TORBAY COUNCIL

Clerk:	Governance Support	Governance Support
Telephone:	01803 207013	Town Hall
E-mail address:	governance.support@torbay.gov.uk	Castle Circus
Date:	Friday, 13 June 2025	Torquay
		TQ1 3DR

Dear Member

HEALTH AND WELLBEING BOARD - THURSDAY, 19 JUNE 2025

I am now able to enclose, for consideration at the Thursday, 19 June 2025 meeting of the Health and Wellbeing Board, the following reports that were unavailable when the agenda was printed.

Agenda No	Item	Page
5.	**Better Care Fund - Chris Lethbridge**	(Pages 3 - 130)
9.	**Turning the Tide on Poverty - Lincoln Sargeant/Julia Chisnell**	(Pages 131 - 138)

Yours sincerely

Governance Support
Clerk

This page is intentionally left blank

TORBAY COUNCIL

Title: **Torbay Better Care Fund End of Year Return 2024 – 25 &**

Torbay Better Care Fund 2025-26 Plan

Wards Affected: All

To: Torbay Health and Wellbeing Board **On: 19 June 2025**

Contact: Justin Wiggin, Senior Locality Manager, NHS Devon

E-mail: justin.wiggin@nhs.net

1. Purpose

Torbay Better Care Fund (BCF) Plan has been submitted in line with national timelines and requirements. Torbay's plan received approval from the regional BCF panel, progressed to the national panel where it has also been endorsed. The Torbay Better Care Fund Plan is being presented to Torbay Health and Wellbeing Board in-line with national requirements.

The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery. This report:

- Provides an update on the BCF performance and spend for 2024/25 (copy attached).
- Provides details of the BCF plan for 2025/26 (copy attached).

2. Analysis

2.1 BCF Outturn for 2024/25

In June, Torbay's End of Year 24/25 template return was submitted in accordance with national requirements.

2.2 Metric Targets

2.2.1 Avoidable Admissions

Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions rate per 100,000 population – a set of conditions such as acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, and pulmonary oedema.

We measure this as we would expect to be able to manage these conditions without a need for hospital admission.

Performance for 2023/24:

		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Torbay	2024/25 Target	172	172	172	172
	2024/25 actual	195.7	199.2	183.1	172.

Data at the time of submission indicates Torbay's performance was **on track** to meet the target in Quarter 4 and an improving position throughout the 2024/25 financial year. Further information is provided in the planning return.

2.2.2 Falls

Definition: Emergency hospital admissions due to falls in people aged 65 & over, directly standardised rate per 100,000.

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes. This measure is an important measure around joint working between adult social care and health partners (e.g. urgent community response services) to prevent hospital admissions and reduce falls which will improve outcomes for older people and support independence. We measure this as with the right support in place we should be able to prevent falls in older people.

This was a new BCF indicator in 2023/24.

	2024/25 Plan for year	Outturn 2024/25
Torbay	1968.4	2144

Data at the time of submission indicates performance for the Local Authority area was **not on track** to meet the target. Whilst the target has not been met in 2024/25 this is an improved position from 2023/24 where the outturn achieved 2221.9 per 100,000 population. Further information is provided in the planning return.

2.2.3 Discharge to Usual Place of Residence

Definition: The percentage of people who are discharged from acute hospital to their usual place of residence.

We measure the number of people who return to their usual place of residence at the point of discharge to ensure as many people as possible are able to return to living independently at home.

Performance for 2024/25:

		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Torbay	Planned	91.3%	91.3%	91.3%	91.3%
	Actual (est)	91.06%	89.8%	89.87%%	90.25%

Data at the time of submission indicates performance within Torbay was **not on track** to meet the target. Further information is provided in the planning return.

2.2.4 Residential Admissions

Definition: Long-term support needs of older people (65 & over) met by admission to residential & nursing care homes per 100,000 population.

Avoiding permanent placements in residential and nursing care homes is a good measure of our ability to support people to live independently at home for as long as possible.

	2024/25 Plan	2024/25 Actual
Torbay	669	810

The metric has been classified as **"data not available"**. Draft data was included in the return to suggest 907 admissions per 100,000 population. 810 admissions per 100,000 population has been published.

There is a caveat in the application of this data. The target was set using SALT return methodologies. The methodology of data collection and breadth of information has changed. Local Authorities are now requested to use a Client Level Dataset (CLD). Due to differences in national guidance between previous and new data collection methodologies, this does not allow the 2024/25 actual performance to be measured against the 2024/25 plan.

3 Torbay HWBB BCF Plan 2025/26

3.1 Situation

The Department for Health and Social Care (DHSC) and NHS England (NHSE) published guidance, January 2025 for the development of Better Care Fund (BCF) Plans for the 2025-26 financial year.

BCF Plans require joint development between Integrated Care Boards, Local Authorities, NHS providers and voluntary, community and social enterprise sector to develop a joint plan to further support integration in local areas, address national objectives and work to achieve delivery against key performance indicators BCF seeks to positively impact.

Torbay's plan has been developed jointly with system partners, co-written and co-produced via BCF governance arrangements and planning meetings along with wider engagement via Local Care Partnership meetings where possible.

The 2025-26 planning guidelines outlines the need for Integrated Care Board and Local Authority Chief Executives to sign off plans. Local Health and Wellbeing Boards retains oversight and formal endorsement for BCF Plans to be "signed off" by local systems.

3.2 Background

The Better Care Fund (BCF) is the only mandatory policy to facilitate integration between Health and Social Care, providing a framework for joint planning and commissioning. The BCF brings together ring-fenced budgets from NHS allocations, ring-fenced BCF grants from Government, the Disabled Facilities Grant, and voluntary contributions from local government budgets. Each Health and Wellbeing Board has responsibility for the oversight of the BCF and is accountable for its delivery.

3.3 National Policy and Planning

National planning requirements for the BCF are set out within The Better Care Fund (BCF) Policy Framework and was published on January 2025 by DHSC & DLUHC. The Policy Framework set out the Government's objectives for 2025-26 including:

Objective 1: reform to support the shift from sickness to prevention

- Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:
- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

Objective 2: reform to support people living independently and the shift from hospital to home

- Local areas must agree plans that:
- help prevent avoidable hospital admissions
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care

The following table provides an overview of planning timescales. BCF plans are expected to be submitted 31 March 2025. Due to NHS Devon Executive Committee, meeting 1 April 2025, NHSE BCF Leads have approved and extension of Devon's submission date to 1 April 2025.

Date	Publication/key milestone
30 January 2025	Better Care Fund planning requirements published • submission guidance, metrics handbook and headline frequently asked questions available on Better Care Exchanges • planning template HWB submission templates available to systems on Better Care Exchange. • HWB areas allocations available on Better Care Exchange
3 February 2025 onwards	Webinar series to support local planning – full details to be shared via BCF bulletin and Better Care Exchange.
Week commencing 27 January 2025	Functional template issued followed functional testing.
February	Proactive and supportive discussions with HWB areas or groups of areas at risk of facing higher challenge to successful delivery.
3 March 2025	Draft headline HWB submissions to be made to regional better care managers for feedback and discussion.
31 March 2025 (noon)	Full HWB submission to be made to the national Better Care Fund team and regional better care managers.
May	Outcome letters to HWB areas.
30 September 2025	Section 75 agreements must be in place across HWB areas.

Three documents form the combined elements of a Better Care Fund Plan. These are:

1. Narrative Plan
2. Planning Template – focusing on utilisation of finance and targets aligned to key performance indicators
3. Demand and Capacity Plans – focusing on complex discharge (pathway 1-3 discharges) and community capacity to avoid admission

Devon, Plymouth and Torbay plans are included in the appendix of this report.

3.4 Monitoring Better Care Fund

Monitoring of Better Care Fund plans will be undertaken on a quarterly basis, and will commence in quarter 1 2025-26. These reports will need to be signed off by HWB chairs ahead of submission. Reporting will be streamlined from previous years and include:

- a short narrative on progress against metrics
- spend to date
- where planned expenditure has changed, a summary of important changes and confirmation that these have been agreed by local partners and continue to meet national conditions
- A full end-of-year report will also be required to account for spend and this report will also be required to include a comparison with the intermediate care demand and capacity plan.

3.5 Enhanced support and oversight

Where Better Care Fund plans are adrift from agreed trajectories including both finance and performance, local areas will be required to engage in enhanced support and oversight from NHSE.

The reason for enhanced support and oversight may include, but not be limited to:

- current performance against headline metrics (2024-25) – and therefore risks to performance in 2025-26
- the identification of significant risks through the assurance process
- failure of HWB areas to agree a plan
- not meeting BCF national conditions across the 2025-26 delivery cycle

4 Key Focus of BCF Activity

Torbay's BCF plan has been developed locally, however ensures consideration is given to strategic commissioning and delivery across the wider Devon ICS footprint. This has ensured an element of consistency across Torbay, Devon and Plymouth. Where programmes of activity apply solely to Torbay HWBB area this has been clearly outlined to provide a Torbay specific BCF plan. The plan also reflects local variation and nuances in how services are delivered.

The below table provides an overview of the three main themes which BCF plans described in terms of activity. BCF plans form part of wider system delivery and investments. The below outlines areas where BCF investments are being directly made along with activity funded and delivered via alternative sources and aligns where possible to delivery described within the NHS Operating Plan 2025-26 and Torbay Adult Social Care Transformation Programmes.

Shift from sickness to prevention	Support people living independently and the shift from hospital to home	Achieve more timely and effective discharge from acute
Timely, proactive and joined-up support for people with more complex health and care needs – **Neighbourhood Health Teams** • Population health management • Modern general practice • Standardising community health services • Neighbourhood multidisciplinary teams (MDT) • Integrated intermediate care • Urgent neighbourhood services	**Prevent hospital admission** Approaches to prevent hospital admissions includes: • Increase GP capacity to deliver a Same Day Primary Care Hub pilot • Delivery of enhanced health in care homes to provide a more proactive approach to managing the health needs of care home residents • Ensure sufficient capacity within Urgent Community Response • Delivery of Care Co-ordination Hub model sees the ambulance service stream suitable 999 calls to expert clinicians who can advise, prescribe and refer to appropriate primary and community pathways. • Delivery of High Intensity Users Programme to understand the reason for repeat attendance in ED and support the client with the route cause and wider social determinants which may be driving behaviours. • Same Day Emergency Care and Frailty Same Day Emergency Care diverting patient appropriately away from Emergency Departments to have their needs met by clinicians via an alternate model of care.	1) Establish robust **demand and capacity plans** to ensure market sufficiency for P1-3 discharges across Devon ICB footprint. 2) Ensure **robust and consistent data collection** against BCF metrics, focus on discharge to normal place of residence, NCTR and delays from discharge ready dates. 3) Review current VCSE capacity and delivery to inform a future **VCSE discharge support model** across Devon ICB 4) Learning from early adopter areas in Devon, **develop a revised pathway 1 reablement specification and contract** to achieve consistent outcomes across Devon ICB. 5) Consolidation of pathway 2 provision across Devon ICB including a review of capacity and **P2 therapeutic models** across localities, understand impact of **P2 reablement** block contracts procured in 2024/25 and define further commissioning intentions for 2025/26 working towards John Bolton / IPAC models within localities. 6) Focus on **shifting pathway demand** from pathway 2 to pathway 1 and **reduce lengths of stay across all pathways, including, improving assurance of quality of discharge and delivery of Home First approach** 7) 25/26 will see the creation of a bespoke pan-Devon **End of Life discharge pathway**.

5 Performance

BCF Policy Framework 2025/26 introduces a set of national headline and supplementary metrics:

1. Emergency admissions to hospital for people aged over 65 per 100,000 population
    a. *Unplanned hospital admissions for chronic ambulatory care sensitive conditions*
    b. *Emergency hospital admissions due to falls in people aged 65+*

2. Average length of discharge delay for all acute adult patients, derived from a combination of:

a. *proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)*
b. *for those adult patients not discharged on their DRD, average number of days from the DRD to discharge*
c. *Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 14-20 days and 21 or more.*

3. Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population
    a. *Hospital discharges to usual place of residence*
    b. *Proportion of people receiving short-term reablement following hospital discharge and outcomes following short-term reablement*

The below provides an overview of the agreed key performance indicators:

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,754	1,833	1,714	1,952	1,780	1,820	1,978	1,807	n/a	n/a	n/a	n/a
	Number of Admissions 65+	665	695	650	740	675	690	750	685	n/a	n/a	n/a	n/a
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	n/a	n/a	n/a	n/a
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
	Rate	1,641	1,672	1,588	1,670	1,625	1,588	1,738	1,638	1,722	1,688	1,662	1,635
	Number of Admissions 65+	622	634	602	633	616	602	659	621	653	640	630	620
	Population of 65+	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913

8.2 Discharge Delays

*Dec Actual annual data are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after	n/a	n/a	n/a	n/a	n/a	0.29	0.22	0.37	n/a	n/a	n/a	n/a
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	91.5%	91.8%	88.3%	n/a	n/a	n/a	n/a
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	3.4	2.7	3.2	n/a	n/a	n/a	n/a
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43
Proportion of adult patients discharged from acute hospitals on their discharge ready date	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	762.3	701.6	830.8	195.2	195.2	197.8	197.8
	Number of admissions	289	266	315	74	74	75	75
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913

6 Performance

The below table outlines the total financial values as reflected in the Torbay Better Care Fund 2025-26 plan.

Funding stream	Torbay
Disabled Facilities Grant	£2,641,358
NHS Minimum Contribution	£16,724,252
LA BCF Grant	£10,902,595
Additional LA Contribution	-
Additional NHS Contribution	-
Total	**£30,268,205**

Details of investments can be found in “planning template” for Torbay Health and Wellbeing Board.

7 Development of Section 75 Agreements

The s.75 (NHS Act 2006) Agreement which governs the use of the BCF will be signed by Devon County Council and NHS Devon ICB (Devon HWBB area) and Torbay Council, NHS Devon ICB and Torbay and South Devon NHS Foundation Trust (Torbay HWBB area), following confirmation of national approval of the 25/26 plan, by the 30 September 2025.

8. Recommendations

- Torbay Health and Wellbeing Board approves the 2024/25 End of Year Report.
- Torbay Health and Wellbeing Board approves the Torbay Better Care Fund Plan 2025 – 26.

Appendices

Background Papers:
The following documents/files were used to compile this report:

Appendix

List of background papers

Paper	
Torbay HWBB End of Year Return 2024-25	Torbay BCF_24-25 EOY Reporting Temp
Torbay HWBB BCF 2025-26 Narrative Plan	Torbay%20BCF%202025_26%20Narrative
Torbay HWBB BCF 2025-26 Planning Template	Torbay BCF 2025-26 Planning Template F
Torbay HWBB BCF 2025-26 Demand & Capacity Plan	Torbay BCF 2025-26 FINAL V2 Capacity ar

This page is intentionally left blank

Better Care Fund 2024-25 EOY Reporting Template

0

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

HM Government

NHS England

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:	Torbay	
Completed by:	Justin Wiggin	
E-mail:	justin.wiggin@nhs.net	
Contact number:	01803 396332	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Thu 19/06/2025	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

Complete

	Complete:	
2. Cover	Yes	For further guidance on requirements please refer back to guidance sheet - tab 1.
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	Expenditure Underspent or Overspent
8. Year End Feedback	Yes	

<< 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: Torbay

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off	
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.	
Confirmation of Nation Conditions	
National Condition	**Confirmation**
1) Jointly agreed plan	Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes

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:

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2024-25 EOY Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Torbay

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

Metric	Definition	For information - Your as reporte	
		Q1	Q2
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	172.0	172.0
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.3%	91.3%
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.		
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)		

nly be available system-wide and other local intelligence.

planned performance ed in 2024-25 planning 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
172.0	172.0	183.1	Target met
91.3%	91.3%	89.87%	Target not met
	1,968.4	410.5	Target not met
	669	not applicable	Data not available to assess progress

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*
High Intensity Use South Devon and Torbay Full complement of staff to deliver the service has not been in place during Q4 2024/25	High Intensity Use South Devon and Torbay Delivery of formal South HIU Service commenced Feb 2025, now with 4 months delivery in place. An initial snapshot of 5 clients indicates reductions by each
-	Funding for VCSE Organisations to support discharge Torbay •Home from Hospital support service •Long term asset-based support for those
Falls and Management Exercise (FAME) Waiting list for extended service continues to be high. SDEC	Falls and Management Exercise (FaME): •New specification aligned across West Devon, South Devon and Torbay, with aligned metrics. •South and Torbay 12 week programme now
We have used the methodology used to complete ASCOF returns for this metric before it was stood down, but we are aware that the recording of admissions data can be inconsistent which impacts accuracy when	Work ongoing to build reablement capacity/utilisation both within dedicated rehab bedded unit and within widening community offer to both reduce spot purchase for short term placements and

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*
Q4 Actual 128.1 against Q4 target of 172.0. There is very little data for March which has given a much lower value than expected. If we use January and February and assume similar performance then performance is	High Intensity Use South Devon and Torbay Recruitment now completed, full complement of staff to be in place July 2025. This will result in an increased number of clients being able to be worked with.
Q4 actual data 90.25%	Pathway 2 Discharge work being undertaken to develop discharge pathway in to Jack Sears and to ensure appropriate clients who require reablement are referred.
Full year impact is 2144 against a target of 1,968.4	E-TEP implementation Care Homes, Hospices and Primary Care have been given access to E-TEP systems. Frailty SDEC
Data as of March 2025 = 907	The 24/25 planned estimate was calculated using historical data with a consideration to the strategic direction to reduce the number of admissions, although our contract data shows a consistent increase in the number of

Complete:
Yes
Yes
Yes
Yes

Better Care Fund 2024-25 EO

5. Capacity & Demand

Selected Health and Wellbeing Board:

5.1 Assumptions

1. How have your estimates for capacity and demand changed since the last re

The Torbay BCF capacity and demand has seen changes in P1-3 activity compare
Pathway 1, -48% decrease in discharges
Pathway 2, 127% increase in discharges
Pathway 3, - 6% increase in discharges

Throughout 2024-25 Torbay has seen a difference in reported activity against pl

2. Do you have any capacity concerns for 25-26? Please consider both your co

There are no concerns regarding capacity for 25-26. For 25-26 Torbay will deve
Social Care Reablement to support discharge and avoid admission. Jack Sears is
people being discharged in to P2 short term service. Torbay will explore the ne

Urgent Community Response is performing well. Torbay has seen an increase ir
activity and will continue into 25/26.

3. Where actual demand exceeds capacity, what is your approach to ensuring last reporting period.

Whilst demand has differed from 2024/25 forecast, there is sufficient capacity v
footprint.

4. Do you have any specific support needs to raise? Please consider any priorit

None.

Guidance on completing this sheet is set out below, but should be read in conj

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative qu

You should reflect changes to understanding of demand and available capacity f

- 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

Hospital Discharge

This section collects actual activity of services to support people being discharge 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-terr

Community

This section collects actual activity for community services. You should input the recovery, including Urgent Community Response and VCS support and this appl

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Y Reporting Template

Torbay

eporting period? Please describe how you are building on your learning across the year where an

ed to the Q3 return. Compared to Q3:

lanned. Overall there appears to be 21.75% more discharges into the Torbay Council footprint (165

mmunity capacity and hospital discharge capacity.

lop a new community reablement / P1 reablement specification for for the independent sector ma
operating well with increased levels of occupancy as Torbay's therapeutic led P2 reablement provi
ed for further block arrangements with a strong reablement and outcomes focus.

n reported activity throughout 2024/25 with services working towards national targets. This has su

that people are supported to avoid admission or to enable discharge? Please describe how this ir

within the market to cater for needs. There are no concerns in realtion to the level of capacity avai

ties for planning readiness for 25/26.

junction with the separate guidance and q&a document

estions. Please answer all questions in relation to both hospital discharge and community sections

for admissions avoidance and hospital discharge since the completion of the original BCF plans, incl

the profile of discharge pathways.

ed from acute hospital. You should input the actual activity to support discharge across these differ

n care home placement (pathway 3)

e actual activity across health and social care for different service types. This should cover all servic
lies to all commissioned services not just those from the BCF.. The template is split into these types

	Checklist
y changes were needed.	
5 actual vs 1295 planned). There is	Yes
rket. This will complement UCR and sion. There are still high numbers of	Yes
pported both step up and step down	
nproves on your approach for the	
lable within the Torbay Council	Yes
	Yes

of the capacity and demand template.

uding

ent service types and this applies to all

:e intermediate care services to support
; of service:

Complete:

5. Capacity & Demand

Selected Health and Wellbeing Board:

Actual activity - Hospital Discharge
Service Area
Reablement & Rehabilitation at home (pathway 1)
Reablement & Rehabilitation at home (pathway 1)
Short term domiciliary care (pathway 1)
Short term domiciliary care (pathway 1)
Reablement & Rehabilitation in a bedded setting (pathway 2)
Reablement & Rehabilitation in a bedded setting (pathway 2)
Other short term bedded care (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)
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Actual activity - Community
Service Area

Social support (including VCS)
Urgent Community Response
Reablement & Rehabilitation at home
Reablement & Rehabilitation in a bedded setting
Other short-term social care

25 EOY Reporting Template

Torbay

	Prepopulated demand from 20	
Metric	**Jan-25**	**Feb-25**
Monthly activity. Number of new clients	59	56
Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	3	3
Monthly activity. Number of new clients	0	0
Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0
Monthly activity. Number of new clients	39	37
Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	6	6
Monthly activity. Number of new clients.	0	0
Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0
Monthly activity. Number of new clients	12	11
Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	3	3

	Prepopulated demand from 20	
Metric	**Jan-25**	**Feb-25**

Monthly activity. Number of new clients.	53	49
Monthly activity. Number of new clients.	189	183
Monthly activity. Number of new clients.	14	5
Monthly activity. Number of new clients.	12	12
Monthly activity. Number of new clients.	0	0

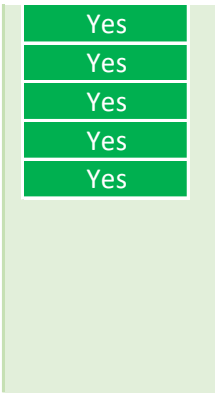
24-25 plan	Actual activity (not including spot purchased capacity)			Actual activity through only spc (doesn't apply to time to servic	
Mar-25	Jan-25	Feb-25	Mar-25	Jan-25	Feb-25
59	47	41	50	0	0
3	3	3	3		
0	0	0	0	0	0
0	0	0	0		
38	15	7	5	6	16
6	3	7	7		
0	0	0	0	0	0
0	0	0	0		
12	0	0	0	3	8
3	2	4	4		

24-25 plan	Actual activity:		
Mar-25	Jan-25	Feb-25	Mar-25

50	67	61	98
189	171	163	177
5	7	8	6
9	7	10	12
0	0	0	0

ɔt purchasing e)
Mar-25
0
0
8
0
3

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes


Yes
Yes
Yes
Yes
Yes

Better Care Fund 2024-25 EOY Reporting Template

6. Income actual

Selected Health and Wellbeing Board: Torbay

	2024-	
Source of Funding	Planned Income	Actual income
DFG	£2,321,869	£2,321,869
Minimum NHS Contribution	£14,646,915	£14,646,915
iBCF	£8,837,572	£8,837,572
Additional LA Contribution	£0	£0
Additional NHS Contribution	£0	£0
Local Authority Discharge Funding	£2,065,023	£2,065,023
ICB Discharge Funding	£1,848,000	£1,848,000
Total	**£29,719,379**	

25	
Carried from previous year (23-24)	Actual total income (Column D + E)
£0	£2,321,869
	£14,646,915
	£8,837,572
	£0
	£0
	£2,065,023
	£1,848,000
	£29,719,379

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Further guidance for completing Expe

Schemes tagged with the following will count towards the
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribut

Schemes tagged with the below will count towards the pla
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, onl
- **Source of funding** selected as 'Minimum NHS Contribut

2023-25 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes

5	DFG Related Schemes
6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)
12	Home-based intermediate care services
13	Urgent Community Response

14	Personalised Budgeting and Commissioning
15	Personalised Care at Home
16	Prevention / Early Intervention
17	Residential Placements
18	Workforce recruitment and retention
19	Other

Scheme type
Assistive Technologies and Equipment
Home Care or Domiciliary Care
Bed based intermediate Care Services
Home-based intermediate care services
Residential Placements
DFG Related Schemes
Workforce Recruitment and Retention
Carers Services

nditure sheet

planned **Adult Social Care services spend** from the NHS min:

ion'

anned **Out of Hospital spend** from the NHS min:

ly the NHS % will contribute)
ion'

Sub type
1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other
1. Independent Mental Health Advocacy 2. Safeguarding 3. Other
1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other
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

1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other
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
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
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

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

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

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

1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other
1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
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
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

Units
Number of beneficiaries
Hours of care (Unless short-term in which case it is packages)
Number of placements
Packages
Number of beds
Number of adaptations funded/people supported
WTE's gained
Beneficiaries

Description
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).
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.
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.
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'

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
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.
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.
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.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

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.
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.
Provides support in your own home to improve your confidence and ability to live as independently as possible
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.

Various person centred approaches to commissioning and budgeting, including direct payments.
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.
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.
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.
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.
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.

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: Torbay

	2024-25					
Running Balances	Income	Expenditure to date	Percentage spent	Balance		**If underspent, please provide reasons**
DFG	£2,321,869	£1,124,998	48.45%	£1,196,871	Underspent!	All underspend committed see narrative below
Minimum NHS Contribution	£14,646,915	£15,147,678	103.42%	-£500,763	Overspent!	Increased utilisation of Jack Sears
iBCF	£8,837,572	£8,933,709	101.09%	-£96,137	Overspent!	overspend on discharge hub and additional resources in Baywide community team to
Additional LA Contribution	£0	£0		£0		
Additional NHS Contribution	£0	£0		£0		
Local Authority Discharge Funding	£2,065,023	£1,055,015	51.09%	£1,010,008	Underspent!	lower than planned utilisation of dom care contracts.
ICB Discharge Funding	£1,848,000	£2,261,109	122.35%	-£413,109	Overspent!	over utilisation of P2 spot placements
Total	**£29,719,379**	**£28,522,509**	**95.97%**	**£1,196,870**	Underspent!	All underspend committed see narrative belowrelating to DfG

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	£3,614,290	£6,142,359	£0
Adult Social Care services spend from the minimum ICB allocations	£4,869,500	£10,425,830	£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	Front Door	First point of contact for adult social	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Social Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 158,490	£158,490		
2	Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		285	274	Number of adaptations funded/people supported	Other	DFG	LA			Private Sector	DFG	£ 2,321,869	£1,124,998		In addition to the circa £1.1m that has been spent on DFG adaptations in 24/25, approximately £1.2m of the original DFG
3	Carers Services	Care Act 2014 related duties	Carers Services	Carer advice and support related to Care Act duties		4656	6367	Beneficiaries	Social Care		LA			NHS	Minimum NHS Contribution	£ 989,955	£1,074,321		
4	SPACE LD Support in the Community	Provision for people with LD	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care		NHS			Private Sector	Minimum NHS Contribution	£ 150,630	£27,676		
5	Brixham Day Centre	Multi Disciplinary Teams that are supporting independence including Anticipatory Care	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 192,301	£188,269		
6	Technology Enabled Care	Using technology in care processes to support self management	Assistive Technologies and Equipment	Assistive technologies including telecare		358	640	Number of beneficiaries	Social Care		NHS			Private Sector	Minimum NHS Contribution	£ 305,357	£455,740		
7	Sensory Team	Supporting adults to live independent lives	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care		LA			NHS	iBCF	£ 445,035	£445,035		
8	Intermediate Care Baywide - (P&B)	Intermediate Care Teams	Home-based intermediate care services	Other	To support discharge, prevention of	1200	1021	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 418,414	£398,826		
9	Intermediate Care Baywide - (P&B)	Intermediate Care Teams	Bed based intermediate Care Services (Reablement,	Other	To support discharge, prevention of	480	78	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£ 418,414	£398,826		
10	Safeguarding	Implementation of Care Act duties in response to safeguarding	Care Act Implementation Related Duties	Safeguarding		0	0		Social Care		LA			NHS	Minimum NHS Contribution	£ 980,701	£1,040,593		

11	Rapid Response	Rapid Response Torbay	Home-based intermediate care services	Reablement at home (to support discharge)		696	601	Packages	Community Health		NHS			NHS	Minimum NHS Contribution	£ 1,047,136	£856,885		
12	Reablement Team Torbay	Reablement Services	Other	Other	Baywide Team	0	0		Social Care		NHS			NHS	Minimum NHS Contribution	£ 572,071	£590,336		
13	Reablement Block Beds Intermediate Care	Reablement Services	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		9	5	Number of placements	Community Health		NHS			Private Sector	Minimum NHS Contribution	£ 634,501	£159,712		Hewitt & Kingsmount blocks have expired - no activity for Q3 & Q4.
14	Reablement Block Beds Intermediate Care	Reablement Services	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		24	178	Number of placements	Community Health		NHS			Private Sector	Minimum NHS Contribution	£ 1,760,812	£2,477,582		83% (24 Beds) of Q3 JS Activity
15	Paignton Health and Well Being Centre	Multi Disciplinary Teams that are supporting independence including Anticipatory Care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Community Health		NHS			NHS	Minimum NHS Contribution	£ 93,192	£87,219		
16	Hospital Discharge Hub	staff to support hospital discharge	Integrated Care Planning and Navigation	Other	Joint assessment, care navigation and planning		0		Acute		NHS			NHS	iBCF	£ 986,400	£764,431		
17	VCSE Schemes	VCSE support for people in their own homes and supporting hospital	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess			0		Community Health		NHS			NHS	iBCF	£ 544,137	£514,119		
18	Pathway 1 Escalation Care Service	Supporting Hospital Discharge; 3 contracts and 1 co-ordinator	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		1580	777	Hours of care (Unless short-term in which case it is packages)	Community Health		nhs			Private Sector	Local Authority Discharge	£ 2,065,023	£1,055,015		Number of packages started in Agincare and Baycare ECS since 01/04/24. Baycare = 552
19	Pathway 2 Block Contract Beds in the	Block contracts to support hospital discharge	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		30	32	Number of placements	Community Health		nhs			Private Sector	ICB Discharge Funding	£ 1,848,000	£2,261,109		Hill House block placements in Q4. All other block contracts expired
20	Reablement Block Beds Intermediate Care	Reablement Services	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		5	36	Number of placements	Community Health		nhs			NHS	Minimum NHS Contribution	£ 413,131	£342,797		17% (5 beds) of JS activity
21	Baywide Community Team (Community	Community Health Service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Community Health		NHS			NHS	iBCF	£ 6,862,000	£7,210,125		
22	Baywide Community Team (Social Care)	Social Care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Social Care		LA			NHS	Minimum NHS Contribution	£ 4,310,927	£4,663,506		
23	Support Independence at Home (Enabling,	Domicillary Care packages	Home Care or Domiciliary Care	Domiciliary care packages		614	605	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			NHS	Minimum NHS Contribution	£ 824,078	£812,039		
24	Commissioning Team	Commissioning Markets Team	Enablers for Integration	Joint commissioning infrastructure		0	0		Social Care		LA			NHS	Minimum NHS Contribution	£ 1,376,805	£1,414,860		

Better Care Fund 2024-25 EOY Reporting Template

8. Year End Impact Summary

Selected Health and Wellbeing Board: Torbay

Confirmation of Statements	
Question statements	**Confirmation**
Overall delivery of BCF has improved joint working between health and social care	Yes
Our BCF schemes were implemented as planned in 2024-25	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

Highlight success and challenges within reference to the most relevant enablers fr
Logic model for integrated care - SCIE
Success and Challenges
2 key successes observed towards driving the enablers for integration
2 key challenges observed towards driving the enablers for integration

If the answer is "No" please provide an explanation:

om SCIE logic model:
Narrative
Joint commissioning and pooled or aligned resources The Torbay system continues to demnstrate the benefits of integration between health and social care. The pooled budget arrangements and overarching s75 agreement have been reviewed and continued throughout 2024-25.
Good quality and sustainable provider market that can meet demand Whilst we have good joint commissioning, the challenges around housing in Torbay do have an impact on Adult Social Care and population health outcomes. Torbay continues to improve areas, such as Transitions to Adulthood, where early identification of people who are at higher risk of

Checklist Complete:
Yes
Yes
Yes

Yes
Yes

This page is intentionally left blank

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1
HWB	**Torbay Council**
ICB	**NHS Devon**

Section 1: Overview of BCF Plan

This should include:

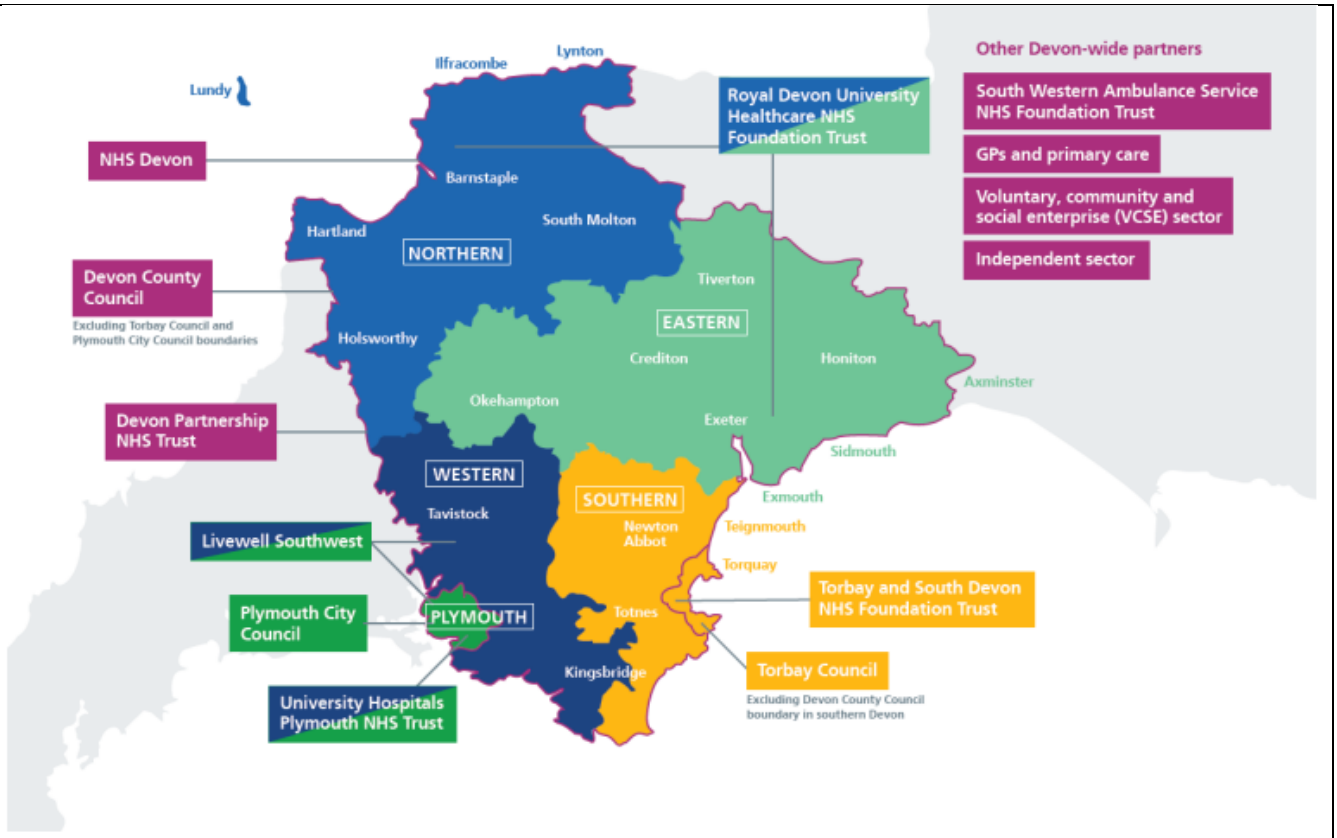
- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

Priorities for 2025-26

The Devon Integrated Care System, "One Devon, Five-Year Joint Forward Plan, 2025-2030, sets out how we will work together across the health and care system to respond to the One Devon Integrated Care Strategy. This plan brings together the collective ambitions of NHS organisations, local authorities, and other system partners to ensure a coordinated and aligned approach to improving health and care services for the people of Devon.

Devon is a complex Integrated Care system, with many different arrangements delivering functions across a unique geography. Elements of the plan are delivered across a range of provisions including:

- Two unitary authorities (Plymouth City Council and Torbay Council). • One county council (Devon), with eight district councils.
- 117 GP practices across 31 Primary Care Networks (PCNs) .
- Devon Partnership Trust (DPT) and Livewell South West (LWSW) provide mental health services.
- Four acute hospitals – North Devon District Hospital and the Royal Devon and Exeter Hospital, both managed by the Royal Devon University Healthcare NHS Foundation Trust (RDUH), Torbay and South Devon NHS Foundation Trust (TSDFT) and University Hospitals Plymouth NHS Trust (UHP).
- One ambulance trust – South Western Ambulance Service NHS Foundation Trust (SWASFT).
- Dental surgeries, optometrists and community pharmacies.
- A care market consisting of independent and charitable/voluntary sector providers.
- Many local voluntary sector partners across our neighbourhoods.



The JFP consolidates various local plans across the system, including, but not limited to:

- The NHS Devon Annual Plan.
- NHS Operational Plans.
- Joint local health and wellbeing strategies.
- Plans developed at a Local Care Partnership (LCP), Provider Collaborative and NHS Provider level.
- Internal local authority plans (e.g., adult social care, children's services).
- Better Care Fund Plans contribute to the effective delivery and shaping of resources.

One Devon main challenges

There are consistent challenges found across the Devon Integrated Care System footprint. These includes:

- An ageing and growing population with increasing long-term conditions, co-morbidity and frailty.
- Climate change.
- Complex patterns of urban, rural and coastal deprivation.
- Housing quality and affordability.
- Economic resilience.
- Access to services, including socio-economic and cultural barriers.
- Poor health outcomes caused by modifiable behaviours and earlier onset of health problems in more deprived areas.
- Varied education, training and employment opportunities, workforce availability and wellbeing.
- Unpaid care and associated health outcomes.
- Changing patterns of infectious diseases.

- Poor mental health and wellbeing, social isolation, and loneliness.
- Pressures on health and care services (especially unplanned care).

Our Joint Forward Plan

Priorities for the Joint Forward Plan are set out below. As with previous years the JFP continues to focus on; improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development. Each aim includes a series of programmes. Programmes of particular importance to achieving Better Care Fund outcomes and delivery within Health and Wellbeing Board footprints are; Community services and Urgent and Emergency Care.

Vision	Equal chances for everyone in Devon to lead long, happy and healthy lives			
Aims	Improving outcomes in population health and healthcare	Tackling inequalities in outcomes, experience and access	Enhancing productivity and value for money	Helping the NHS support broader social and economic development
Themes	**Healthy People**	**Healthy, safe communities**	**Healthy, sustainable system**	
Programmes	Primary Care and Dental	Housing	Clinical Service Change	
	Community Services	Employment	System-wide productivity and efficiency	
	Elective Care	Suicide Prevention	Integrated clinical support services	
	Urgent Care	Green Plan	Shared non-clinical support services	
	Children and Young People	Health Protection	Clinical Effectiveness, research, Innovation & Improvement	
	Maternity, Neonatal and Women's Health		Estates and Infrastructure	
	Adult Mental Health		Workforce	
	Learning Disability, Autism and Neurodiversity		Digital and Data	

Torbay Council's Adult Social Care (ASC) Strategy outlines how we work together to deliver improved adult social care services for residents in Torbay. As part of the strategy, we have co-produced the following priorities. Details of the activities we will carry out to meet these are including in section 2 "priorities for intermediate care".

Priority 1: Helping people to live well and independently.
Priority 2: Helping people to regain their independence

Priority 3: Helping people with care and support needs to live independently, safely and with choice and control.

Underpinning these priorities, we will:

- Develop and grow our workforce; and
- Engage and consult with service users, their families and carers and our partners.

For further detail please see Adult Social Care Strategy - Torbay Council

Our ASC Strategy is supported by our overarching ASC Commissioning Blueprint. It shows the needs and social policy driving adult services in Torbay. Torbay's commissioning approach seeks to:

- Reduce the systemic use of residential care to meet social care needs;
- Increase the use of enabling housing-based models of care and support so that people have a greater choice and control over how, where and with whom they live, as well as who and how their care is provided; and
- Increase the number of people able to maintain their own independence through their own strengths and those in the community around them.

For further detail please see ASC Commissioning Blueprint - Torbay Council

Adult Social Care Transformation

We know that Torbay council have areas of performance that outlie in comparator data. The key areas of concern are Torbay Council have brought a Transformation partner into the Torbay system to identify areas of work that will improve outcomes and cost for Adult social care. The key areas of focus for this work are ensuring appropriate advice, guidance and signposting with a digitally enabled front door into social care, developing a wider and consistent reablement offer to all people who have potential for recovery/improvement before commissioning a service, improving our TECH for people who draw on services, review of practice, process and legal literacy and finally streamlining Hospital discharge processes.

Alongside this there needs to be a continued focus on the role of commissioning in shaping the market and the range of products that are available to ensure we support people in the least restrictive way by building confidence in TECH, Enabling and Direct Payments to ensure our key objectives around strength based, person centred and outcome based approaches are taken alongside appropriate formal support commissioned by the LA when needed.

Key changes since the previous plan

As with previous years plans (23-25), the BCF has been developed jointly by local authorities and NHS Devon colleagues and will continue to facilitate collaborative working across partners and stakeholders within the Devon ICS footprint.

Torbay has a strong history of integrated working and can be proud of the many benefits that this brings to residents, our services and the ICS. Within Torbay delivery of acute health, community

health and social care have been delivered by the pioneering arrangements with the integrated care organisation, Torbay and South Devon NHS Foundation Trust which brings many benefits to people, services and the system. This includes benefits from integration, improved collaboration between services, standardisation of pathways across different sectors, development of new ways of working for our collaborative workforce and importantly delivering better continuity of care for our local population.

Since the 23/25 submission there has been significant development as an integrated care system and within our local care partnerships, as well as embedding our overall Devon ICS Strategy and Forward Plan.

The BCF plan will support the One Devon Joint Forward plan and address the inconsistences in access and availability in our communities, as we learn from them as to how best the BCF can meet local need. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi, the absolute and relative proportion of our lives spent in ill-health has increased.

Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care.

The **Neighbourhood Health Guidelines** set a framework for how systems can move towards a community-centric model of healthcare delivery, working towards achieving the **three strategic shifts** set by the government for the NHS in 2024. This will enable systems to build services tailored to local needs, existing infrastructure and relationships with the overall focus being to set the foundation for the neighbourhood model in the future. The ICB are working with community partners to look at developing a roadmap for the development and delivery of Neighbourhood Health Services to get a position on the strengths and assets we already have in each LCP.
NHS-England-Neighbourhood-Health-Guidelines-for-2025-26.pdf

Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception. Some places have already made progress in developing an integrated local approach to NHS and social care delivery. The full vision for the health system will be set out in the 10 Year Health Plan, including proposals to help make this emerging vision for neighbourhood health a reality, informed by existing work and public, staff and stakeholder engagement.

As part of the wider transformation work being undertaken in Torbay, we are reviewing the costing models we use to determine fee rates for Older People (OP) care homes (residential and nursing). Establishing the price paid for this care is important to secure services, manage our budgets, seek to understand provider costs, and maintain a good relationship with our care homes.

As commissioners of adult social care this will enable us to better secure value for money services within our care homes, to support hospital discharge for those people where residential care is still appropriate.

Market Development to support complex discharges, keeping people well and independent in the community

We are developing a ***Supported Living complex tier framework*** to ensure appropriate and effective commissioning within our supported living for people with complex care needs. This will support both the LA and NHS to manage outcomes for people who require higher and bespoke packages.

We are working on a specification to develop a wider ***reablement model*** that would serve to change wider culture within our domiciliary market away from relying on an ongoing time and task model. We are looking to develop a partnership that will provide closer working with our MDT's working to set care goals with some of our providers delivering outcome focused work to reduce ongoing dependencies by focusing on regaining independence for individuals by using TECH, engaging the voluntary sector and using care to regain key mobility, functional and cognitive skills that in turn build confidence for people following a health or social care event.

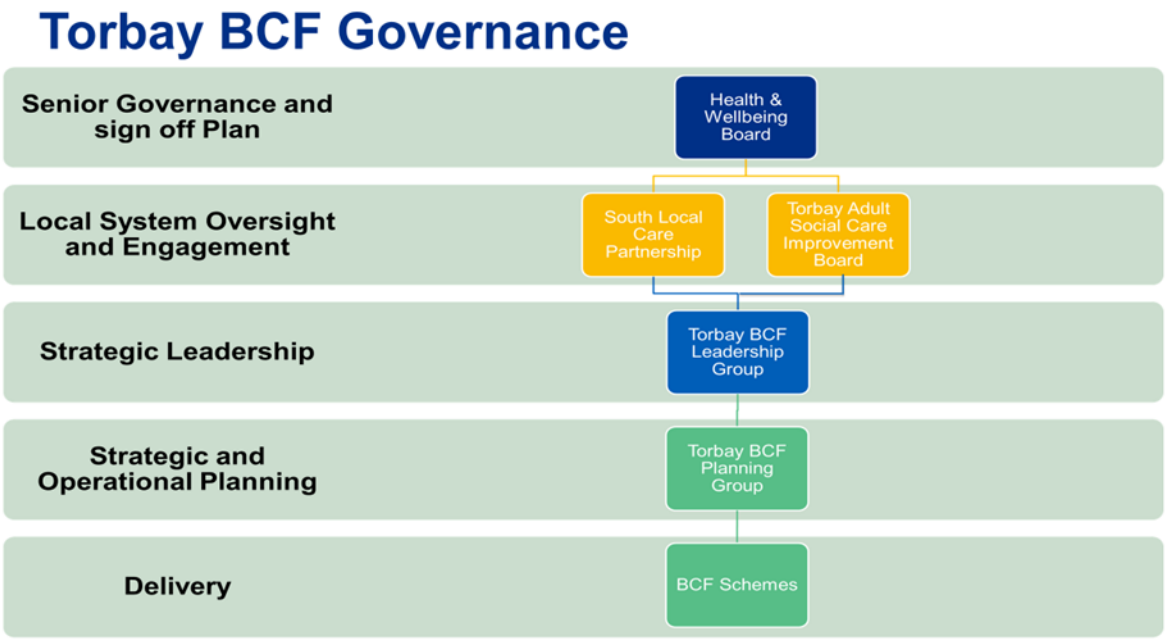
Approach for the development of plan and governance

- Outline the process used for the development of the plan, including stakeholder engagement in local health and care plans and use of data and insights.
- The governance structure in place and roles and responsibilities of partners
- Partners commitment to continuous learning and improvement, including engaging with enhanced support and oversight from the BCF programme if needed

The One Devon Partnership is responsible for developing the Integrated Care Strategy for the Devon ICS footprint and works together as NHS, local councils, voluntary sector, and many other stakeholders as outlined below:

There are five established local care partnerships (LCPs) that when combined form the whole of One Devon Integrated Care System, of these one (South LCP) encompasses the Torbay Council and

Torbay Health & Wellbeing Board footprint. The governance arrangements for Torbay's Better Care Fund (Torbay Council footprint) is shown below:



The process to develop Torbay Better Care Fund Plan 2025-26 has included:

- Planning and review - undertake development of BCF plan narrative, review current delivery and proposed strategic direction to ensure alignment of Torbay BCF to local, Devon ICS and national priorities.
- Financial review of 2023-24 schemes for investment to identify alignment with revised BCF national objectives
- Capacity and demand – modelling demand and capacity across pathways 1 – 3 and ensuring capacity of therapeutic support and workforce models in considered within projections for 2025-26
- Metrics – alignment of new BCF metrics with NHS operating plan and Adult Social Care monitoring.

The process has been:

- overseen, monitored and co-ordinated by Torbay BCF Leadership Group.
- Engagement of system partners has been managed through the above activity, Torbay BCF leadership Group, South Local Care Partnership and Torbay Health and Wellbeing Board
- Torbay BCF leadership group agrees the final version of the BCF plan prior to internal organisational agreement within NHS Devon, Torbay Council and Torbay and South Devon NHS Foundation Trust.
- Torbay Health and Wellbeing Board is responsible for formally signing off the Better Care Fund Plan, monitoring and scrutinising delivery.

The Torbay system is committed to continuous learning and improvement. During 2024-25 Torbay BCF has welcomed the introduction of BCF quarterly assurance meetings with regional BCF leads. Torbay will continue to fully engage in these collegiate conversations and engage in enhanced support and oversight from the BCF Programme where required.

Alignment with plans for improving flow in urgent and emergency care services

A key system priority remains addressing the urgent care and system flow challenges frequently being experienced across Devon ICS and the impact delayed discharge has on the whole system flow. The success of delivering the Devon Urgent and Emergency Recovery Plans relies heavily on ensuring the integrated community services supported by the BCF remain responsive to the continued high demand and be able to enhance the support at times of greater pressure or demands across the care pathway. Transformation of these services, focussing initially on hospital discharge, will bring significant improvements to the experience of all those transitioning through our integrated health and social care services.

The Better Care Fund plan supports the strategic delivery of joint system, NHS and Local Authority priorities. The BCF recognises the priorities outlined in the NHS Operating plan and the need to:

- Reduce the time people wait for elective care.
- Improve A&E waiting times and ambulance response times compared to 2024/25.
- Improve patients' access to general practice.
- Improve patient flow through mental health crisis and acute pathways.

Addressing the BCF objectives; reform to support the shift from sickness to prevention and, reform to support people living independently and the shift from hospital to home will help to focus improvements particularly relating to improving A&E waiting times and patient flow through mental health and acute pathways across Devon. BCF planning, implementation and delivery is an integral part of wider system planning to deliver system wide improvements.

The BCF plan and investments has a strong focus on; supporting and developing intermediate care, ensuring capacity and sufficiency of complex discharge pathways and focusing on integrated health, social care and VCSE working to support admission avoidance. This sits within and is complementary to Across the Devon ICS footprint and complementary to achieving the BCF objectives, as a system we will:

- Optimise **UEC demand management initiatives** by implementing the Neighbourhood health core components, including embedding an approach to population health management, risk stratification and whole pathway working for vulnerable groups including frailty and respiratory.
- Improve **access to urgent care outside of hospital** through urgent treatment centres, mental health crisis resolution and home treatment teams, virtual wards and urgent community response teams.
- Join up urgent & emergency care services through a **single point of access** that is accessible to ambulance services and ensuring urgent community response services enable ambulance services to **increase see & treat** activity.
- Apply **'discharge to assess'** principles, aligned to the Better Care Fund objectives and goals, by: assessing people's short-term recovery needs at home where possible immediately after discharge; conducting longer-term care assessments following an initial recovery period.
- Address **inequalities** within the UEC pathway, ensuring parity of esteem for patients with urgent mental and physical health needs, and consider the needs of those who make high

intensity use of emergency departments. Apply best practice to reduce long waits for patients presenting in ED with mental health needs, including use of UEC mental health action cards.

The Devon System Coordination Centre (SCC) sits at the centre of our approach to ensuring and improving flow in urgent and emergency care services. The SCC serves as a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible. The SCC is responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies. The OPEL Framework contains specified and incremental core actions for the SCC at each stage of OPEL. The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow. The function of the SCC ensure a concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

Through a joined up collaborative approach, the SCC supports proactive co-ordination of a system response to operational pressures and risks. The SCC utilises available information and intelligence to assess and validate local assurance submissions with regards to planning for events that impact on UEC and wider system pathways that require specified operational planning. Through daily system calls, the SCC, through its Visibility of operational pressures and risks across providers and system partners ensures that Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges can de be response to in a Dynamic approach, and where required will leverage services which are directly/indirectly supported through the BCF schemes.

Locality representatives from the ICB across our three HWB footprints actively feed in and support the SCC in ensuring the Local system challenges are supported thought providing targeted interventions and speciality knowledge to ensure to Flow out into our community services as well as ensuring the right capacity is matched against demand to ensure services are delivered as effectively as possible. Examples include, Discharge planning and unblocking barriers to reduce time spent in hospital for our patients.

A brief description of the priorities for improving intermediate care (and other short-term care).

Our plans for Intermediate Care align to those of the national framework which aims to:

1. Improve demand and capacity planning
2. Improve workforce utilisation through a new community rehabilitation and reablement model
3. Implement effective care transfer hubs
4. Improve data quality

Our approach to intermediate care aligns to Torbay Health and Wellbeing Board priorities, in particular, priority Healthy Ageing and associated cross-cutting areas of; good housing, reducing inequalities and supporting carers.

Intermediate Care plans are joint approaches between patients and their families, acute, community health, social care, VCSE sector and wider services to reduce delays in discharge, improve flow and work to a home first approach. Plans continuing into 2025/26 aim to:

- **Reduce Length of Stay**: Increasing the percentage of patients discharged by or on day seven of their admission.
- **Enhance Patient Flow**: Working with local authority partners to streamline discharge processes and reduce the average length of stay.
- **Leverage Digital Tools**: Fully utilizing digital tools to transition from analogue to digital systems, improving efficiency and patient care.
- **Shift from Hospital to Home**: Emphasizing the transition from hospital care to home care, ensuring patients can recover in the comfort of their own homes.
- **Integrate Care**: Enhancing collaboration between health and social care services to provide seamless support for patients during discharge.
- **Provide Support for Independent Living**: Implementing strategies to help people live independently, reducing the need for prolonged hospital stays.
- **Streamlined Processes**: Simplifying planning and reporting processes to improve efficiency and accountability.

This will be delivered by our Hospital Discharge Programme Board. This work will have a particular focus on utilising our revised demand and capacity plan to ensure market sufficiency of pathway 1, 2 and 3 provision, emphasising utilisation of in-house and increasing block contracts to achieve better patient outcome, particularly in pathways 1 and 2. Reablement specifications will continue to be embedded to further support a home first approach. A policy and practice group will ensure adherence to the national intermediate care framework and work to change culture and practice to achieve John Bolton practice models for discharge.

Torbay Council's Adult Social Care (ASC) Strategy further strengthens our joint approach to delivering Intermediate Care service. The Strategy outlines how we work together to deliver improved adult social care services for residents in Torbay. As part of the strategy, we have co-produced the following priorities and the activities which we will carry out to meet these.

Priority 1: Helping people to live well and independently.

- Have strengths-based conversations;
- Provide accessible information, advice and guidance;
- Use our community front door and community sectors; and
- Provide more support for carers.

Priority 2: Helping people to regain their independence

- Provide a rapid/crisis response;
- Increase community reablement; and
- Develop a short-term care centre.

Priority 3: Helping people with care and support needs to live independently, safely and with choice and control.

- Encourage an increase in the use of Direct Payments;
- Enable the provision of extra care and supported living housing options;
- Have good and outstanding care homes; and
- Provide specialist dementia care.

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

Torbay Better Care Fund is committed to delivering the national BCF objectives:

- ***Objective 1: reform to support the shift from sickness to prevention***
- ***Objective 2: reform to support people living independently and the shift from hospital to home***

In developing our plan, we have taken into consideration national guidance linked to Neighbourhood Health Teams, High Impact Change Model along with local plans to avoid unplanned admissions to Emergency Department and reduce the risk of people moving into long-term residential care.

The Better Care Fund Plan aligns to the NHS Operating Plan and should not be seen as independent from the wider system. Torbay BCF is interdependent of wider schemes linked to urgent and emergency care, discharge from hospital, flow management, admission avoidance, prevention and maintenance of health and social care conditions within the community.

Objective 1: Shift from sickness to prevention

Timely, proactive and joined-up support for people with more complex health and care needs

In 2025/26, the Torbay system will build upon the long history of integrated working via the Integrated Care Organisation. Timely, proactive and joined-up support for people with more complex health and care needs will be achieved by implementing the Neighbourhood Health Teams approach. Elements of the 6 core components of an effective neighbourhood health service are in place and well established:

1. Population Health Management
2. Modern General Practice

3. Standardising community health services
4. Neighbourhood multi-disciplinary teams
5. Integrated intermediate care
6. Urgent neighbourhood services

In 2024/25 a community services review was undertaken to better understand and commence standardisation of community services. Population health management approaches have supported communities most in need and supported better population health.

The maturity of PHM has grown in the last 12 months and will continue into 2025/26. PHM in conjunction with primary care Brave AI pilot sites will identify patients most at risk of unplanned admission to hospital in the next 12 months. Multi-disciplinary teams including primary care, social care, community health and VCSE organisations will plan joint approaches to manage patients holistic needs to manage ill health and prevent needs escalating.

Intermediate care and urgent neighbourhood services such as urgent community response and home from hospital (virtual ward) services are well established and improvements has been made to increase the number of clients engaging with UCR, increase virtual ward bed numbers and occupancy to work towards and achieve national targets.

Work has now commenced, bringing system partners together to effectively map services and pathways aligned to neighbourhood health teams. A detailed plan will be developed in 2025/26 to formally develop and commence the implementation of a new neighbourhood model of care.

Investments being made specifically by Torbay BCF to support this objective includes Baywide Intermediate Care service, Front End Services - First point of contact for social care, including social care navigation through improved information, advice & guidance.

Use of home adaptations and technology

Home adaptations and technology are key enablers to maintaining independence and supporting a shift from sickness to prevention. The Disabled Facilities Grant will continue to be invested in Torbay's population. Community health and social workers will continue to support and direct clients to the disabled facilities grant in cases where assessments indicate the need for home adaptations. The number of clients using TEC enabled care has increase from 1200 to just over 1600 people between April 2024 – December 2024. Further investment into TEC enabled care is being made by Torbay BCF in 2025/26.

Support people living independently and the shift from hospital to home

Prevent hospital admission

Much of what has been discussed above will support prevent hospital admissions. In addition to this a coherent Devon wide programme of Emergency Department Demand Management is being undertaken. Approaches to prevent hospital admissions includes:

- Increase GP capacity to deliver a Same Day Primary Care Hub pilot
- Delivery of enhanced health in care homes to provide a more proactive approach to managing the health needs of care home residents
- Ensure sufficient capacity within Urgent Community Response

- Delivery of Care Co-ordination Hub model sees the ambulance service stream suitable 999 calls to expert clinicians who can advise, prescribe and refer to appropriate primary and community pathways.
- Delivery of High Intensity Users Programme to understand the reason for repeat attendance in ED and support the client with the route cause and wider social determinants which may be driving behaviours.
- Same Day Emergency Care and Frailty Same Day Emergency Care diverting patient appropriately away from Emergency Departments to have their needs met by clinicians via an alternate model of care.

Achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)

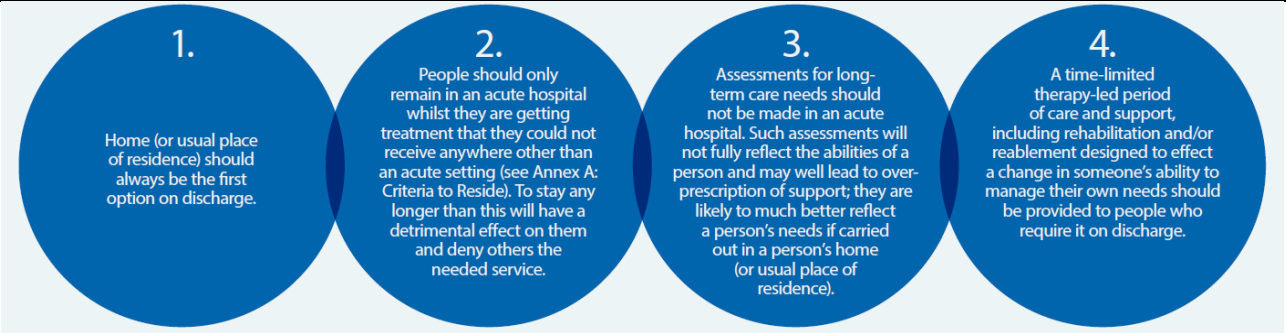
Across Devon ICS footprint we operate a Discharge to Assess model for acute hospital discharges. This ensures all individuals have an appropriate short-term need identified and coordinated through a Discharge Transfer Hub, pending longer term assessment following an initial recovery period. We promote a Home First approach to maximise the proportion of individuals who are discharged back to their usual place of residence. Funding, commissioning and performance management for this is managed through the local Better Care Fund arrangements.

Early discharge planning is managed within the acute setting:

- Through use of computerised notes, the HDT (Hospital Discharge Team) can be alerted to frequent attenders through use of flags on notes.
- Hospital discharge attendance at board rounds to hear about the complex patients prior to them being medically fit for discharge
- Good links with the avoidance teams who will alert issues early on in patients' journey
- Attendance at 7 day stay meetings which highlights the most complex patients. HDT alongside site management teams on ward will set up weekly MDT to ensure D/C plan on track
- Community teams in-reach and link with staff on ward re patients known to them
- Education/training to new employees- nurses and therapists that Discharge is everyone's responsibility
- Daily MDT with community teams -allows team to be alerted by them if a complex community patient is admitted
- Early referral to the Hospital Discharge Team is encouraged for complex patients

Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

At the heart of our approach to Hospital discharge and intermediate care is through establishing a Home first approach. The Torbay Health and Wellbeing Board footprint for hospital discharge is delivering the Home First / discharge to access.



This incorporates the following principles

- Home First will truly be the first option.
- Supported by the reinforcement of a Home First culture, maximising opportunities for our discharge coordination hub, and ensuring access into pathway 1 is as efficient as possible.
- Our therapy teams will work in a more integrated way across acute and community teams to improve outcomes for individuals.
- We will move to services designed around a neighbourhood footprint, underpinned by a PHM methodology to offer appropriate services that respond to local needs operating in an integrated way.
- Ensure referrals can be made directly from the community (step-up) or as part of hospital discharge planning (step-down), applying a 'Home First' approach, with assessments and interventions delivered at home where possible and working closely with urgent neighbourhood services.
- From an Adult Social Care perspective and reversing the principles of a Home First approach, we will strengthen and ensure adequate and timely access to a social care re-ablement front door offer.

Discharge to assess model improvements to be made throughout 2025/26 are:

1. Establish robust demand and capacity plans to ensure market sufficiency for P1-3 discharges across Devon ICB footprint.
2. Ensure robust and consistent data collection within acute providers to support accurate data recording and reporting against BCF metrics, with a particular focus on discharge to normal place of residence, NCTR and delays from discharge ready dates.
3. Review current VCSE capacity and delivery to inform a future VCSE discharge support model across Devon ICB
4. Learning from early adopter areas in Devon, develop a revised pathway 1 reablement specification and contract to achieve consistent outcomes across Devon ICS.
5. Consolidation of pathway 2 provision across Devon ICB including a review of capacity and P2 therapeutic models across localities, understand impact of P2 reablement block contracts procured in 2024/25 and define further commissioning intentions for 2025/26 working towards John Bolton / IPAC models within localities.
6. Focus on shifting pathway demand from pathway 2 to pathway 1 and reduce lengths of stay across all pathways, including, improving assurance of quality of discharge (Devon Transfer of Care programme outputs) and better reporting/monitoring aligned to NHS Devon Patient Safety Quality team.

7. 25/26 will see the creation of a bespoke pan-Devon End of Life discharge pathway.

Reduce the proportion of people who need long-term residential or nursing home care
The discharge to assess model is key to reducing the proportion of people who need long-term residential or nursing home care. There is still much work to be done to ensure patients are discharged on appropriate pathways and to continue to work towards achieving the Prof John Bolton, best practice models for discharge. However, we have strong foundations to continue this work.

Our approach includes discharge transfer of care hubs manage the discharge process. In-reach models are utilised with therapeutic input to better identify and ensure patients are discharged on appropriate pathways and maximises opportunity for reablement and discharge to normal place of residence. Trusted assessors are in place working in partnership with care providers to assess, manage and expedite discharges.

The focus of the last 12 months has been to commence implementation of reablement models of care, initially focusing on pathway 2. Early data indicates only 2% of patients move on to long-term residential care when discharged from a P2 block booked therapeutic led reablement bed. Further embedding this approach into 2025/26 will continue to support a reduction in utilisation of long-term residential care.

Aids and adaptations delivered through community equipment service contracts successfully contribute to discharging to a person's normal place of residence. Adaptations via seizure sensors through to specialist beds support a person to return home and increases opportunity to remain at home and reduce the risk of long-term residential admission.

Value for money
The Torbay approach to the development and deployment of our Better Care Fund centres on a clear evaluate and review methodology that ensures we take the learning from each years Better Care Fund into our development of subsequent year's plans. The governance infrastructure outlined within section 1, describes a close alignment to the delivery of the BCF and our local place-based arrangements, the South Local Care Partnership. Aligning our BCF approach and our place-based development forums ensures that we engage the full range of system partners (including health, social care, acute, community, VCSE and carers) and responds to local strategies as set out across the Integrated Care Strategy, Joint Forward Plan, Adult Social Care Strategy and Commissioning Blue Print (see section 1).

For 2025/26 planning purposes we have undertaken an extensive review of current investments to understand impact of delivery and check alignment against the updated BCF objectives and ensure they support delivery of the updated BCF metrics. As can be seen this has led to a degree of consolidation of previous investments, whilst ensuring many of high performing schemes have continued, we have shifted further investment into our homebased reablement offers. This will ensure we continue to deliver against the ambitions set out within our Intermediate Care Plan and the BCF plan for 25/26 by increasing the proportion of individuals who are discharged back home following a hospital stay and increase capacity for individuals to be supported at home during a period of escalation/crises. This work closely follows national best practice and capitalises on the

success we have had over the last year in optimising discharge pathways. Our performance over the last year and ambitions for our metric delivery over the next year reflect this.

Our review ensures we maximise value for money of investment. As can be seen a number of schemes funded last year have been stood down and we have re-focused investment to maximise the resources we have available. We have carefully considered our demand and capacity planning and have commenced a process to establish a home-based intermediate care offer that will place less reliance on costly out of area/agency resource.

The plan describes a set of investments that offer targeted and coordinated interventions for people living in the community to ensure they are supported to remain at home wherever possible, delivering the shift from hospital to home. Our proposals reflect recognised best practice models.

Consolidation of Discharge Fund

The 2025/26 Better Care Fund Policy Framework consolidated the Local Authority and ICB Discharge Funds into the NHS Minimum contribution and Local Authority Grant. The rationale for this was to provide greater flexibility in areas of investment.

The Hospital Discharge programme remains an important and central part of Better Care Fund plans in Torbay. In line with our intermediate care plan and the continued delivery of this into 25/26 and following a review of schemes, Torbay Better Care Fund will continue to retain, as a minimum, a budget in-line with BCF funding allocations. For Torbay the combined discharge allocation is £3,913,023.

By utilising our revised demand and capacity plan we will:

- Ensure market sufficiency of pathways 1, 2 and 3 provision.
- Emphasise utilisation of in-house and increase block contracts to achieve better patient outcome, particularly in pathways 1 and 2.
- Reablement specifications will continue to be embedded to further support a home first approach.
- We are increasing the proportion of investment that focuses on pathway 1. We will launch and embed the new P1 model post procurement.
- We will also continue with our pathway 2 reablement specification to continue to drive improvements in patient care.
- A policy and practice group will ensure adherence to the national intermediate care framework and work to change culture and practice to achieve John Bolton practice models for discharge, receive appropriate community support to prevent readmission or transition from P2 to long-term residential care.
- Changes will be made at a local level to shift our current demand from P3 to P2 and P2 to P1, ensuring the right pathways are being maximised.
- Torbay will continue to invest in the VCSE sector including; VCSE hospital in-reach and medium-term support in the community to avoid readmission.
- Wider BCF investments will focus on Hospital Discharge Hub teams and Rapid Response services.

We recognise that the admissions avoidance space is equally as important to ensure flow within UEC, and our out of hospital teams for discharge under DTA and Admissions avoidance under UCR complement each other and work closely together to ensure the right care is delivered in the right place at the right time. Investment into the VCSE sector for well-being co-ordination will also support admission avoidance.

Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans

The development of goals set against the three-headline metrics of the BCF plan have been created where appropriate in-line with the NHS Operating Plan.

Emergency Admissions to hospital for people over 65

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,754	1,833	1,714	1,952	1,780	1,820	1,978	1,807	n/a	n/a	n/a	n/a
	Number of Admissions 65+	665	695	650	740	675	690	750	685	n/a	n/a	n/a	n/a
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	n/a	n/a	n/a	n/a
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
	Rate	1,641	1,672	1,588	1,670	1,625	1,588	1,738	1,638	1,722	1,688	1,662	1,635
	Number of Admissions 65+	622	634	602	633	616	602	659	621	653	640	630	620
	Population of 65+	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913

Our goals for reducing the number of admissions for individuals over 65 to hospital directly aligns to our approach as set out with in our 2025/26 operating plan response. The Devon approach centres on our Out of Hospital Transformation programme which sets out sustainable models for community service delivery and support/enable the shift from acute to community provision. Across our operating plan approach, we have articulated plans that strengthen the community service provision and provide targeted interventions that keep people out of hospital wherever possible. This aligned to our Home-Based Intermediate Care re-commissioning, will strengthen capacity not only through discharge but also ensure access to reablement staff in admission avoidance space.

Services and investments made through our BCF and wider system funding, includes initiatives such as the:

- **Urgent Community Response** which has a jointly designed Devon specification, signed up by all UCR providers across Devon with all 3 meeting the specification and NHSE delivery expectations, and an aim to continue to develop and grow the service.
- **Virtual wards** in Devon have an agreed specification, supporting 10 standard clinical conditions and the RDUH Trust in Devon consistently meets all virtual ward KPI's.
- Further detail of admission avoidance schemes have already been discussed earlier in this document. This programme of activity has been developed throughout 2024/25 and will

continue into 2025/26. This has allowed us to implement a stretch target for Emergency Admissions.

Discharge Delays - Average length of discharge delay for all acute adult patients

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.29	0.22	0.37	n/a	n/a	n/a	n/a
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	91.5%	91.8%	88.3%	n/a	n/a	n/a	n/a
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	3.4	2.7	3.2	n/a	n/a	n/a	n/a
	Apr 25 Plan	**May 25 Plan**	**Jun 25 Plan**	**Jul 25 Plan**	**Aug 25 Plan**	**Sep 25 Plan**	**Oct 25 Plan**	**Nov 25 Plan**	**Dec 25 Plan**	**Jan 26 Plan**	**Feb 26 Plan**	**Mar 26 Plan**
Average length of discharge delay for all acute adult patients	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43
Proportion of adult patients discharged from acute hospitals on their discharge ready date	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00

There are a range of investments that directly attribute to delivering our improvements against this essential metric. The Torbay Hospital Discharge programme already discussed previously within this document is a key contributor to achieving this metric. Plans described in the Hospital Discharge Programme align to the NHS Operating Plan submission. The Hospital Discharge Programme is managed through a collaborative improvement programme, bringing together commissioners (health and social care) along with acute, community partners and the VCSE. This includes oversight of key internal flow metrics to enable real time monitoring of the use of DRD's to support tracking of forthcoming discharges and enable horizon scanning of any surges in capacity requirements.

Discharges for 25/26 include:

- **Reducing Length of Stay**: Increasing the percentage of patients discharged by or on day seven of their admission.
- **Enhancing Patient Flow**: Working with local authority partners to streamline discharge processes and reduce the average length of stay.
- **Leveraging Digital Tools**: Fully utilizing digital tools to transition from analogue to digital systems, improving efficiency and patient care.
- **Shift from Hospital to Home**: Emphasizing the transition from hospital care to home care, ensuring patients can recover in the comfort of their own homes.
- **Integrated Care**: Enhancing collaboration between health and social care services to provide seamless support for patients during discharge.
- **Support for Independent Living**: Implementing strategies to help people live independently, reducing the need for prolonged hospital stays.
- **Streamlined Processes**: Simplifying planning and reporting processes to improve efficiency and accountability.

The BCF directly funds a range of services that deliver the Discharge to Assess model within the city and capacity to ensure and enable a timely discharge from hospital. This includes:

Pathway 1:

- Reablement Pathway 1 specification – reablement focused short term interventions to support individuals in meeting rehab/reablement goals
- Home Based Intermediate Care – this is delivered by specialist reablement workers, operating under care plans designed with clear therapy goals and interventions. This is more intensive than the Hospital to Home service but enables a tailored resource to flex to individual need.

Pathway 2:

- A range of dedicated commissioned units, "Jack Sears", currently located in Torquay. 2025/26 commissioning intentions will be to consolidate the reablement P2 specification and reflect on its impact on wider P2 short term services.
- Spot purchase beds, commissioned with a warp around community-based therapy team along with an enhanced medical cover arrangement. This service operates in tandem to flex and respond to individual need and support individuals in achieving therapy goals and onward assessment activity to enable return home.

Residential Admissions - Long term support needs of older people met by admission to residential and nursing care homes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	762.3	701.6	830.8	817.7	807.1	796.6	786.0
	Number of admissions	289	266	315	310	306	302	298
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913

In the 2023-25 BCF plan we described how Devon ICS footprint had faced a significant challenge in the years following the pandemic with a rapid growth in the proportion of individuals needs who were being met through a care home admission, and that our plan for these 2 years sought to stem the rapid increase. We described how in the context of the demographic pressures facing the Devon system our ambitions of maintaining a steady position was ambitious.

During 2024/25 our plans to reduce the numbers of people moving into long-term residential care have not been achieved. Reflecting on the Q3 2024/25 position Torbay was performing at a rate of 862.5 per 100,000 population. 2025/26 metrics have been amended to reflect this position. Whilst the target is higher than 2024/25 this still provides a stretch target for the 2025/26 financial year.

We are more confident this year of our ambition and have assumed that the existing approaches (outlined below) will continue to manage the pressure we face, however, we also believe that our connected work on hospital discharge improvement and principally furthering our Home First approach will have a significant impact on improving our performance on this metric. Placing fewer people into residential beds on discharge and supporting people via therapeutic led models of P2 reablement beds will reduce the risks of deterioration/dependency and thereby reduce the risks of them converting to longer term care.

The main focus of work will be aligned to the development of Neighbourhood Health Teams (discussed above) and utilise guidance from the High Impact Change Model - Reducing preventable admissions to hospital and long-term care. The model focuses on two goals and five high impact changes that help realise one or both goals.

The two goals are:

- Goal 1: Prevent crisis: Actions to prevent crises developing or advancing into preventable admissions
- Goal 2: Stop crisis becoming an admission: Actions to divert or prevent an attendance at A&E becoming an admittance to hospital or long-term bed-based care

The five high impact changes and the goal or goals they relate to:

- Change 1: Population health management approach to identifying those most at risk
- Change 2: Target and tailor interventions and support for those most at risk
- Change 3: Practise effective multi-disciplinary working
- Change 4: Educate and empower individuals to manage their health and wellbeing
- Change 5: Provide a coordinated and rapid response to crises in the community

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

A review of 2024/25 Torbay Demand and Capacity plan has been undertaken as part of the BCF 2025/26 planning approach. A comparison of Q1-Q3 planned and reported data has informed the development of 2025/26 demand and capacity plans.

Table 1 illustrates the planned discharges between April and December 2025 across pathways 1 – 3. Table 2 illustrates actual data reported in BCF quarterly Demand and Capacity returns.

Table 1

Torbay	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total	%
P1 Planned	57	59	57	58	58	59	59	59	59	**525**	**54**
P2 Planned	38	39	39	39	38	39	39	39	38	**348**	**36**
P3 Planned	11	11	12	11	12	11	11	12	11	**102**	**10**
Total	106	109	108	108	108	109	109	110	108	**975**	**100**

Table 2

	Block									Spot											Difference against planned
Torbay	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total	%	%
P1 Actual	87	85	90	93	69	68	81	92	93										758	62	44%
P2 Actual	4	4	10	18	15	25	21	12	20	40	25	19	25	22	24	35	20	19	358	30	3%
P3 Actual										10	10	12	16	14	7	5	13	8	95	8	-7%
Total	91	89	100	111	84	93	102	104	113	50	35	31	41	36	31	40	33	27	1211	100	24%

2024/25 reported data indicates an 24% overall increase in discharges / people accessing combined P1-3 provision. Based on reported data there is variance against planned activity. Variance between recorded data for each pathway is as follows; pathway 1 (44%), pathway 2 (-3%) and pathway 3 (-7%). Local data has been cross referenced with SUS data to check validity. Data quality has improved throughout 2024/25 and we are assured by the data to be able to set realistic Demand and Capacity plans for 2025/26.

Torbay's 2025/26 demand and capacity plan has taken into account:

- 2024/25 actual performance and assumes
- 3.5% uplift based on SUS data, expected increased in UEC demand and flow through to complex discharges.
- Pathway 1 data provides block booked arrangements (in-house and independent sector provision). Average monthly discharges equate to capacity for 78 discharges per month. Within our commissioning arrangements Torbay has built in extra capacity to manage up to 137 P1 discharges per month.
- Pathway 2 assumes a two-model delivery, (block) reablement and short term services rehab / recover (spot).
    - Based on 2024/25 performance, block contracts assume 26 step down beds, operating at 70% occupancy with a 21 day average LoS. This provides additional capacity and room to support a further 9-10 discharges per month through our specialist therapy led model.
    - Spot provision will be procured as required and assumes a 28 day average LoS.
- Pathway 3 will all be secured via spot purchases to allow flexibility and with the aim to further reduce P3 utilisation.

It should be noted the Torbay Demand and Capacity template reflects the expected number of discharges across pathways 1 – 3. The additional capacity (described above) and flexibility to support our aspirations to move discharge quotas from P3 to P2 and P2 to P1 is not reflected in the demand and capacity template.

During 2024/25 procurement activity has been undertaken. Pathway 2 saw the introduction of Jack Sears, Torbay's specialist therapy led reablement centre. This is showing a positive impact on patient outcomes. The broader impact on P2 provision will be closely monitored in 2025/26 to help explore any further transformational and commissioning activity required in P2 provision.

In 2025/26 a new reablement specification will be launched, taking learning from partners in the Devon County Council footprint to drive further improvements in this area.

The Torbay Demand and Capacity Plan is based on current performance with expected increase in forecasts. The BCF plan discusses our aspiration to see a positive move in discharges from P3 to P2 and P2 to P1. The flexibility in Torbay provision has been described above. However, detailed plans will be created as part of a wider Devon ICS programme of activity. Trajectories will be amended in Torbay's BCF D&C plan in coming months.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

- Do you have any improvement plans to support therapy capacity for rehabilitation and reablement interventions or good practice you can share?

Intermediate care supports recovery and rehabilitation at home or in community settings, typically for up to six weeks, aiming to improve patient flow by enabling timely discharges and reducing unnecessary hospital admissions. The NHS England pilot (2024/25) in seven regions, including Devon, focused on refining workforce planning and addressing gaps in service provision for intermediate care.

Royal Devon and Exeter University Hospitals NHS Foundation Trust (RDUH) manages Short-term Services Teams (STST) across clusters in North Devon and Eastern regions like Exeter, East, and Mid-Devon.

These teams provide community rehabilitation services lasting up to six weeks, alongside community nursing.

Integration with wider Adult Health and Social Care teams ensures holistic support. STST's support extends to Woodland Vale Care Home in Torridge, providing community rehab and recuperation beds via joint commissioning arrangements with other stakeholders.

Torbay and South Devon NHS Foundation Trust (TSDFT) collaborates with Devon County Council (DCC) to deliver cross-organisational intermediate care services across four locality footprints.

This includes community rehabilitation, reablement services, and unplanned community interventions through Integrated Care (IC) teams, Urgent Care Response (UCR) teams, and rapid response teams.

While staffing models vary between localities, there's integration across TSDFT and DCC/TC ASC teams to ensure seamless care delivery.

The below table provides a summary of service models and how community rehabilitation and reablement is provided across Devon. The below is not extensive of all arrangements but provides a helpful snapshot of approaches.

D2A	Who (provider)	Who (team)	What	Where	How
P1	DCC	Social Care and Reablement (SCR), provided across three places.	SCR teams provides community reablement (≤3 weeks).	One SCR team per place, covering: • North Devon • East Devon • South Devon	• Different models across each place, as determined by ICS's devolution of decision-making to place • North and South Devon places deliver SCR with a support workforce only; East Devon includes OT oversight and input
P1	RDUH (North Devon)	Short-term services teams (STST), nested within the wider Adult Health and Social Care teams (HSCTs), with one of these across each cluster supported.	The STST provides: • Community rehab (≤6 weeks) • Community nursing Wider HSCTs provide: • Respiratory services • Lymphoedema services • Pathfinder team *(Northern clusters only)*	One HSCT per Northern cluster: • Ilfracombe and South Molton • Barnstaple • Torridge • Holsworthy, Bude and surrounding villages	• Different staffing models between Northern and Eastern teams as a result of Trusts merging in 2022 • In each cluster, there is a shared staffing model across HSCTs to cater for large geography and high travel times • Integrated with DCC adult social care (ASC) teams, although limited day-to-day support between support workers and therapy leads • Supported by the voluntary and third sector
P1	RDUH (Exeter, East and Mid-Devon)			And one per Eastern cluster: • Crediton, Moretonhampstead and Okehampton • Honiton, Ottery St Mary and Cranbrook • Exmouth, Woodbury, Budleigh • Exeter (South and West) • Exeter (Central and East) • Tiverton and Cullompton • Sidmouth, Seaton and Axminster	
P2	Woodland Vale Care Home	STST supports care home staff	• Community rehab beds • Community recuperation beds	Provided in Torridge (Torrington)	• Support provided by STST • Block-purchased via joint commissioning arrangements with ICB and DCC
P1	TSDFT and DCC	Cross-organisational intermediate care (IC) services, provided across four locality footprints. There are also two UCR teams and two rapid response teams.	IC teams provide community rehab and reablement services. UCR and rapid-response teams are also provided across the patch to deliver unplanned community interventions and reablement where needed.	One IC team per locality, covering: • Moor-to-Sea locality • Coastal locality • Newton Abbot locality	• Different IC staffing models between locality teams, with some leaning more heavily on unregistered staff compared to registered staff • Four UCR and rapid response teams also provide reablement across TSD under a UCR umbrella • Standalone specialist community rehab stroke and neuro services are provided separately, and are out of scope • Some integration across TSDFT and DCC/TC ASC teams
P1	TSDFT and TC			One IC team in Torbay locality	
P2	TSDFT	Individual community hospital teams from TSDFT, supporting numerous community hospitals and care homes.	Bed-based care and support provided by community hospital teams and care home leads, with some in-reach and specialist support provided by community teams as required.	Five community hospital sites across: • Brixham Community Hospital • Dawlish Community Hospital • Newton Abbot Community Hospital • Teignmouth Community Hospital • Totnes Community Hospital	• Community hospital teams support patients receiving P2 bedded care in the relevant community hospital • Specialist therapy teams provide support where required for patients with neurological needs • TSDFT has recently introduced 'care home lead' roles which are joint-funded from nursing and IC teams to work alongside care homes where relevant in-house capability does not exist for patients in bedded care in care homes

The approach for Torbay, through our intermediate care plan delivery focuses on the step change in P3 to P2 and P2 to P1 activity which will as a result delivery benefits for releasing therapy and assessment capacity to focus on Home based intermediate care delivery. We are also in the process of working up plans to ensure that our home-based intermediate care services in Devon (Hospital to Home and DTA) are maximising opportunities to work closer together to improve patients' outcomes, efficiency and productivity.

The externally commissioned Rapid Support Service (RSS), addresses the short-term reablement needs of Devon residents as part of the wider Intermediate Care system. The RSS model shifts from reactive, task-focused long-term care to a supportive reablement approach, emphasising prevention, early intervention, and progression. The goal is to help individuals achieve greater independence, enhance their well-being, and reduce reliance on long-term care.

Key outcomes include:

- **Faster Recovery**: Encouraging positive risk-taking to help individuals regain independence after illness or adverse health events.
- **Living independently at Home**: Enabling people to live safely at home for longer, improving quality of life through a strengths-based approach.
- **Outcome-Focused Care**: Transitioning from time and task-based care to outcome-focused delivery with a skilled, innovative workforce.
- **Pathway 1 Discharges** (care at home): Increasing the number of recoveries at home to prevent long-term residential or nursing care placements.
- **Reducing Delays**: Alleviating care transfer delays between health and social care systems, reducing avoidable hospital admissions and demand for long-term services.

Key highlights of our Intermediate Care services workforce are:

- The age distribution of NHS staff in Devon is slightly lower (-3%) than the national average, meaning its workforce has fewer people over the age of 55 than other models across the country
    - RDUH and TSDFT have a blended average of 18% of staff aged ≥55, with RDUH's workforce being slightly younger
- In DCC, however, this proportion is over double that of its NHS partners with 36% of staff aged ≥60
    - This is almost 10% higher than the national average for social care staff, and may pose a medium-term risk for the council
- The proportional distribution of teams' staff bandings is closely mirrored between RDUH and TSDFT
    - On average, 46% of the workforce is Band 5 and above
- The blended average banding of staff shows that the majority of each Trust's workforce comprises 32-35% of Band 3s, with a very small proportion of Band 4s present
    - Similarly, over 90% of DCC's SCR team are Band 3s
    - This could represent a potential opportunity for growth into Band 4 and Band 5 career pathways across Devon as an ICS
- Where known, turnover rates (RDUH) and vacancies (TSDFT) are:
    - slightly lower than the national averages for each metric
    - significantly lower than those of the other sites
- In RDUH, turnover rates have dropped materially in the last 12 to 18 months across both the registered and unregistered workforce; this could indicate successful initiatives to retain staff
- In TSDFT, the primary role vacancies experienced are (rehab) support workers; this could represent an opportunity for further career pathway development through Bands 4 and 5 to support recruitment

Devon's Intermediate Care Modelling pilot (2024) and subsequent Devon Intermediate Care Report (2025) highlighted opportunities to develop a core model and vision which enables local variation on top of a consistent foundation along with better data and intelligence to support demand and capacity. This features within our Hospital Discharge Transformation plans discussed earlier in this document.

Key considerations which will be further explored in 2025-26 include:

- Expand Band 4 roles with targeted training.
- Streamline Pathway 1 processes and improve equipment logistics.
- Enhance goal-setting practices and care alignment using standardised templates.
- Increase engagement with voluntary and community resources.
- Develop validated outcome measures for intermediate care.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Within Torbay, as part of the development of our Adult Social Care Strategy - Torbay Council we have co-produced our vision for Adult Social Care with our community, voluntary and care sectors working in partnership with Torbay Council and Torbay and South Devon NHS Foundation Trust staff as we work to deliver improved adult social care services for residents in Torbay.

Our shared vision is:

Thriving communities where people can prosper.

Our mission statement is:

We will work with our local community to support residents in Torbay to maximise their own wellbeing and independence, advising and guiding them around the best health and social care systems for them. Those who offer and provide support services will feel empowered to enable people to engage fully in their own decision making on choices of care. By working with our community this way, we will create a new way of supporting each other to achieve wellbeing for everyone - those receiving support and personal assistance and those giving it.

In particular, our system of care and support will be:

- **Focused on outcomes and wellbeing**
  Care and support is focused on promoting our wellbeing in all its facets – physical, mental, emotional and spiritual – and the outcomes we decide are important to us.

  It also promotes equity and inclusion by ensuring different groups in the population experience similar outcomes.

- **Personalised, co-created and flexible**
  We have a say and shape care and support both individually and at community/ local level.

Care and support adapts to our needs as they change, and recognises our diversity and individual preferences, beliefs and circumstances. When we lack capacity there are advocates to represent our prior wishes and best interests. When needed people will be supported by appropriate interpreting services and advocacy.

- **Proactive and preventative**
  We can access support to enhance our health and wellbeing and reduce inequalities across communities. Care and support is easily available at an early stage to help slow or prevent escalation into crisis, or before we have acute care needs.

For further information please see our Adult Social Care Strategy - Torbay Council

Engagement

People and Communities Framework

The draft One Devon People and Communities Framework has been developed and is awaiting sign off through the relevant governance channels. The Framework demonstrates how working together across the system widens the opportunity of engagement to the whole population, ensuring that the voices of those who experience health inequalities, or those who live in rural, coastal or remote locations have an equal chance to be heard and influence decision-making.

Devon Engagement Partnership

The Devon Engagement Partnership (DEP) is the vehicle that will support One Devon in effectively and meaningfully listening to and working with people and communities across Devon. The membership includes representation from LCPs, Healthwatch, VCSE organisations, provide and acute colleagues and NHS Devon.

One Devon Insight Library

The starting point for any engagement should be – "what do we already know?". The One Devon insight library brings together all the insights from engagement by NHS Devon and key system partners since 2018. This library of insights is currently available in an offline version but the vision over the next 12 months is to have this a searchable library as part of an online engagement platform.

Devon 10 Year plan engagement programme

The Devon 10-year plan engagement programme has been extensive, and views have been sought from across the county. To date, over 3000 pieces of individual feedback has been received that provides a representative view from across the County. As part of the programme – 5 engagement days took place – 1 held in Paignton and 1 in Ivybridge.

The findings from this engagement are going to inform the development of the national 10-year health plan whilst informing local priorities and pieces of work.

The 10-year clinical strategy has a vision of delivering outstanding integrated care, unlocking better outcomes, reducing inequalities, and improving lives across Devon and the wider region. The strategy represents the start of a long-term programme of change, clinical transformation journey and defines the basis for collaboration- putting the needs of the patients and population at the heart of integration. The strategy, clinical models and associated work has had input and co-

development from partners including the ICP, LCP and ICS' (Devon and Cornwall). Collaboration between these partners is integral for the continual development and delivery of interlinked strategies. Years 2-5 of the clinical strategy focus on meeting local need to deepen place-based integration and develop end-to-end patient pathways, implement data-driven population health management approaches to care and to develop digital infrastructure to support PHM and networked care.

To improve services for disabled people, the Health and Care Act, since 2022, has had an explicit focus on addressing health inequalities. Many disabled people live in a home that is not adapted to their needs – we know that a decent home is the foundation for an independent life. Funding provided by the BCF ensures those with a disability have an equal opportunity to remain living independently, with the adaptations likely to improve the health and wellbeing of those individuals. The planned strategies to be deployed across 2025-26 will enhance provision, options, speed, compliance, and demand versus need, and will contribute to the addressing of inequalities through an improved service. This will involve health and care services working with local communities and the VCSE to deliver CORE20Plus5 targets and implement high impact interventions.

Carers' health is known to be worse than that of non-carers due to the pressures of the role and is why Carers UK are calling for GP practices to identify carers quickly and to promptly inform of services available to help them look after their own health and wellbeing. The BCF funding ensures there is a service advocating for carers and thus contributes to the addressing of health inequalities.

One Devon signed a commitment to carers through a number of pledged principles, demonstrating a recognition of the value and contribution made by unpaid carers. The principles include the identification and supporting of carers, enabling informed choice, staff awareness, information sharing, effective support, respecting carers as experts and carers roles who are changing or more vulnerable.

A renewed and informed focus on Equality, Diversity & Inclusion (EDI) ensures services for patients take a considered approach to their delivery and actively seek to reduce differences in outcomes and inequalities. The vision is for EDI to be embedded in everything we do, and we are proud of the work to date to make this ambition a reality. While our organisational cultural competence is increasing, and the importance and recognition of EDI across the system is growing, there is a recognition there is still work to do. Our strategies describe an innovative approach to inclusion that prioritises co-production and collaborating with community partners to understand the needs of our diverse communities in Devon. Inclusion should be at the heart of organisational cultures and is set to be the foundation of joint working across our system.

Population Health Management (PHM) is an enabler in the aim of reducing health inequalities. The PHM programme will guide our primary care networks to identify and target specific patients and populations at risk of deteriorating physical and mental health due to factors such as social vulnerability and long-term conditions. The programme, and the linked One Devon Dataset, will provide health & care systems with data / intelligence to identify and provide proactive and evidence based integrated care for key population groups using digital and direct means to support people to live and manage their conditions in their communities and reduce inequalities in health

and wellbeing. For our commissioned services, Equality Impact Assessments are completed for key decisions, and include consideration of census and other population data.

This page is intentionally left blank

Better Care Fund 2025-26 Update Template

Data Sharing Statement

Data sharing Statement

Please see below important information regarding Data Sharing and how the data provided

Advice on local information governance which may be of interest to ICSs can be seen at:

https://data.england.nhs.uk/sudgt/

Please provide your submission using the relevant platform as advised in submission and su

Purpose of Data Collection

NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory
strategic planning, financial management, workforce planning, and system feedback, as mar

Type and Scope of Data

Patient-level data, including identifiable information like NHS numbers, is not required.
Data includes finance, activity, workforce, and planning information as specified in the natio
The BCF planning template is categorized as "Management Information," and aggregated da

Access, Sharing, and Publication

The BCF planning template is categorised as 'Management Information' and data submitted
section. Please also note that all BCF information collected here is subject to Freedom of Inf
Internal Access: Data will be accessed by NHS England national and regional teams on a "nee
External Sharing: Data will be shared with partner organisations and Arms' Length Bodies (A
of Health and Social Care (DHSC) and NHS England) for joint working and policy developmer
Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plan
share it publicly or use it for journalism or research without prior consent from the HWB (fo
All information is subject to Freedom of Information requests.

Storage and Security

Data will be securely stored on NHS England servers. Shared data will be minimised and han
The BCF template is password-protected to ensure data integrity and accurate aggregation.

Data Analysis and Use

NHS England will analyse data submissions for feedback, reporting, benchmarking, and syste
Triangulation with other data may be conducted to support deeper analysis and insights anc

Concerns

For any questions about data sharing, please contact your regional Better Care Managers or

during this collection will be used. This statement covers how NHS England will use the information prov

pporting technical guidance.

y duties, including improving healthcare quality, efficiency, and transparency. The data supports operati
ıdated by the NHS Act 2006 and relevant regulations.

ınal guidance documents.
ıta, including narrative sections, will be published on the NHS England website and gov.uk.

will be published in an aggregated form on the NHS England website and gov.uk. This will include a narr
ormation requests.
ed-to-know" basis and may be shared internally to support statutory responsibilities.
LBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Dep
nt.
s. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange
r single HWB data) or BCF national partners (for aggregated data).

dled per confidentiality and security requirements.
Breaches may require resubmission.

em improvement.
d inform decision-making.

the national Better Care Fund team england.bettercarefundteam@nhs.net

vided.

onal and

ative

partment

e) cannot

Better Care Fund 2025-26 Update Template

1. Guidance

HM Government

NHS England

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.

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

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

Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

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

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select ‘yes’ in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto populate the rate per 100,000 population for each month

https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.

https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.

https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24

Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements)

This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the four National conditions are as below:

- National condition 1: Plans to be jointly agreed
- National condition 2: Implementing the objectives of the BCF
- National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)
- National condition 4: Complying with oversight and support processes
- How HWB areas should demonstrate this are set out in Planning Requirements

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. 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 Better Care Exchange) 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 (MHCLG, DHSC, NHS England) 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.

Governance and Sign off

Health and Wellbeing Board:	Torbay	
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No	
If no indicate the reasons for the delay.	Our Health and Wellbeing Board will not be able to formally sign t	
If no please indicate when the HWB is expected to sign off the plan:	Thu 19/06/2025	<< Please enter using the format, DD/MM/YYYY

Submitted by:	Justin Wiggin
Role and organisation:	Senior Locality Manager (South and West), NHS Devon ICB
E-mail:	justin.wiggin@nhs.net
Contact number:	01803 396 332
Documents Submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative
	C&D National Template

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	David	Thomas	david.thomas@torbay.gov.uk	Torbay Council
	Health and Wellbeing Board Chair					
Named Accountable person	Local Authority Chief Executive	Mrs	Anne-Marie	Bond	anne-marie.bond@torbay.gov.u	Torbay Council
	ICB Chief Executive 1	Mr	Steve	Moore	steve.moore20@nhs.net	NHS Devon ICB
	ICB Chief Executive 2 (where required)					
	ICB Chief Executive 3 (where required)					
Finance sign off	LA Section 151 Officer	Mr	Malcolm	Coe	malcolm.coe@torbay.gov.uk	NHS Devon ICB
	ICB Finance Director 1	Mrs	Kirsty	Denwood	kirsty.denwood@nhs.net	NHS Devon ICB
	ICB Finance Director 2 (where required)					
	ICB Finance Director 3 (where required)					
Area assurance contacts	Local Authority Director of Adult Social Services	Mrs	Anna	Coles	anna.coles@torbay.gov.uk	Torbay Council
	DFG Lead	Mrs	Tara	Harris	tara.harris@torbay.gov.uk	Torbay Council
	ICB Place Director 1	Mrs	Karen	Barry	karen.barry@nhs.net	NHS Devon ICB
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)					
	ICB Place Director 3 (where required)					

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes	
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes	
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes	
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes	
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes	

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan
BCF planning timelines running alongside NHS ops plan submission dates, current data used consistent with ops plan as of 25/03/2025. However, may be subject to change in later submission date for NHS Ops plan.

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

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Torbay

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,641,358	£2,641,358	£0
NHS Minimum Contribution	£16,724,252	£16,724,252	£0
Local Authority Better Care Grant	£10,902,595	£10,902,595	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£30,268,205**	**£30,268,205**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£5,060,633
Planned spend	£5,524,842

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,641	1,672	1,588	1,670	1,625	1,588	1,738	1,638	1,722	1,688	1,662	1,635

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	830.8	195.2	195.2	197.8	197.8

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Torbay

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Torbay	£2,641,358
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£2,641,358**

Local Authority Better Care Grant	Contribution
Torbay	£10,902,595
Total Local Authority Better Care Grant	**£10,902,595**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS Devon ICB	£16,724,252
Total NHS Minimum Contribution	**£16,724,252**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£16,724,252**	

	2025-26
Total BCF Pooled Budget	**£30,268,205**

Funding Contributions Comments
Optional for any useful detail
Not applicable

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Torbay

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£2,641,358	£2,641,358	£0
NHS Minimum Contribution	£16,724,252	£16,724,252	£0
Local Authority Better Care Grant	£10,902,595	£10,902,595	£0
Additional LA contribution	£0	£0	£0
Additional NHS contribution	£0	£0	£0
Total	**£30,268,205**	**£30,268,205**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£5,060,633	£5,524,842	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Disabled Facilities Grant related schemes	DFG Related Schemes	2. Home adaptations and tech	Social Care	Local Authority	DFG	£ 2,641,358	
2	Discharge support and infrastructure	Hospital Discharge Hub Team	5. Timely discharge from hospital	Community Health	NHS	NHS Minimum Contribution	£ 750,000	
3	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Rapid Response Torbay	5. Timely discharge from hospital	Community Health	NHS	NHS Minimum Contribution	£ 900,000	
4	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Reablement Torbay	5. Timely discharge from hospital	Community Health	NHS	NHS Minimum Contribution	£ 600,000	
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Intermediate Care Torbay Team	5. Timely discharge from hospital	Community Health	NHS	NHS Minimum Contribution	£ 1,900,000	
6	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Care Home Block Beds - Jack Sears x 29 & Hill House x 4	6. Reducing the need for long term residential care	Community Health	Private Sector	NHS Minimum Contribution	£ 2,775,000	

7	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Agin Care & Baycare block contracts for Hospital Discharge Pathway	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 1,050,000	
8	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Care Home Spot IC & Hospital Discharge Pathway 2	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 2,229,410	
9	Wider local support to promote prevention and independence	Front end services - First point of contact for social care, social care navigation through information,	1. Proactive care to those with complex needs	Social Care	NHS	Local Authority Better Care Grant	£ 1,800,000	
10	Wider local support to promote prevention and independence	Health & Social Care Co-ordinators working with multi-disciplinary teams, GP and voluntary sector	1. Proactive care to those with complex needs	Other	NHS	Local Authority Better Care Grant	£ 825,000	
11	Wider local support to promote prevention and independence	Community based provision for people with learning diabilities through community hub	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 50,000	
12	Wider local support to promote prevention and independence	(Brixham) Day service to improve quality of life, education, health and social welfare, promote	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 200,000	
13	Wider local support to promote prevention and independence	(Paignton) Day service to improve quality of life, education, health and social welfare, promote	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 100,000	
14	Wider local support to promote prevention and independence	VCSE support for people in their own homes and supporting hospital discharge. Ward based VCSE support	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 300,590	
15	Assistive technologies and equipment	Using technology in care processes to support self management	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 305,000	
16	Evaluation and enabling integration	Joint infrastructure for Integrated Commissioning Function between NHS and Local Authority	1. Proactive care to those with complex needs	Social Care	NHS	Local Authority Better Care Grant	£ 950,000	
17	Wider local support to promote prevention and independence	Sensory Team supporting adults to live independent lives	1. Proactive care to those with complex needs	Social Care	NHS	Local Authority Better Care Grant	£ 448,000	
18	Long-term home-based social care services	Transforming Long-term Home-based Social Care through Innovation as part of transforming Integrated ASC	1. Proactive care to those with complex needs	Social Care	NHS	NHS Minimum Contribution	£ 4,379,217	
19	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Transforming short-term Home-based Social Care through Innovation as part of transforming Integrated	2. Home adaptations and tech	Social Care	NHS	NHS Minimum Contribution	£ 545,035	
20	Long-term residential/nursing home care	Transforming Long-term bed-based Social Care through Innovation as part of transforming Integrated ASC	6. Reducing the need for long term residential care	Social Care	NHS	Local Authority Better Care Grant	£ 6,524,595	
21	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Pathway 1 and VCSE reablement initiative	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 804,000	
22	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Pathway 1 / Domiciliary care reablement initiative	4. Preventing unnecessary hospital admissions	Community Health	Private Sector	NHS Minimum Contribution	£ 191,000	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

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

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	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.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Torbay

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,754	1,833	1,714	1,952	1,780	1,820	1,978	1,807	n/a	n/a	n/a	n/a	This rate has been populated using the baseline admissions for this group of patients in SUS for 2024-25 and an assumption that performance will continue largely unchanged, with consideration given to the trend shown by the supporting indictors.
	Number of Admissions 65+	665	695	650	740	675	690	750	685	n/a	n/a	n/a	n/a	
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	n/a	n/a	n/a	n/a	
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
	Rate	1,641	1,672	1,588	1,670	1,625	1,588	1,738	1,638	1,722	1,688	1,662	1,635	
	Number of Admissions 65+	622	634	602	633	616	602	659	621	653	640	630	620	
	Population of 65+	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	37,913	

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.29	0.22	0.37	n/a	n/a	n/a	n/a	This has been populated in line with the provider submission for the Operational Plan for 2025/26, supported by local data where available.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	91.5%	91.8%	88.3%	n/a	n/a	n/a	n/a	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	3.4	2.7	3.2	n/a	n/a	n/a	n/a	
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
Average length of discharge delay for all acute adult patients	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	0.43	
Proportion of adult patients discharged from acute hospitals on their discharge ready date	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	762.3	701.6	830.8	195.2	195.2	197.8	197.8		The figures provided have been determined using the analysis of historic data. The data has been weighted to land nearer to the lower end of expected projections, representing an ambitious goal to reach from the current known position, but still reflective of the challenges in Torbay with placements and the increases seen during
	Number of admissions	289	266	315	74	74	75	75		
	Population of 65+*	37,913	37,913	37,913	37,913	37,913	37,913	37,913		

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Torbay

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes	Plan to be signed off by ICB and LA internal governance processes, NHS Devon Exec	01/04/25	Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes	Plan to be signed off at Torbay HWBB	19/06/25	Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

This page is intentionally left blank

BCF Capacity & Demand Template 2025-26

1. Guidance

Overview

This template has been unlocked to allow editing as required. It is optional to submit capacity & demand figures as per this template format and a customised format of this will be accepted.

Note on entering information into this template

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

Data can be input into the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. You should select your HWB from the top of the sheet which will also reveal pre-populated trusts for your area.

2. Once you are satisfied with the information entered the template should be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

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

3. Capacity and Demand

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

This template follows the same format as last year and so contains all the previously asked for data points including demand (referrals), block and spot capacity, average duration of treatment and time from referral to treat all split by pathway. It is however only required that some form of data points are submitted to show projected demand (disaggregated by step-up and step-down) and capacity for intermediate care and other short term care. The additional data points on average treatment time, time to treat and spot/block capacity split are optional but have remained in case you may find these data points useful.

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

List of data points in template:

3.1 C&D Step-down

Estimates of available capacity for each month of the year for each pathway.
Estimated average time between referral and commencement of service.
Expected discharges per pathway for each month, broken down by referral source.
Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

Version 1.1

Health and Wellbeing Board:	Torbay
Completed by:	Justin Wiggin
E-mail:	justin.wiggin@nhs.net
Contact number:	01803 396332
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes

Once complete please send this template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'C&D - Name HWB' for example 'C&D - County Durham HWB'. Please also copy in your Better Care Manager.

<< Link to the Guidance sheet

Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Torbay

Step-down

Capacity - Demand (positive is Surplus)	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-5	-6	-4	-6	-4	-5	-6	-4	-5	-5	-5	-4	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-12	-12	-11	-13	-12	-12	-12	-11	-12	-12	-11	-12	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
16	Contact Hours per package
0	Contact Hours per package
25	Average LoS (days)
0	Average LoS (days)
28	Average LoS (days)

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	79	81	75	83	78	76	82	76	78	80	72	78												
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	1	3	1	1	1	2	2	4	3	1	2												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0												
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	25	26	25	26	26	25	26	25	26	26	23	26	5	6	4	6	4	5	6	4	5	5	5	4
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	3	3	3	3	3	3	3	3	3	3	3	3												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0												
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	12	12	11	13	12	12	12	11	12	12	11	12
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	4	4	4	4	4	4												

Demand - Step-down		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	1141	1186	1096	1213	1140	1113	1189	1097	1144	1164	1046	1137
Reablement & Rehabilitation at home (pathway 1)	Total	79	81	75	83	78	76	82	76	78	80	72	78
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	70	72	67	74	70	68	73	67	70	71	64	69
	OTHER	9	9	8	9	8	8	9	9	8	9	8	9
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												
	(blank)												

Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST													
	OTHER													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**30**	**32**	**29**	**32**	**30**	**30**	**32**	**29**	**31**	**31**	**28**	**30**	
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	28	30	27	30	28	28	30	27	29	29	26	28	
	OTHER	2	2	2	2	2	2	2	2	2	2	2	2	
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
O-19 short term bedded care (pathway 2)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST													
	OTHER													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**12**	**12**	**11**	**13**	**12**	**12**	**12**	**11**	**12**	**12**	**11**	**12**	
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	11	11	10	12	11	11	11	10	11	11	10	11	
	OTHER	1	1	1	1	1	1	1	1	1	1	1	1	
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													
	(blank)													

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Torbay

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	3	4	4	3	2	2	3	1	3	5	1	2
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours	
Full Year	Units
0	Contact Hours
8	Contact Hours
28	Average LoS
0	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.	74	83	78	72	48	54	54	78	67	58	46	56
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	41	45	45	36	39	51	49	44	63	63	42	48
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	8	8	8	8	8	8	8	8	8	8	7	8
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	74	83	78	72	48	54	54	78	67	58	46	56
Reablement & Rehabilitation at home	41	45	45	36	39	51	49	44	63	63	42	48
Reablement & Rehabilitation in a bedded setting	5	4	4	5	6	6	5	7	5	3	6	6
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

This page is intentionally left blank

Meeting: Torbay Health & Wellbeing Board **Date:** 19 June 2025

Wards affected: All

Report Title: Torbay Turning the Tide programme report

When does the decision need to be implemented? No decision required; report for information

Cabinet Member Contact Details: Hayley Tranter, Cabinet Member Adult & Community Services, Public Health & Inequalities Hayley.Tranter@torbay.gov.uk

Director Contact Details: Lincoln Sargeant, Director of Public Health Lincoln.Sargeant@torbay.gov.uk

Author: Julia Chisnell, Consultant in Public Health Julia.Chisnell@torbay.gov.uk

1. Purpose of Report

1.1 This paper provides a high level summary of the Torbay Council Turning the Tide programme, for members' information and engagement. Members previously received a written report in September 2024 and have received quarterly oral updates on progress.

2. Reason for Proposal and its benefits

2.1 The programme oversees and supports initiatives to help people experiencing difficulties associated with the challenges of poverty in Torbay.

3. Recommendation(s) / Proposed Decision

3.1 Members are asked to note the report and consider how they may wish to be engaged in the future work programme.

Supporting Information

1. Introduction

1.1 The report covers the following:

- A short summary of the programme to date

- Workshop and outputs February 2025
- Action planning 2025/26
- Synergies and opportunities
- Opportunities for involvement.

2. Torbay Turning the Tide programme to date

2.1 Torbay Council's Turning the Tide programme was modelled on the Marmot principles first set out in *Fair Society, Healthy Lives* in 2008 Fair Society Healthy Lives (The Marmot Review) - IHE (instituteofhealthequity.org). The programme is chaired by Torbay Council's Director of Public Health and has input from cross-Council departments as well as partners across the health, care and voluntary sectors in Torbay. In 2022/23 the programme evolved to respond to the cost of living challenges facing local families and communities, placing a stronger focus on the drivers of poverty and ill-health including food, fuel, employment, skills and economic stability.

3. Workshop and outputs February 2025

3.1 Additional members were coopted into the programme during 2024 and contributed to a workshop for the Council Senior Leadership Team on 3 February 2025. This involved a deep dive into the data around inequalities and social mobility, sharing of case studies describing the experiences of local individuals and families, and a scenario exercise designed to highlight the drivers for poverty and the levers for change. Members then undertook a review of our collective strengths, weaknesses, opportunities and threats in relation tackling poverty, and prioritised areas for action for 2025/26.

4. Action planning 2025/26

4.1 The aim of the programme was reconfirmed as 'breaking the cycle of poverty and promoting social mobility in Torbay'.

4.2 A priority group for especial focus during 2025/26 was identified as young people and families, where interventions are both critical and timely in terms of influencing future life chances and having a positive impact on successive generations.

4.3 The table below is the resulting action planning framework. This covers the target populations, settings, activities, levers and measures, from which actions are built up.

Vision	**Breaking the cycle - promoting social mobility in Torbay**								
We want to…	Promote aspiration			Support young people out of benefits			Support people out of ill health into work		Build resilience
We will work with…	Education			Businesses			Anchors		Communities & places
Areas of activity	Training – indivs & employers	Coach-ing & men-toring	Role models & peer support	Explore non-traditional jobs & roles	Disability confident employer	Transport (home/ work/ educ/ health/ social)	Apprentice ships	Health support & coaching	Housing support pathways
Target groups for extra help	Care experienced	Carers	Homeless single males	Health conditions & disabilities	Neurodiverse; PWLD; SMI	Neighbour hoods	People in Youth Justice pathways	NEETs	
Settings	Schools & Colleges	Family Hubs		Business forums & networks		Community groups & venues	NHS, GP practices		
Mechanisms, Enablers, Levers	Connect to Work	Shared Prosperity Fund		DfE 16-19 funding	Workwell		Make it an LCP priority	Combined Authority (Adult Skills & Educ Fund; Transport; Housing)	
Measures	**Short term**	Work & skills (NEETs, DWP stats re work & health)		**Longer term**	Deprivation, economic, heath & disability		**People & commu-nity**	Wellbeing; resilience; connections	

4.4 Action areas identified so far cover:

- Supporting people (back) into work, including from long term ill-health
- Reducing the risk of care experienced young people experiencing poverty, with budgeting advice and practical support
- Promoting disability confident employers
- Improving housing conditions for people with long term health conditions (eg respiratory) or on discharge from hospital

These actions are being refined and other action areas identified. It is important that the Turning the Tide programme focuses on those areas where action is not already happening elsewhere, and our combined efforts can have most impact.

4.5 A Turning the Tide dashboard is being developed to inform the work. This will include measures that give an indication of worsening or improving conditions for our target populations in the Bay, for example referrals for housing support, and use of food banks or social supermarkets. Individual indicators

may be capable of more than one meaning but taken together they will give us a sense of progress or otherwise.

5. Synergies and opportunities

5.1 There are a number of policies and programmes which have a strong synergy with the Turning the Tide programme, or which offer a potential lever to promote the work. Additional members representing these areas have been invited to join the group to ensure a consistent approach and to help us to maximise impact where we have common priorities.

5.2 These include:

- The Workwell and Connect to work programmes bringing together employment and health
- The community wealthbuilding programme
- The work of the anchor institutions network
- Torbay Economic Strategy (joint workshop scheduled for 24 June)
- Torbay Place Board priority programme areas, in particular economic development
- The NHS 10 year plan and the shift from ‘treatment to prevention’
- The South Local Care Partnership agenda including the new inequalities strategy and the proposed priority around health and work
- The South West as a Marmot Region (tackling inequalities)
- The Coastal navigator network proposal June 2025
- Joint Strategic Needs Assessment 2025 presenting the latest picture of population need and inequalities
- The opportunity to influence the priorities of the Torbay Joint Health & Wellbeing Strategy 2026

6. Opportunities for involvement

6.1 Members are invited to highlight any areas of their work that would usefully be aligned with the Turning the Tide programme and to identify how they may wish to be involved.

7. Financial Opportunities and Implications

7.1 None specific to this report although the programme takes account of the economic challenges faced by communities in Torbay and will look to lever existing investment, or to prepare future national funding bids, in support of the poverty reduction agenda.

8. Engagement and Consultation

8.1 None.

9. Tackling Climate Change

9.1 Improving energy efficiency is one of the objectives of the programme.

10. Associated Risks

10.1 Risks relating to this programme are held on individual programme risk registers where relevant.

11. Equality Impacts - Identify the potential positive and negative impacts on specific groups

	Positive Impact	Negative Impact & Mitigating Actions	Neutral Impact
Older or younger people	Y		
People with caring Responsibilities	Y		
People with a disability	Y		
Women or men	Y		
People who are black or from a minority ethnic background (BME) (Please note Gypsies / Roma are within this community)	Y		
Religion or belief (including lack of belief)	Y		
People who are lesbian, gay or bisexual	Y		

People who are transgendered			Y
People who are in a marriage or civil partnership			Y
Women who are pregnant / on maternity leave	Y		
Socio-economic impacts (Including impact on child poverty issues and deprivation)	Y		
Public Health impacts (How will your proposal impact on the general health of the population of Torbay)	Y		

10. Cumulative Council Impact

10.1 None.

11. Cumulative Community Impacts

11.1 Impact is expected to be positive if programmes are delivered.

This page is intentionally left blank