Appendix 2

SUMMARY OF THE ANNUAL PROGRESS PER QUARTER:

QUARTERLY ACTIVITY TRACKING		NATIONAL CONDITIONS
Q1	The continued ICB discharge funding in 2024/25 allowed for improvements to our bridging service utilisation, model standardisation, and further embedding of the model to continue to reduce delays for pathway 1[1] patients. Additionally, this ensured more patients received access to timely care at home which reduced the risk of deterioration due to unnecessary hospital stays, allowing more patients to have the opportunity to recover at home as the most appropriate support for their on-going care to be identified through an assessment at home.	**National Condition 1:** *Plans to be jointly agreed.* **Continues to be met**.
		National Condition 2: ***Implementing BCF Policy Objective 1:*** *Enabling people to stay well, safe and independent at home for longer.* **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners.
		National Condition 3: ***Implementing BCF Policy Objective 2:*** *Providing the right care in the right place at the right time.* **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detailed planned versus delivered outputs for the BCF funded services.
		National Condition 4: *Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services*. **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all. The quarter 1 submission template also detailed planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services.

Appendix 2

Q2	**Avoidable admissions** *(Unplanned hospitalisation for chronic ambulatory care sensitive conditions)* *NHS metric* – **Data not available to assess progress due to ICB Business Intelligence team working on adapting their reporting format.** **Discharge to normal place of residence** *(Percentage of people who are discharged from acute hospital to their normal place of residence)* *NHS metric* – **On track to meet target.** **Falls** *(Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000*) *NHS metric* – **Data not available to assess progress due to ICB Business Intelligence team working on adapting their reporting format.** **Residential admissions** *(Rate of permanent admissions to residential care per 100,000 population (65+)* *Local authority metric* – **Not on track to meet target.** • H&F rise in numbers of residential placements due largely to increase in level of resident need as they are being discharged from hospital. The BCF through discharge funding is helping to manage this as it is enabling a focus on strengthening our bridging services as we work on its utilisation, model standardisation, and further embedding of the model to help reduce delays for pathway 1 patients. • Our extra care stepdown facility "Minterne Lifestyle beds" is operating at full capacity and we are working at better understanding how to improve the residents move on through the discharge pathway so we maximise it use. We are also meeting with extra care, learning disabilities and mental health supported living providers to discuss innovative ways to ensure	**National Condition 1:** *Plans to be jointly agreed.* **Continues to be met.** **National Condition 2:** ***Implementing BCF Policy Objective 1:*** *Enabling people to stay well, safe and independent at home for longer.* **Continues to be met:** the relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detailed planned versus delivered outputs to date for the BCF funded services. **National Condition 3:** ***Implementing BCF Policy Objective 2:*** *Providing the right care in the right place at the right time.* **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also details planned versus delivered outputs to date for the BCF funded services. **National condition 4:** *Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services.* **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services.

	we increase admission into extra care settings from their specialist supported living services.	
Q3	**Avoidable admissions** *(Unplanned hospitalisation for chronic ambulatory care sensitive conditions)* *NHS metric* – **Data is currently unavailable to assess progress due to suspected issues with the National BCF Data.** The ICB Business Intelligence team is collaborating with the National Team to investigate the issue and develop a solution for setting future plans and monitoring progress. While work is ongoing to resolve the data issue, in H&F there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including: • Health & Care Partnership (HCP) Diabetes workstream across primary, community and secondary care for timely monitoring, management and prevention of complications. • Flu vaccination promotion programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions. • HCP frailty workstream with focus on frailty pathway to better support frail adults with chronic conditions in the community. **Discharge to normal place of residence** *(Percentage of people who are discharged from acute hospital to their normal place of residence)* *NHS metric* – **On track to meet target.** Whilst we are on track to meet this target by year-end, we are facing some challenges, including an increase in patient acuity, which is causing delays. This requires additional assessments to determine if patients are suitable for discharge to their usual place of residence. A programme of work is in place to improve discharge and the flow out of acute hospitals. This includes discharge funding to support a	**National Condition 1:** Plans to be jointly agreed. **Continues to be met:** The timescales for agreeing BCF plans, and assurance set by NHSE and are typically as follows: • BCF planning requirements published by NHSE around April each year. • BCF planning submission around June each year. • Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation around July each year. • Approval letters issued giving formal permission to spend (NHS minimum) around September each year. • All section 75 agreements to be signed and in place around October each year. **National Condition 2:** ***Implementing BCF Policy Objective 1****:* *Enabling people to stay well, safe and independent at home for longer.* **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services. **National Condition 3:** ***Implementing BCF Policy Objective 2:*** *Providing the right care in the right place at the right time.*

	bridging service and better joint working between health and social care. The implementation of the bridging (bridging to home service) has significantly reduced delays in Pathway 1 and facilitated more patients to return home within 12 hours of being discharge ready. It also mitigated the necessity for long-term care in residential/nursing settings. In essence, it has ensured that patients are discharged to usual place of residence, averting the escalation of their care needs. There is also a continued focus as a sector on improving our discharge levels and implementing measures to improve flow through local and sector partnership working. The local schemes/initiatives supporting this metric are: • Early discharge planning • Home first • Enhanced support and training for care homes • Multi-agency focus on discharge home from hospital • Multi agency input for reablement and managing people at home **Falls** *(Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000)* *NHS metric* – **On track to meet target.** It is to be noted that there were previously data quality issues with the Falls data produced by the National BCF Team on NHS Futures, which did not match the Falls data in the Public Health Outcomes Framework (used to set the 24/25 plan). This discrepancy was believed to be due to Transfers data being excluded from the National BCF Data however, this issue has been resolved in Q3. Although the BCF Data from the National BCF Team now includes Transfers, making it more consistent with the Falls data in the Public Health Outcome Framework, it should be noted that the 24/25 plan was initially set using National BCF team data that did not include	**Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services. **National Condition 4:** ***Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services*.** **Continues to be met:** a list of relevant BCF funded services that were jointly agreed by all partners. The quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services.

	transfers. Additionally, the Public Health Outcome Framework data was outdated, making it difficult to create a sensible plan. **Residential admissions** *(Rate of permanent admissions to residential care per 100,000 population (65+)* *Local authority metric* – **Not on track.** The aim of this measure is to support residents to achieve optimal independence and thus avoid residential care where possible. The aim is to remain below 72 residential placements by the end of the year. We were at 63 placements by the end of quarter 3 (9 placements below the target). Our rise in numbers of residential placements is largely due to a consistent increase in complexity of resident's needs on discharge from hospital as demonstrated by the increase in emergency care placements made by the local authority which has doubled between December 23 to December 24 from 43 to 83 placements. We have been trialling and exploring options for meeting more complex needs in the community for example piloting "Lifestyle units" through Extra Care provision and we are meeting with supported living providers to discuss other innovative ways in response to increased acute discharge from hospital. However, current ordinarily available provision such as Extra Care is not the appropriate setting to meet the needs of residents who may require 24 hours care and support. Families and Carers are also finding it increasing difficult to cope at home with their loved ones who have complex needs. These factors culminate into additional demand for residential placements. Going forward we intend to monitor our levels of residential admissions within a range as this is more likely to take account of the unpredictability and complexity of residents needs as we continue to strive to keep our residents living at home in the community for a long	

	as possible and manage the demand for residential placements at the same time. Adult social care is also developing a sufficiency strategy which aims to review what social care provision is on offer locally and develop the market to meet future needs of our residents.	