Better Care Fund 2024-25 EOY 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.

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

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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

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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**	**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

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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 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: - 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%	94.33%	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. 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. 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

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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. 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. 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

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5. Capacity & Demand

Selected Health and Wellbeing Board: Hammersmith and Fulham

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:
		Jan-25	Feb-25	Mar-25	Jan-25	Feb-25	Mar-25	Jan-25	Feb-25	Mar-25	
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

Service Area	Metric	Prepopulated demand from 2024-25 plan			Actual activity:			Checklist Complete:
		Jan-25	Feb-25	Mar-25	Jan-25	Feb-25	Mar-25	
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

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6. Income actual

Selected Health and Wellbeing Board: Hammersmith and Fulham

Source of Funding	2024-25 Planned Income	Actual income	Carried from previous year (23-24)	Actual total income (Column D + E)	Checklist 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 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 EOY Reporting Template

7b. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Hammersmith and Fulham

	2024-25					
Running Balances	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

Checklist Complete:
Yes
Yes
Yes

Confirmation of Statements		
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	
Our BCF schemes were implemented as planned in 2024-25	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	

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. 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. 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