Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Leicestershire

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)	165.1	163.5	161.8	160.2	198.7	189.0	Not on track to meet target	Challenges in demand have been met with increased daily sitrep calls and activity to manage flow. Increased support from community services at the front-door have been required to avoid admissions.	Intermediate care initiatives, particularly for pathway 1 improvements are moving to step-up modelling to increase avoided admissions.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.7%	92.6%	95.1%	91.7%	92.4%	92.2%	Not on track to meet target	Increase in reablement demand in order to ensure people return home with the model for intermediate care, has resulted in additional support from partners to ensure sufficient capacity to discharge patients	The target in Q2 was missed by 0.4%. Work is still underway to ensure all patients within UHL and LPT hospital sites receive a face to face visit in order to maximise independence for people to return home. This has resulted	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,628.1	412.1	471.5	Not on track to meet target	Currently looking at approx 10% off target at projected approx 1700 emergency admissions due to falls. The falls sub-group is suporting to ensure that falls work has a positive improvement on rates of admissions	Work to improve the contract for the falls car support services is underway in order to ensure people are supported to return hom. Proactive falls assessment tools are also being developed to enhance community	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				515	2022-23 ASCOF outcome: 552.8		On track to meet target	Currently on track to meet the target with support from the system to ensure as many people in the comminity are supported to remain at home.	Forecast for the full year, based on the position at the end of Q3 is 522.7 admissions per 100,000 population. The new integrated model of locality support between therapy and reablement teams has helped to ensure	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				90.0%	2022-23 ASCOF outcome: 89.2%		On track to meet target	Support from partners in locality teams to maximise reablement capacity has seen an ability for the service to take over and above the anticipated demand in the last two months.	Data in the metric isn't cumulative but represents a different three months of discharges (final year figures being discharges Oct-Dec). Latest performance is 87% but has been >90% at point through 2023/24 to date.	Yes

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