Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Stockton-on-Tees

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	286.5	260.9	298.2	280.0	The recording of avoidable admissions is increasing across the patch, hence we are seeing higher indicator values than the previous year	We will aim to meet the ambition through our BCF funded admission avoidance and prevention schemes as well as wider initiatives such as UCR, Ageing Well and virtual ward.
	Number of Admissions	615	560	640	-		
	Population	197,213	197,213	197,213	197,213		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	370	299	337	352		

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

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	1,511.4	1,782.0	1,782.0	Estimated falls indicator values for this year have decreased so we have carried forward this years estimate to 2023/24	A project was initiated across Tees to scope, map, and review the existing pathways across the system responding to Level 1 & 2 falls in the community.
	Count	545	637	637		
	Population	37,518	37518	37518		

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

		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	Quarter (%)	93.7%	93.4%	93.4%	93.4%	Plan to maintain already high performance.	We have several schemes and initiatives in place to support this including our Home First Service. Our agreement to continue to fund 4 weeks discharge to assess could
	Numerator	4,074	3,913	4,050	3,825		
	Denominator	4,347	4,190	4,337	4,096		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		potentially mean fewer people are discharged straight from hospital to 'home' but maximises their potential to do so.
	Quarter (%)	93.4%	93.4%	93.4%	93.4%		
	Numerator	4,718	4,622	4,519	4,494		
	Denominator	5,053	4,951	4,839	4,813		

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	449.3	653.8	429.8	433.7	COVID had an impact on care home admission resulted lower figure in 21/22 but a higher figure in 22/23. The estimated figure in 22-23 is the actual figure. Plan for 23-24 is higher based on increase in population of over 65	Continued plan to focus on the 'Home First' model and work closely with the Trust, community services and the independent domiciliary care providers to support people to return to their own homes and other alternatives to residential care,
	Numerator	166	251	165	170		
	Denominator	36,948	38,391	38,391	39,200		

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

		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 (%)	90.2%	90.2%	94.3%	91.4%	Based on previous submissions, continue to use Q3 data. Data has been verified and is correct. The denominator in 22/23 is lower because workforce issues impacted the capacity. Following a relatively successful recuritment drive, we are anticipating more	Proactive analysis of those coming out of hospital is used to monitor performance and provide continual feedback, as well as putting in place a range of different options, strong resilience in community services and support to help people stay at
	Numerator	92	92	83	96		
	Denominator	102	102	88	105		

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

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.