Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Harrow

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	1,250.0	2,030.0	Details of the local demand context and the risks to capacity in H2 21/22 are contained in the Winter Plan, jointly agreed by the LA, acute trust, CCG and community provider. The proposed plan is equal to the total number of ACS	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	10.3%	11.1%	Reverting to 19/20 performance would imply a substantial deterioration in current performance, even allowing for increased levels of delays during the winter period. To reduce lengths of stay (LoS) at the local Trust (LNWUHT), the Integrated Discharge Hub has been introduced to bring all partners together to optimise discharges and ensure patient care is provided in the	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	4.9%	5.9%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	Supported Discharge Services including Home First continue to support discharge from hospital, with the priority being to support patients to live at their home. The Integrated Discharge Hub works with all partner organisation to place the patient in the best place aiming	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	466	365	445	350	ASC has a target of 146 admissions and achieving this supported through a range of actions. ASC continues to implement and embed a strengths based approach to person centred planning, including the Hospital Team within the integrated discharge hub. The discharge to assess process is being explored to increase reablement
	Numerator	185	146	181	146	
	Denominator	39,675	39,988	40,634	41,727	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.3%	91.1%	90.0%	The target is to retain 90% performance. There is a range of services to support safe and timely hospital discharge, including the restructure of ASC SW teams to increase capacity to deliver reablement to support quicker hospital discharge and reviews with appropriate support in the community.
	Numerator	250	329	325	
	Denominator	280	361	361	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.