Better Care Fund 2023/24 National Metrics Proposed Targets and Rationale

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	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	231.1	185.1	229.3	200.0	Avoidable Admissions 23/24 plan set using the data published by BCF National Team on the BCF Portal. The plan is derived by taking the 22/23 actual number of admissions and reducing this by 1% and then using this to calculate the Indicator Value. Please note Q4 has been updated since the last submission and is now based on the Q4 22/23 actual data published by BCF team whereas previously it was based on a forecasted 22/23 Q4 position which was significantly different to the actual Q4 22/23 position. Please note the Q4 22/23 actual position as per the BCF National team data is quite different to the Q4 22/23 plan data auto-populated by this template.	2023/24 activity that will contribute to delivery of the target includes: **Scheme 1:** Proactive case management at neighbourhood level supported by Care Connection Teams and H4All Wellbeing Service to identify people most at risk of admission. The relevant services to address need are then identified, depending on level of complexity of need. This would include social prescribing for lower level needs. Two Same Day Urgent Care Hubs are also due to open, one in the north of the borough in July and one in the south in October, with the intention of supporting people with non-urgent health issues and diverting people from A & E. The hubs will include community diagnostics. Although funded outside of the BCF, new enhanced primary care service provision during 2023/24 will see new community-based arrangements for anti-coagulant, ECG, pessaries and phlebotomy provision in place. Included within scheme 1 and funded via DFG is telecare equipment, the preventative benefits of which can help to support independence. **Scheme 2:** The identification of and support for unpaid carers is also crucial to delivery of the target to prevent escalation of both the carer and the cared for person. **Scheme 3:** Assistance with higher levels of needs needs would be provided from community and community health services, e.g., Reablement, Rapid Response, District Nursing, Continence Service, Community Adult Rehabilitation. People living in the community with ongoing care needs who satisfy the National Eligibility Criteria for Adult Social Care would be supported with homecare or more personalised approaches to addressing their need via Direct Payments. Bed-based step-up provision is also being commissioned for admission avoidance purposes. Included within this scheme is the community equipment service that supports daily living activities.
	Number of Admissions	638	511	633	-		
	Population	306,870	306,870	306,870	306,870		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	229.4	183.5	228.4	238.4		

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,869.1	2,039.0	2,018.0	Falls 2022/23 estimate was calculated using a combination of the Public Health Outcome Framework Data and the Falls Standardisation Tool Shared by the BCF team. The 2023/24 plan was set by reducing the 2022/23 actual by 1% and re-calculated the indicator value.	2023/24 activity that will contribute to delivery of the target reflects Hillingdon's approach is two-fold, i.e., seeking to prevent falls from occurring in the first instance and then preventing recurrence where a person has fallen. Scheme 1: The CNWL falls service offers a multidisciplinary, consultant-led clinic that provides comprehensive assessment and specialist diagnostics to people who have had a fall or are at risk of falling. Referrals are via CCTs. The clinic can refer people to specialities and signpost them to relevant agencies, e.g., Age UK. The service also provides an 8-week, evidence-based falls prevention exercise programme either in people's homes or in group settings at Northwood Health Centre and Riverside Unit. In addition to proactive case management at neighbourhood level, a pilot Frailty Assessment Unit at the Hospital, the funding for which is not included within the BCF, also identifies people living with frailty who are most at risk of falling and proactive case management is provided by CCTs and direct support delivered by the Rapid Response Team for people with the most complex needs.
	Count	800	873	865		
	Population	41,314	41,314	41,314		

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	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 (%)	92.8%	91.7%	92.3%	92.6%	Discharge to Usual Place of Residence 23/24 plan was set by using historical data to forecast a 23/24 position and then apply a 1% improvement to this forecasted position to obtain a 23/24 plan. The forecasted (do nothing) estimate was Q1 92.5%, Q2 91.4%, Q3 92.0% and Q4 90.7%.	2023/24 activity that will contribute to delivery of the target includes: **Scheme 2:** Supporting unpaid carers through via Adult Social Care and/or the Carer Support Service to reduce risk of it not being possible for the cared for person to return home. **Scheme 3:** Support for older people with lower level needs via the Age UK Home from Hospital Service (Pathway 0). People on pathway 1 will be supported via the Reablement Service and community-based NHS provided services such as Rapid Response, Community Adult Rehab Service, Community Matrons and District Nursing. Collectively these services will provide wrap-around care and support to address the specific needs of people thereby supporting discharge to their usual place of residence where possible. On going care needs for people who meet the National Eligibility Criteria for Adult Social Care are addressed through homecare provision. Aids to support daily living needs are provided through the integrated community equipment service.
	Numerator	5,237	5,333	5,232	4,599		
	Denominator	5,644	5,815	5,669	4,966		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	92.8%	91.7%	92.3%	90.9%		
	Numerator	5,587	5,688	5,585	5,617		
	Denominator	6,023	6,205	6,054	6,177		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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	704.2	776.3	593.6	603.9	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 2022/23 was 171, which compares to 204 in 2021/22. 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 2022/23 73% of permanent admissions resulted from a conversion from short-term placements. The target takes into consideration the increase in the older people population, increased levels of acuity as a legacy of the pandemic and the fact that some short-term placements are unavoidable and appropriate to meet need, including needs of unpaid carers. Our NW London ambition is to work collectively to create more sustainable market conditions for residential care by having a joined-up NW London approach for managing homes and collectively identify where our pressure points are to support medium and longer term planning around demand and capacity.	2023/24 activity that will contribute to delivery of the target includes: Scheme 1 Case management at neighbourhood level undertaken by Care Connection Teams. Scheme 3: Support to remain at home provided through community services, including District Nursing, Rapid Responses & Community Adult Rehab Service, Reablement. Scheme 4: Alternative to residential placement provided within extra care where need can be met safely. Final placement decision will continue to be made at head of service level.
	Numerator	296	340	260	270		
	Denominator	42,033	43,800	43,800	44,713		

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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 (%)	90.4%	90.5%	94.5%	94.9%	The denominator is based on the estimated Hospital Reablement capacity for each month during Q3, i.e., the sample period. 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) Increased acuity of people being discharged into the service generally; b) Readmissions related to the original cause of admission; c) Readmissions for different reasons. The NW London ambition is to align reablement with other services and pathways which help get patient's home and by doing so help residents recover in more familiar settings and reduce the number of patients staying in hospital for longer than they need to.	2023/24 activity that will help achieve target includes: Scheme 1: Neighbourhood development – 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 3: Reactive care and delivered via the community health provider, e.g., District Nursing, Community Adult Rehabilitation Service. Support to unpaid carers would be delivered via services funded under scheme 2: Support for carers. This could be either from the Council following a carer's assessment and/or via the Carer Support Service.
	Numerator	104	95	121	149		
	Denominator	115	105	128	157		