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
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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.

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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