Better Care Fund 2022-23 Template

Metrics

Slough Wellbeing Board

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
Rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000 population)	Rate per 100,000	113.0	107.0	111.0	90.2	Ambition is modelling activity in last year through proactive work in community in Care Homes, LAP and ICDM looking to impact at least 3% improvement Q1 and Q2 and increasing to 5% Q3 and Q4. New pathways and services (Urgent Care Response and virtual wards) have come on line and will further impact through this year. Anticipatory care of people with chronic conditions helping proactive identification through Connected Care (risk stratification) and intervention in community MDTs.	Embedding the Urgent Care Response pathways and support in Slough. Operation of the Local Access Point for coordinating same day integrated assessment and response. Anticipatory Care Planning and proactive approach to people with people with moderate frailty MDT cluster meetings in PCN localities for management of people with complex and chronic conditions Increased capacity in Intermediate Care for step-up from community
	Numerator	169	160	166	135		
	Denominator	149,600	149,600	149,600	149,600		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	110	104	106	85		

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	Quarter (%)	93.3%	92.6%	92.3%	91.7%	Q1 taken from SUS data pack. Ambition reflects activity last year and anticipated increase from actual Q1 figures. Achieving a rate of 92.8% represents a stretch particularly with significant system pressure to maintain capacity and flow through the hospital and interim placements/step down to alternative care settings are being commissioned and used as part of the D2A pathway. However, the review of intermediate care services in this year presents opportunity for additional capacity and support more people back to their home with reablement and OT support	Plan to improve on 21-22 to achieve a minimum rate of 92.8% and be higher than the national average for Welbeing boards. Improve and extend reablement offer to support more people to return home. D2A packages of support people with Home First Approach.
	Numerator	2,687	2,625	2,581	2,409		
	Denominator	2,880	2,836	2,797	2,626		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	91.4%	92.4%	92.8%	92.8%		
	Numerator	1,953	2,126	2,368	2,145		
	Denominator	2,136	2,301	2,551	2,312		

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	Annual Rate	488.5	478.5	478.5	469.0	Maintain at previous plan rates against an increasing older population and increasing acuity of patients discharged from acute hospital.	Review and reconfiguration of reablement and intermediate care services creating more capacity and greater rehab focus. Integrated Care Teams, Local Access Point, virtual wards and
	Numerator	76	76	76	76		
	Denominator	15,557	15,884	15,884	16,205		

nursing care homes, per 100,000 population							Urgent Care response supporting people with complex care needs

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

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 (%)	76.6%	65.2%	78.9%	78.2%	Slough's ambition to increase number of discharges into reablement services and enhance and extend the reablement capacity for both hospital discharges and step up support for referrrals from the community	Review of reablement services has been completed and in to consultation phase. Plan to go live from Nov 22. Will provide greater capacity and increase numbers into reablement on discharge and from community.
	Numerator	36	43	56	61		
	Denominator	47	66	71	78		