Better Care Fund 2024/25 National Metrics Targets and Rationale

8.1 Avoidable admissions

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	255.7	214.4	230.3	224.0	There has been a dramatic drop in the indicator value between August 23 and November 24 and this has been raised with the National BCF Team. We have therefore assumed that there is a data quality issue and ignored these months in the forecasting that are very low values and replaced with an average from the previous months. We have then applied a 1% reduction to calculate the Indicator Value as 2024/25 plan.	2024/25 activity that will contribute to delivery of the target includes: **Scheme 1:** Proactive case management at neighbourhood level supported by Care Connection Teams and H4All Wellbeing Service to identify people most at risk of admission. The relevant services to address need are then identified, depending on level of complexity of need. This would include social prescribing for lower level needs. Two Same Day Urgent Care Hubs opened in 2023/24, one in the north of the borough in July 2023 and one in the south in january 2024, with the intention of supporting people with non-urgent health issues and diverting people from A & E. The hubs will include community diagnostics. Included within scheme 1 and funded via DFG is telecare equipment, the preventative benefits of which can help to support independence. DFG funding for major adaptations is also included within scheme 1 and changes to discretionary limits in 2024/25 is expected to increase flexibilities and opportunities for adapting the homes of residents to maximise the time they are able to continue living in their home. **Scheme 2:** The identification of and support for unpaid carers is also crucial to delivery of the target to prevent escalation of both the carer and the cared for person. **Scheme 3:** Assistance with higher levels of needs would be provided from community and community health services, e.g., Reablement, Rapid Response, District Nursing, Continence Service, Community Adult Rehabilitation. People living in the community with ongoing care needs who satisfy the National Eligibility Criteria for Adult Social Care would be supported with homecare or more personalised approaches to addressing their need via Direct Payments. Included within this scheme is the community equipment service that supports daily living activities.
	Number of Admissions	706	592	-	-		
	Population	304,792	304,792	-	-		
		2023-245 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Indicator value	253.1	211.9	237.5	234.2		

8.2 Falls

		2023-24 Plan	2023-24 Estimated	2024-25 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,018.0	2,018.0	1,998.0	Due to the falls data from the National BCF being so significantly lower than the National Outcome Framework falls data for Hillingdon this it was decided it could not be used to set a baseline. The 2023/24 plan has therefore been used as the baseline and a 1% reduction applied to create the 2024/25 plan.	2024/25 activity that will contribute to delivery of the target reflects Hillingdon's approach is two-fold and has not changed since 2023/24, i.e., seeking to prevent falls from occurring in the first instance and then preventing recurrence where a person has fallen. **Scheme 1:** The CNWL falls service offers a multidisciplinary, consultant-led clinic that provides comprehensive assessment and specialist diagnostics to people who have had a fall or are at risk of falling. Referrals are via CCTs, the funding for which sits outside of the BCF. The clinic can refer people to specialities and signpost them to relevant agencies, e.g., Age UK. The service also provides an 8-week, evidence-based falls prevention exercise programme either in people's homes or in group settings at Northwood Health Centre and Riverside Unit. In addition to proactive case management at neighbourhood level, a Frailty Assessment Unit at the Hospital, the funding for which is not included within the BCF, also identifies people living with frailty who are most at risk of falling and proactive case management is provided by CCTs and direct support delivered by the Rapid Response Team for people with the most complex needs.
	Count	865	865	856		
	Population	41,314	41,314	41,314		

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.8%	91.28%	92.3%	90.9%	For Discharge to Usual Place of Residence we have taken the data from the National BCF Data Set they produced and used the data to produce a forecast for 24/25. Please note for 2023/24 data we have used the actual data for April 2023 – Jan 2024. The available March 2024 data has not been used as this appears incomplete and very low. The Feb 2024 data also looked low and so we also used a forecasted position for Feb 2024. We have then applied a 1% increase to this 24/25 forecast to get a 24/25 plan.	2024/25 activity that will contribute to delivery of the target is as described in the 2023/24 submission, and includes: **Scheme 2:** Supporting unpaid carers through via Adult Social Care and/or the Carer Support Service to reduce risk of it not being possible for the cared for person to return home. **Scheme 3:** Support for older people with lower level needs via the Age UK Home from Hospital Service (Pathway 0). People on pathway 1 will be supported via the Reablement Service and community-based NHS provided services such as Rapid Response, Community Adult Rehab Service, Community Matrons and District Nursing (Reactive Care Service. Collectively these services will provide wrap-around care and support to address the specific needs of people thereby supporting discharge to their usual place of residence where possible. On going care needs for people who meet the National Eligibility Criteria for Adult Social Care are addressed through homecare provision. Aids to support daily living needs are provided through the
	Numerator	5,586	5,285	5,585	5,617		
	Denominator	6,059	5,757	6,054	6,177		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Quarter (%)	92.2%	91.8%	92.3%	91.4%		
	Numerator	6,221	5,892	6,024	6,611		
	Denominator	6,745	6,420	6,526	7,232		

							integrated community equipment service. In addition, there is scope via the Hospital Discharge Grant, a discretionary grant funded from Disabled Facilities Grant to address issues that may hinder discharge and return to usual place of residence such as repairs to heating systems and/or broken doors or windows.

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 Estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	629.3	603.9	726.9	700.6	The figures submitted for this metric are based on anticipated sequel to action, i.e., what the social care professional believes is likely to happen. This means that the actual number of permanent admissions is below the numerator which relates to the Adult Social Care Outcomes Framework measure that the Council is required to report against to NHS Digital. For example, the actual number of permanent admissions in 2023/24 was 244. All proposed permanent admissions go through a rigorous review process at head of service level to check that this is the most appropriate means of addressing need. However, in 2022/23 73% of permanent admissions resulted from a conversion from short-term placements. The target takes into consideration the increase in the older people population, increased levels of acuity as a legacy of the pandemic and the fact that some short-term placements are unavoidable and appropriate to meet need, including needs of unpaid carers. The 2024/25 target has been set by applying a 1.5% reduction on the 2023/24 outturn. This has not been set lower because Hillingdon has a robust process in place for ensuring that a residential placement is the most appropriate means of addressing assessed need.	2024/25 activity that will contribute to delivery of the target, and has not changed since 2023/24, includes: **Scheme 1:** Case management at neighbourhood level undertaken by Care Connection Teams. **Scheme 3:** Support to remain at home provided through community services, including District Nursing, Rapid Responses & Community Adult Rehab Service, Reablement. **Scheme 4:** An alternative to residential placement provided within extra care where need can be met safely. Final placement decision will continue to be made at head of service level.
	Numerator	260	270	325	320		
	Denominator	41,314	44,713	44,713	45,673		