Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Trafford

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.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	193.2	169.8	185.3	135.9	166.0	On track to meet target	Hospital at Home establishment wihtin the locality. There are a number of initiatives in place within secondary care however further development of the community based team/model is needed for H@H to be fully operational.	The New Trafford Crisis Response Service will serve to support avoidable admissions with a range of opportunities to refer to the service both within the community and primary care as well as from the front door of the Urgent Care services.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.5%	91.5%	91.5%	91.5%	90.89%	On track to meet target	None identified. Whilst performance was lower in Q1, performance in Q2 to date shows improvement to 92.14% with YTD perfomance of 91.50%, in line with our submitted plan.	The Rapid MDT for P3 Discharge to Assess Beds servic, which reviews residents admitted into a bed within 48 hours, is supporting more of our residents to return home, moving from P3 to P1. Additional	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	2,003.0				490.2	On track to meet target	There have been a number of capacity and demand challenges in relation to community OT and Physio, much related to the legacy of Covid-19 pandemic, impacting on falls avoidance whilst there are lifting and response services in place. However, through the additional investment in therapy resource this should be mitigated by the implementation of the new Community Response Service, both from a Crisis Response and D2A Pathway 1 (IMC at Home) perspective. Additional capacity within community therapy will also expediate the continued action of the Community Rehabilitation recovery plan within the locality, that plays an important role in falls prevention.	We have implemented the new Trafford Community Response Service as part of a 2 hour urgent response within the community as part of a wider MDT model as well as the D2A Pathway 1 model which will enhance domicillary based support and provide an IMC at home. This will support patients at risk of admission or readmission to secondary care including patients who are at risk of falling. We have also established our Community Recovery plan. The introduction of the Rapid MDT to P3 D2A beds, which includes social care, nursing and therapy has also supported a reduction in falls in the care home setting by reviewing residents within 48 hours of admission. OT and Physio assessment at this early stage of admisison, supports the reduction of falls	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	559					Not on track to meet target	This data includes both residential and nursing admissions, 26 Nursing, 53 Residential, on checking this excludes CHC - continuing health care. Q1 reporting albeit slightly higher, Q2 decreasing to be more in	Trafford Control Room (TCR) is the centre point for all referalls who require H&SC P1&P3 and are triaged through TCR to provide a timely response to discharge arrangements. The control room offer an	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	92.0%					On track to meet target	86.2% this is 8 percentage points of the same period of the previous year, if the same improvement is seen this year as it was in 22/23 then we will exceed our target	The new Trafford Community Response Service as part of a 2 hour urgent response within the community as part of a wider MDT model as well as the D2A Pathway 1 model which will enhance domicillary based	Yes