Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Barnsley

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	344.7	304.5	342.8	296.9	Work to reduce avoidable admissions has seen a positive impact on admissions for ambulatory care sensitive condition in Barnsley and latest data shows a slight decrease in admissions and therefore the ambition is to maintain this reduction through 2022/23. The Q4 ambition is higher than the reported figure in 2021-22 but is reflective of longer term trends which indicate that the low figure was unusual given the winter period.	Through the work of the Care Closer to Home Board and the Proactive Care Group we continue to deliver services and initiatives aimed at preventing admission - examples include activity to support those with frailty such as access to physical activity. The Rightcare Barnsley Service and IC and reablement step up offers also continues to support people in their own homes or the community by providing access to appropriate community support.
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	325	287	323	355		

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

8.3 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 (%)	92.5%	93.3%	93.0%	92.3%	In Barnsley the rate of discharge to normal place of residence is high as a result of the comprehensive discharge pathways and community/Social Care services in place to support people to live independantly or with support. The 2022-23 plan is therefore to maintain the good levels of performance from 2021-22	Continued delivery and development of the strong discharge arrangements including D2A. Strengthening of Neighbourhood Teams approach and integtrated service delivery across Primary/Community and Social Care Services
	Numerator	6,592	6,612	6,434	5,977		
	Denominator	7,128	7,086	6,915	6,474		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	92.9%	93.4%	93.1%	92.3%		
	Numerator	6,177	6,498	6,344	5,901		
	Denominator	6,647	6,958	6,815	6,392		

8.4 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	659.7	641.1	849.5	847.7	Targets were based on adoption of new approach to screening and referrals. This has led to a significant drop in the number of people being assessed. However targets for placements was impacted by a drop in community homecare capacity and continued recovery from pandemic across the system, which increase the need for residential short term placements.	Changes to the way people access Adult Social Care will be introduced that make better use of community resources and look to promote prevention and reablement support to delay or avoid admissions
	Numerator	321	320	424	432		
	Denominator	48,660	49,914	49,914	50,959		

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

		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 (%)	85.5%	85.5%	90.6%	90.0%	Reablement is a key priority for ensuring the right support is offered to people and we are not supporting people before they need to be. Service is being supported through a development programme for adopting strength based conversations with people to change the way reablement support is offered. The plan is to maintain the high proportion of people still at home at 91 days from 2021/22	Introduce a new reablement pathway that enables all referrals for long term adults social care support to be offered reablement support. This would be supported by continued partnership / joint working with health colleagues to maximise use of reablement and intermediate care capacity to support the discharge pathways
	Numerator	124	124	126	126		
	Denominator	145	145	139	140		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.