TORBAY COUNCIL

Title: Torbay Better Care Fund 2024 - 25

Wards Affected: All

To: Torbay Health and Wellbeing Board **On: 26 September 2024**

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1. Purpose

Torbay Better Care Fund (BCF) Plan has been submitted in line with national timelines and requirements. Torbay's plan received approval from the regional BCF panel, progressed to the national panel where it has also been endorsed. The Torbay Better Care Fund Plan is being presented to Torbay Health and Wellbeing Board in-line with national requirements.

The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery. This report:

- Provides an update on the BCF performance and spend for 2023/24 (copy attached).
- Provides details of the BCF plan for 2024/25 (copy attached).

2. Analysis

2.1 BCF Outturn for 2023/24

In May, Devon and Torbay's End of Year 23/24 template return was submitted in accordance with national requirements.

2.2 Metric Targets

2.2.1 Avoidable Admissions

Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions rate per 100,000 population – a set of conditions such as acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, and pulmonary oedema.

We measure this as we would expect to be able to manage these conditions without a need for hospital admission.

Performance for 2023/24:

		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Torbay	2023/24 Target	171.3	170.8	188.8	172.1
	2023/24 actual	192.4	188.2	188.8	172.1

Data at the time of submission indicates Torbay's performance was **on track** to meet the target in Quarter's 3 and 4. Further information is provided in the planning return and section 4 of this report.

2.2.2 Falls

Definition: Emergency hospital admissions due to falls in people aged 65 & over, directly standardised rate per 100,000.

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes. This measure is an important measure around joint working between adult social care and health partners (e.g. urgent community response services) to prevent hospital admissions and reduce falls which will improve outcomes for older people and support independence. We measure this as with the right support in place we should be able to prevent falls in older people.

This is a new BCF indicator for 2023/24 and the target is an attempt to establish a baseline.

	2022/23 Actual	2023/24 Plan for year	Estimated outturn 2023/24
Torbay	1714.9	1714.9	2221.9

Data at the time of submission indicates performance for the Local Authority area was **not on track** to meet the target. Further information is provided in the planning return and section 4.

2.2.3 Discharge to Usual Place of Residence

Definition: The percentage of people who are discharged from acute hospital to their usual place of residence.

We measure the number of people who return to their usual place of residence at the point of discharge to ensure as many people as possible are able to return to living independently at home.

N.B. This metric will not continue after 2024/25.

Performance for 2023/24:

		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Torbay	Planned	89.9%	90.9%	89.6%	90.6%
	Actual (est)	91.1%	89.9%	89.6%	90.6%

Data at the time of submission indicates performance within Torbay was **on track** to meet the target. Further information is provided in the planning return.

2.2.4 Residential Admissions

Definition: Long-term support needs of older people (65 & over) met by admission to residential & nursing care homes per 100,000 population.

Avoiding permanent placements in residential and nursing care homes is a good measure of our ability to support people to live independently at home for as long as possible.

	2022/23 Actual	2023/24 Plan	2023/24 Actual (est)
Torbay	771.6	566.1	735.2

Data at the time of submission indicates performance was **not on track** to meet the target. Further information is provided in the planning return. below.

2.2.5 Reablement

Definition: The proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

We measure this to ensure our support services are successful in enabling people to return to and maintain their independence after a spell in hospital.

Reablement seeks to support people and maximise their level of independence in the long term, to minimise their need for ongoing support.

	2022/23 Actual	2023/24 Plan	2023/24 Actual (est)
Torbay	77.0%	77.2%	77.2%

Data at the time of submission indicates Torbay's performance was **on track**.

The sufficiency of home care services has increased in the independent sector but we need to ensure this is fully utilised in the most cost-effective way. There has been a significant reduction in expensive agency usage due to an increase in the workforce (mainly attributable to international recruitment), and we are adapting our commissioning plans accordingly.

3 BCF Plan for 2024/25

Better Care Fund plans are required to be developed and signed off by Health and Wellbeing Boards within each Local Authority footprint. Last year national guidance required the creation of a two year plan covering 2023/24 and 2024/25. This year national guidance requires an addendum to the plan to be produced.

In June, Torbay's Better Care Fund Plan addendum for 2024/25 was submitted in line with national timelines and requirements. Torbay's plan and passed through regional and national assurance. The local system has received a letter of approval

from the national Better Care Fund team to confirm the Torbay plan has been endorsed.

Following national approval, Torbay Council, NHS Devon and Torbay and South Devon NHS Foundation Trust must develop and sign a S.75 (NHS Act 2006) agreement by 30 September 2024.

3.1 Metric Targets

2024/25 national planning guidance requires two objectives and four key performance indicators (metrics) to be addressed in the BCF plan.

National Objectives	Metrics for 2024/25
Enabling people to stay well, safe and independent at home for longer	Unplanned admission for ambulatory sensitive chronic conditions *(Avoidable Admissions)*
	Emergency hospital admissions due to falls in people over 65 *(Falls)*
	Admission to long-term residential care for people over 65
Provide the right care in the right place at the right time	Discharge to usual place of residence

The indicator for the percentage of people still at home 91 days after discharge from hospital to reablement or rehabilitation is not required for 2024/25. A replacement measure is being developed nationally and will be introduced later.

3.1.1 Avoidable Admissions

Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions rate per 100,000 population – a set of conditions such as acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, and pulmonary oedema.

We measure this as we would expect to be able to manage these conditions without a need for hospital admissions.

Plan for 2024/25:

	Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Torbay	2023/24 actual	192.4	188.2	188.8	172.1
	2024/25 plan	172	172	172	172

The data has been populated using the actual known performance for the metric in the 2023-24 financial year as a guide as reported through the SUS (Secondary Uses Service) data set. The outturn for Q3 2023/24 was 188.8 (Torbay). Q4 actual performance has been used to set the 2024-25 plan.
Local capacity and demand and our local plan to meet the ambition is taken into consideration when setting the targets. In addition, during 2023/24 a comprehensive review of all BCF investments was undertaken to ensure resource is used to best effect, focused on improving outcomes and achieving local targets. The review has been used to inform appropriate trajectories for 2024/25.

Work will continue into 2024-25 to prevent avoidable admissions through a range of investments from BCF. This includes intermediate care and rapid response teams, and hospital discharge commissioning arrangements supporting Pathway 1 (care at home) and Pathway 2 (short term care home placements).

As part of wider funding and connection to strategic programmes of work across Devon ICS footprint:

1. Virtual ward development will have a greater focus on community response and avoiding admission for patients on the following pathways: frailty, respiratory and cardiology. Integrated working between acute, urgent community response, intermediate care , social care and primary care will ensure more people are supported within the community without the need to be admitted to hospital.

2. Care co-ordination hubs are being developed to work with the ambulance service, Urgent Community Response teams and social care to identify clients at risk of admission and ensure the correct wrap-around support is in place in the community.

3. High Intensity Users service model and commissioning approach is in progress across the Devon County Council footprint. This builds upon and improves the current service offer by undertaking targeted work to identify and support clients who attend Emergency Departments (ED) most frequently and ensure community support is in place to reduce the need to attend ED.

4. Care Home support will continue with further development and implementation of the refreshed Enhanced Health in Care Homes framework. The commissioned service Immedicare will continue to provide 24/7 remote nurse-led support to care homes to manage client needs and avoid admission.

3.1.2 Falls

Definition: Emergency hospital admissions due to falls in people aged 65 & over, directly standardised rate per 100,000.

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes. This measure is an important measure around joint working between adult social care and health partners (e.g. urgent

community response services) to prevent hospital admissions and reduce falls, which will improve outcomes for older people and support independence.

We measure this as with the right support in place we should be able to prevent falls in older people.

This was a new BCF indicator for 2023/24 so we have been working to establish an accurate baseline and target.

	2023/24 (est)	2024/25 Plan for year
Torbay	2221.9	1968.4

The data has been populated based on actual performance for this metric in the 2023-24 financial year as reported through the SUS (Secondary Uses Service) dataset. Actual recorded data within Torbay's was accurate at the point of submitting the revised 2024/25 plan. The Torbay plan for 2024-25 has been set against the actual 2023-24 outturn to set a stretch target.
Activity which will help us reduce the number of falls include:

- Reablement will be a key feature to support people who are frail and at risk of falling within the community.

- A new Community Urgent and Emergency Care Clinical model is being developed.

- A workstream dedicated to making improvements in Falls, Frailty and End of Life care is being implemented. The objective is to establish consistent, proactive, clinical care and support for people living in care homes that will result in a reduction in ambulance 'see and treat' and conveyances, unplanned attendances and admissions for people living in care homes.

- We will adopt a whole-systems approach across primary care and community services to support care homes to
    - reduce conveyance to hospital for a fall where there is an alternative community response, and
    - improve advanced care planning to reduce reliance on urgent and out of hours responses, reduce emergency admissions and improve the proactive care of older people

- An Urgent Community Response (UCR) workstream will focus on the development of a core clinical model for UCR to provide a consistent approach across Devon and ensure that providers are working to national specification at all times. The project scope includes an identified gap analysis, exploring commissioning and funding differences which impact delivery and a core set of KPIs.

- The Community Urgent and Emergency Care Clinical model is not reliant on additional funding being allocated but more how as a system we better

respond to challenges in an integrated, collective way. BCF funded services are part of the clinical model including intermediate care, reablement and rapid response.

3.1.3 Discharge to Usual Place of Residence

Definition: The percentage of people who are discharged from acute hospital to their usual place of residence.

This is an important marker of the effective joint working of local partners and is a measure of the effectiveness of health and social care services in supporting people back to independence.

Plan for 2024/25:

	Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Torbay	2023/24 actual	91.1%	89.9%	89.6%	90.6%
	2024/25	91.3%	91.3%	91.3%	91.3%

The data has been populated based on actual performance for this metric in the 2023-24 financial year as reported through the SUS (Secondary Uses Service) dataset.

BCF will continue to fund the Hospital Discharge Hub to support discharge to usual place of residence.

The development of a Community Urgent and Emergency Clinical model includes a workstream focusing on hospital discharge. Its focus is to reduce acute bed occupancy and the length of stay for patients in hospital through ensuring timely discharges to enable improved flow which includes:

- Reducing hospital delays

- Right size capacity across discharge pathways 1 - 3

Torbay has a Hospital Discharge Transformation programme in place to ensure effective flow of patient from an acute setting back in to the community. These programmes also plan for the commissioning of community-based care via domiciliary care, rehab and reablement placements and residential care provision.

Key milestones include commissioned and delivered capacity to meet discharge demand, care transfer hubs meet all 9 of the national key principles for an effective hub and improved quality of discharge and standardised approach to the role of Community Hospitals.

The Local Authority and ICB Discharge grants will be used in conjunction with the above workstream to maximum effect to ensure sufficient capacity for each pathway.

3.1.4 Residential Admissions

Definition: Long-term support needs of older people (65 & over) met by admission to residential & nursing care homes per 100,000 population.

Avoiding and delaying permanent placements in residential and nursing care homes is a good measure of how we support people to remain independent in their own homes.

	2023/24 Actual (est)	2024/25 Plan
Torbay	735.2	669.3

We have seen significant impact of the Discharge to Assess process, leading to an increase in permanent residential admissions and nursing care settings. The placement trend remained upwards through much of 2023/24.

The 2024/25 target represents a 4.2% (Devon) and 8.9% (Torbay) stretched target reduction from 2023/24 based on a comparison of the mean denominator for the year compared to March 2024 and aligns with our Market Sustainability and Improvement Fund (MSIF – a national funding stream) analysis and spending plans.

A key aim of the Hospital Discharge Programme Steering Group is to ensure there is sufficient capacity for both short and long stay residential and nursing care home beds. This is informed with the mapping of current performance, utilisation, outcomes and the identification of gaps. This supports the system to ensure better value delivery mechanisms on a county-wide rather than locality level.

3.2 Finance 2024/25

To support the achievement of the national objectives and metrics, each Health and Wellbeing Board area receives investment via NHS and Local Authority partners to plan and commission services, which reduce reliance on urgent and emergency care, supports intermediate care, timely discharge and maintains peoples' independence within the community.

The funding received for 2024/25 is as follows:

Funding Sources	**Torbay**
Disabled Facilities Grant	2,321,869
NHS Contribution	14,646,915
Improved BCF Grant	8,837,572
Additional Local Authority Contribution	
Additional ICB Contribution	

Local Authority Discharge Funding	2,065,023
ICB Discharge Funding	1,848,000
Total	**29,719,379**

The planning return details where funding is to be spent in 2024/25.

4 Development of Section 75 Agreements

The s.75 (NHS Act 2006) Agreement which governs the use of the BCF will be signed by Devon County Council and NHS Devon ICB (Devon HWBB area) and Torbay Council, NHS Devon ICB and Torbay and South Devon NHS Foundation Trust (Torbay HWBB area), following confirmation of national approval of the 2024/25 plan, by the 30 September 2024.

5. Recommendation

5.1 Torbay Health and Wellbeing Board approves the 2023/24 End of Year Report

5.2 Torbay Health and Wellbeing Board approves the Torbay Better Care Fund Plan 2024 – 25.

Appendices

Background Papers:
The following documents/files were used to compile this report:

Appendix

List of background papers

Background Paper: Planning Return 2024/25

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TORBAY HWBB BCF 2024-25 Planning Ter

Background Paper: Outturn Return 2023/24

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