

Better Care Fund 2024-25 Q2 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 ICB's, local authorities and service providers) for the purposes noted above.

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

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

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

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

Checklist (2. Cover)

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate 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 HWB's 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 first 6 months of the year, and any support needs particularly for winter and ongoing data issues.

5.2 C&D H1 Actual Activity

Please provide actual activity figures for April - September 24, 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 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.

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>



HM Government



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2. Cover

Version 3.6

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Herefordshire, County of	
Completed by:	Marie Gallagher and Adrian Griffiths	
E-mail:	Marie.Gallagher1@herefordshire.gov.uk	
Contact number:	01432 260435	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 09/12/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the

Complete

	Complete:	
2. Cover	Yes	For further guidance on requirements please refer back to guidance sheet - tab 1.
3. National Conditions	Yes	
4. Metrics	Yes	
5.1 C&D Guidance & Assumptions	Yes	
5.2 C&D H1 Actual Activity	Yes	
6. Expenditure	Yes	

[<< Link to the Guidance sheet](#)

^^ Link back to top

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Herefordshire, County of

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		
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	
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes	
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes	
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes	

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes

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4. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

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				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs <i>Please:</i> - 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. <i>Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics</i>	Variance from plan <i>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</i>	Mitigation for recovery <i>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</i>
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator: 2.3i)	212.0	212.0	212.0	212.0	117.7	On track to meet target	Ongoing system focus with partners across the system to provide support for the management of long term conditions (LTC) continues to develop.	Q1 - 121 Q2 - 121 Care Home practitioners continue to work closely with providers- links with WVT LTC ACP's via discharge and single point of access continues to improve.		
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.4%	91.4%	91.4%	91.4%	91.48%	On track to meet target	The availability of capacity in Pathway 1 service to enable discharge to usual place of residence requires daily focus - this has significantly improved recently following system focus.	Q1 - 91% Q2 - 92% BCF fund the bridging team which is supporting the improvements related to patients discharged to usual place of residence on the day that they no longer meet the criteria to reside.		
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,696.0	317.7	On track to meet target	UEC demand Therapy recruitment to provide capacity for timely access to falls clinics continues to challenge us although improvements have been made in Q2 and we are projecting further improvement is Q3.	Q1 - 356 Q2 - 350 Falls related functions ensure a preventative and responsive element to patients who have fallen or at risk of falling.		
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				520	not applicable	On track to meet target	Performance at Q2 (260.5) is on track to achieve a level of admissions below target for 2024/25 (520). The Care home market in Herefordshire remains vibrant, with the market significantly geared in relation to self-funders, with the county being a destination for affluent people to move to in later life. This proves challenging in relation to the ability of the council to commission care at or near its standard fee rates resulting in average costs of placements being higher than other Councils in the West Midlands region. The council is also seeing an increase in the number of self-funders requiring support from the council as a result of their funds having depleted. High numbers of people being discharged from hospital in to bedded care remains a challenge.	236.7 - Despite the challenges outlined, activity in 2024/25 has significantly improved, with levels of permanent admissions each month being lower than in 2023/24 D2A system wide review during 2023/24, increased capacity in the home care market and improvements in delivery of home based D2A support are evidencing improvements in system flow, supporting more people to return home following a hospital episode.		

Complete:

Yes

Yes

Yes

Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

5.1 Assumptions

1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.

Remain unchanged. Focus on reducing demand for PW3 due to learnings over last six months and increasing use of hospital admission avoidance (CRH)

2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?

Focus on hospital admission avoidance in an attempt to reduce demand of D2A once admitted to hospital. We have workstreams for operations and process, pathway 3 discharges, data, commissioning, and communications, each reporting to an integrated system discharge board.

3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?

It is usual to have capacity concerns ahead of the winter due to the unpredictability of demand when heading into winter. Assured that system working in Herefordshire means that any actual capacity issues are dealt with as a system and resolved as a priority by using spot purchase for packages of care and care home D2A.

4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?

System approach to solving any blocks to discharge. Local processes in place to support escalation to ensure senior manager involvement of all providers at the right time to prevent longer length of stay (LOS). Use of Community Response Hub (CRH) to access community urgent response to prevent admissions.

Checklist Complete:

Yes

Yes

Yes

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 6 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 service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q2 Reporting Template

S. Capacity & Demand

Selected Health and Wellbeing Board:

Herefordshire, County of

Herefordshire, County ofReablement & Rehabilitation at home (pathway 1)

TTHerefordshire, County ofReablement & Rehabilitation at home (pathway 1)

Herefordshire, County ofShort term domiciliary care (pathway 1)

TTHerefordshire, County ofShort term domiciliary care (pathway 1)

Herefordshire, County ofReablement & Rehabilitation in a bedded setting (pathway 2)

TTHerefordshire, County ofReablement & Rehabilitation in a bedded setting (pathway 2)

Herefordshire, County ofOther short term bedded care (pathway 2)

TTHerefordshire, County ofOther short term bedded care (pathway 2)

Herefordshire, County ofShort term residential/nursing care for someone likely to require a longer term care home placement (pathway 3)

TTHerefordshire, County ofShort term residential/nursing care for someone likely to require a longer term care home placement (pathway 3)

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through <u>only</u> spot purchasing (doesn't apply to time to service)					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Reablement & Rehabilitation at home (pathway 1)	Monthly activity: Number of new clients	84	86	81	69	83	84	54	45	43	37	53	49	26	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days)	3.71	3.71	3.71	2.71	2.71	2.71	5.018518519	5.688888889	4.891891892	6.509433962	4.959183673	5.346153846						
Short term domiciliary care (pathway 1)	All packages (planned and spot purchased)																		
Short term domiciliary care (pathway 1)	Monthly activity: Number of new clients	8	21	28	34	27	26	0	0	0	0	0	0	0	16	20	18	10	16
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days)	3.71	3.71	3.71	2.71	2.71	2.71	6.375	6.95	4.888888889	4.5	5.5625	3.928571429						
Short term domiciliary care (pathway 1)	All packages (planned and spot purchased)																		
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity: Number of new clients	37	47	41	39	50	42	13	14	17	24	12	15	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days)	4.31	4.31	4.31	3.31	3.31	3.31	5	5.5	6.252994118	6.666666667	5.5	5.4						
Reablement & Rehabilitation in a bedded setting (pathway 2)	All packages (planned and spot purchased)																		
Other short term bedded care (pathway 2)	Monthly activity: Number of new clients	11	20	6	7	5	11	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days)	8.79	8.79	8.79	6.79	6.79	6.79	0	0	0	0	0	0	0					
Other short term bedded care (pathway 2)	All packages (planned and spot purchased)																		
Short term residential/nursing care for someone likely to require a longer term care home placement (pathway 3)	Monthly activity: Number of new clients	18	18	15	22	7	4	0	0	0	0	0	0	0	21	19	18	8	11
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)	9.01	9.01	9.01	7.01	7.01	7.01	15.04761905	11.26315789	17.44444444	18.625	15.54545455	15.21428571						
Short term residential/nursing care for someone likely to require a longer term care home placement (pathway 3)	All packages (planned and spot purchased)																		

Herefordshire, County ofSocial support (including VCS)

Herefordshire, County ofUrgent Community Response

Herefordshire, County ofReablement & Rehabilitation at home

Herefordshire, County ofReablement & Rehabilitation in a bedded setting

Herefordshire, County ofOther short term social care

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Social support (including VCS)	Monthly activity: Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly activity: Number of new clients	17	18	17	14	17	17	0	0	0	0	0	0
Reablement & Rehabilitation at home	Monthly activity: Number of new clients	32	33	31	26	31	30	5	5	3	3	2	4
Reablement & Rehabilitation in a bedded setting	Monthly activity: Number of new clients	6	6	6	6	6	6	0	0	1	1	0	0
Other short term social care	Monthly activity: Number of new clients	0	0	0	0	0	0	15	7	9	2	6	2

Checklist
Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

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 descriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

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

Better Care Fund 2024-25 Q2 Reporting Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

Running Balances	2024-25			
	Income	Expenditure to date	Percentage spent	Balance
DFG	£2,474,535	£1,033,203	41.75%	£1,441,332
Minimum NHS Contribution	£16,893,372	£8,143,061	48.20%	£8,750,311
IBCF	£6,782,841	£3,012,859	44.42%	£3,769,982
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,584,906	£779,914	49.21%	£804,992
ICB Discharge Funding	£2,221,943	£1,303,594	58.67%	£918,349
Total	£29,957,597	£14,272,631	47.64%	£15,684,966

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	£4,800,617	£4,800,765	£0
Adult Social Care services spend from the minimum ICB allocations	£7,263,293	£3,342,297	£3,920,996

Checklist	Column complete:	Yes	Yes
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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 (£)	Comments
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	n/a		Social Care		LA			Private Sector	Minimum NHS Contribution	£45,056	£22,528	
51	Community Resilience & Prevention	Community Commissioning	Prevention / Early Intervention	Other	Commissioning & contracting for community-	0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£535,207	£205,455	YTD Underspend is due to vacancies being held pending staffing restructure
52	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1140	334	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,321,847	£1,012,870	YTD underspend is due to staffing vacancies
52	Support for Hospital Discharge	Integrated Discharge- Hillside ICC	Bed based intermediate Care Services (Reablement, Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		117	29	Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	£440,340	£238,758	YTD overspend is due to increased agency costs
52	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£301,226	£125,522	YTD underspend is due to staffing vacancies
52	Support for Hospital Discharge	Brokerage	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£277,027	£143,514	YTD underspend is due to staffing vacancies
52	Support for Hospital Discharge	ART	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£383,330	£102,922	YTD Underspend is due to vacancies being held pending staffing restructure
52	Support for Hospital Discharge	HLT	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£222,379	£108,483	YTD underspend is due to staffing vacancies
53	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£403,855	£177,379	YTD underspend is due to staffing vacancies
54	Social Care Complex Needs	DoLs / AMHPs	Care Act Implementation Related Duties	Independent Mental Health Advocacy		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,001,473	£532,087	YTD overspend is due to increased medical professional costs
54	Social Care Complex Needs	Safeguarding	Care Act Implementation Related Duties	Safeguarding		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£286,395	£130,360	YTD overspend is due to increased agency costs
54	Social Care Complex Needs	Transitions	Integrated Care Planning and Navigation	Care navigation and planning		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£283,407	£139,842	YTD underspend is due to staffing vacancies
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Other	Carer support and advice	0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£225,000	£112,500	
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	n/a		Community Health		NHS			Private Sector	Minimum NHS Contribution	£133,306	£66,653	

52	Support for Hospital Discharge	Integrated Discharge- LICU	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		151	34	Number of placements	Community Health		NHS			Private Sector	Minimum NHS Contribution	£1,055,333	£527,667	
57	Carers Support	Acorns Children's Hospice	Carers Services	Respite services		21	11	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£32,995	£16,498	
57	Carers Support	St Michael's Hospice Carer's Support	Carers Services	Respite services		288	144	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£268,177	£134,089	
33	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		174	90	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£2,474,535	£1,033,203	YTD overspend is due to timing difference in actual spend on projects compared to plan
151	Community Resilience & Prevention	Talk Community Grants	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£91,686	£67,655	YTD overspend is due to small increase in contract costs
151	Community Resilience & Prevention	Talk Community Management	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£248,674	£67,572	YTD Underspend is due to vacancies being held pending staffing restructure
151	Community Resilience & Prevention	Talk Community Brokers	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£142,699	£55,119	YTD Underspend is due to vacancies being held pending staffing restructure
151	Community Resilience & Prevention	Talk Community Development	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£330,234	£182,871	YTD underspend is due to staffing vacancies
151	Community Resilience & Prevention	Talk Community Directory	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£142,656	£27,050	YTD underspend is due to reduction in website costs
151	Community Resilience & Prevention	Talk Community Service Director	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£130,350	£116,000	YTD overspend is due to increased agency costs
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Prevention / Early Intervention	Other	Falls Prevention & Responder		n/a		Social Care		LA			Local Authority	iBCF	£44,000	£22,000	
151	Community Resilience & Prevention	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy			n/a		Social Care		LA			Local Authority	iBCF	£207,950	£77,542	
152	Support for Hospital Discharge	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	n/a		Social Care		LA			Local Authority	iBCF	£85,457	£42,729	
152	Support for Hospital Discharge	Additional Costs of D2A beds (Ledbury ICU)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		38	9	Number of placements	Social Care		LA			Local Authority	iBCF	£265,484	£132,742	
154	Social Care Services	Locality Social Work Teams	Integrated Care Planning and Navigation	Care navigation and planning		0	n/a		Social Care		LA			Local Authority	iBCF	£4,003,096	£1,669,192	YTD Underspend is due to vacancies being held pending staffing restructure
154	Social Care Services	Social Care Business Delivery & Practice Improvements	Enablers for Integration	Workforce development		0	n/a		Social Care		LA			Local Authority	iBCF	£255,122	£134,197	YTD underspend is due to staffing vacancies
154	Social Care Services	Shared Lives	Residential Placements	Other	Shared Lives	57	57	Number of beds	Social Care		LA			Local Authority	iBCF	£252,827	£123,923	YTD underspend is due to staffing vacancies
401	Support for Hospital Discharge	Integrated Discharge beds @ Hillside Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		228	57	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge	£870,977	£472,256	YTD overspend is due to increased agency costs
28	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	n/a		Social Care		LA	0.0%		Local Authority	Local Authority Discharge	£193,620	£80,682	YTD underspend is due to staffing vacancies
35	Support for Hospital Discharge	Housing Hospital Discharge Team	High Impact Change Model for Managing Transfer of Care	Housing and related services	0	0	n/a		Social Care		LA	0.0%		Local Authority	iBCF	£98,173	£49,087	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	n/a		Social Care		LA	0.0%		Local Authority	Minimum NHS Contribution	£28,546	£12,538	YTD underspend is due to staffing vacancies
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Social Care		LA	0.0%		NHS Community Provider	Minimum NHS Contribution	£252,388	£126,194	
56	Care Market Development	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Community Health		LA	0.0%		NHS Community Provider	iBCF	£128,681	£64,341	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Community Health		NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£8,111,719	£4,055,859	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Community Health		NHS	0.0%		NHS Community Provider	ICB Discharge Funding	£415,926	£207,963	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	n/a		Community Health		LA	0.0%		NHS	ICB Discharge Funding	£56,000	£30,502	YTD overspend is due to professional costs being higher than expected
33	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	0	250	75	Packages	Social Care		LA	0.0%		Private Sector	Local Authority Discharge	£520,309	£226,977	YTD underspend is due to staffing vacancies

