

2025/26 BCF Plan Q2 Performance Template

3. National Conditions

| Confirmation of Nation Conditions | | |
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| 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) Plans to be jointly agreed | Yes | |
| 2) Implementing the objectives of the BCF | Yes | |
| 3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place | Yes | |
| 4) Complying with oversight and support processes | Yes | <div style="text-align: right; margin-bottom: 5px;">▼</div> |

4. Metrics

4.1 Emergency admissions

| Plan | | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan |
|---|--------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Emergency admissions to hospital for people aged 65+ per 100,000 population | Rate | 1,840.4 | 1,909.8 | 1,713.0 | 1,805.6 | 1,759.3 | 1,805.6 | 1,933.0 | 1,666.7 | 1,898.2 | 2,002.4 | 1,770.9 | 1,863.5 |
| | Number of Admissions 65+ | 795 | 825 | 740 | 780 | 760 | 780 | 835 | 720 | 820 | 865 | 765 | 805 |
| | Population of 65+ | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 | 43,198.0 |

| Assessment of whether goal has been met in Q3 | Not on track to meet goal |
|--|---|
| <p>You may use this box to provide a very brief explanation of overall progress if you wish.</p> | <p>Whilst we have made good progress, we are slightly off track from the target with total emergency admissions April to December 7,480 (December based on an average of Oct and Nov as actual not available) against plan of 7,055.</p> <p>As reported at Q2, work is in progress via our three Integrate Neighbourhood Teams to embed multidisciplinary enhanced case management for the 10,000 most frail patients that includes regular frailty reviews and rapid support to prevent crises. At 31/12/25 50% of the severe frailty population were under enhanced case management, which was contributing to a 36% reduction in emergency admissions from this group of residents. A community-based intravenous antibiotic service, funded via the BCF, will support up to 200 residents during 2025/26 and prevent admission. This service also supports discharge by meeting this need in the community rather than a hospital setting and therefore impacts on 4.2: Discharge delays.</p> <p>The borough-wide Reactive Care Coordination Hub referred to in the Q2 update went live in December 2025. This provides single-call</p> |

access to our maturing Reactive Care Service, which comprises of the Urgent Community Response (UCR), Community Rehab, Palliative Integrated Care and the Mental Health Lighthouse Services (8am - 8pm 7 days a week). BCF funding has facilitated the introduction of a senior clinician available 8am–8pm, seven days a week to strengthen on-the-spot decision-making for complex cases, enabling more people to be safely managed at home. It is intended that from January the UCR model will align with virtual wards to enable up to 17 days of community-based care for people living with frailty and heart failure to reduce inappropriate admissions and Emergency Department attendances.

The BCF has funded additional GP and nurse practitioner staffing in the three local access hubs in the borough and will support approximately 50 additional rapid access appointments a week as part of the Same Day Urgent Care Service during 2025/26 to divert residents from attending the Emergency Department at Hillingdon Hospital.

There is a project in place to further integrate Reablement and Rehab Services that will eventually come within the purvey of the Hub. During Q3 the capacity of the Lighthouse Service has increased from 4 people diverted from A & E in Q2 to 10. In November a mobile diagnostics service to care homes and people in the community living with frailty went live.

A Key achievement for Q3 is seeing a reduction in NEL admissions from care homes. This has been achieved through the overall work being delivered in relation to the Reactive care and Proactive care workstreams. With the main areas of improvement coming from having a senior clinical decision maker, community diagnostics (with an increasing direct referral from carehomes) and focussed education with care homes in relation to Falls training and increasing the uptake of residents with an urgent care plan (UCP).

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| | <p>Several non BCF initiatives underway which support lift shift away from acute, these are not funded via BCF arrangements but helpful context in respect of emergency admissions metrics:</p> <p>NWL is reducing emergency admissions through digital front doors, 111 assessments, and Same Day Emergency Care Services. The mobilisation of Integrated Care Coordination hubs and increased UCR capacity is aimed at lowering ambulance conveyances and supporting two-hour response targets. The mobilisation of frailty virtual ward will enables home-based interventions, while enhanced community and neuro-navigator support helps prevent unnecessary admissions and supports timely discharges. The Pharmacy First scheme is reducing admissions by ensuring appropriate access to care, deescalating care needs, and facilitating timely and efficient discharges.</p> |
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4.2 Discharge Delays

| Original Plan | Apr 25 Plan | May 25 Plan | Jun 25 Plan | Jul 25 Plan | Aug 25 Plan | Sep 25 Plan | Oct 25 Plan | Nov 25 Plan | Dec 25 Plan | Jan 26 Plan | Feb 26 Plan | Mar 26 Plan |
|---|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days) | 0.37 | 0.37 | 0.37 | 0.37 | 0.37 | 0.29 | 0.41 | 0.32 | 0.36 | 0.37 | 0.37 | 0.37 |
| Proportion of adult patients discharged from acute hospitals on their discharge ready date | 93.9% | 93.9% | 93.9% | 93.9% | 93.9% | 95.2% | 94.2% | 93.5% | 92.8% | 93.9% | 93.9% | 93.9% |
| For those adult patients not discharged on DRD, average number of days from DRD to discharge | 6.00 | 6.00 | 6.00 | 6.00 | 6.00 | 6.00 | 7.00 | 5.00 | 5.00 | 6.00 | 6.00 | 6.00 |

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|---|--|
| Assessment of whether goal has been met in Q3 | Not on track to meet goal |
| | <p>We have shown an improved position in relation to the number of delayed days between the discharge ready date and date discharged. We have an average plan of 6 days, but we have exceeded this by 1 day with the actual at 5 days.</p> |

You may use this box to provide a very brief explanation of overall progress if you wish

We are slightly behind target in relation to the percentage of patients being discharged on the DRD. Our target is 94% whereas our actual is 91% (Average discharged on DRD Apr - Nov (Dec data not available)).

The No Criteria to Reside (NC2R) project reported in Q2 remains in place. December saw an actual average of 33 per day against a target of 34, which represents an improvement of 34% in the volume of daily NC2R from Q2 and we are now on track to meet our local target. These improvements help stabilise bed capacity and improved flow.

Developments with our Reactive Care Service that will also impact on discharge are mentioned in response to 4.1 above. An additional development is a project to integrate Reablement and Rehabilitation Services to remove duplication and streamline pathways. The first phase of this is integration between our Bridging Care and D2A Therapy Services to form a single D2A service to support Pathway 1 discharges. Our P1 discharge performance was the best in NWL in December but there is scope to reduce length of stay in the Bridging Care Service, which is delivered by an independent sector provider. The current Bridging Care and D2A Therapy Services are funded through the BCF. We have also seen some improvements in utilisation and reduced length of stays in our community step down beds in Q3.

4.3 Residential Admissions

| Actuals + Original Plan | | 2023-24 | 2024-25 | 2025-26 | 2025-26 | 2025-26 | 2025-26 |
|--|----------------------|------------------|----------------------|-----------------------------|----------------------------|--------------------------|--------------------------|
| | | Full Year Actual | Full Year CLD Actual | Plan Q1 (April 25- June 25) | Plan Q3 (July 25- Sept 25) | Plan Q3 (Oct 25- Dec 25) | Plan Q4 (Jan 26- Mar 26) |
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Rate | 907.9 | 463.0 | 104.2 | 92.6 | 92.6 | 104.2 |
| | Number of admissions | 386.0 | 200.0 | 45.0 | 40.0 | 40.0 | 45.0 |
| | Population of 65+* | 43198.0 | 43198.0 | 43198.0 | 43198.0 | 43198.0 | 43198.0 |

| Assessment of whether goal has been met in Q3 | On track to meet goal |
|---|--|
| You may use this box to provide a very brief explanation of overall progress if you wish. | <p>We are meeting this metric with 120 permanent admissions between April and December 2025. Just over 80% of permanent placements were conversions from short-term, which is a slight reduction on what was reported in Q2 (83%) but reflects a continuing trend. As stated at Q2, the Council has robust processes that include sign-off by an assistant director level panel.</p> <p>In addition, there is a good support offer for unpaid carers delivered via the Carers Support Service contract that includes short break options and peer support, the funding for which is included within the BCF. Respite provision can also be accessed from the Council following a carer's assessment.</p> |

5. Expenditure

| Source of Funding | 2025-26 | | DFG Q3 Year-to-Date Actual Expenditure |
|-----------------------------------|--------------------|-------------------------------------|--|
| | Planned Income | Updated Total Plan Income for 25-26 | |
| DFG | £6,341,993 | £6,341,993 | £3,600,202 |
| Minimum NHS Contribution | £27,145,109 | £27,145,109 | |
| Local Authority Better Care Grant | £9,212,761 | £9,212,761 | |
| Additional LA Contribution | £29,175,125 | £29,175,125 | |
| Additional NHS Contribution | £2,285,950 | £2,285,950 | |
| Total | £74,160,938 | £74,160,938 | |

| | Original | Updated | % variance |
|----------------------------|--------------------|--------------------|------------|
| Planned Expenditure | £74,160,938 | £74,160,938 | 0% |

| | | % of Planned Income |
|---|--------------------|---------------------|
| Q3 Year-to-Date Actual Expenditure | £54,913,874 | 74% |

If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

Income streams reporting to plan except DFG, which is showing a £1,156k underspend, and NHS additional contribution, which is has a £449k overspend. The DFG underspend reflects the gradual impact of the change to our grants policy that was intended to give the Council greater flexibility in how it supports the independence of older and disabled residents. The NHS additional contribution overspend relates to increased costs arising from the new community equipment service contract. Increased local authority community equipment costs are capitalised using DFG funding.