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Lancashire Better Care Fund Metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Actual	
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,003.7				Not available until March 2023	
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**	**14 Days or more**	**21 days or more**
		12.0%	12.0%	6.4%	6.4%	12.8%	7.1%
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.1%				92.6%	
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	600				TBC …due May 5th	
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	87.4%				TBC…due May 5th	

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Metric	Challenges and Support Needs	Achievements
Avoidable admissions	• Development of 2HR Urgent Community Response has had an impact on social care but there is no associated funding for social care. This links to ICAT and direct access for social care. • There have been developments in respiratory Virtual wards, ambulatory pathways and SDEC, however there has still been an increase in NEL demand. A Home first pathway directly from A&E has been implemented to deflect patients, however workforce challenges have impacted effectiveness, and the offer has not been consistent. Availability of step-up placements has been impacted due to C-19 and Care home outbreaks, and Social Care Providers have had workforce issues, which have needed to be mitigated by bringing new providers online. • Impact of COVID increased unplanned admissions with regard to chronic conditions due to the nature of the virus • Lack of packages of care - due to impacts of COVID • The system has struggled to maintain 2020-21 performance. National capacity challenge. • We need to understand the analysis for avoidable admission to ensure we have the right community capacity for 2022/23	• ICAT have a step-up pathway into their service which enables direct referral for urgent social care support to enable a person to remain at home and avoid admission • The 2hr response pathway has included Mental Health and Social Care, to ensure a no wrong front door approach. There has been a focus on trusted assessment and seamless referrals to reduce delays. There has been close joint working between local social care teams and community health teams, to help support people to stay home and prevent admission, despite C-19 challenges. • Consultants working within ED to allow for swift discharge, implementation of the SDEC (same day emergency care unit) that allow for treatment, return home and linking with community support • 2 hr UCR introduced, pulse oximetry, virtual ward, C@Home, access to digital.
Length of Stay	Weekend Discharges remain challenging, due to Care Home acceptance of new admissions at weekends and some support services having reduced capacity over the weekend period. Social Care packages and EMI bed availability remain challenging due to C-19 outbreaks and staff sickness,	• The review of ICAT teams has led faster discharge processes and supports a multidisciplinary approach to these patients with a long length of stay in planning discharge. This takes into account the Hospital Discharge Guidance. Introduction of Crisis Plus which is an 24/7

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	however, there is good joint working between health and social care to address operational issues. Community Teams also have staff sickness and capacity challenges, and workload is often prioritised for the most urgent needs, which is impacted planned work backlogs and waits.	Home based care support service which is an alternative to residential care and supports the reduction of Length of stay for people with complex needs. • There are daily reviews of the patients awaiting discharge 7 days a week. There is also increased focus on 'golden patients' and increasing discharges before 10am. The number of discharges in the week has increased. The home first pathway and D2A processes are supporting timely discharges, despite care market challenges. • Rapid Response, REACT, ICAT, Frailty teams etc. are now embedded in system working to improve this. • The introduction of weekly face to face LOS meetings with colleagues from LCC and Age UK along with consultants. Where they discuss the 'intend to reside' protocol along with the patient's pathway and EDD.
Discharge to normal place of residence	• Capacity within the social care market. Significant challenges in the market with recruitment, vacancies and attracting new people to the market. • During times when there is limited capacity to support individuals to return home, alternative placements will be sought. However, these are always temporary and where possible include therapy input. The ultimate aim is to enable a return to home as soon as possible. The current challenge has been Therapy staffing, staff vacancies and sickness which are sometimes delaying therapy input in community. • Care Home and intermediate care capacity significantly, if temporarily, increased Q3/Q4 to mitigate acute pressures, but policy and omicron worked against this.	• Increased capacity within our Home First pathway has continued to increase the overall percentage of people returning home. We have embedded an ethos of Home First and all of our ICAT teams work to towards an outcome of the person returning home. We also have a Roving Night service which supports people with night time needs and helps to avoid residential care admissions. • Home First pathway and Residential D2A follow up, have high proportions of people returning to their own home, and this is monitored and compared across Lancashire Places, to enable benchmarking. • The Blackpool Transfer of Care Hub is a system level co-ordination centre that links together all local Heath & Social Care services to aid timely discharge from hospital. It consists of multi-disciplinary & interdisciplinary working, encompassing contribution from, and access to, a wide

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		range of services including community, primary care, social care, housing & the voluntary sector. • 3rd. Sector & ICC support has significantly enriched the local response • A targeted report is produced each week; "the top 5" patients are discussed, and active medical plans are in put place for each patient.
Res Admissions*	Hospital escalations have continued to push residential admissions as the default option. Capacity within the social care market. Significant challenges in the market with recruitment, vacancies and attracting new people to the market. Lack of EMI and EMD beds across the system, home closures due to covid, lack of clarity re covid guidance, homes unable to access patients.	• We have embedded an ethos of Home First and all of our ICAT teams work to towards an outcome of the person returning home and only in complex or exceptional circumstances people are discharged to a residential care setting. We have also increased capacity within Home First service provision. • Block purchased beds to support the system, which allowed for swift discharge of patients whilst waiting for permanent placements • Significant ill-health avoided by primary and community care initiatives re. vaccination. • CATCH triage referrals for pathways 1-3 which includes permanent admission to residential care were appropriate.
Reablement	• Pressure on reablement and rehabilitation services due to ongoing pandemic activity. • Capacity within the social care market. Significant challenges in the market with recruitment, vacancies and attracting new people to the market.	• Our reablement service has a good track record in promoting independence and helping people to remain in their own home for as long as possible. • H& SC reablement programmes are embedded in system working • CATCH triage or referrals for pathways 1-3 which includes reablement option.