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

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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.

Health and Wellbeing Board:	Dorset	
Completed by:	Sarah Sewell	
E-mail:	sarah.sewell@dorsetcouncil.gov.uk	
Contact number:	01305 221256	
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:	Wed 20/11/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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3. National Conditions

Selected Health and Wellbeing Board: Dorset

			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: Dorset

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
		Q1	Q2	Q3	Q4		
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	145.6	151.1	156.7	151.2	98.0	On track to meet target
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.0%	92.0%	92.0%	92.0%	91.57%	On track to meet target
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,933.3	324.6	On track to meet target
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				397	not applicable	On track to meet target

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*
please note Q2 error in data both with the national SUS pack and local coding, data validation is underway	Focused system workstream in 2024/25 centred on reducing preventable admissions with key objective to drive up utilisation and impact of key services e.g. step-up frailty virtual wards	On track	N/A
please note Q2 error in data both with the national SUS pack and local coding, data validation is underway	Work around higher complexity people being supported via core offer or virtual ward.	On track	N/A
please note Q2 error in data both with the national SUS pack and local coding, data validation is underway	Continue to build on current community offers to prevent admission due to falls, including frailty SDEC services. 24/7 care home support is avoiding 90% of care home falls being conveyed.	On track	N/A
Please note error remains in population calculation BCF target outturn based on correct DC area population is 473.63. At Q1 & 2 performance was 482.32 and 451.91. Improvements in the rate of admissions between Q1 and Q2 show progress towards reducing permanent admissions, we continue to consistently reduce the overal number month on month and remain cautiously optimistic that our target can be achieved through Q3 and Q4.	BCF investment into Reablement led approaches (Home First Accelerator as previously outlined in our returns) and Homecare capacity is continuing to enable us to reduce reliance on residential placements. This is because more people are are to regain their independence, particualrly following discharge from hospital, enabling them, where needed, to be supported at home. We no longer rely on residential care due to lack of homecare - our local homecare market is meeting our demand. Our LA strategy around Extra Care is also developing, with tendering concluding at end of Q2 to enable higher levels of care and support to be provided in our existing settings, again delaying and reducing demand for care home placements. One new scheme is due to open in Q3, but in the main this commissioning intervention will take time to show in performance as schemes are in the main fully occupied.	We are on track	n/a

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5. Capacity & Demand

Selected Health and Wellbeing Board: Dorset

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.	
Overall demand was higher than predicted on both P1 and P2 during first 4m months of 2024/25. This is reflective of higher levels of UEC demand across the county. July was a particularly challenging month and has taken several weeks to recover to more normal levels (as reflected in the data). We also took the decision to close 11 ICB commissioned D2A beds in the West of county at end of Q1 due to poor flow and LLOS for those individuals. August and September activity has been more in line with our anticipated plan. P3 has operated at slightly lower levels than predicted which is in line with our strategy to ensure the majority of people are supported in a core intermediate care offer via P1 and P2. Length of delay has reduced in P2 but not seen any material change in P1. Key areas of learning: Processes have worked better when we have had an on-site Transfer of Care hub working and higher on-site presence on wards facilitating discharge. We have not yet been able to get this working in a sustainable way. There has also been considerable collective effort on reducing LLOS (50 day+ delays) in acute and community hospitals which has helped with reducing 'lost' bed days. One of our challenges remains the volume of peope who are not suitable for our core intermediate care services (higher need/complexity). Some of this is due to risk-averse decision-making at hte point of referrals; others reflect a geniune gaps in commisisoned offers that we need to address going forward. We have recently completed a diagnostics of our UEC and intermediate care pathway supported by Newton. This built on the BCF support programme diagnostic that was completed in Q1 and has validated and provided additional depth to the work we have been doing and is helping to shape our next stage improvement plan	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?	
Our focus ofr winter is centred on making better use of the capacity we have by reducing LOS in these spaces; and simplifying processes for accessing this capacity. This is focus of our Transfer of Care workstream which is being supported through the BCF programme and is one of the 6 key workstreams put forward by Newton as part of the next phase of this work. To enable this we are focusing in 3 key spaces: 1) taking out steps in decision-making at start of process (either by TOC working on-site and/or extension of trusted assessor capabilities between teams) 2) Greater focuse on earlier discharge planning in all bedded spaces, amd particularly for those at risk of becoming a complex discharge. A planning tool is being rolled out from December across all acute sites. 3) Earlier and more effective escalation to senior-decision makers when a person is likely to become a long LOS. This is helping us to undertaken better risk assesmsents of discharge plans and work through how our services can flex to meet need. There is no flex currently in resource plans for additional surge capacity so reducing LOS in intermediate care service is key to increase throughput in order to best meet winter demand	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
There remains a cohort of individuals for who there is not a commissioned intermediate care offer. This is largely those with challenging behaviours, linked often to delirium and/or dementia, who needs cannot be safely met in our standard intermediate care offer. At the moment, many of these end up being assessed for long-term care needs in hospital which is not in line with our D2A approach. We are currently testing some new models of care with our virtual wards to see if they can support safe discharge for delirium patients. There is firther work to do in this space and this will be a key discussion in hte next round of BCF planning The key risk for winter is that demand continues to operate at a higher level than planned for. The last 2 months have been more in line with expected levels and it is hoped this will conitnue. However, to mitigate we are also looking at admission prevention offers to see how we can better connect and utilise them as part of our winter response. This includes SDEC and Virtual Ward services linking through our CAre Co-ordination Hub and with stronger linkes to social care and VCSE support.	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?	

There are two strands to our approach on this 1) Strenghthening out TOC approach with an on-site MDT who are worknig together to make the best use of cpacity available, including flexing and bledning of availavble resources and a more proactive approach with wards and acute teams to support more positive risk-taking in order to get someone home (evidence has shown that our approach is quite risk averse and bed dependent) 2) Effective and early identification and escalation of issues that are/will inhibit flow. We know that the need for higher dependency /compexity solution is in part linked to the lenhth of delay in hospital. Proactively managing this risk is key and we are testing an enhanced process both early discharge planning and escaltion as part of our winter mitigation	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: Dorset

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual acti 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**
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	191	184	194	186	216	186	221	201	222	239	230	206	0
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	6	6	6	5	5	5	6	6	6	7	8	7	
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0	
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	86	94	94	78	94	109	93	131	103	127	83	115	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	14	14	14	11	11	11	14	9	13	13	11	12	
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	6	6	6	6	6	10	13	5	1	3	3	4	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	14	14	14	11	11	11	14	9	13	13	11	12	
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	17	15	25	22	26	39	0	0	0	0	0	0	18
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)	51	50	50	45	45	40	51	19	81	60	41	47	

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.	298	296	278	273	329	336	382	294	329	356	322	365
Urgent Community Response	Monthly activity. Number of new clients.	653	653	653	653	653	653	646	679	636	604	602	552
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	123	123	123	123	123	131	134	114	148	144	158	155
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	10	15	13	10	12	9	13	12	15	14	19	8
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

...ity through only spot purchasing (doesn't apply to time				
May-24	Jun-24	Jul-24	Aug-24	Sep-24
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
14	14	17	18	14

Checklist

Complete:

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

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

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Dorset

<< Link to summary sheet

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£4,529,287	£2,219,259	49.00%	£2,310,028
Minimum NHS Contribution	£35,044,629	£17,200,390	49.08%	£17,844,239
iBCF	£12,450,566	£6,098,960	48.99%	£6,351,606
Additional LA Contribution	£58,299,500	£27,685,095	47.49%	£30,614,405
Additional NHS Contribution	£36,224,148	£18,068,760	49.88%	£18,155,388
Local Authority Discharge Funding	£2,909,250	£1,316,151	45.24%	£1,593,099
ICB Discharge Funding	£3,500,773	£2,593,701	74.09%	£907,072
Total	**£152,958,153**	**£75,182,316**	**49.15%**	**£77,775,837**

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	£9,907,649	£10,565,234	£0
Adult Social Care services spend from the minimum ICB allocations	£13,914,160	£6,635,156	£7,279,004

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	Maintaining Independence	A combination of telecare, wellness and digital participation services	Other			0	0		Social Care		LA			Private Sector	iBCF	£2,329,214	£1,164,607	
2	Strong and sustainable care markets	Funding of residential placements	Residential Placements	Care home		154	77	Number of beds	Social Care		LA			Private Sector	iBCF	£4,251,898	£1,999,625	
3	Strong and sustainable care markets	Funding for domiciliary care	Home Care or Domiciliary Care	Domiciliary care packages		55	35	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£1,241,282	£620,641	
4	Strong and sustainable care markets	Enabling service improvement	Other			0	0		Social Care		LA			Local Authority	iBCF	£1,102,300	£551,150	
5	High Impact Changes/ Implementation	Social work staffing capacity to maintain DTOC performance	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care		LA			Local Authority	iBCF	£2,223,817	£1,111,909	
6	Strong and sustainable care markets	Resource to manage and review care market	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity		0	0		Social Care		LA			Local Authority	iBCF	£209,629	£104,815	
7	High Impact Changes/ Implementation	Manage the impact of the confirmed NHS reductions to the existing BCF	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care		LA			Local Authority	iBCF	£1,092,426	£546,213	
8	High Impact Changes/ Implementation	Provision of reablement services	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care		LA			Private Sector	Minimum NHS Contribution	£3,671,278	£1,835,639	
9	Maintaining Independence	Dorset Accessible Homes Service administering DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		1000	216	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£4,529,287	£2,219,259	
10	Maintaining Independence	Mental health & dementia support - nursing home	Residential Placements	Nursing home		69	41	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,525,252	£1,262,626	
11	Maintaining Independence	Dorset Accessible Homes Service provision of AT and equipment	Assistive Technologies and Equipment	Community based equipment		1140	296	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£637,277	£318,638	
12	High Impact Changes/ Implementation	Integrated crisis and rapid response service	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care		LA			Private Sector	Minimum NHS Contribution	£785,379	£392,689	
13	Maintaining Independence	Occupational Therapy capacity to support minor aids and adaptations,	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity		0	0		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,443,189	£721,594	
14	High Impact Changes/ Implementation	Various funding arrangements	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,419,860	£709,930	
15	High Impact Changes/ Implementation	Various funding arrangements	High Impact Change Model for Managing Transfer of Care	Other	Various funding arrangements	0	0		Social Care		LA			NHS Acute Provider	Minimum NHS Contribution	£165,716	£82,858	
16	High Impact Changes/ Implementation	Various funding arrangements	High Impact Change Model for Managing Transfer of Care	Other	Various funding arrangements	0	0		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£446,977	£223,488	
17	Carers	Direct payment budget for carers	Carers Services	Respite Services		300	203	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£116,099	£107,693	
18	Carers	Carers case workers	Carers Services	Carer advice and support related to Care Act duties		73	39	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£268,891	£168,774	
19	Carers	Carer's support service to support those care for people with mental health	Carers Services	Carer advice and support related to Care Act duties		60	319	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£117,667	£52,188	
20	Carers	Carer engagement	Carers Services	Carer advice and support related to Care Act duties		94	125	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£7,769	£2,993	
21	Carers	Respite care, short breaks for carers	Carers Services	Respite Services		350	171	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£478,196	£125,566	
22	Carers	GP practice carers support accreditations scheme	Carers Services	Other	GP training	86	44	Beneficiaries	Social Care		LA			NHS	Minimum NHS Contribution	£8,393	£4,197	
23	Carers	Carers training programme	Carers Services	Other	Carers training/ activities	2200	1151	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£115,928	£71,825	
24	Maintaining Independence	Dorset Integrated Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		3900	1557	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution	£1,144,700	£635,000	
25	Strong and sustainable care markets	Joint purchasing of care	Residential Placements	Care home		884	1007	Number of beds	Social Care		LA			Private Sector	Additional LA Contribution	£55,058,800	£26,004,378	

26	Moving on from Hospital Living	Pooled budget of LD cohort to live in community	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care		LA			Private Sector	Additional LA Contribution	£1,213,000	£592,500	
27	Maintaining Independence	Dorset Integrated Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		4600	10872	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	£2,879,944	£1,439,972	
28	Moving on from Hospital Living	Pooled budget of LD cohort to live in community	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Community Health		NHS			Private Sector	Minimum NHS Contribution	£3,767,826	£1,883,913	
29	Strong and sustainable care markets	Continuing Health Care placements	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Continuing Care		NHS			Private Sector	Additional NHS Contribution	£26,592,162	£13,296,081	
30	Integrated health and social care locality teams	District nursing capacity to support locality working	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£12,027,977	£6,013,989	
31	Integrated health and social care locality teams	Combination of community services and intermediate care services	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Community Health		NHS			NHS Community Provider	Additional NHS Contribution	£7,660,895	£3,830,448	
32	Maintaining Independence	A combination of telecare, wellness and digital participation services	Assistive Technologies and Equipment	Assistive technologies including telecare		683	448	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution	£574,000	£298,717	
33	Maintaining Independence	Work with Citizen's Advice to support information, advice and guidance	Care Act Implementation Related Duties	Other	Citizen's Advice	0	0		Social Care		NHS			Charity / Voluntary Sector	Additional NHS Contribution	£100,048	£50,024	
34	Strong and sustainable care markets	Advocacy CHC appeals	Care Act Implementation Related Duties	Independent Mental Health Advocacy		0	0		Social Care		NHS			Charity / Voluntary Sector	Additional NHS Contribution	£51,816	£25,908	
35	Maintaining Independence	Integrated crisis and rapid response service	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care		LA			Private Sector	Minimum NHS Contribution	£592,987	£296,493	
36	Integrated health and social care locality teams	Funding distributed over aligned budgets - Governance process to confirm exact	Other			0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£2,454,719	£1,227,360	
37	Maintaining Independence	Integrated crisis and rapid response service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Social Care		LA			Private Sector	Minimum NHS Contribution	£367,951	£183,976	
38	Strong and Sustainable Market	Home care capacity investment	Home Care or Domiciliary Care	Domiciliary care packages		300	93	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Local Authority Discharge	£2,563,700	£1,281,850	
39	High Impact Changes/ Implementation	RCR domiciliary care supporting people out of hospital	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	0		Social Care		LA			Private Sector	Local Authority Discharge	£345,550	£34,301	
40	Maintaining Independence	New schemes to be confirmed in line with priority developments	Other			0	0		Social Care		LA			Private Sector	Minimum NHS Contribution	£745,354	£73,989	
41	Maintaining Independence	Home First Accelerator Programme	Community Based Schemes	Other	Sustainable Care Models	0	0		Social Care		LA			Private Sector	Additional NHS Contribution	£1,819,227	£866,299	
43	Maintaining Independence	Thriving Communities VSCE programme	Community Based Schemes	Other	VCSE	0	0		Social Care		LA			Private Sector	Additional LA Contribution	£309,000	£154,500	
44	Maintaining Independence	Recovery Focussed (RCR) enhanced home care	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	0		Social Care		LA			Private Sector	ICB Discharge Funding	£1,750,000	£1,750,000	
45	Strong and sustainable care markets	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		LA			Private Sector	ICB Discharge Funding	£420,000	£210,000	
46	Maintaining Independence	Home First Accelerator Programme	Community Based Schemes	Other	Sustainable Care Models	0	0		Social Care	0	LA	0.0%		Private Sector	ICB Discharge Funding	£1,330,773	£633,701	