Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Barnsley

National data may be unavailable at the time of reporting. As such, please utilise 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 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,290.0	Not on track to meet target	Whilst there was a reduction in the number of admissions in the first half of the year this increase in the second half and is anticipated to be a slight increase on 2021/22. Covid has impacted upon the health of some people with ambulatory care sensitive conditions such as Asthma leading to increased exacerbations and presentation to health services including primary care and hospital services over the winter period	Through Barnsley PCN care coordinators embedded in all GP practices are continuing to support people with LTC's to access regular health checks and the services they need to manage their condition and reduce execerbation that results in hospital admissions	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.9%	On track to meet target	As a result of increased acuity of patients being seen and treated in hospital there has been an increase in the need to discharge patients who do not meet the criteria to reside into intermediate care services prior to being able to return to the normal place of residence.	Home first approach has contributed to enabling appropriate people to continue to be discharged to their normal place of residence or receive additional support in the community before returning to normal place of residence..	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	848	On track to meet target	.	Implementation and embedding of a strengths based approach to supporting individuals with the care and support reguired, working alongside community services has resulted in a reduction in the number of people requiring permanent admission to residential care	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%	Not on track to meet target	During 2022/23 we have seen a slight reduction in number of people who are able to remain at home following discharge from Hospital into reablement services. This has been mainly due to increased acuity of patients being discharged from hospital not meeting the criteria to reside which has impacted across discharge pathways and resulted in increased readmissions to hospital.	Reablement services have continued to support increasing numbers of patients in the community as a part of the dischare pathways with the aim of maintaining independence. Good partnership working to ensure integrated approach to care for people following admission into hospital.	Yes