Better Care Fund 2024-25 EOY 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 Q3 (For Q4 data,please refer to data pack on BCX)	Assessment of whether ambitions have been met	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	199.9	Target not met	Demand continues to rise nationally for emergency care, however, the system will support with development of community care models.	BCF funding has supported development of crisis support services howver, this will be futher invested in in 25-26 to meet demand. Additionally, intermediate care and virtual wards will be focused on step-up and admission avoidance in 25-26.	The data for 24-25 shows that the target was missed by approximately 32 people per 100,000 population. Recognising national trends in increasing admissions may have meant that the target was too ambitious to achieve in the current climate of demand.	The focus for the LLR system will be on the development of community care models particularly in expansion of current good performance to ensure capacity meets demand. Additional investment in neighbourhood models of care and step-up activity should mitigate the increase seen in this financial year.	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%	92.22%	Target met	Challenges around meeting demand for discharge to assess beds are being looked at with colleagues across the region. With the LLR HD model being a fore runner of best practice for cohorts with high needs	BCF funding has supported the intermediate care model which has increased capacity in home care services ensuring more people go home. In turn discharging to bedded community care has also helped to ensure as many people return home after a period of RRR as possible	There is a 0.9% variance from plan.	For 25-26 an increase in RRR provision from hospital is hoped to increase further the number of people that return to their normal place of residence. This includes care home environments being supported to have residents return.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,756.9	388.4	Target met	Challenges remain on reducing admissions overall however, focused work on admissions due to falls from care homes has helped to support the delivery of this metric	Q4 data shows that this metric was projected to be met with a performance of 1682.9. Focus on crisis response services in the community and care home admissions has helped to reduce the numbers of faller	There is an approximate 3% improvement on the planned target	Focus on reducing admisisons and retianing and expanding schemes such as the falls response car aim to improve this metric further in 25-26	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				494	not applicable	Target not met	Challenges around changes to population data make this target hard to set and measure performance against. If this could be standardised nationally at the start of the finiancial year before targets are set it woud be beneficial to systems	Work to prevent long term admissions from hospitals has had performance improved however, increased community admissions have increased performance. Proactive care work on PNG 9/10/11 will better suport people and carers at home before crisis point	The plan was a rate of 494 per 100,000 population based on an actual admissions figure of 798. The outturn is 583.8 per 100,000 based on 899 admissions (and a smaller population figure of 153,982 from ONS MYE 2023)	Proactive care MDT's looking at ensuring people in high need population groups have got a care plan will aim to support people to remain at home. This includes developing palliative care and VW services	Yes

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