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

NHS England

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2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist Complete:
Health and Wellbeing Board:	County Durham	Yes
Completed by:	Paul Copeland	Yes
E-mail:	paul.copeland@durham.gov.uk	Yes
Contact number:	3000265190	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

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3. National Conditions

Selected Health and Wellbeing Board: County Durham

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

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4. Metrics

Selected Health and Wellbeing Board: County Durham

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 *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:
		Q1	Q2	Q3	Q4							
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	211.8	171.0	193.3	185.3	242.3	Data not available to assess progress	Although there has been some improvement in the coding at CDDFT, we are still seeing uncoded HRG's in more recent data as well as historic. Avoidable admissions may increase with further data	Urgent Community Response (UCR) is having a positive impact upon avoidable admissions alongside Primary Care admissions avoidance. Additional Intermediate Care bed capacity is also an	Not Applicable.	We only have July 2024 frozen SUS data therefore unable to provide a clear Q2 position.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.5%	92.5%	92.5%	92.5%	91.09%	Data not available to assess progress	We only have July 2024 frozen SUS data therefore unable to provide a clear position.	The effective use of intermediate care/ reablement at home impacts positively on discharge to normal place of residence.	Not Applicable.	We only have July 2024 frozen SUS data therefore unable to provide a clear Q2 position.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,477.0	326.0	Data not available to assess progress	Although there has been some improvement in the coding at CDDFT, the rate of falls may increase with further data refreshes.	Services including UCR, anticipatory care, short term interventions, osteoporosis/ falls services, care connect responder, aids and equipment services all support improvements.	Not Apllicable.	We only have July 2024 frozen SUS data therefore unable to provide a clear Q2 position.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				740	not applicable	On track to meet target	None.	Between April-September 2024 we have had 421 permanent admissions which equates to a rate of 351.1/ 100,000 population. Improved community services including short term interventions are	Not Applicable.	Not Applicable.	Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: County Durham

5.1 Assumptions

	Checklist Complete:
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.	
Over the winter period we expect to see an increase in demand which is likely to peak between January - Fecbruary 2025. However, advanced planning by commissioning and use of both IC beds alongside therapy support should enable optimal lengths of stay. We are currently piloting a new model of reablement alongside our existing service to support those people returning home from hospital which will extend capacity. Provider activity and capacity is monitored by commissiong on an ongoing basis.. The impact of the additional capacity has been reflected in the data.	Yes
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?	
County durham Winter Planning group is a seasonal multi-agency task and finish group which oversees health and social care system preparedness for winter. Meetings began in September 2024 and have been held fortnightly in the lead up to winter. Plans have been shared inrelation to NHS bed capacity / winter presuures via LADB; Primary Care pressures helped by pharmacy support, COPD/ asthmas review clinics; Social Care through the County Durham Care Partnership and use of mutual support, grant initiatives and workforce developments and finally Public Health through surveillance and outbreak management, infection control, vaccinations and the adverse weather protection health plan.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
We do not anticipate any capacity concerns in relation to care homes, the domiciliiary care market remains stable with no waiting list for care. Additional capacity for IC beds developed by commissiong through the Hospital Discharge Fund and the MSIF Workforce Fund is in place for winter to support unnecessary hospital admissions and discharge. We have commissioned additional services to support people with mental health and/or housing needs to support a number of more challenging hospital discharges.	Yes
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?	
Based upon historical evidence and experience in County Durham we do not anticipate that demand will exceed capacity.	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

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5. Capacity & Demand

Selected Health and Wellbeing Board: County Durham

Actual activity - Hospital Discharge

Service Area	Metric	Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through only spot purchasing (doesn't apply to time to service)						Checklist Complete:
		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	71	68	117	70	98	81	0	0	0	0	0	0	135	119	95	136	124	118	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	1	1	1	1	1	1	1	1	1							Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	111	87	68	86	65	75	5	5	2	8	8	8	125	151	106	148	94	33	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1							Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	102	95	113	100	98	90	38	35	33	37	30	32	4	0	0	11	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2							Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0							Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	8	7	9	7	7	7	0	0	0	0	0	0	3	2	0	3	1	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)	3	3	3	3	3	3	3	3	3	3	3	3							Yes

Actual activity - Community

Service Area	Metric	Prepopulated demand from 2024-25 plan						Actual activity:						
		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.	34	52	39	36	50	44	42	35	33	48	30	32	Yes
Urgent Community Response	Monthly activity. Number of new clients.	561	612	701	859	693	638	891	1005	974	899	945	988	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	50	41	46	39	46	56	71	76	62	52	44	39	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	22	21	24	22	21	19	42	40	15	26	26	24	Yes
Other short-term social care	Monthly activity. Number of new clients.	33	27	32	25	25	29	8	13	9	14	11	10	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

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: County Durham

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£7,622,316	£3,811,158	50.00%	£3,811,158
Minimum NHS Contribution	£56,088,850	£28,044,426	50.00%	£28,044,424
iBCF	£30,866,855	£15,433,428	50.00%	£15,433,427
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£7,212,475	£3,606,238	50.00%	£3,606,237
ICB Discharge Funding	£5,557,970	£2,778,985	50.00%	£2,778,985
Total	**£107,348,466**	**£53,674,235**	**50.00%**	**£53,674,231**

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	£15,938,861	£8,926,395	£7,012,466
Adult Social Care services spend from the minimum ICB allocations	£24,176,559	£17,106,358	£7,070,201

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 (£)	Comments
1	Short Term Intervention Services	Intermediate Care Services	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			N/A		Community Health		Joint	86.3%	13.7%	NHS Community Provider	Minimum NHS Contribution	£6,947,720	£3,473,860	
2	Short Term Intervention Services	Intermediate Care Services	Integrated Care Planning and Navigation	Support for implementation of anticipatory care			N/A		Community Health		LA			Private Sector	Minimum NHS Contribution	£525,000	£262,500	
3	Short Term Intervention Services	Intermediate Care Services	Home-based intermediate care services	Reablement at home (to support discharge)		2159	1136	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,500,409	£750,205	The piloting of a new model of reablement offers an opportunity for a phased change in the delivery of
4	Short Term Intervention Services	Intermediate Care Services	Integrated Care Planning and Navigation	Support for implementation of anticipatory care			N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£1,113,825	£556,913	
5	Equipment and Adaptations for Independence	Equipment Loans	Personalised Care at Home	Physical health/wellbeing			N/A		Community Health		Joint	83.4%	16.6%	Private Sector	Minimum NHS Contribution	£4,206,677	£2,103,339	
6	Equipment and Adaptations for Independence	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		635	334	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£7,622,316	£3,811,158	
7	Equipment and Adaptations for Independence	Disability Adaptations	Personalised Care at Home	Physical health/wellbeing			N/A		Community Health		Joint	6.0%	94.0%	Private Sector	Minimum NHS Contribution	£1,302,050	£651,025	
8	Equipment and Adaptations for Independence	Telecare	Assistive Technologies and Equipment	Assistive technologies including telecare		3327	1751	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£500,000	£250,000	The use of technology in care delivery is important in supporting self management and in maintaining independence.
9	Equipment and Adaptations for Independence	Wheelchairs	Personalised Care at Home	Physical health/wellbeing			N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£1,384,581	£692,291	
10	Supporting Independent Living	Supported Living and Associated Activity	Community Based Schemes	Other	Supported Living and Associated Activity		N/A		Community Health		Joint	24.7%	75.3%	Private Sector	Minimum NHS Contribution	£5,040,498	£2,520,249	
11	Supporting Carers	Carer Advice and Support	Carers Services	Other	Carer Advice and Support	26950	N/A	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£1,355,785	£677,893	
12	Social Inclusion	Support to Promote Increased Inclusion	Prevention / Early Intervention	Other	Support to Promote Increased		N/A		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,121,000	£560,500	
13	Care Home Support	Support for Care Homes	Workforce recruitment and retention				N/A	WTE's gained	Social Care		Joint	14.0%	86.0%	Private Sector	Minimum NHS Contribution	£1,774,000	£887,000	
14	LD Complex Needs	Support for LD Complex Needs	Personalised Care at Home	Other	Support for LD Complex Needs		N/A		Social Care		LA			Private Sector	iBCF	£1,500,000	£750,000	
15	Dementia-Related Complex Needs	Support for Dementia Complex Needs	Personalised Care at Home	Other	Support for Dementia Complex Needs		N/A		Social Care		LA			Private Sector	iBCF	£3,000,000	£1,500,000	

17	Whole System Capacity	Whole System Capacity	High Impact Change Model for Managing Transfer of Care	Other	Whole System Capacity		N/A		Social Care		LA			Private Sector	iBCF	£2,822,376	£1,411,188	
18	Transforming Care	Transformational Change	Integrated Care Planning and Navigation	Other	Transformational Change	0	N/A		Social Care		Joint	19.6%	80.4%	Local Authority	Minimum NHS Contribution	£14,935,954	£7,467,977	
19	Transforming Care	Developing and Maintaining Care Services	Enablers for Integration	Integrated models of provision			N/A		Social Care		LA			Private Sector	Minimum NHS Contribution	£14,381,352	£7,190,676	
22	Whole System Synergy/Hospital Discharge	Carers Support	Care Act Implementation Related Duties	Other	Carers Support	0	N/A		Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge	£322,466	£161,233	
28	Whole System Synergy/Hospital Discharge	NEAS Transport Top Slice	Other			0	N/A		Other	Ambulance Transport	NHS			NHS	ICB Discharge Funding	£555,797	£277,899	
29	Whole System Synergy/Hospital Discharge	Additional Medical Cover for Hospice Care	Workforce recruitment and retention			1.4	1	WTE's gained	Community Health		NHS			NHS	ICB Discharge Funding	£90,000	£45,000	
30	Whole System Synergy/Hospital Discharge	Intermediate Care Capacity Support	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1800	947	Number of placements	Social Care		NHS			NHS	ICB Discharge Funding	£2,400,000	£1,200,000	
31	Whole System Synergy/Hospital Discharge	MH Hospital Discharge Extension Scheme	Workforce recruitment and retention			100	N/A	WTE's gained	Mental Health		NHS			NHS	ICB Discharge Funding	£616,000	£308,000	
32	Whole System Synergy/Hospital Discharge	Transfer of Care Hub	Integrated Care Planning and Navigation	Care navigation and planning		3	1		Acute		NHS			NHS	ICB Discharge Funding	£213,000	£106,500	
33	Whole System Synergy/Hospital Discharge	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare	0	20	9	Number of beneficiaries	Social Care	0	LA	0.0%		Private Sector	Local Authority Discharge	£472,920	£236,460	
34	Whole System Synergy/Hospital Discharge	Residential Placements (Emergency)	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	2	1	Number of beds	Social Care	0	LA	0.0%		Local Authority	Local Authority Discharge	£800,000	£400,000	
35	Whole System Synergy/Hospital Discharge	Workforce Recruitment and Retention	Workforce recruitment and retention	Improve retention of existing workforce	0	0	N/A	WTE's gained	Social Care	0	LA	0.0%		Local Authority	Local Authority Discharge	£5,217,089	£2,608,545	
36	Whole System Synergy/Hospital Discharge	eMAR Funding - Care Homes	Other	0	eMAR Funding	0	N/A		Social Care	0	LA	0.0%		Private Sector	Local Authority Discharge	£400,000	£200,000	
37	Whole System Synergy/Hospital Discharge	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment	0	700	368	Number of beneficiaries	Community Health	0	NHS	0.0%		Private Sector	ICB Discharge Funding	£1,335,000	£667,500	
38	Whole System Synergy/Hospital Discharge	Advanced nurse practitioner service to support patients at risk of admission or needing	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	4	2		Community Health	0	NHS	0.0%		NHS Community Provider	ICB Discharge Funding	£348,173	£174,087	
39	Social Care and System-Related Support	Social Care and System-Related Support	Personalised Budgeting and Commissioning	0	0	0	N/A		Social Care	0	LA	0.0%		Private Sector	iBCF	£23,544,479	£11,772,240	