TORBAY COUNCIL

Title: **Torbay Better Care Fund Quarter 3 Return 2025 – 26**

Wards Affected: All

To: Torbay Health and Wellbeing Board **On: 5 March 2026**

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1. Purpose

Torbay Better Care Fund (BCF) Plan 2025/26 was developed and submitted within nationally mandated timelines. Torbay's plan received approval from the regional BCF panel, progressed to the national panel where it was also endorsed. Torbay Health and Wellbeing Board signed off The Torbay Better Care Fund Plan, 19 June 2025 satisfying its role of BCF oversight in-line with national requirements.

The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery and monitoring of progress. This report:

- Provides an update on the BCF performance and spend for October - December, Quarter 3, 2025/26 (copy attached).

2. Analysis

2.1 Torbay BCF Quarter 3 return 2025/26

30 January 2026, Torbay's BCF Quarter 3 2025/26 template was submitted in accordance with national requirements.

National Better Care Fund planning guidance committed to less onerous monitoring of BCF plans for local Health and Wellbeing Boards. The quarter 3 return has therefore focused on:

- An overview of the 3 main metrics
- Assurance of local finances with high level summary of spend

In previous years, BCF capacity and demand plans have also required oversight. This continues not to be featured in the quarter reporting template.

2.2 Metric Targets

2.2.1 Emergency Admissions

The “Emergency Admissions” key performance indicator measures the number of admissions to hospital in people aged 65 and over within the Health and Wellbeing Board area. The aim being to reduce the total number of people and rate per 1000 population being admitted to ED.

This replaces the previous “avoidable admissions” metric which monitored unplanned hospitalisation for chronic ambulatory care sensitive conditions such as acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, and pulmonary oedema.

Performance for 2025/26:

		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	Number of admissions 65+	622	634	602	633	616	602	659	621	653	640	630	620
	Rate (target)	1,640.6	1,672.2	1,587.8	1,669.6	1,624.8	1,587.8	1,738.2	1,638.0	1,722.4	1,688.1	1,661.7	1,635.3
	Rate Achieved	1635.0	1794.0	1807.0	1857.0	1700.0	1870.0	2066.0	1932.0	1932.0			
	Population of 65+	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0

Data at the time of submission indicates Torbay’s performance was **“not on track to meet goal”**. Further information is provided in the quarter 3 return.

Assurance

Current national data is only available up to October 2025 via the DHSC Exchange. A review of local SUS data indicates Torbay is off target for Q3 with the number of admissions being 790 (October), 739 (November) and 739 (December) against a plan of 659, 621 and 653.

A Devonwide workstream has been in place throughout 2025/26 to ensure a concerted approach to admission avoidance.

- **Enhanced Clinical Validation (ECV) of NHS 111 emergency outcomes**. Some patients advised by NHS 111 to attend ED may not require hospital-based care. Project aims to have more experienced clinicians assessing these patients and then directing them to a more appropriate service. DOS page to automate ED cases going to senior clinical validators each day 1000-1400 went live w/c 14 December. Early feedback is positive, awaiting data update. Variable compliance with target emphasizing priority to automate and embed process.

- **Effective Navigation to ED alternatives**. Spokes are at different stages of maturity therefore the system still needs to maintain the 'hub' model that been implemented for +18mths and supports attendance avoidance by circa 360 patients per month. Care Coordination Hub: Contract variation with PPG for Care Coordination Hub running until Sep26; option for hub light model from April, dependent on progress with links between hub and spoke services and improved 111-999 interface. Spoke Services: Work in progress to establish urgent care coordination development group to oversee implementation of plans, due to meet January (date TBC). Challenges getting traction on the 111-999 "cell" which will oversee 111-999 actions, difficulty identifying the most appropriate leads for SWASFT. Action highlights from Nov/Dec include PPG/ICB review of Care Co hub MOU , meeting with SWASFT 12th Jan. Frailty training for hub clinicians completed and link with new south community frailty service (The Harbour) made, additional spoke services for west (CFVW, acute VW) added to the DOS.

- **Out of Hospital Respiratory Transformation**.

i. Increasing access to spirometry & FeNO to support diagnosis and optimisation of asthma and COPD. LMC agreement reached, now moving to implementation.
ii. Pulmonary rehab: Increase availability of pulmonary rehabilitation services to reduce attendances, admissions and length of stay. Provider meetings taking place to understand issues and actions being taken to improve, business cases to expand capacity received and being considered.
iii. Optimising COPD Management for high-risk patients. Targeting patients at greatest risk of exacerbations via GP system searches Review including meds, inhaler technique, vaccinations, antibiotic rescue packs, how to identify a flare-up and what to do. Scheme complete and now being evaluated, including metrics.
iv. Children and Young People information and digital navigation system to reduce avoidable ED attendances. Pre-contract stage. Assessment of digital assurance has been escalated but core clinical safety assurance documentation still outstanding.

- **Primary Care Network (PCN) Acute Care Service pilots** within each locality to deliver increased primary care capacity for 'same day urgent care' patients within key identified areas. Pilots in place until Mar26 with an additional circa 6,500 primary care appointments utilised during Nov. As the PCN ACS paper for the Board has been deferred, confirmation on next steps is yet to be agreed. In the meantime, we will continue to engage proactively with PCN leads and share updates as soon as further information becomes available.

- **Rapid Response and Intermediate Care Services** underpins admission avoidance work with Rapid Response delivering short term (up to 7 days) of emergency care where someone is experiencing a crisis. Urgent Community Response is performing well in Torbay with a 93% response rate. Pathway 1 and admission avoidance reablement specification has been awarded. The contract is now being mobilised between community health, social care and the independent sector provider.

- The Devon **End of Life** Task & Finish Programme is a multi-agency collaboration between commissioners and providers of End of Life care, aimed at co-designing solutions to current current commissioning and care related challenges. Workstreams include:
  - Early Identification: Embedding the Gold Standards Framework (GSF) across Devon (project plan in development)
  - After Death Care: Standardised clinical guidance and certification (documentation in development publication expected in Spring 2026)
  - End of Life Medications: Strengthening oversight, accountability and safe delegation (documentation in development publication expected in Spring 2026)
  - Hospice at Home Service: Specialist overnight support for patients and families provided by Marie Curie (re-procurement complete and contract extended to March 2027)
  - Integrated Care Plan: Person centred records on the Devon and Cornwall Care Record (project on track)
  - Electronic Treatment Escalation Plan (eTEP): System wide implementation (project on track, all providers live (Royal Devon University Hospital NHS Trust 21 January) only a very small number of General Practices yet to sign up.

Torbay Better Care Fund has also provided additional investment to support the admission avoidance metric. Two areas have been invested in which are interconnected and both linked to the Living Well @ Home contract:

1. Additional capacity is being sourced via packages of care to support admission avoidance. This will fund additional domiciliary care support to keep people well in the community and reduce reliance on both long-term bedded care and admittance to ED.
2. Increase Reablement Capacity and Reach - Rapidly scale access to reablement interventions by expanding external delivery capacity through three of the Living Well@Home providers contracted with, following a procurement process led by Torbay Council. The project will ensure that all new referrals into adult social care are assessed for reablement potential as a first-line response.
3. Increase Replacement Care Capacity – The LivingWell@Home contract now offers replacement care through all LivingWell@Home providers. The aim is to support carers to be able to continue care for their loved one at home following a break.

In addition to the above, Torbay Better Care Fund Leadership Team provides scrutiny of performance at a local level. An improvement plan has been requested from TSDFT to outline how, local activity will improve current performance. Key areas of work which have been implemented are:

1. Frailty Harbour at Home – an integrated community based acute frailty service providing the right care closer to home for older people living with frailty.
2. Frailty Same Day Emergency Care (SDEC)

The anticipated impact of the above two initiatives is:

- Transfer to acute only 9.03% of patients who are frail (vs 10–30% benchmark).
- Over 90% remain at home, avoiding Emergency Department attendance and admission.
- Care-home conveyance reductions observed during operational hours.
- Anticipated diversion 5–10% of frailty presentations from Emergency Department / AMU.
- Prevents unnecessary conveyance for clinically stable frailty cases.
- 15–16 bed equivalents avoided from CHAH + Frailty Hub modelling.
- 20–30% reduction in avoidable over-65 admissions projected.
- 4,900–5,300 annual bed days avoided.
- Further improvements in flow, reduced Lengths of Stay, and supports Emergency Department performance.

2.2.2 Discharge Delays

The 2024/25 metric which measured the percentage of people who are discharged from acute hospital to their usual place of residence has been replaced in 2025/26. This key performance indicator now focuses on the length of time from a person's discharge ready date (DRD) to their actual point of discharge.

Within the BCF plan we continue to focus on people being discharged from acute hospital settings via a Home First approach and to their usual place of residence. For all patients discharged from an acute bed in Torbay and South Devon NHS Foundation Trust, 85% of people are discharged home, requiring no support (pathway 0), 9% (P1) home with support, 4% (P2) bed based reablement and 2% (P3) residential / nursing care. For all discharges from TSDFT, 94% of people are discharged home with or without the need for support.

The below table focuses on complex discharges (Pathways 1 – 3). The table shows a 7% lower than expected number of discharges to long-term residential or nursing care (P3). Both pathway 1 and pathway 2 have seen higher levels of discharges than expected, 10% and 61% respectively.

	April 2025 – December 2025					
	TORBAY Forecast (no. of people)	**TORBAY Forecast % of complex discharges**	**TORBAY Actual (no. of people)**	**TORBAY % variance against forecast**	**TORBAY Actual % of discharges**	**TRUST footprint % of discharges**
P1	708	65%	784	10%	59%	62.5%
P2	275	25%	451	61%	34%	24%
P3	107	10%	89	-7%	7%	13.5%

Total	**1,090**	**100%**	**1,324**	**8%**	**100%**	**100%**

Torbay continues to perform well against the Better Care Fund metrics linked to hospital discharge. On average 91% of patients are discharged on their discharge ready date. The average length of delay for those not discharged on their DRD is 4.33 days. Torbay consistently outperforms wider Devon Local Authorities, peer group, region and national average performance. The below table illustrates nationally reported data via the Department for Health & Social Care, Better Care Fund Dashboard

Performance for 2025/26:

Discharge Delays		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
Proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)	Target	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%	89.3%
	Achieved	91.0%	92.0%	94.0%	89.0%	92.0%	89%	88.92%	90.15%				
For those adult patients not discharged on DRD, average number of days from DRD to discharge	Target	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
	Achieved	3.88	3.74	3.84	6.19	3.35	3.86	5.03	4.75				

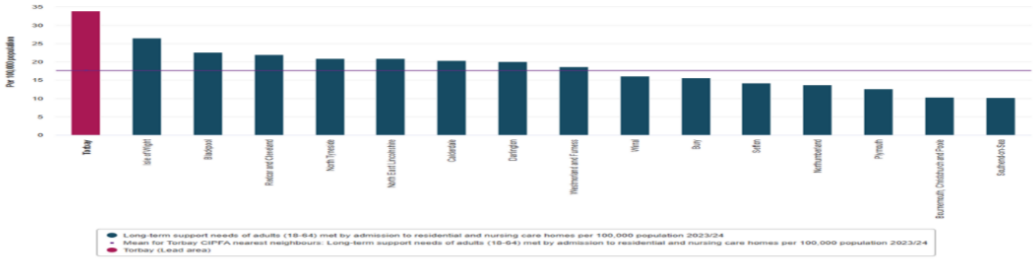
Data at the time of submission indicates performance within Torbay was **"on track to meet the goal"**. Further information is provided in the quarter 3 return.

2.2.3 Residential Admissions

There has been no change to the residential admissions key performance indicator. The definition remains: Long-term support needs of older people (65 & over) met by admission to residential & nursing care homes per 100,000 population.

Avoiding permanent placements in residential and nursing care homes is a good measure of our ability to support people to live independently at home for as long as possible. Torbay remains an outlier for the number of working age adults whose needs are being met by long term residential and nursing care homes (per 100,000 population). The below graph is a comparison of Torbay against the CIPFA group.

Long term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes per 100,000 for Torbay and Torbay CIPFA:



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Performance for 2025/26:

Residential Admissions		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	762.3	809.7	195.2	195.2	197.8	197.8
	Number of admissions	289.0	307.0	74.0	74.0	74.0	74.0
	Achieved			75.0	66.0	69.0	
	Population of 65+	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0	37,913.0

Whilst Torbay remains an outlier for long-term residential and nursing needs, improvements are being made. The residential admission target is an annual target and measured at year end. The 2025/26 target is 296 admissions per 100,000 population of people aged 65+. Quarter monitoring is being undertaken to review Torbay's current position. The metric has been classified as **"on track to meet goal"**.

3 Torbay BCF Expenditure Q3 2025/26

3.1 Finance overview

Reporting requirements for monitoring BCF expenditure has been simplified. 2024/25 reporting required expenditure to be reported on for each budget line or area of investment. The national reporting for 2025/26 requires HWBB areas to:

1. Re-confirm the level of investment made into local BCF schemes
2. Provide a single year to date spend position
3. Provide assurance on the accuracy of spend if reporting exactly 50% of overall spend
4. Provide context if spending levels have a variance of +/-5%

Local monitoring of each investment line continues within TSDFT with additional oversight by NHS Devon and Torbay Council.

Torbay BCF has reported a Q3 position of £30,268,205 representing an expenditure of 70% of overall Torbay BCF investment.

Better Care Fund 2025-26 Q3 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Torbay

	2025-26		
Source of Funding	Planned Income	Updated Total Plan Income for 25-26	DFG Q3 Year-to-Date Actual Expenditure
DFG	£2,641,358	£2,641,358	£822,061
Minimum NHS Contribution	£16,724,252	£16,724,252	
Local Authority Better Care Grant	£10,902,595	£10,902,595	
Additional LA Contribution	£0	£0	
Additional NHS Contribution	£0	£0	
Total	**£30,268,205**	**£30,268,205**	

	Original	Updated	% variance
Planned Expenditure	**£30,268,205**	£30,268,205	**0%**

		% of Planned Income
Q3 Year-to-Date Actual Expenditure	£21,083,874	**70%**

4. Recommendations

- Torbay Health and Wellbeing Board approves the Q3 2025/26 Torbay BCF Report.

Appendices

Background Papers:
The following documents/files were used to compile this report:

Appendix

List of background papers

Paper	
Torbay HWBB Q3 Return FINAL 2025-26	TORBAY%20BCF%20 2025-26%20Q3%20R