Slough Borough Council

Report To:	Slough Wellbeing Board
Date:	18 June 2024
Subject:	Better Care Fund Plan 2024-25
Chief Officer:	Marc Gadsby, Executive Director Adult Social Care
Contact Officer:	Mike Wooldridge, Integration Delivery Lead, Frimley ICB
Ward(s):	All
Exempt:	NO
Appendices:	Appendix 1 - Summary of year end outturn 2023/24 Appendix 2 - Summary of BCF narrative plan update 2024/25 Appendix 3 - Better Care Fund metrics update for 2024-25 Appendix 4 - BCF updated expenditure plan 2024/25

1. Summary and Recommendations

1.1 This report sets out to present Slough's Better Care Fund Plan 2024/25 to the Wellbeing Board. The report provides a summary of the BCF programme in 2023/24 along with the updated plan for this year including finance, governance and our approach and priorities for integration in Slough.

Recommendations:

The Wellbeing Board is recommended to note the contents of the Better Care Fund Plan and the areas of joint investment by the partners from the pooled budget. BCF schemes are set within the national policy framework and aimed at supporting Slough residents to live independently at home, avoid unnecessary admissions to hospital where possible, and if they are admitted to hospital, experience a timely and well-coordinated discharge and transfer from hospital back home.

Reason: Better Care Fund plans require statutory approval from Wellbeing Boards. Deadline for submission of plans was 10 June subject to Board approval.

2. Report

Introductory paragraph

The Better Care Fund (BCF) is a national government programme aimed at bringing health and social care partners together to deliver more person-centred and integrated care at a

local partnership level. Announced in 2014 and then launched in 2015, the BCF programme requires Health and Wellbeing Boards to pool local budgets between the NHS and local authorities with the aim of reducing the barriers often created by separate funding streams. The framework remains largely unchanged with the core purpose to protect adult social care and promote integration locally aligned with local authorities and health as partners.

The Better Care Fund programme is developed, agreed and managed between Slough Borough Council and the Frimley Integrated Care Board. Working together with local stakeholders and delivery partners it aims to improve, both directly and indirectly, the health and wellbeing outcomes for the people of Slough.

Last year a two-year plan was developed, submitted and subsequently assured by the national team. This was presented to Wellbeing Board on 23 January 2023. A refreshed plan for year two was submitted on 10 June 2024 with updated data, metrics and spend plan.

The 2024/25 BCF Plan is written and produced in accordance with the national policy framework to demonstrate that it meets the criteria and conditions that apply to the BCF and is subject again to a national assurance process.

The Better Care Fund directly supports delivery of priority three within Slough's Joint Wellbeing Strategy, that is the integration of Health and Social Care. It also supports the Corporate Plan 2023-27 strategic priority for 'A town where residents can live healthier, safer and more independent lives' particularly in addressing health inequalities but also in respect of 'maximising independence, confidence and capacity for self-management ... to enable people to live the life they want, stay independent at home for longer and reduce the need for emergency and statutory services' (page 14).

Background

Background and supporting information is included in the appendices 1-4

3. Implications of the Recommendation

3.1 Financial implications

	ICB Contribution	Council Contribution
Minimum ICB contribution	£11,836,867	
Disabled Facilities Grant		£1,244,197
iBCF		£3,989,414
Discharge Fund (LA)		£932,183
Discharge Fund (ICB)	£1,243,745	
Total	**£13,080,612**	**£6,165,794**

The total value of the BCF Pooled Budget for 2024/25 is **£19,246,406**

The updated BCF expenditure plan is included in Appendix 4. The expenditure is across 54 schemes listed. These are agreed and managed between the partners of the pooled budget agreement under section 75 agreement (NHS Act 2006).

3.2 Legal implications

There are legal implications arising from how funds are used, managed and audited within a Pooled Budget arrangement under section 75 of the NHS Act 2006. The Council and Frimley ICB have a section 75 contract agreement drawn up and signed between the partners.

The section 75 enables NHS bodies and local authorities to enter into arrangements which are prescribed in secondary legislation. The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, as amended, is the relevant secondary legislation that sets out details of the permitted arrangements as follows:

- NHS bodies can carry out local authorities' health-related functions together with their NHS functions
- local authorities can carry out NHS functions together with their local authority health-related functions
- NHS bodies and local authorities can establish and run a pooled fund which is made up of contributions by the partners, and out of which payments may be made towards carrying out the functions that are within the scope of the arrangements
- such arrangements can only be formed if it is likely to lead to an improvement in the way in which the functions are exercised
- any partnership arrangements entered into under section 75 of the NHS Act 2006 do not affect the liability and accountability of NHS bodies or local authorities for the exercise of any of their functions (s.75(5))

3.3 Risk management implications

The Health and Social Care Partnership acts the Programme Board for the BCF and oversees and monitors risks in relation to the BCF programme. A risk register identifies, and scores risks of delivery of the programme together with actions to mitigate or manage those risks.

3.4 Environmental implications

None identified.

3.5 Equality implications

The BCF aims to improve outcomes and wellbeing for the people of Slough through effective protection of social care and integrated activity to live healthier, more independent lives in the community and reduce emergency and urgent health demand.

The BCF narrative plan (presented to Wellbeing Board 23 January 2023) includes a section on how the plan contributes to reducing health inequalities and disparities for the local population.

Impact assessments are undertaken as part of planning of any new scheme or investment to ensure that there is a clear understanding of how various groups identified within the Equalities Act (2010) may potentially be affected.

3.6 Procurement implications

There may be procurement implications when commissioning and procuring services with BCF funding. The agreed commissioning lead, whether ICB or local authority, would take advice and follow their own procurement procedures in line with public contracts regulations to ensure value for money and social value.

3.7 Workforce implications

There are workforce challenges for the health and social care system in ensuring there sufficiently trained workforce, with the required skills and experience to meet the growing needs of the population in both volume and complexity.

As we move towards closer integration of health and social care service there will be closer collaborative working to deliver integrated care including new ways of working in partnership with others. The BCF programme is therefore aligning together with other change programme activities happening across the wider Frimley Integrated Care System as well as the local integration of services happening at place.

3.8 Property implications

None

4. Background Papers

Previous BCF Board papers presented 23 January 2023:

- BCF narrative plan 2023-25
- BCF expenditure plan 2023-25

- Appendix 1 - Summary of year end outturn 2023/24
- Appendix 2 - Summary of BCF narrative plan update 2024/25
- Appendix 3 - Better Care Fund metrics update for 2024-25
- Appendix 4 - BCF updated expenditure plan 2024/25

Appendix 1 - Summary of year end outturn 2023/24

Metric	Definition	Planned Performance as reported in 23/24 planning	Assessment of progress	Challenges and support needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q1 – 95.0 Q2 – 93.0 Q3 – 91.0 Q4 – 89.0	Not on track to meet target	Q4 achieved 154.3 which was significant improvement on Q1-3 which averaged 183.1 but still falling short of plan. Further detailed analysis to be done to understand cohort(s) of patients to identify risk and divert.	Anticipatory Care Coordinators in each PCN identifying and screening cohorts of 'at risk' patients. Urgent Care Response and Virtual Ward are helping to avoid admissions as well as the Local Access Point for triaging care and support for people with complex needs and frailty. MDT cluster meetings in PCN localities for complex case management.
Discharge to normal place of residence	Percentage of people who were discharged from acute hospital to their normal place of residence	Q1 – 91.4% Q2 – 91.7% Q3 – 91.7% Q4 – 92.0%	On track to meet target	Increasing numbers of patients with high levels of acuity and the pressure to maintain flow out of hospital when no longer meeting criteria to reside occasionally means bedded interim care arrangements required.	Maintaining good flow out of the hospital using discharge funds to create capacity and fund interim D2A care arrangements as well as additional brokerage for coordinating care and placements for discharge.
Falls	Emergency admissions due to falls in people aged over 65 (standardised rate per 100,000)	1,653.9	Not on track to meet target	Actual is near plan target by a difference of 4 admissions. Data collection and reporting on emergency falls admissions continues to be a challenge.	A falls prevention working group has been established to review falls data, pathways and services in Slough to ensure people are referred early and appropriately into the right services to assess, support and maintain strength and balance to reduce risk of falls and injury.

Residential admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	428	On track to meet target	Provisional data using ADASS popn data (15,557) is showing 456.4 against our plan rate. Actual number placed (71) is on plan.	Reduced access to care home beds in Slough in this year has required even greater focus on effective use of available beds and effective reablement services with wrap-around care and support for people to remain in their own home.
Reablement	Proportion of older people (65+) still at home 91 days after being discharged from hospital into reablement / rehabilitation services	77.3%	Not on track to meet target	Provisional data is showing an outturn of 74.5% (73/98). Small numbers can skew overall performance. 3 more would have achieved target. Reablement offered universally so not selected on likely success criteria but opportunity for all to maximise independence.	There has been increased use of the external care market to provide additional capacity for reablement.

1.2 Delivery of the Better Care Fund 2023/24

Statement	Response	Comments
The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	BCF continues to be at the centre of the joint planning and decision making between partners with integration being one of the top priorities for the Slough Wellbeing Strategy
Our BCF schemes were implemented as planned in 2023-24	Agree	BCF schemes continued or were implemented as planned. The End of Life Care at home scheme did not commence in this year pending work to align contracts and activity across the wider system and East Berks local authorities
The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality	Agree	The BCF is central to the delivery of integrated care in Slough and funds the operation of integrated teams with a multi-agency, multi-professional workforce. It also funds the operation of our intermediate care services providing rehabilitation and reablement

1.3 Outline two successes observed towards driving the enablers towards integration (expressed in SCIE login model) in 2023/24

SCIE Logic Model Enablers, Response category:	Response
4. Empowering users to have choice and control through an	The Coproduction Network (CPN) has grown in its membership in this year and is central to our engagement and co-design of services in Slough bringing together health and social care managers with

asset based approach, shared decision making and co-production	residents of Slough with lived experience. Members of the CPN make a valued contribution at all our board and stakeholder groups, most recently on the newly established Older People Steering Group and the various task and finish groups within that workstream, as well as the Carers Steering Group. They also are represented on the Panel for the Community Fund.
3. Integrated electronic records and sharing across the system with service users	Our Connected Care Programme continues to develop the Shared Care Record leading to better care and treatment for people through sharing key information across acute, community, primary and social care. It is also an analytical tool in order to support our Population Health Management approach helping to identify cohorts of risk and contribute reducing health inequalities and proactive management of people with long term conditions, frailty and complex care needs. There is remote digital management support offer to Care Homes and for people living with chronic, poorly managed diabetes to help manage and avoid deterioration.

1.4 Outline two key challenges observed towards driving the enablers towards integration (expressed in SCIEs logic model) in 2023/24

SCIE Logic Model Enablers, Response category:	**Response**
5. Integrated workforce: joint approach to training and upskilling of workforce	The workforce capacity and skills training is not currently sufficient to meet the growing needs of the population in both volume and complexity from the shift in demand from the acute hospital to supporting within the community. There continues to be a gap between demand and capacity with need for trained, professional health and social care staff with the required skills and experience to work as an integrated workforce in the community. As a consequence there is an over reliance on locum and interim staff to cover substantive roles pushing up workforce costs. This continues to be the most significant risk and challenge to meeting future delivery of our integrated care model
8. Pooled or aligned resources	The ICB continues to develop how works strategically and consistently to support population health management across the wider system whilst retaining focus on Place Based delivery of community-based health and social care. Slough has particular challenges in terms of the health inequalities across a diverse population and communities. The financial position of the local authority has meant looking at ways in which BCF can invest in ways to further support integration and reduce health inequalities. The Wellbeing Board has also asked for greater parity in BCF spend allocation and priorities in future towards greater investment in early intervention services for children and young people and services for children and young people with complex needs

Appendix 2 - Summary of BCF narrative plan update 2024/25

Capacity & Demand
The implementation of the EPIC system has started to provide much more accurate data on the number of people being discharged from hospital on the pathways 0-3. This data started from July 2023 and so not yet available. for a full year's reporting. Numbers were initially low and variable reliability but the data capture and quality has been improving with provision of training and feedback on the data showing. Prior to this numbers were estimated based on expected ratio against overall discharge numbers with some data being provided by reablement and purchasing and brokerage teams in social care. The EPIC data has very recently been written in to a PowerBI dashboard that enables BCF leads to see numbers without personally identifiable data. Capacity and demand plans for this year have been made using the available information from the EPIC report on discharge activity coupled with available capacity in services with additional spot purchasing of packages and beds where/as required to ensure flow from the hospital. Community capacity and demand is taken from analysis of various areas. BCF contributes to a voluntary sector infrastructure service which includes 3 community connector roles taking referrals from both hospital and the community. There has been some gaps in recruiting to these roles to become full capacity but over the last 3 quarters over 500 people have been supported through these roles. One is based in the hospital taking referrals from discharge team, discharge lounge, the wards and reception area. The others are community based and take self-referrals as well as from Adult Social Care. Urgent Care activity is profiled and modelled on this year's activity. The reablement team takes referrals from community to avoid admission as well as supporting hospital discharge. The proportion can vary during the year, but numbers averaged on approx. numbers over the year. Step up beds in the community hospitals are also used to avoid admission. Numbers tend to be low, particularly with availability now of the UCR and virtual ward. The capacity for these beds is shared with partners across the east of Berkshire.
Intermediate Care
Our commissioned intermediate care services are primarily through the Reablement and Independence Service hosted by Slough Borough Council. The service currently provides quite limited capacity in terms of direct care and reablement hours with the majority being purchased externally from the wider domiciliary care market. Demand and capacity over that provided by the in-house team is met by the external market through a range of providers commissioned on an individual basis by the PBBT (personal budgets and brokerage team). Some additional funding is allocated to securing a number of interim short term beds (5 beds with each of 3 providers) to ensure availability and sufficient capacity for bedded care (pathway 2). EPIC is a newly embedded system hosted by FHFT which is starting to provide more accurate reporting on the activity across the various pathways and the length of time from referral to commencement. Data currently goes back to July '23 but data capture and entry is improving to produce more accurate reports going forward.
Impact on admission prevention
Using Discharge Funds we have entered into contract arrangements for 15 community beds to provide interim care and ensure flow out of the hospital for those still needing bedded care arrangements. These tend to be pathway 3 but with some able to return home with support packages of care. Slough's care home market is limited and so strategic priority and investment is to support that maximises independence and enables people to remain at home with tailored packages of care and support. More detail around how our BCF investments in Slough contribute to helping people to remain at home (national condition 2) is included in the BCF narrative 2023-25.
Impact on discharge improvement
As described above we have used discharge fund investment to secure interim care beds in the community but also invested in the domiciliary care market to ensure interim packages of care can be set up and operating quickly to support people home. There is also additional ASC DF into brokerage support in this year to increase capacity in the team to liaise between hospital SW team and the provider market.
Changes to Adult Social Care Discharge Fund (a) learning
Changes to the discharge fund have been made from analysis of capacity/demand activity and ensuring balance of sufficient investment against the various discharge pathways. Discharge and flow group established to review and monitor pressures and address thematic problems or difficulties. In 2023-24 there was specific focus on establishing effective discharge pathways for housing/homelessness and mental health. Evaluation of discharge funds is ongoing but has in 23/24 contributed majorly to maintaining discharge and flow from the acute hospital with the additional investment and in-line with the national use and investment of DF outlined in the report.

Slough, like many other areas, has workforce challenges and is competing in a limited market for staff with the requisite skills. Our own learning, and that reflected in the national evaluation, is to continue to use the ASC DF primarily for extending existing services and building additional capacity in interim beds and short-term packages of care. Recruitment to professional roles is needed but difficult with the short-term nature of the DG. We are committed to building sustainable staffing capacity using 'core' BCF for the longer term, for example in the hospital social work team.
Changes to Adult Social Care Discharge Fund (b) additional investment
Better Care Fund Delivery Group oversees the management of the BCF programme at local level, monitoring activity and delivery against the programme, consider proposals and business case for future investment and decision-making. Each scheme grouped into areas of activity and focus (e.g. intermediate care, prevention, equipment/adaptations) and KPIs reported and measured within local model. The majority of BCF investment is into areas that support people living with frailty to remain living healthy and well in the community and, if they do have to go into hospital, to return home quickly. The Slough Wellbeing Board is keen to see more investment from BCF being made into the areas of activity children and young people services given the younger profile of the borough and the BCF partnership has been requested to consider expanding its priorities and spend allocation in the future to include: a) early intervention services for children and young people; b) services aimed at children and young people with complex needs. No firm proposals or business case(s) have yet been developed but investments to be considered against demand, priorities and maintaining delivery against the national conditions and metrics of the BCF.

Appendix 3 - Better Care Fund metrics update for 2024-25

3.1 Avoidable admissions

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	182.0	178.6	91.0	89.0
	Number of Admissions	217	213	-	-
	Population	158,289	158,289	-	-
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
	Indicator value	155	153	150	147

Rational for how the ambition was set including how learning and performance to date in 2023/24 has been taken into account, impact of demographic and other demand drivers. Describer how the ambition represents a stretch target for the area
Overall average rate of 175.9 achieved in 23/24 with significant reduction in Q4. Aim is to maintain this improvement trajectory through 24/25 against increased population and increased acuity of patients.
Please describe your plan for achieving the ambition set and how BCF funded services support this
Anticipatory Care Coordinators funded through BCF investment in each PCN to identify cohorts of people at risk with mild/moderate frailty to screen and offer proactive intervention and support with referral to MDT for coordinated, integrated assessment and response. Urgent Care Response service established together with access to virtual ward to provide rapid clinical response to people to avoid admission. Local Access Point operates as part of the Integrated Care Decision Making model to receive and triage assessment and response to avoid admission.

Responder service in place to response to community alarm for welfare or falls response and avoid ambulance call out and conveyance to hospital.

3.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,659.3	1,683.5	1,651.8
	Count	275	279	280
	Population	16,573	16573	16951

Rational for how the ambition was set including how learning and performance to date in 2023/24 has been taken into account, impact of demographic and other demand drivers. Describer how the ambition represents a stretch target for the area
Rate of falls estimated has not quite achieved plan. A local falls group has been established with a falls needs assessment completed looking at data from various sources and activity across our falls support, recovery and prevention services. The plan has been set to improve on outurn and last year plan by improving access and outcome of those supported through local falls services. This is set against an increasing population figures of people over 65
Please describe your plan for achieving the ambition set and how BCF funded services support this
Task and finish working group established to review falls pathway and services in Slough to ensure people are referred early and appropriately into the right services to assess, support and maintain strength and balance to reduce risk of falls and injury.

3.3 Discharge to usual place of residence

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.7%	91.9%	91.7%	92.0%
	Numerator	2,530	2,633	2,079	2,101
	Denominator	2,760	2,865	2,268	2,284
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
	Quarter (%)	92.0%	92.0%	92.0%	92.0%
	Numerator	2,176	2,409	2,094	2,180
	Denominator	2,365	2,618	2,275	2,370

Rational for how the ambition was set including how learning and performance to date in 2023/24 has been taken into account, impact of demographic and other demand drivers. Describer how the ambition represents a stretch target for the area

Performance has improved since 2022/23 in actual outturn. The plan is to continue on this improvement trajectory to achieve a 92% outturn. This is set within the context of higher levels of frailty and acuity of people being discharged from hospital.
Please describe your plan for achieving the ambition set and how BCF funded services support this
Home First Discharge to Assess pathways in place to support home where possible supported by Reablement and Rehabilitation services to help maximise independence at home and in the community. Investment in community equipment, Assistive Technology and Disabled Facilities Grant. Providing support to families and Carers

3.4 Residential admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	266.0	428.4	428.4	424.8
	Numerator	41	71	71	72
	Denominator	15,411	16,573	16,573	16,951

Rational for how the ambition was set including how learning and performance to date in 2023/24 has been taken into account, impact of demographic and other demand drivers. Describer how the ambition represents a stretch target for the area
Plan is to improve on estimated outturn rate of 2023/24 against increasing over 65 population. Target is for a maximum of 72 permanent placements in 2024/25. For ASCOF ADASS are using 15,557 for this indicator giving a rate of 456.4 in 2023/24 (for 71 placements). This is provisional pending validation of the statutory returns for this year.
Please describe your plan for achieving the ambition set and how BCF funded services support this
Our plan is continue emphasis and focus on prevention and early intervention to support people to live at home. Our BCF investments and schemes are detailed in the narrative plan 2023-25 (national condition 2) submitted in June '23. This includes upstream interventions that will contribute to avoiding admissions. Our Home First and D2A approach ensures people supported to return home wherever possible with home based reablement in the community with access to interim care beds with rehab/therapy input to support to return home if bed-based care initially required.

Appendix 4 - BCF updated expenditure plan 2024/25

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
1	Reablement and Independence Service (RIS) - previously RRR	Intermediate Care and Reablement Service	Home-based intermediate care services	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£2,858,239	£3,006,867
2	Integrated Care Services / ICT	Community Health and Integrated Care Teams	Community Based Schemes	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£941,931	£995,244
3	Intensive Community Rehabilitation	Community Health led rehabilitation service	Home-based intermediate care services	Community Health	LA	NHS Community Provider	Minimum NHS Contribution	Existing	£82,000	£82,000
4	Intensive Community Rehabilitation	Community Health led rehabilitation service	Home-based intermediate care services	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£211,950	£223,946
5	D2A pathway - community D2A beds (Windmill)	Community interim beds supporting discharge	High Impact Change Model for Managing Transfer of Care	Social Care	NHS	Private Sector	Minimum NHS Contribution	Existing	£141,953	£146,004
6	D2A pathway - OT, SW and interim care packages	Discharge to Assess assessment, care planning and interim support	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£284,000	£298,768
7	GP support for hospital discharge	Trusted Assessor supporting discharge from ED	High Impact Change Model for Managing Transfer of Care	Primary Care	NHS	NHS	Minimum NHS Contribution	Existing	£51,350	£52,438

8	Integrated Care Decision Making and Local Access Point (SBC)	Integrated Care - cluster, locality access point	Integrated Care Planning and Navigation	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£283,507	£298,249
9	Integrated Care Decision Making and Local Access Point (SBC)	Integrated Care - cluster, locality access point	Integrated Care Planning and Navigation	Community Health	NHS	NHS Community Provider	Minimum NHS Contribution	Existing	£172,794	£181,471
10	Community Integration Manager	Management of Integrated Care Decision Making and Locality Access Point	Enablers for Integration	Community Health	NHS	NHS	Minimum NHS Contribution	Existing	£83,361	£85,112
11	Care Coordinators - anticpatory care	Care Coordinators in PCNs for anticipatory care	Prevention / Early Intervention	Primary Care	NHS	NHS	Minimum NHS Contribution	Existing	£132,000	£132,000
12	Integrated Equipment Service	Disability aids and mobility equipment	Assistive Technologies and Equipment	Social Care	LA	Private Sector	Minimum NHS Contribution	Existing	£163,000	£167,000
13	Integrated Equipment Service	Disability aids and mobility equipment	Assistive Technologies and Equipment	Community Health	NHS	Private Sector	Minimum NHS Contribution	Existing	£758,431	£762,982
14	Disabled Facilities Grant	Aids and adaptations	DFG Related Schemes	Social Care	LA	Local Authority	DFG	Existing	£1,140,680	£1,244,197
15	Hospital Social Work Team	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£664,000	£698,528
16	Nursing Home Placements	Nursing Care Home Placements	Residential Placements	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£500,000	£500,000

17	Care Act Funding	Supporting delivery of Care Act requirements	Care Act Implementation Related Duties	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£296,000	£296,000
18	Adult Social Care Protection	Additional Social Care protection maintaining capacity	Personalised Care at Home	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£798,291	£839,802
19	improved Better Care Fund	iBCF grant funds to LA	Enablers for Integration	Social Care	LA	Local Authority	iBCF	Existing	£3,989,414	£3,989,414
20	End of Life Advice Line	Advice and support to families and carers 24/7	Personalised Care at Home	Community Health	NHS	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£152,059	£155,860
21	EOL nightsitting service	Night sitting as part of EOLC service	Carers Services	Social Care	NHS	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£16,387	£16,797
22	End of Life Care at Home Service	Specialist support to support at home at end of life	Home Care or Domiciliary Care	Social Care	NHS	Charity / Voluntary Sector	Minimum NHS Contribution	New	£55,000	£55,000
23	Care Home Programme Manager	Care Home quality programme	Enablers for Integration	Community Health	NHS	NHS	Minimum NHS Contribution	Existing	£26,400	£22,973
24	Stroke Support Service	Stroke support service for stroke survivors and their families	Community Based Schemes	Social Care	LA	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£57,000	£57,000
25	Dementia Care Advisor	Post-diagnosis support for people with dementia and their carers	Community Based Schemes	Mental Health	LA	NHS Mental Health Provider	Minimum NHS Contribution	Existing	£30,000	£30,000

26	Integrated Wellbeing service - cardio wellness	Commissioned primary prevention support for health and wellbeing	Community Based Schemes	Social Care	LA	Private Sector	Minimum NHS Contribution	Existing	£151,000	£151,000
27	Integrated Wellbeing service - falls prevention	Commissioned primary prevention support for health and wellbeing	Community Based Schemes	Social Care	LA	Private Sector	Minimum NHS Contribution	Existing	£90,000	£90,000
28	Telecare	Assistive Technology to maximise independence at home	Assistive Technologies and Equipment	Social Care	LA	Private Sector	Minimum NHS Contribution	Existing	£72,000	£72,000
29	Carers Support	Support to carers and young carers	Carers Services	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£216,000	£216,000
30	Voluntary Sector Infrastructure support and Community Fund	Support to the community and voluntary sector	Enablers for Integration	Social Care	LA	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£218,000	£218,000
31	Information and Advice Service	Information and Advice	Prevention / Early Intervention	Social Care	LA	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£140,000	£140,000
32	Responder Service	First response service	Prevention / Early Intervention	Social Care	LA	Private Sector	Minimum NHS Contribution	Existing	£130,000	£130,000
33	OT/SALT services	OT/SALT support for children and young people	Enablers for Integration	Community Health	LA	NHS Community Provider	Minimum NHS Contribution	Existing	£242,000	£0

34	Paediatric hotline	Telephone advice to GPs with paediatric consultant support	Personalised Care at Home	Acute	NHS	NHS Acute Provider	Minimum NHS Contribution	Existing	£52,260	£55,218
35	Connected Care	Shared Care Records	Enablers for Integration	Other	NHS	Private Sector	Minimum NHS Contribution	Existing	£200,000	£200,000
36	Alamac	IT system monitoring capacity and flow	Enablers for Integration	Acute	NHS	Private Sector	Minimum NHS Contribution	Existing	£48,269	£52,368
37	Programme Management functions	Programme Management Office functions	Enablers for Integration	Social Care	LA	Local Authority	Minimum NHS Contribution	Existing	£170,000	£170,000
38	Integration Delivery Lead	BCF and integration programme lead	Enablers for Integration	Social Care	NHS	NHS	Minimum NHS Contribution	Existing	£93,803	£95,773
39	Interim care packages (D2A)	Short-term care support for Home First/D2A	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Private Sector	Local Authority Discharge Funding	Existing	£350,000	£423,183
40	Interim Care beds (D2A)	Short-term care home placements for D2A	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Private Sector	Local Authority Discharge Funding	Existing	£173,310	£437,000
41	Additional brokerage and purchasing team capacity	Additional capacity to purchasing team for coordinating placements and packages	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	Local Authority Discharge Funding	Existing	£36,000	£72,000
41	Handyperson, repairs, deep	Housing related support to facilitate	High Impact Change Model	Social Care	LA	Private Sector	ICB Discharge Funding	Existing	£20,000	£20,000

	cleans, de-clutter	discharge, including MH and homeless prevention	for Managing Transfer of Care							
42	Vol and community support and signposting	Support to pathway P0+ discharges from hospital reducing risk of readmissions	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	ICB Discharge Funding	Existing	£12,000	£12,000
43	Interim Care Beds	Short-term care home placements for D2A	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	ICB Discharge Funding	Existing	£426,807	£437,000
44	LD discharge liaison and support	Supporting people with cognitive support in discharge	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	ICB Discharge Funding	Existing	£30,000	£30,000
45	Mental Health discharges	Accommodation and support to facilitate discharge	High Impact Change Model for Managing Transfer of Care	Social Care	LA	Local Authority	ICB Discharge Funding	New	£20,000	£20,000
46	Developing Partnerships programme	Funds to support further integration and hubs	Enablers for Integration	Social Care	NHS	NHS	Minimum NHS Contribution	New	£150,000	£150,000
47	Risk share / pooled funds supporting discharge	Pooled funding for complex (P3) discharges pending further assessment and funding decisions	High Impact Change Model for Managing Transfer of Care	Social Care	NHS	NHS	Minimum NHS Contribution	New	£100,000	£100,000
48	BCF funds to be allocated	new/increases to min NHS investment in	Other	Community Health	NHS	NHS	Minimum NHS Contribution	New	£369,805	£892,467

		out of hospital services								

New additional schemes 2024/25

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Area of Spend	Commissioner	Provider	Source of Funding	New/ Existing Scheme	Expenditure 24/25 (£)
49	Interim care packages (D2A)	Short term care for Home First /D2A	High Impact Change Model for Managing Transfer of Care	Social Care	Social Care	Private Sector	ICB Discharge Funding	New	£165,000
50	ICB spot purchase beds	Interim care beds supporting discharge	High Impact Change Model for Managing Transfer of Care	Social Care	Social Care	Private Sector	ICB Discharge Funding	New	£171,000
51	Provider in IRIS	Weekend domiciliary care support facilitating discharge	High Impact Change Model for Managing Transfer of Care	Social Care	Social Care	Private Sector	ICB Discharge Funding	New	£30,000
52	Pharmacy support to Home First, home care and supported living	Dedicated pharmacy support to i) support D2A, ii) home care and supported living	High Impact Change Model for Managing Transfer of Care	Community Health	Community Health	NHS	ICB Discharge Funding	New	£70,000
53	Additional capacity in reablement supporting discharge	Additional funding for reablement capacity supporting	Home-based intermediate care services	Social Care	Social Care	Local Authority	ICB Discharge Funding	New	£100,000

		discharge pathway							
54	ICB Discharge Funds contingency/to be allocated	ICB funds to be allocated	Other	Social Care	Social Care	Private Sector	ICB Discharge Funding	New	£188,745