BRIEFING	TO:	Health and Wellbeing Board
	DATE:	Wednesday, 28th January 2026
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	TITLE:	HWBB Report for Rotherham BCF 2025/26 Quarter 3 Reporting Template

Background

1.1 The purpose of this report is to agree the contents of the BCF Q3 Reporting Template which will be submitted to NHS England regarding the metrics and expenditure of Rotherham's Better Care Fund Plan for 2025/26.

1.2 The overall delivery of the Better Care Fund continues to have a positive impact and improves joint working between health and social care in Rotherham.

Key Issues

2.1 The BCF Quarter 3 template covers reporting on: national conditions, metrics and expenditure.

2.2 Below is a summary of information included within the BCF submission:

2.3 National Conditions

There are a total of 4 national conditions for 2025/26 which continue to be met through the delivery of the plan as follows:

- Plans to be jointly agreed.
- Implementing the objectives of the BCF.
- Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC).
- Complying with oversight and support processes.

3. BCF Metrics

There are three BCF metrics within the BCF Q3 Template for 2025/26 which measures the impact of the plan as follows:

3.1 **Emergency admissions to hospital for people aged 65+ per 100,000 population** - This measure was reported as not on target to meet goals.

	It was noted In the Q3 template, the BCF updated the population counts for people aged 65 and over, to use the latest 2024 mid-year estimates from the Office for National Statistics (ONS). This population figure is now used as the denominator when calculating the planned rate of emergency admissions to hospital for people aged 65+ per 100,000. As a result, the rates have changed slightly. **Achievements** - This indicator measures the rate of emergency hospital admissions among people aged 65 and over, expressed as a crude rate per 100,000 population. Emergency admissions are unplanned, urgent admissions that may occur via A&E, direct referral from a GP, or other clinical pathways. As part of quarterly reporting, figures are provided for each month. Using locally held SUS data, there has been some month-on-month variation across the quarter. In October, the actual figure was 2207.6 compared with a planned 2088.0, above plan. In November, the actual was 2020.0 against a planned 1955.6, slightly above plan. The data currently available for December is incomplete and therefore does not provide an inaccurate comparison at the current time. **Challenges and any support needs** - A key priority for the Rotherham urgent and emergency care recovery plan in 2025-26, is to reduce avoidable conveyances and admissions in order to meet the national 4-hour standard, G&A occupancy levels and no criteria to reside. **Variance from Plan –** Overall, the quarter 3 figures are slightly higher than the planned values across October and November 2025. **Mitigation for Recovery –** There is a significant amount of activity happening to reduce avoidable conveyances and admissions, however due to the aging population and Rotherham's health inequalities, we are continuing to see high levels of demand. Winter schemes were enacted from November 2025, and the acute respiratory infection hub was opened early due to flu hitting early. Additional activity has been put in place to increase the uptake in vaccination rates as well as additional capacity in the Hospital at Home (virtual ward) pathways. There is ongoing work with Yorkshire Ambulance Services to promote PUSH models to reduce avoidable conveyances, and targeted work is planned to support the top 5 GP practices and care homes that convey to hospital.
3.2	**Average length of discharge delay for all acute adult patients, derived from a combination of:** **• proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)** **• for those adults patients not discharged on their DRD, average number of days from the DRD to discharge -** This measure was reported as on track to meet goals. **Achievements** - The Discharge Ready Date (DRD) is the specific date that a patient is ready to be discharged from the acute setting either to their 'home' or to any intermediate level of care. It can be used to identify any delay between DRD and the actual date of discharge.

	The indicator metric used is an average derived from a combination of proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD) and the average number of days patients that are not discharged on their discharge ready date take to be discharged. This report covers data for the third quarter of 2025–26 relating to the Discharge Ready Date (DRD) metric. Local SUS data shows that in October, the recorded average was 0.58 compared with a planned 0.65. The figure increased in November to 0.74 above the planned 0.65, and provisional data for December shows an increase to 0.80, above the planned 0.65. Across the three months of Quarter 3, the average proportion of adult patients discharged on their date of discharge was 85.5% in October, 81.9% in November, and 81.8% in December. For adult patients not discharged on their DRD, the average number of days from DRD to discharge decreased during the first two months of Quarter 3 compared with September's figure, at 4.00 days in October and 4.08 days in November. Provisional data for December currently shows an increase to 4.40 days, this is expected to change. **Challenges and any support needs** - Discharge pathways have been pressured due to increased demand and acuity. There has been an increase in complex discharge referrals of 10% from December 2024 to December 2025, and 34% from December 2023 to December 2025. Taking a snapshot at the turn of the year, from 2023 there were 42 patients awaiting complex discharge. This rose to 60 in 2024, and 70 in 2025. At the equivalent time at the start of 2026, this reduced to 58 discharges, against the backdrop of significant increases in referrals. The team are currently carrying some vacancies and response times are expected to improve when these are filled. **Variance from Plan –** In Q3 2025–26, the Discharge Ready Date (DRD) metric showed mixed variance from the plan. October's average (0.58) was below the planned 0.65, November was above plan at 0.74 vs. 0.65, and December exceeded the planned 0.65 with an actual of 0.80. **Mitigation for Recovery –** TRFT have carried out extensive work to reduce discharge delays for Pathway 0 patients including senior management long length of stay reviews and consistent reviewing of discharge delays and action cards. The Transfer of Care Hub continues to embed, with real time MDT discussions reducing delays. General and acute bed occupancy rates in Rotherham hospital were reduced from a high of 97.5% on 19th December to 78.46% on Christmas morning, meeting the national target of 80% occupancy. This was achieved through activity such as the 12 days of Christmas MADE event (multi-agency discharge event) and strong partnership working.
3.3	**Long-term admissions to residential care homes and nursing homes for people age 65 and over per 100,000 population –** On track according to the BCF dashboard/CLD. Adult Social Care (ASC) has been undergoing a change in how statutory information is collected. Up to 2024 the data was collected at year end, compiled onto spreadsheets and submitted to government. During 24/25 this process continued but there was a quarterly submission of data extracted direct from the adult social care database and processed centrally – this is called Client Level Data (CLD). Some data such as safeguarding is still collected using the previous method, however CLD is now entirely used for calculating admissions data.

The BCF return has always been populated using the local definitions that previously populated the spreadsheets. BCF has now shifted to using the CLD return and the CLD definitions are different than the previously used local ones.

This data has always historically revised down before it becomes stable. Looking back at Quarter 1 the two numbers are very alike, but at the point of collection for Q3 they are very different. According to the BCF dashboard that is now available nationally, Rotherham is on target, according to the latest local data Rotherham is over target – but this data always historically revises down over the year.

The issue is further compounded by the fact that the return demands data being run almost at the point of the end of the quarter and this does not give time for write up processes to fully conclude. CLD itself is not submitted until the end of the month following quarter end and therefore the CLD number presented below is the indicative number prior to validation.

Both numbers are presented below. The most reliable quarter we have at this point is Q1 which appears to be right around target regardless of the method used.

The two numbers for Q3 vary by a greater margin than in previous quarters, the data will be rerun at month end prior to submission, where it is expected the numbers will be closer together:

	Q1	Q2	Q3
Local Actual	83	95	106
Local per 100,000	154.94	177.34	197.87
CLD Actual	81	84	68
CLD per 100,000	151.2	156.8	126.94
Target Actual	**82**	**82**	**82**
Target per 100,000	**153.07**	**153.07**	**153.07**

Achievements - Rotherham's strategic aim is to support more people to remain independent for longer at home and BCF funding is being used to support this. An impact of the strategy is therefore to reduce admissions to care homes. However, this needs to be balanced in the context of an ageing population and Rotherham's challenging levels of deprivation.

The Council have completed a review of in-house services with changes in roles and responsibilities of teams including the discharge team, enablement and in house community beds. This is leading to improved partnership working and releasing capacity.

Adult Social Care are continuing to work with Health partners to reduce short term placements in care homes, many of which translate into long term stays.

The Council also continues to closely monitor the rates of admission with a focus on home first, and residential care being only considered where there are no other appropriate alternatives to meeting needs.

Approval has been given to a Place review of intermediate care provision and the commissioned community bed base. An anticipated benefit is to support more people at home and reduce long term placements.

	Activity and outturn data is subject to amendments and additional system recording with revised admissions totals for each month. The 2025-26 BCF target has been set to a population rate of 563.6, which equates to 317 admissions over the year. **Challenges and any support needs** – Shortage of capacity in Pathway 1 can result in increased numbers of short stay placements. National and local evidence shows that those placed in short term care often convert to longer term care. **Variance from Plan –** BCF dashboard/CLD better than plan. Local data currently over plan but traditionally revises down. **Mitigation for Recovery –** The next phase of the discharge to assess model is planned for January 2026. This is funded by in year BCF monies but has been delayed due to recruitment challenges. There has been a review of the discharge processes at each of the 3 commissioned bed bases and action plan is in place. The aim of both is to reduce length of stay and return more people home quicker.
4. **4.1**	**Bench Marking** The BCF Operational Group are requesting South Yorkshire and regional data to enable a benchmarking exercise.
5. **5.1**	**Expenditure** The Q3 Year-to-Date Actual Expenditure for BCF funded schemes. covering the period from 1st October to 31st December 2025, has been included in the Q3 template.
Key Actions and Relevant Timelines	
6.1	**The Better Care Fund Executive Group held on Monday 19th January 2026 approved (on behalf of the Health and Wellbeing Board) the:** **i) Documentation for submission to NHS England (NHSE) on 30th January 2026.**
Implications for Health Inequalities	
7.1	Addressing health inequalities is integral to the allocation of BCF resource and funded schemes. This includes contributing to achieving the strategic aims of developing healthy lifestyles and prevention pathways, supporting prevention and early diagnosis of chronic conditions and targeting variation.
7.2	BCF funded schemes which reduce health inequalities include carer support, social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.
Recommendations	

8.1	**That the Health and Wellbeing Board notes the:** **i) Documentation for submission to NHS England (NHSE) on 30th January 2026.**