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

HM Government

NHS England

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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:	Sunderland	
Completed by:	Lisa Jones	
E-mail:	lisa.jones@sunderland.gov.uk	
Contact number:	07793894127	
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:	Fri 06/06/2025	<< 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'.

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

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

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

6. Income actual	Yes	
7b. Expenditure	No	Expenditure Underspent or Overspent
8. Year End Feedback	Yes	

<< Link to the Guidance sheet

^^ Link back to top

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3. National Conditions

Selected Health and Wellbeing Board: Sunderland

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

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4. Metrics

Selected Health and Wellbeing Board: Sunderland

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

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q3 (For Q4 data,please refer to data pack on BCX)	Assessment of whether ambitions have been met	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	274.3	263.2	296.8	292.6	138.7	Target not met	A system diagnostic identified some key challenges in relation to avoidable admission for chronic ambulatory care sensitive conditions, including: •Complexity of patient need and decisions making: A high portion of avoidable admissions involve older adults (70+) with complex needs, often requiring specialist, risk-based decisions for community-based care. In addition, risk aversion among practitioners and differing opinions between teams can also lead to non-ideal discharge pathways or delays, sometimes resulting in admission where avoidance might have been possible with earlier, coordinated planning. •System complexity & navigation: The urgent and emergency care system involves multiple teams with overlapping purposes and criteria. Navigating this can be challenging, with issues in communication, siloed knowledge, and incomplete referral pathways between services.This complexity can hinder effective admission avoidance, as coordinating specialist input and community response becomes difficult, especially out of hours. For example, paramedics cited difficulties accessing timely decisions or support from some community services, making A&E conveyance the default. •Access/use of alternatives: services designed to avoid admission exist (e.g., Recovery at Home/UCR, SDEC, Interface/Frailty teams), but they are not always fully utilised. SDEC for example, has been limited due to capacity constraints, specific criteria, operating hours, and decision-making on appropriateness of patients. The diagnostic found that SDEC capacity was often taken up by non-SDEC work (inpatients, planned appointments), reducing its availability for urgent, avoidable admissions. Although the diagnostic suggested sufficient budgetary capacity within Recovery at Home, managing demand fluctuations and optimising processes (like reducing travel time) were needed to meet potential unmet demand effectively •Prevention & proactive care: The diagnostic identified opportunities for better crisis prevention, particularly through earlier frailty identification and advance care planning. A significant number of patients whose crises were deemed preventable were already	Key achievements are summarised below: •Establishment of a Care Closer to Home steering group. •Respiratory Virtual Wards were implemented after Quarter 1, positively impacting future admission avoidance performance. •Proactive care pathways have been established within the community, incorporating community MDTs to support more comprehensive and proactive care planning. •The Two-Hour Urgent Community Response (2HUCR) service is meeting its delivery targets while managing an increasing volume of support request •Establishment of Care Coordination Hub	N/A	The Care Closer to Home programme will be a key driver for improving ACSD admissions. This will include implementation of key areas of improvement identified within the system diagnostic, including: •Improving the connection and referral pathways between acute front-door teams (e.g. Interface/Frailty) and community services (e.g Recovery at Home/UCR). •Implementing a 'pull' model for teams like Interface, enabling them to proactively identify and assess suitable patients in A&E earlier, rather than relying solely on potentially delayed referrals. •Improving integrated working between specialist teams (Frailty, Interface, Recovery at Home, Virtual Ward) to facilitate comprehensive assessments and timely redirection to community or virtual ward care. •Reducing conveyance avoidance through establishment of Care Coordination Hub. •Strengthen proactive prevention through earlier identification and management of frailty, including advance and proactive care planning, particularly for patients already known to the system. Targeted interventions towards cohorts known to be frequent service users across primary, secondary, and social care, using data to identify those at highest risk of escalating needs and admission. Improve data sharing and collaboration between primary care, secondary care, and social care at a place/neighbourhood level to proactively manage populations and address health inequalities.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.6%	92.1%	92.7%	93.2%	91.71%		Key challenges preventing hospital discharge to a person's usual place of residence in Sunderland include: •Delayed discharge planning: Discharge planning often only commences once a patient is declared medically fit for discharge, leading to sequential processing and delays. •Sequential processes & siloed Working: The discharge process involves multiple teams often working in sequence rather than collaboratively, leading to inefficiencies and delays. •Weekend discharges: There is a significant drop in discharges, particularly non-complex (Pathway 0) ones, over the weekend, leading to patients waiting unnecessarily and causing backlogs at the start of the week. •Late referrals: Referrals to essential services like Occupational Therapy (OT) and Physiotherapy are sometimes made only after a patient is medically fit, delaying assessments and discharge readiness. •Ineffective MDT Huddles: Ward huddles vary in effectiveness, sometimes lacking focus on discharge progress, clear actions, or appropriate challenge between disciplines. •Capacity & resource challenges: capacity in domiciliary care and home-based reablement services is a significant barrier, forcing patients into interim beds (Pathway 3) or delaying discharge home. •Suboptimal discharge decisions: A significant proportion (around 40%) of discharge outcomes were considered non-ideal in case reviews, with patients often discharged to settings offering less independence than potentially achievable, some of this is attributed to risk aversion among staff and perceived risks associated with discharging patients home. •Challenges in implementing a 'Home First' Approach: The system sometimes defaults to bed-based solutions (Pathway 2 or 3) even when	Sunderland has secured support to implement a system improvement programme in partnership with South Tyneside, which is due to commence shortly. This programme will provide signficiant transfromational support to the system, addressing key challenges and barriers to effective, home-first discharge, and this will be a key strategy within Sunderland's neighbourhood health plan. Following a strategic BCF review in 24/25, Sunderland's BCF plan has been rewired to support this, and wider neighbourhood level delivery, enabling the BCF to function as a critical system enabler for health and care improvement.	As identified under column J, variations in performance related to discharge to usual place of residence, have been assessed under a system diagnostic, with key issues identified as relating to: weekend discharges, home-based reablement capacity, delayed referrals to therapies and risk-aversion. These issues have been factored into a system improvement programme with South Tyneside.	Mitigations for recovery which will be implemented via the System Diagnostic improvement programme and Care Closer to Home arrangements, include: •Increasing capacity and utilisation of home-based reablement •Improving effectiveness of home-based reablement by focusing on maximising the independence gained by service users, improving goal setting, and ensuring appropriate therapy input. •Adopting a 'Reablement First' mentality; embedding a system-wide culture where home-based reablement is the default consideration before increases in care packages or residential placements. •Strengthen MDT working - enhancing collaboration in discharge planning, ensuring timely input from therapy, social work, and other relevant professionals. •Implementing earlier discharge planning and improve family engagement to understand expectations, provide information, and address concerns proactively. •Addressing risk aversion: Support staff in making positive, risk-aware decisions, potentially through clearer pathways, better MDT support, and shared protocols	No
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,400.0	208.6	Target met	Main challenges include: - Ability to access data across the system to maximise opportunities to target support at those most at risk - Embedding of a consistent falls assessment across the system - Ongoing funding for strength and balance activity within communities	Continued improvements in emergency admissions due to falls Ongoing strategy and plan across the system for falls Commencement of data sharing agreements for falls data Implementation of online falls assessment Continued delivery of falls and balance support across the system	N/A	N/A	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				930	not applicable	Target not met	Provisional data available suggests this target has not been met with a rate of 974 admissions in 24/25 pending final confirmation. Whilst the target has not been met this is an improving picture. Availability and capacity of preventative/community health services to reduce hospital admissions and readmissions remains an area of challenge along with families perceptions	Continued reduction in admissions to permanent care: - Care closer to home steering group - Recommissioning of domiciliary care services with reablement focus	Variance from the plan is due to volume of hospital discharge, patient and family perception of need, ensuring patients are streamed via the correct pathway.	The provisional end of year rate subject to ratification is 974 slightly above the target of 940. A continuation of funding allows the block book community support to facilitate hospital discharge resulting in reduction of people being placed in temp care leading to deconditioning. In addition a new service has been commissioned for dom care ensuring a reablement approach in all care services. The transfer of care	Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Sunderland

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Full data sharing agreement in place for hospital admission and discharge between SCC and STFST, this is used to verify and valdiate pathways into services. This is also used to calculate potential demand with the 2 more closely aligned. An uptick in use of R@H has been noted in Q4 for step up from community as capacity within R@H has increased.	Yes
2. Do you have any capacity concerns for 25-26? Please consider both your community capacity and hospital discharge capacity.	
There are some capacity concerns for bed based reablement due to improvement works in one site and demand at a key point throuhout the year. This is being managed via the use of temp care capacity. Hospital discharge capacity remains a priority for the system and we work collectively on an ongoing basis to review issues, concerns and process to ensure this remains fit for purpose and adjust accordingly on an ongoing basis to make any improvements needed.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Capacity issues for bed based reablement (P2) are managed via the offer of temp admission to a care home placement followed by bed based reablement as soon as it becomes available to ensure we are maximising residents opportunity to rehabilitate. Capacity issues for R@H (P1) are managed via short term domicliary care then onward to R@H as it becomes available to ensure we are maximising residents opportunity to rehabilitate.	Yes
4. Do you have any specific support needs to raise? Please consider any priorities for planning readiness for 25/26.	
Further work needs to continue to address data and recording issues across the system which is ongoing.	Yes

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

5.1 Guidance

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

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

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

Hospital Discharge

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

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

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

- Other short term bedded care (pathway 2)

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

Community

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

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

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5. Capacity & Demand

Selected Health and Wellbeing Board: Sunderland

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist Complete:
Service Area	**Metric**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	81	81	81	67	66	69	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	5	5	6	4.8	3.4	5.4				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	53	53	53	43	56	55	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	11	11	11	8.7	9.1	9.9				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	47	55	48	48	48	49	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	5	5	2.4	4.4	4.2				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	29	35	18	63	46	53	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	20	20	20	15.9	10.8	14				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			
Service Area	**Metric**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	
Social support (including VCS)	Monthly activity. Number of new clients.	180	180	180	182	165	133	Yes
Urgent Community Response	Monthly activity. Number of new clients.	732	601	631	757	641	642	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	18	10	15	32	32	33	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	5	7	5	3	4	3	Yes
Other short-term social care	Monthly activity. Number of new clients.	10	10	10	40	49	25	Yes

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6. Income actual

Selected Health and Wellbeing Board: Sunderland

Source of Funding	2024-25 Planned Income	2024-25 Actual income	2024-25 Carried from previous year (23-24)	2024-25 Actual total income (Column D + E)	Checklist Complete:
DFG	£4,423,428	£4,423,428	£0	£4,423,428	Yes
Minimum NHS Contribution	£30,774,637	£30,774,637		£30,774,637	Yes
iBCF	£18,683,789	£18,683,789		£18,683,789	Yes
Additional LA Contribution	£348,151	£348,151		£348,151	Yes
Additional NHS Contribution	£0	£0		£0	Yes
Local Authority Discharge Funding	£4,365,730	£4,365,730		£4,365,730	Yes
ICB Discharge Funding	£3,364,254	£3,364,254		£3,364,254	Yes
Total	**£61,959,989**			**£61,959,989**	

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

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

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

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

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

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

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

Better Care Fund 2024-25 EOY Reporting Template

7b. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Sunderland

	2024-25					
Running Balances	Income	Expenditure to date	Percentage spent	Balance		**If underspent, please provide reasons**
DFG	£4,423,428	£4,418,340	99.88%	£5,088	Underspent!	Slight DFG underspend to be c/fwd. into 25/26.
Minimum NHS Contribution	£30,774,637	£31,099,727	101.06%	-£325,090	Overspent!	
iBCF	£18,683,789	£18,683,789	100.00%	£0		
Additional LA Contribution	£348,151	£348,151	100.00%	£0		
Additional NHS Contribution	£0	£0		£0		
Local Authority Discharge Funding	£4,365,730	£4,365,730	100.00%	£0		
ICB Discharge Funding	£3,364,254	£3,364,340	100.00%	-£86	Overspent!	
Total	**£61,959,989**	**£62,280,077**	**100.52%**	**-£320,088**	Overspent!	

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	£8,745,279	£20,725,584	£0
Adult Social Care services spend from the minimum ICB allocations	£9,991,951	£12,293,624	£0

Checklist Column complete: No 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
3	Living Well	Assistive Technology and Telecare	Assistive Technologies and Equipment	Assistive technologies including telecare	N/A	2128	2128	Number of beneficiaries	Social Care	0	LA			Private Sector	iBCF	£ 1,117,301	£1,117,301		
3	Living Well	Community-based Equipment	Assistive Technologies and Equipment	Community based equipment	N/A	9031	9031	Number of beneficiaries	Social Care		LA			Private Sector	iBCF	£ 948,292	£948,292		
2	Mental Health, Learning Disabilities and	Independent Mental Health Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Charity / Voluntary Sector	iBCF	£ 521,344	£521,344		
3	Living Well	Carers advice and support	Carers Services	Carer advice and support related to Care Act duties	N/A	166	166	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	iBCF	£ 280,000	£280,000		
5	Urgent Care	Multi-disciplinary teams that are supporting independence	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	iBCF	£ 881,889	£881,889		
5	Urgent Care	Multi-disciplinary teams that are supporting independence	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF	£ 576,860	£576,860		
4	Ageing Well	Domicillary Care Packages	Home Care or Domiciliary Care	Domiciliary care packages	N/A	137309	137309	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£ 2,800,304	£2,800,304		
3	Living Well	Housing Floating Support	Housing Related Schemes						Social Care		LA			Charity / Voluntary Sector	iBCF	£ 197,144	£197,144		
3	Living Well	Care navigation and planning	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Charity / Voluntary Sector	iBCF	£ 667,500	£667,500		
3	Living Well	Bed-based intermediate care with rehabilitation	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)	N/A	13	13	Number of placements	Social Care		LA			Private Sector	iBCF	£ 60,349	£60,349		
3	Living Well	Bed-based intermediate care with rehabilitation accepting step up and step down	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users	N/A	6	6	Number of placements	Social Care		LA			Private Sector	iBCF	£ 662,301	£662,301		
4	Ageing Well	Rehabilitation at home (to support discharge)	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	1135	1135	Packages	Social Care		LA			Private Sector	iBCF	£ 549,605	£549,605		
4	Ageing Well	Telecare response	Urgent Community Response						Social Care		LA			Private Sector	iBCF	£ 1,588,237	£1,588,237		
2	Mental Health, Learning Disabilities and	Direct payments staff	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	iBCF	£ 91,240	£91,240		
2	Mental Health, Learning Disabilities and	Direct payments	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	iBCF	£ 2,106,000	£2,106,000		

4	Ageing Well	Extra Care	Residential Placements	Extra care	N/A	55	55	Number of beds	Social Care		LA			Private Sector	iBCF	£ 1,004,805	£1,004,805		
1	Mental Health, Learning Disabilities and	Learning Disability and Mental Health Supported Living	Residential Placements	Other	LD and MH Supported Living	134	134	Number of beds	Social Care		LA			Private Sector	iBCF	£ 4,630,618	£4,630,618		
3	Living Well	Adaptations, including statutory DFG grants	DFG Related Schemes	Adaptations, including statutory DFG grants	N/A	83		Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£ 3,930,546	£3,796,818		Reduction in contracted spend to fund additional AT equipment
3	Living Well	Handyperson Services	DFG Related Schemes	Handyperson services	N/A	2612	2674	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£ 442,882	£453,474		
3	Living Well	Assistive Technology	DFG Related Schemes	Other	Assistive Technology	95	319	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£ 50,000	£168,048		Additional AT equipment
3	Living Well	Community-based Equipment	Assistive Technologies and Equipment	Community based equipment	N/A	10476	10476	Number of beneficiaries	Social Care		LA			Private Sector	Local Authority Discharge	£ 1,100,000	£1,100,000		
4	Ageing Well	Rehabilitation at home (to support discharge)	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	325	325	Packages	Social Care		LA			Private Sector	Local Authority Discharge	£ 763,600	£763,600		
3	Living Well	Assistive Technology including Telecare	Assistive Technologies and Equipment	Assistive technologies including telecare	N/A	632	632	Number of beneficiaries	Social Care		LA			Private Sector	Local Authority Discharge	£ 332,000	£332,000		
4	Ageing Well	Domicillary care to support hospital discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	N/A	3909	3909	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Local Authority Discharge	£ 797,169	£797,169		
3	Living Well	Bed-based intermediate care with rehabilitation to support discharge	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)	N/A	121	121	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge	£ 950,000	£950,000		
4	Ageing Well	Domicillary care to support hospital discharge	Workforce recruitment and retention			16	16	WTE's gained	Social Care		LA			Private Sector	Local Authority Discharge	£ 128,538	£128,538		
4	Ageing Well	Domicillary care to support hospital discharge (D2A)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	N/A	12620	12620	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Local Authority Discharge	£ 257,376	£257,376		
5	Urgent Care	Hospital Discharge Service	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)	N/A	87		Packages	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 42,111	£42,111		
5	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)	N/A	157		Packages	Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 75,996	£76,000		
5	Urgent Care	Community Integrated Teams	Community Based Schemes	Integrated neighbourhood services		104			Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 173,668	£171,608		
4	Ageing Well	Community Stroke Rehabilitation	Carers Services	Other	N/A	95		Beneficiaries	Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 45,909	£48,199		
3	Living Well	Care Act Funding	Care Act Implementation Related Duties	Other	Carers	0			Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 901,000	£901,000		
3	Living Well	Carers Services	Carers Services	Carer advice and support related to Care Act duties	N/A	1000		Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 92,000	£92,000		
5	Urgent Care	Recovery at Home - Community Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users	N/A	326		Number of placements	Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 1,943,040	£1,943,040		
5	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)	N/A	2044		Packages	Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 989,862	£989,862		
3	Living Well	Community Equipment Service	Assistive Technologies and Equipment	Community based equipment	N/A	23144		Number of beneficiaries	Social Care		NHS			Local Authority	Minimum NHS Contribution	£ 2,719,591	£3,076,018		
4	Ageing Well	NHS Funding for Social Care	Home Care or Domiciliary Care	Domiciliary care packages	N/A	194392		Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 3,964,475	£3,964,453		
2	Mental Health, Learning Disabilities and	NHS Funding for Social Care	Residential Placements	Supported housing	N/A	27		Number of beds	Mental Health		LA			Local Authority	Minimum NHS Contribution	£ 926,437	£926,437		
3	Living Well	Community Integrated Teams	Community Based Schemes	Integrated neighbourhood services		0			Community Health		NHS			Private Sector	Minimum NHS Contribution	£ 982,045	£969,517		
3	Living Well	Recovery at Home	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)	N/A	612		Packages	Community Health		NHS			Private Sector	Minimum NHS Contribution	£ 292,995	£292,995		
5	Urgent Care	Community Therapy	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	30		Packages	Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 147,197	£139,000		
5	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	14		Packages	Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 71,483	£67,500		
5	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	671		Packages	Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 266,598	£266,598		
5	Urgent Care	Community Integrated Teams	Community Based Schemes	Integrated neighbourhood services		0			Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 1,209,776	£1,209,776		
3	Living Well	Recovery at Home	Urgent Community Response			6490			Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 2,168,864	£2,168,864		

5	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	479		Packages	Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 83,568	£83,568		
5	Urgent Care	Community Integrated Teams	Community Based Schemes	Integrated neighbourhood services		0			Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 653,883	£653,883		
2	Mental Health, Learning Disabilities and	Mental Health, Learning Disability and Autism - Bed-based intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)	N/A	219		Number of placements	Mental Health		NHS			Local Authority	Minimum NHS Contribution	£ 520,198	£520,198		
2	Mental Health, Learning Disabilities and	Mental Health, Learning Disability and Autism - Workforce recruitment and	Workforce recruitment and retention			30		WTE's gained	Mental Health		NHS			Local Authority	Minimum NHS Contribution	£ 237,501	£237,501		
2	Mental Health, Learning Disabilities and	Mental Health, Learning Disability and Autism - Residential Placements	Residential Placements	Other	Short Breaks	58		Number of beds	Mental Health		NHS			Local Authority	Minimum NHS Contribution	£ 132,502	£132,502		
3	Living Well	High Intensity Users	Prevention / Early Intervention	Risk Stratification		0			Community Health		NHS			Local Authority	Minimum NHS Contribution	£ 103,184	£123,821		
5	Urgent Care	Care Act Funding	Care Act Implementation Related Duties	Other	Carers	0			Social Care		NHS			Local Authority	Minimum NHS Contribution	£ 100,000	£100,000		
4	Ageing Well	End of Life Care	Home Care or Domiciliary Care	Domiciliary care packages	N/A	9013		Hours of care (Unless short-term in which case it is packages)	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 180,967	£158,107		
4	Ageing Well	Recovery at Home	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)	N/A	143		Packages	Community Health		NHS			Private Sector	Minimum NHS Contribution	£ 68,819	£64,202		
5	Urgent Care	Urgent Care Services	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		105			Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 297,352	£297,352		
5	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)	N/A	2950		Packages	Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 1,670,346	£1,670,346		
5	Urgent Care	Urgent Community Response	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users	N/A	948		Number of placements	Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 2,173,158	£2,173,157		
4	Ageing Well	NHS Funding for Social Care	Residential Placements	Extra care	N/A	107		Number of beds	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 1,952,597	£1,952,597		
4	Ageing Well	NHS Funding for Social Care	Residential Placements	Care home	N/A	69		Number of beds	Social Care		LA			Local Authority	Minimum NHS Contribution	£ 3,152,357	£3,152,357		
4	Urgent Care	Ageing Well	Urgent Community Response			0			Mental Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 817,646	£817,646		
4	Urgent Care	Recovery at Home	Home-based intermediate care services	Reablement at home (to support discharge)	N/A	2399		Packages	Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£ 1,220,689	£1,220,689		
6	Infrastructure	Population Health Management Development	Enablers for Integration	Joint commissioning infrastructure					Other	Commissioning	Joint	0.5	0.5	Local Authority	Additional LA Contribution	£ 100,000	£100,000		
6	Infrastructure	Integrated Commissioning	Enablers for Integration	Joint commissioning infrastructure					Other	Commissioning	Joint	0.5	0.5	Local Authority	Additional LA Contribution	£ 110,000	£110,000		
6	Infrastructure	Integrated Commissioning Development	Enablers for Integration	Programme management	0	0			Other	Commissioning	Joint	0.5	0.5	Local Authority	Local Authority Discharge	£ 37,047	£37,047		
6	Urgent Care	System-level diagnostic	Enablers for Integration	Programme management	0	0			Other	Commissioning	Joint	0.5	0.5	Local Authority	Minimum NHS Contribution	£ 37,047	£37,047		
3	Living Well	District Nursing	Community Based Schemes	Integrated neighbourhood services	0	0			Other	0	0	0		NHS Acute Provider	Minimum NHS Contribution	£ 359,776	£359,776		
3	Living Well	Recovery at Home	Home-based intermediate care services	Reablement at home (to support discharge)	0	444		Packages	0	0	0	0		Local Authority	ICB Discharge Funding	£ 925,000	£925,000		
3	Living Well	Farmborough Court	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)	0	154		Number of placements	0	0	0	0		Local Authority	ICB Discharge Funding	£ 589,019	£589,019		
6	Urgent care	NEAS	Other	0	Avoidable admissions	0			0	0	0	0		NHS Acute Provider	ICB Discharge Funding	£ 336,425	£336,425		
6	Urgent care	Integrated Discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0			0	0	0	0		NHS Acute Provider	ICB Discharge Funding	£ 942,896	£942,896		
6	Urgent care	Integrated Discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0			0	0	0	0		NHS Acute Provider	ICB Discharge Funding	£ 570,914	£571,000		
3	DFG	DFG underspend (preventative use of DFG to reduce avoidable admissions)	Housing Related Schemes	0	DFG carry forward from 2023/24	0			Social Care	0	LA	0		Private Sector	Additional LA Contribution	£ 138,151	£138,151		Source of funding should be DFG and not Additional LA Contribution. This figure relates to 23 c/fwd. DFG monies.

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Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)

Better Care Fund 2024-25 EOY Reporting Template

8. Year End Impact Summary

Selected Health and Wellbeing Board: Sunderland

Checklist Complete:
Yes
Yes
Yes

Confirmation of Statements

Question statements	Confirmation	If the answer is "No" please provide an explanation:
Overall delivery of BCF has improved joint working between health and social care	Yes	
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 from SCIE logic model:

Logic model for integrated care - SCIE

Success and Challenges	Narrative

2 key successes observed towards driving the enablers for integration	•Sustainable Care Provider Market - The health and care market deliver a range of high quality, person centred and flexible services to the residents of Sunderland and one of the ways this is evidenced is by the CQC ratings of the local provider markets. Sunderland is higher than both the national and regional average of CQC ratings and this is sustained through effective and collaborative commissioning and well managed relationships. Market Oversight Networks are in place with providers from each of the care markets that operate in Sunderland. A Care Home and Community Services Oversight Network, which has a health and social care system wide membership is also in place and will support with the implementation of the neighbourhood health approach. Different models of care delivery have been established within the home care market, to support the hospital discharge process and enhance the current bed-based and community reablement offer. These arrangements have contributed to the success of the discharge to assess approach and enabled the home care market to support people to be discharged from hospital in a timely manner. The reablement service has also shown flexibility and maximised their capacity, by changing staff rotas and available support slots to respond to the discharge pressures in the hospital. The service has implemented a "Trusted Assessor" approach by accepting new customers direct from the Transfer of Care Hub. Any customer who the service then identifies as not requiring ongoing reablement is then referred into Social Work for an assessment. The reablement service continues to support the person in the community until a longer term care and support solution has been commissioned. •Leadership and Governance - The Sunderland BCF Implementation and Monitoring Group has undertaken a strategic review of its BCF, which has contributed to key improvements in leadership and governance of the BCF as part of a BCF transformational roadmap, specifically: 1)Establishing a system-wide vision for integration and innovation: The review has resulted in consolidation of schemes for efficiency, fostering two-way communication between governance groups (like the BCF Implementation & Monitoring Group and Place Committee), and promoting the use of shared data platforms for all partners as part of a transformational roadmap. In addition, spreading awareness of the BCF through stakeholder briefings, and aligning the BCF with broader policies (such as neighbourhood health) has supported a more collaborative input and increased alignment with strategic priorities. Recommendations for broader partner involvement in re-evaluation exercises and regular development sessions, will further solidify this and this has been articulated within the BCF transformational roadmap. 2) Commitment to local leadership: The plan delegates responsibility for core service specifications and financial updates to respective local governance groups, empowering them to manage changes in real-time. It also highlights the importance of neighbourhood-level data. Recommendations ensure named local leads for expenditure lines and clear roles within working groups, fostering local autonomy while maintaining cohesion through defined communication channels	Yes
2 key challenges observed towards driving the enablers for integration	Digital records, data and shared information - there are ongoing challenges in relation to the recording and sharing of data to support more robust approaches to capacity and demand management, and metrics reporting. These challenges have been picked up via the BCF roadmap and will continue to be improved through NHS FDP developments. The BCF Implementational and Monitoring group membership has also been adapted to support key data improvements, including Trust representation and the introduction of a clinical lead role. Joint commissioning arrangements and the ability to pool and align resources effectively have been constrained by the ongoing ICB changes and the impact of cost savings and efficiency programmes on both the LA and ICB. The NHS Health Reforms and the Independent Commission of Adult Social Care is likely to require a partial reset of the BCF and the implications of this are not yet fully understood, which makes investment in long-term improvement programmes challenging. That being said. the Health and Wellbeing Board and Place Committee have signalled an intent for the BCF to become a key strategic vehicle in delivering programmes of transformation, including neighbourhood health commissioning, with the changes to BCF schemes and governance arrangements supporting this.	Yes