Agenda Item 5
HWB/09/24

Report title: Better Care Fund Plan Quarter 3 Report 2023-25	
Report to: Essex Health and Wellbeing Board	
Report author: Peter Fairley, Director for Strategy, Policy and Integration	
Date: March 2024	**For:** Decision
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County Divisions affected: All Essex	

1 Purpose of Report

1.1 This report seeks the endorsement of the board of Quarter 3 report on the Better Care Fund.

2 Recommendations

2.1 To endorse the Quarter 3 report on the Better Care Fund, which was submitted to NHSE on 9th February.

2.2 To note the performance against the BCF metrics.

2.3 To consider any areas where we need greater focus for quarters 4 and into next year.

3 Background and Proposal

3.1 The Better Care Fund (BCF) is a pooled fund between Essex County Council and the three NHS Integrated Care Boards in Essex. In 2023/24, the value of the Essex BCF pooled fund is £193.9m, increasing to £209.6m in 2024/25.

3.2 The Essex Health and Wellbeing Board will receive quarterly performance reports. Due to the timescales between the publication of the national reporting template and the availability of the national datasets to complete this, it was not possible to bring the completed report to HWB ahead of the due submission date of 9th February 2024. The report has been submitted subject to endorsement from the board.

4 Metrics and performance

4.1 There are national metrics used to measure progress published in the Better Care Fund Policy Framework 2023-2025.

4.2 Within the quarterly report we are required to provide an update on the metrics. The reporting template draws from national datasets which provide figures for quarter 2. Metrics used for residential admissions and reablement are only produced annually.

I. **Avoidable admissions (specific to Acute) -** This metric measures the number of times people with specific long-term conditions, who should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, convulsions and epilepsy, and high blood pressure. The metric includes all ages; the rate is standardised to account for differences in the age and sex distribution of the population.

Planned performance for this measure was 175 per 100,000 people over 65. Actual performance was 158.1.

Assuming that the current trend for that quarter continues, we expect to meet the target.

II. **Permanent admissions to residential and care homes -** This metric measures the rate of permanent new admissions for the over 65 population per 100k.

The target for this year is 350 per 100k. The national data is not provided for the Q3 report.

Since the report was submitted the measure for Essex was rebased at a higher level to account for admissions where an adult had been placed in temporary residential care and then moved into a permanent placement. The rebased numbers show Essex to still be outperforming the national and regional averages. Rates of admission have shown an improving (downward) trend between August and February.

III. **Effectiveness of reablement -** This metric measures the number of people supported to stay at home after receiving reablement.

The target in Essex for 2023/24 is for at least 89% of the people who have received reablement services to remain out of hospital for 91 days following completion of reablement.

Internal figures for Q3 show a fall in the proportion of older people still at home 91 days after discharge from hospital to 86.7%. Further work is required to understand the reasoning for this and how this trend can be reversed. We are focussed on getting the right cases into reablement, where we think someone can truly benefit and where a difference can be made to long term outcomes. This may mean that we work with complex cases, at some risk of hospital readmission. It is our aim in future to ensure that adjacent provision in the NHS can be mobilised alongside our reablement offer, to help ensure people remain in their own homes as long as possible.

IV. **Hospital Discharge -** The new discharge metric measures the proportion of patients discharged to their usual place of residence. Essex exceeded the target of 93.4% in Q2 with actual performance recorded as 93.5%. The data for Q3 at the time of reporting reported this metric at 93.6%, close to the target of 93.7%. Given the current trends, it is likely that the target of 94% for the year 2023/24 is likely to be met.

V. **Emergency Hospital Admissions due to Falls in People Over 65 -** This is a new metric for the BCF designed to assess health service utilisation rather than need, as many injurious falls will not result in emergency admission. Our target is 2,000.

Q2 performance was 458.5. At the time of reporting Q3 data (October and November) recorded a figure of 190 per 100,000.

5 Achievements

Part of the report requires us to highlight some of the schemes contributing to the delivery of the metrics. In quarter 3 this included:

Carers intensive Support Team - Since the team began in April 22 until end of December 2023, in line with the reporting KPI's and outcomes they have

- Received 372 referrals
- Interacted with 61 different system partners
- Avoided ED admission for 100% of carers referred
- Avoided emergency respite for cared for living at home for 100% of referrals
- 30 facilitated admissions for Carers to Southend Hospital Day Assessment Unit to support continuation of caring role
- 1/3 of carers have accepted referrals to NHS Talking Therapies to support mental health

Ward Led Enablement – The impact evaluations completed for MSE and North Essex demonstrated an increase in under 7 days Length of Stay (LOS) and reductions in patients with a LOS of 21+ days since the start of ward led enablement.

Integrated neighbourhood teams and locality working on:

- Prevention and self-care – including promoting the uptake of screening programmes, awareness campaigns and community engagement, and sharing intelligence across all PACT partners (health and social)
- Identification -Utilising population health management data, appropriate systems, registers and assessment tools to identify those in need of advice, guidance, care and support.
- Pro-active care planning, care delivery and management of complex patients – through well attended, holistic approach to MDTs and working with providers and system partners to develop / share pathways to provide the right support, in the right place, at the right time.

- Preventing escalation of need - Working together to identify rising risk and putting care plans in place that anticipate need.
- Urgent Care delivered at local level - Timely urgent response based on patient need, providing crisis support to deliver care in an individual's home

6 List of appendices

- BCF Quarter 3 Report.