# Better Care Fund 2021-22 Template

**6. Metrics**

Selected Health and Wellbeing Board: Havering

## 8.1 Avoidable admissions

| | | 19-20 Actual | 20-21 Actual | 21-22 Plan | Overview Narrative |
|---|---|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i) | Available from NHS Digital (link below) at local authority level. Please use as guideline only | Not published at time of BCF submission | | 1,079.9 | Plan to maintain the pre covid rates, if not improve on. |

>> link to NHS Digital webpage

**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

## 8.2 Length of Stay

| | | 21-22 Q3 Plan | 21-22 Q4 Plan | Comments |
|---|---|---|---|---|
| Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for:<br>i) 14 days or more<br>ii) 21 days or more<br>As a percentage of all inpatients<br><br>(SUS data - available on the Better Care Exchange) | Proportion of inpatients resident for 14 days or more | 12.2% | 14.2% | We are utilising 19/20 Performance as the plan for 21/22. |
| | Proportion of inpatients resident for 21 days or more | 6.1% | 7.6% | |

**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

## 8.3 Discharge to normal place of residence

| | 21-22 Plan | Comments |
|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | 94.8% | We are utilising 19/20 Performance as the plan for 21/22. |

**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

## 8.4 Residential Admissions

| | | 19-20 Plan | 19-20 Actual | 20-21 Actual | 21-22 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 | 600 | 632 | 602 | 594 | There are many services based in the community that look to enable people to remain at home rather than go into residential and nursing care. These include assitive technology, use of DFG, voluntary sector partners who support carers, look to reduce social isolation and build peer support networks in the community. The quality of |
| | Numerator | 285 | 295 | 280 | 280 | |
| | Denominator | 47,500 | 46,709 | 46,518 | 47,166 | |

**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.**

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

| | | 19-20 Plan | 19-20 Actual | 21-22 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% | 89.3% | 89.8% | We continue to work with our provider to improve the impact of reablement itself. Assistive technology is considered to support people when they are going through the reablement process. Wider preventative services are brought together with the reablement provider in dedicated sessions to ensure links to |
| | Numerator | 187 | 200 | 211 | |
| | Denominator | 210 | 224 | 235 | |

**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 splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

## Better Care Fund 2021-22 Template

**7. Confirmation of Planning Requirements**

Selected Health and Wellbeing Board: Havering

| Theme | Code | Planning Requirement | Key considerations for meeting the planning requirement<br>These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) | Confirmed through | Please confirm whether your BCF plan meets the Planning Requirement? | Please note any supporting documents referred to and relevant page numbers to assist the assurers | Where the Planning requirement is not met, please note the actions in place towards meeting the requirement | Where the Planning requirement is not met, please note the anticipated timeframe for meeting it |
|---|---|---|---|---|---|---|---|---|
| NC1: Jointly agreed plan | **PR1** | **A jointly developed and agreed plan that all parties sign up to** | Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?<br><br>Has the HWB approved the plan/delegated approval pending its next meeting?<br><br>Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan?<br><br>Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? | Cover sheet<br><br>Cover sheet<br><br>Narrative plan<br><br>Validation of submitted plans | Yes | | | |
| | **PR2** | **A clear narrative for the integration of health and social care** | **Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:**<br>• How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally.<br><br>• The approach to collaborative commissioning<br><br>• The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this.<br><br>• How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include<br>- How equality impacts of the local BCF plan have been considered,<br><br>- Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these | Narrative plan assurance | Yes | | | |
| | **PR3** | **A strategic, joined up plan for DFG spending** | **Is there confirmation that use of DFG has been agreed with housing authorities?**<br><br>• Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home?<br><br>• In two tier areas, has:<br>- Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or<br>- The funding been passed in its entirety to district councils? | Narrative plan<br><br>Confirmation sheet | Yes | | | |
| NC2: Social Care Maintenance | **PR4** | **A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution** | Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)? | Auto-validated on the planning template | Yes | | | |
| NC3: NHS commissioned Out of Hospital Services | **PR5** | **Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?** | Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)? | Auto-validated on the planning template | Yes | | | |
| NC4: Plan for improving outcomes for people being discharged from hospital | **PR6** | **Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?** | • Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including:<br>- support for safe and timely discharge, and<br>- implementation of home first?<br><br>• Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year?<br><br>• Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts? | Narrative plan assurance<br><br>Expenditure tab<br><br>Narrative plan | Yes | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Agreed expenditure plan for all elements of the BCF | **PR7** | **Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?** | • Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated)<br><br>• Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box)<br><br>• Has funding for the following from the CCG contribution been identified for the area:<br>- Implementation of Care Act duties?<br>- Funding dedicated to carer-specific support?<br>- Reablement? | Expenditure tab<br><br>Expenditure plans and confirmation sheet<br><br>Narrative plans and confirmation sheet | Yes | | | |
| Metrics | **PR8** | **Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?** | • Have stretching metrics been agreed locally for all BCF metrics?<br><br>• Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric?<br><br>• Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale?<br><br>• Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more? | Metrics tab | Yes | | | |