Better Care Fund 2024-25 Q2 Reporting Template

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.

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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 ICB's, 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 2023-24 will prepopulate 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.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first 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.

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

- on track to meet the ambition
- Not on track to meet the ambition
- 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 M and N 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 HWB's 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 H1 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 first 6 months of the year, and any support needs particularly for winter and ongoing data issues.
5.2 C&D H1 Actual Activity
Please provide actual activity figures for April - September 24, 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.

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.
Underspend - 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.
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 6a.

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

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2. Cover

Version 3.0

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.*

			Checklist Complete:
Health and Wellbeing Board:	Hammersmith and Fulham		Yes
Completed by:	Julius Olu, Rashesh Mehta, Chakshu Sharma		Yes
E-mail:	Julius.Olu@lbhf.gov.uk; rasheshmehta@nhs.net; Chakshu.sharma(		Yes
Contact number:	07887 524 892, 07507637721		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Mon 28/10/2024	<< Please enter using the format, DD/MM/YYYY	Yes

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'. This does not apply to the ASC

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

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	No
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

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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**	**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

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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 Q1	Assessment of progress against the metric plan for the reporting period	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	49.2	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 signficant data quality issues and therefore this data cannot be currently used to compare to the 24/25 plan to monitor performance.	x	x	In H&F locally there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including: - 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.	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%	94.98%	On track to meet target	We are on track to meet this target by year-end. However, 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 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. We are also continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. 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	x		Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,294.0	38.5	Data not available to assess progress	Falls Actual Performance YTD data for 24/25 published by the National BCF team appears to not be comparable to the Public Health Outcomes Framework - Data used to set the 24/25 plan. The data published by the National BCF team for 24/25 is so much lower than the data used to set the 24/25 plan that it is felt it cannot be used even to reliably look at the trend of the falls data to make an estimation on the Q2 performance.	Falls prevention service in place along with a VCSE service providing a 52 week falls prevention programme.	x	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 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.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				308	not applicable	Not on track to meet target	Target 309.5 (62 people) Q1 actual = 139.8 (28 people) Q2 actual = 209.6 (42 people)	Our rise in numbers of residential placement is due largely to increase in level of resident need as they are being discharged from hospital. BCF through discharge funding is helping as it is enabling us to 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. In addition this will ensure more patients get access to timely care at home which reduces the risk of deterioration due to unnecessary hospital stays and that more patients have the opportunity to recover at home as the most appropriate support for their on-going care will be identified through an assessment at home. Where possible most people should continue to live in their own home with the clinical wraparound they need and the social care support. Only when this is not possible, should nursing and residential care be offered. Our stepdown extracare facility ""Minterne Lifestyle beds"" is operating at full capacity and we are working at better understanding how to improve the residents move on and ensureing that appropriate multi-disciplinary wraparound support is effectively supporting discharge from hospital. We are also meeting with extra care, learning disabilities and mental health supported living providers to discuss innovative ways to ensure we increase admission into extra care settings from the specialist supported living services.	x		Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Hammersmith and Fulham

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	
We have further enhanced the reliability of data from OPTICA, as well as data collected for community beds. However, our projections and methodology remain consistent, with no significant changes implemented. We may have to revisit our prepopulated demand numbers for "social support (including VCS)" and in the community as it appears significantly higher that our activity - It would be useful to have a definition for "Social Support (including VCS)". We also need to revisit our prepopulated demand numbers for "Reablement & Rehabilitation at home" as they are significantly high also.	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
The initial projections and plans were shaped by our focus on winter preparedness, so no fundamental changes have been made. Capacity in both bridging schemes and newer initiatives has been carefully planned to ensure they are fully mobilized and embedded in advance of the winter season. This proactive approach supports our readiness to meet increased demand during this critical period.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Clarity on funding – Several key areas of discharge are being supported by the Adult Discharge Fund. We are yet to receive confirmation of next year's funding, which could impact critical areas like recruitment for these schemes. To ensure sustainable planning for services over the winter and into 2025/26, it would be beneficial for funding clarity to be provided to systems, ahead of the winter period. There are some concerns regarding the resilience of the community equipment service, particularly as we approach the winter months. Addressing potential challenges related to equipment will be important to ensure smooth hospital discharges and support admission prevention efforts.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
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. Additionally, bridging care provides essential capacity to support patients in transitioning safely back home. For more complex discharge scenarios, we target them through our specialized schemes designed for Pathway 3 cases, along with addressing those with unclear commissioning pathways, ensuring that all patient needs are met effectively. Admission avoidance: Locally there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including: • 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	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

- actual demand in the first 6 months of the year
- 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

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5. Capacity & Demand

Selected Health and Wellbeing Board: Hammersmith and Fulham

Checklist

Complete:

Actual activity - Hospital Discharge

Service Area	Metric	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 Complete:
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	51	57	54	57	57	56	35	42	34	41	32	45	0	0	0	0	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	2	2	2	2	2	2							Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	32	37	36	37	37	36	32	37	36	37	37	36	11	13	12	13	13	12	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	1	1	1	1	1	1							Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	26	30	29	30	30	29	25	17	18	12	18	8	0	0	0	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	2	2	2	3.6	3.2	2.9	2.7	3.1	3.1							Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	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	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	27	32	31	32	32	31	19	8	10	6	12	7	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)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	10	10	10	10	10	10	10	10	10	10	10							Yes

Actual activity - Community

Service Area	Metric	Prepopulated demand from 2024-25 plan						Actual activity:						Checklist
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	
Social support (including VCS)	Monthly activity. Number of new clients.	66	72	60	41	46	79	16	23	15	22	24	34	Yes
Urgent Community Response	Monthly activity. Number of new clients.	89	89	90	91	92	89	98	89	94	107	98	97	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	40	31	13	44	36	41	4	11	10	8	8	6	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	10	8	14	4	7	8	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The 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 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care 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 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Hammersmith and Fulham

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£1,631,323	£372,000	22.80%	£1,259,323
Minimum NHS Contribution	£18,135,401	£9,067,700	50.00%	£9,067,701
iBCF	£10,027,236	£5,013,618	50.00%	£5,013,618
Additional LA Contribution	£7,518,282	£3,628,479	48.26%	£3,889,803
Additional NHS Contribution	£4,421,746	£2,210,873	50.00%	£2,210,873
Local Authority Discharge Funding	£2,343,005	£1,184,072	50.54%	£1,158,933
ICB Discharge Funding	£1,584,046	£523,262	33.03%	£1,060,784
Total	**£45,661,039**	**£22,000,004**	**48.18%**	**£23,661,035**

Comments if income changed

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	£5,134,072	£19,495
Adult Social Care services spend from the minimum ICB allocations	£7,867,257	£3,933,629	£3,933,628

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 (£)	Expenditure to date (£)	Comments
001	NHS Community Service - Anticipatory Care	Anticipatory care planning and delivery	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£416,796	£208,398	Note activity (Outputs) not in plan
002	Community Independence Service (ICB)	Community Independence Service - Health Element	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£3,694,066	£1,847,033	Note activity (Outputs) not in plan
003	Community Neuro	Community Neuro	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£923,373	£461,687	Note activity (Outputs) not in plan
004	Falls Prevention	Commmunity based Falls Prevention service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£220,650	£110,325	Note activity (Outputs) not in plan
005	Original 256 (Stroke Pathway & Open Age)	Original 256 (Stroke Pathway & Open Age)	Integrated Care Planning and Navigation	Care navigation and planning		0	N/A		Community Health		NHS			Private Sector	Minimum NHS Contribution	£47,956	£23,978	Note activity (Outputs) not in plan
006	NHS Community Service - Ageing Well Rapid	Ageing Well Rapid Response	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£361,709	£180,855	Note activity (Outputs) not in plan
007	Red Cross	Red Cross	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	N/A		Community Health		NHS			Private Sector	Minimum NHS Contribution	£68,329	£34,165	Note activity (Outputs) not in plan
008	Safeguarding	Safeguarding	Care Act Implementation Related Duties	Safeguarding			N/A		Community Health		NHS			Local Authority	Minimum NHS Contribution	£47,070	£23,535	Note activity (Outputs) not in plan
009	Community Equipment	Community Equipment	Assistive Technologies and Equipment	Community based equipment		13568	2516	Number of beneficiaries	Community Health		NHS			Local Authority	Minimum NHS Contribution	£1,213,082	£606,541	To plan
010	Night Nursing	Community night nursing service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£70,679	£35,340	Note activity (Outputs) not in plan
011	Community Matrons	Community matrons	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£441,335	£220,668	Note activity (Outputs) not in plan
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	21	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£529,798	£264,899	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	38	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£784,156	£392,078	To plan
014	Tissue Viability	Community tissue viability service	Community Based Schemes	Integrated neighbourhood services		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£181,125	£90,563	Note activity (Outputs) not in plan
015	District Nursing	District nursing care in community	Community Based Schemes	Integrated neighbourhood services		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£1,268,019	£634,009	Note activity (Outputs) not in plan

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	£588,084	Note activity (Outputs) not in plan
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	£3,007,332	Note activity (Outputs) not in plan
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	£338,213	Note activity (Outputs) not in plan
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	£778,208	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	£892,966	To plan
021	PFI Contract Monitoring	Contract Monitoring	Enablers for Integration	Programme management			NA		Community Health		NHS			Local Authority	Additional NHS Contribution	£26,349	£13,175	Note activity (Outputs) not in plan
022	Direct Payment	Direct Payment/ (Personal Budget)	Personalised Care at Home	Physical health/wellbeing		0	N/A		Community Health		NHS			Local Authority	Additional NHS Contribution	£44,655	£22,328	Note activity (Outputs) not in plan
023	Joint Equipment Contract Monitoring	Contract Monitoring	Enablers for Integration	Programme management			NA		Community Health		NHS			Local Authority	Additional NHS Contribution	£16,194	£8,097	Note activity (Outputs) not in plan
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	£26,582	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	£22,495	To plan
026	Look Ahead North East Cluster	Look Ahead North East Cluster	Housing Related Schemes			0	N/A		Mental Health		NHS			Local Authority	Additional NHS Contribution	£71,344	£35,672	Note activity (Outputs) not in plan
027	London Cyrenians North West Cluster	London Cyrenians North West Cluster	Housing Related Schemes			0	N/A		Mental Health		NHS			Local Authority	Additional NHS Contribution	£24,572	£12,286	Note activity (Outputs) not in plan
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	£11,829	Note activity (Outputs) not in plan
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	£14,204	Note activity (Outputs) not in plan
030	Groundswell Peer Support	Groundswell Peer Support	Personalised Care at Home	Mental health /wellbeing		0	N/A		Community Health		NHS			Local Authority	Additional NHS Contribution	£16,806	£8,403	Note activity (Outputs) not in plan
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	£7,348	Note activity (Outputs) not in plan
032	S256 Recurrent Reablement	Enhanced Bolstering	Home-based intermediate care services	Reablement at home (to support discharge)		347	173	Packages	Community Health		NHS			Local Authority	Additional NHS Contribution	£267,755	£133,878	To plan
33	7 Day Social Work Service (Formerly System Resilience)	7 Day Social Work Hospital Discharge Service	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Community Health		NHS			Local Authority	Additional NHS Contribution	£446,807	£223,403	Note activity (Outputs) not in plan
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	0				NHS			Local Authority	ICB Discharge Funding	£654,100	£327,050	To plan
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			2				NHS			Local Authority	ICB Discharge Funding	£110,000	£55,000	To plan
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	N/A				LA			Local Authority	Local Authority Discharge	£2,343,005	£1,184,072	Note activity (Outputs) not in plan
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	£784,233	
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	£1,184,072	
40	Direct Payment	Direct Payment/ (Personal Budget)	Personalised Budgeting and Commissioning			0	0		Continuing Care		LA			Private Sector	Additional LA Contribution	£129,859	£64,930	
41	Joint Equipment Budget	Community Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		1927	1749	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	£877,300	£443,482	
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	£189,993	
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	£296,190	
44	Housing Support/ PATHS	Supporting Discharges related to Homelessness	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Mental Health		LA			Charity / Voluntary Sector	Additional LA Contribution	£25,248	£12,624	

45	Dual Diagnosis Worker	Dual Diagnosis Worker	Prevention / Early Intervention	Other	Frontline clinical post	0	0		Mental Health		LA			Charity / Voluntary Sector	Additional LA Contribution	£29,642	£14,821	
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	£22,147	
47	Safeguarding	Safeguarding Board Costs	Enablers for Integration	New governance arrangements		0	0		Social Care		LA			Local Authority	Additional LA Contribution	£106,575	£53,288	
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	0		Social Care		LA			Local Authority	Additional LA Contribution	£797,400	£398,700	
49	Disabled Facilities Grant	Adaptations made to homes to promote community independent living	DFG Related Schemes	Adaptations, including statutory DFG grants		201	40	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£1,631,323	£372,000	
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	143763		Social Care		LA			Private Sector	iBCF	£5,808,036	£2,904,018	
51	IBCF	Residential Placements	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		69	27		Social Care		LA			Private Sector	iBCF	£4,219,200	£2,109,600	
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	28	Number of placements	Community Health	0	NHS	0.0%		NHS Community Provider	ICB Discharge Funding	£120,574	£60,287	To plan
53	Supporting patients where there is unclear commissioning (non-CHC)	To facilitate discharge for patients not meeting CHC or ASC criteria e.g. delirium/stoma care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Continuing Care	0	NHS	0.0%		NHS	ICB Discharge Funding	£220,584	£55,000	The mobilization process has been delayed longer than expected due to challenges related to workforce availability and operational processes. As a result, for Q2, we are prioritizing funding for complex neuro cases that require one-on-one support in specialized settings. This targeted approach is designed to help patients maximize their rehabilitation potential and facilitate their timely discharge, which will in turn create capacity within the system to improve patient flow. Additionally, we will focus on mobilizing the workforce and addressing other essential resources for Continuing Healthcare (CHC) and Local Authority (LA) cases, which currently lack clarity. This strategy will ensure funding is utilized effectively and efficiently
54	Strategic Support from NWL ICB Central Team	Central ICB Support for Borough based teams	Workforce recruitment and retention	Local recruitment initiatives	0	1	0	WTE's gained	Other	NWL ICB	NHS	0.0%		NHS	ICB Discharge Funding	£50,500	£25,250	To plan
55	Pathway 3 Capacity for complex needs	Health funding for complex care patients in P3 beds/other settings. For conditions including dementia and challenging behaviour	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)	0	8	1	Number of placements	Community Health	0	NHS	0.0%		Local Authority	ICB Discharge Funding	£428,288	£675	We drafted a specific business case for P3 complex discharges which was completed in August. Some of the schemes in the business case had anticipated start dates in September but have been delayed. We have been supporting the discharge of more complex residents since September and updated costs will appear in the subsequent report.
56	Disabled Facilities Grant	Adaptations made to homes to promote community independent living	DFG Related Schemes	Adaptations, including statutory DFG grants	0	42	9	Number of adaptations funded/people supported	Social Care	0	LA	0.0%		Local Authority	Additional LA Contribution	£355,128	£164,000	To plan

Adding New Schemes:

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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)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
			<Please Select>														