BCF Planning Template 2024-25

1. Guidance

Overview

Note on entering information into this 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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

2. 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 in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checker column, which can be found on each individual sheet, 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'.

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

6. Please ensure that all boxes on the checklist are green before submission.

7. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

4. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

4.2 Hospital Discharge

A new text field has been added this year, asking for a description of the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation. Please answer this briefly, in a couple of sentences.

The capacity section of this template remains largely the same as in previous years, asking for estimates of available capacity for each month of the year for each pathway. An additional ask has now also been included, for the estimated average time between referral and commencement of service. Further information about this is available in the capacity and demand guidance and q&a documents.

The demand section of this sheet is unchanged from last year, requesting expected discharges per pathway for each month, broken down by referral source.

To the right of the summary table, there is another new requirement for areas to include estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways. Please estimate this as an average across the whole year.

4.3 Community

Please enter estimated capacity and demand per month for each service type.

The community sheet also requires areas to enter estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2024-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations, DFG allocations and allocations of ASC Discharge Fund grant to local authorities for 2024-25. The iBCF grant in 2024-25 remains at the same value nationally as in 2023-24.

2. The sheet will be largely auto-populated from either 2023-25 plans or confirmed allocations. You will be able to update the value of the following income types locally:

- ICB element of Additional Discharge Funding
- Additional Contributions (LA and ICB)

If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

3. The sheet will pre populate the amount from the ICB allocation of Additional Discharge Funding that was entered in your original BCF plan. Areas will need to confirm and enter the final agreed amount that will be allocated to the HWB's BCF pool in 2024-25. As set out in the Addendum to the Policy Framework and Planning Requirements; the amount of funding allocated locally to HWBs should be agreed between the ICB and councils. These will be checked against a separate ICB return to ensure they reconcile.

4. The additional contributions from ICBs and councils that were entered in original plans will pre-populate. Please confirm the contributions for 2024-25. If there is a change to these figures agreed in the final plan for 2024-25, please select 'Yes' in answer to the Question 'Do you wish to update your Additional (LA/ICB) Contributions for 2024-25?'. You will then be able to enter the revised amount. These new figures will appear as funding sources in sheet 6a when you are reviewing planned expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2023-24 (i.e. underspends from BCF mandatory contributions) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field at the bottom of the sheet to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet has been auto-populated with spending plans for 2024-25 from your original 2023-25 BCF plans. You should update any 2024-25 schemes that have changed from the original plan. The default expectation is that plans agreed in the original plan will be taken forward, but where changes to schemes have been made (or where a lower level of discharge fund allocation was assumed in your original plan), the amount of expenditure and expected outputs can be amended. There is also space to add new schemes, where applicable.

If you need to make changes to a scheme, you should select yes from the drop down in column X. When 'yes' is selected in this column, the 'updated outputs for 2024-25' and 'updated spend for 2024-25' cells turn yellow and become editable for this scheme. If you would like to remove a scheme type please select yes in column X and enter zeros in the editable columns. The columns with yellow headings will become editable once yes is selected in column X - if you wish to make further changes to a scheme, please enter zeros into the editable boxes and use the process outlined below to re-enter the scheme.

If you need to add any new schemes, you can click the link at the top of the sheet that reads 'to add new schemes' to travel quickly to this section of the table.

For new schemes, as with 2023-25 plans, the table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet, please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.

- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn ""yellow"". Please select the Sub Type from the dropdown list that best describes the scheme being planned.

- Please note that the dropdown list has a scroll bar to scroll through the list and all the options may not appear in one view.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.

- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

- A change has been made to the standard units for residential placements. The units will now read as 'Beds' only, rather than 'Beds/placements'

6. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.

7. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.

- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.

- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.

- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

Better Care Fund 2024-25 Update Template

2. Cover

Version 1.3.0

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. 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.

		Complete:
Health and Wellbeing Board:	Rotherham	Yes
Completed by:	Karen Smith	Yes
E-mail:	karen-nas.smith@rotherham.gov.uk	Yes
Contact number:	01709 254870	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Joanna	Baker-Rogers	joanna.baker-rogers@rotherham.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Christopher	Edwards	christopher.edwards7@nhs.net	Yes
	Additional ICB(s) contacts if relevant	Miss	Claire	Smith	claire.smith138@nhs.net	Yes
	Local Authority Chief Executive	Mrs	Sharon	Kemp	sharon.kemp@rotherham.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Ian	Spicer	ian.spicer@rotherham.gov.uk	Yes
	Better Care Fund Lead Official	Mr	Scott	Matthewman	scott.matthewman@rotherham.gov.uk	Yes
	LA Section 151 Officer	Mrs	Judith	Badger	judith.badger@rotherham.gov.uk	Yes

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	SYICB (Rotherham Place) Finance Officer	Mrs	Wendy	Allott	wendy.allott@nhs.net
	SYICB (Rotherham Place) Health & Care Portfolio Lead	Mrs	Steph	Watt	steph.watt@nhs.net
	Local Authority Head of Finance	Ms	Gioia	Morrison	gioia.morrison@rotherham.gov.uk

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4.2 C&D Hospital Discharge	Yes
4.3 C&D Community	Yes
5. Income	Yes
6a. Expenditure	No
7. Narrative updates	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: Rotherham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£3,341,770	£3,341,770	£0
Minimum NHS Contribution	£25,556,953	£25,556,953	£0
iBCF	£14,480,543	£14,480,543	£0
Additional LA Contribution	£5,102,000	£5,102,000	£0
Additional ICB Contribution	£0	£0	£0
Local Authority Discharge Funding	£3,383,583	£3,383,583	£0
ICB Discharge Funding	£2,473,000	£2,473,000	£0
Total	**£54,337,849**	**£54,337,849**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£7,262,562
Planned spend	£14,901,953

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£9,089,163
Planned spend	£14,975,000

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	286.0	281.0	322.0	296.0

Falls

		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	1,920.0	1,824.0
	Count	976	927
	Population	52551	52551

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 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)	94.4%	94.7%	94.7%	95.4%

Residential Admissions

		2022-23 Actual	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	666	564

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	0
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	0
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Rotherham

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing												Capacity surplus (including spot puchasing)											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	494	500	499	485	494	494	494	515	527	505	515	488	1314	1320	1319	1305	1314	1314	1314	1335	1347	1325	1335	1308
Short term domiciliary care (pathway 1)	-6	0	0	1	1	1	1	2	0	4	7	8	-6	0	0	1	1	1	1	2	0	4	7	8
Reablement & Rehabilitation in a bedded setting (pathway 2)	-10	-5	-2	3	1	-1	-1	-2	24	25	28	21	-10	-5	-2	3	1	-1	-1	-2	25	43	45	44
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
2	Contact Hours per package
2.5	Contact Hours per package
26	Average LoS (days)
26	Average LoS (days)
0	Average LoS (days)

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

There is a well-established contract with Age UK for hospital after care support which now supports discharge from the acute and community bed base providing transport, non-personal enablement, advice and access to low level equipment. The service also provides safety netting for those at risk. It is anticipated that around 1,651 people will receive this service to support hospital discharges in 2024/25.

Two VCS pilots are underway. The first is a social prescriber link worker who in- reaches into the emergency department for admission avoidance and facilitates discharge. The second is piloting personal health budgets to facilitate timely discharge. This is through the Community Group 'We Ask You Respond". It is anticipated that around 490 people will receive these types of services to support hospital discharges in 2024/25.

Yes

Capacity - Hospital Discharge		Refreshed planned capacity (not including spot purchased capacity												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	827	823	822	821	820	821	825	829	831	833	832	826	820	820	820	820	820	820	820	820	820	820	820	820
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	1	2	1	2												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	30	28	27	26	26	26	24	24	23	30	30	30	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	64	58	57	56	54	55	55	60	66	68	68	67	0	0	0	0	0	0	0	0	1	18	17	23
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	1	1	2	1	1	2	1	1	2	2												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	2	3	7	0	4	4	4	2	3	2	5	8	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	3	2	0	2	2	1	2	2	1	1	4												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	1	1	1	0	3	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	1	1	1	0	1	0	1	9												

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Demand - Hospital Discharge		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Expected Discharges:	Total Discharges	**445**	**417**	**416**	**414**	**409**	**413**	**415**	**400**	**375**	**399**	**386**	**414**
Reablement & Rehabilitation at home (pathway 1)	Total	**333**	**323**	**323**	**336**	**326**	**327**	**331**	**314**	**304**	**328**	**317**	**338**
	THE ROTHERHAM NHS FOUNDATION TRUST	279	279	279	279	279	279	279	279	279	279	279	279
	OTHER	54	44	44	57	47	48	52	35	25	49	38	59
Short term domiciliary care (pathway 1)	Total	**36**	**28**	**27**	**25**	**25**	**25**	**23**	**22**	**23**	**26**	**23**	**22**
	THE ROTHERHAM NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	36	28	27	25	25	25	23	22	23	26	23	22
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**74**	**63**	**59**	**53**	**53**	**56**	**56**	**62**	**42**	**43**	**40**	**46**
	THE ROTHERHAM NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	74	63	59	53	53	56	56	62	42	43	40	46
Other short term bedded care (pathway 2)	Total	**2**	**3**	**7**	**0**	**4**	**4**	**4**	**2**	**3**	**2**	**5**	**8**
	THE ROTHERHAM NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	2	3	7	0	4	4	4	2	3	2	5	8
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**3**	**0**	**1**	**0**
	THE ROTHERHAM NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	1	1	1	0	3	0	1	0

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
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Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Rotherham

Community

Refreshed capacity surplus:

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	11	11	-8	-18	5	-30	11	7	18	5	11	14
Urgent Community Response	-80	-80	-80	-80	-80	-80	-80	-80	-80	-80	-80	-80
Reablement & Rehabilitation at home	-29	-44	-52	-47	-46	-46	-51	-39	-31	-45	-60	-42
Reablement & Rehabilitation in a bedded setting	4	4	1	2	7	0	-4	0	4	4	-3	3
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours

Full Year	Units
1678	Contact Hours
7200	Contact Hours
28929	Contact Hours
21	Average LoS
0	Contact Hours

Checklist

Complete:

Checklist
Yes
Yes
Yes
Yes
Yes

Capacity - Community

Please enter refreshed expected capacity:

Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Checklist
Social support (including VCS)	Monthly capacity. Number of new clients.	43	43	41	41	39	48	42	43	44	49	49	49	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	220	220	220	220	220	220	220	220	220	220	220	220	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	503	503	502	502	501	501	505	509	511	513	512	510	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	13	13	10	13	14	13	16	14	13	15	18	20	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community

Please enter refreshed expected no. of referrals:

Service Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Checklist
Social support (including VCS)	32	32	49	59	34	78	31	36	26	44	38	35	Yes
Urgent Community Response	300	300	300	300	300	300	300	300	300	300	300	300	Yes
Reablement & Rehabilitation at home	532	547	554	549	547	547	556	548	542	558	572	552	Yes
Reablement & Rehabilitation in a bedded setting	9	9	9	11	7	13	20	14	9	11	21	17	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: Rotherham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Rotherham	£3,341,770
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£3,341,770**

Local Authority Discharge Funding	Contribution
Rotherham	£3,383,583

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS South Yorkshire ICB	£2,473,000	£2,473,000	
Total ICB Discharge Fund Contribution	£2,473,000	£2,473,000	

iBCF Contribution	Contribution
Rotherham	£14,480,543
Total iBCF Contribution	**£14,480,543**

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
Rotherham	£470,000	£1,249,000	
Rotherham	£1,500,000	£1,500,000	
Rotherham	£2,222,038	£2,353,000	
Total Additional Local Authority Contribution	**£4,192,038**	**£5,102,000**	

NHS Minimum Contribution	Contribution
NHS South Yorkshire ICB	£25,556,953
Total NHS Minimum Contribution	**£25,556,953**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£25,556,953**	**£25,556,953**	

	2024-25
Total BCF Pooled Budget	**£54,337,849**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
DFG and iBCF carry forwards identified separately in Local Authority additional contributions

Better Care Fund 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Rotherham

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure	Balance
DFG	£3,341,770	£3,341,770	£0
Minimum NHS Contribution	£25,556,953	£25,556,953	£0
iBCF	£14,480,543	£14,480,543	£0
Additional LA Contribution	£5,102,000	£5,102,000	£0
Additional NHS Contribution	£0	£0	£0
Local Authority Discharge Funding	£3,383,583	£3,383,583	£0
ICB Discharge Funding	£2,473,000	£2,473,000	£0
Total	**£54,337,849**	**£54,337,849**	**£0**

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	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,262,562	£14,901,953	£0
Adult Social Care services spend from the minimum ICB allocations	£9,089,163	£14,975,000	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Previously entered Outputs for 2024-25**	Updated Outputs for 2024-25	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
1	Adult Mental Health Liaison	Adult mental health support in community supporting independence and recovery	Integrated Care Planning and Navigation	Care navigation and planning			0		Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
2	Falls Service	Community service (health) supporting reablement/prevention to	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
3	Reablement	LA Reablement Service	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		920	920	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
3	Domiciliary Care	Provision of domiciliary care services to help people live in their own homes	Home Care or Domiciliary Care	Domiciliary care packages		34022	31662	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Minimum NHS Contribution
4	Community Stroke Service	Integrated stroke pathway to support early discharge/rehabilitation	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
5	Community Neuro Rehab	Integrated neuro pathway to support early discharge and rehabilitation	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
6	Breathing Space	Community based service for people with Chronic Obstructive Pulmonary	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution

7	Otago Exercise Programme	Falls prevention exercise programme	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution
8	Mediquip (Wheelchairs & Equipment)	Integrated Community Equipment Service	Prevention / Early Intervention	Other	small items of equipment to enable people to		0		Social Care		NHS			Private Sector	Minimum NHS Contribution
8	Mediquip (Wheelchairs & Equipment)	Integrated Community Equipment Service	Prevention / Early Intervention	Other	small items of equipment to enable people to				Social Care		NHS			Private Sector	iBCF
9	Community OT	Occupational Therapy Assessments	Prevention / Early Intervention	Other	OT assessments carried out by community		3000		Social Care		LA			NHS Community Provider	Minimum NHS Contribution
9	Community OT	Occupational Therapy Assessments	Prevention / Early Intervention	Other	OT assessments carried out by community		3000		Social Care		LA			NHS Community Provider	Additional LA Contribution
10	Disabled Facilities Grant	Major property adapatations to enable people to continue to live independently within	DFG Related Schemes	Adaptations, including statutory DFG grants		201	223	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
10	Disabled Facilities Grant	Community alarm and Equipment service to support independent living	Assistive Technologies and Equipment	Community based equipment		2200	2300	Number of beneficiaries	Social Care		LA			Local Authority	DFG
10	Additional Disabled Facilities Grant schemes	Additional major Adaptations	DFG Related Schemes	Other	Balance brought forward from slippage in	201	223	Number of adaptations funded/people	Social Care		LA			Local Authority	Additional LA Contribution
11	Age UK Hospital Discharge	Hospital Discharge supporting flow	Personalised Care at Home	Physical health/wellbeing			1637		Other	Charity / Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12	Stroke Association Service	VCS provision to support stroke survivors	Personalised Care at Home	Physical health/wellbeing			0		Other	Charity / Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
13	Intermediate Care	Residential Rehabilitation for patients who cannot return home from hospital	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		550	550	Number of placements	Social Care		LA			Local Authority	Additional LA Contribution
13	Intermediate Care	Residential Rehabilitation for patients who cannot return home from hospital	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		375	375	Number of placements	Social Care		LA			Local Authority	Minimum NHS Contribution
13	Intermediate Care	Residential Rehabilitation for patients who cannot return home from hospital	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		288	288	Number of placements	Social Care		NHS			Private Sector	Minimum NHS Contribution
13	Intermediate Care - Home first	Rehabilitation and reablement pathway home	Home-based intermediate care services	Reablement at home (to support discharge)		375	375	Packages	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution
13	Intermediate Care - Therapy	Rehabilitation and reablement pathway home	Bed based intermediate Care Services (Reablement,	Other	Social Care	375	375	Number of placements	Social Care		LA			NHS Community Provider	Minimum NHS Contribution
13	Intermediate Care - Therapy	Rehabilitation and reablement pathway home	Bed based intermediate Care Services (Reablement,	Other	Social Care	375	375	Number of placements	Social Care		LA			NHS Mental Health Provider	Minimum NHS Contribution
13	Intermediate Care - GP Cover	GP support for bed based intermediate care services	Bed based intermediate Care Services (Reablement,	Other	GP Cover	375		Number of placements	Primary Care		LA			NHS Community Provider	Minimum NHS Contribution
13	Intermediate Care	Rehabilitation and reablement pathway home	Home-based intermediate care services	Reablement at home (to support discharge)		375	375	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
14	Direct Payments	Personal budget to support an individual social care plan and support	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	Minimum NHS Contribution
14	Supported Living	A range of services to support the independence of people with a learning disability	Residential Placements	Supported housing		8	7	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution
15	Care Act	Deprivation of Liberty Safeguards (Dols) support	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Private Sector	Minimum NHS Contribution

15	Care Act	Direct Payments and Domiciliary Care provision	Care Act Implementation Related Duties	Other	Direct Payments and Domiciliary Care provision		0		Social Care		LA			Private Sector	Minimum NHS Contribution
16	Mental Health rehabilitation services	Rehabilitation and support in a bed base provision	Residential Placements	Care home		3	3	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution
17	Learning Disabilities independent	Learning disabilities residential placements	Residential Placements	Learning disability		11	11	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution
17	Learning Disabilities Domiciliary Care	Learning Disabilities Domiciliary Care packages	Home Care or Domiciliary Care	Domiciliary care packages		1661	1546	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Minimum NHS Contribution
18	Free Nursing Care	NHS Funded Nursing Care	Residential Placements	Nursing home		98	125	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution
19	GP Case Management	Empowering GP's to take full responsibility for all health and social care input	Community Based Schemes	Other	GP Support for Long Term Conditions		0		Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
20	Care Home Support Service	Integrated community service to care homes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
21	Hospice - end of Life Care	EOLC support to ensure needs are meet	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
22	Social Prescribing	Links patients in primary care with non medical support within the community and	Prevention / Early Intervention	Social Prescribing			0		Other	Health and Social Care	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
23	Social Work Support (A&E, Case	Includes Fast Reponse and Supported Discharge Pathways teams	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)			0		Social Care		LA			Local Authority	Minimum NHS Contribution
24	Care co-ordination Centre	A single point of contact for health and social care professionals providing	Community Based Schemes	Integrated neighbourhood services			0		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
25	Carers Support Services	Implement Carers Strategy to support unpaid carers across the borough	Carers Services	Carer advice and support related to Care Act duties		30000		Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
25	Carers Support Services	Carers Emergency Scheme	Carers Services	Carer advice and support related to Care Act duties		30		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
25	Carers Support Services	Direct Payments and domiciliary care provision	Carers Services	Respite services		50	23	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution
26	Joint Commissioning Team	Joint Commissioner team staffing costs	Enablers for Integration	Joint commissioning infrastructure					Other	Commissioning	NHS			Local Authority	Minimum NHS Contribution
27	IT to Support Community Transformation	Digital enablers to support integration of community services	Enablers for Integration	System IT Interoperability					Other	Information sharing	NHS			NHS	Minimum NHS Contribution
28	BCF Risk Pool	Risk pool - contingency for unforeseen cost pressures	Other						Other	Contingency	NHS			NHS	Minimum NHS Contribution
29	Adaptation of Liquid Logic to support care	Support IT infrastructure and promote integrated working	Enablers for Integration	System IT Interoperability					Social Care		LA			Local Authority	iBCF
30	Rotherham Place DTOC Project Manager	Strategic Project Manager post to support hospital discharge pathway	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			NHS Acute Provider	iBCF
31	Health Inequalities	Project support to implementation population health priorities	Integrated Care Planning and Navigation	Support for implementation of anticipatory care					Other	Public Health	LA			Local Authority	iBCF
32	Trusted Assessor	Assessments and care planning to reduce delays in hospital discharges	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Acute		NHS			NHS Acute Provider	iBCF

33	Social Care Sustainability	Older People Residential placements	Residential Placements	Care home		79	75	Number of beds	Social Care		LA			Private Sector	iBCF
33	Social Care Sustainability	Older People Domiciliary Care provision	Home Care or Domiciliary Care	Domiciliary care packages		68537	63784	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	iBCF
33	Social Care Sustainability	Provision of direct payments to support people within their own homes	Personalised Budgeting and Commissioning				0		Social Care		LA			Private Sector	iBCF
33	Social Care Sustainability	Residential placements for younger adults with a Learning Disability.	Residential Placements	Learning disability		25	20	Number of beds	Social Care		LA			Private Sector	iBCF
34	Care Market Capacity and sustainability	Supporting the increase in provider costs, for example, due to the increase in NLW	Residential Placements	Other	Meeting increasing costs of placements	889		Number of beds	Social Care		LA			Private Sector	iBCF
35	Care Market Capacity and sustainability	Supporting the increase in LD provider costs, including the increase in NLW plus	Residential Placements	Supported housing		13	11	Number of beds	Social Care		LA			Private Sector	iBCF
36	Prevention and Early Intervention	Voluntary Sector advice and Support at front of access	Prevention / Early Intervention	Other	Advice and Guidance				Social Care		LA			Charity / Voluntary Sector	iBCF
37	Prevention and Early Intervention	Advocacy support, advice and guidance for people with a learning disability	Prevention / Early Intervention	Other	Advice and Guidance				Social Care		LA			Charity / Voluntary Sector	iBCF
38	Perform Plus	Coaching Programme to increase capacity and performance of the social	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	iBCF
39	Reablement - Additional staffing	Increase capacity of reablement service	Workforce recruitment and retention					WTE's gained	Social Care		LA			Local Authority	iBCF
40	Spot purchase Reablement beds	Short term provision within the independent sector to support hospital discharge	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		150		Number of placements	Social Care		LA			Private Sector	iBCF
41	Escalation wheel	Supports oversight on system prsessures to conentrate actions/escalation on	Enablers for Integration	Data Integration					Acute		NHS			NHS Acute Provider	iBCF
42	Community Services	Contingency for additional demand for Community Services	Community Based Schemes	Other	Contingency		0		Social Care		LA			Local Authority	iBCF
43	Tactical Brokerage	To broker residential and home care packages of care from commissioned providers	Other						Social Care		LA			Local Authority	iBCF
44	Winter Bed Capacity	Discharge Pathways and Patient Flow	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Other	Winter Planning	NHS			Private Sector	iBCF
45	Integrated Discharge Team	Multi-disciplinary teams to support hospital discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF
46	Early Planning Team	Social Work team to support hospital discharges	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
47	Additional Winter Capacity	Winter Planning contingency	Other						Social Care		LA			Local Authority	iBCF
48	Digital Champion	Digital Champion lead - Assistive Technology	Assistive Technologies and Equipment	Digital participation services		5000		Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution
49	Additional Social work Capacity	Additional Social work Capacity - Learning Disabilities	Workforce recruitment and retention					WTE's gained	Social Care		LA			Local Authority	Additional LA Contribution
50	PCN Social Work Practitioners	Additional roles to link with PCN's as part of anticipatory care model	Workforce recruitment and retention				0	WTE's gained	Social Care		LA			Local Authority	Additional LA Contribution

51	Prevention and Early Intervention	NEW front door prevention capacity to ensure deflection	Prevention / Early Intervention	Other	2 FTE posts				Social Care		LA			Local Authority	Additional LA Contribution
52	Self-Assessment	Implementation of self-assessment and the LAS citizen portal	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Local Authority	Additional LA Contribution
53	Suicide Prevention	Suicide Prevention	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Local Authority	Additional LA Contribution
54	Trusted Reviewer (Home Care)	To avoid admission, free up capacity ACI	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			Local Authority	Additional LA Contribution
55	Deflection from the front door	Prevention Services - VCS	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Local Authority	Additional LA Contribution
56	Integrated Brokerage Support Service	Additional Brokerage resources	Workforce recruitment and retention				1.5	WTE's gained	Social Care		LA			Local Authority	Additional LA Contribution
57	Digital Health Record	ASC providers to access digital health record	Enablers for Integration	Data Integration					Social Care		LA			Local Authority	Additional LA Contribution
58	Winter Planning	Additional Winter Capacity	Other						Social Care		LA			Local Authority	Additional LA Contribution
59	Crisis Support	Remodelling of MH crisis service / offer	High Impact Change Model for Managing Transfer of Care	Housing and related services			0		Social Care		LA			Local Authority	Additional LA Contribution
60	Carers Support Services	Careres Strategy	Carers Services	Other	Other	30000	30000	Beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution
61	Home Care/Care Home sustainability	To meet the challenges of escalating cost pressures within this service, relating to	Workforce recruitment and retention	Improve retention of existing workforce		1378		WTE's gained	Continuing Care		NHS			Private Sector	ICB Discharge Funding
62	SYHA Discharge Support	Additional housing inreach on to ward to support with housing issues to support	Housing Related Schemes						Mental Health		NHS			Private Sector	ICB Discharge Funding
63	Community Equipment	Supply and delivery of additional Community based equipment to increase ability	Assistive Technologies and Equipment	Community based equipment		183		Number of beneficiaries	Community Health		NHS			Private Sector	ICB Discharge Funding
64	Alternative to Admission	Spot purchase short term stay to help manage a crisis situation.	Bed based intermediate Care Services (Reablement,	Other	Crisis alternative	2		Number of placements	Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
65	Hospice - Clinical Nurse Specialist	Clinical Nurse Specialist which will enable increased community activity allowing	Workforce recruitment and retention					WTE's gained	Community Health		NHS			Charity / Voluntary Sector	ICB Discharge Funding
66	Hospice - Increased Inpatient Unit	Improve the management of discharge from the hospice thus increasing bed	Other	Other	Hospice beds - supported flow through IPU beds				Community Health		NHS			Charity / Voluntary Sector	ICB Discharge Funding
67	CHC – assessments	Increase number and speed of assessments to improve flow	Other	Additional or redeployed capacity from current care workers					Continuing Care		NHS			Private Sector	ICB Discharge Funding
68	Integrated Discharge Team	Additional avoidance / front door capacity	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Local Authority Discharge
69	Reablement expansion	Additional hours dedicated to hospital discharge + funding for a Deputy	Home-based intermediate care services	Reablement at home (to support discharge)		92	92	Packages	Social Care		LA			Local Authority	Local Authority Discharge
70	Davies Court Intermediate Care	Support discharge capacity and admission avoidance	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		190		Number of placements	Social Care		LA			Local Authority	Local Authority Discharge
71	Rothercare - installer	Additional post to support discharge and avoidance	Enablers for Integration	Data Integration					Social Care		LA			Local Authority	Local Authority Discharge

72	Housing Officer	Housing officer align to ACT/IDT	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	Local Authority Discharge
73	CHC assessors	CHC co-ordinators in practice hub	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Local Authority Discharge
74	MH Discharge	MH discharge co-ordinator due to DToC	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Local Authority Discharge
75	Intermediate Care	Athorpe Lodge 24 Community Beds fee Uplift	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		288		Number of placements	Social Care		NHS			Private Sector	Local Authority Discharge
76	Incentive payment - Fees for Nursing EMI Beds	Incentive payment - Fees for Nursing EMI Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		56	0	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge
77	Trusted Assessor for Care Homes	Trusted Assessor for Care Homes over 7 days	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			NHS	Local Authority Discharge
78	Administrative Support	Administrative Support	Other						Social Care		LA			Local Authority	Local Authority Discharge
79	Fast Response	Fast Response - additional capacity to accommodate discharge - up to 3 day period	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			0		Social Care		LA			Private Sector	Local Authority Discharge
80	Home Care	Home Care Temporary Block Capacity - if capacity shortfall home care	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		49	41	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Local Authority Discharge
81	LA Discharge funding 24/25	Balance of LA Discharge funding to be allocated for 24/25	Other				0		Social Care		LA			Local Authority	Local Authority Discharge

Back to top

Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'		Outputs for 2024-25	Units (auto-populate)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding
42	Healthwatch	Consumer champion for patients, service users and public for both health and	Care Act Implementation Related Duties	Other	Increased responsibilities to meet Care Act				Social Care		LA			Charity / Voluntary Sector	iBCF
42	Health Care Portfolio Lead post	Contribution to Joint health and care 8C portfolio lead role	Workforce recruitment and retention	Other	0.5 wte		1.5	WTE's gained	Community Health		NHS			NHS	iBCF
42	Virtual Wards	Admission avoidance/Early Discharge from hospital	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Acute		NHS			NHS Acute Provider	iBCF
82	Vulnerable Adults Manager post	Co-ordination of the vulnerable adults pathway	Prevention / Early Intervention	Risk Stratification					Mental Health		LA			Local Authority	Additional LA Contribution
83	Carers Link Officers	To improve timeliness of carers assessments	Carers Services	Carer advice and support related to Care Act duties			75	Beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution
84	Workforce Planning Officer	Workforce planning to ensure adult social care workforce has the right skills	Workforce recruitment and retention	Improve retention of existing workforce			1	WTE's gained	Social Care		LA			Local Authority	Additional LA Contribution
7	Otago Exercise Programme	Falls prevention exercise programme	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Additional LA Contribution
85	Community Infection Prevention and	IPC leads in care homes to promote Infectoin Prevention and Control	Prevention / Early Intervention	Risk Stratification					Community Health		LA			Local Authority	Additional LA Contribution
86	Contingency	Non recurrent contingency to meet any additional pressures	Other		Contingency				Social Care		LA			Local Authority	Additional LA Contribution

76	Short Term spot placements	Short Term spot beds to support Hospital Discharges	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)			56	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge
87	Complex needs Intermediate Care	1:1 capacity for complex or double handed IMC cases	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)			383	Number of placements	Social Care		LA			Local Authority	Local Authority Discharge
88	Proportionate Care Lead	To look at safe single handed care in bed and community based locations	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
89	Vocationally Qualified Assessment	To support the Proportionate Care Lead for single handed care	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
90	Waiting Lists / LD Review Officer	To support timely assessments and reviews	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
91	Operations Manager (Provider Services)	Additional capacity to support service transformation	Other		Increased leadership capacity				Social Care		LA			Local Authority	Local Authority Discharge
92	Home from Hospital - extension	Bridging service prior to RMBC enablement service capacity	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	Local Authority Discharge
93	Deputy Head of Mental Health Services	Oversight and management of the Approved Mental Health Professional Service	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
94	Additional capacity at front door	To support timely assessments	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
95	Additional Commissioning Capacity	To carry out data entry requirements to identify risks and promote quality in	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Local Authority	Local Authority Discharge
96	Contract Compliance Officers x 2 FTE	To promote quality in contracted provision to support complex hospital	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Local Authority Discharge
97	Rothercare - additional staffing	Enhanced service provision and response	Assistive Technologies and Equipment	Assistive technologies including telecare			8000	Number of beneficiaries	Social Care		LA			Local Authority	Local Authority Discharge

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 eight 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 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: Rotherham

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

We have conducted a capacity and demand actuals exercise in 2023/24, refreshing our previous model, alongside evaluating the impact of the national discharge monies. Assumptions have been agreed through both data collection and service engagement. Throughout the work, data quality issues have been identified and mitigated through service engagement. The outcomes have informed future allocation of resource, taking into account seasonal variations. This has evidenced a significant gap in IDT, reablement, rapid response and therapy services in meeting the needs of those with complex needs which the BCF has been used to support to increase capacity in the community. It is anticipated that there will be a continued need for further reablement and urgent care resource in order to support short term care and increase in out of hospital capacity. In total, 59 intermediate care beds are currently required (based on 85% occupancy) with only 54 beds commissioned available. Growth is likely to continue to increase and it is predicted that 68 beds may be required by 2027/2028. Demand for intermediate care bed space is highest between October to March. To manage demand 74 intermediate care beds are currently required. Virtual ward beds have been introduced which may reduce the need for additional beds in future. We are also utilising population health data to assess provision against outcomes and value for money, managed through the BCF assurance framework. We have developed our digital offer including a whole system command centre and performance dashboard to help manage system flow and anticipate and respond to system pressures.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

BCF and discharge monies have been invested in supporting care in the community for admission avoidance and discharge. This includes reablement, urgent response and the virtual ward, an increase in social workers for hospital avoidance and discharge and funding for market sustainability in domiciliary care. Additional intermediate care surge and winter beds have been spot purchased over the winter period to support hospital discharges and prevent admissions to hospital. The discharge funding has been used to increase capacity due to increased levels of attendance and hospital admissions during Quarter 4 of 2023/24. A Hospital at Home service has been commissioned since November 2023. This has reduced the number of acute bed days where there was no capacity in reablement and has released capacity in the nursing urgent response team by enabling the right level of care to optimised. Funding has therefore been extended to September 2024. We will continue to invest in services which support independence and self-management and support more people at home, whilst acknowledging the greater complexity, dependency and acuity of an ageing society. Programming efficiencies within the Reablement Service have released capacity with the service operational from 7.00 am to 10.00 pm 7 days a week. The ability to enable more people as soon as possible is a core commitment to improve outcomes for greater independence for individuals and to ensure that social care provision, which has been increasingly hard to source is channelled to those who need it most. The Reablement Service is working closely with the Integrated Rapid Response Service to support assessment and case management. A reablement assessor and co-ordinator are both part of the urgent community hub to facilitate triage and a more flexible use of resource. A hybrid health and social care support worker role has been developed and implemented. The role is hosted by the Foundation Trust providing a flexible resource which works across the urgent pathways including the virtual ward, urgent community response and pathway 1 discharges as demand requires. We will continue to build on our successful investment and partnership working with the voluntary and community sector and have embedded our urgent and emergency social prescribing pilot in our main contract. In 2023-24 Age UK supported 2,400 discharge contacts, urgent and emergency social prescribing 351, with service users reporting an 88% improvement in wellbeing and our personal health budget discharge pilot 86 discharges home, providing over 1,000 additional support hours. Frailty and ambulatory care are two of our 2024-25 high impact change iniatives which will provide the opportunity to review our current provision and develop a more integrated multi-disciplinary cross organisation approach. This will help us to further develop our prevention offer including physical fitness, out of hospital pathways and streaming at the acute front door to support more people home and reduce avoidable short stay admissions.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

The BCF funded schemes continue to support our joint approach to continued integration of health and social care provision, working collaboratively with the voluntary and community sector. This will continue to support further improvements of outcomes for people with care and support needs to help people remain independent at home for as long as possible, reduce avoidable ambulance conveyances and attendances in ED and therefore admissions. It will help ensure people receive the right level of care according to their needs at that time. The Council, along with partners have continued to focus on a strengths-based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised, thus increasing choice and control. We have reviewed our approach to pro-active care working in partnership with primary and secondary community care and the voluntary sector to target those at risk of deterioration and work with the individual, families and carers to agree advanced care plans which support what matters to them. We have further strengthened our approach to integrated assessment and triage to ensure right levels of care for improved patient outcomes and effective use of system resources. This has included investment in and roll out of the Transfer of Care hub for admission avoidance. We have strengthened and embedded our approach and use of assistive technology and proportionate care across partners. We have focussed on greater promotion of the use of individual budgets via a direct payment, strength based, focussed assessment of well-being and clear evidence of a person's needs. Consideration is also taken in relation to eligibility criteria, support planning, completion of Continuing Health Care and Decision Support Tool checklists. We have provided targeted support in the community for the most complex, vulnerable and /or highest acuity people including those in crisis, mental health and complex continuing care which cannot be met through currently commissioned provision. We have continued to develop our workforce, working in partnership across health and social care to provide attractive and flexible career opportunities, development schemes and integrated services and roles. The Council's Aids and Adaptation Policy which has been approved and now implemented is making use of Regulatory Reform Order (RRO). The new policy details how the Council intend to exercise their powers under the RRO, as this allows the Council to use Government funding for the DFG more flexibly, improving outcomes for people with care and support needs and maintaining them longer in the community.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

The first phase of implementation of our Transfer of Care Discharge to Assess model was completed in 2023/24 with the co-location of health, care and voluntary sector specialists to enable a multi-disciplinary approach to providing the right level of care, at the right time and right place for individuals. As the Transfer of Care hub is based in the community it is more attuned to the level of risk that can be safely supported in a person's home than an acute based service. This supports timely discharge and increases the number of discharges home. Over 400 D2A assessments have been conducted in the community over this period, reducing the amount and cost of care required and the number of Care Act assessments required, the majority of which are now carried out at home. The Transfer of Care hub for urgent responses is staffed 24 hours a day, 7 days a week with specialist teams available in core hours aligned to the higher periods of demand. The Reablement Service is working closely with the Integrated Rapid Response Service to support assessment and case management. A reablement assessor and co-ordinator are both part of the urgent transfer of care hub to facilitate triage and a more flexible use of resource. A new hybrid health and social care support worker role has been developed and implemented. The role is hosted by the Foundation Trust providing a flexible resource which works across the urgent pathways including the virtual ward which has suppoted over 2,000 step up and step down patients since its launch in December 2022, urgent community response and pathway 1 discharges as demand requires. BCF funding also provides funding for brokerage to provide support over the weekend to facilitate hospital discharges. We have developed our digital offer including a whole system command centre and performance dashboard to help manage system flow and anticipate and respond to system pressures. We will continue to seek to invest in continuing health care to support higher levels of acuity at home and provide targeted support to meet needs relating to mental health, learning disabilities and autism.The Council's Aids and Adaptation Policy is now making use of Regulatory Reform Order (RRO) to reduce delayed transfers of care and enable faster hospital discharge to a suitable home enviornment.

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

Checklist Complete:	Linked KLOEs (For information)
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

Our capacity and demand tool was refreshed in 2023-24 to inform winter planning and the exercise will be repeated for 2024-25. This has been developed between the Local Authorry, The Rotherham Foundation Trust and Rotherham ICB and is reflected in BCF and NHS capacty and demand plans and includes changes in UEC capacity and demand and flow estimates in NHS activity operational plans.
Outcomes are used to support development of intermediate care and reablement and discharge pathways with involvement of the Local Authority, ICB and The Rotherham Foundation Trust. We re-aligned our escalation framework in winter 2023-24 with the national framework and integrated it with the South Yorkshire ICB system. The framework flexes up and down according to system level. A new community esclation wheel along with the existing acute wheel provides a comprehensive overview of all pressure points to inform operational decision making. Pressures were successfully contained pre-Christmas despite the impact of industrial action, however we have seen unprecedented demand in the emergency department, with high levels of acuity resulting in an increased number of beds over and above planned escalation levels. This has, in turn, put pressure on discharge pathways. Pressure on GP appointments and industrial action has impacted at Place level. For the first time this winter, as part of our home first strategy, we did not block purchase winter beds but used spot purchase beds, cohorted on three sites, utilised according to need. This worked well in practice, but was challenged as some of our planned commissioned bed base had to temporarily close due to staffing challenges. In order to plan an annual review of winter pressures will be carried out which will inform plans for the following year. In 2023-24 £500k was ring fenced from the BCF monies to support winter pressures. This was used to increase capacity in reablement, therapy and urgent response in the community, provide additional GP appointments through an acute respiratory primary care hub, extend patient transport for same day discharge and invest in support for mental health crisis community beds and housing support.

Yes

Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	**Yes**

Yes

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.

Capacity and demand modelling has been based on establishing a baseline level of resource required throughout the year to support our avoidance and discharge pathways. This approach has been developed through the Rotherham Place Urgent and Emergency Programme in 2023-24. The aim of this workstream was to gain a better understanding of whole system flow, including pressure points. This work will be built on in 2024-25 including improving our understanding of current capacity and demand, by refreshing our performance tool and developing an integrated performance dashboard which is monitored through our monthly Place Urgent and Emergency Care Group. We are reviewing and streamlining our data sources including Trust and Council business insights dashboards, South Yorkshire ICB reporting and the regional discharge packs and data base, which has reduced the local reporting burden. This provides a better understanding of day to day variations as well as seasonal trends and the impact of interventions so we have a more robust baseline and can better target short term seasonal investment strategies. We will continue to use BCF monies to secure specialist resource to help with the modelling of this information as well as planning and implementing a step change in how we support admission avoidance and discharge. The Market Sustainability and Improvement Plan Capacity Plan also takes into account the capacity that is required in the adult social care market to meet those with complex needs, thus reducing admissions to hospital. The Market Position Statement also details the number of people that is supported through adult social care commissioned services, predicting future demand and the Council's future commissioning intentions.

Yes

Has the area described how shared data has been used to understand demand and capacity for different types of int

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.

The Council, in partnership with Rotherham ICB, utilised the additional discharge fund to commission additional capacity across adult social care and health to support timely and safe discharge from hospital into the community by reducing the number of delays in hospital over the winter period of 2023/24. The main focus was on a 'home first' approach and D2A model. The funding supported admission avoidance including investment in a hospice clinical nurse specialist, the Rothercare pendant alarm scheme and social worker resource in the Emergency Department. Discharge monies enabled more people to be discharged to an appropriate setting with health and social care provided according to individual need. Funding was used to prioritise approaches that were most effective in freeing up the maximum number of physical and mental health beds and reducing bed days lost including extending service hours and weekend working. Discharge funding provided additional resource to support the review of care packages and carry out assessments within a 24 hour period to improve patient flow. Additional reablement co-ordinator and support worker roles increased capacity. Investment in the brokerage service extended the service hours and provided an enhanced offer for complex care. Flow through mental health beds was supported through funding of a discharge co-ordinator and housing officer. Ongoing recruitment and cost of living pressures impacting on home care and care home providers was recognised and supported through targeted uplifts.

Yes

Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan?

Is the plan for spending the additional discharge grant in line with grant conditions?

Please describe any changes to your Additional discharge fund plans, as a result from

- **Local learning from 23-24**
- **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**

The additional discharge fund will target ongoing barriers to discharge and invest in services which will improve whole system flow. This includes investment in social workers and CHC co-ordinators to reduce assessment delays and on-going investment in reablement, urgent community response and the Integrated Discharge Team to support more people at home through admission avoidance including deflection from the emergency department and discharge home. A new home from hospital service was commissioned in 2023-24 to provide bridging support when no reablement capacity was available over the winter period. This has been extended in 2024-25 as it not only reduced discharge delays but also released capacity in our other bridging service which is delivered by health. This meant nursing resource was not used to support lower level needs, thereby ensuring the right level of care is provided, at the right time and place, releasing capacity and providing better value for money. Investment in pathway 1 capacity is reflected in Tab 4.3, reablement and rehabilitation at home, however there were challenges in practice in realising and releasing the capacity in 2023-24 particularly in reablement and urgent response, which resulted in some unmet demand. Due to system pressures we had to focus resource on discharge at peak times, at the expense of prevention. To address this for 2024-25 health have consolidated urgent response resource into a single team and a cross system task and finish group is reviewing ways of working to release capacity and a new recruitment strategy is being developed to ensure we can support both priorities in 2024-25.

Additional intermediate care, surge and winter beds were commissioned on a spot purchase basis to meet seasonal pressures. These have offered short term care and support to avoid a hospital admission, particularly from the emergency department, where the person could not immediately return home and for discharges waiting for a home care package, equipment, or other ongoing services, with a plan for them to return home safely. For those with complex health and care needs, short-term nursing care placements were also funded to free up hospital capacity over the winter period. This is reflected in Tab 4.3 community capacity and demand.

Pressures on mental health services continued to be an issue in 2023-24. We saw particular challenges in A&E with some very long waits. We improved our escalation processes, but lack of mental health bed availability contributed to A&E breaches and poor patient experiences. Funding for crisis beds, a housing in-reach role and a mental health social work discharge co-ordinator will continue in 2024-25.
We saw an increase in end of life patients in 2023-24. The fund will continue to be used to improve the management of discharge from the hospice and a Clinical Nurse Specialist will enable increased community activity allowing for better management of discharged hospital patients.

The voluntary and community services were commissioned to run a pilot to provide personal health budgets to address barriers to discharge. The pilot demonstrated benefits in reducing length of stay, but duplicated some advocacy activity provided by other commissioned VCS services. For 2024-25 we are incorporating the budgets in our Hospital After Care Service delivered by Age UK.

The rapid evaluation of the 2022 to 2023 discharge fund shows that funding was mostly utilised to increase the number of discharges and support the reduction of discharge delays which is a similar pattern seen in Rotherham. Learning from this and our own experiences we have identified some key roles for 2024-25 to change how we work to stem growth in demand and provide better value for money. This includes a Proportionate Care Lead to provide Vocationally Qualified Assessment to provide safe single handed care in bedded and community based locations; a waiting lists / LD review officer to support timely assessments and reviews; an Operations Manager (Provider Services) to provide additional capacity to support service transformation; a Deputy Head of Mental Health Services to provide oversight and management of the Approved Mental Health Professional Service to support complex hospital discharges and additional staffing for Rothercare to enhance service provision, response and use of assistive technology, equipment and adaptations to support hospital discharges. Additional commissioning and compliance officers are being recruited to identify risks and promote quality in contracted provision which will increase access to short-term packages of

Yes

Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?

We have reviewed our current offer including further capacity and demand analysis and utilising population health data to assess provision against outcomes and value for money, managed through the BCF assurance framework. We will continue to invest in services and development which support independence and self-management and support more people at home, whilst acknowledging the greater complexity, dependency and acuity of an ageing society . We have extended the operational hours in key areas such as pharmacy, the discharge lounge and weekend working, additional seasonal capacity, targeted winter roles and beds, investment in avoidance pathways, development of the integrated transfer of care hub and D2A model and the Place escalation wheel. Our plan is to continue increasing capacity within the community through increased use of reablement services, assistive technology, aids and adaptations, supporting unpaid carers and other housing related options. This, in turn, will reduce the number of existing intermediate care beds, although they are well utilised at present. Through development of the discharge to assess model with the majority of assessments taking place in the community and the expansion of our urgent and community Transfer of Care hub we are expecting to make some efficiency savings through a reduction in the level of care required, hand offs and more flexible allocation of resources. BCF funded schemes including urgent community response, reablement at home, reablement and rehabilitation in a bed setting, community occupational therapy, aids and adaptations, assistive technology. Voluntary and community services which will continue to have an impact on reducing unplanned and emergency hospital admissions (including falls for older people aged 65 years and over) and decrease the number of older people whose long-term support needs were met by admission to residential and nursing care homes.

Yes

Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

1

#REF!

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: Rotherham

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	301.4	296.4	250.9	242.0	Performance for 2023/24 was challenged, thought to be linked to system pressures and industrial action. National planning guidance has indicated to plan for no further industrial action. Rotherham has also established a number of key priority areas for 2024/25 including frailty which are expected to impact on avoidable admissions. A slight reduction has therefore been planned, noting the above but accepting this has been a challenging area.	ACS admissions in 2023-24 were more challenging than expected, particularly in Q3 and Q4. This is thought to be linked to high winter pressures particularly in primary care, linked to areas such as children's respiratory conditions. A key priority for the Rotherham urgent and emergency care recovery plan in 2024-25 is to reduce avoidable conveyances and admissions in order to meet the national 4 hour standard, G&A occupancy levels and no criteria to reside. This includes developing alternative out of hospital pathways and four high impact change projects relating to frailty, ambulatory care and respiratory and diabetes pathways which are associated with high levels of admission. A number of BCF funded services contribute to admission avoidance including short-term packages of social care, reablement, rehabilitation, intermediate care, assistive technology, equipment and adaptations and other community services.	Yes
	Number of Admissions	898	883	-	-			
	Population	266,183	266,183	-	-			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
	Indicator value	286	281	322	296			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,770.4	1,920.0	1,824.0	Performance for 2023/24 was slightly above plan. Frailty and falls have been established as key priority areas for 2024/25. A slight reduction has therefore been planned on 2023/24, noting there is more work to be done to understand the impact of the priority work as we go through 2024/25.	BCF funded services, that support admission avoidance including short-term packages of social care, reablement, rehabilitation, intermediate care, home from hospital, assistive technology, equipment and adaptations and other community services will support this ambition as part of this area being identified as a priority for Rotherham.	Yes
	Count	900	976	927			Yes
	Population	52,551	52551	52551			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
	Quarter (%)	94.4%	94.7%	93.5%	94.0%	Rotherham has performed well against plan in 2023/24 as it was a	Rotherham has performed well against plan in 2023/24 and plans to	Yes

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)	Numerator	6,708	6,797	6,216	6,003	key area in our urgent and emergency care recovery plan. As part of this we developed a discharge to assess model with the majority of all assessments now taking place in the community and a Transfer of Care Hub. We will continue to build on this in 2024-25. We will co-locate our health and social care admission avoidance and discharge teams together in the Transfer of Care Hub which will be based in the community to continue to grow discharge home. Our new care home trusted assessor role will help to support residents returning to their care home	continue with these levels of performance in 2024/25. Performance has been strong during 2023/24 and above target in every month. Rotherham was above national % discharged to usual place of residence when the plan was set in 2023/24. As performance is above national levels, the trajectory has been set to 94.4% in Q1 and 95.4% in Q4, based on previous upper levels of performance. This will be supported by BCF funded services that support out of hospital delivery of care including short-term packages of social care, reablement, rehabilitation, intermediate care, home from hospital, assistive technology, equipment and adaptations and other community services which are financed by the discharge fund.	Yes	
	Denominator	7,105	7,180	6,648	6,386				
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan				
	Quarter (%)	94.4%	94.7%	94.7%	95.4%				
	Numerator	6,773	6,865	6,356	6,151				
	Denominator	7,176	7,252	6,714	6,450			Yes	

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
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	666.0	571.7	542.9	563.6	Rotherham's strategy aim is to support more people to remain independent for longer at home. We have therefore used BCF monies to support this. An impact of the strategy is therefore to reduce admissions to care homes. This does need to be balanced against the ageing population and Rotherham's challenging levels of deprivation. In 2024-25 commissioner and provider adult social care colleagues are working with health on a project to reduce short term placements in care homes, many of which translate into long term stays. The 2024-25 plan aims to take account of these factors. The 317 target equating to a rate of 563.6 is below the regional benchmark of 643.7, and moves Rotherham more in line with the England value of 560.8.	The 317 target equating to a rate of 563.6 is below the regional benchmark of 643.7, and moves Rotherham more in line with the England value of 560.8. It is anticipated that the 317 target wil be met in 2024/25. The Council continues to closely monitor the rates of admission with a continued focus on home first and residential care being only considered where there are no other appropriate alternatives to meeting needs. This will be supported by BCF funded services that support out of hospital delivery of care and reduce admissions to 24 hour care including short-term packages of social care, reablement, rehabilitation, intermediate care, home from hospital, assistive technology, equipment and adaptations and other community services which are financed by the discharge fund.	Yes
	Numerator	350	317	301	317			Yes
	Denominator	52,551	55,448	55,448	56,244			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Have all elements of the Planning template been completed? *Paragraph 11*	Cover sheet Cover sheet Cover sheet Cover sheet
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update	
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Cover sheet Planning Requirements
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** **- Support people to remain independent for longer, and where possible support them to remain in their own home** **- Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?	

Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?	
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	PR 4 and PR6 are dealt with together (see above)	
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services and NHS commissioned out of hospital services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?	

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? Paragraph 12	
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?	