Better Care Fund 2024-25 Q2 Reporting Template

1. Guidance

Overview

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

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

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

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

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

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

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

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

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

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

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

4. Metrics

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

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

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

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

- on track to meet the ambition
- Not on track to meet the ambition
- data not available to assess progress

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

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

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

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.
Activity
'For reporting across 24/25 we are asking HWB's to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs particularly for winter and ongoing data issues.
5.2 C&D H1 Actual Activity
Please provide actual activity figures for April - September 24, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Useful Links and Resources

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

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

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

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

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

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

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2. Cover

Version 3.6

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:	Redcar and Cleveland
Completed by:	Kathryn Warnock
E-mail:	kathryn.warnock@nhs.net
Contact number:	07766554805
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'. This does not apply to the ASC

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

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

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

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3. National Conditions

Selected Health and Wellbeing Board: Redcar and Cleveland

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

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4. Metrics

Selected Health and Wellbeing Board: Redcar and Cleveland

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	200.0	158.0	188.4	151.6	240.3	Not on track to meet target	Q1 saw a higher than expected regional rate of admissions, but early Q2 data shows an improvement. The challenges are our demographics which are well recognised. We don't have any support needs at this stage.	Our BCF funded admission avoidance and prevention schemes, such as our support to care home schemes, continue to contribute to reduce unplanned admissions, alongside wider initiatives such as UCR and hospital at home.	We will review this after we receive Q2 data, but STHFT and NTHFT are currently still submitting Same Day Emergency Care (SDEC) activity to Inpatients. However, the removal of this activity to ECDS was reflected in our Avoidable Admissions and Falls plans	We are only slightly over target so feel that the initiatives we have in place will help us achieve the target year end We will continue to collectively monitor performance throughout the year through review of BI information and at regular meetings.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.4%	92.4%	92.5%	92.5%	91.23%	On track to meet target	Although slightly under target for Q1 we hope this will improve in Q2. We have not identified any particular challenges or support needs and are confident in our joined up processes to facilitate discharges.	We have numerous schemes and initiatives in place to support this metric including our Transfer of Care Hub, Home First Service and increased reablement capacity.	Our ongoing implementation of discharge to assess could potentially mean fewer people are discharged straight from hospital to 'home' but maximises their potential to return home after the assessment period.	Not required	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,580.7	308.0	On track to meet target	Performance is better than expected.	We continually aim to reduce emergency admissions due to falls through our BCF funded initiatives such as assistive techology and support to care homes and through the joint plans being developed around falls prevention. We have a South Tees falls prevention strategy in place with a clear action plan to make preventing falls 'everyone's business' and we have a 'Steady on Your Feet' self-assessment on line tool.	N/A	Not required	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	712				not applicable	Not on track to meet target	Although a lower rate than in comparison to previous years, we are currently above target due in part to higher numbers of adults being discharged from hospital on Pathway 2 converting from D2A funded placements to long term care and also due to the Local Authority demographics. No support needs are currently identified.	The Transfer of Care Hub processes continue to sustain improved hospital discharge flow and focus on a home first pathway 1 discharge wherever possible. We are increasing our investment in reablement and independence teams and infrastructure to ensure we are better equipped to support people discharged from a period of hospital stay to return to their preferred place of residence. Our increased BCF spend on Unpaid Carer Support will also increase the offer to carers to reduce carer breakdown and premature admission to residential care facilities.	The probable reasons for the variance from plan are outlined in the challenges section. We currently only have Q1 data so will review again when the latest information is available.	We hope our ongoing initiatives and focus on pathway 1 discharges with reablement wherever possible will bring us back on target. Care home and home care capacity remains good.	Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Redcar and Cleveland

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	
Estimates for capacity and demand are as predicted. There is fluctuation in demand but this is within anticipated levels. Increased capacity and efficiency in our Home First Service has enabled more referrals to be taken for reablement at home. We are seeking some dedicated BI support to help with capacity and demand planning.	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
We have a weekly operational meeting with colleagues from the acute hospitals, ICB, NECS and neighbouring Local Authorities. This responds to any challenges in terms of demand and capacity and manages winter surge activity. Strategically we have the South Tees Strategic Oversight Group which will support with escalation as required. Our multi-agency Transfer of Care Hub continues to support with safe, appropriate and timely discharges from hospital which helps to free up capacity and BCF and Discharge Fund investment in reablement services supports with discharges and admission avoidance. We continue to fund a Discharge to Assess period for patients in pathways 1 and 2 from the Discharge Funding available until March 2025.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
None identified currently.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
Our commissioning model allows for flexibility to support periods of peak demand	Yes

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

5.1 Guidance

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

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

- actual demand in the first 6 months of the year
- modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

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

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

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

- Other short term bedded care (pathway 2)

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

Community

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

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

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5. Capacity & Demand

Selected Health and Wellbeing Board: Redcar and Cleveland

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)					
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	41	42	41	41	40	41	78	71	65	87	81	75	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2.6	2.6	2.6	2.6	2.6	2.6	2.1	2	1.7	1.7	5.9	1.6						
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	0	0	0	0	0	0						
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	21	21	20	21	20	21	24	20	18	19	18	18	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	3.2	3.2	3.2	3.2	3.2	3.2	1.6	2	1.6	1.7	2	2.3						
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	19	19	19	20	19	19	28	13	16	19	9	17	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	5	5	5	5	5	2.5	2.9	2	1.7	3.6	5.1						
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	5	5	5	6	5	5	1	1	2	1	4	2	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	6.5	6.5	6.5	6.5	6.5	6.5	1	1	1	1	1	1						

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Social support (including VCS)	Monthly activity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10
Urgent Community Response	Monthly activity. Number of new clients.	548	602	643	590	610	600	540	534	527	589	593	547
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	5	5	5	5	4	5	10	10	10	10	10	10
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	6	6	6	6	6	6	5	4	6	5	5	6
Other short-term social care	Monthly activity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Yes
Yes
Yes
Yes
Yes

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

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

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

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

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Redcar and Cleveland

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£1,952,698	£558,836	28.62%	£1,393,862
Minimum NHS Contribution	£14,491,426	£7,162,405	49.43%	£7,329,021
iBCF	£6,927,994	£3,463,997	50.00%	£3,463,997
Additional LA Contribution	£1,694,502	£867,500	51.19%	£827,002
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,618,823	£728,751	45.02%	£890,072
ICB Discharge Funding	£1,247,473	£577,426	46.29%	£670,047
Total	**£27,932,916**	**£13,358,915**	**47.82%**	**£14,574,001**

Comments if income changed

Required Spend

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

	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,130,284	£2,606,394	£1,523,890
Adult Social Care services spend from the minimum ICB allocations	£8,621,497	£5,098,004	£3,523,493

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
1	Recovery and Reablement - Social Care CCG	Community Reablement & Independence Team	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1612	806	Packages	Social Care		NHS			Local Authority	Minimum NHS Contribution	£1,117,750	£558,875	
1	Recovery and Reablement - Community Health	Community Reablement & Independence Team	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		162	81	Packages	Social Care		NHS			Local Authority	Minimum NHS Contribution	£112,150	£56,075	
1	Recovery and Reablement - Additional Rapid	Community Reablement & Independence Team	Urgent Community Response			0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£147,950	£73,975	
1	Recovery and Reablement	Community Reablement & Independence Team	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		878	439	Packages	Social Care		NHS			Local Authority	iBCF	£578,600	£289,300	
2	Supported Living	Supported Living Schemes	Housing Related Schemes			0	0		Social Care		NHS			Private Sector	Minimum NHS Contribution	£25,653	£9,916	
3	Intermediate Care Centre	Intermediate Care Centre - a 40 bed facility.	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		357	179	Number of placements	Social Care		NHS			Local Authority	Minimum NHS Contribution	£1,766,600	£883,300	
3	Intermediate Care Centre - Therapists	Therapists providing reablement at the Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		357	179	Number of placements	Social Care		NHS			NHS Acute Provider	Minimum NHS Contribution	£332,000	£166,000	
3	IC Medical Cover	GP medical cover for patients at the Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		357	179	Number of placements	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£5,273	£2,637	
4	Carers Support Service	Identification, advice and support	Carers Services	Carer advice and support related to Care Act duties		1649	825	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£233,200	£86,530	
5	Young Carer Support	Support to young carers	Carers Services	Carer advice and support related to Care Act duties		849	424	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£56,250	£28,125	
6	Hospital Based Carer Support	Information and support in hospitals	Carers Services	Carer advice and support related to Care Act duties		178	89	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£38,800	£16,161	
7	Digital Explorers	To support adults age 55+ to expand their knowledge and confidence in using digital	Assistive Technologies and Equipment	Digital participation services		184	92	Number of beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£30,000	£12,500	
8	Befriending	Age UK - befriending service for older people in their own home	Prevention / Early Intervention	Social Prescribing		0	0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£45,492	£11,150	
9	MIND reablement - mental health recovery	Mental Health service for older people	Prevention / Early Intervention	Other	Other mental health/wellbeing	0	0		Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£28,815	£6,250	

10	Welfare Rights - advice service in GP surgeries	Contribution to welfare rights service to provide advices sessions in GP surgeries	Prevention / Early Intervention	Social Prescribing		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£61,400	£30,700	
11	Overnight Planned Care Service	Specific service for clients in own home requiring dom care during the night -	Home Care or Domiciliary Care	Domiciliary care packages		12000	6000	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£282,957	£141,475	
12	Care Act Provision	Care Act Implementation Duties	Care Act Implementation Related Duties	Other	Maintaining Social Care		NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£587,575	£293,800	
13	Urgent Care Admissions and Avoidance - 3	3 consultants at A&E	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£143,735	£71,868	
14	Urgent Care Admissions and Avoidance -	Therapies AAU	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£174,256	£87,128	
15	Urgent Care Admissions and Avoidance - 7 day	7 Day Staffing/Medical Decision Maker	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£296,494	£148,247	
16	Emergency Performance at Acute Provider	To support current acute activity	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£1,733,441	£866,721	
17	Disabled Facilities Grants	Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		207	63	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£1,952,698	£558,836	Delays due to reduced staff capacity
17	Disabled Facilities Grants	Adaptations	DFG Related Schemes	Handyperson services		2377	1189	Number of adaptations funded/people supported	Social Care		LA			Local Authority	iBCF	£198,450	£99,225	
18	Integration and Practice Standards team	Team who design and aid implentation of intergration	Enablers for Integration	Integrated models of provision			NA		Social Care		LA			Local Authority	iBCF	£110,550	£55,275	
19	Residential Care	Residential Placements	Residential Placements	Care home		34	17	Number of beds	Social Care		LA			Private Sector	iBCF	£1,377,750	£688,875	
19	Residential Care	Residential Placements	Residential Placements	Care home		53	27	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,247,252	£1,123,611	
20	Home Care	Ensuring people receive the necessary care provision to enable them to remain in	Home Care or Domiciliary Care	Domiciliary care packages		165000	82500	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£3,357,894	£1,678,947	
20	Home Care	Ensuring people receive the necessary care provision to enable them to remain in	Home Care or Domiciliary Care	Domiciliary care packages		82000	41000	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,773,135	£886,568	
21	Direct Payments	Personalised budgeting re. care plans and packages	Personalised Budgeting and Commissioning				NA		Social Care		LA			Private Sector	iBCF	£1,100,800	£550,400	
21	Direct Payments	Personalised budgeting re. care plans and packages	Personalised Budgeting and Commissioning				NA		Social Care		LA			Private Sector	Minimum NHS Contribution	£761,732	£380,866	
22	CHESS urgent response and training - support	Urgent response arrangement for care homes re. medical emergencies etc	Urgent Community Response			0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£215,202	£107,601	
23	Medicines Management	Pharmacy techs doing care home audits improving the way care homes handle	Prevention / Early Intervention	Risk Stratification	Preventing admissions to acute setting	0	0		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£63,781	£31,891	
24	Nutrition Team	Nutrition and hydration training and support to care homes across South Tees	Prevention / Early Intervention	Risk Stratification		0	0		Community Health		NHS			Local Authority	Minimum NHS Contribution	£117,759	£100,110	
25	End of Life	CCG SPC nurse developing training and support to care homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£31,282	£15,641	
26	Infection Control	CCG Infection Prevention Control Nurse training to care homes	Prevention / Early Intervention	Risk Stratification		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£32,144	£16,072	
27	Trusted Assessor Lead	Trusted Assessor to supervise and lead the Trusted Assessor Team	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£50,150	£22,721	
27	Trusted Assessor - Care Homes	Trusted Assessor to facilitate patient discharge to care homes	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£52,800	£23,274	
27	Trusted Assessor - Intermediate Care Centre	Trusted Assessor to facilitate patient discharge to care homes	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£50,950	£0	No one in post currently
27	Trusted Assessor - Mental Health	Trusted Assessor to facilitate patient discharge re mental health patients	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£48,250	£21,612	
28	Single Point of Access	Multi disciplinary service hub to provide first point of contact	Integrated Care Planning and Navigation	Assessment teams/joint assessment			NA		Community Health		NHS			Local Authority	Minimum NHS Contribution	£55,260	£15,142	
28	Single Point of Access - Social Worker	Social Worker to help enable multi disciplinary service hub to provide first point of	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£51,650	£25,825	

28	Single Point of Access - Coordinator & Call	Co-ordinator and call handler to help enable multi disciplinary service hub to	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£60,333	£30,167	
29	BCF Project Management	To manage and administer the BCF programme	Enablers for Integration	Programme management		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£123,551	£115,500	
30	Seven Day Working Hospital Social Work Team	To enable 7 day working and facilitate 7 day hospital discharges	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		0	0		Social Care		LA			Local Authority	Minimum NHS Contribution	£194,850	£97,425	
31	DTOC Officer	Officer dealing with the avoidance of delayed transfers of care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Acute		NHS			Local Authority	Minimum NHS Contribution	£58,850	£26,630	
32	OT Postural Management	OT staffing to facilitate, advise and support in respect of postural management in care	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		NHS			Local Authority	Minimum NHS Contribution	£58,883	£29,425	
33	Health Call - remote clinical monitoring in care	Remote clinical monitoring system for care homes	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Community Health		NHS			NHS	Minimum NHS Contribution	£44,000	£22,000	
34	EDT Frailty Team - 7 day service	Frailty team for Emergency Department to reduce admissions of frail patients	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£275,000	£137,500	
35	Falls Training	OT training for care home staff on falls prevention and management	Prevention / Early Intervention	Risk Stratification			NA		Community Health		LA			Local Authority	Minimum NHS Contribution	£46,230	£24,867	
36	Transfer of Care Hub	Strategic System Lead and 4 Care Co-ordinators to expand an intergrated transfer of	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£127,500	£63,750	
37	South Tees Home First Service	A Home First community based service to ensure that patients are discharged home	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£250,000	£125,000	
38	Meds Support in the Community	To support home care providers with effective training and support to	Prevention / Early Intervention	Risk Stratification	Preventing admissions to acute setting	0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£47,198	£23,599	
39	Deprivation of Liberty Best Interest	Contribution to the costs of DOLS BIA assessments and legal fees	Care Act Implementation Related Duties	Safeguarding			NA		Social Care		LA			Local Authority	iBCF	£203,950	£101,975	
40	Tees Valley Digital Care Home Support	To provide IT digital support to care homes re. NHS mail, Microsoft Teams etc	Enablers for Integration	System IT Interoperability		0	0		Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£58,765	£29,383	
41	Discharge to Access Occupational	OT staff to assess and facilitate discharges from care homes within a 4 week period	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0		Community Health		LA			Local Authority	Minimum NHS Contribution	£100,350	£51,089	
42	Risk Share	Continuation of D2A funded schemes	Other		Discharge to assess remains a potential risk to	0	0		Community Health		NHS			NHS	Minimum NHS Contribution	£148,167	£397	
43	Effective Discharge -D2A Pathways	To facilitate streamlined D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		128	64	Number of placements	Continuing Care		NHS			Private Sector	Local Authority Discharge	£1,229,478	£614,739	
45	Care Home Seating & Postural Care Support	Specialist Chairs for Care Homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		LA			Private Sector	Additional LA Contribution	£25,000	£16,372	
46	VCS Supporting Discharge	VCS Service working alongside the Transfer Of Care Hub to ensure that the	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Community Health		LA			Charity / Voluntary Sector	Additional LA Contribution	£100,000	£39,333	
47	Animal Assisted Therapy	Visits to individuals in their homes with trained therapy dogs	Personalised Care at Home	Mental health /wellbeing		0	0		Community Health		LA			Private Sector	Additional LA Contribution	£10,000	£0	Discontinued. Funding no longer required
52	Risk Share	Continuation of D2A funded schemes	Other		Discharge to assess remains a potential risk to	0	0		Community Health		NHS			NHS	Additional LA Contribution	£447,279	£400,544	
53	Effective Discharge -D2A Pathways	To facilitate streamlined D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		13	6	Number of placements	Continuing Care		NHS			Private Sector	ICB Discharge Funding	£131,057	£65,528	
54	Reablement - overtime payments	To fund overtime payments to Reablement Staff	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		24	12	Packages	Social Care		LA			Local Authority	ICB Discharge Funding	£15,532	£7,766	
55	Social Care Flow Lead	Officer to facilitate proactive co-ordination of social care flow	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care		LA			Local Authority	ICB Discharge Funding	£48,500	£29,547	
56	Interim Travel payments	Interim Travel Payments to Domiciliary care users	Workforce recruitment and retention				NA	WTE's gained	Social Care		LA			Private Sector	ICB Discharge Funding	£44,976	£22,488	
58	Tees Community Equipment Services	Additional resources to support increased discharge requirements	Assistive Technologies and Equipment	Community based equipment		348	230	Number of beneficiaries	Community Health		NHS			Local Authority	ICB Discharge Funding	£77,321	£38,661	
59	Complex Discharge Co-ordinator	Officer for early identification of complex hospital discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			NHS Acute Provider	ICB Discharge Funding	£13,943	£6,972	
60	In reach assessment & support for	A dedicated in-reach nurse at Teesside Hospice	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		NHS			NHS Community Provider	ICB Discharge Funding	£25,950	£12,975	

61	Ambulance Discharge Costs	Funding to support patient transport for discharges	Other			0	0		Other		NHS			NHS	ICB Discharge Funding	£124,000	£62,000	
62	Enhanced Reablement & Independence	Increasing Capacity in Reablement & Rapid Response	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		562	281	Packages	Social Care		LA			Local Authority	Local Authority Discharge	£389,345	£114,012	
68	Therapies Team - Intermediate Care Centre	Employment of an additional therapist to enhance the capacity of the existing	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		56	28	Number of placements	Social Care		LA			Local Authority	ICB Discharge Funding	£50,470	£23,639	
70	Home Group Tees Valley Mental Health Hospital	Team offers housing and social support to patients following discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			Charity / Voluntary Sector	ICB Discharge Funding	£64,125	£32,063	
71	South Tees Domiciliary Care Medication	Two pharmacy technicians posts to support and facilitate medicines pathways.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health		NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£53,167	£26,584	
72	South Tees - Intergrated Therapy Triage -	Two intergrated therapist posts for centralised triage team.	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	0		Community Health		NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£73,444	£36,722	
17	Disabled Facilities Grants	Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants	0	71	35	Number of adaptations funded/people supported	Social Care		LA	0.0%		Private Sector	Additional LA Contribution	£668,826	£334,413	
63	Enhanced Resource to Improve Pathway	An additional team manager within the Transfer of Care Hub and a D2A Lead Co-	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Acute		LA	0.0%		Local Authority	ICB Discharge Funding	£130,600	£63,371	
73	2 Brokerage Officers	Increasing capacity within the Brokerage team will enable officers to directly reduce the	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	ICB Discharge Funding	£72,299	£35,501	
74	Data Analyst	Data Intergration to support commissioning	Enablers for Integration	Joint commissioning infrastructure	0	0	0		Social Care		LA	0.0%		Local Authority	ICB Discharge Funding	£48,700	£22,263	
75	Digitalisation of telecare	Ensuring switch over from analogue to digital services	Assistive Technologies and Equipment	Digital participation services	0	1500	750	Number of beneficiaries	Community Health		LA	0.0%		Local Authority	ICB Discharge Funding	£100,000	£50,000	
76	Overtime for front line care staff.	Overtime for front line care staff to facilitate timely discharge arrangements and	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	ICB Discharge Funding	£300,000	£104,652	
77	Commissioning Officer VCS Supporting	VCS Service working alongside the Transfer Of Care Hub to ensure that the	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health		LA	0.0%		Local Authority	Additional LA Contribution	£46,332	£16,158	
78	Carers Cost of Living Fund	Grants to unpaid carers	Carers Services	Other	Grants to assist - food vouchers/white	50	25	Beneficiaries	Social Care		LA	0.0%		Charity / Voluntary Sector	Additional LA Contribution	£20,000	£10,000	
79	Carers Together - counselling and psychotherapy	Counselling and psychotherapy service for carers experiencing emotional	Carers Services	Other	Counselling and psychotherapy service for carers	75	38	Beneficiaries	Social Care		LA	0.0%		Charity / Voluntary Sector	Additional LA Contribution	£18,200	£18,200	Scheme complete
80	Best Interest Assessor	The Assessor will liaise with ward staff, linking into TOC Hub to support complex	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£48,819	£0	There has been a delay in starting this scheme but it will go ahead
81	Meadowgate Intermediate Care Centre - Culture	Learning programme for all staff delivered through MGI and the Mindset, Language	High Impact Change Model for Managing Transfer of Care	Other	Learning programme for all staff delivered	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£22,500	£0	There has been a delay in starting this scheme but it will go ahead
82	Community Reablement Service - Access	Implementation of the Access CM system will improve the pathway 1 discharge interface	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity	0	0	0		Social Care		LA	0.0%		Private Sector	Additional LA Contribution	£43,400	£0	There has been a delay in starting this scheme but it will go ahead
83	Ask SARA	The initiative will promote adults' independence, by using a self-assessment tool	Assistive Technologies and Equipment	Other	Assistive Technologies and Equipment	1320	660	Number of beneficiaries	Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£20,750	£0	There has been a delay in starting this scheme but it will go ahead
84	Enhanced OT Assessment Clinic - Meadowgate	We propose to further maximise the current offer, with assistive technology and	High Impact Change Model for Managing Transfer of Care	Other	We propose to further maximise the current offer,	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£20,000	£0	There has been a delay in starting this scheme but it will go ahead
85	SCO Post supporting discharge from	The additional post will work to support a reduction in delayed transfer of care and	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£41,000	£0	There has been a delay in starting this scheme but it will go ahead
86	Digital Solutions to Support Unpaid Carers	The procurement of digitally-compatible telecare equipment with the specific	Assistive Technologies and Equipment	Assistive technologies including telecare	0	400	200	Number of beneficiaries	Community Health		LA	0.0%		Private Sector	Additional LA Contribution	£45,000	£11,250	
87	Sustaining Tenancies, Enabling People	STEP prioritises helping adults access safe and secure accommodation, this support	Housing Related Schemes	0	0	0	0		Social Care		LA	0.0%		Charity / Voluntary Sector	Additional LA Contribution	£72,228	£0	There has been a delay in starting this scheme but it will go ahead
88	Brokerage Officer - Complex Needs	An additional Officer in the service will not only improve performance overall, as well	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£35,668	£0	There has been a delay in starting this scheme but it will go ahead
66	Mental Health Support for Homecare Staff	To support home care staff through the programme Mind Matters	Other	0	To support home care staff through the programme	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£9,500	£11,875	Slight overspend but scheme now complete

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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 (£)
89	We Care You Care	Website development to give information and guidance for all carers across the South	Carers Services	Carer advice and support related to Care Act duties		100	50	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£21,235	£0
90	Transfer of Care Access Business Support	Administrative support to Hospital Social Work Team based at the Transfer Of Care	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Additional LA Contribution	£25,500	£9,355