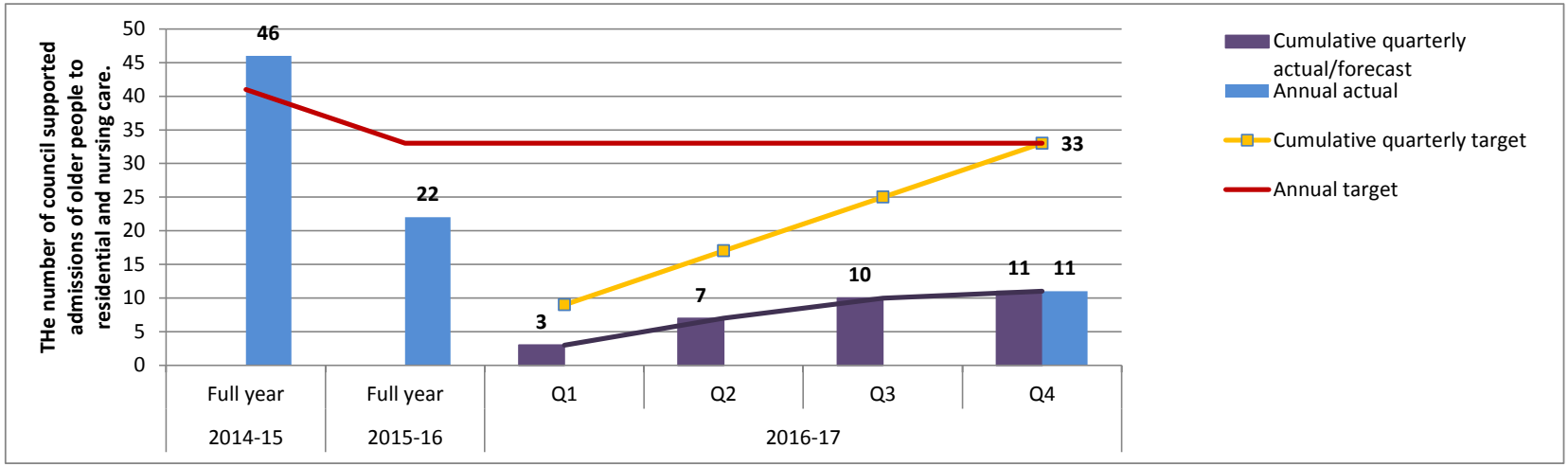
Metric 1 - Residential Admissions

GREEN: Well established good performance against this metric continued across 2016-17, with just 11 people permanently entering Council funded residential or nursing care across Q1-Q4, just 33% of the target ceiling of 33 by the end of the year, and half the number of people admitted in 2015-16.
This equates to a rate of 118 per 100,000 65 and over popoulation for the year, against a target of 355.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes



Outcome Sought:
Reducing inappropriate admissions of older people (65+) in to residential care

Rationale:
Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care.

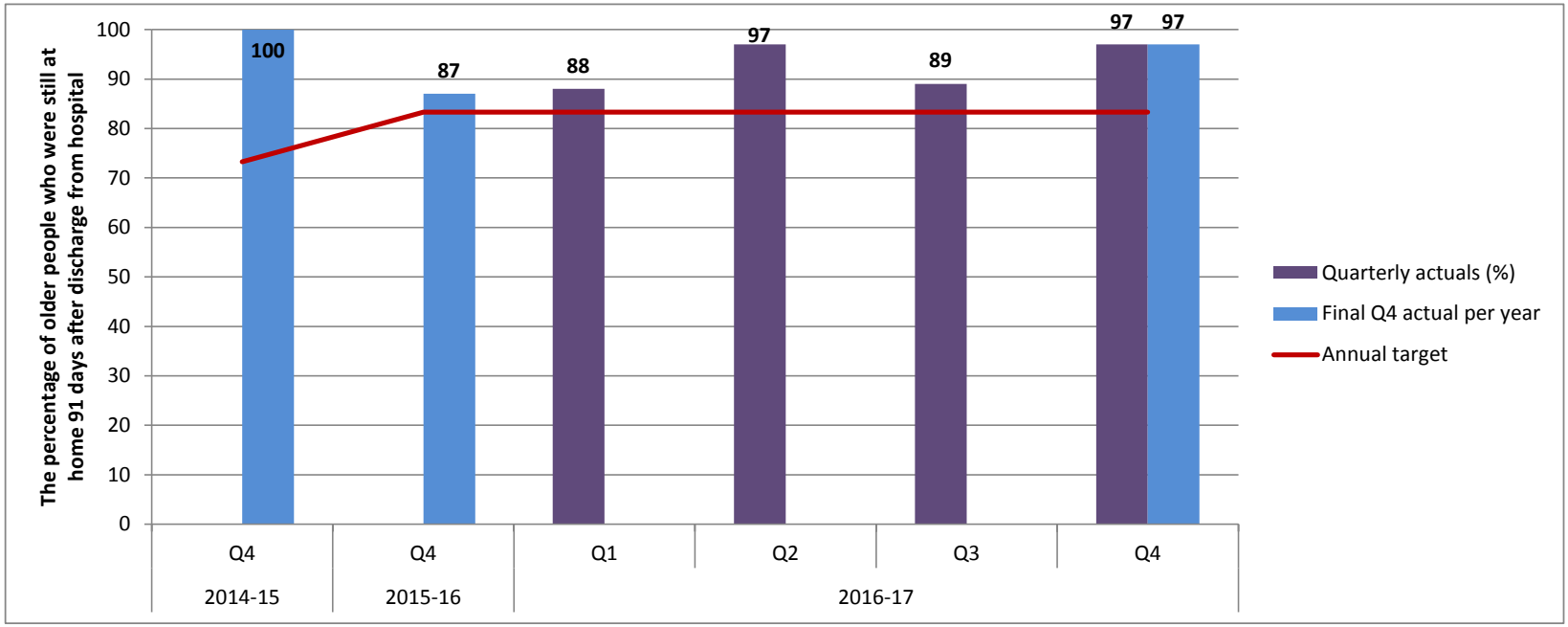
Definition:
The number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over).

Reporting Schedule:
Metric will be reported quarterly. Q1 update early Aug 2017.

Metric 2 - Reablement

GREEN: The pattern of people receiving reablement services and remaining at home 91 days after discharge remained consistently above the target of 83.3%, across the year. **Formal final BCF reporting is based on Q4 performance, when 97% of recipients were still at home 91 days after discharge into reablement services, 13.7% above target.** The average rate of success across the year was 93%.

Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
NB: Q4 data forms the official annual return



Outcome Sought:
Increase in effectiveness of these services whilst ensuring that those offered service does not decrease

Rationale:
Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal

Definition:

This measures the number of older people aged 65 and over discharged to their own home or to a residential or nursing care home during a 3 month period (October-December), who are at home or in extra care housing or an adult placement scheme setting three months (91 days) after the date of their discharge from hospital as a percentage of all those who were offered rehabilitation services following discharge from hospital.

Reporting Schedule:

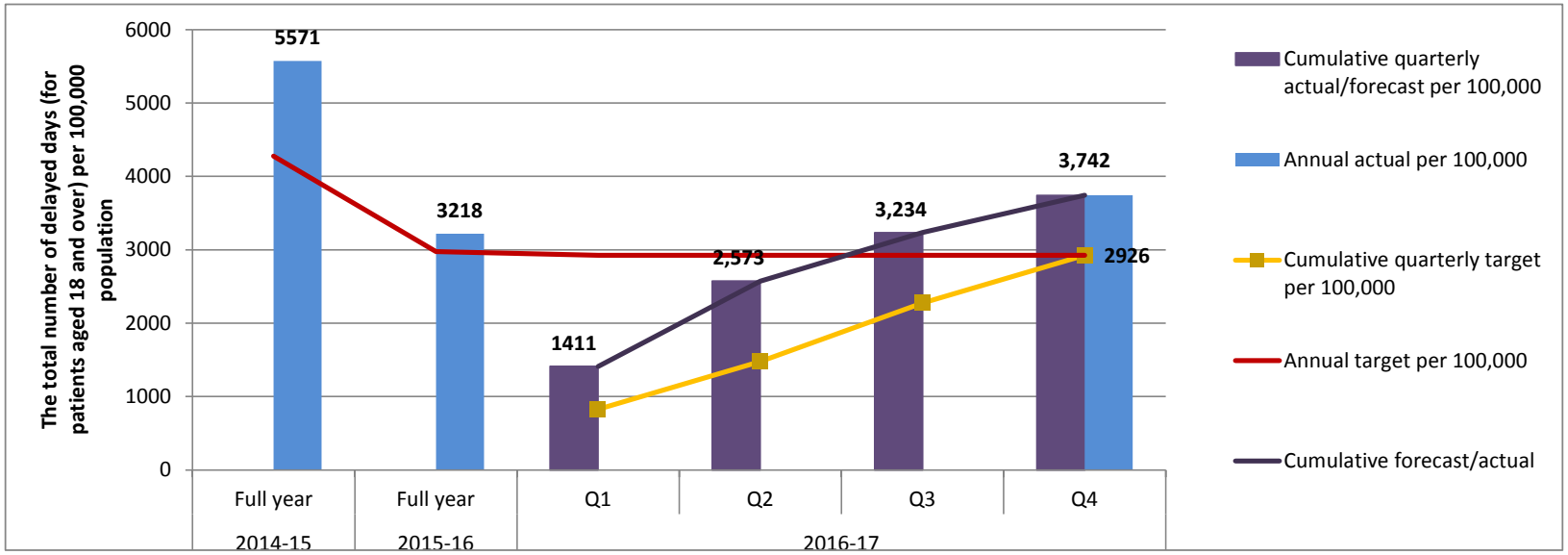
Formally, the metric is updated annually. The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital is collected **1st October to 31st December** for the relevant year. Same individuals are then checked 91 days later (i.e. January to March). Next formal update March 2018.

Local quarterly updates are calculated alongside this. Q1 update early Aug 2017.

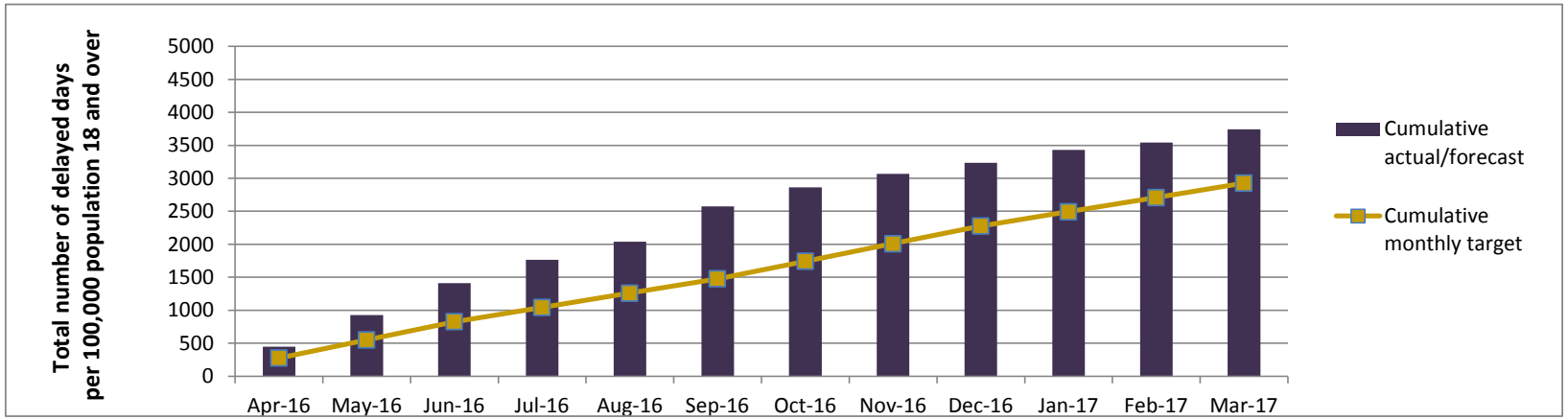
Metric 3 - Delayed Transfers of Care

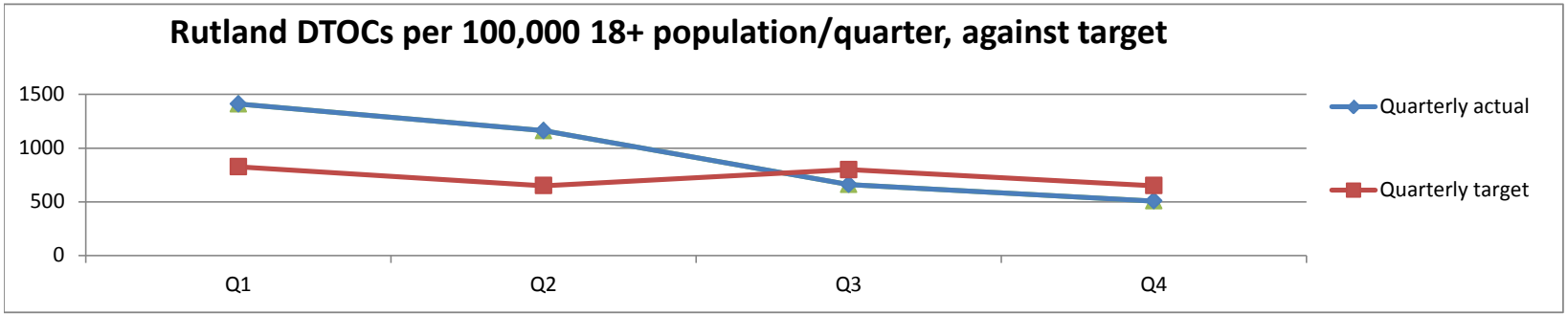
AMBER on the overall year's performance, as the very ambitious target set by Rutland for total DTOCs was exceeded, BUT GREEN for Q3 and Q4 when DTOC rates have been brought below the target ceiling and sustained there. Following a difficult start to the year, DTOC rates were brought down quarter on quarter across the year, until they are now running at the average rates achieved by the two best performing areas nationally (London and the North East). Continuing proactive management of DTOCs through successive rounds of process and system improvement has delivered strong results. In September 2016, it was predicted that the year's outturn would be 174% of the annual target, whereas by year end, this had reduced to 128% - still over target for the year overall, but markedly less so. In addition to the performance charts below, month by month DTOC detail is available on the sheet 'Additional Tables - DTOCs'.

Delayed transfers of care (delayed days) from hospital (aged 18+), per 100,000 population - performance by quarter



Delayed transfers of care (delayed days) from hospital (aged 18+), per 100,000 population - performance by month





Outcome Sought:
Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Rationale:
This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

Definition:
Delayed transfer of care per 100,000 population per month.

Reporting Schedule:
Full Q1 data available mid Aug 2017.

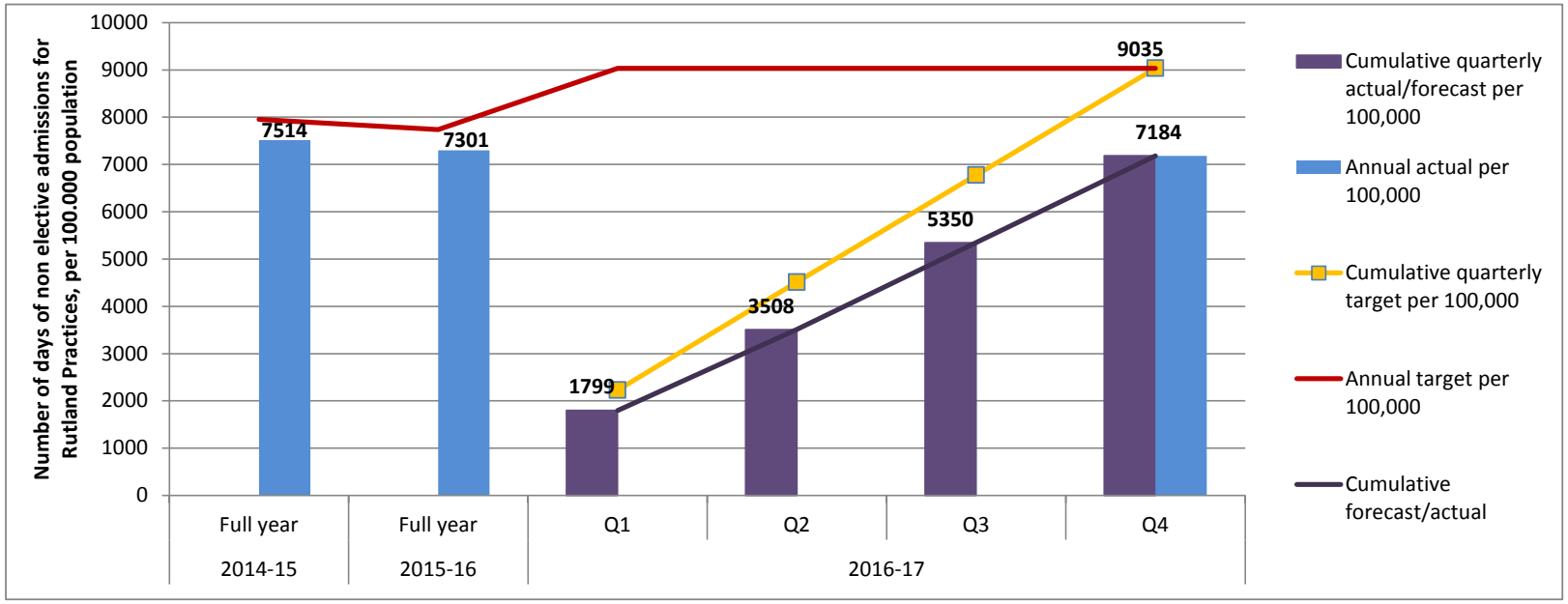
Metric 4 - Non-Elective admissions (general and acute) - Risk share associated metric

GREEN: Rutland both met its annual target for non elective admissions in 2016-17 and had fewer non elective admissions in 2016-17 than in the two previous years. Across the year, Rutland saw 7,184 days of emergency admissions per 100,000 18+ population, relative to a target for the year of 9,035 (a variance of -1851). There were 117 fewer nights per 100,000 18+ population than in 2015-16.

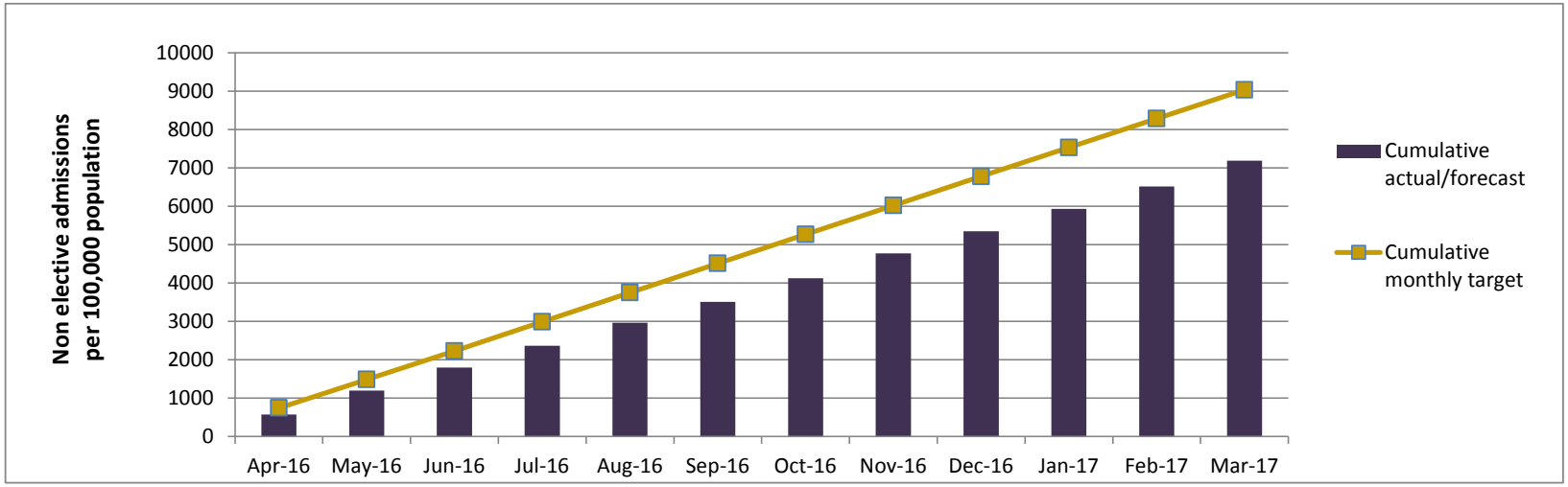
Active work continues locally to manage health and social care services in ways that help to avoid hospital admissions wherever possible and actions are being identified to further strengthen admissions prevention in the next BCF programme.

NB: The data has changed slightly relative to previous reports due to a change in calculation method arising from the change of Commissioning Support Unit. In this case, it has marginally reduced admissions, improving reported performance.

Total non-elective admissions in to hospital (general and acute), all ages. Per 100,000 population - quarterly



Total non-elective admissions in to hospital (general and acute), all ages. Per 100,000 population - monthly



Outcome sought:

Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system

Rationale:

Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for non-elective admissions

Definition:

Non-Elective admission data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected by providers (both NHS and IS) who provide the data broken down by Commissioner.

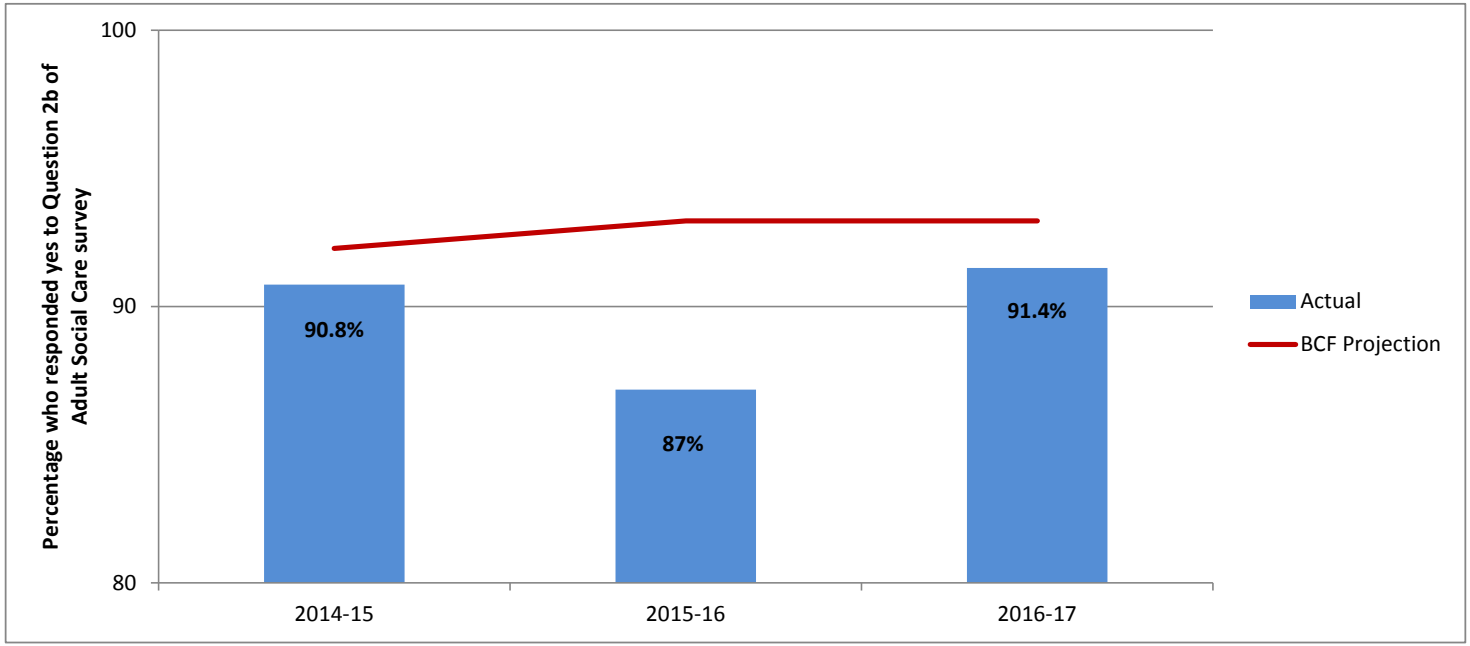
Reporting Schedule:

Updated quarterly from non elective admission statistics for Rutland practices supplied by GEM CSU (Greater East Midlands Commissioning Support Unit). Next quarter available Aug 2017.

Metric 5 - Patient/Service User Experience

AMBER: The unvalidated data for 2016-17 indicates that 91.4% of respondents agreed that care and suport services helped them to have a better quality of life. Although this figure falls slightly short of a very challenging target (93.1%) it is the highest figure achieved over the last three years (90.8% in 2014/15 and 84% in 2015-16). Further analysis will be undertaken once national data is published to benchmark the figure and trend both nationally and in other, similar areas.
The Council will also continue to look at ways to learn more about user experience and user satisfaction in 2017-18.

Do care and support services help you to have a better quality of life?



Outcome Sought:
To take steps to begin to understand patient experience in relation to the delivery of integrated care.
Rationale:
Effective engagement of patients, the public and wider partners in the design, delivery and monitoring of services.
Definition:
Based on the percentage who responded yes to survey Adult Social Care survey question 2b. " Do Care and Support Services help you to have a better quality of life".

Reporting Schedule:
Data reported from annual Adult Social Care users survey. Next update will be April/May 2018.

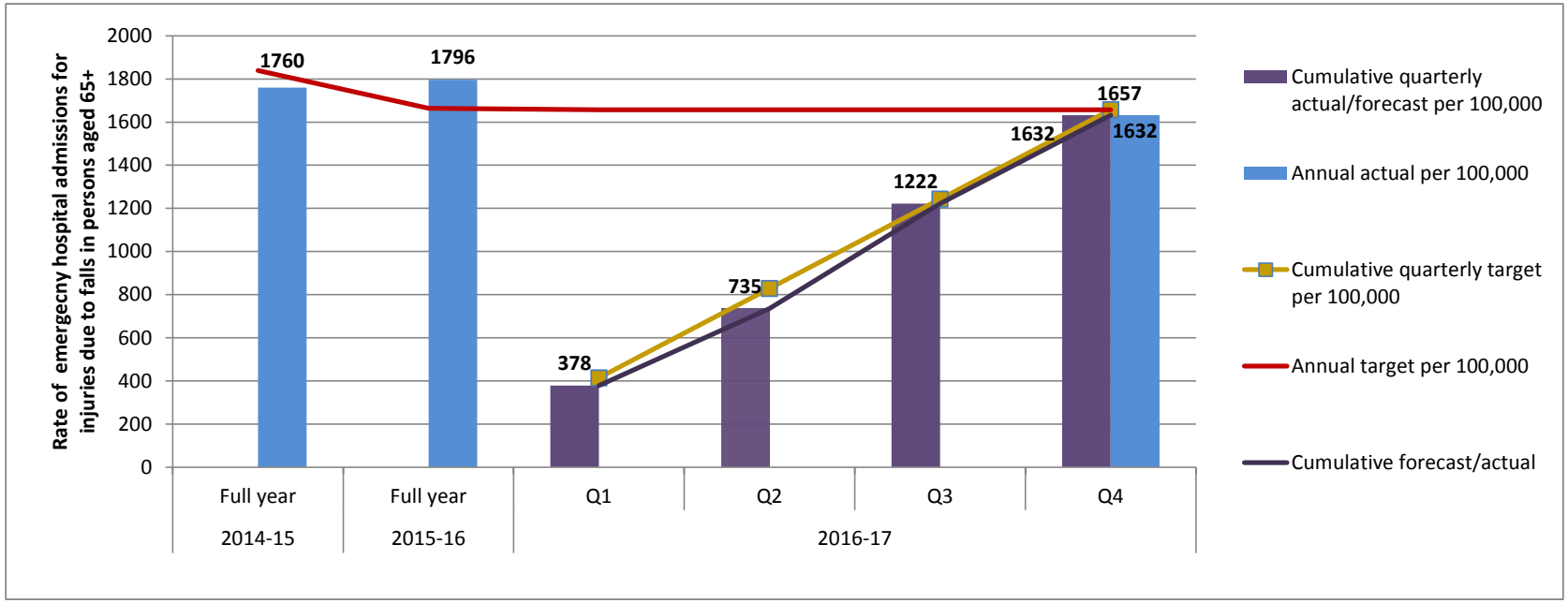
Metric 6 - Local Metric - Over 65s Falls

GREEN: Due to a difference in methodology between the former and new Commissioning Support Units, the number of admissions attributed to falls injuries has risen. **By year end, the number of falls was still nevertheless under the ceiling target, but with a narrower margin than previously reported.** There were 1,632 falls per 100,000 65+ population, relative to a target ceiling of 1,657. Just three additional falls injuries would have exceeded the target.

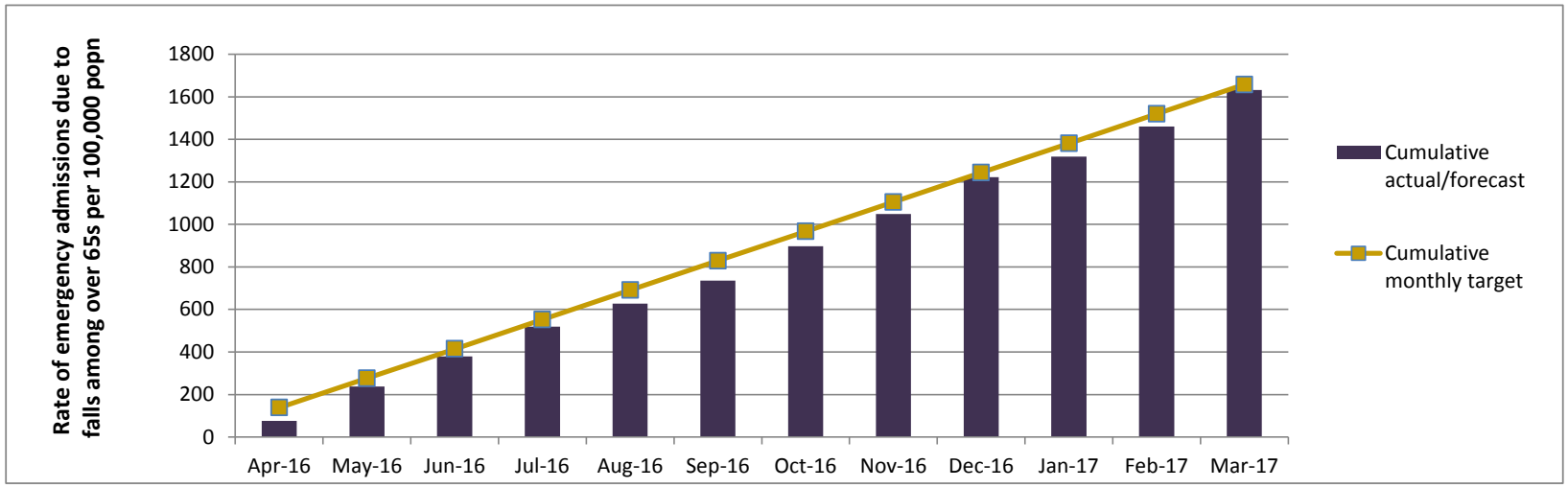
Complementing this metric, the Public Health Outocmes Framework released new figures in May relating to falls admissions. Rutland has 2 green and 6 amber indicators relating to falls, with better performance on falls in the 80+ population than those 65-79, underlining the need to continue to be proactive in falls prevention.

Falls prevention interventions are being defined for the next programme, alongside LLR BCT/STP work to define a set of LLR wide falls prevention and management interventions. An increased focus on care home falls prevention, for example, inclduding via pre-emptive therapies and increased use of assistive technology are anticipated, as well as increased work encouraging people to remain active in the community.

Rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population - quarterly



Rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population - monthly



Outcome Sought:

To reduce the number of admissions for injuries due to falls

Rationale:

Falls are frequent but often preventable events, rather than an inevitable part of ageing, and preventing them supports the other objectives of the BCF plan, including the prevention agenda, avoiding non-elective admissions to hospital and avoiding or posponing permanent admissions to residential homes. Once a fall has occurred, reablement activities can also help to ensure people remain out of hospital once discharged.

Definition:

Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population

Reporting Schedule:

Sourced from Public Health Outcomes Framework, last update 14/15. Currently working with Arden & GEM CSU data processed by Leicestershire County Council Public Health analysts. Transitioning to data provided by Midlands and Lancashire CSU. Q1 data due mid Aug 2017.