**Report to HEALTH AND WELLBEING BOARD**

# Better Care Fund 2025-26 Quarter 2 Submission

**Portfolio Holder:**
Councillor Barbara Brownridge, Cabinet Member Health & Social Care

**Officer Contact:** Jayne Ratcliffe, Director of Adult Social Care (DASS)

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**Date:** 15th January 2026

## Purpose of the Report

In order to meet the national funding conditions of the Better Care Fund, this report seeks Health and Wellbeing Board's retrospective approval on the submission of Oldham's Quarter 2 Better Care Fund (BCF) submission.

The Board should note, that in order to meet the deadlines set for the above submission, which was the 11th November 2025 the template was submitted under the delegation which was agreed by Health and Wellbeing Board on the 3rd April 2025 (Health and Wellbeing Board Report on BCF Q2 and 3 submissions and 2025-26 planning templates).

## Requirement from Oldham's Health and Wellbeing Board

1. a) Note the content of the Quarter 2 Report
   b) Provide retrospective approval for their submission to the Regional Better Care Fund panel

## 1. Background

### The Better Care Fund

1.1 The Better Care Fund's vision has been to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. The BCF Policy Framework centres of these objectives and now sets separate National Condition for each:

- **To support the shift from sickness to prevention** – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
- **To support people living independently and the shift from hospital to home** – including help prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

1.2 As well as supporting delivery of the *Next Steps to put People at the Heart of Care*, the BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services.

1.3 Differing from the previous year, the current BCF plan is only for one financial year for the period 2025-26, with the delivery of the BCF supporting two key priorities for the health and care system that align with the two existing BCF objectives of:

- improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services
- tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

1.4 The reporting schedule for 2025-26 is outlined in table 1 below, including suggested sign off by the Health and Wellbeing Board. Due to the timing of reporting (and considering dates and when templates become available) can be subject to change in year, the Health and Wellbeing Board agreed at the meeting in April 2025 to delegate the sign off of reports which could not be agreed at full Board to the Director of Adult Social Care in consultation with the Deputy Place Lead (see appendix 1):

| Report | Submission Deadline | Health and Wellbeing Board sign off |
|---|---|---|
| ~~Quarter 1~~ | ~~15th August 2025~~ | ~~11th September 2025 (Retrospective)~~ |
| Quarter 2 | 11th November 2025 | 15th January 2026 (Retrospective) |

| Report | Submission Deadline | Health and Wellbeing Board sign off |
|---|---|---|
| Quarter 3 | 31st January 2025 | 5th March 2026 (Retrospective) |
| End of Year Report | 29th May 2026 | TBC |

## 2. 2025-26 Quarter 2 Report

2.1 The Quarter 2 submission for this year only required the following:

- Confirmation of meeting national conditions (which we confirmed)
- Review of whether metrics were on track
- High level spend data

The report was submitted on time and is attached at Appendix 2.

2.2 Metric 1: Emergency admissions to hospital for people aged 65+ per 100,000 population. This was reported as on track to meet the goal, with Greater Manchester data suggesting that admissions are generally falling for this cohort and were below the 682 target during quarter 2.

2.3 Metric 2: Average length of discharge delay for all acute adult patients. This was reported as on track to meet the goal, which was an improvement from the quarter 1 position. The average delay for the quarter was 8.61 days. Local data does show there was a spike in August, with recovery in September, which is attributed to staff holidays. The general trend is downwards compared to 2024-25.

2.4 Metric 3: Long term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population. This was reported as on track to meet the goal. During the year to date there have been 122 admissions, which is tracking below the annual target of 272, based upon two quarters (14 below target for admissions), however we anticipate a slight increase in admissions over the winter period.

2.5 Expenditure for the year to date up to Quarter 2 was reported as £1,294,152 for Disabled Facilities Grant, with a total spend in the quarter of £21,235,793. It was noted that actual expenditure was 50% of planned income due to the fact that the majority of contracts are block arrangements, for example with the Northern Care Alliance or the Pennine Care Foundation Trust. This creates a consistent monthly expenditure profile with no material seasonal variation, meaning year-to-day spend aligns closely with of the annual plan.

2.6 Work is already underway with providers and commissioners to start to shape the plan for 2027-26 in relation to what the local system needs are and further information on this will be brough to the Board in due course.

## 3. Case Studies of services funded through BCF in 2025-26

3.1 Case Study – Falls Prevention

Mrs A aged 89 attends a weekly falls prevention classes at Tandle View Court in Royton.

- In the 12 months prior to attending the classes Mrs A had 3 falls.
- She had a stroke prior to her referral, has LVF (left ventricular failure), Heart Disease, Stage 3 Kidney Disease, Osteoporosis, Diverticulitis, Hiatus Hernia and Anxiety. She was on multiple medications.
- The left side of her body was affected by the stroke and she was unable to lift her arm up above shoulder level. She had stopped going out due to anxiety and a fear of falling due to being unsteady.
- Following an assessment by the CRAFT (Community Rehab and Falls Team) she received several home visits and a home exercise programme. She follows the home exercise programme 3 times a week and attends the weekly falls prevention class.
- Her confidence and balance have improved since joining the class. After struggling with some of the upper body exercises she is now able to lift her left arm fully up.
- She also enjoys the social time after the class, saying that this is almost as important as the exercises. She has made friends and has started going out again, joining in with some of the activities at Tandle View Court on other days of the week.
- ***"I really enjoy the classes and I always make sure I do my exercises at home. I know that's really important. I was surprised when I managed to lift my arm up, I hadn't realised how much I had improved. All of a sudden I could just do it. I had fallen a few times before I was sent to the falls classes but I haven't fallen while I've been coming here."***

3.2 Reablement Occupational Therapy

- The Reablement OT Assessed a resident in Extra Care Housing and identified the need for riser/recliner chair.
- The bariatric bed had no mattress retainers and mattress was slipping off the bed becoming a high falls risk. The OT exchanged the bed for one with mattress retainers and ordered a riser/recliner chair.
- Patient outcomes were increased independence moving from bed and around home, reduced risk to skin integrity, patient educated about falls risk and no need for increased carers due to independence maintained/improved.
- ***"I would have slipped off that bed and injured myself, this chair is better, and I can move about more now."***
- Patient is now able to stand from the chair independently and can mobilise into the extra care housing social lounge improving their quality of life.

## 4. Key Issues for the Health and Wellbeing Board to Discuss

4.1 a) Note the content of the Quarter 2 submission

b) Provide retrospective approval for the submission to the Regional Better Care Fund panel

## 5. Recommendation

4.1 It is recommended that the Health and Wellbeing Board agree to sign off the Better Care Fund Quarter 2 submission

## 6. Appendices

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| 1. | Health and Wellbeing Board report which delegated submission |  HWB Report_BCF Q2&3 Submissions ar |
| 2. | Quarter 2 Submission |  Oldham HWB 2025-26 Quarter 2.xls: |