Better Care Fund 2025/26 End of Year Reporting Template

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 Q4:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	The outturn for 2025/26 is 9,644 admissions against a planned target of 9,490, which means that performance was marginally above the plan. The 2026/27 target has been set within the context of the 2025/26 performance outcome, growth in the 65 + and 80+ population and the proactive care work being undertaken within Neighbourhood Teams to focus on older people in the specialist segmentation within our Whole Systems Integrated Care (WSIC) database, i.e., older people in the group of people living with complex conditions such as frailty, dementia, serious mental illness and people at end of life, and applying a 30% reduction. Our Reactive Care Coordination hub has now mobilised, alongside increased Urgent Community Response (UCR) capacity funded via the BCF, supporting reductions in ambulance conveyances and delivery against the two hour response standard. The frailty virtual ward, which funded external to the BCF, has been mobilised to enable home based interventions for high risk patients, while enhanced community and neuro navigator support has helped prevent unnecessary admissions and support timely discharge. The Pharmacy First scheme has further contributed by improving access to appropriate care, de-escalating presenting need and supporting both admission avoidance and earlier discharge.

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

Assessment of whether goal has been met in Q4:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	The 2025/26 outturn shows that nearly 91% of adult patients were discharged on their discharge ready date (DRD) against a target of 93.9%. The average number of delayed days between the DRD and the actual discharge date was 5.1 days against a target of 5.9 days, which is positive. A No Criteria to Reside (NC2R) project was instigated in 2025/26 that identified the importance of senior clinical decision maker arrangements and dedicated housing support for housing-related delays and these have been reflected in funding arrangements for 2026/27. Bridging care to support dicharge to assess continues to be in place aligned with therapy provision and reablement support for people on pathway 1. Block step-down beds are in place to provide additional capacity to existing bed-based rehab provision by the NHS community provider. System escalation arrangements, alongside the continued use of Optica, have enabled improved grip on discharge delays, supporting proactive troubleshooting and escalation where required.

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 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 Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	There were 170 permanent admissions to care homes during 2025/26, which was the target. It should be emphasised that there is a robust process in place for agreeing permanent placements that ensures that it is the least restrictive option available to address assessed need.