## Better Care Fund 2024-25 Q2 Reporting Template

**4. Metrics**

Selected Health and Wellbeing Board: Leicestershire

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

| Metric | Definition | For information - Your planned performance as reported in 2024-25 planning Q1 | Q2 | Q3 | Q4 | For information - actual performance for Q1 | Assessment of progress against the metric plan for the reporting period | Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan*** | Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics* | Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan* | Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan* | Complete: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Avoidable admissions** | Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i) | 165.1 | 163.5 | 161.8 | 160.2 | 195.4 | On track to meet target | Only one month for quarter 2 is available for reporting. This figure is 121.3. The average for Q1 plus July is 159.3 which suggests the indicator is now on target. | During the first quarter of 24-25 UHL experienced an increase in attendences of 30%. Partners are aiming to work on several schemes to reduce this during the winter. This includes, more efficient ways of supporting people in the community prior to admission across health and social care functions to support community intake models of care and additional support to housing to prevent admissions working with extra care. Reablement community capacity has increased by 20% to support more people at home. | NA | NA | Yes |
| **Discharge to normal place of residence** | Percentage of people who are discharged from acute hospital to their normal place of residence | 92.7% | 92.6% | 95.1% | 91.7% | 92.11% | Not on track to meet target | This indicator is less than 1% off target across the first two quarters. We have set a challenging target overall. The demand modelling shows a reduction in P2 and P3 discharges to plan showing that we are maximising P1 discharges overall | P1 capacity has improved by 13% compared to the same period last year. This has been funded through BCF and discharge grant intermediate care initiatives in communities including integrated therapy and reablement teams and increased capacity in reablement by investing in additional staffing. | This indicator shows that the average for the two quarters so far is 91.7%. This is 1.3% below target overall but 0.9% below the average target projected for the first 2 quarters. | Mitigations are already in place. Currently system discharge grant is supporting reablement team capacity rejections with domiciliary care packages and two-week review unless capacity is sought prior to review stage | Yes |
| **Falls** | Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | 1,756.9 | | | | 418.5 | On track to meet target | Only one month of data is available for the 2nd Quarter. Based on the data available for the year so far the forecasted year end actual is 1716.4 which is better than the target of 1756.9 | Currently there is work underway to improve the use of AT within peoples own homes and in care homes. This is funded through BCF and discharge grant to enable a reduction in falls. A joint piece of work across the LA and ICB reviewing falls services is underway to have further inpact on reducing falls admissions. | NA | NA | Yes |
| **Residential Admissions** | Rate of permanent admissions to residential care per 100,000 population (65+) | 494 | | | | NA | On track to meet target | The current forecast for the full year 2023/24 is 845 admissions or 548.9 per 100k population aged 65 or over. At 845 admissions, this is 18 lower than than the previous year and better than our target which was based on a reduction of 10 admissions. It should be noted that the population figure used in the BCF template was based on ONS projections from 2018 (159,368). This is over-inflating the population level and therefore pushing down the target per capita rate (494). The ONS MYE for 2023 is 153,982 and will most likely be used in ASCOF reporting. This gives the rate per 100k as 548.9. | The Intermediate Care work across the system has showed a reduction in usage of P2 and residential care overall. This is focused on rehabilitation and reablement integrated in the community supporting more people home. Both services are partly supported by BCF and Discharge grant monies. Since July 2022 when discharges to residential care beds was at it's highest, partners have worked to reduce this by approx 30%. The reduction in 2024 has seen this increase to around 50% since 2022. The demand modelling shows the reduced usage to that predicted which was based on the previous years demand. | NA | NA | Yes |

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