Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Oxfordshire

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	622.3	705.0	Current performance in 21/22 suggests a significant increase in pressure over 20/21 where NEL for ACS were suppressed by the pandemic. With the implementation of AW UCR and measures in our winter plan we expect to deliver 95% of the 2018/19 baseline	**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: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.0%	7.4%	Oxfordshire AEDB manages progress towards the Oxford University Hospital metric of no more than 12% of open acute beds occupied by people with length of stay >21 days. This target represents a reduction from the March 21 baseline from 14%. The BCF metric is not one that has been monitored before and the average length of stay approach needs to be understood in terms of its sensitivity to the measures	**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	3.7%	3.4%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
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)	93.0%	The current proportion of people discharged home is 91% with 7.2% going into pathway 2 step down beds; however, if we break that down into people aged over 65 the proportion is 88% going home and 10% going into pathway 2. The increased reablement capacity funded as part of our surge plan will positively impact these	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their 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	567	466	442	429	Residential admissions to nursing homes are driven both from the community and as part of hospital discharge. We are continuing to work with housing provider partners to develop Extra Care Housing and have designed a new care approach into those flats as part of Live Well at Home. We will continue to drive our Home
	Numerator	724	597	576	570	
	Denominator	127,705	128,126	130,189	132,728	

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.

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
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	67.2%	77.0%	The impact of reablement on longer-term care needs is set out in the narrative and with the Home First and strengths-based prevention work we anticipate that this will mean a recovery in the numbers of people still at home 90 days after reablement episode to 77%
	Numerator	1,700	184	308	
	Denominator	2,000	274	400	

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.