Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board:

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.

Barnsley

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

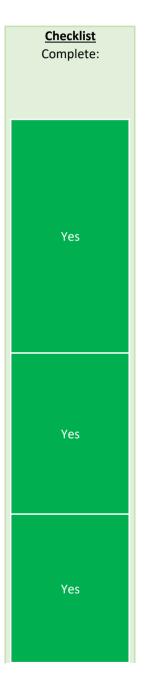
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

| Metric | Definition | For information - Your planned performance as reported in 2022-23 planning | | Challenges and any Support Needs | Achievements |
|--|--|---|-------------------------|--|---|
| Avoidable admissions | Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i) | | | - | Through Barnsley PCI embedded in all GP p to support people wit regular health checks need to manage their execerbation that res admissions |
| Discharge to normal place of residence | Percentage of people who are discharged from acute hospital to their normal place of residence | 92.9% | | 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 enabling appropriate be discharged to thei residence or receive a community before re of residence |
| Residential Admissions | Rate of permanent admissions to residential care per 100,000 population (65+) | 848 | On track to meet target | | Implementation and strengths based appr individuals with the c reguired, working alo services has resulted number of people rec admission to resident |

CN care coordinators P practices are continuing with LTC's to access ks and the services they eir condition and reduce esults in hospital

h has contributed to te people to continue to eir normal place of e additional support in the returning to normal place

d embedding of a proach to supporting care and support longside community d in a reduction in the requiring permanent ential care



| 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% | 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 | Reablement services I support increasing nu community as a part of pathways with the ain independence. Good ensure integrated app people following adm |
|------------|--|-------|---|--|
| | | | | |

s have continued to numbers of patients in the t of the dischare im of maintaining of partnership working to pproach to care for mission into hospital.

