Appendix 2A - Central Bedfordshire Q1 submission: National Metrics

Better Care Fund Template Q1 2018/19

Metrics

Selected Health and Wellbeing Board: Central Bedfordshire

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	Reducing non-elective admissions remains a challenge and the health and care system are working to reduce demand in key areas such as older people and 0-4s.	Bedfordshire CCG is collaborating with neighbouring CCGs with a mutual 111 provider to implement the 111 online service. Herts Urgent Care (111 Provider) has put in place a revised clinical model which was approved and supported financially by BCCG. Extended GP access covering 100% of BCCG population is underway. Early Intervention Vehicle pilot with EEAST and the Council to provider paramedic and OT support to attend to residents in need of no-emergency support was successful. The work of the Enhanced Health in Care Homes workstream and complex care support for frail elderly people is aimed at reducing non-elective admissions from care homes. Proactive support to Care Homes was implemented in Ivel Valley and a frail elderly nurse practitioner is working across West Mid Beds to support people at home and in Care Homes. A number of preventative interventions are also being implemented. This includes baseline remote monitoring.	None
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	The challenge is availabilty of the right type of accommodation to meet the needs of an ageing population whilst maintaining focus on enabling people to remain independent for as long as possible. There are also important challenges of capacity in the home care market.	Additional investment in workforce supporting new framework for domiciliary care and incentive payments to hold packages when people are admitted to hospital. Implementing community catalyst to provide additional capacity in care market, particularly for rural areas.	None

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Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress	Due to reporting timescales, we are unable to report on Q1 outturn, as there is a timelag in securing the data.	Q4 outturn activity improved upon Q3. Q4 reported 97.6% of customers were still at home 91 days after discharge. The Rehabilitation and Reablement services are now working as an integrated	None
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	Coordinating discharges across 7 hospitals remains challenging, however work is ongoing to liaise with partners in acute trusts to monitor patient flow.	Although full data for Q1 is not available, DToC for Central Bedfordshire has demonstrated a slight increase month on month from February 2018, but a review of April and May 2018 against performance in the same period last year indicates a decrease in the total delayed days per 100,000 population. Initiatives implemented to reduce delays include: A DToC tracker which provides oversight and opportunity for timely response to notification of discharge. Trusted Assessors in place , with 100% of assessments being completed within 24 hours, and safe and timely discharges being supported. The Red Bag scheme is in place and early feedback is largely positive.	None