Better Care Fund 2024-25 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Please submit this template by 14 February 2025

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

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

- On track to meet the ambition
- Not on track to meet the ambition
- Data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions

Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.

5.2 C&D H1 Actual Activity

Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure from all 3 quarters to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Please use the Discontinue column to indicate if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent.

If you would like to amend a scheme, you can first 'discontinue' said scheme, then re-enter the scheme new data into the 'add new schemes' section.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

Better Care Fund 2024-25 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: City of London

			Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes		Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off			Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.			Yes
Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q3 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: City of London

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q2 (For Q3 data,please refer to data pack on BCX)	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan*	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	52.3	49.7	47.2	44.8	20.4	On track to meet target	N/A	Data only includes October, but currently the indicator is 10.2, with only one spell. Total year to date i s 4 people.	N/A	N/A	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.8%	96.6%	94.5%	93.6%	92.9%	On track to meet target	N/A	We achieved 93.18% for Q3 which is slightly below target but an increase from Q2. Small numbers of patients can have a great impact on percentages but largely people are returning home.	N/A	N/A	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				733.6	317.2	Not on track to meet target	Data only includes October, but currently the indicator is 114, with only one spell. The direction of travel is positive as it has dropped from 8 falls in Q1 to 4 falls in Q2.	N/A	The year to date data shows an indicator value of 1024.74; however the total number of falls is only 13.	A local falls group has been established with consultants and service leads to review the C&H falls pathway. Public Health will cease funding for a community strength and balance falls prevention service at the end of March 2025. Pathway mapping work is underway to identify gaps in the pathway, and data review of the potential impact on other services. C&H Place Team working with partner organisations to consider ways to mitigate the impact, redesign the pathway and explore ways resources could potentially be redeployed to support existing services. Data is broken down at PCN and practice level and shows falls for the Neaman Practice, which is the only GP within the City of London.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				575	not applicable	On track to meet target	N/A	N/A	N/A	N/A	Yes

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: City of London

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Our overall activity isn't significantly different than planned. What was surpising was the number of people requiring admission to residential care just before Christmas. There were some complex needs and it took longer to place than normal, resulting in delays to discharge. This isn't a trend we expect to continue.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
We do not have any capacity concerns for Q4.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Not Applicable.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
We do not have any support needs to raise.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Actual demand in the first 9 months of the year
- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist Complete:
Service Area	**Metric**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	5	4	5	8	4	6	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	1	1	1	0	0	0				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	1	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	0	0	2	0	0	0	1	0	1	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	6	0	7				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	9	0	7	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	0	0	0	0	5	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	0	0	0				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			Checklist Complete:
Service Area	**Metric**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	
Social support (including VCS)	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly activity. Number of new clients.	8	7	8	5	4	4	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	0	0	1	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

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

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

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

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

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2024-25 Q3 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: City of London

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£40,457	£0	0.00%	£40,457
Minimum NHS Contribution	£943,650	£746,463	79.10%	£197,187
iBCF	£323,659	£323,659	100.00%	£0
Additional LA Contribution	£43,563	£0	0.00%	£43,563
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£75,627	£75,627	100.00%	£0
ICB Discharge Funding	£8,881	£8,881	100.00%	£0
Total	**£1,435,837**	**£1,154,630**	**80.42%**	**£281,207**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£247,339	£438,606	£0
Adult Social Care services spend from the minimum ICB allocations	£172,763	£295,708	£0

Checklist	Column complete:	Yes		Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
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	0		Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 60,000	£45,000		
2	CoL-Carers' support	To provide specialist indpendent support, information and advice for	Carers Services	Other	Provides specialist independent	80	88	Beneficiaries	Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 60,000	£45,000		
3	Brokerage pilot (one-year)	To provide a more efficient and effective commissioning of placements including for	Residential Placements	Other	Commissioning	12	2	Number of beds	Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 65,000	£65,000		
4	CoL-Discharge Scheme	To prevent hospital admissions and provide an intensive discharge to assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0		Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 163,000	£140,708		
5	Disabled Facilities Grant	To support Diasbled people to live more independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		5	0	Number of adaptations funded/people supported	Social Care	0	LA			Private Sector	DFG	£ 40,457	£0		
6	iBCF	Meeting adult social care needs by delivering a targeted, preventative,	Care Act Implementation Related Duties	Other	Adult social care support		0		Social Care	0	LA			Local Authority	iBCF	£ 323,659	£323,659		
7	Adult Cardiorespiritory Enhanced and	ACERS Respiratory Service is a 7 day service, that provides care and support to anyone	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 23,033	£17,736		
8	Bryning Day Unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly programme	Prevention / Early Intervention	Other	Physical health and wellbeing	0	0		Acute	0	NHS			NHS Acute Provider	Minimum NHS Contribution	£ 14,356	£11,054		
9	Asthma	This service will offer asthma expertise in the community in order to train health	Community Based Schemes	Other	Education and training of HCP and patients.	0	0		Acute	0	NHS			NHS Acute Provider	Minimum NHS Contribution	£ 1,422	£1,095		
10	St Joseph's Hospice	Community-based and inpatient palliative care services	Personalised Care at Home	Physical health/wellbeing		0	0		Other	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 86,111	£64,776		
11	Paradoc	The service provides an urgent GP and paramedic response service to patients	Urgent Community Response			0	0		Primary Care	0	NHS			NHS Acute Provider	Minimum NHS Contribution	£ 21,213	£16,334		
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	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 163,823	£126,898		
13	Adult Community Nursing	To provide an integrated, case management service to patients living within the	Personalised Care at Home	Physical health/wellbeing		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 218,759	£169,197		
16	DES Supplementary Care Homes	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing		0	0		Primary Care	0	NHS			NHS	Minimum NHS Contribution	£ 5,475	£4,106		
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	0		Primary Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 10,744	£8,484		
19	Local authority discharge funding	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 75,627	£75,627		

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	0	LA			Local Authority	ICB Discharge Funding	£ 8,881	£8,881		
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	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 9,283	£0		
22	Out of hours rapid response end of life care service	Rapid response overnight support, information and crisis internvention to	Personalised Care at Home	Physical health/wellbeing		0	0		Other	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 3,998	£2,999		
23	Neighbourhood Programme	Neighbourhoods is our major transformation programme for the redesign of	Community Based Schemes	Integrated neighbourhood services	0	0	0		Other	0	NHS	0		NHS	Minimum NHS Contribution	£ 19,792	£14,844		
24	Care Transfer hub	Health and Social Care staff to work together to support discharge.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health	0	NHS	0		NHS Acute Provider	Minimum NHS Contribution	£ 17,642	£13,232		
25	DFG carry forward	DFG allocation now confirmed and 23/24 allocation carried forward	DFG Related Schemes	Adaptations, including statutory DFG grants	0	5	0	Number of adaptations funded/people supported	Social Care	0	LA	0		Private Sector	Additional LA Contribution	£ 43,563	£0		