Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Wiltshire

National data may be unavailable at the time of reporting. As such, please use data that may only

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and

Achievements Please describe any achievements, impact observed or lessons learnt wh

Metric	Definition	For informa Q1
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	134.6
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.7%
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	

/ be available system-wide and other local intelligence.

please highlight any support that may facilitate or ease the achievements of metric plans

ıen considering improvements being pursued for the respective metrics

ation - Your planned performance as reported in 2023-24 planning			For information - actual performance for Q1	For information - actual performance for Q2
Q2	Q3	Q4		
131.6	157.4	140.3	137.7	139.7
92.2%	92.1%	92.1%	90.5%	91.8%
		2,227.0	406.4	455.3
		317	2022-23 ASCOF outcome: 531.7	
		75.2%	2022-23 ASCOF outcome: 77.9%	

Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3
Not on track to meet target	None
On track to meet target	None
On track to meet target	None
Not on track to meet target	Target set was very low comparatively. Our monitoring shows we have already exceeded the target. We are investigating the reasons for the increase in PW3 which will inform a more accurate baseline for 2024-25.
On track to meet target	None

Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
Analysis shows that the most common conditions for hospitalisation are COPD, Atrial Fibrillation and Heart failure. We have started some work to understand prevention methods across social care, public health and	Yes
Increased capacity in the HomeFirst services enables us to support an increasing number of patients on this pathway.	Yes
Targeted training in the UCR service has improved both the response times to Falls and has enabled more falls to be managed wihtin the community. Conveyances to hospital following falls is 46 in 2023 to date.	Yes
The introduction of the PW2 Hub model beds that provide co-ordinated rehabilitation is ensuring more people are able to return to independent living in their own homes. An increase in capacity in our HomeFirst	Yes
Reablement and HomeFirst services continue to deliver coordinated support to ensure people discharged from hospital get the support they need to live independently at home.	Yes