Better Care Fund 2024-25 End of Year Report

19th June 2025

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Oldham Council

Purpose

The Better Care Fund (BCF) requires areas to jointly agree to deliver health and social care services supporting improvement in outcomes against the following BCF policy objectives:

- Enable people to stay well, safe and independent for longer
- Provide the right care in the right place at the right time.

The Hospital Discharge Fund, Disabled Facilities Grant and the Improved Better Care Fund (iBCF) are elements of the Better Care Fund 2024-25

Oldham's allocation

Funding source	2023/24	2024/25
Disabled Facilities Grant	£2,343,287	£2,55,942
Minimum NHS contribution	£21,951,512	£23,193,968
Improved Better Care Fund (iBCF)	£11,187,623	£11,187,623
Additional LA contribution	£0	£0
Additional ICB contribution	£822,739	£762,916
LA Hospital Discharge Fund	£1,568,487	£2,615,146
ICB Hospital Discharge Fund	£1,420,360	£1,975,895
Total	£39,294,008	£42,290,490

Reporting and timelines

- The Health and Wellbeing Board signed off the BCF plan for 2024-25 at the July Health and Wellbeing Board and agreed to delegate sign off to approve the quarter reports to the Chief Executive of the Council and Deputy Place Lead at this time, in consultation with DASS and Lead Member.
- Quarterly submissions were submitted on the following dates:
  - Quarter 1 - 29th August 2024
  - Quarter 2 – 31st October 2024
  - Quarter 3 – 31st January 2025
- End of Year Report due on 6th June

Year End Report Summary

- Reporting on set metrics
- Capacity and demand – Intermediate care for hospital discharge step down and community step up
- Expenditure and outputs achieved for all cost lines
- End of year impact summary

Metrics – ICB Led

Avoidable Admissions

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS outcome Framework indicator 2.2i)
  - Data not available for Q4 however performance to date suggests on target

Discharge to normal place of residence

- % of people who are discharged from acute hospital to their normal place of residence
  - Data not available for Q4 however performance in first three quarters was on track

Falls

- Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,00
  - Target not met, data not available for Q4 but performance up to Q3 was below target

Metrics – LA Led

Residential Admissions

- Rate of permanent admissions to residential care per 100,000 population (65+)
  - Based upon local data, anticipated year end position for this measure is 256 admissions which would equate to a per 100,000 rate of 659 which would be below target of 685 admissions per 100,000.
  - We continue to work to ensure we meet the needs of residents who are experiencing rapid discharge from hospital due to hospital trusts pressures. This has meant that individuals are not healthy enough to be reenabled. We are working closely with enable to ensure the in-reach offer to individuals in residential, nursing care & short stay care is utilised.
  - Anticipated year end position for this measure is 246 admissions which would equate to a per 100,000 rate of 634 which would be below target of 685 admissions per 100,000.
  - We continue to work to ensure we meet the needs of residents who are experiencing rapid discharge from hospital due to hospital trusts pressures. This has meant that individuals are not healthy enough to be reenabled. We are working closely with enable to ensure the in-reach offer to individuals in residential, nursing care & short stay care is utilised.

Capacity and Demand

- Monitors pathway 1, 2 and 3 hospital discharge demand against activity
  - Tracking consistent with demand, with the exception of Reablement and Rehabilitation at home, this has seen a reduction in Quarter 4, this is related to historic data quality issues, with quarter 4 provider a more accurate picture than previously.
- Community Activity
  - On track or above, except for the Community Reablement Issue as above
  - Other short term social care as zero due to end of Home from Hospital which had reported on this line up until the end of October 2024

Capacity and Demand Commentary

- Continuing to see increased acuity at the point of hospital discharge with a shortage of specialist nursing placements causing delays to discharge
- Working closely across the system with strengthened Integrated Discharge Team
- Local Focus on Home First and emphasis on Reablement (which links to the end of Home from Hospital in year)
- Reviewing Intermediate Care offer as part of 2025-26 plan
- Increased therapy support within Intermediate Care and ARCC to reduce long-term permanent care and encourage hospital avoidance
- Strengthened capacity into Urgent Care Response Team, including Falls Pick Up Service for hospital avoidance

Spend

- Home from Hospital reports underspend as this service ended 31st October 2025. Underspend of £56,183 re-allocated to Mental Health Assessment and Rehabilitation
- Bank Holiday Enhancements were only in place for the Easter 2024 Bank Holidays, providers did not claim the full value which was allocated, the underspend of £22,416 reallocated to Rapid Discharge Service
- All other spend was track against planned spend
- Issue noted with the spend tracking at the top of the expenditure tab. Working with both Finance Teams to resolve and may require input from BCF team to resolve

Outputs

- The majority of outputs were on track
- Some outputs are below target due to decommissioning / ending in year this includes Home from Hospital and Bank Holiday Enhancements – these have a reduced spend compared to planned expenditure

Year End Impact Summary

Key successes:

- Integrated system benefiting residents by allowing them to move seamlessly between health and social care to meet their needs.
- Early support and intervention, reduced length of stay in hospital and better-quality outcomes such as living independently

Key challenges:

- Pressure across the whole system means it is difficult to ‘shift’ anything in line with demand, when pressures and demand are being seen throughout
- Increased acuity at discharge remains a challenge, particularly due to a shortage of specialist nursing provision but also in people being optimised to be ready for reablement at discharge

Case Study – Medlock Court Reablement

- The woman had carers at home prior to Hospital admission so the main goals were to improve transfers and mobility and some kitchen tasks to a safe level to return home to previous or reduced package. A care plan and therapy plan/goals were put in place on arrival, completing alongside the lady.
- Staff encouraged, reassured and motivated throughout her stay as the lady could become anxious at times. A holistic way of working was operated, looking at both physical and emotional needs. The lady's main goal was to be able to return home.
- Staff/therapy managed to progress the lady through her stay and reached her baseline and better for mobility and kitchen tasks. Transfers were being worked on against usual transfer heights at home. There was question of the lady needing a short stay due to struggling with transfers without the use of a hoist and therefore her safety was priority, but we wanted to ensure all avenues were explored as the lady's wish was to return home. MioCare utilised the Helpline service for the loan of a mobile hoist in order to carry out a home visit with the lady and the therapists (Helpline delivered and collected the piece of equipment afterwards), the result being the lady managed well in her own home environment without the use of a hoist. Further equipment was identified and ordered for discharge.

Outcomes

- As a result of her 3 week stay at Medlock she was discharged home with a restart of her existing care package, remained at one carer supporting and with the additional equipment in place was able to remain as independent as possible and stay at home. Therapy conducted a follow up visit on the day of discharge.
- Feedback later received was she was managing well at home and thanked the team in helping her meet her goal(s).

Case Study – Community Reablement

- 96-year-old woman, who was returning to borough from staying with family following having a pacemaker fitted which had reduced mobility in her arms. She had previously not been receiving care, but had returned from family without a plan in place due to a family conflict.
- Following an urgent referral via the ARCC Team, the Reablement Service arrived at the home within 10 minutes of the woman arriving home. The woman was shaken up and unable, able to manage on her own as she had no food in the house, which was cold and required cleaning.
- Staff assisted with getting food and settling the woman for the first night and made referrals in to Age UK Oldham for support with shopping and meals.
- Following the start of the support the staff could quickly see an improvement in mood and confidence. This meant she was able to work with the service on her mobility and regaining the confidence to take on her own task and regain her independence.

Outcomes

- Three weeks of reablement were provided after which point she was back in the community alone doing what she had previously enjoyed, which was walking and catching the bus to town.
- No other services were required long-term.

Urgent Care Response Team (UCR) – Hospital Avoidance

- 75-year-old woman with Guillain-Barre Syndrome who is quadriplegic, with a tracheostomy, night ventilation, PEG fed, with a long-term catheter. She lives at home with husband and has 24-hour double cover package of care.
- Had a fall from her wheelchair whilst out with carers, attended hospital and had her legs splintered due to fractures, discharged with District Nurse support.
- A week later she returned to hospital due to low blood pressure and confusion. She was reviewed and sent home before blood tests were returned.
- The following day the GP referred her to UCR asking for monitoring over the weekend following the return of the blood test which indicated infection. The GP had prescribed anti-biotics for a possible chest infection on urinary tract infection.
- UCR visited for the next 3 days and monitored her condition. Patient felt well and declined to attend hospital. She was reviewed by the Out of Hours GP and Urgent Care Hub. Her carers monitored for deterioration and took hourly observations to ensure she did not deteriorate.

Outcome

- The patient was able to remain in her own home whilst receiving treatment

Recommendations

- Note the content of the End of Year Submission for Better Care Fund
- Note the sign off is via Chief Executive of the Council and Deputy Place Lead at this time, in consultation with DASS and Lead Member
- Retrospective sign off will take place at Health and Wellbeing Board on 19th June 2025