2022/23 BCF National Metrics and Rationale

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	230.0	212.9	237.4	201.5	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 the 21/22 Q1-Q4 Actual Observed values and Indicator methodology was produced by the BCF Team.	There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows: • The development of our virtual wards programme. • Continued roll out of post covid syndrome clinics. • Go live of respiratory hub-lets. • Continued work roll out of virtual monitoring. • 111/999 Push pilots with urgent community response continue. The following activity within the BCF plan will contribute to the delivery of the targets: Scheme 1: Neighbourhood development - Proactive case management at neighbourhood level supported by Care Connection Teams and H4All Wellbeing
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	228	210	235	199		
	Denominator						

8.2 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 (%)	92.3%	92.4%	92.1%	91.4%	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 internal improvements within trusts and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, though this remains our longer term plan. There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows: • The development of our virtual wards programme. • Continued roll out of post covid syndrome clinics. • Go live of respiratory hub-lets. • Continued work roll out of virtual monitoring. • 111/999 Push pilots with urgent community response continue. The following activity within the BCF plan will contribute to the delivery of the targets: Scheme 4: Urgent and emergency care - The work of the Integrated Discharge Team and in particular posts that operate across organisational boundaries.
	Numerator	5,543	5,621	5,384	4,961		
	Denominator	6,006	6,081	5,846	5,428		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)						
	Numerator	5,121	5,212	4,998	4,599		
	Denominator	5,495	5,563	5,354	4,966		

8.3 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	682.8	791.1	688.8	776.1	The figures submitted for this metric are based on anticipated sequel to action, i.e., what the social care professional believes is likely to happen. This means that the actual number of permanent admissions is below the numerator which relates to the figure submitted for the Council's Short and Long-term Support (SALT) return to NHS Digital. For example, the actual number of permanent admissions in 2020/21 it was 149 and in 2021/22 it was 204. All proposed permanent admissions go through a rigorous review process at head of service level to check that this is the most appropriate means of addressing need. However, in 2021/22 58% of permanent admissions resulted from a conversion from short-term placements and it is anticipated that this may increase in 2022/23 due to pressures placed on households by the cost-of-living crisis.	2022/23 activity that will help achieve target includes: <u>Scheme 1: Neighbourhood development</u> – Early identification of people at risk of admission and/or loss of independence through active care planning in primary care and multi-disciplinary team approach. Support through Wellbeing Service and other VCS partners to address contributors to deterioration, e.g., social isolation. Joint VCS and community provider role in addressing falls and risk of falls. <u>Scheme 2: Supporting Carers</u> - Identification of carers, assessing their needs and putting appropriate support in place with the aim of reducing number declining to continue with caring role after cared for person has gone into a short-term placement. Referral through to Carer Support Service (see narrative plan) will be key to accessing appropriate information, advice, and support.
	Numerator	287	340	296	340		
	Denominator	42,033	42,976	42,976	43,800		
8.4 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 (%)**	91.8%	90.6%	90.4%	90.5%	The level of ambition takes into consideration that the review period will be taking place during Q4, i.e., the main winter months and the severity of the winter, will impact on the deliverability of the target. Other factors include: a) Readmissions related to the original cause of admission; b) Readmissions for different reasons; and c) Deaths, which may be related to a Covid-19 resurgence and flu virulence. Denominator based on current numbers being discharged to the service. Unable to increase due to staffing issues.	2022/23 activity that will help achieve target includes: <u>Scheme 1: Neighbourhood development</u> – Liaison with neighbourhood teams to ensure identification of people at risk of readmission and deployment of resources to address needs. This would include services funded via scheme 4: *Urgent and emergency care* and delivered via the community health provider, e.g., District Nursing, Community Adult Rehabilitation Service. <u>Scheme 2: Supporting carers</u> – Identification of carers to ensure access to support that will enable them to undertake a caring role or to continue in it.
	Numerator	89	77	104	55		
	Denominator	7	85	115	105		