Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Dorset

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	595.4	595.4	The most recent national data available is for 2019/20. CCG colleagues are in the process of extracting activity data from internal system to test reconcile it with the 2019/20 published data. Dorset has an observed number lower than that expected. Given the effects of COVID which makes persons less likely to consult

>> link to NHS Digital webpage

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.

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	10.8%	10.8%	Our implementation and further plans for Home First in Dorset, as outlined in the narrative plan, are supporting delivery against this metric. Working as a local system, greater integrated and partnership working is enabling people to leave hospital to go home more quickly in their recovery period . Examples include, our focussing of BCF funded Reablement Services into short term interventions to support be at home, also the closer intergrated working in Cluster Teams at a local level to
	Proportion of inpatients resident for 21 days or more	5.7%	5.7%	

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.

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)	91.6%	8.2 references our commitment to embed Home First and how funds and resources have been focussed on short term interventions at home. In addition a Trusted Assessor pilot has been established, utilising iBCF funding, to support indivduals in hospital to return to their care home (as their usual place of residence). Via

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	550	491	460	429	The ethos of Home First has emphasised the already established focus to reduce residential admission. Partnership working to increase provision of reablement, therapy and rehabilition support to promote independence is a priority for the Home First Programme in Dorset. Unfortunately, like many other
	Numerator	603	540	514	488	
	Denominator	109,600	110,049	111,765	113,704	

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 (%)	84.0%	81.2%	77.5%	Performance against this metric has dropped from 19-20 actual to 78.6% in 20-21. This is linked to impact of Hospital Discharge Policy; people are being dicharged from hospital earlier in their recovery and therefore often require more support initially - increasing potential for some re-admission. Activity decribed at 8.4
	Numerator	1,008	242	630	
	Denominator	1,200	298	813	

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.