2024/25 BCF Q2 Update

29th October 2024

Harrow Borough Based Partnership

Supporting better care and healthier lives

Implementation of the 2024/25 BCF financial plan

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£1,877,785	£938,893	50.00%	£938,892
Minimum NHS Contribution	£20,157,574	£10,037,602	49.80%	£10,119,972
iBCF	£6,663,537	£3,331,769	50.00%	£3,331,768
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,557,029	£811,687	52.13%	£745,342
ICB Discharge Funding	£2,945,861	£726,538	24.66%	£2,219,323
Total	**£33,201,786**	**£15,846,489**	**47.73%**	**£17,355,297**

- Although Harrow BCF expenditure was slightly below plan at the end of Q2 (47.73%; £754k below the half-year plan of £16.6m) the full grant will be spent in the 24/25 financial year.

- This reflects the lead time required to implement discharge funded schemes that were not signed off by NHSE until the beginning of September.

Health and care system capacity and demand

The initial projections and plans were shaped by our focus on winter preparedness, so no fundamental changes have been made. Capacity in both bridging schemes and newer initiatives has been carefully planned to ensure they are fully mobilized and embedded in advance of the winter season. This proactive approach supports our readiness to meet increased demand during this critical period.

Several key areas of discharge are being supported by the Adult Discharge Fund. We are yet to receive confirmation of next year's funding, which could impact critical areas like recruitment for these schemes. To ensure sustainable planning for services over the winter and into 2025/26, it would be beneficial for funding clarity to be provided to systems, ahead of the winter period.

NWL ICS has established a standardized rehabilitation and Pathway 2 (P2) offer, centrally coordinated through a single point of access known as the Intermediate Care Escalation Hub. This serves as one of the key enablers for facilitating timely discharges.

Additionally, bridging care provides essential capacity to support patients in transitioning safely back home. For more complex discharge scenarios, we target them through our specialized schemes designed for Pathway 3 cases, along with addressing those with unclear commissioning pathways, ensuring that all patient needs are met effectively.

2024/25 metrics

Definition	Plan	Actual	Assessment of progress	Challenges and Support Needs	Achievements
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	225	Data not available	Data not available to assess progress	In the Avoidable Admission Indicator data published by the National BCF team the Indicator value drops dramatically during 23/24 with these extremely low figures continuing into 24/25. So there appears to be significant data quality issues and therefore this data cannot be currently used to compare to the 24/25 plan to monitor performance.	• Admission avoidance strategy developed by Harrow Borough Partnership. • Reduction in ACS conditions included in NWL INT Core Outcome Indicators to reflect INT focus on collaborative support to patients at risk of avoidable admission. • Virtual wards programme • Respiratory hub-lets • Virtual monitoring • 111/999 Push pilots with urgent community response
Percentage of people who are discharged from acute hospital to their normal place of residence	95.9%	94.89%	Not on track to meet target	Although performance in Q1 is below target the underperformance is small and could potentially be rectified in subsequent quarters.	Discharge funding used to support P3 patients in own home through provision of intensive home care as alternative to residential care from September 2024.

2024/25 metrics

Definition	Plan	Actual	Assessment of progress	Challenges and Support Needs	Achievements
Emergency hospital admissions of people over 65 years resulting from falls (age standardised per 100,000)	339	Data not available	Data not available to assess progress	Falls Actual Performance YTD data for 24/25 published by the National BCF team appears to not be comparable to the Public Health Outcomes Framework - Data used to set the 24/25 plan. The data published by the National BCF team for 24/25 is so much lower than the data used to set the 24/25 plan that it is felt it cannot be used even to reliably look at the trend of the falls data to make an estimation on the Q2 performance.	The recently implemented Integrated Intermediate Care Coordination Service (ICCS) provides specialist Falls Prevention, identifying people at risk of falls for intervention.
Rate of admission to permanent residential care (per 100,000)	85.0%	Data not available	Data not available to assess progress	This is annual measure; data is not yet available to assess progress towards the target.	• Discharge funding used to support P3 patients in own home through provision of intensive home care as alternative to residential care from September 2024. • The recently implemented Integrated Intermediate Care Coordination Service (ICCS) provides multi-disciplinary, multi-agency support to meet the needs of patients discharged from hospital, with the aim of maintaining independence in the community.