Better Care Fund 2025-26 Update Template

Data Sharing Statement

Data sharing Statement

Please see below important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided.

Advice on local information governance which may be of interest to ICSs can be seen at:

https://data.england.nhs.uk/sudgt/

Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

Purpose of Data Collection

NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory duties, including improving healthcare quality, efficiency, and transparency. The data supports operational and strategic planning, financial management, workforce planning, and system feedback, as mandated by the NHS Act 2006 and relevant regulations.

Type and Scope of Data

Patient-level data, including identifiable information like NHS numbers, is not required.
Data includes finance, activity, workforce, and planning information as specified in the national guidance documents.
The BCF planning template is categorized as "Management Information," and aggregated data, including narrative sections, will be published on the NHS England website and gov.uk.

Access, Sharing, and Publication

The BCF planning template is categorised as 'Management Information' and data submitted will be published in an aggregated form on the NHS England website and gov.uk. This will include a narrative section. Please also note that all BCF information collected here is subject to Freedom of Information requests.
Internal Access: Data will be accessed by NHS England national and regional teams on a "need-to-know" basis and may be shared internally to support statutory responsibilities.
External Sharing: Data will be shared with partner organisations and Arms' Length Bodies (ALBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and NHS England) for joint working and policy development.
Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plans. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange) cannot share it publicly or use it for journalism or research without prior consent from the HWB (for single HWB data) or BCF national partners (for aggregated data).
All information is subject to Freedom of Information requests.

Storage and Security

Data will be securely stored on NHS England servers. Shared data will be minimised and handled per confidentiality and security requirements.
The BCF template is password-protected to ensure data integrity and accurate aggregation. Breaches may require resubmission.

Data Analysis and Use

NHS England will analyse data submissions for feedback, reporting, benchmarking, and system improvement.
Triangulation with other data may be conducted to support deeper analysis and insights and inform decision-making.

Concerns

For any questions about data sharing, please contact your regional Better Care Managers or the national Better Care Fund team england.bettercarefundteam@nhs.net

Better Care Fund 2025-26 Update Template

1. Guidance

HM Government

NHS England

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
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

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- 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 in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto-populate the rate per 100,000 population for each month

- This will then auto populate the rate per 100,000 population for each month
https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65
Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.
https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/
Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.
https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24
Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements)

This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the four National conditions are as below:

- National condition 1: Plans to be jointly agreed
- National condition 2: Implementing the objectives of the BCF
- National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)
- National condition 4: Complying with oversight and support processes
- How HWB areas should demonstrate this are set out in Planning Requirements

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. 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 Better Care Exchange) 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 (MHCLG, DHSC, NHS England) 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.

Governance and Sign off

		Complete:
Health and Wellbeing Board:	Hammersmith and Fulham	Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes	Yes
If no indicate the reasons for the delay.		Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

Submitted by:	Chakshu Sharma, Rashesh Mehta, Sharlene Spence	Yes
Role and organisation:	Programme Manager, AD Place H&F, ASC Rpogramme	Yes
E-mail:	chakshu.sharma@nhs.net; rasheshmehta@nhs.net; s	Yes
Contact number:	07507637721, 07341672970	Yes
Documents Submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative	Yes
	C&D National Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Alexandra	Sanderson	alexandra.sanderson@lbhf.gov.uk	LBHF	Yes
	Health and Wellbeing Board Chair	Cllr	Bora	Kwon	Bora.Kwon@lbhf.gov.uk	LBHF	
	Local Authority Chief Executive	Cllr	Sharon	Lea	chief.executive@lbhf.gov.uk	LBHF	Yes

Named Accountable person	ICB Chief Executive 1		Rob	Hurd	rob.hurd@nhs.net	NWL ICB	Yes
	ICB Chief Executive 2 (where required)						
	ICB Chief Executive 3 (where required)						
Finance sign off	LA Section 151 Officer		Sukvinder	Kalsi	Sukvinder.Kalsi@lbhf.gov.uk	LBHF	Yes
	ICB Finance Director 1		Steve	Bloomer	stephen.bloomer@nhs.net	NHS NWL ICB	Yes
	ICB Finance Director 2 (where required)						
	ICB Finance Director 3 (where required)						
Area assurance contacts	Local Authority Director of Adult Social Services		Katherine	Willmette	Katharine.Willmette@lbhf.gov.uk	LBHF	Yes
	DFG Lead		Bernard	Stewart	bernard.stewart@lbhf.gov.uk	LBHF	No
	ICB Place Director 1		Sue	Roostan	susanroostan@nhs.net	NHS NWL ICB	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)						
	ICB Place Director 3 (where required)						

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	No	Following the reduction of the additional contriubution communicated in March 25, we have followd the BCF resolution process and developed a revised joint plan which was agreed by the regional team 1/07/25. The plan will be ratified by the HWB on 10/09/25.	Yes

National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	No	Following the reduction of the additional contriubution communicated in March 25, we have followd the BCF resolution process and developed a revised joint plan which was agreed by the regional team 1/07/25. The plan will be ratified by the HWB on 10/09/25.	Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	No	Following the reduction of the additional contriubution communicated in March 25, we have followd the BCF resolution process and developed a revised joint plan which was agreed by the regional team 1/07/25. The plan will be ratified by the HWB on 10/09/25.	Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	No	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements. The HWB has sighted and this will be assured on 10th September 2025. The plan will be assured on 10 Sept 2025.	Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	No	The HWB is fully sighted that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner. The plan will be assured on 10 Sept 2025.	Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan	
There are a number of interim placements that we are planning to make permenant in the new financial year, which may impact the targets depending on the number of new placements coming through.	Yes

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

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Hammersmith and Fulham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,855,793	£1,855,793	£0
NHS Minimum Contribution	£20,061,025	£20,061,025	£0
Local Authority Better Care Grant	£12,370,241	£12,370,241	£0
Additional LA Contribution	£8,397,608	£8,397,608	£0
Additional ICB Contribution	£4,471,198	£4,471,198	£0
Total	**£47,155,865**	**£47,155,865**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£8,176,055
Planned spend	£8,176,441

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	2,201	2,176	2,101	2,052	2,002	1,977	2,076	1,877	2,057	2,057	2,057	2,057

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	1.05	1.05	1.05	1.05	1.04	1.08	1.21	1.28	0.63	1.04	1.04	1.04

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	379.4	149.7	94.8	89.8	89.8

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Hammersmith and Fulham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Hammersmith and Fulham	£1,855,793
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£1,855,793**

Local Authority Better Care Grant	Contribution
Hammersmith and Fulham	£12,370,241
Total Local Authority Better Care Grant	**£12,370,241**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Hammersmith and Fulham	£8,397,608	See Expenditure tab
Total Additional Local Authority Contribution	**£8,397,608**	

Complete:

Yes

Yes

NHS Minimum Contribution	Contribution
NHS North West London ICB	£20,061,025
Total NHS Minimum Contribution	**£20,061,025**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	Yes

Yes

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS North West London ICB	£4,471,198	NHS additional Fund
Total Additional NHS Contribution	**£4,471,198**	
Total NHS Contribution	**£24,532,223**	

Yes

	2025-26
Total BCF Pooled Budget	**£47,155,865**

Funding Contributions Comments Optional for any useful detail
Not applicable

Yes

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Hammersmith and Fulham

<< Link to summary sheet

	2025-26		
Running Balances	Income	Expenditure	Balance
DFG	£1,855,793	£1,855,793	£0
NHS Minimum Contribution	£20,061,025	£20,061,025	£0
Local Authority Better Care Grant	£12,370,241	£12,370,241	£0
Additional LA contribution	£8,397,608	£8,397,608	£0
Additional NHS contribution	£4,471,198	£4,471,198	£0
Total	**£47,155,865**	**£47,155,865**	**£0**

	Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£8,176,055	£8,176,441	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Long-term home-based community health services	Anticipatory care planning and delivery	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 425,757	
2	Urgent community response	Community Independence Service (ICB Health Element)	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 3,773,488	
3	Wider local support to promote prevention and independence	Community Neuro - Multidisciplinary teams that are supporting independence, such as anticipatory care	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 943,225	
4	Wider local support to promote prevention and independence	Commmunity based Falls Prevention service	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 225,394	
5	Evaluation and enabling integration	Original 256 (Stroke Pathway & Open Age) - Care Navigation & Planing	4. Preventing unnecessary hospital admissions	Community Health	Private Sector	NHS Minimum Contribution	£ 48,987	
6	Urgent community response	NHS Community Service - Ageing Well Rapid Response	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 369,486	
7	Discharge support and infrastructure	Red Cross - High Impact Change Model for Managing Transfer of Care	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 69,798	
8	Wider local support to promote prevention and independence	Safeguarding (Care Act Implementation Related Duties)	1. Proactive care to those with complex needs	Community Health	Local Authority	NHS Minimum Contribution	£ 48,082	
9	Assistive technologies and equipment	Community Equipment	2. Home adaptations and tech	Community Health	Private Sector	NHS Minimum Contribution	£ 1,239,164	
10	Long-term home-based community health services	Community Night Nursing Service	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 72,198	
11	Long-term home-based community health services	Community Matrons	6. Reducing the need for long term residential care	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 450,824	
12	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Intermediate care Beds (Alexandra Ward) – CLCH - Bed based intermediate Care Services to Support Discharge (Reablement, rehabilitation, wider	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 541,188	
13	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Intermediate care Beds (Athlone Ward – CLCH) - Bed based intermediate Care Services to Support discharge (Reablement, rehabilitation, wider short	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 801,015	
14	Long-term home-based community health services	Community Tissue Viability Service (Integrated Neighbourhood Services)	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 185,019	

15	Long-term home-based community health services	District Nursing Care in Community (Integrated Nighbourhood Services)	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,176,911	
16	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Independence Service - Joint Element (High Impact Change Model for Managing Transfer of Care i.e. Home First/Discharge to	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 1,222,391	
17	Long-term home-based social care services	S256 Transfer to Social Care - Reablement & Packages of Care (High Impact Change Model for Managing Transfer of Care i.e Multi-	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 6,251,039	
18	Long-term home-based social care services	Care Act Implementation Services (descriptor to change)	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 703,010	
19	Long-term residential/nursing home care	Farm Lane PFI - Health (Residential Placements in Care UK Nursing Home)	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Additional NHS Contribution	£ 1,589,878	
20	Long-term residential/nursing home care	St Vincent PFI - Health (Residential Placements in Care UK Nursing Home)	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Additional NHS Contribution	£ 1,824,329	
21	Evaluation and enabling integration	PFI Contract Monitoring (Programme Management Support - Enabler for Integration)	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Additional NHS Contribution	£ 26,916	
22	Personalised budgeting and commissioning	Direct Payment/ Personal Budget for Personalised Care at Home (Physical Health & Wellbeing) (TO BE REMOVED TO THE S75 FOR 2025/26)	6. Reducing the need for long term residential care	Social Care	Private Sector	Additional NHS Contribution	£ -	REMOVED TO THE S75 FOR 2025/26
23	Evaluation and enabling integration	Joint Equipment Contract Monitoring (Programme Management Support - Enabler for Integtration)	2. Home adaptations and tech	Social Care	Local Authority	Additional NHS Contribution	£ 16,542	
24	Long-term home-based social care services	LD Placement Reviewing Officer Dual Diagnosis Worker	1. Proactive care to those with complex needs	Social Care	Local Authority	Additional NHS Contribution	£ 54,307	
25	Support to carers, including unpaid carers	Carer's Advice, Info & Support Service related to Care Act duties (Scheme type - Workforce Recruitment & Retentions)	3. Supporting unpaid carers	Social Care	Local Authority	Additional NHS Contribution	£ 45,956	
26	Housing related schemes	Supported People Services - Look Ahead North East Cluster	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional NHS Contribution	£ 72,878	
27	Housing related schemes	Supported People Services - London Cyrenians North West Cluster	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional NHS Contribution	£ 25,101	
28	Housing related schemes	Housing Support (PATHS)/ Hospital Liaison Scheme to support Early Discharge Planning	1. Proactive care to those with complex needs	Social Care	Local Authority	Additional NHS Contribution	£ 24,168	
29	Housing related schemes	Dual Diagnosis Worker Supporting Personalised Care at Home (Mental Health & Wellbeing)	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional NHS Contribution	£ 29,018	
30	Housing related schemes	Groundswell Peer Support (Personalised Care at Home - Mental Health & Wellbeing support)	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional NHS Contribution	£ 17,167	
31	Evaluation and enabling integration	Contract Monitoring for Supporting Housing Projects (Programme Management Support - Enabler for Integtration)	1. Proactive care to those with complex needs	Social Care	Local Authority	Additional NHS Contribution	£ 15,012	
32	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	S256 Recurrent Reablement - Enhanced Bolstering (Home based Intermediate Care Services / Reablement at home to Support Discharge)	5. Timely discharge from hospital	Social Care	Local Authority	Additional NHS Contribution	£ 273,512	
33	Discharge support and infrastructure	7 Day Social Work Service (Formerly System Resilience) - High Impact Change Model Managing Transfer of Care i.e. Multi-	1. Proactive care to those with complex needs	Social Care	Local Authority	Additional NHS Contribution	£ 456,413	
34	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	ICB Discharge Funding - Bridging care service to support patients on P1 pathway to be discharged home sooner (Home First/Discharge to Assess -	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 654,100	
35	Discharge support and infrastructure	Mintern - Discontinued in 25/26	5. Timely discharge from hospital	Social Care	Local Authority	Additional NHS Contribution	£ -	Mintern - Discontinued in 25/26

36	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	ICB Discharge Funding - Bridging Care - Reviewing Officers x 2 supporting discharge process for patients to be discharged home sooner (Home	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 110,000	
37	Long-term home-based social care services	LA Discharge Funding (Hospital Discharge Programme - High Impact Change Model for Managing Transfer of Care i.e. Home	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 2,344,005	
38	Long-term residential/nursing home care	Farmlane PFI - LA (Contract Beds Older People)	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Additional LA Contribution	£ 1,639,061	
39	Long-term residential/nursing home care	St Vincent PFI - LA (Contract Beds Older People)	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Additional LA Contribution	£ 2,652,373	
40	Personalised budgeting and commissioning	Direct Payment/ (Personal Budget) - Personalised Budgeting and Commissioning (To BE REMOVED and Transferred to the S75)	6. Reducing the need for long term residential care	Social Care	Private Sector	Additional LA Contribution	£ -	removed and transfered to S75
41	Assistive technologies and equipment	Community Equipment - LA (Joint Equipment Budget)	2. Home adaptations and tech	Social Care	Private Sector	Additional LA Contribution	£ 930,400	
42	Housing related schemes	Supported People Services - Look Ahead North East Cluster LA	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional LA Contribution	£ 481,326	
43	Housing related schemes	Supported People Services - London Cyrenians North West Cluster LA	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional LA Contribution	£ 598,555	
44	Housing related schemes	Housing Support/ PATHS - LA - Supporting Discharges related to Homelessness (Early Discharge Planning)	1. Proactive care to those with complex needs	Social Care	Local Authority	Additional LA Contribution	£ 25,879	
45	Housing related schemes	Dual Diagnosis Worker (supporting prevention and early intervention)	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional LA Contribution	£ 30,383	
46	Housing related schemes	Groundswell Peer Support (Community Based Scheme - MEH)	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	Additional LA Contribution	£ 45,401	
47	Wider local support to promote prevention and independence	Safeguarding (LA Safeguarding Board Costs - New Governance arrangements)	1. Proactive care to those with complex needs	Social Care	Local Authority	Additional LA Contribution	£ 411,300	
48	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Independence Service (LA) Joint Element (High Impact Change Model for Managing Transfer of Care i.e Multi-	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 1,169,500	
49	Disabled Facilities Grant related schemes	Disabled Facilities Grant (Adaptations made to homes to promote community independent living)	2. Home adaptations and tech	Social Care	Private Sector	DFG	£ 1,855,793	
50	Long-term home-based social care services	LA Better Care Grant / IBCF - Home Care or Domiciliary Care to support discharges	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 5,808,036	
51	Long-term residential/nursing home care	LA Better Care Grant/ IBCF - Residential Placements (High Impact Change Model for Managing Transfer of Care i.e Multi-	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Local Authority Better Care Grant	£ 4,218,200	
52	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Community Based Schemes - Rehab beds in Furness Ward, Willesden. Line 2 of 2 (Shared scheme to improve access to and outcomes for	5. Timely discharge from hospital	Other	NHS Community Provider	NHS Minimum Contribution	£ 120,574	
53	Discharge support and infrastructure	Supporting patients where there is unclear commissioning (non-CHC) (To facilitate discharge for patients not meeting CHC or ASC criteria e.g.	5. Timely discharge from hospital	Other	NHS	NHS Minimum Contribution	£ 87,500	
54	Evaluation and enabling integration	Strategic Support from NWL ICB Central Team (Central ICB Support for Borough based teams)	5. Timely discharge from hospital	Other	NHS	NHS Minimum Contribution	£ 33,750	
55	Long-term residential/nursing home care	Pathway 3 Capacity for complex needs (Health funding for complex care patients in P3 beds/other settings. For conditions including	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 428,288	
56	Disabled Facilities Grant related schemes	Disabled Facilities Grant - Adaptations made to homes to promote community independent living	2. Home adaptations and tech	Social Care	Local Authority	Additional LA Contribution	£ 413,431	
57	Discharge support and infrastructure	Supporting patients where there is unclear commissioning (non-CHC) - NEW LOCAL SCHEME	5. Timely discharge from hospital	Other	NHS	NHS Minimum Contribution	£ 69,834	

58	Discharge support and infrastructure	E-wallets to support swift discharges from hospital	5. Timely discharge from hospital	Other	NHS	NHS Minimum Contribution	£ 10,000	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.

15	Urgent Community Response	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.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Hammersmith and Fulham

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	2,221	2,196	2,121	2,071	2,022	1,997	2,096	1,897	n/a	n/a	n/a	n/a	We used our 24/25 actual data & forecasted figures for Q4 as the baseline for 25/26 and then applied 1% improvement / reduction. In terms of plans of achieving the ambition and how BCF service support this: 1. Avoidable Admissions: There are a number of programmes underway which will continue to provide us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows: • The development of our virtual wards programme • Continued roll out of post covid syndrome clinics • Respiratory hub-lets • Continued work roll out of virtual monitoring • 111/999 Push pilots with urgent community response 2. Falls Prevention: In H&F, we have a falls prevention service. The service provides assessment, advice, exercise and strength and balance groups for older people who are at risk of falling. The service aims to prevent falls and unnecessary admission to hospital by seeing a patient before an injurious fall occurs or after a fall to rebuild strength, balance and confidence. This assessment will identify 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. 3. Discharge to usual place of residence: We are continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, though this remains our longer term plan. 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	Yes
	Number of Admissions 65+	445	440	425	415	405	400	420	380	n/a	n/a	n/a	n/a		
	Population of 65+*	20,034	20,034	20,034	20,034	20,034	20,034	20,034	20,034	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
	Rate	2,201	2,176	2,101	2,052	2,002	1,977	2,076	1,877	2,057	2,057	2,057	2,057		
	Number of Admissions 65+	441	436	421	411	401	396	416	376	412	412	412	412		Yes
	Population of 65+	20,034	20,034	20,034	20,034	20,034	20,034	20,034	20,034	20,034	20,034	20,034	20,034		

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.

Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	1.15	1.28	1.37	n/a	n/a	n/a	n/a	25/26 plan was set by increasing the 25/26 forecasted position by 1%. The 25/26 forecasted position was calculated using M1 to M10 actual data and forecasted figures for Q4 as baseline. Note - For the Metric "For those adult patients not discharged on DRD, average number of days from DRD to discharge" the template does not let you enter a decimal however, this only affects the first 4 months of the cells so we have added a rounded number to a whole value for the first 4 months. Actual Values for Apr 25 to July 25 is 6.93. We are continuing a focus 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 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 Challenges, Learning and performance to date in 24/25 and next steps for 25/26: So far in 24/25, we have been on track to meet 97% target for discharge to the usual place of residence. However, we did face challenges, including higher patient acuity levels, causing delays. These delays stemmed from the need for additional assessments to ensure patients were ready for discharge to their normal place of residence. The implementation of the bridging (bridging to home service) had significantly reduced delays in Pathway 1 in 24/25 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. Moving forward, 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. H&F have commissioned 3 beds at Ellesmere nursing home in RBKC to support to support the discharge of residents presenting with complex and challenging behaviours, associated with advanced dementia, and delirium, and includes residents requiring 1-1 care and supervision on the ward. This aim is to: • Improve the assessment process and decision making to be completed within the first 14 days and placement completed within 28 days. • Reduce the average length of stay in interim assessment beds. • Reduce system costs. • Reduce length of stay >21 days in hospitals • Reduce the number of medically optimised people who remain in hospital that don't meet the criteria to remain • Improve flow both in hospital and in the interim assessment bed. • To provide evidence to support longer term business case to change future models of care. The pathway currently supports the multidisciplinary assessment of residents within 4 weeks and includes an initial therapy baseline assessment, Care Act Assessment and if appropriate a Continuing Health Assessment by a CHC nurse assessor. The aim that the additional beds at Forrester will be up to 6 weeks' length of stay. Plan to improve discharge & Trajectories: The discharge calls have increased and include senior representation from partners to support and unlock any areas of difficulty for individual patients – this needs consistency so practical solutions can be put in place. To support hospital discharge effectively, we will be addressing housing concerns that may delay the process. Strengthening collaboration by building stronger links with housing services, developing clear escalation pathways Trust are looking at internal delays to support timely discharge recognising that there are gains to be made inside the hospital as well. Priority focus for partnership on older people and dementia to develop and improve MDT working.	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	83.1%	82.0%	84.7%	n/a	n/a	n/a	n/a		
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	6.8	7.1	9.0	n/a	n/a	n/a	n/a		
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
Average length of discharge delay for all acute adult patients	1.05	1.05	1.05	1.05	1.04	1.08	1.21	1.28	0.63	1.04	1.04	1.04		
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.0%	85.0%	85.0%	85.0%	85.0%	84.0%	82.9%	85.5%	87.5%	85.0%	85.0%	85.0%		Yes
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.00	7.00	7.00	7.00	6.93	6.73	7.07	8.87	5.04	6.93	6.93	6.93		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	No	Yes
Local data on average length of delay by discharge pathway.	Number of days	No	Yes

8.3 Residential Admissions

2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	579.0	359.4	379.4	149.7	94.8	89.8	89.8	We anticipate an increase in short term placements becoming permanent placements over the course of the new financial year. This is due to more people being discharged from hospital, being unable to return home due to increased care needs, we also have an aging carer population who may no longer be able to cope with caring responsibilities. The 2021 Census showed a 15.2% increase in people aged 65 and over in H&F compared to the previous 2011 Census. Population estimates published in Sept 2024 indicate a further increase in those aged 80 years+ by the end of 2026. In 2021 over 90% of people with dementia in H&F were over 65 years and the greatest proportion of these were 80 years and over. Adult Social Care monthly statistics published in January 2025 shows that at the end of Sept 2024, 2350 people were in receipt of community-based services and 385 were in receipt of nursing/residential care. The proportion of all H&F residents receiving services at the end of Sept 2024 who received nursing/residential care was 14% compared to 20% on average in London and 29% in England. H&F is more likely to respond to increases in need through community-based services. However, H&F anticipates an increase in the use of residential/nursing care where appropriate to provide care for older people with complex needs, such as those living with dementia. The source of data for this information is: ONS local area Census 2021 profiles Hammersmith and Fulham population change, Census 2021 – ONS 1. Public Health JSNA data on dementia which uses data from a publication on Whole Systems Integrated Care, Northwest London Collaboration of Clinical Commissioning Groups. Population Overview: Dementia. 2021 officesharedservice.sharepoint.com/sites/lbhfbiportal/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2Flbhfbiportal%2FShared Documents%2FReports%2FPublic Health%2FJSNA%2FData Profiles%2Fhf-dementia-report-september-2021%2Epdf&parent=%2Fsites%2Flbhfbiportal%2FShared Documents%2FReports%2FPublic Health%2FJSNA%2FData Profiles 2. Adult social care monthly statistics in development Jan 2025 official-statistics-in-development-long-term-support-16-january-2025.ods 3. Population estimates by ONS published in Sept 2024 Mid-year population estimates and re-scaled population estimates using national population projections for local authorities in England by sex and single year of age, 2018 to 2043 - Office for National Statistics Dementia Report, Hammersmith and Fulham, September 2021: • The estimated number of people with dementia in Hammersmith & Fulham is expected to rise from 1,337 in 2021 by 42% to 1,900 by 2030. • The sharpest increase is expected among people who have severe dementia. In Hammersmith & Fulham, it is estimated that by 2030, 63.1% (1,199/1,900) of people with dementia will have severe dementia, 23.9% (455/1,900) of people with have moderate	Yes
	Number of admissions	116	72	76	30	19	18	18		Yes
	Population of 65+*	20,034	20,034	20,034	20,034	20,034	20,034	20,034		

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Hammersmith and Fulham

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet				No
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet				No
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure				No
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes