

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board:

Haringey

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	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.
		Q1	Q2	Q3	Q4				
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	133.0	128.0	126.0	120.0	152.8	Not on track to meet target	Our system had somewhat higher levels of avoidable admissions in Q1 (though there's often seasonal component to admissions). Community health systems reaching capacity in rapid response & UCR in	BCF Rapid Response, Enhanced Health in Care Homes, Community Health Services & proactive care MACC Team in community all functioning well with good outcomes, e.g. 40% reduction in NEL admissions pre- and
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.0%	93.5%	94.2%	95.0%	92.90%	On track to meet target	Biggest challenge is consistently improving from an already high level of performance (>92.5%) each quarter given monthly warranted fluctuations in complexity of cases in PO-P3 pathways within Haringey.	Positive progress was made on measure. We continue to utilise BCF Plan investments in relation to PO & P1 (including Discharge Fund). This includes additional investment in P1 NHS HomeFirst investment.
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,608.0	324.4	On track to meet target	Our system is doing well, but could better support people with short non-crises interventions relating to information, advice and signposting to services & solutions that could avoid crises or mitigate	Positive progress made on measure, and we are building on our strong position to further development our partly BCF funded Community Health falls service and wider falls network working between NHS, Council
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)					371	On track to meet target	Strong performance despite 15+% increase in people with moderate/severe frailty post-pandemic, i.e. typical acuity of cases in the community - & typical resources to meet these cases - continues to increase.	Our system is performing well as our intention is to help as many people to live independently for as long as possible, including supporting those to recover (ideally at home) following hospitalisation.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services					78.2%	On track to meet target	Strong performance despite 15+% increase in people with moderate/severe frailty post-pandemic, i.e. typical acuity of cases in the community - & typical resources to meet these cases - continues to increase. This	Our system continues to improve due to effective BCF-funded reablement and proactive care models of support in community post-reablement. Successfully improved a number of operational issues in

Checklist Complete:

Yes

Yes

Yes

Yes

Yes