NHS
Black Country
Integrated Care Board
Business Intelligence Team

Dudley BCF Performance

Date : June 2024 (Reporting April 2024 Secondary Care Data, June 2024 Intermediate Care Data, June 2024 Clinical Hub Data, April 2024 Urgent Community Response Data, June 2024 Crisis Response Team Data and, June 2024 Hub Falls Activity Data)

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Metric Definitions

Source : The Better Care Exchange

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Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Collected Annually.

Description: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
Numerator: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from the Short- and Long-Term Support (SALT) return, collected by NHS England. **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.

Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. Collected Annually.

The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for reablement or 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. **Numerator:** Number of in scope discharges. **Denominator:** Number of in scope discharges.

Metric 3: Unplanned hospitalisation for chronic ambulatory care sensitive conditions. Collected Monthly by Central BCF Team, published on Better Care Exchange.

This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The **numerator** is given by the number of finished and unfinished ***admission episodes***, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. Because the **denominator** for the official published measure (***mid-year population estimates*** for England published by the Office for National Statistics (ONS) are only available in June following the end of year in question, baseline data provided in the BCF template uses mid-year estimates for 2020-21 as a denominator).

Metric 4: Discharge to usual place of residence. Collected Monthly by Central BCF Team, published on Better Care Exchange.

This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Maximising the proportion of people who return to their usual place of residence at the point of discharge enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person’s usual place of residence.
Numerator: The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person’s usual place of residence. **Denominator:** All completed hospital spells recorded in SUS for people over the age of 18 – calculation on monthly total. Does not include Same Day Emergency Care (Zero day) admissions.

Metric 5: Metric 5: Reducing the number of emergency hospital admissions due to falls in people over 65

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, This indicator is an important measure around joint working between adult social care and health partners (e.g. urgent community response services) to prevent hospital admissions and reduce falls which will improve outcomes for older people and support independence.
Numerator: Emergency admissions for falls injuries for people over the age of 65, classified by primary diagnosis code (ICD10 code S00 to T98) and external cause (ICD10 code W00 to W19) and an emergency admission code (episode order number equals 1, admission method starts with 2). **Denominator:** Local Authority level estimates of resident population aged 65 and over.

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Emergency Admissions Over 65s

Source : SUS IP Dataset Excluding SDEC

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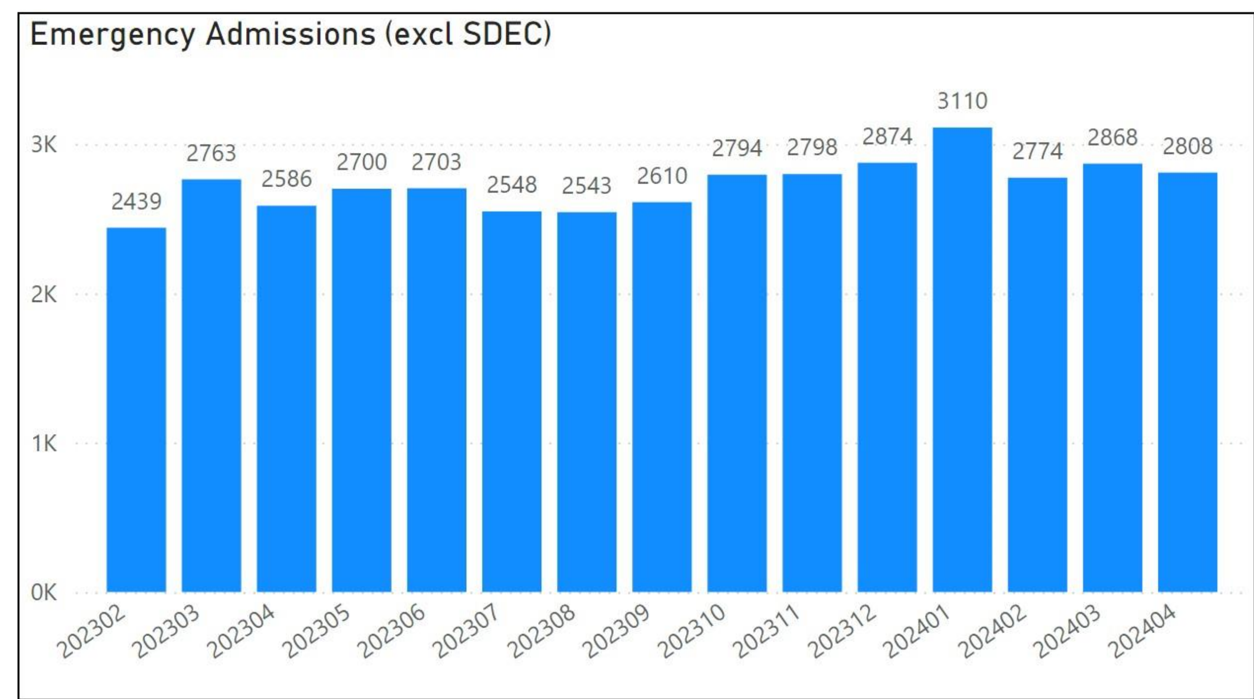
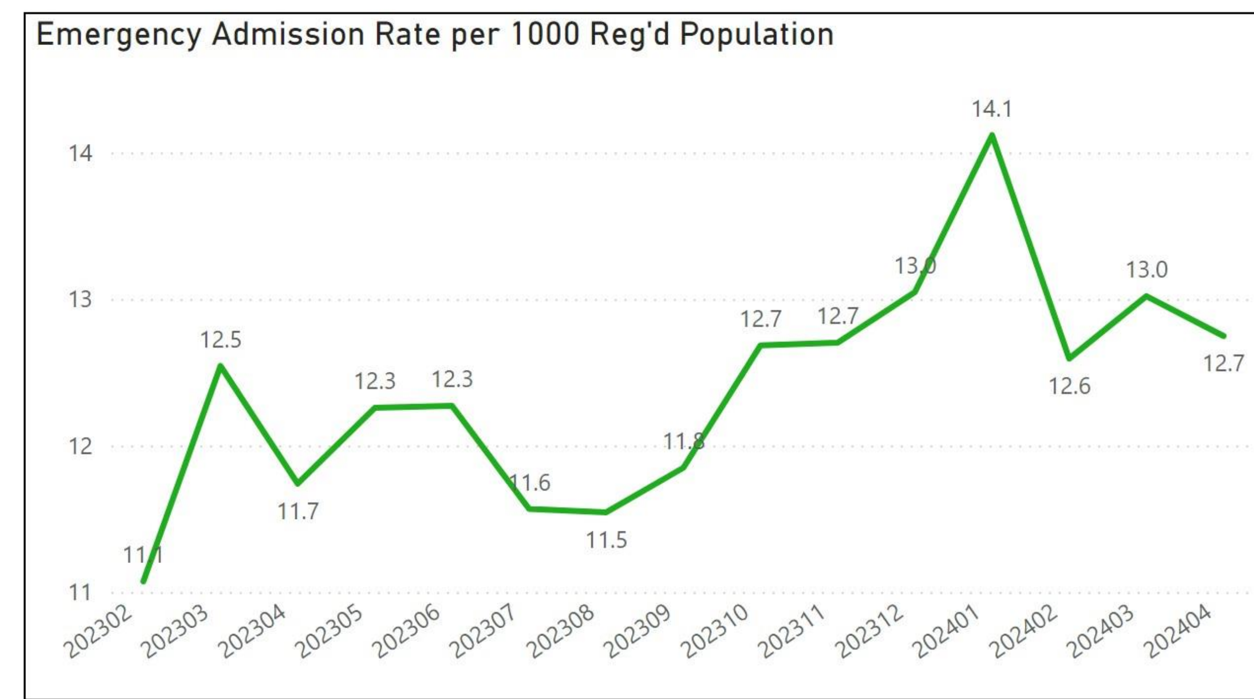
The information below shows emergency admissions (excluding any SDEC - same day emergency care) activity for patients over the age of 65.
The emergency admission rate per 1000 registered population for Dudley has also been included for additional analysis. Recent months has shown an increase in the numbers of admissions, peaked during winter months but admissions are still high compared to the same time period last year.





Metric 5 Dudley Patients Aged 65 and Over Admissions Coded to Falls

Source : Data Published on Better Care Exchange

Period : October 2022 : March 2024

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Average DSR in Reported Period

Organisation	Average
Dudley	167.57
Sandwell	170.05
Walsall	208.72
Wolverhampton	251.95

Organisation	Average
ICB	195.62

Average DSR in Last 3 Months

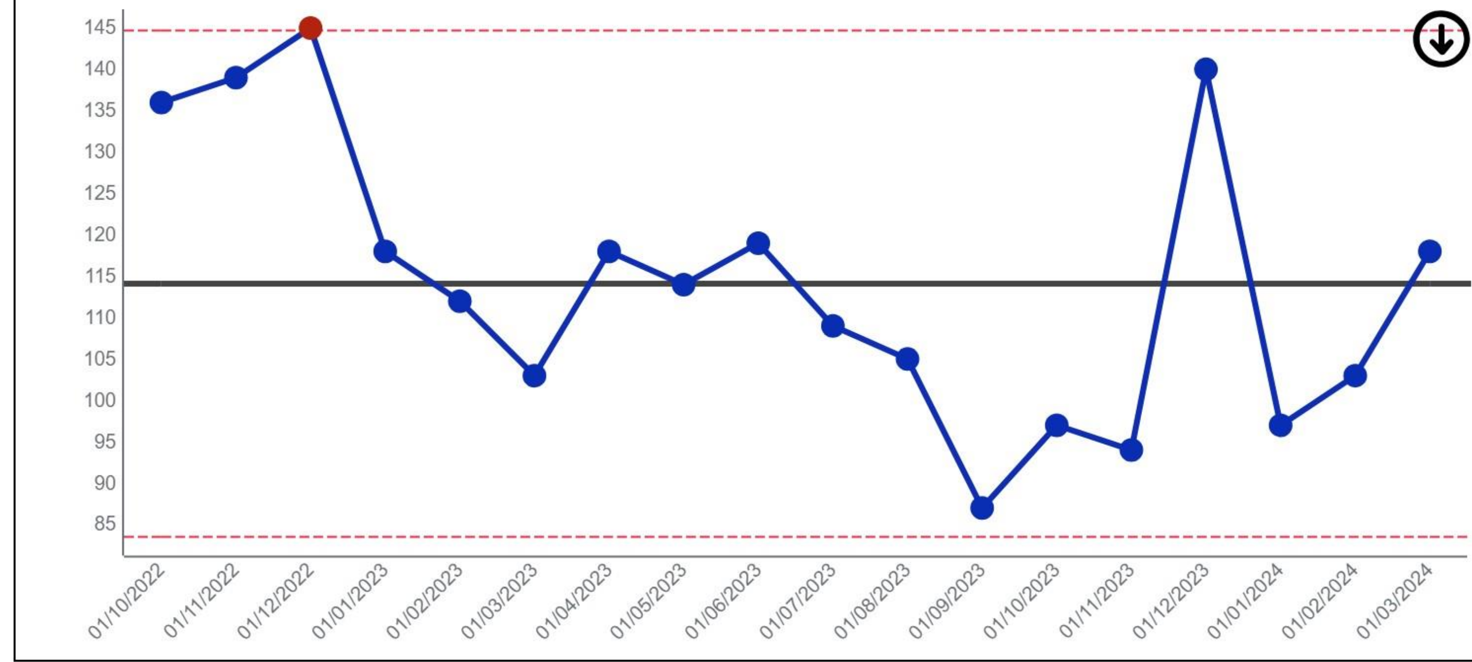
Organisation	Average
Dudley	154.87
Sandwell	150.13
Walsall	182.91
Wolverhampton	241.95

Organisation	Average
ICB	178.62

Average DSR in Latest Month

Organisation	Average
Dudley	170.08
Sandwell	137.11
Walsall	192.77
Wolverhampton	211.77

Organisation	Average
ICB	176.20



Emergency Admissions, Conveyances Over 65s

Source : SUS IP Dataset Excluding SDEC, WMAS Dataset

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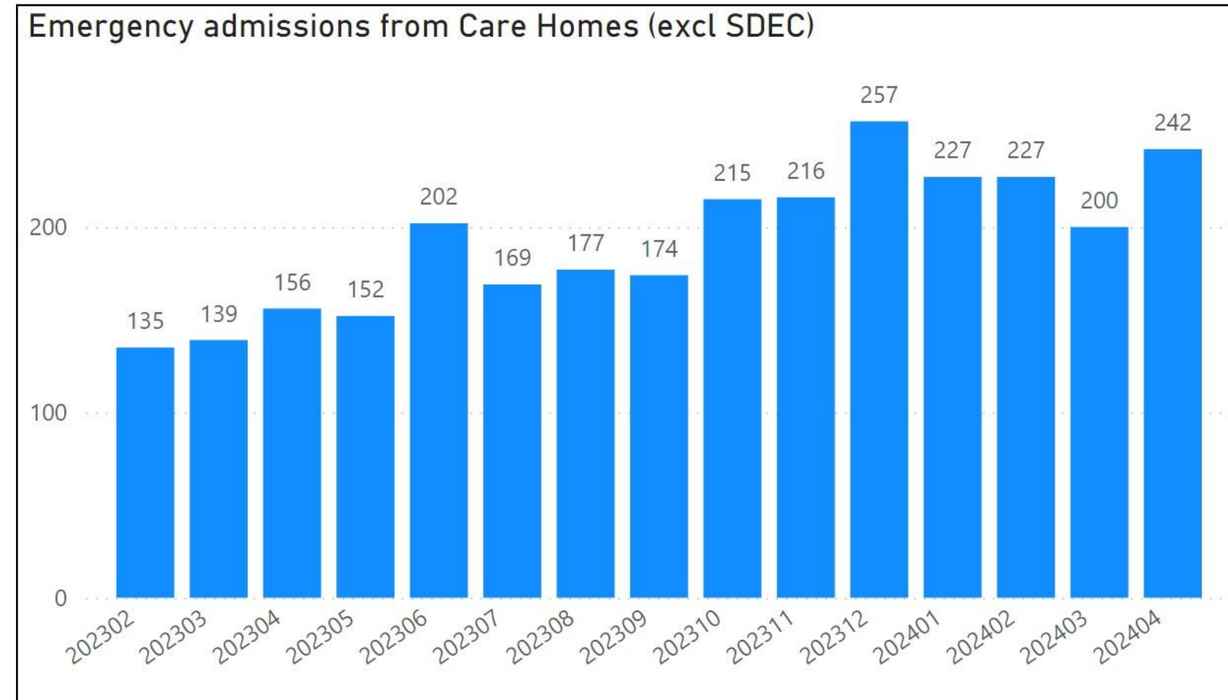

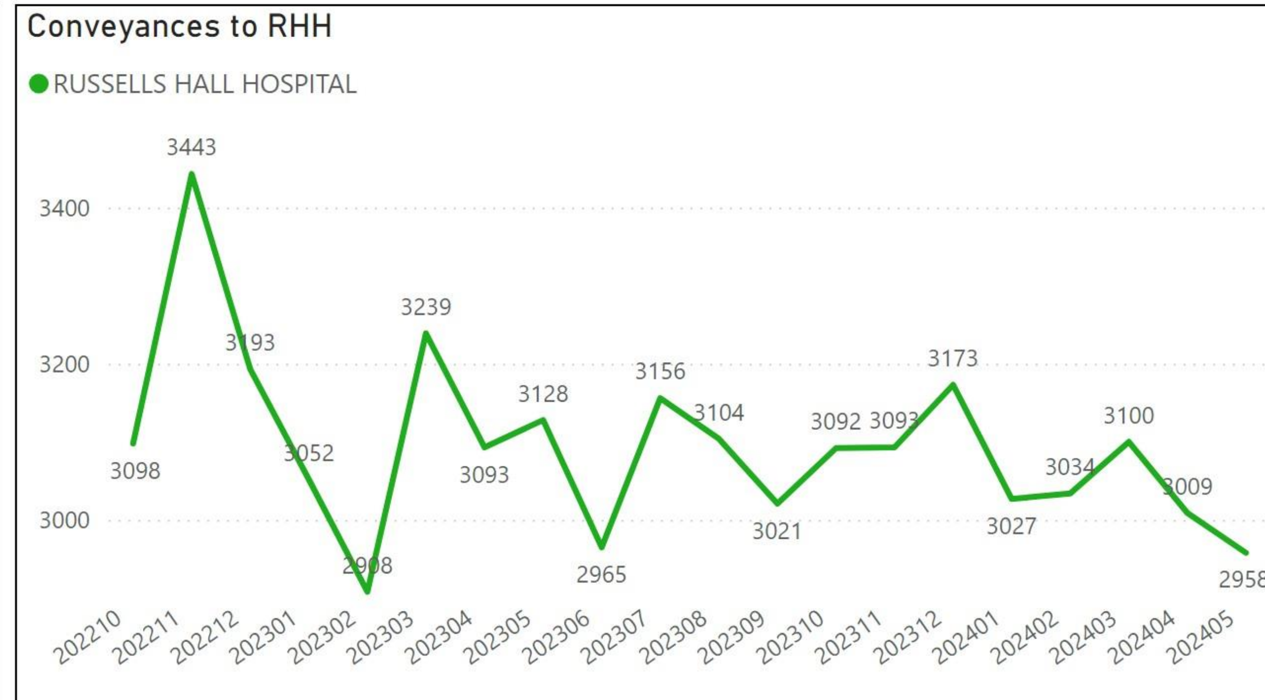

Metric 3 Dudley Avoidable (Chronic Ambulatory Care Sensitive) Admissions

Source : Data Published on Better Care Exchange

Period : October 2022 : April 2024

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Average Rate in Reported Period

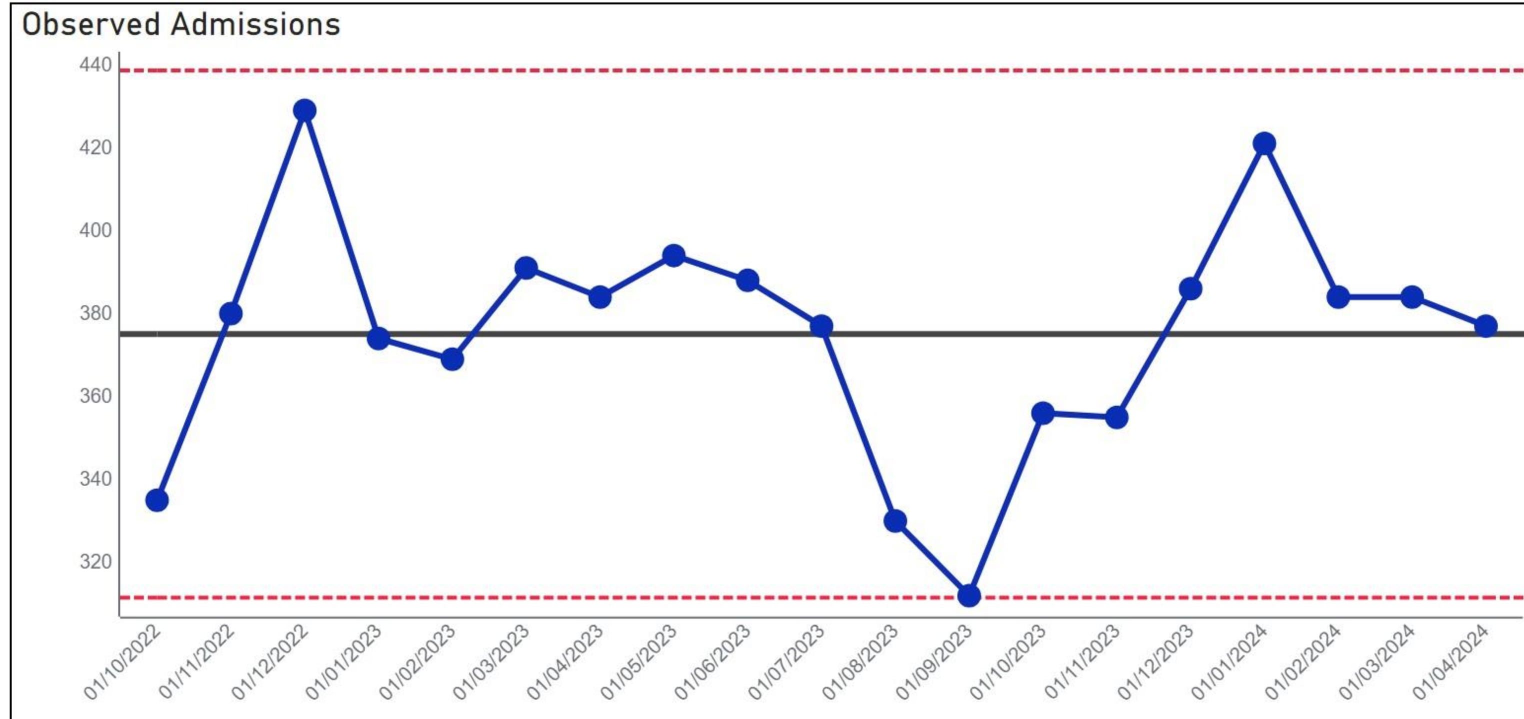
HWB Name	Ave Rate / 1,000 Pop
Dudley	1.16
Sandwell	1.00
Walsall	1.25
Wolverhampton	1.14

Average Rate in Last Three Months

HWB Name	Ave Rate / 1,000 Pop
Dudley	1.17
Sandwell	1.02
Walsall	1.33
Wolverhampton	1.18

Rate in Latest Reported Month

HWB Name	Rate / 1,000 Pop
Dudley	1.16
Sandwell	0.93
Walsall	1.11
Wolverhampton	1.23



Metric 1 - Supporting the long terms needs of older people

Source : Local Authority Colleagues
Period : Q1 2022/23 Q1 2024/25

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HWB Name	Period	1a Admission to residential and care homes 18 – 64 (per 100,000 pop)	1b. Admissions to residential and care homes - 65+ (per 100,000 pop)
Dudley	2022/23 Q1	6.4	457
Dudley	2022/23 Q2	10.70	503
Dudley	2022/23 Q3	11.00	619
Dudley	2022/23 Q4	11.00	533
Dudley	2023/24 Q1	16.9	598
Dudley	2023/24 Q2	18	601
Dudley	2023/24 Q3	18.5	569
Dudley	2023/24 Q4	15.9	534
Dudley	2024/25 Q1	6.3	477

Dudley Clinical Hub Triage - Telephone & Electronic Referrals

Source : Dudley Clinical Hub

Period : April 2023 : June 2024

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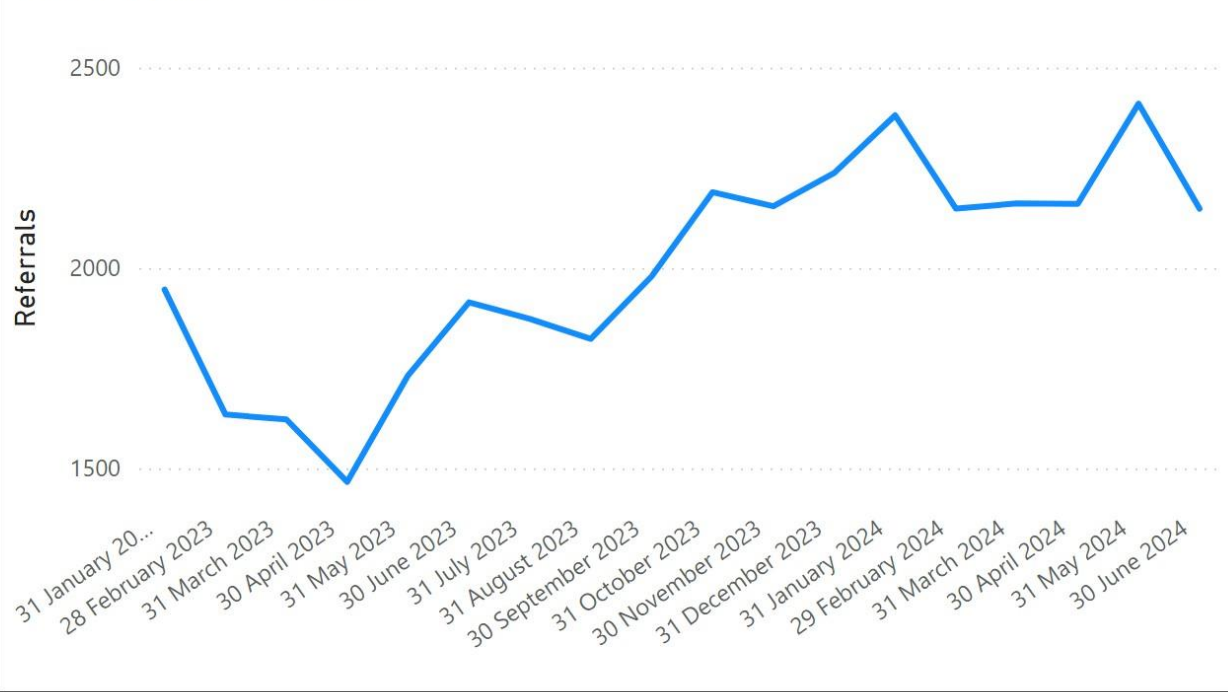


Telephone Referrals by Source

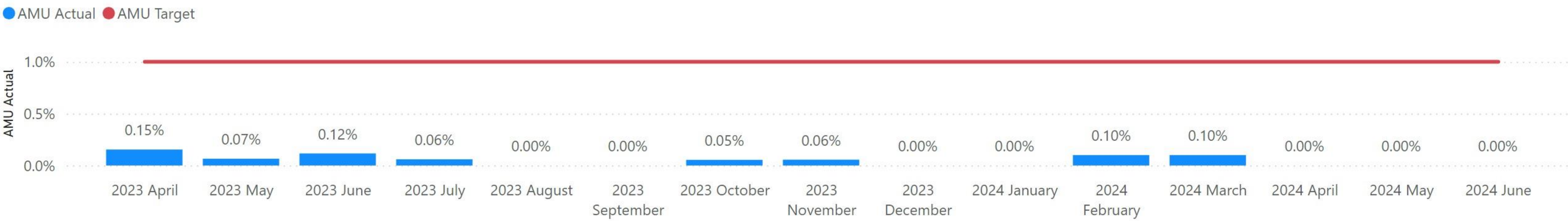
Month	[A] GP REFERRALS	[B] WMAS REFERRALS	[C] 111	[D] CARE HOME REFERRALS	[E] LA REFERRALS	[F] OTHER
01 April 2023	444	230	30	540		222
01 May 2023	576	235	18	560		343
01 June 2023	669	263	12	510		460
01 July 2023	565	274	12	535		487
01 August 2023	571	282	26	545		399
01 September 2023	567	222	24	641		525
01 October 2023	624	272	22	697		574
01 November 2023	588	301	17	709		539
01 December 2023	494	428	24	781		510
01 February 2024	642	370	17	618	18	483
01 January 2024	615	394	25	811	35	501
01 April 2024	595	290	18	698	45	514
01 March 2024	577	287	28	717	46	506
01 May 2024	645	418	11	723	54	543
01 June 2024	561	470	11	529	66	511

- WMAS referrals highest to date
- LA referrals are increasing (these include Telecare. Social Services & Home Carer)
- Care Homes referrals to the Clinical Hub have significantly reduced in June.

Dudley Clinical Hub Triage - Outcome Metrics SDEC, ED, AMU

Source : Dudley Clinical Hub

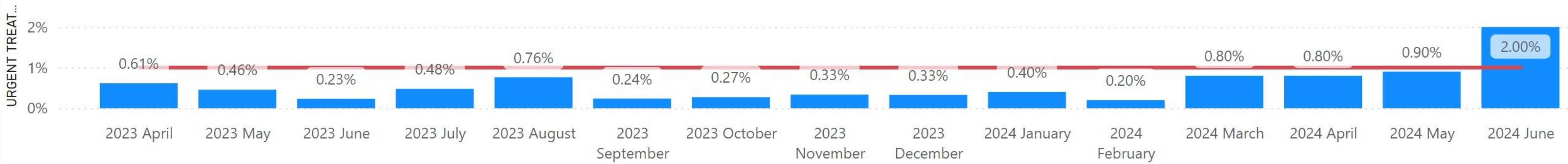
Period : April 2023 : June 2024



Dudley Clinical Hub Triage - Outcome Metrics UTC, Community, Other

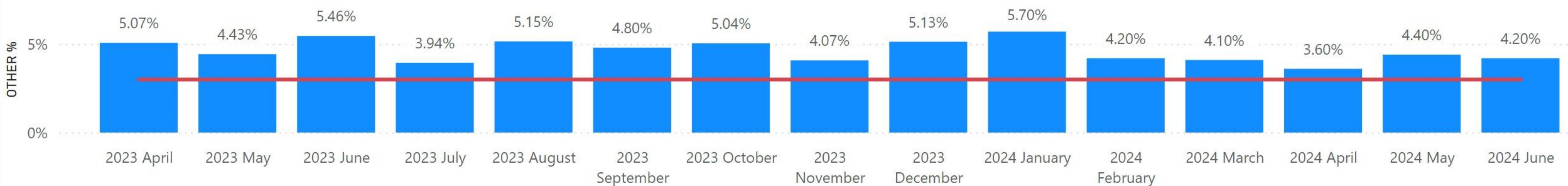
Source : Dudley Clinical Hub
Period : April 2023 : June 2024

Outcome UTC (Target below 1%)



Outcome Community Services (Target above 50%)

Outcome Other (Target above 3%)



Dudley Clinical Hub Triage - Urgent Community Response (UCR) Metric

Source : Dudley Clinical Hub

Period : April 2023 : April 2024

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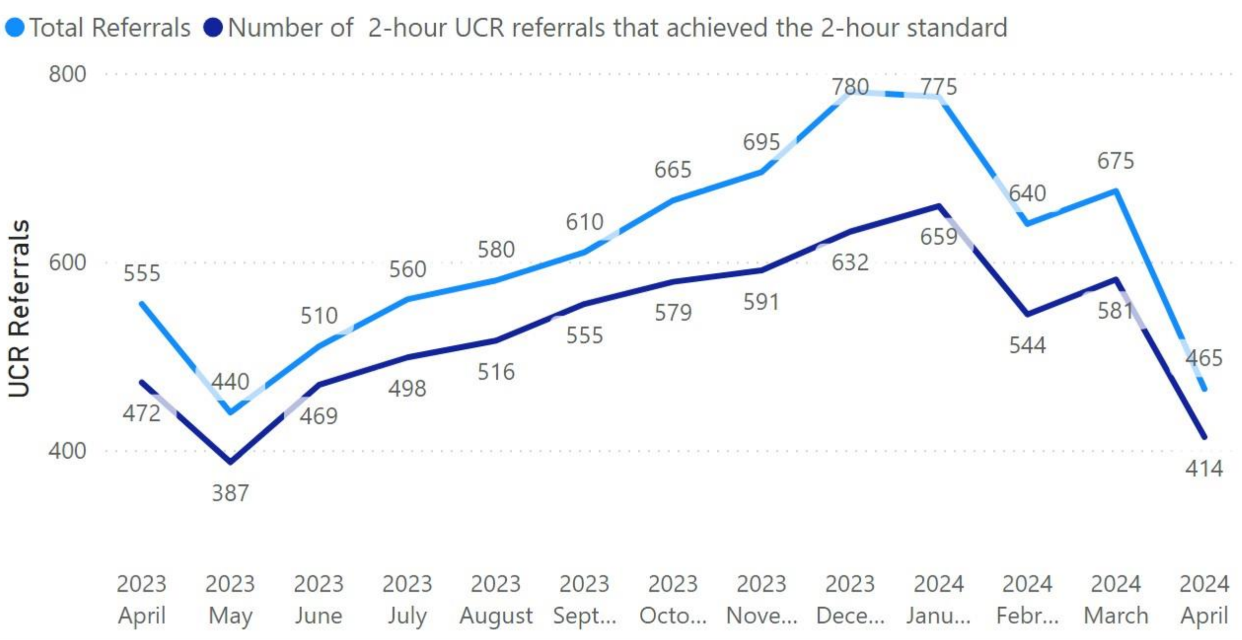

Dudley Clinical Hub Triage - Crisis Response Team (CRT) Metric

Source : Dudley Clinical Hub

Period : April 2023 : May 2024

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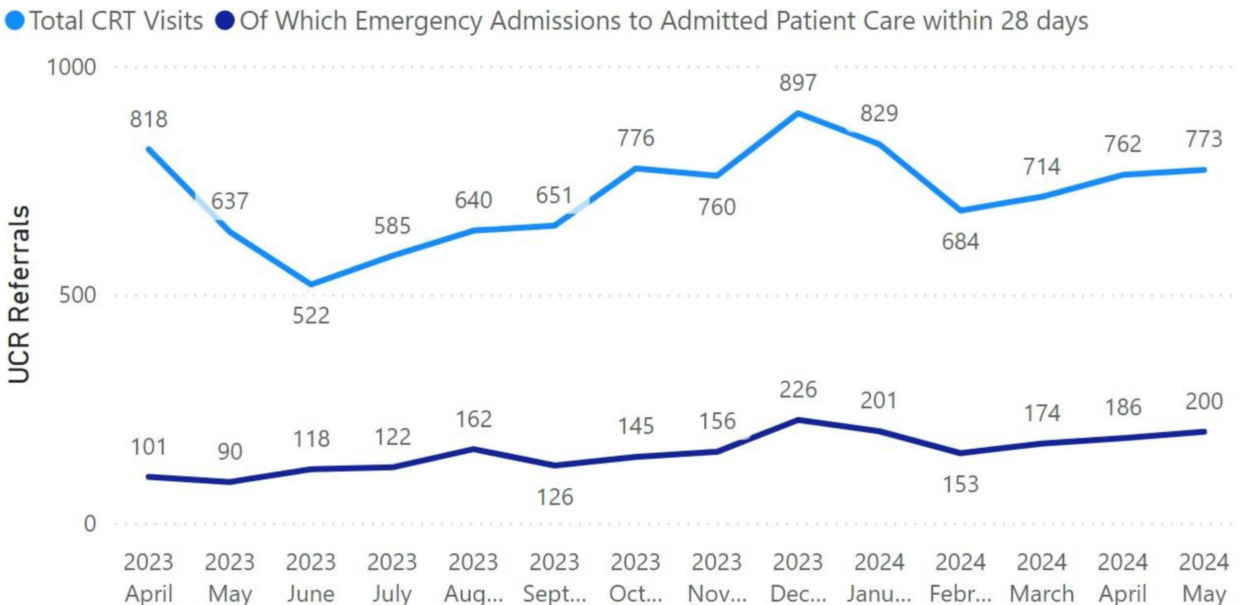

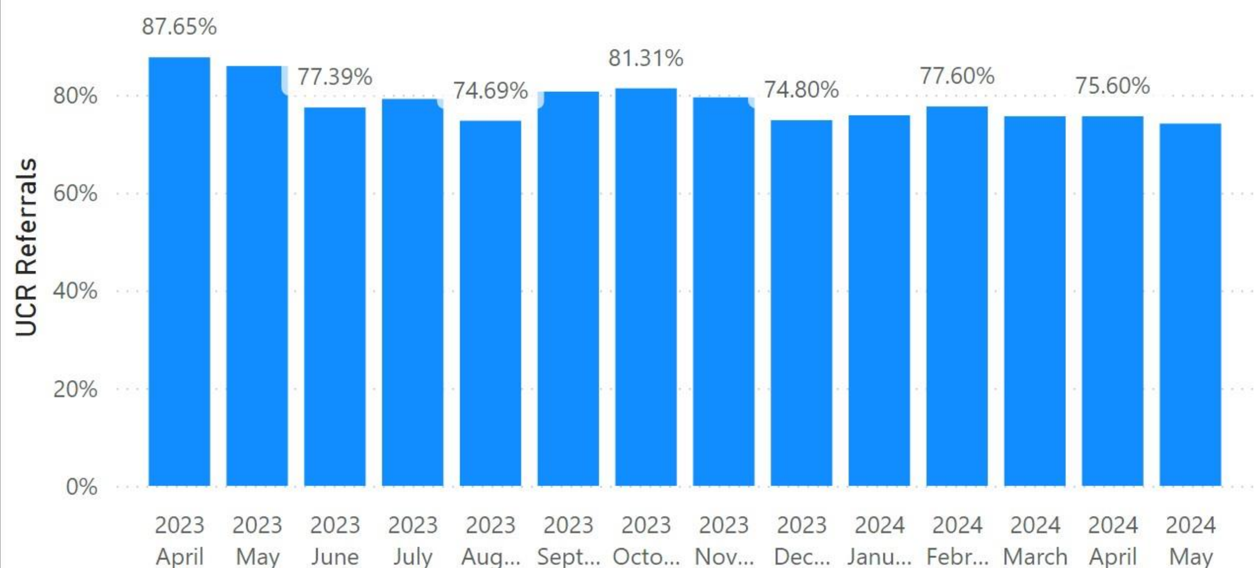

Dudley Clinical Hub Falls Calls, UCR Visits and patients picked up from floor

Source : Dudley Clinical Hub
Period : April 2023 : June 2024

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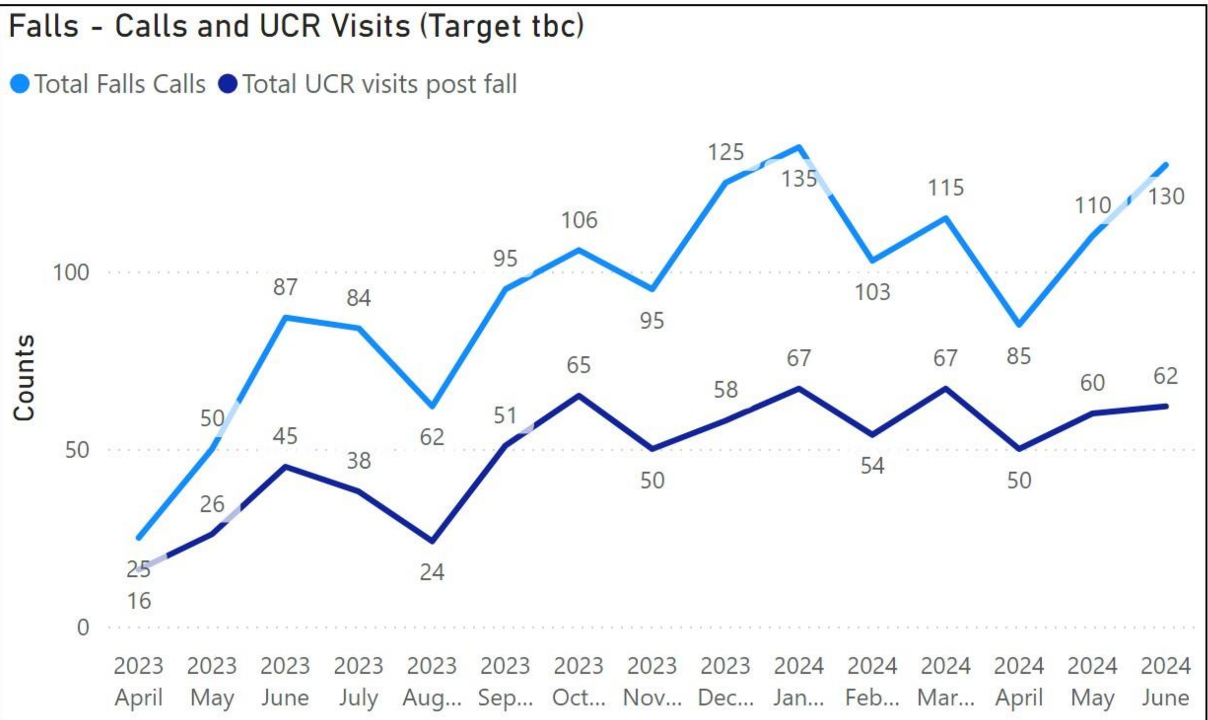

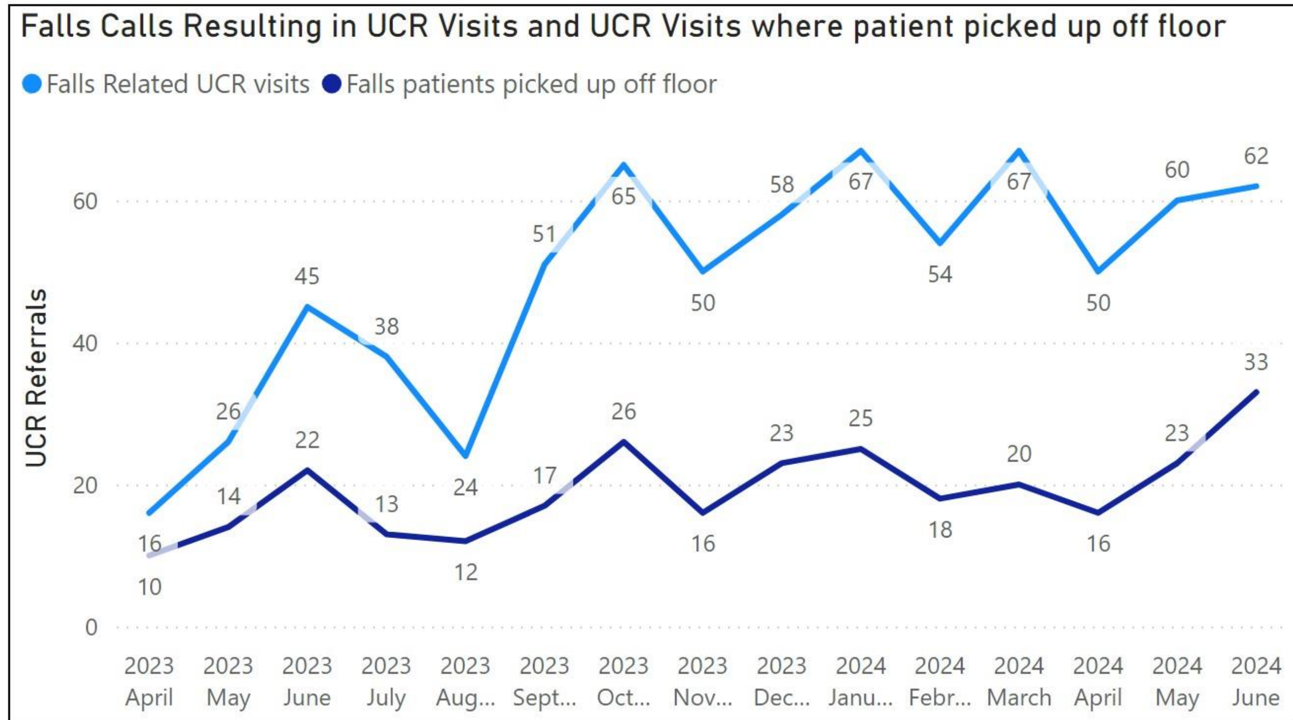

Narrative not provided.

Dudley Clinical Hub Falls Calls and Call Outcomes

Source : Dudley Clinical Hub

Period : April 2023 : June 2024

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Falls - Calls and Call Outcomes

UCR Visit, Advice Given, ED Referral, Service Declined, Other Outcomes

Month	UCR Visit	Advice Given	ED Referral	Service Declined	Other Outcomes	Total
2023 April	16	5				25
2023 May	26	5	6	6	7	50
2023 June	45	14	11		17	87
2023 July	38	18	19		6	84
2023 August	24	14	15		9	62
2023 September	51	18	16		8	95
2023 October	65	15	15	4	7	106
2023 November	50	9	20	12	4	95
2023 December	58	23	27	11	6	125
2024 January	67	28	22	9	9	135
2024 February	54	18	11	10	10	103
2024 March	67	26	10	5	7	115
2024 April	50	19	9	5		85
2024 May	60	19	9	15	7	110
2024 June	62	29	7	28	4	130

Counts (0–140)

Dudley Intermediate Care Metrics -Pathway 2

Source : Intermediate Care Service
Period : April 2023 : June 2024

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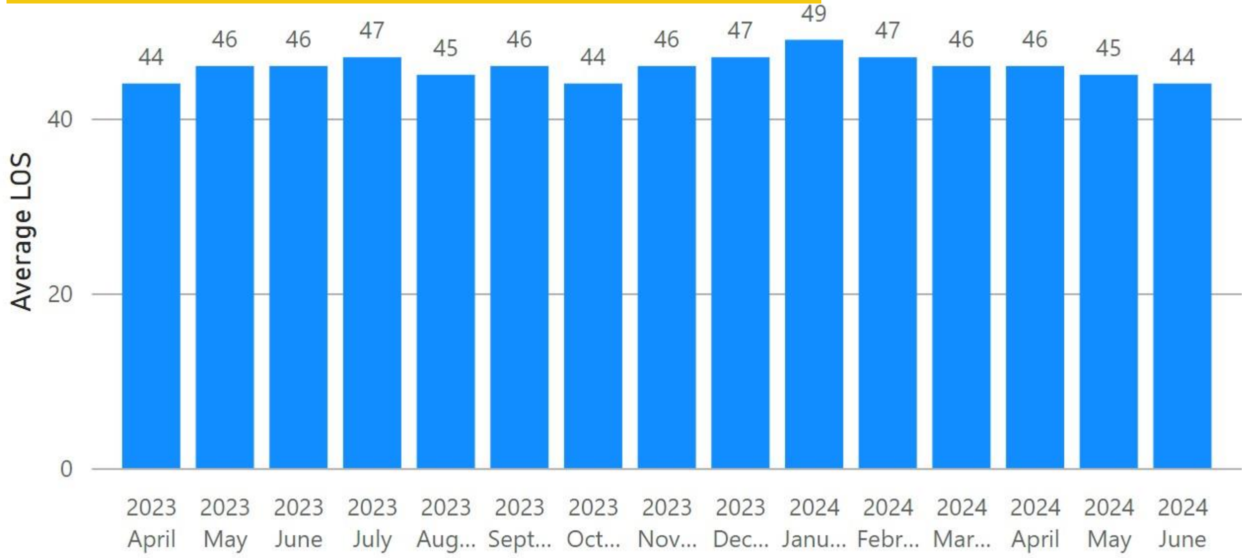
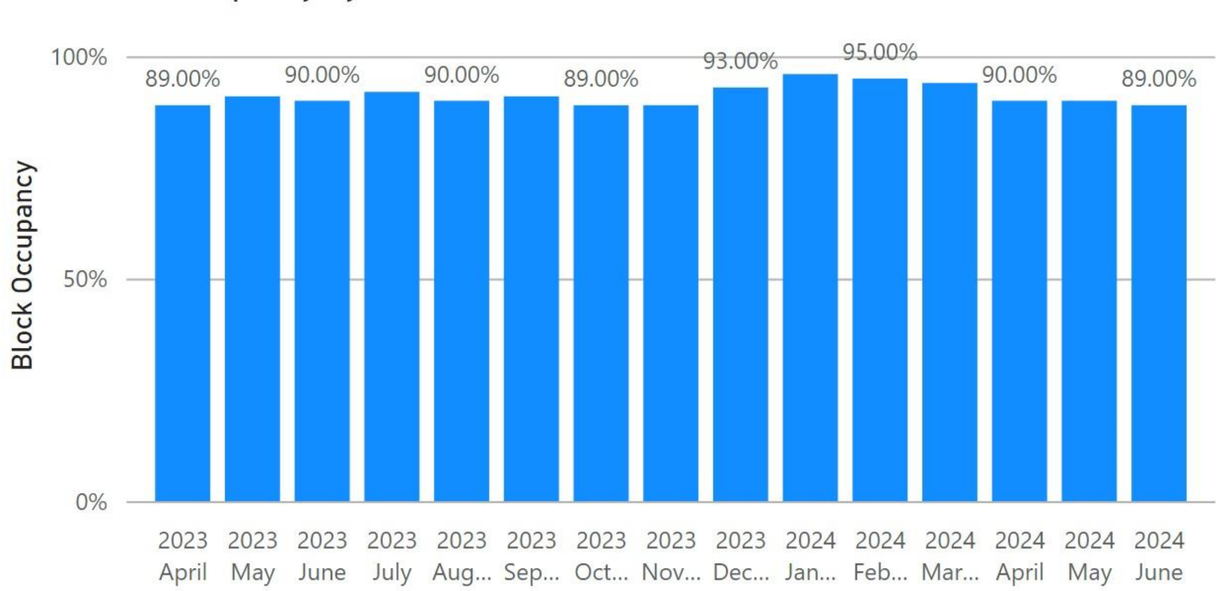
Average Length of Stay (LOS) by Month

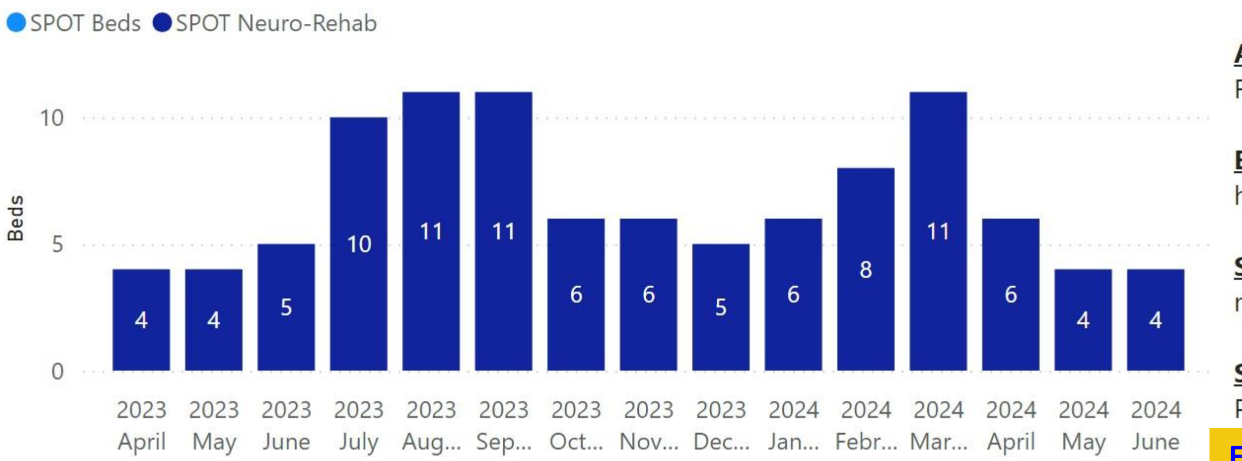
To note: Length of Stay (LOS) does not include specialist rehab



Block Bed Occupancy by Month



SPOT Beds Commissioned by Month



Commentary

Average Length of Stay - the ambition is to achieve an average LOS of 28 to 42 days (Intermediate Care Framework). Multiple projects have been established to reduce average LOS in Dudley.

Block Bed Occupancy - the current model allows flexibility within pathways and prevents unnecessary hospital admissions.

SPOT Beds Commissioned - no SPOT purchased capacity has been required; patient flow has been managed through the substantive bed stock.

SPOT Neuro-Rehab Beds Commissioned - SPOT purchased Neuro-Rehab capacity is required when West Park is unable to accommodate a patient.

Flexed Beds – June 2024 – Pathway 1 = 2 flexed beds and Pathway 3= 5 flexed beds

Virtual Ward

Data Source: NHSE report; snapshot as at 27th June 2024

This information is from the SitRep report DGFT submit to the VW National Team

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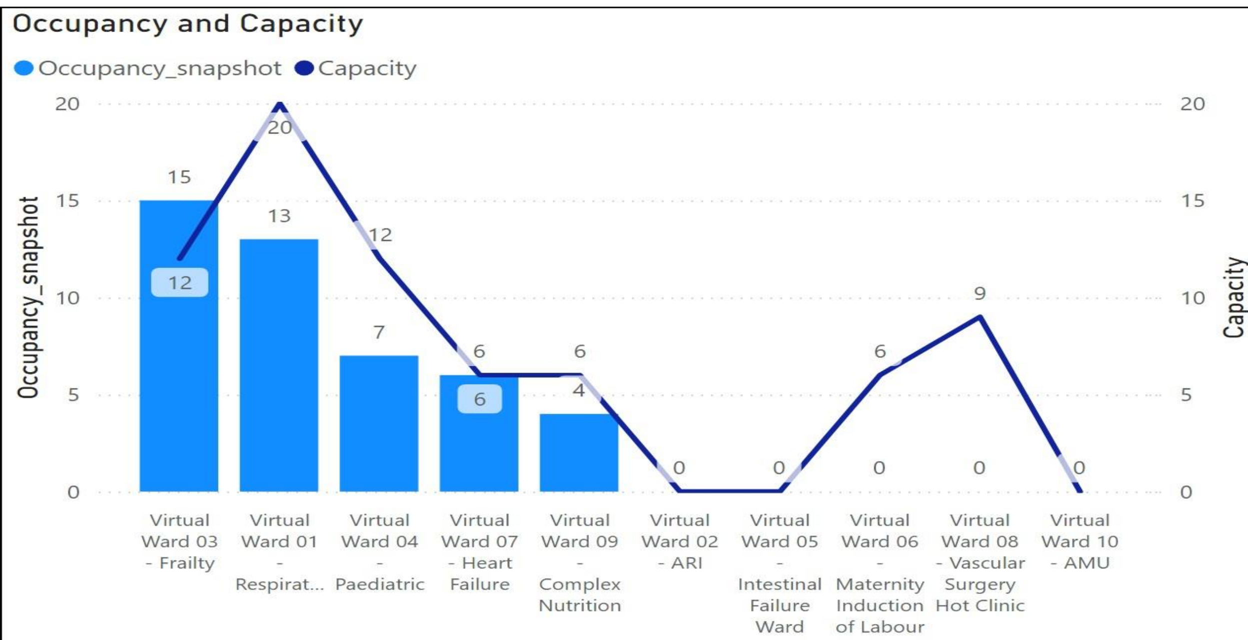

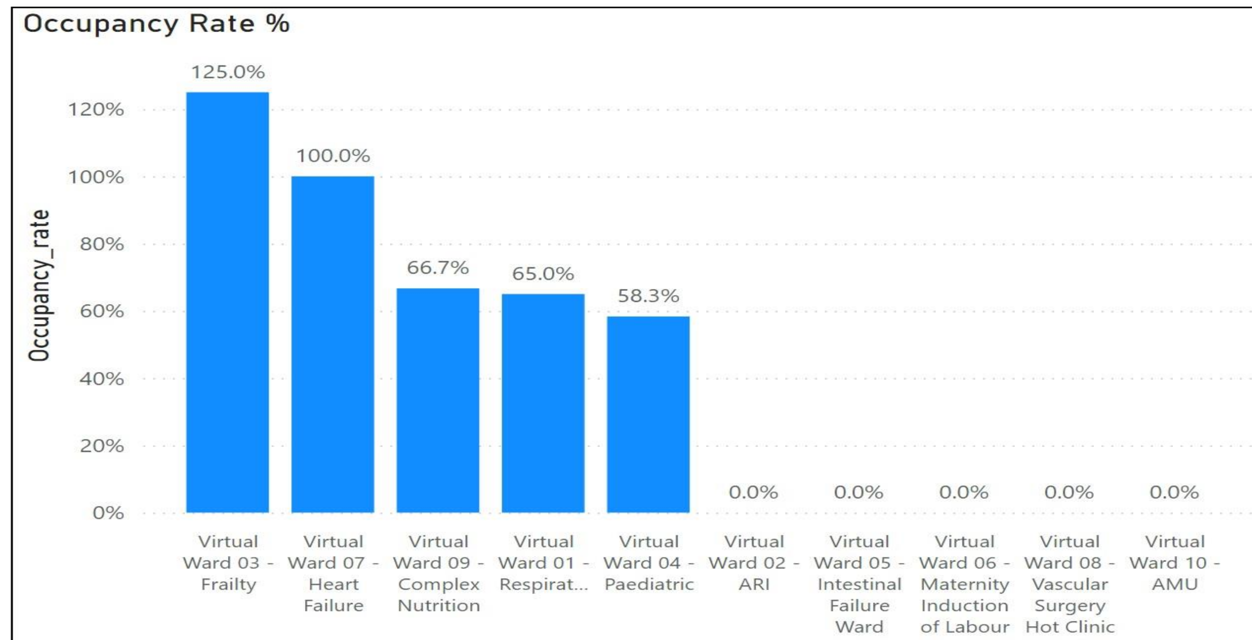

The Directorate Manager for Acute Medicine is currently working with the transformation team as there are some wards on the above data that are no longer in service. The AMU VW is currently being planned for and due to commence in the latter part of the year once positions have been recruited to.

The current wards in operation are:

1. Respiratory
2. Frailty
3. Paediatrics
4. Heart failure
5. Complex nutrition

The frailty Virtual Ward is currently funded for 12 beds but often flex up to 18 which is very much capacity driven. The team actively identify patients for admission avoidance from SDEC FAU or ED direct. They also support earlier supported discharges from inpatient elderly care wards to admit to Virtual Ward. The team are providing a reactive service based upon the needs of the patients each day whilst prioritising discharge and also follow some patients up and work in a virtual clinic system for a number of patients to keep capacity optimised and ensure the team can accommodate as many patients as possible into this pathway. The virtual ward is operated by the SDEC FAU team who deliver the two services concurrently which have been pivotal in getting the ward up and running and the uptake of the wards availability. The demand for this service is ever growing and could be expanded further with investment into the service.

Paediatric activity is variable and in the summer months there is a drop in admissions to C2 and PAU attendances. This usually coincides with school holidays and families being away from home. The occupancy has varied from 30% - 75% the past week. The team proactively recruit onto the PVW to maintain inpatient bed availability.

The heart failure virtual ward is currently running at 100%, on days where the occupancy exceeds 100% is usually due to administrations and changeover of discharge/admission to keep a continuous flow of patients.

The occupancy rate of 66.7% of capacity for complex nutrition virtual ward is inaccurate due to the limitations of patients being admitted to day case areas whilst on VWs as they can't be admitted to two areas simultaneously. So for instance, if a patient attends A2 5 days a week for IVI they are not "admitted to the VW" on oasis but are in fact on the VW.

Metric 2 - Proportion of older people (65 and over) who were still at home 91 days after discha[rge] from hospital into reablement/rehabilitation services

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Source : Local Authority Colleagues
Period : Q1 2022/23 Q1 2024/25

Local Authority metrics are collected on a quarterly basis as the 91 day metric does not lend itself to monthly monitoring. These are local monitoring figures, the official metrics are collected annually.

HWB Name	Period	2. Proportion of people aged 65+ discharged who are still at home after 91 days
Dudley	2022/23 Q1	0.98
Dudley	2022/23 Q2	0.90
Dudley	2022/23 Q3	0.88
Dudley	2022/23 Q4	0.88
Dudley	2023/24 Q1	0.97
Dudley	2023/24 Q2	0.85
Dudley	2023/24 Q3	0.98
Dudley	2023/24 Q4	0.82
Dudley	2024/25 Q1	0.98

Metric 4 Dudley Patients Discharged to Usual Residence (DTUR)

Source : Data Published on Better Care Exchange

Period : October 2022 : March 2024

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Average DTUR in Reported Period

HWB Name	Ave % DTUR
Dudley	93.21%
Sandwell	94.14%
Walsall	95.56%
Wolverhampton	93.12%

Average DTUR in Last Three Months

HWB Name	Ave % DTUR
Walsall	95.46%
Sandwell	93.85%
Dudley	93.38%
Wolverhampton	92.64%

DTUR in Latest Reported Month

HWB Name	Ave % DTUR
Dudley	93.78%
Sandwell	93.86%
Walsall	95.72%
Wolverhampton	93.08%