Better Care Fund 2024-25 EOY Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.

2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the second quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- Target met
- Target not met
- Data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns L and M only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.
5.2 C&D Actual Activity
Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

6. Income

This section require confirmation of actual income received in 2024-25 across each fund.

- Please confirm the total HWB level actual BCF pooled income for 2024-25 by reporting any changes to the planned additional contributions by LAs and NHS as reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre-populate the planned income in 2024-25 from BCF plans, including additional contributions.

7. Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.

The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation. Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation. This shouldn't include spend which has already been allocated in-year and should be the net position.

Underspend - Where there is an underspend please provide details as to the reasons for the underspend.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 7a.

8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2024-25 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of yes/no responses:

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2024-25
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

https://www.scie.org.uk/integrated-care/logic-model-for-integrated-care/#enablers

Please highlight:

4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

Please provide narrative for the above 2 questions.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

Better Care Fund 2024-25 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

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

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

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

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

Health and Wellbeing Board:	Rotherham
Completed by:	Hafsah Taj
E-mail:	Hafsah.Taj1@nhs.net
Contact number:	01709 253870
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Actual Activity	Yes
6. Income actual	Yes
7b. Expenditure	Yes
8. Year End Feedback	Yes

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

Expenditure Underspent or Overspent

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Rotherham

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

Fund 2024-25 EOY Reporti

4. Metrics

Selected Health and Well | Rotherham

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1 Q2 Q3 Q4	For information - actual performance for Q3 (For Q4 data,please refer to data pack on BCX)	Assessment of whether ambitions have been met	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*

Complete:

Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	286.0	281.0	322.0	296.0	225.0	Target met	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.	Avoidable admissions in Q4 2024-25 are currently forecasted to be on target at 237.8 vs a plan of 296.0 admissions per 100,000 population.	Avoidable admissions decreased in Q4, and is below the planned figure.	Provisional figures for Q4 show a downtrend. This suggests that the work on alternative pathways on ED is beginning to have an impact. 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. The growth of	Yes

Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	94.4% 94.7% 94.7% 95.4%	94.26%	Target not met	Q4 figures show a slight decrease in rates, with the latest data from March showing 93.7% against a target of 95.4%.	Provisional Q4 figures, with February and March data still incomplete, are estimated at 93.7%, below the target of 95.4%.	Provisional Q4 estimates (93.7%) show a decrease in the rate, but remains below the Q4 planned figure (95.4%).	Provisional figures for Q4 show a downtrend. There has been a sustained increase in demand to A&E resulting in increased admissions, with escalation beds open over the summer. This has impacted on discharge pathways, particularly enablement. At times it has been necessary to place people in short term bedded community care in order to release acute	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1,824.0	437.1	Target not met	A key priority area for Rotherham in 2024/25 is frailty, which is expected to impact this indicator. A small increase in admissions due to falls in people aged over 65 years has been planned, as previous years trend expected to continue.	Q4 data shows a estimated rate of 505.3, which is higher than the quarterly target of 456.0 (set as 25% of our annual target).	Q4 data shows an estimated rate of 505.3, the rate decreased compared to Q3 but remains higher than the planned figure 456.0 (set as 25% of our annual target).	Rotherham high impact frailty project includes a review of the care homes falls pathway.	Yes

Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	564	not applicable	Target not met	Increased demand across the system, acuity and also linked to the journey of people who previously were in short stay placements that move to long-term.	BCF monies are funding 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.	2024/25 Year End admissions are 3.1% above target due to increased demand across the service.	A task and finish group are looking at better health and social care linkages and solutions for people being discharged from hospital to ensure people are being supported to home first. Quality Assurance Processes are in place to ensure lesser restrictive options are always exhausted before a long-stay placement is considered / agreed.	Yes

Better Care Fund 2024-25 EOY Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Rotherham

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Activity has increased for rehabilitation at home in the community to support hospital avoidance. Activity has decreased for rehabilitation at home (Pathway 1) to support hospital discharge. This is because, it is the same team of staff who support admission avoidance and discharge. As a result of pressures on Pathway 1, there has been a slight increase in short-term bedded care (Pathway 2). Although BCF winter monies had been made available for additional enablement and social worker resource recruitment challenges meant that this could not be fully utilised. BCF money was used to recruit a Place system flow capacity manager but this role did not start until January 2025, so there was a delayed impact.	Yes
2. Do you have any capacity concerns for 25-26? Please consider both your community capacity and hospital discharge capacity.	
We have seen unprecedented levels of demand in our Emergency Department in quarter 4 2025-6. Our 2024-5 plans were based on 260 attendances but the average was over 300 in practice. We are therefore revising capacity and demand plans based on this. It is anticipated that ED demand will be reduced in 2025-6 as work continues on our alternative pathways to ED which will capitalise on a £7M capital build to develop our Same Day Emergency Care offer. In additon we are carrying out a deep dive into attendances to better understand those presenting in an attempt to reduce avoidable activity. However, we have seen very high levels of acuity of those who were admitted, this has played out into discharge pathways with the need for higher levels of support. Given the aging population and home first approach where more people are successfully being supported in the community this is to be expected. We are therefore reviewing the capacity in each of our discharge pathways.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Work is underway at Place to review capacity and demand across all admission avoidance and discharge pathways to ensure we have the right level of resource in the right place according to need. The next phase of the Transfer of Care/Discharge to Assess Model will be implemented in the first half of the year which will reduce pressure points in system flow and enable a more flexible allocation of resource across pathways. The Council have conducted a review of its enablement and integrated discharge service which will increase capacity in 2025-6.	Yes
4. Do you have any specific support needs to raise? Please consider any priorities for planning readiness for 25/26.	
No support needs required for Q4. BCF plans for 2025/26 have already been submitted to NHS England on 31/03/25.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 EOY Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Rotherham

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist Complete:
Service Area	**Metric**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	328	317	338	726	606	467	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	1	12	12	12				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	26	23	22	23	25	23	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	1	2	1				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	43	40	46	79	67	66	5	11	12	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	2	1	2	2	1				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	2	5	8	9	17	13	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	2	2	4	3	4				Yes

Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	1	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	0	1	0	0	0				Yes

Actual activity - Community		**Prepopulated demand from 2024-25 plan**			**Actual activity:**			
Service Area	**Metric**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	
Social support (including VCS)	Monthly activity. Number of new clients.	44	38	35	149	168	117	Yes
Urgent Community Response	Monthly activity. Number of new clients.	300	300	300	276	206	277	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	558	572	552	2014	1955	2164	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	11	21	17	18	18	6	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

Better Care Fund 2024-25 EOY Reporting Template

6. Income actual

Selected Health and Wellbeing Board: Rotherham

Checklist

Complete:

	2024-25				
Source of Funding	Planned Income	Actual income	Carried from previous year (23-24)	Actual total income (Column D + E)	
DFG	£3,341,770	£3,801,597	£0	£3,801,597	Yes
Minimum NHS Contribution	£25,556,953	£25,556,953		£25,556,953	Yes
iBCF	£14,480,543	£14,480,543		£14,480,543	Yes
Additional LA Contribution	£5,102,000	£5,102,000		£5,102,000	Yes
Additional NHS Contribution	£0	£0		£0	Yes
Local Authority Discharge Funding	£3,383,583	£3,383,583		£3,383,583	Yes
ICB Discharge Funding	£2,473,000	£2,473,000		£2,473,000	Yes
Total	**£54,337,849**			**£54,797,676**	

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**

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.

4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams.

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	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	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 Eq	Number of beneficiaries
Home Care or Domiciliary Car	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care	Number of placements
Home-based intermediate car	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and R	WTE's gained
Carers Services	Beneficiaries

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

Better Care Fund 2024-25 EOY Reporting Template

7b. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Rotherham

	2024-25					
Running Balances	Income	Expenditure to date	Percentage spent	Balance		**If underspent, please provide reasons**
DFG	£3,801,597	£3,801,597	100.00%	£0		
Minimum NHS Contribution	£25,556,953	£25,556,953	100.00%	£0		
iBCF	£14,480,543	£14,351,543	99.11%	£129,000	Underspent!	The underspend relates to roles that were recruited in year. The money will be rolled
Additional LA Contribution	£5,102,000	£3,090,384	60.57%	£2,011,616	Underspent!	Monies were carried forward to 24/25 for the DFG and Carers. These have not been
Additional NHS Contribution	£0	£0		£0		
Local Authority Discharge Funding	£3,383,583	£3,383,583	100.00%	£0		
ICB Discharge Funding	£2,473,000	£2,473,000	100.00%	£0		
Total	**£54,797,676**	**£52,657,060**	**96.09%**	**£2,140,616**	Underspent!	See above

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,262,562	£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

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Actual Spend (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
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	NA		Mental Health	0	NHS			NHS Mental Health Provider	Minimum NHS Contribution	£ 1,505,000	£1,505,000		Jo Sarsby
2	Falls Service	Community service (health) supporting reablement/prevention to	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 534,000	£534,000		Jo Sarsby
3	Reablement	LA Reablement Service	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		920	1030	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 1,087,000	£1,087,000		Avanda Mitchell - Hafsah Taj has added outputs from Karen Duke.
3	Domiciliary Care	Provision of domiciliary care services to help people live in their own homes	Home Care or Domiciliary Care	Domiciliary care packages		31662	21950	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 758,000	£758,000		Avanda Mitchell. Liz Callear to ask Performance and Inteligence Team for outputs. .
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	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 597,000	£597,000		Jo Sarsby
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	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 184,000	£184,000		Jo Sarsby
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	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 2,086,953	£2,086,953		Jo Sarsby
7	Otago Exercise Programme	Falls prevention exercise programme	Personalised Care at Home	Physical health/wellbeing			NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£ 20,000	£20,000		Avanda Mitchell
8	Mediquip (Wheelchairs & Equipment)	Integrated Community Equipment Service	Prevention / Early Intervention	Other	small items of equipment to enable people to	0	NA		Social Care		NHS			Private Sector	Minimum NHS Contribution	£ 1,962,000	£1,962,000		Jo Sarsby
8	Mediquip (Wheelchairs & Equipment)	Integrated Community Equipment Service	Prevention / Early Intervention	Other	small items of equipment to enable people to		NA		Social Care		NHS			Private Sector	iBCF	£ 92,000	£92,000		Jo Sarsby
9	Community OT	Occupational Therapy Assessments	Prevention / Early Intervention	Other	OT assessments carried out by community	3000	3029		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£ 497,000	£497,000		Avanda Mitchell - Karen Smith has added outputs
9	Community OT	Occupational Therapy Assessments	Prevention / Early Intervention	Other	OT assessments carried out by community	3000	3029		Social Care		LA			NHS Community Provider	Additional LA Contribution	£ 432,000	£432,000		Avanda Mitchell - Karen Smith has added outputs
10	Disabled Facilities Grant	Major property adapatations to enable people to continue to live independently within	DFG Related Schemes	Adaptations, including statutory DFG grants		223	227	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£ 2,471,770	£2,931,597		Avanda Mitchell. Liz Callear to ask Daniel Peck re outputs.
10	Disabled Facilities Grant	Community alarm and Equipment service to support independent living	Assistive Technologies and Equipment	Community based equipment		2300	1222	Number of beneficiaries	Social Care		LA			Local Authority	DFG	£ 870,000	£870,000		Avanda Mitchell. Liz Callear to ask Sharron Barker for outputs.
10	Additional Disabled Facilities Grant schemes	Additional major Adaptations	DFG Related Schemes	Other	Balance brought forward from slippage in	223	0	Number of adaptations funded/people supported	Social Care		LA			Local Authority	Additional LA Contribution	£ 1,500,000	£205,000		Avanda Mitchell. Liz Callear to ask Daniel Peck re outputs.

11	Age UK Hospital Discharge	Hospital Discharge supporting flow	Personalised Care at Home	Physical health/wellbeing		1637	581		Other	Charity / Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 173,000	£173,000		Jo Sarsby - Hafsah Taj has added the outputs. 416 reported in Q3.
12	Stroke Association Service	VCS provision to support stroke survivors	Personalised Care at Home	Physical health/wellbeing		0	NA		Other	Charity / Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 59,000	£59,000		Jo Sarsby
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	565	Number of placements	Social Care		LA			Local Authority	Additional LA Contribution	£ 1,920,038	£1,920,038		Avanda Mitchell - Karen Smith has added outputs.
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	430	Number of placements	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 1,039,000	£1,039,000		Avanda Mitchell - Karen Smith has added outputs.
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	£ 1,508,000	£1,508,000		Avanda Mitchell - Karen Smith has added outputs.
13	Intermediate Care - Home first	Rehabilitation and reablement pathway home	Home-based intermediate care services	Reablement at home (to support discharge)		375	430	Packages	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£ 886,000	£886,000		Avanda Mitchell - Karen Smith has added outputs.
13	Intermediate Care - Therapy	Rehabilitation and reablement pathway home	Bed based intermediate Care Services (Reablement,	Other	Social Care	375	430	Number of placements	Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£ 542,000	£542,000		Avanda Mitchell - Karen Smith has added outputs.
13	Intermediate Care - Therapy	Rehabilitation and reablement pathway home	Bed based intermediate Care Services (Reablement,	Other	Social Care	375	430	Number of placements	Social Care		LA			NHS Mental Health Provider	Minimum NHS Contribution	£ 100,000	£100,000		Avanda Mitchell - Karen Smith has added outputs.
13	Intermediate Care - GP Cover	GP support for bed based intermediate care services	Bed based intermediate Care Services (Reablement,	Other	GP Cover	375	430	Number of placements	Primary Care		LA			NHS Community Provider	Minimum NHS Contribution	£ 36,000	£36,000		Avanda Mitchell - Karen Smith has added outputs.
13	Intermediate Care	Rehabilitation and reablement pathway home	Home-based intermediate care services	Reablement at home (to support discharge)		375	430	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 377,000	£377,000		Avanda Mitchell - Karen Smith has added outputs.
14	Direct Payments	Personal budget to support an individual social care plan and support	Personalised Budgeting and Commissioning				NA		Social Care		LA			Private Sector	Minimum NHS Contribution	£ 1,283,000	£1,283,000		Avanda Mitchell
14	Supported Living	A range of services to support the independence of people with a learning	Residential Placements	Supported housing		7	7	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 410,000	£410,000		Avanda Mitchell. Liz Callear to add outputs
15	Care Act	Deprivation of Liberty Safeguards (Dols) support	Care Act Implementation Related Duties	Independent Mental Health Advocacy			NA		Social Care		LA			Private Sector	Minimum NHS Contribution	£ 40,000	£40,000		Avanda Mitchell
15	Care Act	Direct Payments and Domiciliary Care provision	Care Act Implementation Related Duties	Other	Direct Payments and Domiciliary Care provision	0	NA		Social Care		LA			Private Sector	Minimum NHS Contribution	£ 661,000	£661,000		Avanda Michell
16	Mental Health rehabilitation services	Rehabilitation and support in a bed base provision	Residential Placements	Care home		3	2	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 209,000	£209,000		Avanda Mitchell. Liz Callear to add outputs
17	Learning Disabilities independent	Learning disabilities residential placements	Residential Placements	Learning disability		11	8	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 984,000	£984,000		Avanda Mitchell. Liz Callear to add outputs
17	Learning Disabilities Domiciliary Care	Learning Disabilities Domiciliary Care packages	Home Care or Domiciliary Care	Domiciliary care packages		1546	1072	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 37,000	£37,000		Avanda Mitchell. Liz Callear to ask Performance and Intelligence Team for outputs.
18	Free Nursing Care	NHS Funded Nursing Care	Residential Placements	Nursing home		125	182	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 1,472,000	£1,472,000		Avanda Mitchell. Liz Callear to ask Performance and Intelligence Team for outputs.
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	NA		Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	£ 1,172,000	£1,172,000		Jo Sarsby
20	Care Home Support Service	Integrated community service to care homes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 321,000	£321,000		Jo Sarsby
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	NA		Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 994,000	£994,000		Jo Sarsby
22	Social Prescribing	Links patients in primary care with non medical support within the community and	Prevention / Early Intervention	Social Prescribing		0	NA		Other	Health and Social Care	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 880,000	£880,000		Jo Sarsby
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	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£ 919,000	£919,000		Avanda Mitchell
24	Care co-ordination Centre	A single point of contact for health and social care professionals providing	Community Based Schemes	Integrated neighbourhood services		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 921,000	£921,000		Jo Sarsby
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	30000	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 237,000	£237,000		Avanda Mitchell
25	Carers Support Services	Carers Emergency Scheme	Carers Services	Carer advice and support related to Care Act duties		30	23	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 23,000	£23,000		Avanda Mitchell - Karen Smith has added outputs from Katy Lewis
25	Carers Support Services	Direct Payments and domiciliary care provision	Carers Services	Respite services		23	19	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£ 301,000	£301,000		Avanda Mitchell - Liz Callear for outputs.
26	Joint Commissioning Team	Joint Commissioner team staffing costs	Enablers for Integration	Joint commissioning infrastructure			NA		Other	Commissioning	NHS			Local Authority	Minimum NHS Contribution	£ 50,000	£50,000		Avanda Mitchell
27	IT to Support Community Transformation	Digital enablers to support integration of community services	Enablers for Integration	System IT Interoperability			NA		Other	Information sharing	NHS			NHS	Minimum NHS Contribution	£ 192,000	£192,000		Jo Sarsby
28	BCF Risk Pool	Risk pool - contingency for unforeseen cost pressures	Other				NA		Other	Contingency	NHS			NHS	Minimum NHS Contribution	£ 500,000	£500,000		Jo Sarsby

29	Adaptation of Liquid Logic to support care	Support IT infrastructure and promote integrated working	Enablers for Integration	System IT Interoperability			NA		Social Care		LA			Local Authority	iBCF	£ 60,000	£60,000		Avanda Mitchell
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			NA		Acute		NHS			NHS Acute Provider	iBCF	£ 85,000	£85,000		Avanda Mitchell
31	Health Inequalities	Project support to implementation population health priorities	Integrated Care Planning and Navigation	Support for implementation of anticipatory care			NA		Other	Public Health	LA			Local Authority	iBCF	£ 90,000	£90,000		Avanda Mitchell
32	Trusted Assessor	Assessments and care planning to reduce delays in hospital discharges	High Impact Change Model for Managing Transfer of Care	Trusted Assessment			NA		Acute		NHS			NHS Acute Provider	iBCF	£ 70,000	£38,000		Avanda Mitchell
33	Social Care Sustainability	Older People Residential placements	Residential Placements	Care home		75	74	Number of beds	Social Care		LA			Private Sector	iBCF	£ 2,779,000	£2,779,000		Avanda Mitchell. Liz Callear to add outputs.
33	Social Care Sustainability	Older People Domiciliary Care provision	Home Care or Domiciliary Care	Domiciliary care packages		63784	44218	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£ 1,527,000	£1,527,000		Avanda Mitchell. Liz Callear to ask Performance and Intelligence Team for outputs - number of res care placements.
33	Social Care Sustainability	Provision of direct payments to support people within their own homes	Personalised Budgeting and Commissioning			0	NA		Social Care		LA			Private Sector	iBCF	£ 700,000	£700,000		Avanda Mitchell
33	Social Care Sustainability	Residential placements for younger adults with a Learning Disability.	Residential Placements	Learning disability		20	19	Number of beds	Social Care		LA			Private Sector	iBCF	£ 2,238,000	£2,238,000		Avanda Mitchell. Liz Caller to add ouputs.
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	900	Number of beds	Social Care		LA			Private Sector	iBCF	£ 4,225,543	£4,225,543		Avanda Mitchell. Liz Callear to ask Performance and Intelligence Team for outputs - number of res care placements.
35	Care Market Capacity and sustainability	Supporting the increase in LD provider costs, including the increase in NLW plus	Residential Placements	Supported housing		11	9	Number of beds	Social Care		LA			Private Sector	iBCF	£ 753,000	£753,000		Avanda Mitchell. Liz Callear to add ouputs.
36	Prevention and Early Intervention	Voluntary Sector advice and Support at front of access	Prevention / Early Intervention	Other	Advice and Guidance		NA		Social Care		LA			Charity / Voluntary Sector	iBCF	£ 50,000	£50,000		Avanda Mitchell
37	Prevention and Early Intervention	Advocacy support, advice and guidance for people with a learning disability	Prevention / Early Intervention	Other	Advice and Guidance		NA		Social Care		LA			Charity / Voluntary Sector	iBCF	£ 55,000	£55,000		Avanda Mitchell
38	Perform Plus	Coaching Programme to increase capacity and performance of the social	Enablers for Integration	Workforce development			NA		Social Care		LA			Local Authority	iBCF	£ 48,000	£48,000		Avanda Mitchell
39	Reablement - Additional staffing	Increase capacity of reablement service	Workforce recruitment and retention				NA	WTE's gained	Social Care		LA			Local Authority	iBCF	£ 87,000	£87,000		Avanda Mitchell
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	135	Number of placements	Social Care		LA			Private Sector	iBCF	£ 107,000	£107,000		Avanda Mitchell - Karen Smith has added outpputs.
41	Escalation wheel	Supports oversight on system prssesures to conentrate actions/escalation on	Enablers for Integration	Data Integration			NA		Acute		NHS			NHS Acute Provider	iBCF	£ 12,000	£12,000		Jo Sarsby
43	Tactical Brokerage	To broker residential and home care packages of care from commissioned	Other				NA		Social Care		LA			Local Authority	iBCF	£ 110,000	£110,000		Avanda Mitchell
44	Winter Bed Capacity	Discharge Pathways and Patient Flow	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Other	Winter Planning	NHS			Private Sector	iBCF	£ 500,000	£500,000		Avanda Mitchell
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			NA		Social Care		LA			Local Authority	iBCF	£ 225,000	£225,000		Avanda Mitchell
46	Early Planning Team	Social Work team to support hospital discharges	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Social Care		LA			Local Authority	iBCF	£ 237,000	£237,000		Avanda Mitchell
47	Additional Winter Capacity	Winter Planning contingency	Other				NA		Social Care		LA			Local Authority	iBCF	£ 273,000	£273,000		Avanda Mitchell
49	Additional Social work Capacity	Additional Social work Capacity - Learning Disabilities	Workforce recruitment and retention				4	WTE's gained	Social Care		LA			Local Authority	Additional LA Contribution	£ 250,000	£250,000		Avanda Mitchell - Liz Callear to add outputs
51	Prevention and Early Intervention	NEW front door prevention capacity to ensure deflection	Prevention / Early Intervention	Other	2 FTE posts		2		Social Care		LA			Local Authority	Additional LA Contribution	£ 100,000	£100,000		Avanda Mitchell. Liz Calllear to add outpurs
52	Self-Assessment	Implementation of self-assessment and the LAS citizen portal	Integrated Care Planning and Navigation	Care navigation and planning		0	NA		Social Care		LA			Local Authority	Additional LA Contribution	£ 51,408	£51,408		Avanda Mitchell
56	Integrated Brokerage Support Service	Additional Brokerage resources	Workforce recruitment and retention			1.5	1.5	WTE's gained	Social Care		LA			Local Authority	Additional LA Contribution	£ 38,530	£38,530		Avanda Mitchell
59	Crisis Support	Remodelling of MH crisis service / offer	High Impact Change Model for Managing Transfer of Care	Housing and related services		0	NA		Social Care		LA			Local Authority	Additional LA Contribution	£ 200,000	£0		Avanda Mitchell. Is this ICB?
60	Carers Support Services	Careres Strategy	Carers Services	Other	Other	30000	30000	Beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	£ 230,000	£0		Avanda Mitchell.
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	1378	WTE's gained	Continuing Care		NHS			Private Sector	ICB Discharge Funding	£ 1,933,930	£1,933,930		Jo Sarsby
62	SYHA Discharge Support	Additional housing inreach on to ward to support with housing issues to support	Housing Related Schemes				NA		Mental Health		NHS			Private Sector	ICB Discharge Funding	£ 60,900	£60,900		Jo Sarsby
63	Community Equipment	Supply and delivery of additional Community based equipment to increase ability	Assistive Technologies and Equipment	Community based equipment		183	183	Number of beneficiaries	Community Health		NHS			Private Sector	ICB Discharge Funding	£ 157,500	£157,500		Jo Sarsby

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	2	Number of placements	Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	£ 157,500	£157,500		Jo Sarsby
65	Hospice - Clinical Nurse Specialist	Clinical Nurse Specialist which will enable increased community activity allowing	Workforce recruitment and retention				NA	WTE's gained	Community Health		NHS			Charity / Voluntary Sector	ICB Discharge Funding	£ 68,250	£68,250		Jo Sarsby
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		NA		Community Health		NHS			Charity / Voluntary Sector	ICB Discharge Funding	£ 63,000	£63,000		Jo Sarsby
67	CHC – assessments	Increase number and speed of assessments to improve flow	Other	Additional or redeployed capacity from current care workers			NA		Continuing Care		NHS			Private Sector	ICB Discharge Funding	£ 31,920	£31,920		Jo Sarsby
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			NA		Social Care		LA			Local Authority	Local Authority Discharge	£ 120,000	£135,545		Avanda Michell
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	95	Packages	Social Care		LA			Local Authority	Local Authority Discharge	£ 437,037	£293,493		Avanda Michell - Karen Smith has added outputs.
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	295	Number of placements	Social Care		LA			Local Authority	Local Authority Discharge	£ 500,000	£344,978		Avanda Michell - Karen Smith has added outputs.
71	Rothercare - installer	Additional post to support discharge and avoidance	Enablers for Integration	Data Integration			NA		Social Care		LA			Local Authority	Local Authority Discharge	£ 30,000	£0		Avanda Michell. 23/25 scheme not carried over to 24/25
72	Housing Officer	Housing officer align to ACT/IDT	High Impact Change Model for Managing Transfer of Care	Housing and related services			NA		Social Care		LA			Local Authority	Local Authority Discharge	£ 50,000	£39,105		Avanda Michell
73	CHC assessors	CHC co-ordinators in practice hub	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Social Care		LA			Local Authority	Local Authority Discharge	£ 150,000	£74,812		Avanda Michell
74	MH Discharge	MH discharge co-ordinator due to DToC	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Social Care		LA			Local Authority	Local Authority Discharge	£ 100,000	£237,005		Avanda Michell
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	288	Number of placements	Social Care		NHS			Private Sector	Local Authority Discharge	£ 93,000	£85,793		Avanda Michell - Karen Smith has added ouptputs.
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			2		Social Care		LA			NHS	Local Authority Discharge	£ 100,000	£88,689		Avanda Michell
78	Administrative Support	Administrative Support	Other				NA		Social Care		LA			Local Authority	Local Authority Discharge	£ 40,000	£0		Avanda Michell
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	0	NA		Social Care	0	LA	0		Charity / Voluntary Sector	iBCF	£ 60,000	£60,000		Avanda Michell
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	1.5	WTE's gained	Community Health	0	NHS	0		NHS	iBCF	£ 50,000	£0		Jo Sarsby
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	0	0	NA		Acute	0	NHS	0		NHS Acute Provider	iBCF	£ 47,000	£0		Jo Sarsby
82	Vulnerable Adults Manager post	Co-ordination of the vulnerable adults pathway	Prevention / Early Intervention	Risk Stratification	0	0	1		Mental Health	0	LA	0		Local Authority	Additional LA Contribution	£ 70,000	£0		Avanda Mitchell
83	Carers Link Officers	To improve timeliness of carers assessments	Carers Services	Carer advice and support related to Care Act duties	0	75	0	Beneficiaries	Social Care	0	LA	0		Local Authority	Additional LA Contribution	£ 60,000	£2,000		Avanda Mitchell - Liz Callear for outputs.New for 24/25. 50% F Dunmow and Nawaz Mohammed.
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	0	1	1	WTE's gained	Social Care	0	LA	0		Local Authority	Additional LA Contribution	£ 70,000	£0		Avanda Mitchell
7	Otago Exercise Programme	Falls prevention exercise programme	Personalised Care at Home	Physical health/wellbeing	0	0	NA		Social Care	0	LA	0		Local Authority	Additional LA Contribution	£ 5,000	£2,330		Avanda Michell
85	Community Infection Prevention and	IPC leads in care homes to promote Infectoin Prevention and Control	Prevention / Early Intervention	Risk Stratification	0	0	NA		Community Health	0	LA	0		Local Authority	Additional LA Contribution	£ 150,000	£8,000		Avanda Mitchell
86	Contingency	Non recurrent contingency to meet any additional pressures	Other	0	Contingency	0	NA		Social Care	0	LA	0		Local Authority	Additional LA Contribution	£ 25,024	£81,078		Avanda Mitchell. Liz,is this project C
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)	0	56	143	Number of placements	Social Care	0	LA	0		Private Sector	Local Authority Discharge	£ 138,000	£478,011		Avanda Mitchell - Karen Smith has added outputs.
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)	0	383	430	Number of placements	Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 100,000	£100,000		Avanda Mitchell - Karen Smith has added outputs.
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	0	0	NA		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 56,400	£55,408		Avanda Michell. Liz-started Nov 24
89	Vocationally Qualified Assessment	To support the Proportionate Care Lead for single handed care	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	NA		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 33,600	£0		Avanda Michell
90	Waiting Lists / LD Review Officer	To support timely assessments and reviews	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	5		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 200,000	£301,500		Avanda Michell - Liz Callear for outputs
91	Operations Manager (Provider Services)	Additional capacity to support service transformation	Other	0	Increased leadership capacity	0	1		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 75,000	£53,839		Avanda Michell
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	0	0	0		Social Care	0	LA	0		Private Sector	Local Authority Discharge	£ 185,000	£276,672		Avanda Michell - Liz Callear for outputs. Home from hospital Cera client no's from Apr 24 to March 2025

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	0	0	1		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 85,462	£80,497		Avanda Michell
94	Additional capacity at front door	To support timely assessments	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	2		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 70,934	£25,016		Avanda Michell
95	Additional Commissioning Capacity	To carry out data entry requirements to identify risks and promote quality in	Prevention / Early Intervention	Risk Stratification	0	0	NA		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 20,000	£360,000		Avanda Michell.
96	Contract Compliance Officers x 2 FTE	To promote quality in contracted provision to support complex hospital	Care Act Implementation Related Duties	Safeguarding	0	0	NA		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 113,000	£76,139		Avanda Michell. Liz-agency started Jan 25.
97	Rothercare - additional staffing	Enhanced service provision and response	Assistive Technologies and Equipment	Assistive technologies including telecare	0	8000	8000	Number of beneficiaries	Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 177,000	£188,392		Avanda Michell
98	Provider Service Redesign	Additional capacity to support service transformation	Other	0	0	3	3		0	0	0	0	0	0	Local Authority Discharge	£ 200,000	£88,689		Avanda Michell - Liz Callear for outputs, 3 staff in post
79	Cera Fast Response	Cera - Fast Response - additional capacity to accommodate discharge - up	Home Care or Domiciliary Care	0	0	0	261	Hours of care (Unless short-term in which case it is packages)	0	0	0	0	0	0	Local Authority Discharge	£ 130,000	£0		Avanda Michell - Liz Callear for outputs. Home from hospital Cera client no's from Apr 24 to March 2025

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'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	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	Planned Expenditure (£)	Expenditure to date (£)

Better Care Fund 2024-25 EOY Reporting Template

8. Year End Impact Summary

Selected Health and Wellbeing Board: Rotherham

Confirmation of Statements			Checklist Complete:
Question statements	**Confirmation**	**If the answer is "No" please provide an explanation:**	
Overall delivery of BCF has improved joint working between health and social care	Yes		Yes
Our BCF schemes were implemented as planned in 2024-25	Yes		Yes
The delivery of our BCF plan 2024-25 has had a positive impact on the integration of health and social care in our locality.	Yes		Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:		
Logic model for integrated care - SCIE		
Success and Challenges	**Narrative**	
2 key successes observed towards driving the enablers for integration	Phase 1 of Rotherham's integrated health and social care Transfer of Care hub has been completed with nursing, therapy, social workers, wellbeing officers and hybrid support workers co-located to triage, refer and assess people to either remain at home, avoiding an unneccessary admission or support discharge to the correct pathway. Another key success is that funding has been provided to improve the health and wellbeing of unpaid carers in Rotherham through a small grants programme. Unpaid carers have reported that this had improved their physical, mental, emotional and social well-being.	Yes
2 key challenges observed towards driving the enablers for integration	Adult Social Care faces an increase in demand for services with an ageing population. We are seeing people with higher levels of acuity, dependency and complexity and more people are presenting at A&E than ever before. A further challenge is also the cost of living crisis which is placing additional pressure on existing budgets and having an impact on the sustainability of the residential and nursing care market, particularly nursing EMI and home care providers. A 5.5% increase has been agreed for all adult social care commissioned providers for 2025-26.	Yes