Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: Stockport

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	245.3	257.3	239.1	204.0	Improvements in flow into and through SDEC seen in Q4 of 2023/24 and the positive impact in reducing the numbers of avoidable ACSC admissions is the basis for seeking improved performance in 2024/25. This is aligned to the aspiration to reduce NEL admissions by 3%.	We are seeking to build on improvements in flow into and through SDEC which were noted as part of the performance monitoring for 2023/24 through and this will have had a direct positive impact in reducing the numbers of avoidable ACSC admissions. Through daily discharge review meetings, regular Multi Agency Discharge Events (MADE), and identifying patients who can be supported using 24 hour step up care as opposed to admission.
	Number of Admissions	834	875	-	-		
	Population	295,243	295,243	-	-		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Indicator value	237.9	249.6	252.5	214.9		

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

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,322.4	2,236.9	2,169.8	There has been a continuing downward trend in falls from 2022/23 following an increase in 2021/22 and system partners are keen to consolodate the reduction whilst seeking a further 3% decrease in this indicator.	The ongoing focus on frailty will continue and system partners are working to widen the work that has taken place. For example the work in a specific locality in Stockport to drive down admissions into hospital from care homes. This focus on frailty and prevention has been part of the success on this target and further investment is required to continue and develop the positive outcomes.
	Count	1,451	1333	1319		
	Population	61,445	59604	60796		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Percentage of people, resident in the HWB, who are	Quarter (%)	92.4%	92.1%	92.6%	92.6%	As a system, Stockport is seeking to increase this indicator to the 2023/24 national average of 92.6%. Performance on this metric has been stable and the plan represents a challenge across system partners	Systems partners are continuing to embed the home first ethos into systems and practice locally with a number of initiatives aiming to drive an increase in the proportion of people returning directly home. For example, the system is working with providers to deliver a robust
	Numerator	6,443	6,493	6,005	6,000		
	Denominator	6,976	7,048	6,485	6,479		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan	partners.	For example, the system is working with providers to deliver a robust 24/7 home support offer at the point of discharge which is reviewed every few days to enable people to receive sustainable levels of home support where this is required as opposed to leaving the hospital via a D2A bed.
	Quarter (%)	92.6%	92.6%	92.6%	92.6%		
	Numerator	6,744	6,814	6,269	6,264		
	Denominator	7,283	7,358	6,770	6,764		

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
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	597.3	556.4	491.0	471.0	Stockport is continuing to drive the development of the suppport offer for people to remain in their own home, especially following a period in hospital. A reduction of 3% to build on the recent progress in this area will stretch the system but provides a sustainable level of improvement.	multi disciplinary invovlement in discharge destination decisions whilst someone is in hospital, swifter flow through the hospital system and greater flexibility of support intensity to manage periods of ill health or stress are key areas of development in Stockport and are anticipated to drive further improvement in this area.
	Numerator	356	340	300	291		
	Denominator	59,604	61,105	61,105	61,783		

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

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.