BRIEFING	TO:	Health and Wellbeing Board
	DATE:	11 December 2024
	LEAD OFFICER	Steph Watt Health and Care Portfolio Lead, SYICB/RMBC E-mail: steph.watt@nhs.net
	TITLE:	Better Care Fund (BCF) Quarter 2 Template 2024/25

Background

1.1	The purpose of this report is to confirm the content of the BCF Quarter 2 Template (Appendix 1) which has been submitted to NHS England regarding the performance, capacity and demand and actual activity of Rotherham's Better Care Fund Plan for 2024/25.
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.
1.3	The BCF Quarter 2 template covers reporting on: national conditions, metrics, actual activity in relation to hospital discharges and the community, expenditure and outputs.

Key Issues

	Below is a summary of information included within the BCF submission:
2.	**National Conditions**
2.1	There are a total of 4 national conditions for 2024/25 which continue to be met through the delivery of the plan as follows:
2.2	A plan has been jointly agreed between both partner organisations.
2.3	Implementation of BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer.
2.4	Implementation of BCF Policy Objective 2: Providing the right care in the right place at the right time.
2.5	Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.
3.	**BCF Metrics**
	There is a total of four BCF metrics within the BCF Q2 Template for 2024/25 which measures the impact of the plan as follows:
3.1	**Avoidable Admissions – Indirectly standardised rate (ISR) of admissions per 100,000 population –** Not on track to meet target.

	Achievements - Avoidable admissions in Q2 2024-25 are currently forecasted to be above target at 289.9 vs a plan of 281 admissions per 100,000 population. While this is slightly above target, it represents a decrease from the previous quarter's figure of 332.7. **Challenges and any support needs** – A key priority for the Rotherham urgent and emergency care recovery plan in 2024-25 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 –** Q1 data shows that the rate of hospitalisations for unplanned chronic ambulatory care-sensitive conditions (340.7) exceeded the planned figure (286.0). However, provisional Q2 estimates (289.9) indicate that the rate is decreasing and expected to be closer with the planned targets. **Mitigation for Recovery -** Provisional figures for Q2 show a downtrend. This suggests that the work on alternative pathways on ED is beginning to have impact. This includes developing alternative out of hospital pathways and four high impact change projects relating to frailty, ambulatory care and respiratory and diabetes pathways which are associated with high levels of admission. The growth of the virtual ward including frailty, respiratory and, most recently, the new heart failure pathway, are contributing to reducing avoidable admissions.
3.2	**Falls – Emergency admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 population –** Not on track to meet target. **Achievements** - Q1 data shows a rate of 522.0, which is higher than the quarterly target of 456.0 (set as 25% of our annual target). **Challenges and any support needs** – A key priority area for Rotherham in 2024/25 is frailty, which is expected to impact this indicator. A small increase in admissions due to falls in people aged over 65 years has been planned, as previous years trend expected to continue. **Variance from Plan –**. Provisional performance for Q2 2024/25 remains slightly above plan but is forecasted to decrease compared to Q1 (542.3). The projected rate for Q2 is 506.3, compared to a target of 456 per 100,000 population. **Mitigation for Recovery –** Rotherham high impact frailty project includes a review of the care homes falls pathway.
3.3	**Discharge to normal place of residence - Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence –** Not on track to meet target**.** **Achievements** - Q1 data was at 94.9%, slightly above the planned figure of 94.4%. Q1 data is currently on track with the planned figure of 94.9%. Provisional Q2 figures, with August and September data still incomplete, are estimated at 93.4%, slightly below the target of 94.7%. A full review will be conducted once the complete data is available. **Challenges and any support needs** – Q2 figures show a slight decrease in rates, with the latest data from September showing 93.4% against a target of 94.7%. Rotherham Place is currently reviewing the falls and frailty pathway for care homes to reduce avoidable conveyances and discharges.

	Variance from Plan – Q1 data was at 94.9%, slightly above the planned figure of 94.4%. Provisional Q2 figures (93.4%) are estimated to have decreased compared to Q1, below the target (94.7%). **Mitigation for Recovery -** Provisional figures for Q2 show a downtrend. There has been a sustained increase in demand to A&E resulting in increased admissions, with escalation beds open over the summer. This has impacted on discharge pathways, particularly enablement. At times it has been necessary to place people in short term bedded community care in order to release acute bed capacity. Work continues to increase capacity in enablement, which has improved over recent weeks.
3.4	**Residential Admissions – Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care home, per 100,000 population –** Not on track to meet target. **Achievements** - BCF monies are funding services that support out of hospital delivery of care and reduce admissions to 24-hour care, including short-term packages of social care, reablement, rehabilitation, intermediate care, home from hospital, assistive technology, equipment and adaptations and other community services which are financed by the discharge fund. **Challenges and any support needs** – There is efficiencies work being undertaken in relation to short stays which will lead to further conversion of people residential stays from short to long-term. **Variance from Plan –** Predictions based on average admissions for the year so far, 686.3 admissions per 100,000 population, 386 admissions. **Mitigation for Recovery -** A task and finish group are looking at better health and social care linkages and solutions for people being discharged from hospital to ensure people are being supported to home first. Quality Assurance Processes are in place to ensure lesser restrictive options are always exhausted before a long-stay placement considered / agreed.
4.	**Capacity and Demand – Assumptions**
4.1	**Estimates for capacity and demand changed since the plan submitted in June 2024.** Actual activity has increased for rehabilitation at home (Pathway 1) to support hospital discharge. Data has been extracted from Power BI referrals into CHAT and domiciliary from acute. Actual activity has also increased for rehabilitation at home in the community to support hospital avoidance. Data includes new contacts from SystmOne which includes Integrated Rapid Response (IRR) and unplanned (two day referrals). Actual activity has also slightly increased for other short-term bedded care (Pathway 2) and short-term residential and nursing care for someone likely to require a long-term care home placement (Pathway 3) to support patients discharged from hospital with complex needs.
4.2	**System Wide Discussions around winter readiness influenced any changes in capacity and demand as part of pro-active management of winter surge capacity.** Seasonal adjustments have been included over the winter period.

4.3	**Capacity concerns or specific support to raise for the winter ahead.** CHC is a responsive service therefore capacity reflects demand. The barrier to this is funding. Additional monies from the fund have been allocated for winter pressures.
4.4	**Actual demand exceeds capacity for a service type, our approach in ensuring that people are supported to avoid admission to hospital and to enable discharge.** Data only shows small variation between demand and capacity due to seasonality.
5.	**Capacity and Demand - Actual Activity**
5.1	Actual activity to support hospital discharges and admission avoidance is included within the Q2 template from 1st April to 30th September 2024.
6.	**Expenditure and Outputs**
6.1	Expenditure and outputs for BCF funded schemes has been included in the Q2 template from 1st April to 30th September 2024.
Key Actions and Relevant Timelines	
7.1	**The Better Care Fund Executive Group held on 31st October 2024 approved (on behalf of the Health and Wellbeing Board) the:** **(i) Documentation for submission to NHS England (NHSE) on 31st October 2024.**
Implications for Health Inequalities	
8.1	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.
8.2	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	
9.1	**That the Health and Wellbeing Board notes the:** **(ii) Documentation that has been submitted to NHS England (NHSE) on 31st October 2024.**