Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Sheffield

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	257.0	236.0	290.6	230.2	279.0	287.4	Not on track to meet target	Due to a delay in data during target setting we now know our 23/24 plan is likely to be far too ambitious and so we're unlikely to meet this target.	Although the city is not hitting this target the numebrs have been consistent with Q3 and Q4 in 2023/34. Progress has been through the ageing well programme and highlights include: - Creating a city-wide multi-agency approach that supports an individual's anticipatory care needs via holistic assessment of needs and care coordination, leading to creation of a jointly shared action plan with the patient wishes at the centre. - Identified individuals in Sheffield at higher risk; with an aim of reducing risk of escalation and involvement from statutory services, reduce duplication, improve outcomes, and advocate for right care at the right time - Embedded a urgent community response pathway to support people in crisis in the community - Expanded City-Wide Care Alarms offer to enable pick up of the immediately fallen and referral to UCR available 24hrs a day - Creation of a service offer for UCR support in care homes - Established a 'Push' model from 999 to Urgent	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	97.8%	97.8%	97.8%	97.8%	98.0%	98.3%	On track to meet target	None	Sheffield is focused on making discharge personal and the home first where appropriate model, with limited use of beds for assessment when an alternative cannot be found. A recent report (31st Jan 24) on discharge progress can be found here - https://democracy.sheffield.gov.uk/documents/s65721/Appendix%202%20-%20Hospital%20Discharge%20Update.pdf	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,023.5	514.0	506.8	On track to meet target	We have challenges replicating the measure locally as validation, however based upon national data received Sheffield HWB is on track to meet this target.	Joint work on the reduction of falls continues and the key progress areas include: - Development of a Sheffield Falls screening tool embedded in "What Matters to Me" shared across services; voluntary, council and health. - Development of a self-assessment falls tool that can be used by clients and staff. - Training of staff in the voluntary sector on Falls risk awareness and self-assessment. - Training of staff across the pathway to enable delivery of falls strength and balance programmes. - Mapping of the current pathway for falls Rehabilitation in the city. - Engagement with staff and residents in council housing to describing the anticipatory care needs of over 60s to prevent falls - The Falls team have written a 'Team Sheffield' Falls plan - Interventions to reduce unnecessary hospital admissions – expansion of falls pick up – Joint initiative between SCC/ICB & YAS	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				683	2022-23 ASCOF outcome: 715.9		On track to meet target	None	As an existing metric which retains the same calculation methodology we are confident with this target. The target is annually assessed and as a snapshot comparison Sheffield is reporting 678 against a target of 683. Historically the number of admissions	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				82.0%	2022-23 ASCOF outcome: 85%		On track to meet target	from paper?	Short Term Intervention Team (STIT) are the Sheffield Council in-house reablement provider, supporting people to return home after a period in hospital, to regain independence. The Service supports on average up to 270 people at any one time and accept referrals seven days a week. The team has been maximising its capacity by reducing duplication, streamlining existing processes and working to the Intermediate Care Framework. The team are performing well against this indicator with a Q3 performance of 85%. This is also against a backdrop of a reduced number of people occupying an acute bed once medically fit for over 7 days and a decreasing number of people readmitted.	Yes

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