BRIEFING		
	TO:	Health and Wellbeing Board
	DATE:	26th June 2024
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	TITLE:	Better Care Fund (BCF) Metrics Report 2023/24

Background

1.1 The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

1.2 The vision for the BCF plan in 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time.

1.3 As part of the BCF plan for 2023/24, measures have been agreed to monitor the success of the BCF schemes. This report provides an update on national measures which have been identified at year end as on target or where there are areas for concern.

Key Issues

2.1 The Better Care Fund for 2023/24 (Appendix 3) consists of 5 Key National Performance Indicators which includes one new indicator in relation to falls.

2.2 ***Avoidable admissions – indirectly standardised rate (ISR) of admissions per 100,000 population***

This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. This includes conditions such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD and pulmonary oedema. It should be noted that not all the admissions included in this indicator are necessarily "avoidable". The data extracted is based purely on coding of conditions and does not necessarily reflect wider factors that may require a patient to be admitted.

ACS admissions were more challenging than expected in 2022/23, particularly in Q3 and Q4. This is thought to be linked to high winter pressures particularly in primary care, linked to areas such as Children's respiratory conditions. The average of last 3 available quarters was used for Q1 and Q2 plan as some stabilisation was expected. Q3 currently assumes a less challenging winter than 2022/23 and assumes a level more in line with previous years. Q4 plan remains an estimate until final data available. 2024/25 is expected to be a key year in terms of same day emergency care and anticipatory care, which will be factored into 24/25 plans.

The national indicator is represented as an indirectly standardised rate. The indicator is presented on the scorecard however as actual admissions for easier interpretation.

	ACS admission levels have been challenged and above plan every month during 23/24. This above plan challenge is thought to be linked to winter and system pressures and impact on industrial action.
2.3	***Falls – Emergency hospital admissions due to falls in people aged 65 years and over directly age standardised rate per 100,000 – New Indicator*** This is a new indicator for 2023-24. The rate per 100,000 population of emergency admissions due to falls in people aged over 65, has shown a small decrease in the last few years. Falls is recognised as an area for review in 2023-24, to streamline services and develop a more integrated pathway. This work is expected to impact this indicator with the impact expected to be clearer once the review is completed. A small decrease in admissions due to falls in people aged over 65 years has been planned, as previous years trend expected to continue. We are currently reviewing the data available for monitoring this indicator as the data within the nationally published BCF pack, does not fully align with that provided nationally to inform the plan. Based on the available national data, we have seen more falls than planned. National data indicates 976 falls against a plan of around 900.
2.4	***% of People who are discharged from acute hospital to their Normal Place of Residence*** Rotherham was above national % discharged to usual place of residence when the plan was set. Performance over last 3 months, when the plan was set was 93.4%, with 94% being upper level of achievement. As performance is above national levels, the trajectory has been set to maintain for Q1 and achieve the higher level of 94% in Q2 and Q4, based on previous upper levels of performance. A slight dip is profiled in for Q3 to account for winter challenges. Performance has been strong during 23/24 above target in every month. It should be noted national data does show around a 0.5% lower performance compared to local data. National data however has historically experienced issues with refreshing, so local data has been used.
2.5	***Long-term support needs of older people (aged 65 years and over) met by admission to residential and nursing care homes (per 100,000 population)*** In 2022-23 Rotherham had 341 new admissions, (population rate 650.91). The 2023-24 BCF target has been reduced to a population rate of 571.71, which equates to 317 admissions over the year. Q1-3 activity and outturn data has been refreshed to capture amendments and additional system recording with revised admissions totals for each month. The year end outturn totals 301 new admissions, 16 below the target of 317, and 40 fewer admissions than in 2022-23. The number of admissions at 301 equates to a population rate of 542.85, 5.05% below the target of 571.71, and 13.2% below the 2022-23 outturn of 625.4. The Council 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.
2.6	***Proportion of older people (65 years and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services*** This is an annual measure and collation of data is undertaken during January to March period each year, to track people aged 65 and over, who have been 'offered' (i.e., commenced) the reablement service during the previous October to December period, to identify those who were still at home 91 days following discharge from hospital.

	Rotherham has seen small decreases in previous years following changes in the service pathway, resulting in an increase in the number of people commencing the service, and a broadening of the cohort to include more complex needs. Recognising the challenges of supporting a wider system, whilst improving current performance, the BCF target for 2023/24 was set at an interim midpoint 'step' of 75.4%. The output from 2023-24 at 81.4% has surpassed target by 6%, and is 8.9% higher than the 2022-23 figure of 72.5%. A total of 204 people were supported during the three-month sample period, 7 less than in 2022-23 and a 3.2% decrease in service provision. All services have seen an increase in the number of people still at home 91 days following discharge from hospital, Lord Hardy Court by 4.7% from 72.7% to 77.4%, Davies Court by 4.2% from 83.3% to 87.5% and Reablement by 2.3% from 78.6% to 80.9%.
Key Actions and Relevant Timelines	
3.1	**The Better Care Fund Executive Group held on 20th May 2024, noted the contents of the report and performance for 2023/24.**
Implications for Health Inequalities	
4.1	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. BCF funded schemes which reduce health inequalities include social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.
Recommendations	
5.1	**That the Health and Wellbeing Board notes the:** **(i) Contents of the report and performance for 2023/24.**