# Better Care Fund 2021-22 Template

**6. Metrics**

Selected Health and Wellbeing Board: Stockport

## 8.1 Avoidable admissions

| | 19-20 Actual | 20-21 Actual | 21-22 Plan | Overview Narrative | |
|---|---|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions<br>(NHS Outcome Framework indicator 2.3i) | Available from NHS Digital (link below) at local authority level.<br><br>Please use as guideline only | 782.0 | 1,043.4 | NB: 20-21 actual not available therefore is estimated based on % reduction in crude rate between 19-20 and 20-21.<br>The plan is to return to 1920 level. As a wider sytem we are developing homebased Tele Health monitoring solutions and a single point of access for commuinty services to support people in their own homes with ACS conidtions. | **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:<br>i) 14 days or more<br>ii) 21 days or more<br>As a percentage of all inpatients<br><br>(SUS data - available on the Better Care Exchange) | Proportion of inpatients resident for 14 days or more | 12.8% | 12.9% | Agreed plan is to restore performance to 1920 baseline. The D2A pathway is established and is now being further developed, there is investment in to a IMC bed base to support P2 Patients and investment in to Age Uk to support P1 discharges. | **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 | 7.5% | 7.8% | | |

## 8.3 Discharge to normal place of residence

| 21-22 Plan | Comments | |
|---|---|---|
| | | **Please set out the overall plan in the HWB area for improving the percentage of people who return to their** |

| | | | |
|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | 91.4% | Agreed plan is to restore performance to 1920 baseline. The whole system works to a home first ethos with a plan to increase P1 discharges as an overall percentage whilst maintaining high levels of P0 discharges. | **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 | 659 | 577 | 439 | 509 | The Stockport system continues to promote and invest in its commitment to a Home First approach. This has seen a reducing the number of people who go on to need a permanent admission to care. The pandemic has had a significant impact on this with a reduction of individuals going into homes due to a reluctance to move permanently into those settings. This has focussed our approaches on the use of Reablement and Intermediate Care to ensure that people are supported to maximise independence and to return to their own home wherever possible. There is a commitment across the system to help people remain in their homes, but also recognises the need that should be require residential or nursing care that should be available at the right time and place for them. | **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.** |
| | Numerator | 390 | 339 | 259 | 304 | | |
| | Denominator | 59,159 | 58,726 | 58,933 | 59,779 | | |

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 |
|---|---|---|---|---|---|
| | Annual (%) | 95.0% | 88.8% | 95.0% | As reported last year Stockport benefits from a well-integrated Intermediate tier service, which includes financial commitment from commissioners within the Council and CCG as well as managerial capacity from the |
| | Numerator | 261 | 355 | 361 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Denominator | 275 | 400 | 380 | Council and therapeutic resource from the Foundation Trust. In the last year a great deal of work has been undertaken to improve our integration and multi-disciplinary approach to discharge out of hospital approaches including our D2A process. The success of this is reliant on integrated care and support outside of hospital to support an individual to regain and maintain their independence and to remain at home avoiding re-admission back into an acute setting. We have a robust MDT and senior leadership oversight through strong governance and accountability. In addition significant progress and improvements have been made to the Council's reablement service at both operational and managerial levels. Finally, plans are well developed at this stage to implement a commissioning strategy for bed based intermediate tier provision. | **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.