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 3.6 [unlocked]

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:	Stockport	
Completed by:	Jon Wilkie	
E-mail:	Jon.Wilkie@stockport.gov.uk	
Contact number:	0161 4744357	
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 27/11/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	No
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

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3. National Conditions

Selected Health and Wellbeing Board: Stockport

		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: Stockport

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)	237.9	249.6	252.5	214.9	222.9	On track to meet target	The target continues to be challenging across the system and partners would welcome any information on innovative approaches from other areas in reducing these admissions.	There is sustained improvement in numbers of these admissions in the current against plan. There is continued focus on ED 4hr performance and improvements in flow into and through SDEC are part of the progress made	not applicable	not applicable	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.6%	92.6%	92.6%	92.6%	92.49%	On track to meet target	The figure is 0.1% away from the target figure and represents a rise from the 23/24 figure of over 1%.	Colleagues across the system are continuing to drive the home first approach through the further alignment of services within the transfer of care hub. We are seeking wherever possible for people return home from hospital by further increasing flexibility in the domiciliary and therapy support available in the community locally through the development of the 7 day offer.	not applicable	not applicable	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,169.8	461.2	On track to meet target	The figure is on target in being less than a quarter of the overall target and by extrapolating the Q1 figure, we are on course to meet the target figure.	There is a ongoing focus across the health and social care system to reduce admissions into hospital from care homes in particular which continues to be rolled out locally. There is continued focus on falls prevention; for example, system wide events held as part of falls awareness week at the end of Q2.	not applicable	not applicable	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				471	not applicable	On track to meet target	The local reporting figures are demonstrating a significant downward trajectory for this measure, with Q2 figure being 523.5 which places Stockport on target to meet the 471 figure by Q4	The locally reported outcome on this measure is moving towards the target performance rate and reflects the drive across the system for admission avoidance, home first from hospital and supporting people to remain independent at home.	not applicable	not applicable	Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Stockport

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.	
The system has continued to move greater numbers of individuals from pathway 2 discharges to return home directly on pathway 1 and this is reflected in the higher actual numbers for pathway 1 and lower for pathway 2 in the actual activity tab. Please note that there are some outliers in the data that we have for June 2024 in particular which is also reflected in the figures but does not represent a genuine reduction in activity. In addition, the community reablement and rehabilitation figures are higher than we have anticipated and are continuing to analyse our data to assure ourselves that this is correctly assigned activity. We are continuing to iteratively assess our capacity and demand modelling but are confident in the ability to continue to flex upwards around pathway 1 discharges and ensure that we are maximising pathway 2 placements in light of developing complexity in need.	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?	
In preparation for winter readiness, the local authority along with system partners have hosted a provider winter planning resilience forum focussed on Resilience and review of Business Continuity Plans. As a system we have worked together on a number of focussed pathway 1, 2 and 3 pilot projects to support safe and timely discharge from hospital, the performance of the pilots will continue to be reviewed regularly and will run over the winter period supporting proactive management of winter surges. We are continuing to refine our Pathway 2 Discharge to Assess journey for individuals to support system flow and avoid delays. Improvements such as reviewing the Standard Operating Procedure for our Pathway 2 bed bases, the introduction of a patient information leaflet and specific D2A provision discussions on staffing structure and prioritisation. We are also refining our Pathway 2 D2A offer through the introduction of Pharmacy Student placements working directly with D2A provisions and multi-agency professionals. We recognise the significant challenges that our providers continue to face within the health and social care sector with regards to recruitment and have committed to hosting a sector based recruitment fair for a second year. The fair is being held in November to support our health and care markets workforce resilience over the winter months. In addition we are working in collaboration with system partners to develop a local offer to support displaced international recruits working in health and social care, this will also support workforce challenges over the winter.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
The system locally continues to focus on driving additional discharges to enable people to return home and is proactively working with adult social care providers to ensure that capacity is available when it is required; refining and reviewing pathways, supporting recruitment and retention alongside proactively addressing anticipated surges in demand through ongoing engagement with data across the system.	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?	
For people requiring social support, we are in regular contact with colleagues in the VCFSE sector as part of weekly meetings around system flow and have established arrangements to flex up capacity as and when required. The system remains confident in the available capacity of providers to further support both numbers and complexity for those who require support in their own home to avoid hospital or facilitate a discharge. The system continues to monitor flow into and out of bed based provision on pathway 2 to maximise the provision and to work with the local care home market to ensure that where additional capacity is required in a period of surging demand. The care home bed capacity is part of this ongoing analysis and we continue to monitor availability where pathway 3 discharges are required and work with the market to ensure that people are not attending hospital except where this is required and that there is readiness for capacity where this is required.	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: Stockport

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	70	70	69	68	70	71	103	103	92	137	128	76	0	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	2	2	2	2	3	3	3	5	5	2							Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	166	174	178	153	175	182	202	206	85	237	191	177	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	3	3	2	2							Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	122	120	124	129	125	128	94	76	69	93	87	87	0	0	0	0	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)	4	4	3	3	3	3	2	1	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	38	39	40	42	39	38	49	41	15	65	29	32	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)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	6	6	6	6	5	4	6	6	6	6	6	6							Yes

Actual activity - Community

Service Area	Metric	Prepopulated demand from 2024-25 plan						Actual activity:						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	
Social support (including VCS)	Monthly activity. Number of new clients.	689	632	640	557	517	576	648	649	634	621	600	608	Yes
Urgent Community Response	Monthly activity. Number of new clients.	17	17	12	19	18	21	17	17	12	19	18	21	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	18	20	19	19	23	18	70	81	70	102	74	66	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	3	4	3	3	2	3	3	0	0	1	4	2	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

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

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.

19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

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

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Stockport

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£3,147,749	£1,309,441	41.60%	£1,838,308
Minimum NHS Contribution	£27,557,919	£14,149,832	51.35%	£13,408,087
iBCF	£9,711,282	£4,855,500	50.00%	£4,855,782
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£2,269,178	£1,134,500	50.00%	£1,134,678
ICB Discharge Funding	£2,602,087	£1,301,000	50.00%	£1,301,087
Total	**£45,288,215**	**£22,750,273**	**50.23%**	**£22,537,942**

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	£7,831,179	£4,230,500	£3,600,679
Adult Social Care services spend from the minimum ICB allocations	£11,745,642	£9,352,025	£2,393,617

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	Neighbourhood LA Services	Investment into community based social care services	Community Based Schemes	Integrated neighbourhood services			NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£3,150,330	£1,661,089	
1	Neighbourhood Medicine Management	Management of community pharmacy drugs and prescriptions	Community Based Schemes	Other	Medicines Management		NA		Community Health		LA			NHS Community Provider	Minimum NHS Contribution	£150,368	£72,254	
1	Neighbourhood Community Nursing	Investment into community based health services.	Community Based Schemes	Integrated neighbourhood services			NA		Community Health		LA			NHS Community Provider	Minimum NHS Contribution	£591,969	£276,585	
1	Neighbourhood End of Life	End of life care aligned to acute trust.	Community Based Schemes	Other	End of Life Care		NA		Community Health		LA			NHS Community Provider	Minimum NHS Contribution	£159,231	£77,475	
1	Neighbourhood Community Mental Health	Investment into community based mental health services.	Community Based Schemes	Integrated neighbourhood services			NA		Mental Health		LA			NHS Mental Health Provider	Minimum NHS Contribution	£418,532	£140,993	
1	Neighbourhood Services - Enhanced Support	Additonal neighbourhood social care service.	Community Based Schemes	Integrated neighbourhood services			NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£605,455	£290,313	
2	Reablement	Step up and Step down reablement services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		216	131	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	£1,225,552	£613,000	
3	Equipment	Provision of equipment to support independent living	Assistive Technologies and Equipment	Community based equipment		3978	2010	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£734,617	£367,500	
3	Equipment	Provision of equipment to support independent living	Other				NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£100,000	£50,000	
4	Demographic / Demand / Price Inflation for ASC	Supporting Adult Social Care care management provision	Other				NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£10,307,986	£5,154,500	
5	Carers Services	One off carers payments and associated staffing costs.	Carers Services	Other	One off carers payments and associated	933	526	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£756,380	£405,623	
6	LD Tenancy - Stockport Road Apartments	Supported accommodation for LD clients.	Residential Placements	Supported housing		5	5	Number of beds	Social Care		LA			Local Authority	Minimum NHS Contribution	£699,148	£452,000	
7	BCF Programme - service delivery	Contribution to the operational and strategic support for the BCF schemes	Enablers for Integration	Programme management			NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£70,000	£35,000	
8	Early Supported Discharge	Support to discharge services.	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£553,000	£276,500	
9	Telecare	Telecare services	Assistive Technologies and Equipment	Assistive technologies including telecare		809	767	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£93,000	£46,500	Referrals have fluctuated and a system wide strategic approach for TEC is in train.
10	Demographic / Demand / Price Inflation for ASC	Supporting Adult Social Care care management provision	Other				NA		Social Care		LA			Local Authority	iBCF	£1,809,000	£904,500	

10	Demographic / Demand / Price Inflation for ASC	Supporting Adult Social Care care management provision	Other				NA		Social Care		LA			Local Authority	iBCF	£6,619,067	£3,309,500	
10	Demographic / Demand / Price Inflation for ASC	Supporting Adult Social Care care management provision	Other				NA		Social Care		LA			Local Authority	iBCF	£1,283,215	£641,500	
11	Disabled Facilities Grant (CAPITAL) (Housing)	All aspects of mandatory and discretionary adaptations.	DFG Related Schemes	Adaptations, including statutory DFG grants		324	106	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£3,147,749	£1,309,441	
12	ASC Discharge Funding	To support pathway 2 direct discharge from hospital	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		419	176	Number of placements	Social Care		LA			Local Authority	Local Authority Discharge	£2,269,178	£1,134,500	Some challenges on occupancy due to acuity of D2A patients.
13	Carers	Provides short term respite care placements, mainly for people at home who have	Carers Services	Respite services		180	93	Beneficiaries	Continuing Care		NHS			Private Sector	Minimum NHS Contribution	£316,281	£158,000	
14	Saffron Ward MH - Step Up / Step Down beds	Contribution to Saffron Ward whichis a 20 bed step down facilitity for patients suffering	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		126	42	Number of placements	Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	£995,692	£498,000	
15	Community Falls Service	Community Falls Service - Steady in Stockport	Community Based Schemes	Integrated neighbourhood services		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£172,812	£86,500	
16	Dementia	Diagnostic Support Worker	Community Based Schemes	Integrated neighbourhood services		0	NA		Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£38,241	£19,000	
17	Expanded Patient Education	Provision of patient education programmes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£132,490	£66,000	
18	Continuing Health Care	Fund to support CHC in the spot purchasing of beds when D2A beds are not available, to	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		254	114	Number of placements	Continuing Care		NHS			Private Sector	Minimum NHS Contribution	£1,826,061	£1,172,500	Reflects increase cost of placements due to acuity of patients
19	Bluebell Ward - New Model of care for ward	Bluebell is a 25-bedded D2A facility managed by Stockport NHS Foundation Trust based	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		300	194	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£2,562,727	£1,281,000	Average length of stay has improved due to less complex patients being admitted
20	GP Development scheme	General practice input into community services and supporting the	Community Based Schemes	Integrated neighbourhood services		0	NA		Primary Care		NHS			Private Sector	Minimum NHS Contribution	£951,736	£476,000	
21	Mental Health	Mental health Crisis response and liaison service	Urgent Community Response			0	NA		Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	£729,680	£365,000	
22	Stockport Health and Care Record	It is a single shared patient record from health and social care in a unified view to	Enablers for Integration	Integrated models of provision			NA		Other		NHS			Private Sector	Minimum NHS Contribution	£181,631	£91,000	
23	Staff resource supporting the Stockport Health	Localities contribution to the GM Care Record. Ongoing management of Stockport	Enablers for Integration	Programme management		0	NA		Other		NHS			NHS	Minimum NHS Contribution	£35,000	£17,500	
24	Commissioning of D2A Beds	To support pathway 2 discharges from hospital.	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		325	137	Number of placements	Community Health		NHS			Private Sector	ICB Discharge Funding	£2,602,087	£1,301,000	Average length of stay has increased due to acuity of patient