BCF National Metrics - Quarterly Performance to end of Q4 2020/21

Indicator	Description	Previous Years outturn				2019/20 Actuals				2019/20		2020/21	2020/21 Actuals				2020/21	Polarity
		2015/16	2016/17	2017/18	2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Plan	Outturn	Total plan	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Q4 YTD Actual	
ASCOF2B(1)	Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	76%	79% (111/152)	**93% (15/152)**	**83%**	No Data	No Data	No Data	**81%**	**84%**	**81%**	**84%**	No Data	No Data	No Data	85% (provisional)	**85% (provisional)**	**Increasing**
CQC Interface	Percentage of older people (65 and over) who are discharged from hospital who recieve reablement/rehabilitation services		0.8% (149/152)	**0.8% (148/152)**	**0.7% (150/152)**	No Data	No Data	No Data	**0.5%**				No Data	No Data	No Data			**Increasing**

Performance Summary - the SALT return for 2020-21 showed that 28 of the 33 people who were eligible to be recorded as having reablement/rehabilitation were at home 91 days after they left hospital. It is higher than the percentage for 2019-20. Although the number of older people discharged from hospital that received reablement/rehabilitation services (33) in 2020-21 Q3 is known, the number of OP that were discharged from hospital in this period is not yet available, so the percentage for 2020-21 cannot yet be calculated. However, when known, It is likely to be less than 1%.

Impact of BCF Schemes

Reablement (HSG) – 17.2% of service users discharged require no care or a reduced level of support; 42.7% require same or increased level of care; 6.6% go into hospital (new or re-admissions); 1.8% go into a care home and 1.4% have died.

Priory Outreach - continued to work with other services and the integration of “One Team” in York, to provide support for a very busy caseload with more complex patient needs and requirements. We have also continued to work closely with other partners CRT, RATS, Social services and HSG to avoid hospital admissions/facilitate discharges. Due to additional funding, we were able to recruit and provide additional health care support in this quarter to a highly vulnerable cohort at home, supporting the above re admission prevention and to facilitate discharge from YH and actively support YICT caseload along with nurse intervention as required.
During this period Priory Outreach have increased their caseload due to the increased demand in the community not only due to the normal winter pressure but also the effects of shielding from Covid and the effects of long Covid and Covid affected families and carers.