwon, Councillor Helen Rowbottom, Caroline Farrar, Katharine Willmette, and Sarah Bright.

## 2. DECLARATIONS OF INTEREST

There were no declarations of interest.

## 3. MINUTES AND ACTIONS

The minutes of the meeting held on 11 December 2024 were agreed as an accurate record.

## 4. H&F SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) LOCAL AREA SELF EVALUATION

Peter Haylock (Operational Director for Education and SEND) presented the report which provided a summary of the Local Area SEND Self Evaluation.

He highlighted the co-produce the service had done with children, young people, families, the community sector, and other partners to build shared solutions. He noted some recent examples of stakeholder engagement:

- Focused group sessions with young people with special educational needs and disabilities (SEND) and Education, Health, and Care Plans, reflecting on the SEND Outcomes framework and its application in their daily lives.
- Monthly meetings between senior managers and our parent carers forum with additional themed surgeries including Housing and Supported Employment Opportunities.
- Reflective sessions to listen to and hear from young people engaged in the supported employment pathway.
- Community engagement sessions hosted in Family Hubs including termly family voice coffee mornings to allow residents and partners to provide feedback on the hubs and discuss current developments.

Peter Haylock also highlighted that Hammersmith & Fulham Council's online support for children and young people aged up to 25 with special educational needs and disabilities had been named the best in England by the National Association of Family Information Services. He noted the online service had been developed together with families, parents, and carers.

**RESOLVED**

1. That the Health and Wellbeing Board notes the contents of the report and contributes any observations.

## 5. H&F SUICIDE PREVENTION STRATEGY 2024-2027

Dr Nicola Lang (Director of Public Health) introduced the item which presented the Council’s suicide prevention strategy, approved by Cabinet on 3 March 2025.

She noted that the strategy was framed around three main concepts – See, Say, Signpost:

- See – we should monitor and understand local suicide data and recognise the factors that increased the risk of suicidality to be able to identify risk factors and target groups at greater risk and provide focussed support.

- Say - share information with a multi-agency partnership that would take responsibility for reducing the local suicide rate by capitalising on individual expertise and resident touch points.
- Signpost – we should signpost residents to appropriate and effective support that was suitable for their needs. We must ensure that a range of services were available and accessible, addressing the risk factors that were seen locally. And strengthen referral routes between services to make sure that the right support can be proactively signposted to by any service the resident has contacted.

Dr Lang discussed the primary demographics (white, middle-aged males) and risk factors (substance misuse) associated with suicide. She also highlighted some of the prevention work done to date, including discharge packs for mental health patients, a refined bereavement offer, and an awareness campaign launched in September of 2024.

The Chair thanked Dr Lang for the strategy and stressed that every life lost to suicide was a tragedy. She then opened the item up for questions.

Councillor Natalia Perez welcomed the strategy and asked for more information on the multi-agency approach. Dr Lang said, thanks to the police, the Public Health team had access to real time notifications alerting officers to unexplained deaths that required checks. She also noted there were two boards in place. The Suicide Case Review which included representatives from adult social care, mental health services, drug and alcohol services, and housing. It was a confidential meeting that reviewed cases in tranches and tried to take immediate learning points to prevent future cases. There was also a Suicide Prevention Strategy Group which included representatives from criminal justice, the ICS, and Healthwatch.

Nadia Taylor (Healthwatch) asked for a brief summary of actions taken to remedy this issue and why Hammersmith & Fulham had the highest rate of suicide in London. She also highlighted a suicide prevention event held by Healthwatch in September. The Chair said the strategy contained detail of work taken to date and actions planned to prevent future deaths. She also noted that the data lagged and the borough may not have the highest rate anymore. Dr Lang added that the statistics on suicide were very sensitive because they were relatively small numbers. However, she noted that all risk factors would be addressed, even if they pertained to one death.

Dr James Cavanagh (H&F GP) noted that Primary Care Networks were investing in active reviews of patients with severe mental illnesses. He felt there were good links with services like Turning Point who could support people with dependency issues. Health recognised the need to take a proactive approach with people who had high risk factors. He noted they were also involved in the case reviews following any suicide so learning could be shared with health and other providers.

**RESOLVED**

1. That the Health & Wellbeing Board noted the Suicide Prevention Strategy 2024-2027, adopted by Cabinet on 3 March 2025.

## 6. BETTER CARE FUND (BCF) QUARTER 3 REPORT 2024-2025

Jacqui McShannon (Executive Director – People) introduced the Better Care Fund paper which set out the London Borough of Hammersmith & Fulham and the H&F Integrated Care Board's quarter 3 report. She noted the report had been submitted to NHS England on 14 February 2025. She asked members to email in any questions about the paper for a written response.

**RESOLVED**

1. That the Health and Wellbeing Board ratified the BCF quarter 3 report for 2024-2025 (Appendix 1).

2. That the Cabinet Member for Adult Social Care and Health receive an end of year report outlining the outcomes of each scheme and the difference it has made for residents of H&F.

## 7. JOINT FORWARD PLAN FOR NORTH WEST LONDON UPDATE

Susan Roostan (H&F ICB Borough Director) and Toby Lambert (H&F ICB Executive Director of Strategy & Population Health) introduced the Joint Forward Plan which set out how North West London's local NHS services and eight local authorities would improve outcomes in population health, prevent ill health and tackle inequalities, enhance productivity and value for money, and support broader economic and social development.

Toby Lambert noted the plan had been prepared and circulated prior to the Government's announcements about the dissolution of NHS England and the reduction to ICB staffing budgets.

Susan Roostan highlighted the plan's nine priorities and noted that the Integrated Neighbourhood Teams would each lead on one priority and share learning:

- Establish integrated neighbourhood teams with primary care at their heart
- Reduce inequalities and improve health outcomes through population health management
- Optimise ease of movement for patients throughout their care – right care, right place
- Embed access to consistent high-quality community services by maximising productivity
- Improve children and young people's mental health and community care
- Improve mental health services in the community and services for people in crisis
- Transform maternity care

- Increase cancer detection rates and deliver faster access to treatment
- Transform the way planned care works

The Chair asked what the impact of the recent Government announcements would mean for the plan. Toby Lambert said they did not have clarity at this time but the headline figures of 50% reductions to NHS England and the ICBs would revelry restrict their capacity.

The Chair questioned the utility of feeding back on a plan that was likely to be redundant in the coming weeks.

Councillor Natalia Perez asked if the priorities would be revisited and when. Toby Lambert said they had planned to revisit them after the NHS 10-Year Health Plan was due in May. He noted that the current priority was the Integrated Neighbourhood Teams but the new NHS 10-Year Plan could change that.

Dr James Cavanagh said health services had been through several restructures but the key themes and issues for our population would remain the same. He felt strategic documents like the Joint Forward Plan were useful. The Chair said that raised the issue of why those issues hadn't changed in 20 years, noting an example of persistently low testing rates for cervical cancer, despite Imperial having invented a home testing kit.

Susan Roostan noted colleagues were working on how to deliver the changes discussed previously, but said partners shouldn't lose sight of the key priorities in the plan.

**RESOLVED**

1. The update on the Joint Forward Plan was noted.

## 8. HEALTHWATCH UPDATE

Ruchi Wadwa (Healthwatch H&F) gave a presentation on the Healthwatch Hammersmith & Fulham Impact Report which detailed the impact of their work since 2020 under 'Your Voice in Health and Social Care' which gave people a voice to improve and shape services and help them get the best out of health and social care provision.

The Chair asked if Healthwatch was linked to the NHS Patient Advice and Liaison Service and if they had feedback from hospitals. Carleen Duffy said they discussed thematic issues with them.

Councillor Natalia Perez said it was good to hear GPs were expanding online booking options but noted some patients had concerns about accessibility and asked if digital inclusion was being considered. Carleen Duffy (Healthwatch H&F) said digital exclusion was an issue and some people preferred to engage with a person rather than book online. She said digital exclusion was not just linked to age, but disability, mental health, and poverty. Healthwatch had signposted people to

charities that provide devices and classes – and had worked with the ICB on this issue. The Chair added that there were good classes on offer at the Macbeth Centre.

Dr James Cavanagh said the NHS did recognise the risk of digital exclusion and had commissioned proactive lines of activity to reach out to people with learning difficulties and those who were very vulnerable.

Councillor Perez, in the section on suicide prevention, noted Healthwatch had advocated for fast-track referrals and increased drop-in mental health services. She asked if this had been incorporated into the Council's Suicide Strategy. Dr Lang said she would take this forward with Healthwatch.

**ACTION: Dr Nicola Lang / Carleen Duffy**

Nadia Taylor reiterated the concerns about digital exclusion, noting that patients and carers had reported there being more appointment slots available on the online booking system than via phone booking. She suggested GP practices should offer the same number of appointments on the phone and online.

**RESOLVED**

1. The update was noted.

## 9. WORK PROGRAMME

There were no comments on the work programme.

## 10. DATES OF FUTURE MEETINGS

The following dates of future meetings were noted:

- 23 June 2025
- 10 September 2025
- 3 December 2025
- 18 March 2026
- 22 June 2026

Meeting started: 6.35 pm
Meeting ended: 7.44 pm

Chair .....

Contact officer: David Abbott
Governance and Scrutiny
Tel: 07776 672877
Email: David.Abbott@lbhf.gov.uk

**LONDON BOROUGH OF HAMMERSMITH & FULHAM**

| | |
|---|---|
| **Report to:** | Health and Wellbeing Board |
| **Date:** | 23/06/2025 |
| **Subject:** | Better Care Fund (BCF) Quarter 4 report 2024-2025 |
| **Report author:** | Sharlene Spence – Programme Manager, People |
| **Responsible Director:** | Katharine Willmette, Director Adult Social Care (DASS) & Sue Roostan, Borough Director, H&F ICB |

## SUMMARY

This Better Care Fund (BCF) paper sets out the London Borough of Hammersmith & Fulham (H&F) and the H&F Integrated Care Board (ICB)'s quarter 4 report. The report will be submitted to NHS England on 6th June 2025, which was the deadline for submission.

NHS England requires the BCF plan and quarterly reports to be approved by the Health and Wellbeing Board (HWB) or the board's Chair on behalf of the HWB where submission deadlines do not align with the sitting of the board. Where NHS England submissions precede the sitting of the board, HWB Chair's approvals will need to be ratified at the next HWB.

## RECOMMENDATIONS

1. That the Health and Wellbeing Board ratifies the BCF end of year quarter 4 report for 2024- 2025 (Appendix 1).

2. That the Cabinet Member for Adult Social Care and Health ratifies 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.

---

## 1. EXECUTIVE SUMMARY

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 H&F BCF quarter 4 report details the following:

    - Planned and actual expenditure to date
    - Planned and actual outputs delivered to date

4. Where activity levels are low for the time of year when compared against the planned target the responsible officer provides justification within the report. At the moment two of the four BCF metrics are not on track to meet target as follows:

    - **Avoidable *admissions*** (Unplanned hospitalisation for chronic ambulatory care sensitive conditions) - **NHS metric – Data is currently unavailable to** assess progress due to suspected issues with the National BCF Data.
      The ICB Business Intelligence team is collaborating with the National Team to investigate the issue and develop a solution for setting future plans and monitoring progress. While work is ongoing to resolve the data issue, in H&F there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including:

        - Health & Care Partnership (HCP) Diabetes workstream across primary, community and secondary care for timely monitoring, management and prevention of complications.
        - Flu vaccination promotion programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.
        - HCP frailty workstream with focus on frailty pathway to better support frail adults with chronic conditions in the community.

    - ***Discharge to normal place of residence*** (Percentage of people who are discharged from acute hospital to their normal place of residence) - **NHS metric – Target met.**

Our local data shows performance improved in Quarter 4. In Quarter 3, we were facing some challenges, including an increase in patient acuity, which was causing delays. This required additional assessments to determine if patients were suitable for discharge to their usual place of residence.

A programme of work is in place to improve discharge and the flow out of acute hospitals. This includes discharge funding to support a bridging service and better joint working between health and social care. The implementation of the bridging (bridging to home service) has significantly reduced delays in Pathway 1 and facilitated more patients to return home within 12 hours of being discharge ready. This improvement boosted performance in discharging patients to their usual place of residence, particularly for Pathway 1 cases. This also effectively mitigated the necessity for long-term care in residential/nursing settings. In essence, it has ensured that patients are discharged to usual place of residence, averting the escalation of their care needs

There has also been a continued focus as a sector on improving our discharge levels and implementing measures to improve flow through local and sector partnership working. The local schemes/initiatives supporting this metric are:

- Early discharge planning
- Home first
- Enhanced support and training for care homes
- Multi-agency focus on discharge home from hospital
- Multi agency input for reablement and managing people at home

- **Falls** (Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000) - NHS metric – **Target met.**

  It is to be noted that there were previously data quality issues with the Falls data produced by the National BCF Team on NHS Futures, which did not match the Falls data in the Public Health Outcomes Framework (used to set the 24/25 plan). This discrepancy was believed to be due to Transfers data being excluded from the National BCF Data. However, this issue appears to have been addressed in the Falls Data produced by the National BCF Team which now includes Transfers making it more consistent with the Falls data in the Public Health Outcome Framework (which was used to set the plan). It should be noted that the 24/25 plan was initially set using National BCF team data that did not include transfers. Additionally, the Public Health Outcome Framework data was outdated, making it difficult to create a sensible plan.

  A Falls prevention service is in place along with a VCSE service providing a 52 week falls prevention programme.

  In H&F this service provides assessment, advice, exercise, 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 falls risk factors and rehabilitation needs.

Individuals are then invited to join an 8-week physical activity programme to improve strength and balance and increase awareness of falls risk factors.

- ***Residential admissions*** (Rate of permanent admissions to residential care per 100,000 population (65+) – **Local authority metric – Target not met.** The aim of this measure is to support residents to achieve optimal independence and thus avoid residential care where possible. The aim is to remain below the predicted target of 72 residential placements by the end of the year. This figure is our best estimate based on previous demand data which we have reviewed based on actual demand. We were at 79 placements by the end of quarter 4 (7 placements above the target).

  Our rise in numbers of residential placements is largely due to a consistent increase in complexity of resident's needs on discharge from hospital as demonstrated by the increase in emergency care placements made by the local authority which doubled between December 23 to December 24 from 43 to 83 placements.

  We have trailed and explored options for meeting more complex needs in the community for example piloting "Lifestyle units" through Extra Care provision and we have been meeting with supported living providers to discuss other innovative ways in response to increased acute discharge from hospital. However, the figures show the sustained demand for residential placements for residents due to increased acuity of need around delirium and frailty. Residents with complex needs are not always suitable for alternative settings to home on discharge such as inpatient rehab settings or Extra Care Housing. Some residents are unable to return to their properties due to significant issues around self-neglect and hoarding, making wrap around care difficult to deliver in those circumstances. Equally some residents with high levels of care require alternative accommodation due to becoming homeless as part of the hospital admission.

  Current ordinarily available provision such as Extra Care is not the appropriate setting to meet the needs of residents who may require 24 hours care and support. Families and Carers are also finding it increasing difficult to cope at home with their loved ones who have complex needs. These factors culminate into additional demand for residential placements.

  There was an expected increase in placements in Quarter 4 due to Winter Pressures. To help manage the expected demand, we dedicated a small number of nursing beds for step down arrangements. Using step down nursing beds enabled several residents to either return home or access Extra Care housing after a period of recovery and further assessment outside the acute hospital setting. There is a variance of 7 long term residential placements that evidences the increase acuity of need from hospital discharge and some of the barriers described in accessing the right accommodation from the acute hospital setting.

  We are working with our providers to explore alternative models of step-down care to support recovery and rehabilitation from hospital admission.

This includes Extra Care Housing and local nursing homes. Adult social care is also developing a sufficiency strategy which aims to review what social care provision is on offer locally and develop the market to meet future needs of our residents.

## 5. FINANCE SUMMARY

The Better Care Fund Consolidated plan for 2024/25 was £45,661,039. The overall out turn spend was £45,275,046 resulting in an net underspend of (£385,993) which represents less than 1% of the overall plan.

This net underspend comprises of the following:-

- An underspend against Disabled Facilities Grant (DFG) of (£413,431), which was largely due to a backlog in assessments and referrals as a result of a shortage in Occupational Therapist staff.
- A joint overspend against Community Equipment of £29,491 due to over performance of activity during the winter months.
- A minor underspend of (£2,053) against the ICB Hospital Discharge funds against support costs.

## BCF PERFORMANCE

6. Overall delivery of BCF has improved joint working arrangements between health and social care, and our BCF schemes were implemented as planned for 2024 -25. The delivery of our BCF plan 2024 -25 has had a positive impact on the integration of health and social care in our locality.

   Two key successes in driving our enablers for integration through:

   - **Joint Commissioning and Pooled or Aligned Resources**
     We continued to see successful outcomes for our residents via our jointly commissioned Pathway 1 and Pathway 3 schemes for Hospital Discharge. Pathway 1 demonstrated increased flow from hospital using care and an assessment function, ensuring a reduction in the length of stay in hospital. We used discharge funds to procure with ICB contribution several care assessments beds providing a multidisciplinary assessment, and ensuring decisions made about long term care outside of the hospital setting.
   - **Collaborative Leadership and Shared Governance**
     Despite the increased demand in the acute trusts and A&E, we continued to support the majority of our residents to return home promptly using creative and flexible models of care. Our social work teams work as part of the 7-day acute Integrated Discharge hubs that helped to develop the Bridging service this year into a hospital/community pathway, overseen by strong system governance, monitoring and collaborative design.

   Two key challenges in driving our enablers for integration through:

   - **Joint Commissioning and pooled or Aligned Budgets**
     Taking a creative approach, we procured assessments beds within an existing scheme with another local authority that had an established model. We plan to develop this within H&F so we have a local model, but it

will require skills from the provider, and additional wrap around support. Draw backs include moving residents more than once after hospital, difficulties moving people on from this setting, and not all providers can support the level of complexity that comes with residents leaving hospital. We will also explore model of care that support people home with increased care needs to support recovery and maintain a home first approach.

- **Collaborative Leadership and Shared Governance:**
  There have been changes in leadership and organisations are going through challenging transformations, but there are strong relationships between system partners and an appetite to develop the governance structures with work plans that continue to deliver creative, integrated and effective models of care for residents from hospital.

7. The BCF quarter 4 report submission deadline date set by NHS England is 6th June 2025. The Chair of the H&F HWB Board approved the final version of the BCF quarter 4 report before officers submitted it to NHS England.

8. The HWB is asked to ratify the BCF end of year quarter 4 submission 2024 - 2025 which is enclosed with this paper.

**HWB BCF requirements**

9. The HWB is required to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2024-25 continue to be met through the delivery of joint BCF plan[1]

10. The four national conditions are as follows:

- National condition 1: Plans to be jointly agreed – **This has been met.**

The timescales for agreeing BCF plans and assurance are set by NHSE and are typically as follows:

  - BCF planning requirements published by NHSE around April each year.
  - BCF planning submission around June each year.
  - Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation around July each year.
  - Approval letters issued giving formal permission to spend (NHS minimum) around September each year.
  - All section 75 agreements to be signed and in place around October each year.

- National condition 2: Implementing BCF Policy Objective 1: *Enabling people to stay well, safe and independent at home for longer* – **This has been met** as the H&F BCF planning template 2024 - 2025 comprises a list of relevant BCF funded services that were jointly agreed by all partners and signed off

[1] Better Care Fund planning

through the HWB Chair's action on the H&F HWB on 5 July 2024. The enclosed quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services.

- National condition 3: Implementing BCF Policy Objective 2: *Providing the right care in the right place at the right time* – **This continues to be met** as the H&F BCF planning template 2024 - 2025 comprises a list of relevant BCF funded services that were jointly agreed by all partners and signed off through the HWB Chair's action on the H&F HWB on 5 July 2024. The enclosed quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services.

- National condition 4: *Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services*. – **This continues to be met** as the H&F BCF planning template 2024 - 2025 comprises a list of relevant BCF funded services that were jointly agreed by all partners and signed off through the HWB Chair's action on the H&F HWB on 5 July 2024. The enclosed quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services.

11. The key purposes of BCF reporting are as follows:

- To confirm the status of continued compliance against the requirements of the fund (BCF)

- In Quarter 3 to confirm activity, where BCF funded schemes include output estimates, and in Quarter 4 the End of Year to confirm actual income and expenditure in BCF plans

- To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics

- To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

**LIST OF APPENDICES**

Appendix 1 - Quarter 4 End of year submission 2024-2025
Appendix 2 - Summary of progress for previous quarters 1-3

# Better Care Fund 2024-25 EOY Reporting Template

0

**1. Guidance**

## Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.



In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

**Note on entering information into this template**

**Please do not copy and paste into the 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

**Note on viewing the sheets optimally**

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

**Checklist ( 2. Cover )**

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, 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'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

**2. Cover**

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. 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:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

**3. National Conditions**

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

**4. Metrics**

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the second quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- Target met
- Target not met
- Data not available to assess progress



You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns L and M only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

**5. Capacity & Demand Actual Activity**

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D Actual Activity".

**5.1 C&D Guidance & Assumptions**
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.
**5.2 C&D Actual Activity**
Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

**6. Income**

This section require confirmation of actual income received in 2024-25 across each fund.

- Please confirm the total HWB level actual BCF pooled income for 2024-25 by reporting any changes to the planned additional contributions by LAs and NHS as reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre-populate the planned income in 2024-25 from BCF plans, including additional contributions.

**7. Expenditure**

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.

The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
**Overspend** - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation. Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation. This shouldn't include spend which has already been allocated in-year and should be the net position.

**Underspend** - Where there is an underspend please provide details as to the reasons for the underspend.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 7a.

## 8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2024-25 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.



**Part 1 - Delivery of the Better Care Fund**

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of yes/no responses:

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2024-25
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality

**Part 2 - Successes and Challenges**

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

https://www.scie.org.uk/integrated-care/logic-model-for-integrated-care/#enablers

Please highlight:

4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

Please provide narrative for the above 2 questions.

## Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

HM Government

NHS England

# Better Care Fund 2024-25 EOY Reporting Template

**2. Cover**

**Version 1.0**

*Please Note:*

*- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. 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.*

| | |
|---|---|
| **Health and Wellbeing Board:** | Hammersmith and Fulham |
| **Completed by:** | Sharlene Spence, Rashesh Mehta, Chakshu Sharma |
| **E-mail:** | sharlene.spence@lbhf.gov.uk; rasheshmehta@nhs.net; Chakshu.sharma@nhs.net |
| **Contact number:** | 07341672970, 07507637721 |
| **Has this report been signed off by (or on behalf of) the HWB at the time of submission?** | |
| **If no, please indicate when the report is expected to be signed off:** | |

**Checklist**

| Complete: |
|---|
| Yes |
| Yes |
| Yes |
| Yes |
| No |
| No |

**Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.**

**Please see the Checklist on each sheet for further details on incomplete fields**

| | Complete: | |
|---|---|---|
| 2. Cover | No | For further guidance on requirements please refer back to guidance sheet - tab 1. |
| 3. National Conditions | Yes | |
| 4. Metrics | Yes | |
| 5.1 C&D Guidance & Assumptions | Yes | |
| 5.2 C&D Actual Activity | Yes | |
| 6. Income actual | Yes | |
| 7b. Expenditure | Yes | Expenditure Underspent or Overspent |
| 8. Year End Feedback | Yes | |

<< Link to the Guidance sheet

^^ Link back to top

# Better Care Fund 2024-25 EOY Reporting Template

**3. National Conditions**

Selected Health and Wellbeing Board: Hammersmith and Fulham

| | | Checklist Complete: |
|---|---|---|
| **Has the section 75 agreement for your BCF plan been finalised and signed off?** | Yes | Yes |
| **If it has not been signed off, please provide the date section 75 agreement expected to be signed off** | | Yes |
| **If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.** | | Yes |

| **Confirmation of Nation Conditions** | | | |
|---|---|---|---|
| **National Condition** | **Confirmation** | **If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:** | |
| **1) Jointly agreed plan** | Yes | | Yes |
| **2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer** | Yes | | Yes |
| **3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time** | Yes | | Yes |
| **4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services** | Yes | | Yes |

## Better Care Fund 2024-25 EOY Reporting Template

**4. Metrics**

Selected Health and Wellbeing Board: Hammersmith and Fulham

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

| Metric | Definition | For information - Your planned performance as reported in 2024-25 planning Q1 | Q2 | Q3 | Q4 | For information - actual performance for Q3 (For Q4 data,please refer to data pack on BCX) | Assessment of whether ambitions have been met | Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan* | Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics* | Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan* | Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan* | Complete: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Avoidable admissions** | Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i) | 60.3 | 43.3 | 58.2 | 51.1 | 12.5 | Data not available to assess progress | In the Avoidable Admission Indicator data published by the National BCF team the Indicator value drops dramatically during 23/24 with these extremely low figures continuing into 24/25. So there appears to be significant data quality issues and therefore this data cannot be currently used to compare to the 24/25 plan to monitor performance. | NA | NA | In H&F locally there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including:<br>- HCP Diabetes workstream across primary, community and secondary care for timely monitoring, management and prevention of complications.<br>- Flu vaccination promotion programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.<br>- HCP frailty workstream with focus on frailty pathway to better support frail adults with chronic conditions in the community. | Yes |
| **Discharge to normal place of residence** | Percentage of people who are discharged from acute hospital to their normal place of residence | 96.7% | 96.7% | 95.7% | 97.0% | 94.33% | Target met | Our local data shows performance improved in Q4. In Q3, we were facing some challenges, including an increase in patient acuity, which was causing delays. This required additional assessments to determine if patients were suitable for discharge to their usual place of residence. | A programme of work is in place to improve discharge and the flow out of acute hospitals. This includes discharge funding to support a bridging service and better joint working between health and social care. The implementation of the bridging (bridging to home service) has significantly reduced delays in Pathway 1 and facilitated more patients to return home within 12 hours of being discharge ready. This improvement boosted performance in discharging patients to their usual place of residence, particularly for Pathway 1 cases. This also effectively mitigated the necessity for long-term care in residential/nursing settings. In essence, it has ensured that patients are discharged to usual place of residence, averting the escalation of their care needs. | NA | NA | Yes |
| **Falls** | Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | | | | 2,294.0 | 579.3 | Target met | Please note previously there were data quality issues with the Falls data produced by the National BCF Team on NHS Futures not matching the Falls data in the Public Health Outcomes Framework (which was used to set the plan) it was believed this was due to Transfers being excluded from the National BCF Data. However, this issue appears to have been addressed in the Falls Data produced by the National BCF Team which now includes Transfers making it more consistent with the Falls data in the Public Health Outcome Framework (which was used to set the plan). It should be noted that the 24/25 plan was initially set using National BCF team data that did not include transfers. Additionally, the Public Health Outcome Framework data was outdated, making it difficult to create a sensible plan. | Falls prevention service in place along with a VCSE service providing a 52 week falls prevention programme.<br>In H&F this 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 stength, balance and confidence. This assessment will identify falls risk factors and rehabilitation needs.<br>Individuals are then invited to join an 8-week physical activity programme to improve strength and balance and increase awareness of falls risk factors. | NA | NA | Yes |
| **Residential Admissions** | Rate of permanent admissions to residential care per 100,000 population (65+) | | | | 308 | not applicable | Target not met | 79 placements made. The figures show the sustained demand for residential placements for residents due to increased acuity of need around delrium and frailty. Residents with complex needs are not always suitable for alternative settings to home on discharge such as inpatient rehab settings or Extra Care Housing. Some residents are unable to return to the their properties due to significant issues around self neglect and hoarding , making wrap around care difficult to deliver in those circumstances. Equally some resident's with high levels of care require alternative accommodation due to becoming homeless as part of the hospital admission. | There was an expected increase in placements in Q4 due to Winter Pressures. But slower growth of numbers between Q3 and Q4 is down in part to over Winter that supported step down arrangements and provided an alternative to Residential care from hospital. Using step down nursing beds enabled several residents to either return home or access Extra Care housing after a period of recovery and further assessment outside the acute hospital setting. | There is a variance of 7 long term residential placements that challenges and demands of increase acuity of need from hospital discharge and some of the barriers described in accessing the right accommodation from the acute hopsital setting. | We are working with our providers to explore alternative models of step down care to support recovery and rehabiltiation from hospital admission. This includes Extra Care Housing and local nursing homes. | Yes |

# Better Care Fund 2024-25 EOY Reporting Template

**5. Capacity & Demand**

Selected Health and Wellbeing Board: Hammersmith and Fulham

## 5.1 Assumptions

| | Checklist |
|---|---|
| **1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.** | |
| No change but Winter pressures had an impact upon Q4 for residential care placements. We made changes to the reablement inclusion/exclusion criteria to ensure that only the most appropriate residents accessed reablement from hospital discharge. This was enabled via the Bridging Pathway 1 Integrated model.<br><br>As stated in our Q3 returns, prepopulated demand numbers for "social support (including VCS)" and in the community appears significantly higher that our activity - It would be useful to have a definition for "Social Support (including VCS)". | Yes |
| **2. Do you have any capacity concerns for 25-26? Please consider both your community capacity and hospital discharge capacity.** | |
| Funding will support Bridging to continue and P3. We will pivot to make further model changes to assessment that will support more people access reablement via the community. | Yes |
| **3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.** | |
| We adapted through the year building on available resources. For example, we commissioned a small number of beds for step down over Winter to support predicted increased demand for alternative accommodation, alongside our P3 Pathway.<br><br>Enabling discharge: Our sector has established a standardized rehabilitation and Pathway 2 (P2) offer, centrally coordinated through a single point of access known as the Intermediate Care Escalation Hub. This serves as one of the key enablers for facilitating timely discharges. | Yes |
| **4. Do you have any specific support needs to raise? Please consider any priorities for planning readiness for 25/26.** | |
| Locally comissioned beds to support P3 - with wrap around support | Yes |

**Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document**

## 5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

**Hospital Discharge**

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

**Community**

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

## Better Care Fund 2024-25 EOY Reporting Template

**5. Capacity & Demand**

Selected Health and Wellbeing Board: Hammersmith and Fulham

| Actual activity - Hospital Discharge | | Prepopulated demand from 2024-25 plan | | | Actual activity (not including spot purchased capacity) | | | Actual activity through only spot purchasing (doesn't apply to time to service) | | | Checklist |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Service Area | Metric | Jan-25 | Feb-25 | Mar-25 | Jan-25 | Feb-25 | Mar-25 | Jan-25 | Feb-25 | Mar-25 | Complete: |
| Reablement & Rehabilitation at home (pathway 1) | Monthly activity. Number of new clients | 58 | 50 | 60 | 46 | 36 | 29 | 1 | 0 | 0 | Yes |
| Reablement & Rehabilitation at home (pathway 1) | Actual average time from referral to commencement of service (days). All packages (planned and spot purchased) | 2 | 2 | 2 | 2 | 2 | 2 | | | | Yes |
| Short term domiciliary care (pathway 1) | Monthly activity. Number of new clients | 37 | 32 | 40 | 27 | 23 | 32 | 7 | 8 | 5 | Yes |
| Short term domiciliary care (pathway 1) | Actual average time from referral to commencement of service (days) All packages (planned and spot purchased) | 1 | 1 | 1 | 1 | 1 | 1 | | | | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly activity. Number of new clients | 31 | 25 | 32 | 21 | 25 | 19 | 0 | 0 | 0 | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Actual average time from referral to commencement of service (days) All packages (planned and spot purchased) | 2 | 2 | 2 | 0 | 0 | 0 | | | | Yes |
| Other short term bedded care (pathway 2) | Monthly activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Other short term bedded care (pathway 2) | Actual average time from referral to commencement of service (days) All packages (planned and spot purchased) | 0 | 0 | 0 | 0 | 0 | 0 | | | | Yes |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Monthly activity. Number of new clients | 32 | 27 | 34 | 4 | 4 | 5 | 2 | 2 | 1 | Yes |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Actual average time from referral to commencement of service (days) All packages (planned and spot purchased) | 10 | 10 | 10 | 10 | 10 | 10 | | | | Yes |

| Actual activity - Community | | Prepopulated demand from 2024-25 plan | | | Actual activity: | | | Checklist |
|---|---|---|---|---|---|---|---|---|
| Service Area | Metric | Jan-25 | Feb-25 | Mar-25 | Jan-25 | Feb-25 | Mar-25 | Complete: |
| Social support (including VCS) | Monthly activity. Number of new clients. | 92 | 96 | 87 | 37 | 22 | 34 | Yes |
| Urgent Community Response | Monthly activity. Number of new clients. | 92 | 92 | 91 | 106 | 72 | 76 | Yes |
| Reablement & Rehabilitation at home | Monthly activity. Number of new clients. | 37 | 37 | 39 | 11 | 4 | 6 | Yes |
| Reablement & Rehabilitation in a bedded setting | Monthly activity. Number of new clients. | 0 | 0 | 0 | 7 | 10 | 15 | Yes |
| Other short-term social care | Monthly activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | Yes |

# Better Care Fund 2024-25 EOY Reporting Template

**6. Income actual**

Selected Health and Wellbeing Board: Hammersmith and Fulham

| | 2024-25 | | | | Checklist |
|---|---|---|---|---|---|
| **Source of Funding** | Planned Income | Actual income | Carried from previous year (23-24) | Actual total income (Column D + E) | Complete: |
| DFG | £1,631,323 | £1,631,323 | £0 | £1,631,323 | Yes |
| Minimum NHS Contribution | £18,135,401 | £18,135,401 | | £18,135,401 | Yes |
| iBCF | £10,027,236 | £10,027,236 | | £10,027,236 | Yes |
| Additional LA Contribution | £7,518,282 | £7,518,282 | | £7,518,282 | Yes |
| Additional NHS Contribution | £4,421,746 | £4,421,746 | | £4,421,746 | Yes |
| Local Authority Discharge Funding | £2,343,005 | £2,343,005 | | £2,343,005 | Yes |
| ICB Discharge Funding | £1,584,046 | £1,584,046 | | £1,584,046 | Yes |
| **Total** | **£45,661,039** | | | **£45,661,039** | |

# 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<br>2. Digital participation services<br>3. Community based equipment<br>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<br>2. Safeguarding<br>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<br>2. Carer advice and support related to Care Act duties<br>3. Other | Supporting people to sustain their role as carers and reduce the likelihood of crisis.<br><br>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<br>2. Multidisciplinary teams that are supporting independence, such as anticipatory care<br>3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0)<br>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)<br><br>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<br>2. Discretionary use of DFG<br>3. Handyperson services<br>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.<br><br>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<br>2. System IT Interoperability<br>3. Programme management<br>4. Research and evaluation<br>5. Workforce development<br>6. New governance arrangements<br>7. Voluntary Sector Business Development<br>8. Joint commissioning infrastructure<br>9. Integrated models of provision<br>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.<br><br>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<br>2. Monitoring and responding to system demand and capacity<br>3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge<br>4. Home First/Discharge to Assess - process support/core costs<br>5. Flexible working patterns (including 7 day working)<br>6. Trusted Assessment<br>7. Engagement and Choice<br>8. Improved discharge to Care Homes<br>9. Housing and related services<br>10. Red Bag scheme<br>11. Other | The ten 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<br>2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)<br>3. Short term domiciliary care (without reablement input)<br>4. Domiciliary care workforce development<br>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<br>2. Assessment teams/joint assessment<br>3. Support for implementation of anticipatory care<br>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.<br><br>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.<br><br>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)<br>2. Bed-based intermediate care with reablement (to support discharge)<br>3. Bed-based intermediate care with rehabilitation (to support admission avoidance)<br>4. Bed-based intermediate care with reablement (to support admissions avoidance)<br>5. Bed-based intermediate care with rehabilitation accepting step up and step down users<br>6. Bed-based intermediate care with reablement accepting step up and step down users<br>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)<br>2. Reablement at home (to prevent admission to hospital or residential care)<br>3. Reablement at home (accepting step up and step down users)<br>4. Rehabilitation at home (to support discharge)<br>5. Rehabilitation at home (to prevent admission to hospital or residential care)<br>6. Rehabilitation at home (accepting step up and step down users)<br>7. Joint reablement and rehabilitation service (to support discharge)<br>8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)<br>9. Joint reablement and rehabilitation service (accepting step up and step down users)<br>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<br>2. Physical health/wellbeing<br>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<br>2. Risk Stratification<br>3. Choice Policy<br>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<br>2. Learning disability<br>3. Extra care<br>4. Care home<br>5. Nursing home<br>6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement<br>7. Short term residential care (without rehabilitation or reablement input)<br>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<br>2. Local recruitment initiatives<br>3. Increase hours worked by existing workforce<br>4. Additional or redeployed capacity from current care workers<br>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 or Domiciliary Care | Hours of care (Unless short-term in which case it is packages) |
| Bed based intermediate Care Services | Number of placements |
| Home-based intermediate care services | Packages |
| Residential Placements | Number of beds |
| DFG Related Schemes | Number of adaptations funded/people supported |
| Workforce Recruitment and Retention | WTE's gained |
| Carers Services | Beneficiaries |

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

**Better Care Fund 2024-25 EOY Reporting Template**

**7b. Expenditure**

To Add New Schemes

Selected Health and Wellbeing Board: Hammersmith and Fulham

| Running Balances | 2024-25 Income | Expenditure to date | Percentage spent | Balance | | If underspent, please provide reasons |
|---|---|---|---|---|---|---|
| DFG | £1,631,323 | £1,217,892 | 74.66% | £413,431 | Underspent! | Under Performance due to significant backlog of assessments by occupational therapists. |
| Minimum NHS Contribution | £18,135,401 | £18,152,014 | 100.09% | -£16,613 | Overspent! | Over Performance in Community Equipment spend for the winter months particularly |
| iBCF | £10,027,236 | £10,027,236 | 100.00% | £0 | | |
| Additional LA Contribution | £7,518,282 | £7,531,160 | 100.17% | -£12,878 | Overspent! | Over Performance in Community Equipment spend for the winter months particularly last quarter |
| Additional NHS Contribution | £4,421,746 | £4,421,746 | 100.00% | £0 | | |
| Local Authority Discharge Funding | £2,343,005 | £2,343,005 | 100.00% | £0 | | |
| ICB Discharge Funding | £1,584,046 | £1,581,993 | 99.87% | £2,053 | Underspent! | £2k Underspend due to slight reduction in support costs |
| **Total** | **£45,661,039** | **£45,275,046** | **99.15%** | **£385,993** | Underspent! | reasons outlined above |

**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).

| | 2024-25 Minimum Required Spend | Expenditure to date | Balance |
|---|---|---|---|
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £5,153,567 | £10,284,756 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £7,867,257 | £7,867,258 | £0 |

**Checklist** Column complete: Yes Yes

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | Planned Outputs for 2024-25 | Outputs delivered to date (Number or NA if no plan) | 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 | Previously entered Expenditure for 2024-25 (£) | Actual Spend (£) | Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent) | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 001 | NHS Community Service - Anticipatory Care | Anticipatory care planning and delivery | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | 0 | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ 416,796 | £416,796 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 002 | Community Independence Service (ICB) | Community Independence Service - Health Element | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ 3,694,066 | £3,694,066 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 003 | Community Neuro | Community Neuro | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ 923,373 | £923,373 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 004 | Falls Prevention | Commmunity based Falls Prevention service | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ 220,650 | £220,650 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 005 | Original 256 (Stroke Pathway & Open Age) | Original 256 (Stroke Pathway & Open Age) | Integrated Care Planning and Navigation | Care navigation and planning | | 0 | NA | | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution | £ 47,956 | £46,667 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 006 | NHS Community Service - Ageing Well Rapid | Ageing Well Rapid Response | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ 361,709 | £361,709 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 007 | Red Cross | Red Cross | High Impact Change Model for Managing Transfer of Care | Early Discharge Planning | | 0 | NA | | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution | £ 68,329 | £68,296 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 008 | Safeguarding | Safeguarding | Care Act Implementation Related Duties | Safeguarding | | | NA | | Community Health | | NHS | | | Local Authority | Minimum NHS Contribution | £ 47,070 | £47,070 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 009 | Community Equipment | Community Equipment | Assistive Technologies and Equipment | Community based equipment | | 13568 | 4127 | Number of beneficiaries | Community Health | | NHS | | | Local Authority | Minimum NHS Contribution | £ 1,213,082 | £1,231,017 | | As per Over-performance provided at M12 reporting to ICB. Please note that the pre-populated figures in the output column J |
| 010 | Night Nursing | Community night nursing service | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ 70,679 | £70,679 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 011 | Community Matrons | Community matrons | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ | 441,335 | £441,335 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 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) | | 43 | 39 | Number of placements | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ | 529,798 | £529,798 | | Expenditure To Plan |
| 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) | | 76 | 80 | Number of placements | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ | 784,156 | £784,156 | | Expenditure To Plan |
| 014 | Tissue Viability | Community tissue viability service | Community Based Schemes | Integrated neighbourhood services | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ | 181,125 | £181,125 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 015 | District Nursing | District nursing care in community | Community Based Schemes | Integrated neighbourhood services | | 0 | NA | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | £ | 1,268,019 | £1,268,019 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 016 | Community Independence Service - Joint | Community Independence Service - Joint Element | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | NA | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £ | 1,176,168 | £1,176,168 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 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 | | | NA | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £ | 6,014,663 | £6,014,663 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 018 | Care Act | Care Act Implementation Services | Care Act Implementation Related Duties | Other | Care Act | | NA | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £ | 676,427 | £676,427 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 019 | Farm Lane PFI | Contract Beds - Care UK | Residential Placements | Nursing home | | 32 | 32 | Number of beds | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 1,556,415 | £1,556,415 | | Expenditure To Plan |
| 020 | St Vincent PFI | Contract Beds - Care UK | Residential Placements | Nursing home | | 30 | 30 | Number of beds | Continuing Care | | NHS | | | Local Authority | Additional NHS Contribution | £ | 1,785,931 | £1,785,931 | | Expenditure To Plan |
| 021 | PFI Contract Monitoring | Contract Monitoring | Enablers for Integration | Programme management | | | NA | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 26,349 | £26,349 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 022 | Direct Payment | Direct Payment/ (Personal Budget) | Personalised Care at Home | Physical health/wellbeing | | 0 | NA | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 44,655 | £44,655 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 023 | Joint Equipment Contract Monitoring | Contract Monitoring | Enablers for Integration | Programme management | | | NA | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 16,194 | £16,194 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 024 | LD Placement Reviewing Officer Dual Diagnosis | LD Placement Reviewing Officer | Workforce recruitment and retention | | | | 1 | WTE's gained | Mental Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 53,164 | £53,164 | | Expenditure To Plan |
| 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 | | | 1 | WTE's gained | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 44,989 | £44,989 | | Expenditure To Plan |
| 026 | Look Ahead North East Cluster | Look Ahead North East Cluster | Housing Related Schemes | | | 0 | NA | | Mental Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 71,344 | £71,344 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 027 | London Cyrenians North West Cluster | London Cyrenians North West Cluster | Housing Related Schemes | | | 0 | NA | | Mental Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 24,572 | £24,574 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 028 | Housing Support (PATHS) | Housing Support (PATHS)/ Hospital Liaison Scheme | High Impact Change Model for Managing Transfer of Care | Early Discharge Planning | | | NA | | Mental Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 23,659 | £23,659 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 029 | Dual Diagnosis Worker | Dual Diagnosis Worker | Personalised Care at Home | Mental health /wellbeing | | | NA | | Mental Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 28,408 | £28,408 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 030 | Groundswell Peer Support | Groundswell Peer Support | Personalised Care at Home | Mental health /wellbeing | | 0 | NA | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 16,806 | £16,806 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 031 | Contract Monitoring for Support Housing | Contract Monitoring for Supporting Housing Projects | Enablers for Integration | Programme management | | | NA | | Mental Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 14,696 | £14,696 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 032 | S256 Recurrent Reablement | Enhanced Bolstering | Home-based intermediate care services | Reablement at home (to support discharge) | | 347 | 57 | Packages | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 267,755 | £267,755 | | Expenditure To Plan. Activity: Please note that the pre-populated figures in the output column J are incorrect and not in |
| 33 | 7 Day Social Work Service (Formerly System | 7 Day Social Work Hospital Discharge Service | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | | NA | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution | £ | 446,807 | £446,807 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 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 | | 0 | NA | | | | NHS | | | Local Authority | ICB Discharge Funding | £ | 654,100 | £654,100 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 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 | | | NA | | | | NHS | | | Local Authority | ICB Discharge Funding | £ | 110,000 | £110,000 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 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 | | 0 | NA | | | | LA | | | Local Authority | Local Authority Discharge | £ | 2,343,005 | £2,343,005 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 38 | Contract Beds Older People (Farm Lane) | Contract Beds | Residential Placements | Nursing home | | 28 | 28 | Number of beds | Social Care | | LA | | | Private Sector | Additional LA Contribution | £ 1,564,309 | £1,564,559 | | Expenditure To Plan |
| 39 | Contract Beds Older People (St Vincent) | Contract Beds | Residential Placements | Nursing home | | 40 | 40 | Number of beds | Social Care | | LA | | | Private Sector | Additional LA Contribution | £ 2,534,986 | £2,534,986 | | Expenditure To Plan |
| 40 | Direct Payment | Direct Payment/ (Personal Budget) | Personalised Budgeting and Commissioning | | | 0 | NA | | Continuing Care | | LA | | | Private Sector | Additional LA Contribution | £ 129,859 | £129,859 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 41 | Joint Equipment Budget | Community Equipment | Assistive Technologies and Equipment | Assistive technologies including telecare | | 1927 | 2873 | Number of beneficiaries | Social Care | | LA | | | Local Authority | Additional LA Contribution | £ 877,300 | £889,927 | | Over Performance in number of residents who were beneficiaries of Community Equipment. Pease note that the pre- |
| 42 | Look Ahead North East Cluster | Look Ahead North East Cluster | Housing Related Schemes | | | | NA | | Social Care | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £ 469,586 | £469,586 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 43 | London Cyrenians North West Cluster | London Cyrenians North West Cluster | Housing Related Schemes | | | | NA | | Social Care | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £ 583,956 | £583,956 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 44 | Housing Support/ PATHS | Supporting Discharges related to Homelessness | High Impact Change Model for Managing Transfer of Care | Early Discharge Planning | | 0 | NA | | Mental Health | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £ 25,248 | £25,248 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 45 | Dual Diagnosis Worker | Dual Diagnosis Worker | Prevention / Early Intervention | Other | Frontline clinical post | 0 | NA | | Mental Health | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £ 29,642 | £29,642 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 46 | Groundswell Peer Service | Groundswell Peer Support | Community Based Schemes | Other | Frontline post | | NA | | Mental Health | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £ 44,294 | £44,294 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 47 | Safeguarding | Safeguarding Board Costs | Enablers for Integration | New governance arrangements | | 0 | NA | | Social Care | | LA | | | Local Authority | Additional LA Contribution | £ 106,575 | £106,575 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 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 | | 0 | NA | | Social Care | | LA | | | Local Authority | Additional LA Contribution | £ 797,400 | £797,400 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 49 | Disabled Facilities Grant | Adaptations made to homes to promote community independent living | DFG Related Schemes | Adaptations, including statutory DFG grants | | 201 | 86 | Number of adaptations funded/people supported | Social Care | | LA | | | Local Authority | DFG | £ 1,631,323 | £1,217,892 | | Under Performance due to significant backlog of assessments by occupational therapists. |
| 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 | 269571 | | Social Care | | LA | | | Private Sector | iBCF | £ 5,808,036 | £5,808,036 | | Expenditure To Plan |
| 51 | IBCF | Residential Placements | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | 69 | 53 | | Social Care | | LA | | | Private Sector | iBCF | £ 4,219,200 | £4,219,200 | | Expenditure To Plan, |
| 52 | Community Based Schemes - Rehab beds in Furness | Shared scheme to improve access to and outcomes for pathway 2 rehab for all age, | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | 0 | 57 | 57 | Number of placements | Community Health | 0 | NHS | 0 | | NHS Community Provider | ICB Discharge Funding | £ 120,574 | £120,575 | | Expenditure To Plan |
| 53 | Supporting patients where there is unclear | To facilitate discharge for patients not meeting CHC or ASC criteria e.g. | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | 0 | 0 | NA | | Continuing Care | 0 | NHS | 0 | | NHS | ICB Discharge Funding | £ 220,584 | £220,584 | | Expenditure To Plan, Note activity (Outputs) were not in plan hence column K marked as NA |
| 54 | Strategic Support from NWL ICB Central Team | Central ICB Support for Borough based teams | Workforce recruitment and retention | Local recruitment initiatives | 0 | 1 | 1 | WTE's gained | Other | NWL ICB | NHS | 0 | | NHS | ICB Discharge Funding | £ 50,500 | £48,446 | | £2k Underspend due to slight reduction in support costs' |
| 55 | Pathway 3 Capacity for complex needs | Health funding for complex care patients in P3 beds/other settings. For | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | 0 | 8 | 15 | Number of placements | Community Health | 0 | NHS | 0 | | Local Authority | ICB Discharge Funding | £ 428,288 | £428,288 | | Expenditure To Plan |
| 56 | Disabled Facilities Grant | Adaptations made to homes to promote community independent living | DFG Related Schemes | Adaptations, including statutory DFG grants | 0 | 42 | 19 | Number of adaptations funded/people supported | Social Care | 0 | LA | 0 | | Local Authority | Additional LA Contribution | £ 355,128 | £355,128 | | Expenditure To Plan |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |

# Better Care Fund 2024-25 EOY Reporting Template

**8. Year End Impact Summary**

Selected Health and Wellbeing Board: Hammersmith and Fulham

| Confirmation of Statements | | | Checklist Complete: |
|---|---|---|---|
| **Question statements** | **Confirmation** | **If the answer is "No" please provide an explanation:** | |
| **Overall delivery of BCF has improved joint working between health and social care** | Yes | | Yes |
| **Our BCF schemes were implemented as planned in 2024-25** | Yes | | Yes |
| **The delivery of our BCF plan 2024-25 has had a positive impact on the integration of health and social care in our locality.** | Yes | | Yes |

| Highlight success and challenges within reference to the most relevant enablers from SCIE logic model: | |
|---|---|
| **Logic model for integrated care - SCIE** | |
| **Success and Challenges** | **Narrative** |

| | | |
|---|---|---|
| **2 key successes observed towards driving the enablers for integration** | Success 1: Joint Commissioning and Pooled or Aligned Resources: We continued to see successful outcomes for our residents via our jointly commissioned Pathway 1 and Pathway 3 schemes for Hospital Discharge. Pathway 1 demonstrated increased flow from hospital using care and an assessment function, ensuring a reduction in the length of stay in hospital. We used discharge funds to procure with ICB contribution a number of care assessments beds providing a multidisciplinary assessment, and ensuring decisions made about long term care outside of the hospital setting.<br><br>Success 2: Collaborative Leadership and Shared Governance. Despite the increased demand in the acute trusts and A&E, we continued to support the majority of our residents to return home promptly using creative and flexible models of care. Our social work teams work as part of the 7-day acute Integrated Discharge hubs that helped to develop the Bridging service this year into a hospital/community pathway, overseen by strong system governance, monitoring and collaborative design. | Yes |
| **2 key challenges observed towards driving the enablers for integration** | Challenge 1: Joint Commissioning and pooled or Aligned Budgets. Taking a creative approach, we procured assessments beds within an existing scheme with another local authority that had an established model. We plan to develop this within H&F so we have a local model, but it will require skills from the provider, and additional wrap around support. Draw backs include moving residents more than once after hospital, difficulties moving people on from this setting, and not all providers can support the level of complexity that comes with residents leaving hospital. We will also explore model of care that support people home with increased care needs to support recovery, and maintain a home first approach.<br><br>Challenge 2: Collaborative Leadership and Shared Governance. There have been changes in leadership and organisations are going through challenging transformations, but there are strong relationships between system partners and an appetite to develop the governance structures with work plans that continue to deliver creative, integrated and effective models of care for residents from hospital. | Yes |

Appendix 2

**SUMMARY OF THE ANNUAL PROGRESS PER QUARTER:**

| QUARTERLY ACTIVITY TRACKING | | NATIONAL CONDITIONS |
|---|---|---|
| **Q1** | The continued ICB discharge funding in 2024/25 allowed for improvements to our bridging service utilisation, model standardisation, and further embedding of the model to continue to reduce delays for pathway 1[1] patients.<br><br>Additionally, this ensured more patients received access to timely care at home which reduced the risk of deterioration due to unnecessary hospital stays, allowing more patients to have the opportunity to recover at home as the most appropriate support for their on-going care to be identified through an assessment at home. | **National Condition 1:**<br>*Plans to be jointly agreed.*<br><br>**Continues to be met**. |
| | | **National Condition 2:**<br>***Implementing BCF Policy Objective 1:***<br>*Enabling people to stay well, safe and independent at home for longer.*<br><br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. |
| | | **National Condition 3:**<br>***Implementing BCF Policy Objective 2:***<br>*Providing the right care in the right place at the right time.*<br><br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detailed planned versus delivered outputs for the BCF funded services. |
| | | **National Condition 4:**<br>*Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services*.<br><br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all. The quarter 1 submission template also detailed planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services. |

| | | |
|---|---|---|
| **Q2** | **Avoidable admissions** *(Unplanned hospitalisation for chronic ambulatory care sensitive conditions)*<br>*NHS metric* – **Data not available to assess progress due to ICB Business Intelligence team working on adapting their reporting format.**<br><br>**Discharge to normal place of residence** *(Percentage of people who are discharged from acute hospital to their normal place of residence)*<br>*NHS metric* – **On track to meet target.**<br><br>**Falls** *(Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000*)<br>*NHS metric* – **Data not available to assess progress due to ICB Business Intelligence team working on adapting their reporting format.**<br><br>**Residential admissions** *(Rate of permanent admissions to residential care per 100,000 population (65+)*<br>*Local authority metric* – **Not on track to meet target.**<br>• H&F rise in numbers of residential placements due largely to increase in level of resident need as they are being discharged from hospital. The BCF through discharge funding is helping to manage this as it is enabling a focus on strengthening our bridging services as we work on its utilisation, model standardisation, and further embedding of the model to help reduce delays for pathway 1 patients.<br>• Our extra care stepdown facility "Minterne Lifestyle beds" is operating at full capacity and we are working at better understanding how to improve the residents move on through the discharge pathway so we maximise it use. We are also meeting with extra care, learning disabilities and mental health supported living providers to discuss innovative ways to ensure | **National Condition 1:**<br>*Plans to be jointly agreed.*<br><br>**Continues to be met.**<br><br>**National Condition 2:**<br>***Implementing BCF Policy Objective 1:*** *Enabling people to stay well, safe and independent at home for longer.*<br>**Continues to be met:** the relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detailed planned versus delivered outputs to date for the BCF funded services.<br><br>**National Condition 3:**<br>***Implementing BCF Policy Objective 2:*** *Providing the right care in the right place at the right time.*<br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also details planned versus delivered outputs to date for the BCF funded services.<br><br>**National condition 4:**<br>*Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services.*<br><br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services. |

| | | |
|---|---|---|
| | we increase admission into extra care settings from their specialist supported living services. | |
| **Q3** | **Avoidable admissions** *(Unplanned hospitalisation for chronic ambulatory care sensitive conditions)*<br>*NHS metric* – **Data is currently unavailable to assess progress due to suspected issues with the National BCF Data.**<br>The ICB Business Intelligence team is collaborating with the National Team to investigate the issue and develop a solution for setting future plans and monitoring progress. While work is ongoing to resolve the data issue, in H&F there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including:<br>• Health & Care Partnership (HCP) Diabetes workstream across primary, community and secondary care for timely monitoring, management and prevention of complications.<br>• Flu vaccination promotion programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.<br>• HCP frailty workstream with focus on frailty pathway to better support frail adults with chronic conditions in the community.<br><br>**Discharge to normal place of residence** *(Percentage of people who are discharged from acute hospital to their normal place of residence)*<br>*NHS metric* – **On track to meet target.**<br><br>Whilst we are on track to meet this target by year-end, we are facing some challenges, including an increase in patient acuity, which is causing delays. This requires additional assessments to determine if patients are suitable for discharge to their usual place of residence. A programme of work is in place to improve discharge and the flow out of acute hospitals. This includes discharge funding to support a | **National Condition 1:**<br>Plans to be jointly agreed.<br>**Continues to be met:** The timescales for agreeing BCF plans, and assurance set by NHSE and are typically as follows:<br>• BCF planning requirements published by NHSE around April each year.<br>• BCF planning submission around June each year.<br>• Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation around July each year.<br>• Approval letters issued giving formal permission to spend (NHS minimum) around September each year.<br>• All section 75 agreements to be signed and in place around October each year.<br><br>**National Condition 2:**<br>***Implementing BCF Policy Objective 1****:*<br>*Enabling people to stay well, safe and independent at home for longer.*<br><br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services.<br><br>**National Condition 3:**<br>***Implementing BCF Policy Objective 2:***<br>*Providing the right care in the right place at the right time.* |

| | | |
|---|---|---|
| | bridging service and better joint working between health and social care. The implementation of the bridging (bridging to home service) has significantly reduced delays in Pathway 1 and facilitated more patients to return home within 12 hours of being discharge ready. It also mitigated the necessity for long-term care in residential/nursing settings. In essence, it has ensured that patients are discharged to usual place of residence, averting the escalation of their care needs.<br><br>There is also a continued focus as a sector on improving our discharge levels and implementing measures to improve flow through local and sector partnership working. The local schemes/initiatives supporting this metric are:<br>• Early discharge planning<br>• Home first<br>• Enhanced support and training for care homes<br>• Multi-agency focus on discharge home from hospital<br>• Multi agency input for reablement and managing people at home<br><br>**Falls** *(Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000)*<br>*NHS metric* – **On track to meet target.**<br>It is to be noted that there were previously data quality issues with the Falls data produced by the National BCF Team on NHS Futures, which did not match the Falls data in the Public Health Outcomes Framework (used to set the 24/25 plan). This discrepancy was believed to be due to Transfers data being excluded from the National BCF Data however, this issue has been resolved in Q3. Although the BCF Data from the National BCF Team now includes Transfers, making it more consistent with the Falls data in the Public Health Outcome Framework, it should be noted that the 24/25 plan was initially set using National BCF team data that did not include | **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services.<br><br>**National Condition 4:**<br>***Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services*.**<br>**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services. |

| | | |
|---|---|---|
| | transfers. Additionally, the Public Health Outcome Framework data was outdated, making it difficult to create a sensible plan.<br><br>**Residential admissions** *(Rate of permanent admissions to residential care per 100,000 population (65+)*<br>*Local authority metric* – **Not on track.**<br>The aim of this measure is to support residents to achieve optimal independence and thus avoid residential care where possible. The aim is to remain below 72 residential placements by the end of the year. We were at 63 placements by the end of quarter 3 (9 placements below the target).<br>Our rise in numbers of residential placements is largely due to a consistent increase in complexity of resident's needs on discharge from hospital as demonstrated by the increase in emergency care placements made by the local authority which has doubled between December 23 to December 24 from 43 to 83 placements. We have been trialling and exploring options for meeting more complex needs in the community for example piloting "Lifestyle units" through Extra Care provision and we are meeting with supported living providers to discuss other innovative ways in response to increased acute discharge from hospital. However, current ordinarily available provision such as Extra Care is not the appropriate setting to meet the needs of residents who may require 24 hours care and support. Families and Carers are also finding it increasing difficult to cope at home with their loved ones who have complex needs. These factors culminate into additional demand for residential placements.<br><br>Going forward we intend to monitor our levels of residential admissions within a range as this is more likely to take account of the unpredictability and complexity of residents needs as we continue to strive to keep our residents living at home in the community for a long | |

| | | |
|---|---|---|
| | as possible and manage the demand for residential placements at the same time.<br><br>Adult social care is also developing a sufficiency strategy which aims to review what social care provision is on offer locally and develop the market to meet future needs of our residents. | |

**LONDON BOROUGH OF HAMMERSMITH & FULHAM**

**Report to:** Health and Wellbeing Board

**Date:** 23/06/2025

**Subject:** Child Death Overview Panel North West London 2023-24 Annual Report

**Report authors:** Dr Nicola Lang, Director of Public Health
Bonnie Blackman Child Death Review Senior Manager (interim)
North West London Integrated Care Board

**Responsible Director:** Jacqui McShannon, Executive Director of People's Services

---

**SUMMARY**

A Child Death Overview Panel (CDOP) is a group of professionals who review all child deaths to identify potential preventable factors and improve child health, safety, and well-being. The panel aims to learn from these deaths to prevent future occurrences and ensure all children receive the best possible care.

This presentation from the North West London CDOP summarises the findings and learning from such cases in Hammersmith and Fulham and North West London in 2023-24.

---

**RECOMMENDATIONS**

1. That the Health and Wellbeing Board note the findings of the North West London CDOP 2023-24 report.

---

**Wards Affected**: All

---

**Background Papers Used in Preparing This Report**
None.

---

**LIST OF APPENDICES**
Appendix 1 - NHS North West London Child Death Review Team Annual Report 2023-2024

North West London Integrated Care System
Working together for better health and care

NHS North West London

# NHS North West London Child Death Review Team

## Annual Report 2023 - 2024

## Health and Wellbeing Board

# What we look for

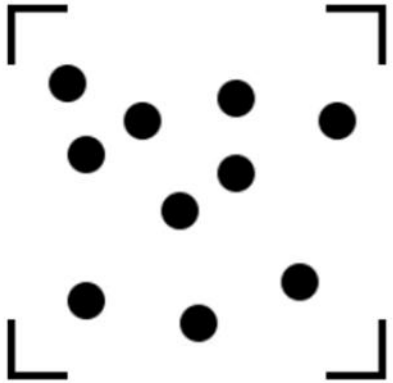
- Cases that should be notified as a serious incident
- Cases affecting the safety and welfare of children
- Wider public health or safety concerns
- Ways to improve holistic care for any children and their families
- Good  practice and opportunities to improve

# Seeking clarity

- Clarify the cause of death
- Determine whether there are contributory factors
- Identify any learning that may prevent future deaths
- Make recommendations to relevant organisations where actions have been identified that might prevent future deaths
- Provide data to the National Child Mortality Database.

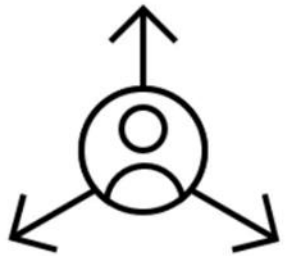
# 2024 From geography to typology; themed panels

- During 2023-2024 NWL convened three different CDOPs
  - A neo natal panel for all babies under 28 days old (neonates)
  - Flute panel which reviewed non “neonates” resident in Brent, Harrow, Hammersmith and Fulham, Kensington and Chelsea and the City of Westminster.
  - Triangle panel which reviewed non “neonates” resident in Hounslow, Ealing and Hillingdon.



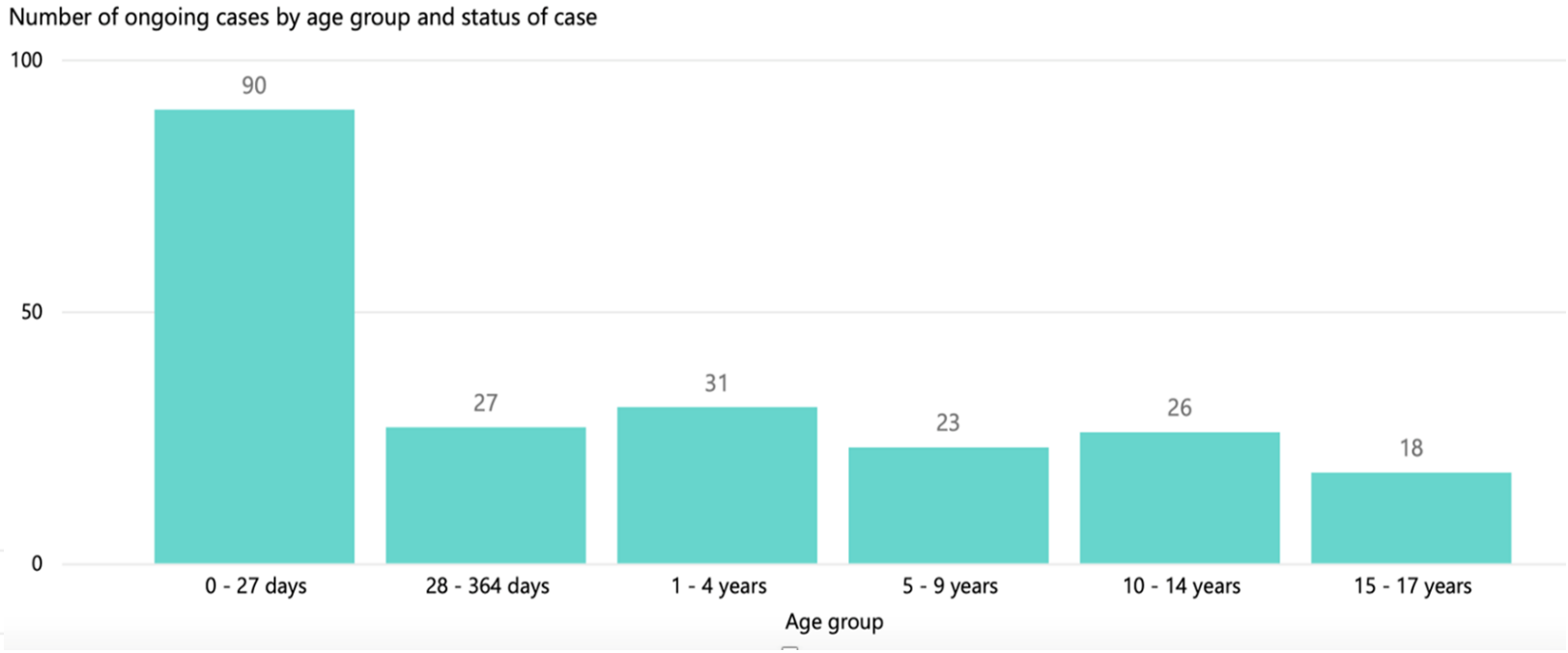
CONTEXT

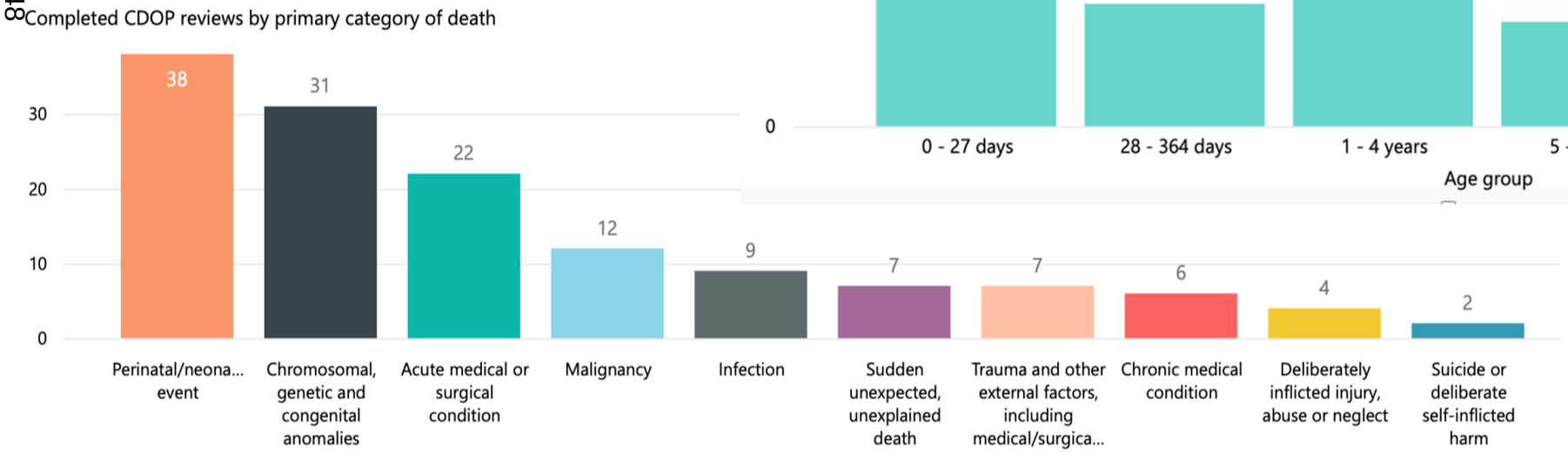
- In September 2024 we have made a change to themed panels:
  - Neonatal
  - Trauma
  - Sudden and unexplained deaths (SUDI)
  - Medical
  - Palliative



PRESENTATION/

# Causes and ages of Death



# Cases by local authority area

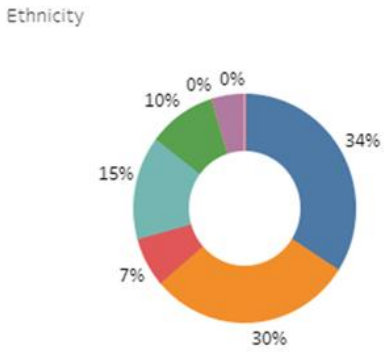
| Local Authority | Deaths Notified | Cases Finalised |
|---|---|---|
| Brent | 26 | 21 |
| Ealing | 24 | 22 |
| Hammersmith and Fulham | 14 | 12 |
| Harrow | 16 | 23 |
| Hillingdon | 20 | 22 |
| Hounslow | 28 | 16 |
| Kensington and Chelsea | 4 | 5 |
| Westminster | 12 | 17 |
| **Total** | **144** | **138** |

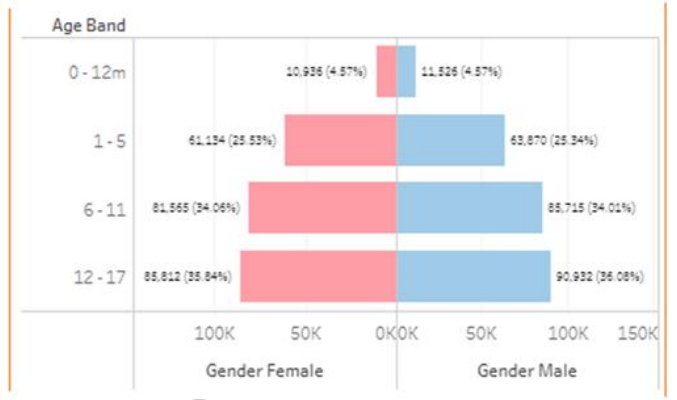
In 2023/24 The CDR Team chaired 55 JAR meetings. Table 1 shows how over five years, while the number of child death notifications (except for a fluctuation during COVID) has remained consistent, the number of JARs has increased. This could suggest an increase in unexpected deaths.

| | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|---|---|
| No of Death Notifications | 150 | 131 | 117 | 145 | 144 |
| No of JARS | 25 | 25 | 30 | 58 | 55 |

Table 1

# Ethnicity & Disproportionality



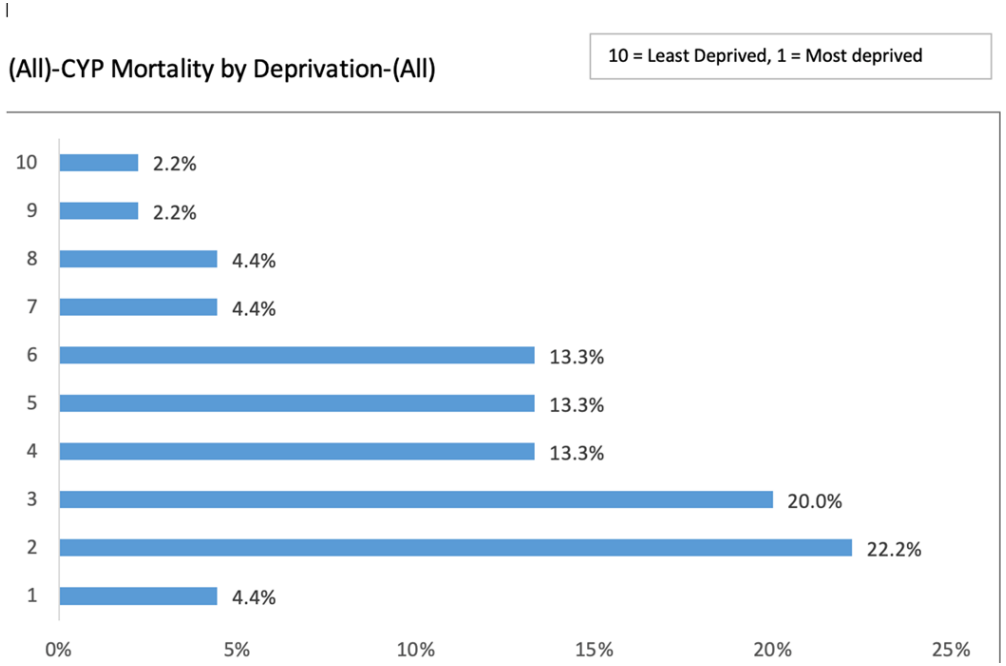




While it seems reasonably clear from the data that children from minority ethnic communities are disproportionately represented in the child death data base, the gathering of ethnic data remains a challenge for the CDR process and more work needs to be done on this to fully understand disproportionality.

# Deprivation – a mixed picture

**Health Inequalities**

- 1 in 10 people have diabetes or non-diabetic hyperglycaemia (NDH) (1 in 16 nationally).
- 1 in 5 adults (18+) has two or more long-term conditions compared to 1 in 4 nationally.
- Alcohol admissions in Ealing are above the average in England, with 2,200 admissions a year per 100,000 people (England 1,815).
- Rates of emergency hospital admissions for self-harm are twice as high in Hounslow as they are Harrow.
- 1 in 4 of our 10-11 year-olds are obese (1 in 5 nationally).
- 17.1% of people in Hillingdon smoke, versus 9.2% in Ealing (13% across NW London - 14% nationally).
- 38,000+ (11%) children and young people aged between 5 and 18 years have a mental health disorder (12% nationally).




**Social and Economic Inequalities**

- 28.6% of people do not have English as a first language (8% nationally
- 8.7% households are overcrowded (3.5% nationally)

# Modifiable Factors and Achievements

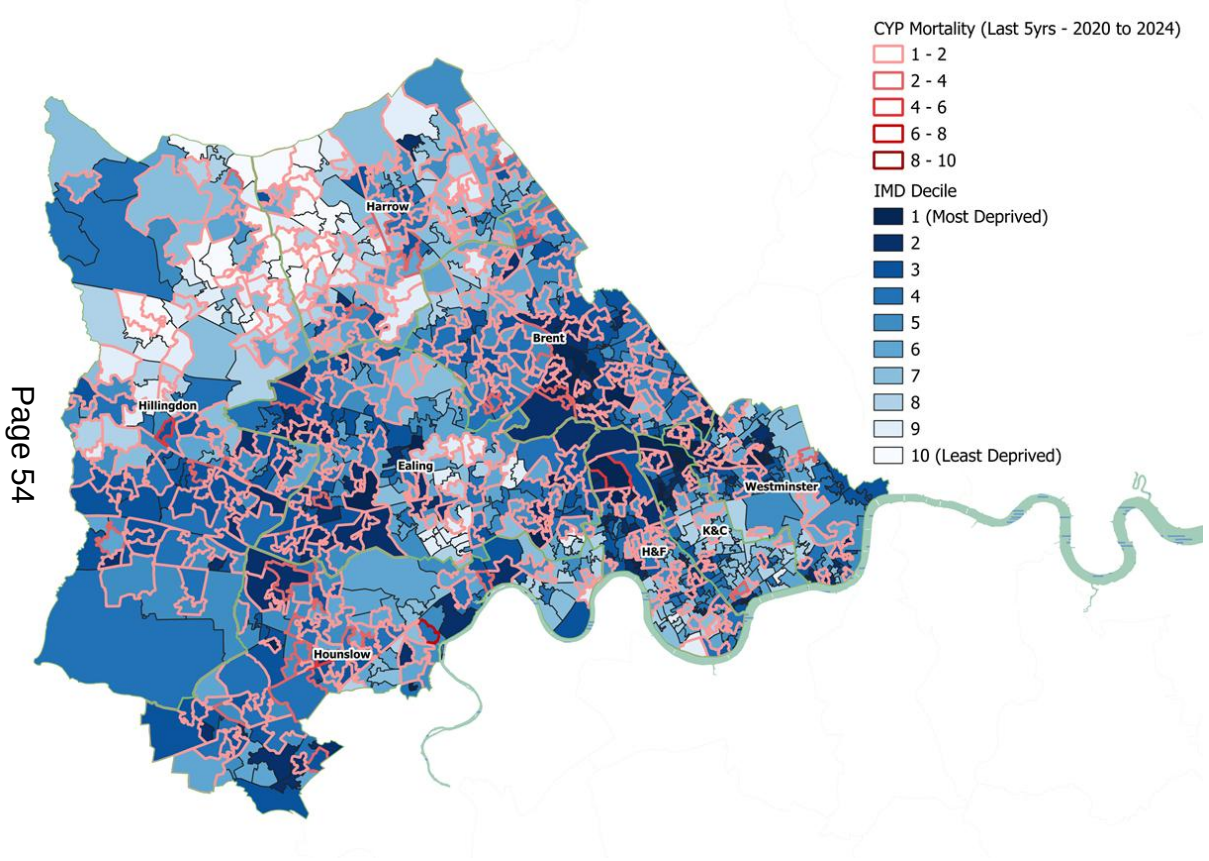
- **Modifiable Factors:**
- 33% in NWL v 48% nationally
  - GPs prescribing to patients abroad
  - Epilepsy in drivers
  - Defibrillators in public spaces
  - Risks of teenagers placed on adult ITU wards
  - Out of hours community nursing
  - Shooting Stars as keyworkers

- **Achievements in 23/24:**
- Worked with local bereavement charities across NWL to ensure that CDR staff and partners understand what is available for families.
- Collaborated with South West London CDR service to produce a London learning event concerning the deaths of young people from knife wounds.
- Encouraged Coroners to reopen cases where the Panel concluded that the coronial outcome had not been informed by all the evidence that had subsequently become available.
- Requested forensic post-mortems where significant concerns had been identified through information shared at JARs.

# Further action required

- Interpreters
- Misaligned long lines
- Consanguinity
- Gestational diabetes and race / ethnicity
- Placental histology
- GBS trial (reporting in 2025)
- Parents not calling emergency services when children are seriously unwell

# The H&F Challenge




- Nearly four times as many children live in poverty in Hammersmith and Fulham's poorest ward 45% as in the richest ward 12.2% (30% nationally).

**LONDON BOROUGH OF HAMMERSMITH & FULHAM**

**Report to:** Health and Wellbeing Board

**Date:** 23/06/2025

**Subject:** Pharmaceutical Needs Assessment 2025-28

**Report author:** Susan Hughes – Programme Lead
Dr Nicola Lang, Director of Public Health

**Responsible Director:** Jacqui McShannon Executive Director of People's Services and Statutory DCS

---

## SUMMARY

Health and Wellbeing Boards (HWWB) have a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population. This is called the Pharmaceutical Needs Assessment (PNA).

The development and delivery of a completed PNA must meet the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the DHSC 2021 guidance.

Hammersmith and Fulham's previous PNA spans the period 2022-25 (see appendix 1), and so we must refresh the PNA for the period 2025-2028 by the end of this calendar year.

The purpose of the PNA is to:

- Map current pharmaceutical services against local health needs.
- Identify gaps in service provision, both current and projected.
- Inform commissioning decisions and market entry for new pharmacies.
- Support service development to address local health priorities and reduce inequalities

---

## RECOMMENDATIONS

1. For the Health and Wellbeing Board to note and comment on the approach.

---

**Wards Affected**: All

---

| | |
|---|---|
| **Our Values** | The H&F Corporate Plan outlines core values that are mirrored in the PNA's approach:<br>• Compassion and Inclusion: The PNA's focus on identifying and addressing service gaps will ensure that no resident is left behind, embodying the Council's commitment to compassion and inclusion.<br>• Financial Efficiency and Sustainability: By providing robust evidence for commissioning and service planning, the PNA will support efficient use of resources and helps avoid duplication, in line with the council's value of being "ruthlessly financially efficient".<br>• Transparency and Accountability: The statutory consultation and publication process for the PNA will ensure transparency, accountability, and compliance with regulatory requirements—key aspects of the Council's governance values.<br>• Prevention and Early Intervention: The PNA will enable early identification of health needs and directs resources toward prevention, supporting the Corporate Plan's focus on proactive, preventative approaches to health and wellbeing. |
| Building shared prosperity | PNAs play a key role in building shared prosperity by:<br>• Reducing health inequalities through targeted interventions in underserved communities, which improves health outcomes.<br>• Supporting community wellbeing by providing accessible healthcare, health advice, and promoting healthy lifestyles.<br>• Enabling local economic development by supporting pharmacies as small businesses.<br>• Facilitating collaboration among public and healthcare professionals for better health planning.<br>• Optimizing resource allocation with up-to-date evidence for effective health investments. |
| Creating a compassionate and inclusive council | A compassionate and inclusive council aims to understand and meet the diverse needs of its community, especially those underserved. In terms of the PNA, this means:<br>• Inclusive Engagement: The Council should use various methods, such as in-person meetings and phone outreach, to connect with those lacking internet access or facing language barriers.<br>• Addressing Health Inequalities: The Council must consider the needs of different groups and show how they will ensure fair access to services.<br>• Transparency and Accountability: Decisions and their reasons should be documented and shared to build trust.<br>• Continuous Improvement: The PNA will be reviewed annually to stay relevant and respond to community feedback. |
| Doing things with local residents, not to them | A core principle in developing PNAs is meaningful engagement with local residents. The process focuses on working with communities instead of imposing decisions on them. This helps services fit the actual needs of the population. Key elements will include:<br>• Early and ongoing engagement, seeking views from patients and the public early in the process. |

| | |
|---|---|
| | • Multiple engagement methods are necessary for inclusivity. Formal consultations are required to inform PNA conclusions.<br>• An inclusive approach targets groups less likely to engage.<br>• Finally, the PNA must report on the consultation process and how feedback was used. |
| Being ruthlessly financially efficient | PNAs are essential tools for identifying and addressing local pharmaceutical needs. When used rigorously, they enable health systems to be financially efficient by targeting investment, avoiding unnecessary duplication, and ensuring that services are provided where they are most needed. This approach supports both effective patient care and responsible use of public funds. |
| Taking pride in H&F | Pharmacies play a crucial role in healthcare and serve as vital community resources. The borough focuses on equity, accessibility, and improving public health services. Resident feedback highlights the convenience, knowledgeable staff, and quality of pharmacy services. Regular assessments ensure these services meet evolving community health needs and involve local input in their development. |
| Rising to the challenge of the climate and ecological emergency | To address the climate and ecological emergency, PNAs should consider:<br>• the environmental effects of pharmaceutical services.<br>• Incorporating the environmental impact of medicines into NHS prescribing guidance.<br>• Reduction in unnecessary prescribing and enhance medicines management.<br>• Focusing on prevention to lower medicine demand.<br>• Adopting sustainable practices in daily operations. |

## Background Papers Used in Preparing This Report

None.

## DETAILED ANALYSIS

1. The PNA assesses whether the current provision of pharmacies and the commissioned services they provide meet the needs of the Hammersmith & Fulham residents and whether there are any gaps, either now or within the lifetime of the needs assessment.

2. The PNA will assess current and future provision with respect to:
   - Necessary Services, which are accessibility of pharmacies and their provision of Essential Services such as dispensing medicines and appliances, repeat dispensing, clinical governance, signposting and support for self-care.
   - Other Relevant Services and Other Services.

3. These are services commissioned by NHS England and the North West London (NWL)Integrated Care System (ICS) for the London Borough of

Hammersmith & Fulham Council, they include: Advanced Enhanced and Other NHS services.

**PNA structure**

4. The PNA will comprise two key sections:
    - An epidemiological description of the borough as well as a general population survey, which will be led by the H&F Business Intelligence Service
    - A technical section outlining provision of key pharmacy services, number of pharmacies per head of population, distance of residents from pharmacies and carrying out a full consultation with all statutory stakeholders about the content of the assessment for a minimum 60-day period.
    - The development and delivery of a completed PNA must meet the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the DHSC 2021 guidance.

**Next steps**

5. To deliver the Pharmaceutical Needs Assessment (PNA) for 2025-28, a specialist provider will be chosen according to Contract Standing Order 9 (CSO 9) and the most suitable and economically advantageous tender will be selected to deliver. The selection process will involve advertising and competition during June 2025, with three quotes obtained through the Council's Capital E Sourcing Procurement Portal.

6. The chosen provider will work with local stakeholders to develop the PNA, conduct needs analysis and surveys and produce the final report for approval by the Health and Well Being Board.

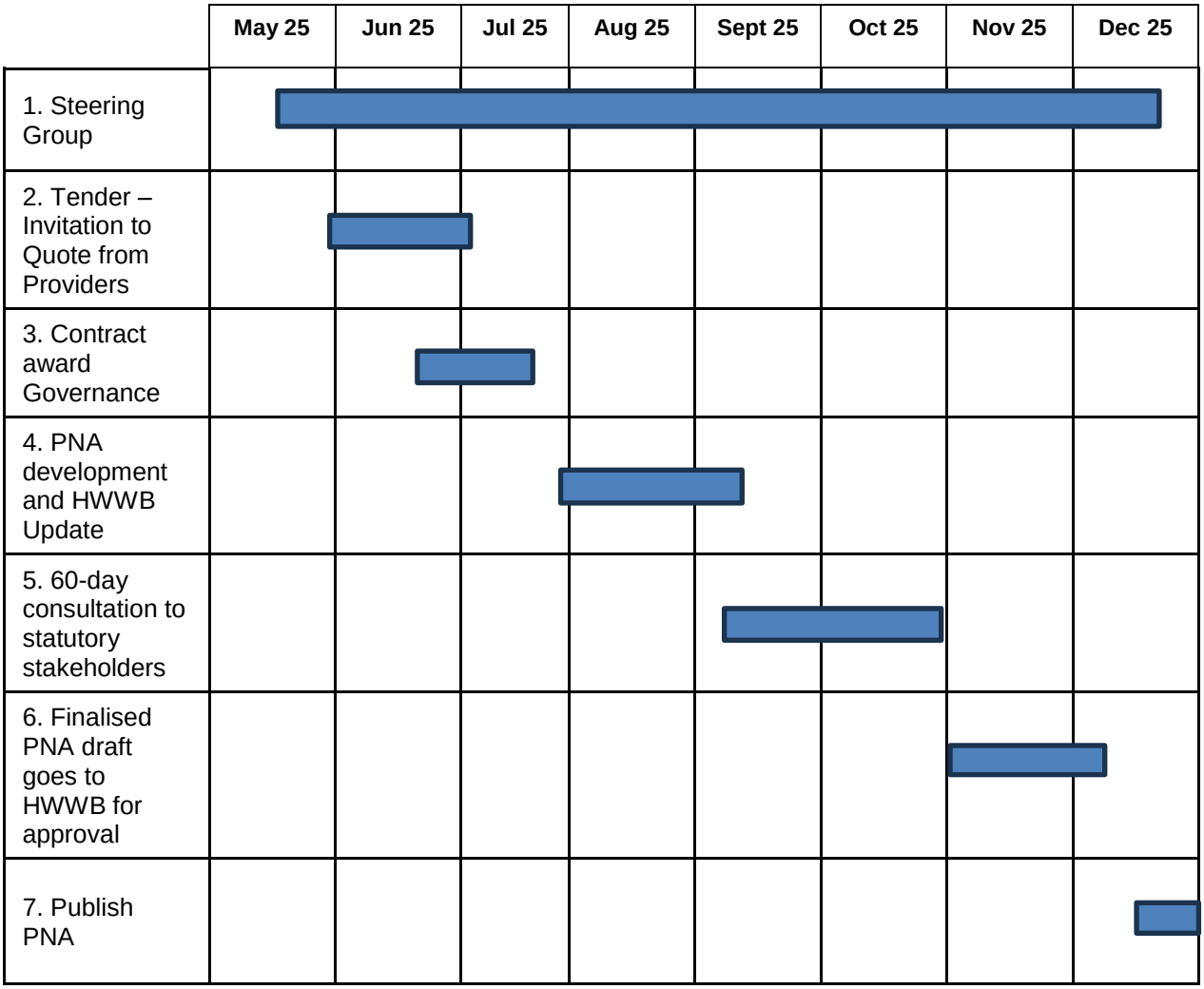
7. The draft PNA will be open for mandatory consultation for 60 days, from approximately 1 September 2025 to 31 October 2025, with results reviewed by the PNA Steering Group in early November 2025 before final publication. Progress updates will be shared with the Health and Well-Being Board in September.

8. The Provider will supply a report that aligns with the 2022-25 PNA report, covering various aspects, including demographics, health needs, local health services, pharmaceutical service access, and pharmacy service details. The Provider will also assist the Business Intelligence Team in mapping local pharmacy services and developing processes for future supplementary statements as needed.

9. A PNA Steering Group will be established and will oversee compliance with health and regulatory standards. The group will be chaired by the Council's Public Health team and will take place monthly over the next six months comprising of representatives from the Local Pharmaceutical Committee, provider of the technical section below, Public health senior representative, Business intelligence lead, NHS lead from the ICB (Integrated Commissioning Board – ICB - Chief Pharmacist) as well as NHSE who are the primary commissioners for the majority of community pharmacy services.

## Timeline

10. The table below provides and indicative timeline for the tender, development and publishing of the PNA.




## APPENDICES

Appendix 1 – H&F Pharmaceutical Needs Assessment 2022-25: https://democracy.lbhf.gov.uk/documents/s121503/Item%207%20LBHF%20PNA%202022-2025.pdf