

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board:

Hammersmith and Fulham

8.1 Avoidable admissions

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|-----------------|----------------------|----------------------|----------------------|----------------------|--|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance) | Indicator value | 29.9 | 38.0 | 31.2 | 20.4 | The Avoidable Admission 22/23 Q1-Q4 plan was calculated by reducing 21/22 Q1-Q4 Actual Observed values by 1% and recalculating the Indicator Value based on this reduced Observed value. Please note | We are continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts |
| | Indicator value | 30 | 38 | 31 | 20 | | |

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|--|--------------------|----------------------|----------------------|----------------------|----------------------|---|---|
| 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) | Quarter (%) | 94.2% | 94.9% | 95.0% | 94.1% | The Discharge to usual place of residence plan was calculated by creating a 22/23 forecast using the 21/22 quarterly values and then applying a 1% reduction to this forecast. Please note the 21/22 actuals were produced by the BCF team. Q1 22/23 plan was set to be the Q1 22/23 actuals (based on M1-M2 22/23 data). | We are continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, |
| | Numerator | 2,997 | 3,153 | 3,018 | 2,878 | | |
| | Denominator | 3,182 | 3,321 | 3,176 | 3,059 | | |
| | 2022-23 Q1 Plan | | | | | | |
| | 2022-23 Q2 Plan | | | | | | |
| | 2022-23 Q3 Plan | | | | | | |
| | Quarter (%) | 94.8% | 95.9% | 96.0% | 95.0% | | |
| | Numerator | 2,967 | 3,136 | 2,999 | 2,857 | | |
| | Denominator | 3,129 | 3,270 | 3,124 | 3,006 | | |

8.4 Residential Admissions

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|--|-------------|-------------------|-----------------|----------------------|-----------------|--|---|
| 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 | 193.4 | 575.6 | 464.2 | 326.1 | Actuals for 1st qtr (April to June) extrapolated | Where possible most people should continue to live in their own home with the clinical wraparound they need and the social care support. Only when this is not possible, should nursing and residential care be offered. However, stepdown care in homes can be invaluable before discharging someone home. |
| | Numerator | 40 | 124 | 100 | 72 | | |
| | | | | | | | |
| | Denominator | 20,687 | 21,544 | 21,544 | 22,081 | | |

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

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

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|-------------|-------------------|-----------------|----------------------|-----------------|--|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 92.1% | 92.7% | 94.1% | 93.8% | Ambition set from targets from the previous years. | We're continuing to redesign the social care front door so that most people have a period of reablement to prevent unnecessary admission into hospital and to facilitate a speedy discharge home. We have a health and social care - strategic sub-group - Support at Home, which reports into the Frailty campaign group of the ICP. |
| | Numerator | 35 | 36 | 48 | 45 | | |
| | | | | | | | |
| | Denominator | 38 | 39 | 51 | 48 | | |

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:

- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Yes

Yes

Yes