Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Rotherham

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	The non elective plan reflects the affordable level of admissions that has been agreed within provider contracts. This affordable level incorporates anticipated growth in activity, the financial constraints within the system and proposed improvement and productivity schemes. The plan is the position agreed with the CCG's regulator NHS England both at a CCG and an Integrated Care System (South Yorkshire and Bassetlaw) level. This is agreed as meeting the national expectations set out in NHS England and NHS Improvement shared planning guidance. This position is aligned with providers' agreed positions and signed off as part of the CCG's contract with each provider. The Health and Wellbeing Board (HWB) level plan is calculated nationally incorporating a percentage of the RCCG plan (97.9%) and a percentage (6.2%) of other SYB CCG's plans. This reflects patients who live in Rotherham but are registered with a GP practice in other localities such as Sheffield and vice versa. The HWB plan is 29582 admissions in 2019-20. The CCGs improvement and productivity schemes go through a significant assurance process, including external review and are monitored across a number of key forums. The key schemes with expected impacts on the level of non elective admissions are: The implementation of an integrated urgent and emergency care centre Remodelling of IC and reablement model to include step-up provision to avoid hospital admission. Further interventions in mental health liaison Development of a more effective ambulatory care pathway Continued provision of social prescribing for LTC and mental health patients Continued case management in risk stratified patients Further developments in integrated locality working Hospice at Home services to provide immediate advice and support for those in community and in care homes. Continued provision of Care-ordination Centre, Integrated Rapid Response, Advanced Nurse Practitioner Service, Intermediate Care Service and GP Local Enhanced Service (LES).

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

19/20 Plan	Overview Narrative

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	16.1	The Rotherham HWB plan is to return to the level of 16.1 daily days, which was previously being achieved. An integrated discharge team (IDT) is fully embedded in the Rotherham system and is driving down DTOC through a single referral route for complex patients. A Multi Disciplinary Team approach across social care, nursing and therapy is in place as part of this single referral route. The monitoring of DTOCs now forms part of a system escalation processes. An increasing MH DTOC position has been identified as the greatest challenge to returning to 16.1 daily delays. This has led to the establishment of a focus group to understand the issues and address barriers. This is supporting the reduction in MH DTOCs and is expected to continue to ensure DTOCs remain in line with national expectations. The group is looking to ensure the same processes are in place for MH as they are in the IDT . Customer journey work is being undertaken and a social worker inpatient ward co-ordinator post is being created. Ensuring links across DTOC and NEA work streams, a trusted assessor in AMU/A&E has also been established to support admission avoidance. A community physician working with care homes will support delivery of enhanced case management for those identified as at risk of attending/admission to A&E. We are spending the winter pressures grant on increasing capacity of the Integrated Discharge Team to carry out assessments, increasing capacity to deliver Intermediate Care and reablement including additional OT capacity, provision of winter beds and additional resources to increase capacity of Age UK hospital discharge service and mental health liaison worker. A new tender for domiciliary care will ensure that joint assessments are carried out, using the trusted assessor model.	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 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	555	503	In order to provide customers with greater independence and choice within a recovery model, admission to 24 hour care is provided only for those people who can no longer be supported to have their needs met by remaining at home in the community. A challenging stretch performance target for 2019/20 of 25 fewer admissions than the 289 made in 2018/19, has been set to achieve service continuous improvement by reducing the number of total admissions to 264 which represents a 10% improvement on last year's rate (from 559 to 503 new admissions per 100,000 population). There is a proportionate range of scheme types and spend to help deliver the metric ambition, some of the higher impact schemes include: reablement, domiciliary care, Breathing Space, Rotherham Equipment and Wheelchair Service, Disabled Facilities Grant, Intermediate Care, Direct Payments, Supported Living and Discharge Pathways and Patient Flow. Performance by March 2020, resulting in fewer than 289 admissions by year end will extend the positive direction of travel trend for a 6th successive year. Based on latest (2017/18) benchmarking data, it would also further improve Rotherham to a better than national average ranking. The above improved 2018/19 performance, continues to demonstrate that the prevent; reduce and delay commitment and new models of best practice service offers, are (for the vast majority) sustaining people to achieve their preferred choice of support - of remaining at home in the community, for as long as they can be supported to do so.	**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.**
	Numerator	287	264		
	Denominator	51,693	52,438		

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 2016 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2016basedprojections
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-

Being Boards.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 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 (%)	89.0%	86.0%	This is an annual measure and collation of data is undertaken during January to March 2020 period to track service users who have been 'offered' (i.e. commenced) the service during October to December 2019, to identify those who were still at home 91 days following discharge from hospital. A performance target for 2019/20 of 86% has been set to achieve a moderate service continuous improvement, by increasing the proportion of people who are discharged from the service, who are subsequently still at home after 91 days later (this would mean approximately 10 extra people for every 11 extra offered the service). The new Adult Social Care (ASC) Pathway, is due to be implemented in October 2019, with an increased focus on reablement at home. It is expected that numbers receiving reablement, within the snapshot period will increase (the 2018/19 actual figures reported were 113/132 = 85.6%). However, the limited target increase to 86% of individuals being at home 91 days later, should enable the service to effectively manage any negative impact of unforeseen change in customer profiles or complexity and to ensure that the service can meet this higher demand, whilst mitigating any increased risk to being able to maintain performance. The 86% target has been agreed as part of the Adult Social Care Key Performance Indicator suite for 2019/20, which has been approved locally and formally reported via the Council's ASC Directorate Leadership Team and joint agency Better Care Fund governance arrangements. Achievement of 86% (123/143) in 2019/20 would achieve a three year upward trend and consolidate benchmarking (using 17/18 published figures), to just above national average and allows for any in year impact of the new ASC Pathway. There is a proportionate range of scheme types and spend to help deliver the metric ambition, some of the higher impact schemes include Reablement, Community Stroke Service, Breathing Space, Rotherham Equipment and Wheelchair Service, Community Occupational Therapy Services, Disabled Facilities Grant, Intermediate Care, , Falls Service, Discharge Pathways and Patient Flow.
	Numerator	162	123	
	Denominator	182	143	

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 merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.