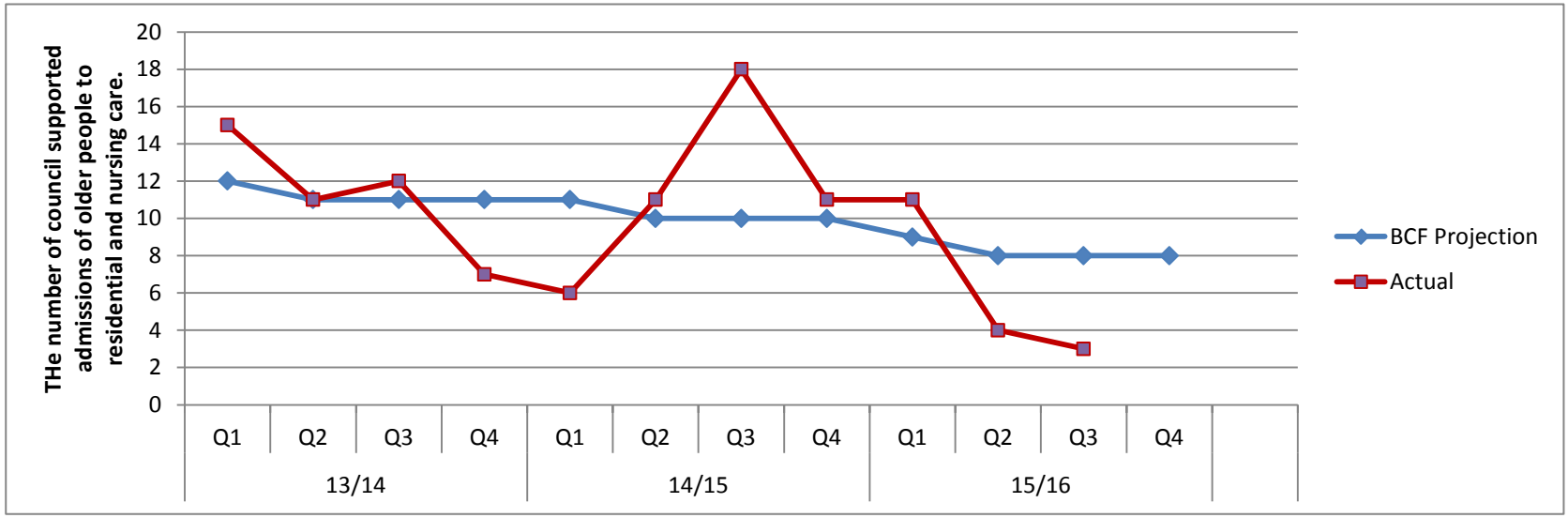
Metric 1 - Residential Admissions

GREEN: The number of permanent residential admissions fell again in Q3 of 2015-16, putting it at the lowest level seen in the last 11 quarters. The programme is on target for this metric.

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).

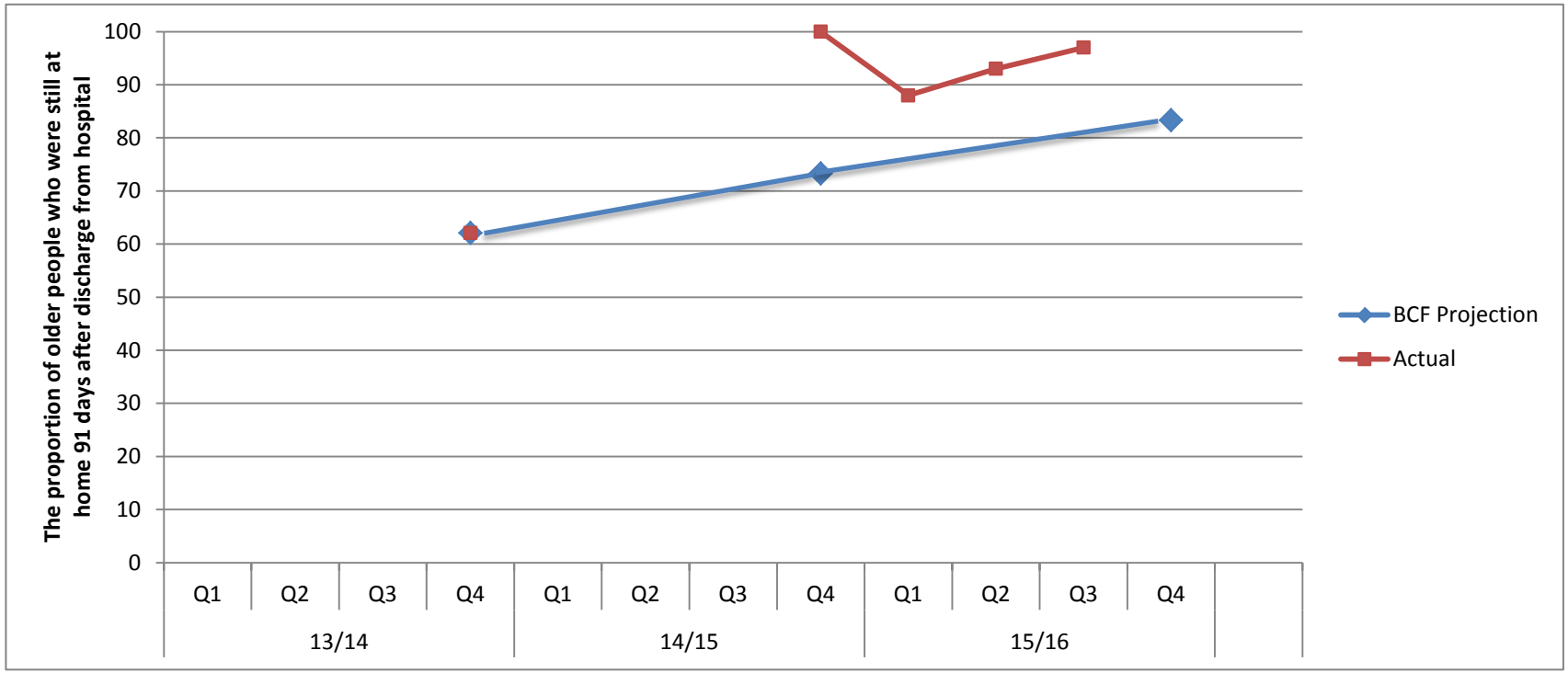
Reporting Schedule:

Metric will be reported quarterly. Next update late Feburary 2016.

Metric 2 - Reablement

GREEN: The pattern of people remaining home 91 days after discharge remains positive. The Q3 rate was an improvement over the last two quarters at 97%, exceeding the BCF Projection target and improving on Q1 and Q2, whcih were both above target. Formal BCF reporting will be based on whether people discharged between 1 Oct and 31 Dec 2015 are still at home 91 days later.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services



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:

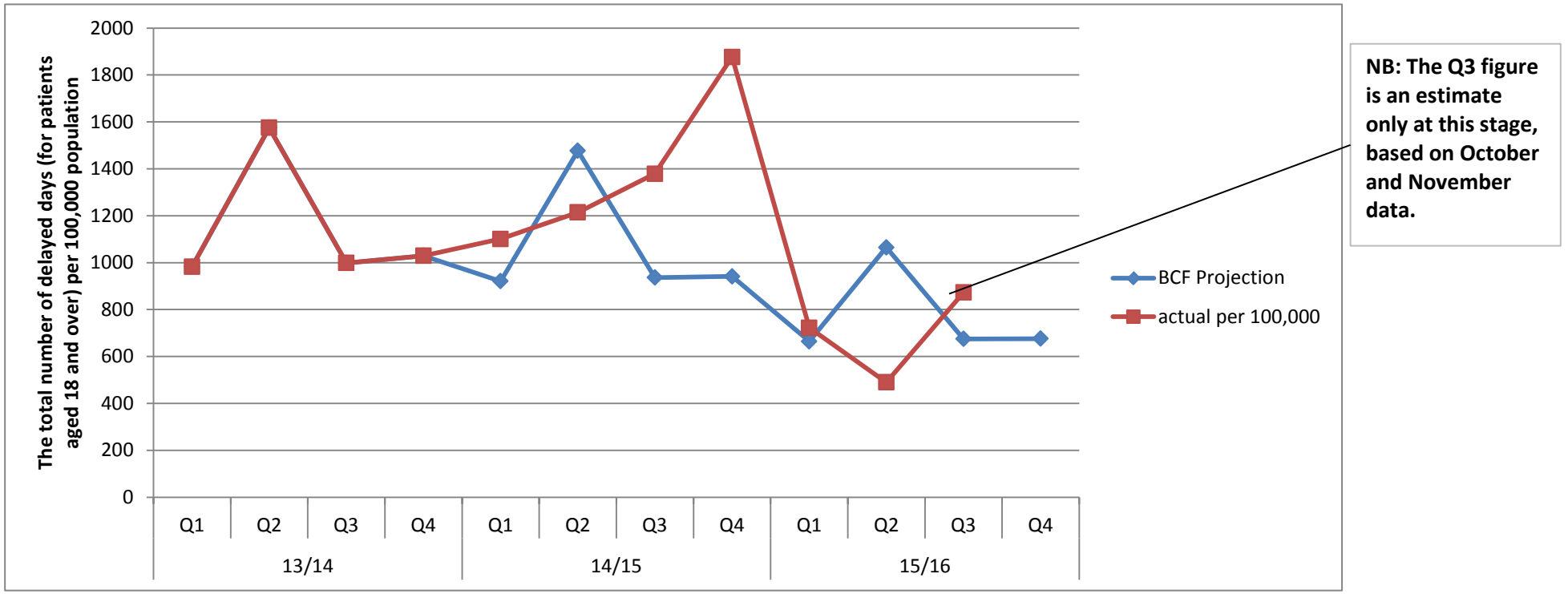
This measures the number of older people aged 65 and over discharged to their own home or to a residential or nursing care home during a 3 month period (October-December), who are at home or in extra care housing or an adult placement scheme setting three months (91 days) after the date of their discharge 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, based on two sets of 3 months data. 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 full quarter update March 2016.
Local updates are calculated alongside this for more frequent insight. Next update February 2016.

Metric 3 - Delayed Transfers of Care

AMBER (from GREEN): Considerable attention is being dedicated to reducing delayed transfers of care. However, performance remains variable. Finalised Q2 figures were favourable and meant that the pay for performance payment was achieved. As December 2015 figures have not yet been relased, the Q3 figure below is an estimate extrapolated fromOctober and November data. This estimate shows DTOCs rising again from the last quarter's low. DTOC issues relating to Peterborough hospitals have been a particular focus across November/December, with managment and operational meetings to identify and address potential system issues. A new approach was also used over Christmas/New Year (commissioning short-term space in residential homes at short notice to avoid discharge delays, with local follow through). Looking to 2016-17, national guidance recommends each area agrees a local action plan for DTOC reduction.

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



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.

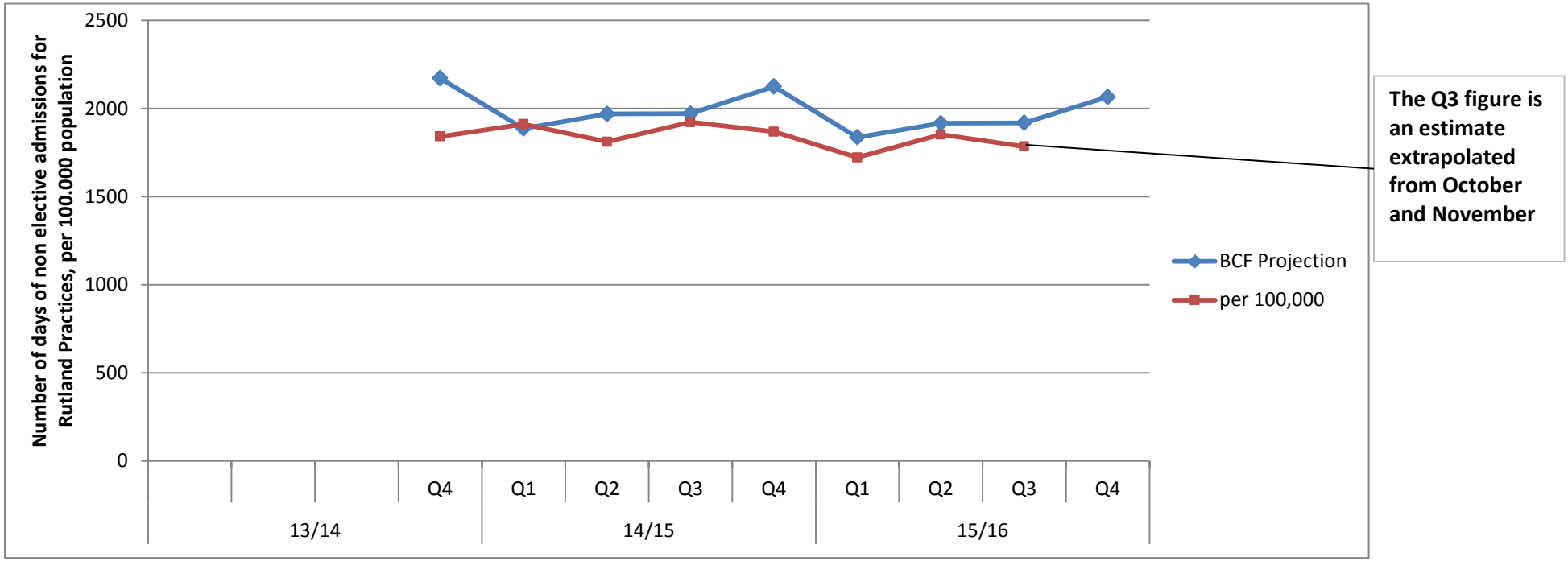
Definition:
Delayed transfer of care per 100,000 population per month.

Reporting Schedule:
Full Q3 figures anticipated before the end of January 2016.

Metric 4 - Non-Elective admissions (general and acute) - Pay for Performance metric

AMBER: Rutland met its pay for performance target for non-elective admissions (NELs) in the first two quarters of this calendar year. December NEL figures are not yet available, so the Q3 figure below is an estimate based on October and November's figures. Although the estimated figure is below the projection, it is not possible to be confident that the NEL pay for performance target will be met, hence the Amber rating. The CCG have also indicated that, in general, they are seeing a trend of rising emergency admissions. Some deeper analysis was requested at the December Integration Executive, to be coordinated by the CCG, to confirm whether there may be areas of work which could help to reduce non elective admissions in Rutland.

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



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

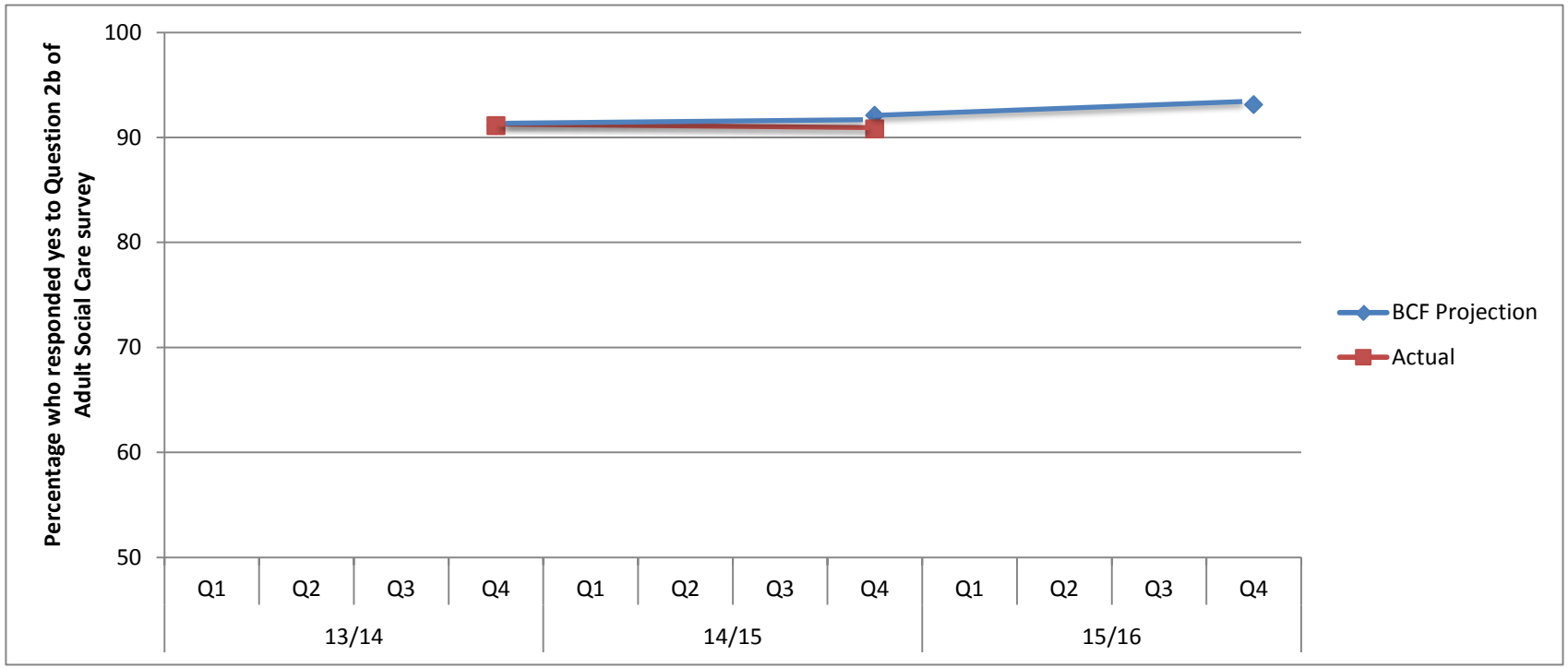
Definition:
Non-Elective admission data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected by providers (both NHS and IS) who provide the data broken down by Commissioner.

Reporting Schedule:
Updated quarterly from non elective admission statistics for Rutland practices supplied by GEM CSU (Greater East Midlands Commissioning Support Unit). Full quarter figures expected by end January 2016.

Metric 5 - Patient/Service User Experience

No RAG rating - this is an annual statistic and not yet available. Target was missed by just over 1% in 2014-15.

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:

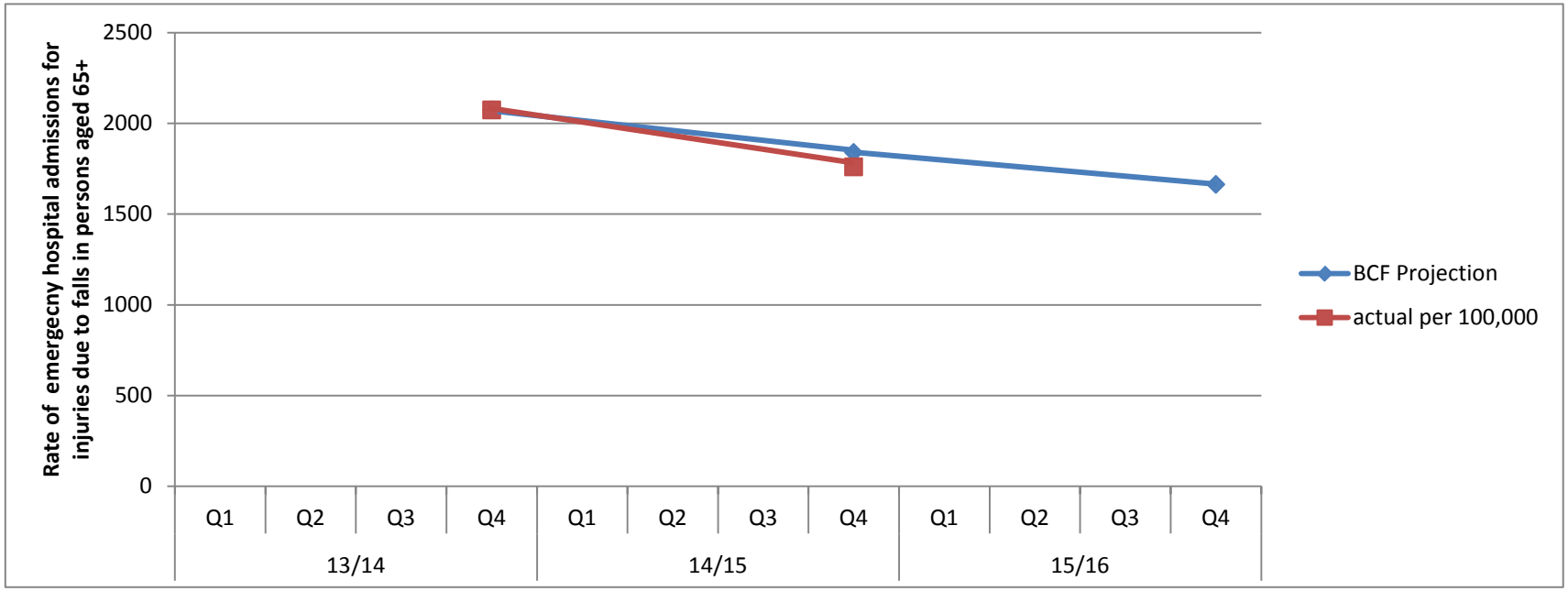
Data reported from annual Adult Social Care users survey. Next update will be March/April 2015.

Metric 6 - Local Metric

There is no formal RAG rating as currently this is annual Public Health data.

The 2014-15 Public Health England figure is now in for falls (see chart). For the most recent GEM CSU update on falls patterns up to the end of September 2015, see Falls highlight report.

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



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 discussing more timely release of data with local health partners and referring to proxy data in the interim from Health.