# Better Care Fund 2023-24 Year End 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 | | | | Assessment of progress against the metric plan for the reporting period | Challenges and any Support Needs | 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 | 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. | We continue to deliver 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 | 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% | On track to meet target | None | We continue to review and define our discharge arrangements as a partnership with the home first ethos. We have seen progress in this area over this quarter and continue to deliver one of the highest levels | Yes |
| **Falls** | Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | | | | 2,023.5 | 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:<br><br>- Development of a Sheffield Falls screening tool embedded in "What Matters to Me" | Yes |
| **Residential Admissions** | Rate of permanent admissions to residential care per 100,000 population (65+) | 683 | | | | On track to meet target | N/A | The home first ethos is seen in our residential placement data. The 22/23 benchmarking on the rate per 100,000 pop was:<br><br>Core Cities = 754 | 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% | | | | On track to meet target | Sheffield has a large reablement service which supports discharge from hospital. A proportion of these people have less reablement potential than others, with the service supporting them with timely | 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 | Yes |

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