Bath & North East Somerset Council

Improving People's Lives

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Better Care Fund 2023 - 5

HWB Q2 Reporting Update

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OVERVIEW

The Quarter 2 was submitted on the 31 October 2023 following approval by Laura Ambler and Natalia Lachkou as HWB representatives.
The return builds on the Narrative Plan and data points submitted in June 2023. There was no quarter 1 return but there will be a 3 and 4.

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5 National Metrics in this return

These are all metrics which are part of national data collection already in place for members of the ICB including the Royal United Hospital, HCRG CG (as the prime provider of community health and social care), ICA and Council. Not all of the provision resulting in these metrics are funded by BCF.

1) Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

2) Unplanned hospitalisation for chronic ambulatory care sensitive conditions

3) Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/ rehabilitation services

4) Discharges to usual place of residence

5) Reducing the number of emergency hospital admissions due to falls in people over 65

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Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

On track for target

- Impact of D2A Care Home Beds funded by BCF continues to support improvement in 23/24. Services such as extra care beds (Pemberley Place)
- 'The right care in the right place at the right time' focus is helping to ensure that services are provided to meet the individual's specific needs
- Impact on permanent admissions may be a longer-term benefit not fully reflected in data yet.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Performing on track for target

- Virtual Hospital support for tier 4 patients – including those with chronic ambulatory conditions. The model includes remote monitoring and provision of IV medications at home.
- Urgent Care Response - performing at or above planned expectations.
- Continued focus on paramedic support within care homes.

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Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

On track for target

- Positive impact with the implementation of the UIP, Care Journey Co-ordinators and improved Care Act Assessment backlog
- Third sector schemes and continuation of work with community services to support readmission avoidance.

Discharge to usual place of residence

Performing on track for target

- Home is Best programme includes a workstream 'Improve flow & capacity for Home'.
- BCF schemes including the ART+ expansion, Brokerage, in-house home care and the home care block
- Better use of community hospitals to support recovery and free up acute settings.

Reducing the number of emergency hospital admissions due to falls in people over 65

Currently slightly below target but expected recovery for end of year

- Data fluctuations over time make projection uncertain
- The Falls Rapid Response Team
- Management of risk of further falls is a key feature including falls pathways services