

Tab 8. 2019/20 Plan Metrics Narrative

6.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
<p>Total number of specific acute non-elective spells per 100,000 population</p>	<p>&gt;&gt; Link to Better Care Exchange for the latest Non-Elective Admissions plan data</p>	<p>The ceiling for 2019/20 is 2,435 admissions against an outturn for 2018/19 of 2,585. This reflects the proportion of the total 18 and over non-elective admissions attributed to the 65 and over population as well as the proportion associated with ambulatory care sensitive conditions, i.e. cases where effective community care and case management can help prevent the need for hospital admission, such as chronic hepatitis B; asthmas; congestive heart failure; diabetes; chronic obstructive pulmonary disease; hypertension; epilepsy; and dementia. Non-elective admissions targets in previous plans have been based on the total number of admissions for the 65 and over population. The 2,435 figure also reflects the target to which the Integrated Care Partnership is working to.</p> <p>The key components of the BCF plan that will contribute to the delivery of the target are:</p> <p><b>Scheme 1: Early intervention and prevention</b></p> <p>Neighbourhood development and the delivery of active case management. Application of risk stratification to identify people requiring active case management. Promotion of assistive technology such as telecare.</p> <p><b>Scheme 4: Integrated Hospital Discharge and the Intermediate Tier</b></p> <p>Intermediate tier: step-up arrangements through use of Reablement and</p>	<p>Please indicate the priority components of your BCF plan in terms of schemes and enabling activity for Health and Social Care Integration which are aimed at having the planned impact on the metric alongside.</p>

		<p>Rapid Response where clinical input is required. Building an appropriate package of care around the resident/patient.</p> <p><b>Scheme 5: Improving care market management and development</b> Implementation of the Enhanced Support for Care Homes and Extra Care Service to reduce admissions from care homes.</p>	
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## 6.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative	
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	13.6	<p><b>Scheme 4: Integrated hospital discharge and the intermediate tier</b> Intermediate tier programme work, which will lead to improved Bridging Service deployment, clarification of Pathway 2, i.e. people with more complex needs requiring a bed-based service that is not in a hospital setting and establish a single point of coordination for all discharges.</p> <p>Hospital Discharge Grant (see tab 4: <i>Strategic Narrative</i>) to impact on reduction in delays for people funding their own care.</p> <p>Direct Housing links with a named Council officer have been established and a simple referral process introduced that will be kept under review.</p> <p>The approval process for out of Hillingdon Social Care delays, e.g. NWHT, West Herts, will be reviewed to ensure accuracy of DTOC reporting.</p> <p>Also see tab 7: <i>High Impact Change Model (HICM)</i></p> <p><b>Scheme 5: Improving care market management and development</b> iBCF and winter pressures funding is being used to support care home and homecare market supply.</p>	Please indicate the priority components of your BCF plan in terms of schemes and enabling activity for Health and Social Care Integration which are aimed at having the planned impact on the metric alongside.

		<p><b>Mental Health</b></p> <p>Weekly discharge conference calls involving reps from CNWL, the CCG and the Council is assisting in managing timely discharges. Having a named contact within Housing is also enabling housing need options to be explored at a much earlier point in a patient's discharge pathway. An additional six bed supported living scheme is due to come on stream during 2019/20 to increase opportunities for step-down. A new care and wellbeing service for people with mental health needs with a greater focus on move-on as part of a recovery programme will be implemented from December 2019, although the impact of this on flow through existing supported living schemes is unlikely to be felt until into 2020/21.</p> <p>The main cause of mental health delays is access to NHS funded rehab provision, of which there is a general shortage and is an issue that is unlikely to be resolved during 2019/20.</p>	
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### 6.3 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	355	408	2019/20 target set to reflect reality of Hillingdon's position. The issue is that 70% of short-term placements convert to long-term. Solution is to reduce number of short-term placements; however, short-term placements necessary to provide short breaks to Carers and delay in delivery of Park View Court extra care scheme will impact on figures in 2019/20 as delay in delivery of Grassy Meadow Court impacted on 2018/19 figures.  2019/20 activity that will help achieve target includes:
	Numerator	145	170	
	Denominator	40 873	41 634	

				<p><b>Scheme 2: Supporting Carers</b> Identification of Carers, assessing their needs and putting appropriate support in place with aim of reducing number declining to continue with caring role after cared for person has gone into a short-term placement.</p> <p><b>Scheme 5: Improving care market management and development</b> Opening of Park View Court extra care scheme and expansion of set-up provision within extra care as an alternative to a care home placement.</p>
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#### 6.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement.	Annual (%)	88	90	<p>The level of ambition takes into consideration the fact that the review period will be taking place during Q4, i.e. the main winter months and the severity of the winter will impact on the deliverability of the target. Other factors include:</p> <p>a) Readmissions related to the original cause of admission; b) Readmissions for different reasons; and c) Deaths.</p> <p>Liaison between Reablement and the Neighbourhood Teams will assist in managing the risk of readmission. However, the Neighbourhood Teams are at different levels of development and the full effect of this initiative may not be felt until 2020/21.</p>
	Numerator	132	135	
	Denominator	150	150	