Better Care Fund 2024-25 EOY Reporting Template

1. Guidance

Overview

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

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

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

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

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

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

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

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

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

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

Checklist (2. Cover)

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

2. Cover

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

3. National Conditions

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

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

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

In summary, the four National conditions are as below:

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

4. Metrics

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

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

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

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

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

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

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

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

5. Capacity & Demand Actual Activity

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

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

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

6. Income

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

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

7. Expenditure

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

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

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

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

8. Year End Feedback

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

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

Part 1 - Delivery of the Better Care Fund

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

The questions are:

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

Part 2 - Successes and Challenges

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

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

Please highlight:

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

Please provide narrative for the above 2 questions.

Useful Links and Resources

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

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

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

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

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

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

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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		For information - actual performance for Q3 (For Q4 data,please refer to data pack on BCX)	Assessment of whether ambitions have been met
Q3	Q4		
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:

Better Care Fund 2024-2

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

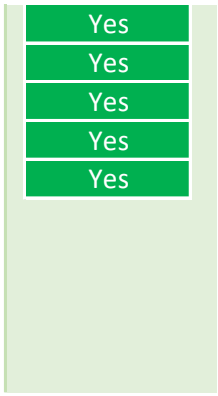
24-25 plan	Actual activity (not including spot purchased capacity)			Actual activity through only spc (doesn't apply to time to servic	
Mar-25	Jan-25	Feb-25	Mar-25	Jan-25	Feb-25
59	47	41	50	0	0
3	3	3	3		
0	0	0	0	0	0
0	0	0	0		
38	15	7	5	6	16
6	3	7	7		
0	0	0	0	0	0
0	0	0	0		
12	0	0	0	3	8
3	2	4	4		

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