Better Care Fund 2024-25 Update Template

2. Cover

HM Government

NHS England

Version 1.0.0

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. 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.

			Complete:
Health and Wellbeing Board:	City of London		Yes
Completed by:	Ellie Ward		Yes
E-mail:	ellie.ward@cityoflondon.gov.uk		Yes
Contact number:	020 7332 1535		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Fri 13/09/2024	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Mary	Durcan	mary.durcan@cityoflondon.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Charlotte	Pomery	charlotte.pomery@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Amy	Wilkenson	amy.wilkinson@hackney.gov.uk	Yes
	Local Authority Chief Executive		Ian	Thomas	Ian.Thomas@cityoflondon.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Judith	Finlay	judith.finlay@cityoflondon.gov.uk	Yes
	Better Care Fund Lead Official		Ellie	Ward	ellie.ward@cityoflondon.gov.uk	Yes
	LA Section 151 Officer		Mark	Jarvis	mark.jarvis@cityoflondon.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

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.

Template Completed

	Complete:
2. Cover	Yes
4.2 C&D Hospital Discharge	Yes
4.3 C&D Community	Yes
5. Income	Yes
6. Expenditure	Yes
7. Narrative updates	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: City of London

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£40,457	£40,457	£0
Minimum NHS Contribution	£943,650	£943,651	-£1
iBCF	£323,659	£323,659	£0
Additional LA Contribution	£0	£43,563	-£43,563
Additional ICB Contribution	£0	£0	£0
Local Authority Discharge Funding	£75,627	£75,627	£0
ICB Discharge Funding	£8,881	£8,881	£0
Total	**£1,392,275**	**£1,435,838**	**-£43,563**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£247,339
Planned spend	£927,873

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£172,763
Planned spend	£357,283

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	52.3	49.7	47.2	44.8

Falls

		2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	748.4	733.6
	Count	80	82
	Population	531	541

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.8%	96.6%	94.5%	93.6%

Residential Admissions

		2022-23 Actual	2024-25 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	403	575

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing												Capacity surplus (including spot puchasing)											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-4	-1	0	0	-1	0	0	0	-2	-2	-1	0	0	0	0	0	0	0	0	0	-1	-1	-1	0
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-3	-3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
25	Contact Hours per package
0	Contact Hours per package
126	Average LoS (days)
0	Average LoS (days)
138	Average LoS (days)

Checklist

Complete:

Checklist
Yes
Yes
Yes
Yes
Yes

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

Support from the Care Navigator - direction to vol sector services such as City Connections or Carers Support. Blitz cleans are available, strengths based practioner support, occupational therapy screening. For associated carers. Please note above, figure for all of Pathway one combined is 25 hours

Yes

Capacity - Hospital Discharge

Service Area	Metric	Refreshed planned capacity (not including spot purchased capacity												Capacity that you expect to secure through spot purchasing												Checklist
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	5	10	7	5	4	4	6	4	5	6	7	5	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1													Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0													Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	4	1	0	0	1	0	0	0	1	1	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	4	4	4	4	4	4													Yes
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0													Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	3	3	0	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	4	4	4	4	4	4													Yes

Demand - Hospital Discharge

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Checklist
Total Expected Discharges:	Total Discharges	**90**	**92**	**92**	**87**	**85**	**84**	**84**	**84**	**86**	**83**	**84**	**95**	Yes
Reablement & Rehabilitation at home (pathway 1)	Total	**5**	**10**	**7**	**5**	**4**	**4**	**5**	**4**	**5**	**6**	**7**	**5**	Yes
	BARTS HEALTH NHS TRUST	2	6	4	2	2	2	3	2	3	3	3	2	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2	1	1	2	0	1	1	1	1	1	2	1	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	1	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1	1	2	1	2	1	1	1	1	2	2	2	Yes
	OTHER	0	1	0	0	0	0	0	0	0	0	0	0	Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes

	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**4**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**2**	**1**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	0	0	0	1	0	0	0	2	1	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	3	0	0	0	0	0	0	0	0	1	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	1	1	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	1	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
Other short term bedded care (pathway 2)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	1	0	0	0	0	0	0	0	0	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	3	0	0	0	0	0	0	0	0	0	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	2	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	(blank)													Yes

	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes
	(blank)													Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Community **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Average LoS/Contact Hours: Full Year	Units	Checklist: Complete:
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0	0	Contact Hours	Yes
Urgent Community Response	1	1	1	1	1	1	1	1	1	1	1	2	1	Contact Hours	Yes
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0	0	Contact Hours	Yes
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0	0	Average LoS	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	0	Contact Hours	Yes

Capacity - Community

Please enter refreshed expected capacity:

Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	8	9	8	9	9	8	9	8	9	9	8	9	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	1	0	1	0	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community

Please enter refreshed expected no. of referrals:

Service Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Urgent Community Response	7	8	7	8	8	7	8	7	8	8	7	7	Yes
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	1	0	1	0	Yes
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: City of London

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
City of London	£40,457
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£40,457**

Complete:

Yes

Local Authority Discharge Funding	Contribution
City of London	£75,627

Yes

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS North East London ICB	£8,881	£8,881	

Yes

Total ICB Discharge Fund Contribution	£8,881	£8,881

iBCF Contribution	Contribution
City of London	£323,659
Total iBCF Contribution	**£323,659**

Yes

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
		£43,563	Carried forward DFG from 23/24
Total Additional Local Authority Contribution	**£0**	**£43,563**	

Yes

NHS Minimum Contribution	Contribution
NHS North East London ICB	£943,650
Total NHS Minimum Contribution	**£943,650**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding

Yes

Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£943,650**	**£943,650**	

	2024-25
Total BCF Pooled Budget	**£1,435,838**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

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

Better Care Fund 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: City of London

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure	Balance
DFG	£40,457	£40,457	£0
Minimum NHS Contribution	£943,650	£943,651	-£1
iBCF	£323,659	£323,659	£0
Additional LA Contribution	£43,563	£43,563	£0
Additional NHS Contribution	£0	£0	£0
Local Authority Discharge Funding	£75,627	£75,627	£0
ICB Discharge Funding	£8,881	£8,881	£0
Total	**£1,435,838**	**£1,435,838**	**£0**

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	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£247,339	£927,873	£0
Adult Social Care services spend from the minimum ICB allocations	£172,763	£357,283	£0

Checklist

Column complete:

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

One or more Funding Sources have an underspend/overpend (see first table at top of this sheet)

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Previously entered Outputs for 2024-25	Updated Outputs for 2024-25	Units	Planned Expenditure Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Previously entered Expenditure for 2024-25 (£)	Updated Expenditure for 2024-25 (£)	% of Overall Spend (Average)	Do you wish to update?	Comments if updated e.g. reason for the changes made
1	CoL-Care Navigator Service	To ensure safe hospital disharge for City of London residents	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution		£63,396	£60,000	97%	Yes	Change in cost of commissioned contract
2	CoL-Carers' support	To provide specialist indpendent support, information and advice for	Carers Services	Other	Provides specialist independent	55	80	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution		£15,175	£60,000	100%	Yes	Continuation and mainstreaming of wider support service which was previously a pilot
3	Brokerage pilot (one-year)	To provide a more efficient and effective commissioning of	Residential Placements	Other	Commissioning	12	12	Number of beds	Social Care		LA			Local Authority	Minimum NHS Contribution		£52,830	£65,000	100%	Yes	Increased costs of the work
4	CoL-Discharge Scheme	To prevent hospital admissions and provide an intensive discharge to	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			0		Social Care		LA			Private Sector	Minimum NHS Contribution		£235,881	£163,000	66%	Yes	Revision based on predicted capacity and demand
5	Disabled Facilities Grant	To support Diasbled people to live more independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		10	5	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG		£37,091	£40,457	48%	Yes	DFG allocation now confirmed
6	iBCF	Meeting adult social care needs by delivering a targeted, preventative,	Care Act Implementation Related Duties	Other	Adult social care support				Social Care		LA			Local Authority	iBCF		£323,659		100%	No	
7	Adult Cardiorespiritory Enhanced and	ACERS Respiratory Service is a 7 day service, that provides care and support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution		£23,446	£23,033	12%	Yes	NHS Contract uplift revised
8	Bryning Day Unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly	Prevention / Early Intervention	Other	Physical health and wellbeing		0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution		£14,613	£14,356	100%	Yes	NHS Contract uplift revised
9	Asthma	This service will offer asthma expertise in the community in order to train	Community Based Schemes	Other	Education and training of HCP and patients.		0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution		£1,447	£1,422	1%	Yes	NHS Contract uplift revised
10	St Joseph's Hospice	Community-based and inpatient palliative care services	Personalised Care at Home	Physical health/wellbeing			0		Other	Charity	NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£88,472	£86,111	27%	Yes	NHS Contract uplift revised
11	Paradoc	The service provides an urgent GP and paramedic response service to patients	Urgent Community Response				0		Primary Care		NHS			NHS Acute Provider	Minimum NHS Contribution		£21,592	£21,213	100%	Yes	NHS Contract uplift revised
12	Adult Community Rehabilitation Team	To provide specialist inter-disciplinary and uni-disciplinary rehabilitation to	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution		£167,915	£163,823	83%	Yes	NHS Contract uplift revised

13	Adult Community Nursing	To provide an integrated, case management service to patients living within the	Personalised Care at Home	Physical health/wellbeing			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution		£224,222	£218,759	67%	Yes	NHS Contract uplift revised
14	Pathway Homelessness Hospital	Multidisciplinary hospital discharge team for homeless individuals. Also	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Other	Works across acute and mental health	NHS			NHS Mental Health Provider	Minimum NHS Contribution		£0		0%	No	
15	Pathway Charity Franchise Fee	Direct Support from Pathway's Support Service	Enablers for Integration	Other	Data, evaluation, workforce				Other	Works across acute and mental health	NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£0		0%	No	
16	DES Supplementary Care Homes	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing			0		Primary Care		NHS			NHS	Minimum NHS Contribution		£5,595	£5,475	2%	Yes	There was no uplift applied to the contract.
17	GP out of hours home visiting service	Primary Care out of hours for patients requiring home visits. Delivered by a social	Personalised Care at Home	Physical health/wellbeing			0		Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£10,914	£10,744	3%	Yes	NHS Contract uplift revised
18	Neighbourhood - Community Pharmacy	Community pharmacy	Integrated Care Planning and Navigation	Other	Community pharmacy		0		Community Health		NHS			NHS	Minimum NHS Contribution		£2,152	£0	3%	Yes	Scheme not funded through BCF going forward
19	Local authority discharge funding	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Social Care		LA			Local Authority	Local Authority Discharge		£74,700	£75,627	25%	Yes	Updated allocation
20	ICB discharge fund	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			0		Social Care		LA			Local Authority	ICB Discharge Funding		£8,881		3%	No	
21	System pressures	Respond to system pressures	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity			0		Social Care		LA			Local Authority	Minimum NHS Contribution		£12,010	£9,283	3%	Yes	Revision based on predicted capacity and demand
22	Out of hours rapid response end of life care	Rapid response overnight support, information and crisis internvention to	Personalised Care at Home	Physical health/wellbeing			0		Other	Charity	NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£3,990	£3,998	1%	Yes	NHS Contract uplift revised

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 eight 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

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: City of London

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

The City of London has small totals for hospital discharge numbers and therefore we are able to accurately monitor and forecast demand. The 2024/25 demand figures are based on 2023/24 actuals + average percentage growth. In terms of predicting capacity, we do not have block contracts but rather contracts we call on for reablement, homecare and a rapid response / Discharge to Assess Scheme. Neither of these have a limit and can manage with demand in a timely way. Residential care is spot purchased.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

No issues identified. Over the last few years we have commissioned additional resources for our Intermediate Care team via Ageing Well, Physical Capacity or Discharge Funding. This additional capacity supports managing seasonal variation and response targets.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

We have a strong preventative approach and good quality services which mean that we are able to keep people independent at home for longer with small numbers of residents tending to enter long term residential care later, and for shorter periods.
The preventative offer includes Occupational Therapy, Strength Based Practitioners, and a rapid response service which can put intensive social care support in place for a period of up to 72 hours to prevent hospital admission. The BCF scheme funds the rapid response service as part of the wider discharge scheme.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

The BCF funds a care navigator to support safe hospital discharge and make the links with adult social care and primary care to prevent any delays in hospital discharge. It also funds a discharge and prevention scheme which includes a rapid response service (as a discharge to assess scheme) to facilitate hospital discharge. The BCF plan also includes money for further development of the Care Transfer Hub. One of the things that causes delays for City of London patients leaving hospital is family input and views. In the NEL sub-region, the Accelerating Care Reform is being used to fund a Carers Support Worker who will also support family carers in terms of facilitating hospital discharge.

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

We have a strong partnership approach across the ICS. Assumptions for intermediate care have been made based on Trust and local authority service level year-end performance.

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	**Yes**

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.

Checklist Complete:	Linked KLOEs (For information)
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?
Yes	

The borough demand volumes across all sub pathways have been derived after a review of MSIF data, 2023-24 service level year-end performance and NHSE Discharge Sitreps for all North East London acute trusts. As City residents use a mix of non-NEL hospitals and NEL hospitals, and the volume of activity per pathway is low, we predominantly used adult social care data for demand per acute site. To be in line with the North East London 2024/25 NHSE operating plan, a 1.6% growth has been applied to the previous years reporting.

Yes	Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.

Discharge monies enhances the capacity of the BCF funded Discharge and Prevention Scheme. Discharge and prevention supports the rapid response requirements to discharge from hospital at earlier stages than pre pandemic; supporting interim equipment needs at pace, assessment at home to stabilisation, wrap around services to support and facilitate the discharge. The scheme includes activities to prevent hospital admission utilising rapid response and additional support to reduce likelihood of admission, supported by strong social work and occupational therapy services. Practitioners engage from hospital admission to discharge and onward pathways, utilising reablement and strength based solutions where appropriate.

Yes	Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Is the plan for spending the additional discharge grant in line with grant conditions?

Please describe any changes to your Additional discharge fund plans, as a result from

- **Local learning from 23-24**
- **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**

We have seen successful delivery of schemes during 2023-24 however, are utilising some of the funding to further develop the City and Hackney Care Transfer Hub which will work closely with the Care Navigator and Discharge scheme to reduce delays and improve patient experience and outcomes. Within our planning work we specifically reviewed and took account of the national evaluation in relation to the monitoring of discharge funding, and in particular the additional discharge funding. As can be seen in the BCF, based on monitoring and demand and capacity modelling, we reduced the overall amount allocated to our discharge scheme but ensured that the additional discharge funding remained allocated to this.

Yes	Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?

Officers in the City of London and the ICB work closely together to oversee all funding streams within the BCF, review performance against metrics and jointly agrees to plans which support transformation and achievement of BCF objectives. Representatives from this group makes recommendations and raises items for consideration with other committees within our Place governance structure.

Yes	Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: City of London

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 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.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	116.2	51.7	38.0	77.0	Population figure for Q2 actual is incorrect. Setting target for the City can be tricky due to the swings we see with the small population. We have taken the average of the 4 quarters, which is 58.10, then applied a 10% reduction for Q1 followed by a 5% reduction per quarter as per below.	We would like analyse the data to see if there is condition specific information available. If we can better understand the activity, we can work with community services or primary care in particular pathways to improve performance. The following services funded are by the BCF and aim to support people living with long-term conditions and/or provide an urgent community response: • Neighbourhoods Programme	Yes
	Number of Admissions	9	4	-	-			
	Population	8,618	5,745	-	-			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
	Indicator value	52.3	49.68	47.2	44.84			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 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.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	847.7	748.4	733.6	Based on the falls dataset provided by NHSE, a 2% improvement has been applied to both the count and indicator of falls, which should fulfil ambition in a conservative manner.	We have a acute falls response service (Paradoc & IIT Rapid Response) operating 7 days per week which works closely with our telecare service (now called technology enabled care) and our local care homes. In addition we have a range of falls prevention services delivered by the voluntary sector and a proactive care programme (some services funded outside of the BCF) which identifies patients at risk and refers into relevant services. Other schemes funded by the BCF which support this target,	Yes
	Count	14	80	82			Yes
	Population	1,464	531	541			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 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.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
	Quarter (%)	93.5%	96.3%	94.2%	93.3%	We have taken into account our performance across 2023-24 and the schemes funded by the BCF or the Discharge Fund. To show an improvement, 0.3% has been applied for the plans for	We have no local care homes or intermediate care beds which has reinforced our Home First approach. The Discharge scheme and Care Navigator Service are key to	Yes
	Numerator	129	105	98	98			

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	138	109	104	105	show an improvement, 0.3% has been applied for the plans for each quarter.	The Discharge scheme and Care Navigator Service are key to enabling people to return home in addition to other community health services funded via the BCF.		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan				
	Quarter (%)	93.8%	96.6%	94.5%	93.6%				
	Numerator	127	105	105	112			Yes	
	Denominator	136	109	111	120			Yes	

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 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.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.		
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	403.2	293.0	644.7	575.3	The number ofadmissions to residential homes are fairly low; however, given our small population size any variation can significantly impact on our annual rate. We have taken into account our performance across 2023-24.	We have a strength-based assets approach designed to help people maximise their independence for as long as possible. We can provide complex care at home but when needs become too great or complex then residential care can be more appropriate. The Discharge scheme and Care Navigator Service are key to enabling people to return home in addition to other community health services funded via the BCF.	Yes	
	Numerator	5	5	11	10			Yes	
	Denominator	1,240	1,706	1,706	1,738				

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

Better Care Fund 2024-25 Update Template

8. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: City of London

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Have all elements of the Planning template been completed? *Paragraph 11*	Cover sheet Cover sheet Cover sheet Cover sheet	Yes				Yes
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update						
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Cover sheet Planning Requirements	Yes	Yes but DFG works differently in the City of London			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** **- Support people to remain independent for longer, and where possible support them to remain in their own home** **- Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?		Yes				Yes

Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?		Yes				Yes
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	PR 4 and PR6 are dealt with together (see above)						
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services and NHS commissioned out of hospital services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?		Yes				Yes
Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? Paragraph 12		Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?		Yes				Yes