Solihull Ageing Well

Dashboard

Quarter 3 – 2022/23

Solihull Ageing Well

Background

- This report is the fourth Solihull Ageing Well dashboard
- Some of the metrics remain under further development
- The data quality of the metrics included within this report will continue to improve over time
- This report was initially produced with the intention to be updated quarterly

Key to Report ratings:

This symbol indicates that the metric is **not** meeting the local target and also that this metric is performing worse than the comparable regional/national average

This symbol indicates that the metric is **not** meeting the local target but that this metric is performing better than or line with the comparable regional/national average

This symbol indicates that the metric is meeting the local target

Outcomes and Metrics Summary Table

Outcome	Metric	Metric description	Threshold	Frequency	Reporting Period
Reducing length of stay in hospital	1	Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	9.8% or less for 14+ days LOS by Qtr4 4.7% or less for 21+ days LOS by Qtr4	Monthly	Qtr3 2022/23
Improved health status for people with chronic ambulatory care sensitive conditions	2	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	315 unplanned hospital admissions per 100,000 population in Qtr3 2022/23	Monthly	Qtr3 2022/23
Improving the proportion of people discharged home to their usual place of residence.	3	Percentage of people, resident in the HWB area, who are discharged from acute hospital to their normal place of residence	95.1% (Qtr3 2022/23)	Monthly	Qtr3 2022/23
Improving the proportion of people discharged home to their usual place of residence.	4	No. of patients discharged down the D2A pathways	P0 = Minimum 50% P1 = Minimum 45% P2 = Maximum 4% P3 = Maximum 1%	Monthly	Jan 23
Delaying and reducing the need for care and support.	5	% of 2 hour referrals seen within the month	70% by Q3	Monthly	Dec 22
Delaying and reducing the need for care and support.	6	No. of people completing a reablement / ablement package within the month	Target to be defined	Monthly	Dec 22
Delaying and reducing the need for care and support.	7	% of LD registered patients who have received an annual healthcheck	75% by end of 22/23	Monthly	Qtr3 2022/23
Delaying and reducing the need for care and support.	8	Number of emergency hospital admissions due to falls in people aged 65 and over	<800 admissions per quarter	Quarterly	Qtr3 2022/23
Delaying and reducing the need for care and support.	9	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	87%	Annual	2021/22
Delaying and reducing the need for care and support.	10	Number of citizens newly diagnosed with dementia - Primary Care Dementia Data (PCDD)	66.67%	Monthly	Qtr3 2022/23

Metric 1.

Data based on Solihull **residents**

***Outcome**: Reducing length of stay in hospital*

(Former) BCF Metric

Lead: Andrew McKirgan

Data Source: Better Care Exchange

Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more, as a percentage of all patients

Target:

- 9.8% or less for 14+ days LOS by Qtr4 2021/22

Lower is better

Current Performance:

- 13.9% of patients staying 14+ days – Qtr3 22/23

England average in Qtr3 – 13.5%

Target:

- 4.7% or less for 21+ days LOS by Qtr4 2021/22

Lower is better

Current Performance:

- 7.6% of patients staying 21+ days – Qtr3 22/23

England average in Qtr3 – 7.7%

Narrative:

This is an indicator on length of time in hospital only for **all patients**, regardless of discharge destination, and could be influenced by a whole range of factors such as acuity of patients and system patient flow. This no longer forms a part of the BCF metrics for 2022/23

The agreed targets are based on historical downward trends in the proportion of patients in hospital for more than 14 and 21 days.

Length of stay for each metric is above the original target, but 14+ day LOS is also performing higher (worse) than the England average, and has remained at 13.9% this quarter (whereas the England average has very slightly increased)

Metric 2. Data based on Solihull **residents**

***Outcome**: Improved health status for people with chronic ambulatory care sensitive conditions*

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

BCF Metric

Lead:
Rhona Woosey

Data Source:
Better Care Exchange

Target:

- 315 unplanned hospital admissions per 100,000 population in **Qtr3** 2022/23 (latest data)

Lower is better

Current Performance:

- 211 unplanned hospital admissions per 100,000 population in **Qtr3** 2022/23 (latest data)

Narrative:

This is a BCF metric and the agreed targets are based on historical trends in unplanned ACSC hospital admissions. This indicator measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure. Data is provided annually by NHS Digital on admission rates per 100,000 population

Quarter 3 2022/23 admission rates for Solihull (211.4) are lower than their corresponding quarterly figures for Quarter 3 2021/22 (260.7).

Compared to other HWBs, Solihull is 50th highest out of 152 HWBs for this indicator in Quarter 3.

Achievements:

- Embedding the Urgent Community response
- Support to Care Homes
- Expansion of pathway 1 services
- Increase in pathway 2 capacity to meet surge demand
- Expansion of Equipment Services
- Roll out of Mangar Elks

Metric 3. Data based on Solihull **residents**

***Outcome**: Improving the proportion of people discharged home to their usual place of residence*

Percentage of people, resident in the HWB area , who are discharged from acute hospital to their normal place of residence

BCF Metric

Lead:
Caroline Potter/Safina Mistry/ Alan Butler

Data Source:
Better Care Exchange

Target:

- 95.1% are discharged from acute hospital to their normal place of residence in Qtr3 2022/23

Higher is better

Current Performance:

- 94.1% are discharged from hospital to their normal place of residence (Qtr3 2022/23)

England average – 92.7%

Narrative:

This is a BCF metric and the agreed targets are based on historical trends in the proportion of patients discharged directly to their normal place of residence.

After a regular out-turn of around 94-96% for this metric pre-COVID, this dipped to a low of less than 87% in Apr20, before steadily climbing back up to pre-pandemic levels by May21. Since this time, the proportion discharged to their usual place of residence has remained just above or below 94%.

Patients admitted with MSK, Immunology and Respiratory patients are the least likely patients to be discharged back to their usual place of residence. Whilst Solihull is not currently achieving the Quarter 3 target, it is currently performing better than the England average.

Metric 4. Data based on Solihull **residents**

***Outcome**: Improving the proportion of people discharged home to their usual place of residence*

Percentage of patients discharged down the D2A pathways

National Hospital Discharge Policy standard

Lead:
Andrew McKirgan

Data Source:
UHB

Target:

- **Pathway 0** = minimum 50%
- **Pathway 1** = minimum 45%
- **Pathway 2** = maximum 4%
- **Pathway 3** = maximum 1%

Higher is better

Current Performance:

Indicator is in development and not complete.

At present a breakdown of Solihull P0 data is not available.

Solihull place P1-P3 data for January 2023:

- P1 – 60%
- P2 - 35%
- P3 – 5%

Narrative:

The current data set is incomplete because of the lack of pathway zero data. The data for the two pathways appears to suggest higher usage of pathways 2 and 3 than the model would suggest, however without the pathway zero information it can not be determined if this is related to higher numbers being able to return home with no care. Work is being conducted to resolve this vital data gap.

The Hospital discharge and community support guidance published 31 March 2022 states that From 1 April 2022, local areas should adopt discharge processes that best meet the needs of the local population. Under the Discharge to assess, home first approach to hospital discharge, the vast majority of people are expected to go home (to their usual place of residence) following discharge. The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs.

Pathway 0 - Likely to be minimum of 50% of people discharged: simple discharge home

Pathway 1 - Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Every effort should be made to follow home first principles, allowing people to recover, reable, rehabilitate or die in their own home.

Pathway 2 - Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Pathway 3 - For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for pathway 0). Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

Metric 5. Data based on UHBC **patients**

Outcome: *Delaying and reducing the need for care and support*

Percentage of 2 hour Urgent Community Response (UCR) referrals seen within the month

National UCR standard

Lead: Steve Nicholls

Data Source: UHB community

Target:

- 70% of appropriate referrals are seen within the 2 hour standard by Qtr3 2022

Higher is better

Current Performance:

- 67.2% of patients seen within 2 hours of referral in Dec-22

England average in Dec-22 – 76.4%

Narrative:

Services should deliver crisis response care for those people who need it within a maximum of two hours. However, where the person being referred requires crisis response care, but delivery of this care within two hours is not clinically or socially appropriate, care should be delivered at the earliest opportunity. National guidance suggests Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of two-hour crisis response demand within two hours from the end of quarter 3.

The performance data included here relates to UHB Community patients only, and includes the latest validated monthly position for Dec22. Performance dipped just below the 70% standard as **a result of increased referrals to the service over recent weeks**. Quarter 3 2022/23 saw the highest number of quarterly referrals received for UCR, with the highest ever month for referrals received being December, with a total of 320

Metric 6. Data based on Solihull **residents**

Outcome: *Delaying and reducing the need for care and support*

Number of people (aged 65 and over) completing a reablement / ablement package within the month

Local Metric

Lead:
Safina Mistry/ Caroline Potter/ Alan Butler

Data Source:
Solihull Council

Target:

- Target to be set for 2023/24 based on 2022/23 activity

Higher is better

Current Performance:

- 297 completed reablement episodes for people aged >65 in Qtr3, compared to 96 in Qtr2 and 57 during Qtr1.
  Apr22-Dec22 position – 450 completed episodes

  21/22 average = 20.8 per month; 22/23 average = 50 per month

Narrative:

The number of people who have completed a period of reablement / ablement during the period (may have commenced in a previous period). Completion is measured to ensure no double counting of people who start and finish their journey in different reporting months.

National guidance is that those how have the potential to be reabled should be offered the ability to do so. Solihull has different routes for reablement / ablement, including an in-house team and services delivered by independent care providers.

The aim of this measure is to see increased usage of reablement / ablement services (HDS/ERS & Reablement), with the intention of reducing longer term care needs and increasing independence.

In Solihull, we are now able to offer more people in hospital a reablement service through the expansion of commissioned care and support

Metric 7. Data based on Solihull **registrants**

Outcome: *Delaying and reducing the need for care and support*

Number of Learning Disabled registered patients who have received an annual health check

National Indicator

Lead: Tom Parker

Data Source: NHS Digital

Target:

- 75% of Annual Health Checks for patients aged 14+ years delivered by GPs (of which 49.5% complete by Qtr3)

Higher is better

Current Performance:

- 47.3% for Solihull GP registered patients up to the end of Qtr3 2022/23

B'ham average Qtr3 2022/23 – 55.4%

Narrative:

The performance data included here relates to patients registered at a Solihull GP Practice (within a Solihull PCN) only. The nationally set target for LD AHCs is 75% or above, of people on a GP LD register to receive an annual heath-check. The target is locally phased across the four quarters, with a target of 49.5% achieved by the end of quarter 3 across BSOL ICB (Birmingham are achieving this target year-to-date)

High quality health checks help reduce the potential inequalities our LD population could face.

There is an ongoing programme of development work which will increase the uptake of high quality health checks, including :

- Ongoing programme of training for practice staff
- CWPT have a comprehensive health facilitation offer to provide support to deliver high quality health checks and to review registers
- Attendance at Practice Manager/ PCN forums to raise awareness and highlight the requirement to deliver LD health checks
- A resource guide has been published guiding practitioners how to undertake a high quality health check
- Empowering patients to raise awareness that they are entitled to a health check
- Within the Universal Offer each practice is completing a quality themed review template annually, to take learning from the health checks undertaken, to inform future improvements

Solihull data: Total number of annual health checks completed April – December = 631; Proportion of the register (1,333) = 47.34%

Metric 8. Data based on Solihull **residents**

Outcome: *Delaying and reducing the need for care and support*

Number of emergency hospital admissions due to falls in people aged 65 and over

Local standard

Lead:
Sarah Chesters

Data Source:
SUS data

Target:

- <800 admissions per quarter

Lower is better

Current Performance:

- *568 falls in Qtr3 2022/23*

Solihull Falls in Qtr2 - 617

Narrative:

2022/23 revised targets are based on 2019/20 figures (taking out the recent impact of COVID-19 on hospital admissions), reflect seasonal variations, and take into account the 2% increase in Solihull residents aged over 65.

The falls data reports Solihull Local Authority residents only, not by GP registration.

Much of the reduction seen this quarter relates to community falls (which account for more than 90% of all falls), although falls in Care Homes have also reduced

The overall performance is the outcome of a comprehensive falls service pathway in the community and care homes.

Metric 9. Data based on Solihull **residents**

Outcome: *Delaying and reducing the need for care and support*

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

BCF Metric

Lead: Caroline Potter/ Safina Mistry/ Alan Butler

Data Source: ASCOF

Target:

- 87%

Higher is better

Current Performance:

- *87.9% (2021/22)*

England Score – 81.8%; Region Score 81.2%

Narrative:

The data above reflects the latest annually published 2021/22 position – where Solihull is now ranked 46 out of 153 LAs.

The number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. (This should only include the outcome for those cases referred to in the denominator).

Local analysis shows that the outturn at the end of Q3 was 86.3% (against the 22/23 target of 86.3%).

There were 146 older people who were discharged from hospital to have reablement services starting between 01 January 2022 and 30 September 2022. 126 of those people were at home on the 91st day, 14 were deceased and 3 people had been admitted to a care home. There were 3 instances where a person's outcome hadn't been recorded ('unknown')

Metric 10 Data based on Solihull **registrants**

Outcome: *Delaying and reducing the need for care and support*

National Standard

Lead: Kathryn Drysdale

Data Source: QOF

Number of citizens newly diagnosed with dementia - **Primary Care Dementia Data (PCDD)**

Target:

- 66.67%

Higher is better

Current Performance (PCDD):

- *52.2% (Dec22)*

The national rate in England currently stands at 62.5%

Narrative:

Dementia describes a group of symptoms which include problems with memory, thinking or language, and changes in mood, emotions, perception and behaviour. Dementia is a progressive disease, which means symptoms may be relatively mild at first, but they get worse over time. Getting a diagnosis of dementia can give you a better understanding of the condition and what to expect. A dementia diagnosis enables an individual to be treated with dignity through access to the right care, support and information. It can also explain changes in behaviour to carers, family and friends, which can enable them to respond supportively. A dementia diagnosis will enable the individual and their loved ones to plan for future care needs, which can reduce the chance of a crisis developing as the condition advances.

From October 2022, The previous metric "Recorded dementia diagnoses" is superseded with the new series named "Primary care dementia data." The figures for equivalent counts will not match between time series due to:

- ***Retrospective application of clinical codes to patient records***
- ***Change in the practices participating in the service***
- ***Changes in patient registration (e.g. recorded death, movement between practices)***
- ***Updates to the clinical codes included in the service specification,***

so nationally published data as it is currently measured will only be backdated to April 2022

This data includes the rate of dementia diagnosis taken from GP systems in Solihull. **As not everyone with dementia has a formal diagnosis, this statistic compares the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over.**