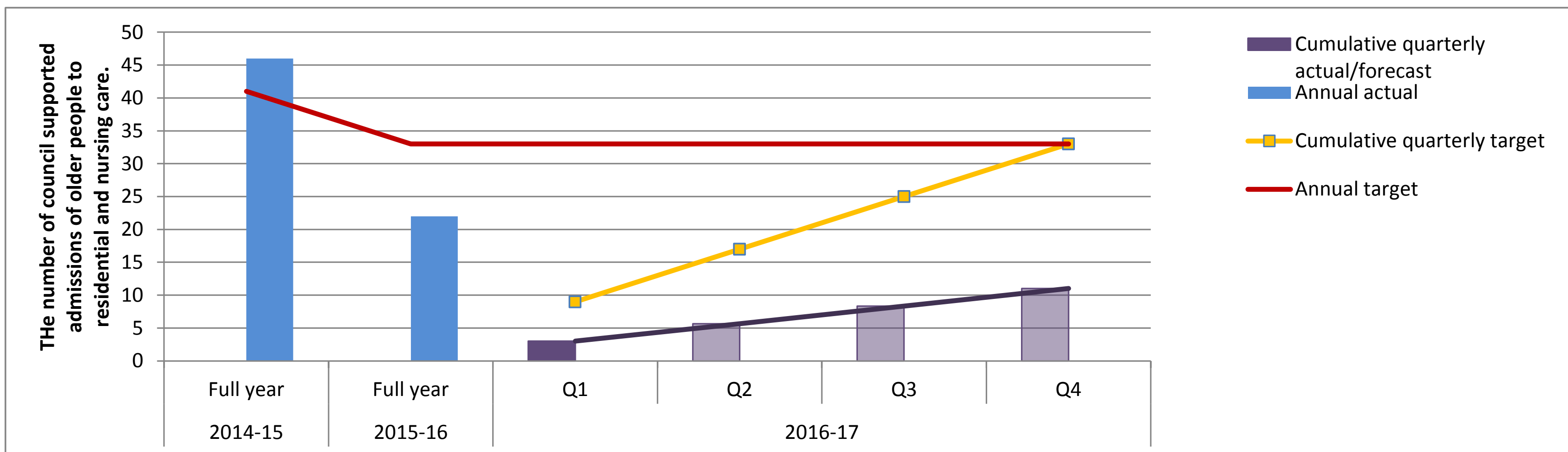
Metric 1 - Residential Admissions

GREEN: Well established good performance against this metric has continued into 2016-17, with just 3 people permanently entering residential or nursing care in Q1 (a third of the Q1 target of 9).

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.

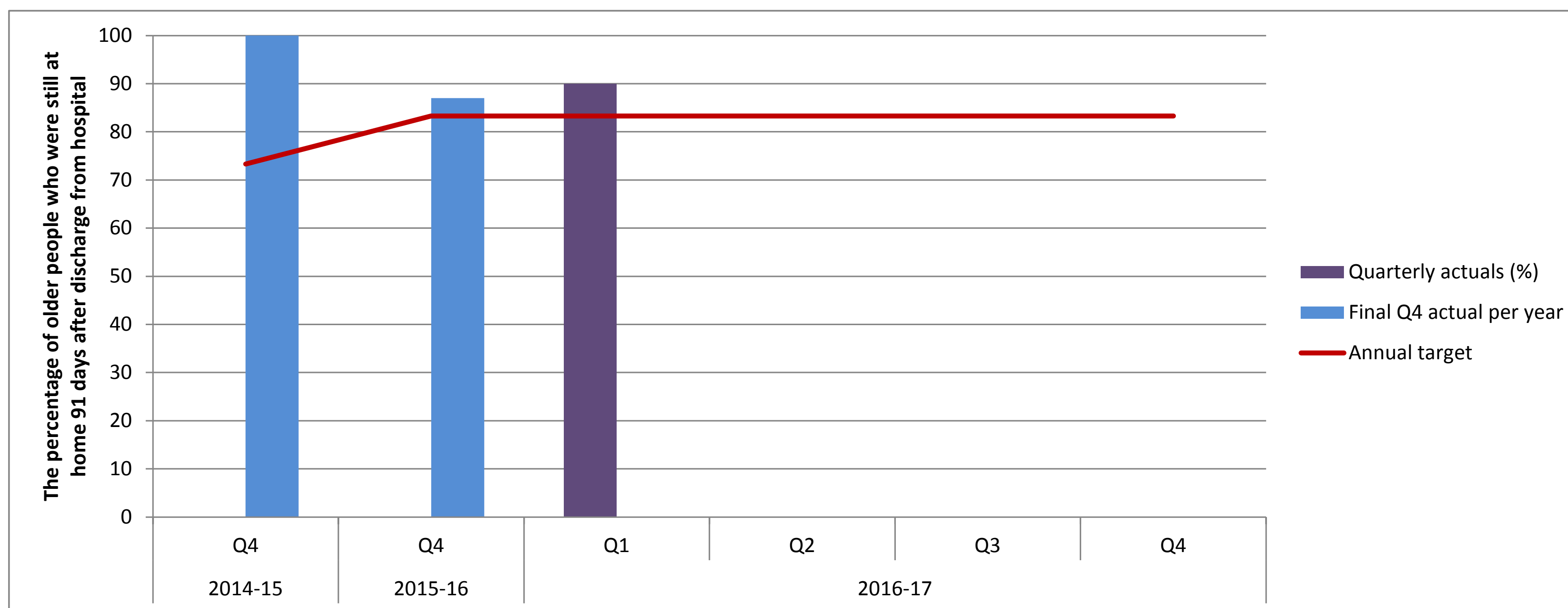
Definition:
The number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over).

Reporting Schedule:
Metric will be reported quarterly. Q2 update late October 2016.

Metric 2 - Reablement

GREEN: Following on from good performance in 2015-16, the pattern of people receiving reablement services and remaining at home 91 days after discharge remains above target, at 90% in Q1 of 2016-17, relative to a minimum target of 83.3%.
Formal final BCF reporting will be based on Q4 performance.

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:

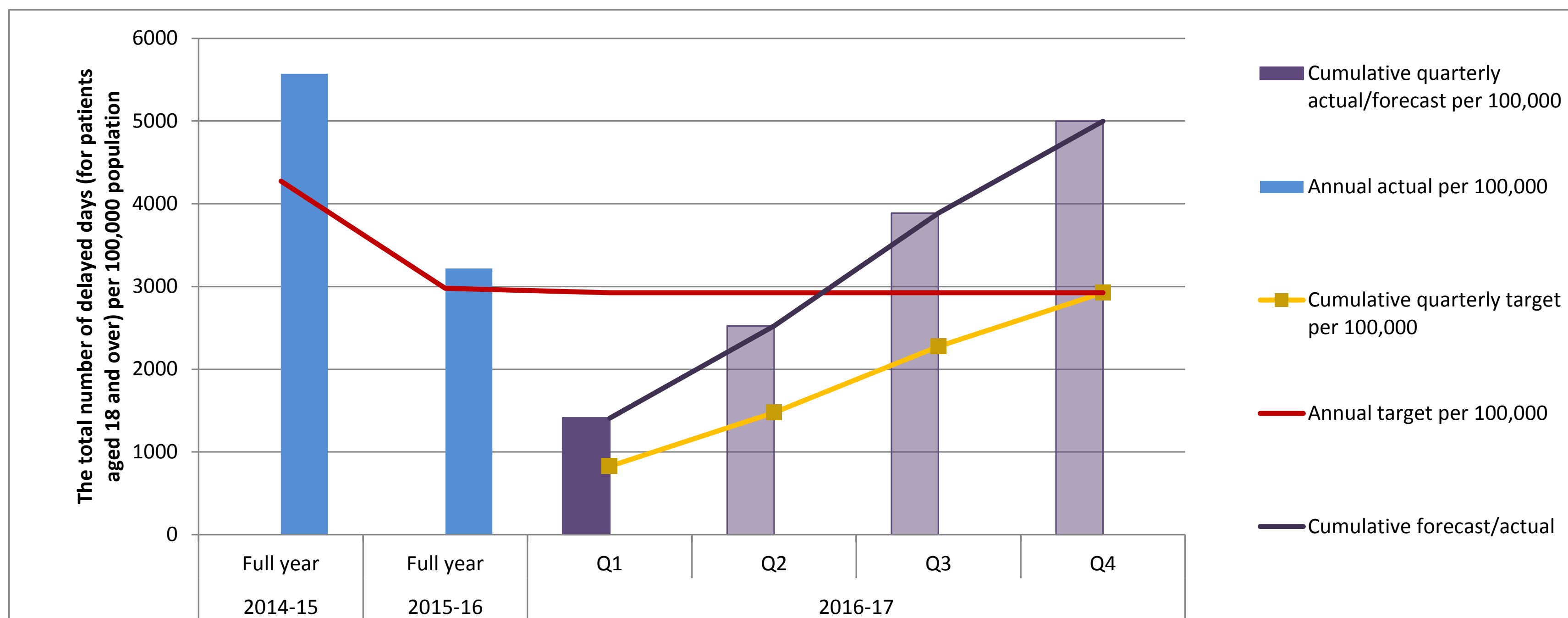
Formally, the metric is updated annually. The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital is collected **1st October to 31st December** for the relevant year. Same individuals are then checked 91 days later (i.e. January to March). Next formal update March 2017.

Local quarterly updates are calculated alongside this. Q2 update end of October 2016.

Metric 3 - Delayed Transfers of Care

AMBER: There were 1411 DTOC days per 100,000 18+ population in Q1, relative to a target of 826. Changes introduced in May which focussed on Peterborough hospital (a care coordination role and use of interim care home beds) are bearing fruit: DTOCs reduced markedly there in June to the lowest level for a year – 31 actual days in June relative to an average of 70 days for April and May. Social care attributable delays also remain negligible across the board (3 actual days in Q1). However, very good progress in some areas is being cancelled out by a diversification in the source of delays: LPT delays doubled between Q4 of 2015-16 and Q1 of 2016-17 from 77 to 158 actual days, in part due to mental health related discharge delays, while mainly NHS attributable delays at other out of area hospitals (in Lincolnshire and Northamptonshire) went up by 77% in the same period (from 44 to 78 actual days). These patterns, shown in the recently released June data, are currently being investigated further, with information flows being improved across an enlarged network of hospitals to ensure more timely sight of future potential delays.
Update Just released July DTOC data, the first of Q2, has shown a net improvement against previous months in 2016-17.

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.

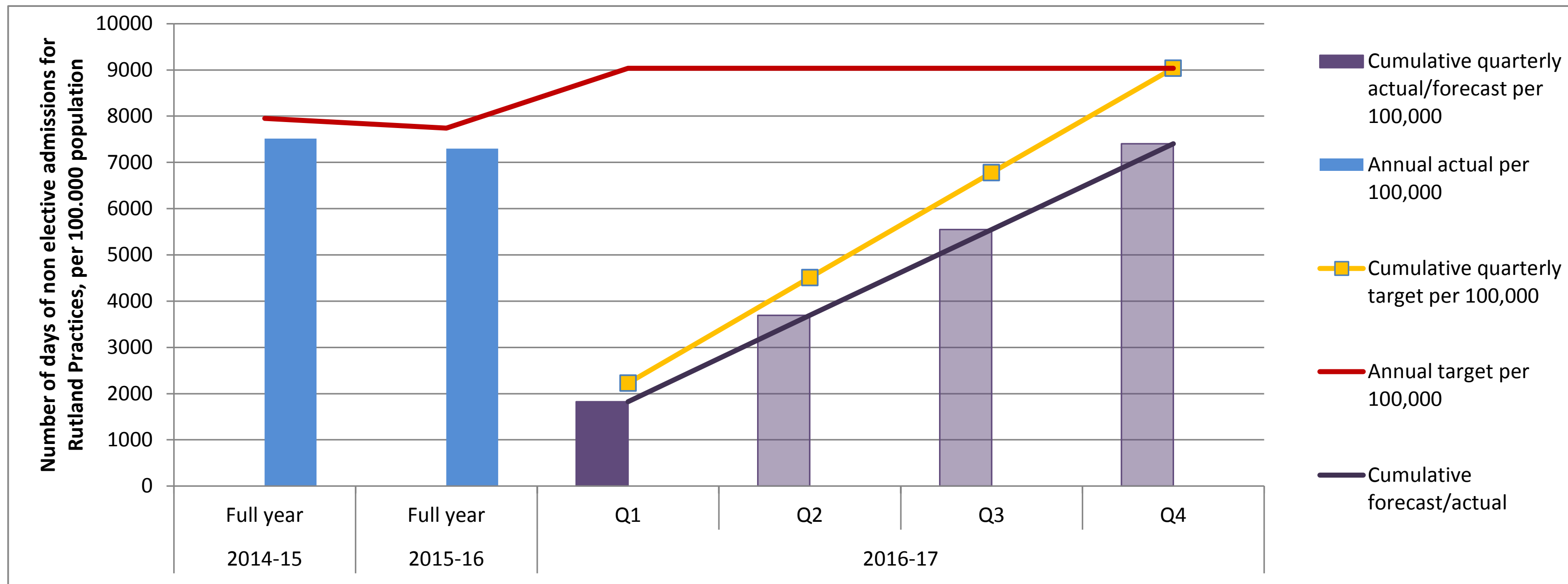
Definition:
Delayed transfer of care per 100,000 population per month.

Reporting Schedule:
Next quarterly update released November 2016.

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

GREEN: Rutland met its pay for performance targets for non-elective admissions (NEAs) last year and positive performance has continued into Q1 of 2016-17, when Rutland had 1823 days of emergency admissions per 100,000 population over 18, relative to a target for the first quarter of 2226 days.

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.

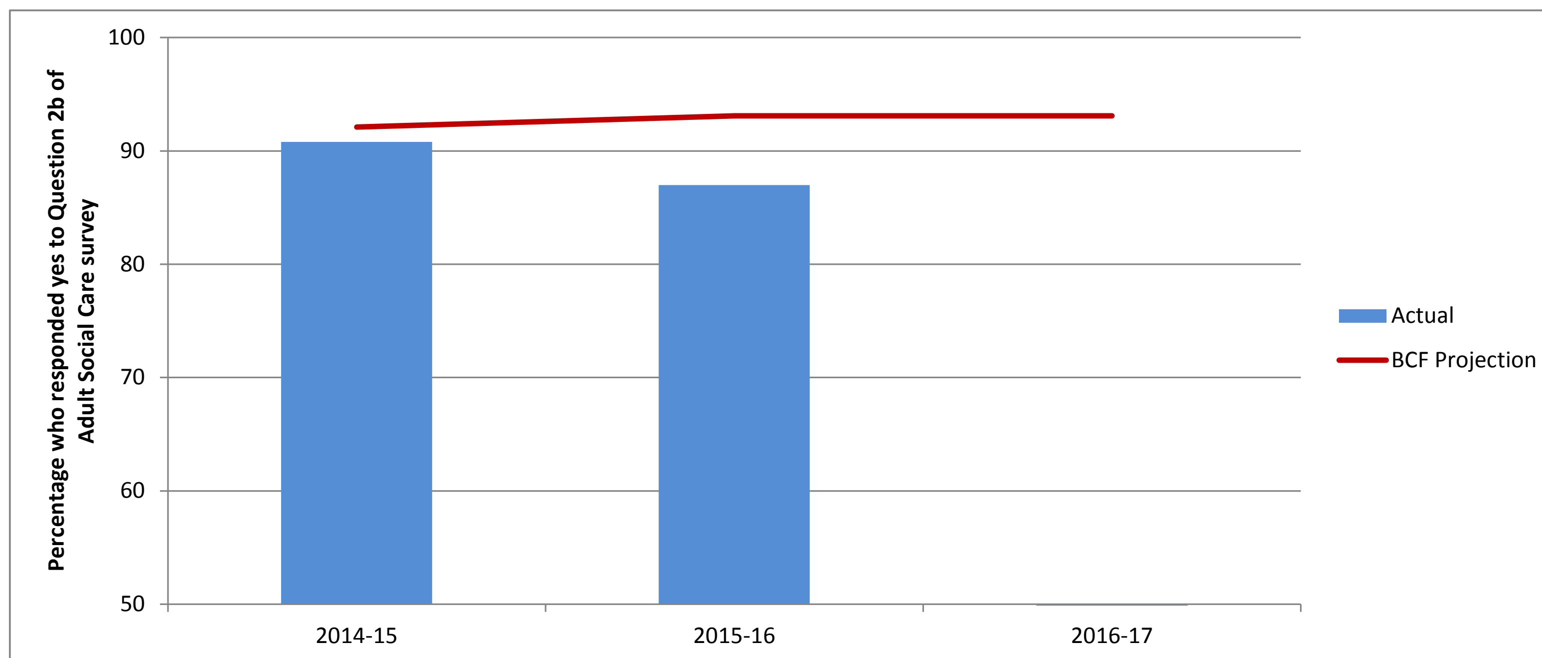
Reporting Schedule:

Updated quarterly from non elective admission statistics for Rutland practices supplied by GEM CSU (Greater East Midlands Commissioning Support Unit). Next quarter available November 2016.

Metric 5 - Patient/Service User Experience

GREY: In 2015-16, although 87% of service users who answered the annual social care survey responded positively to the question "Do Care and Support Services help you to have a better quality of life?", this was relative to a target of 93.1%, which means that Rutland did not meet its target last year. To gain further insight into the customer experience, the Council will be looking at ways to learn more about user experience and user satisfaction across 2016-17, including under the Enablers priority.

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.

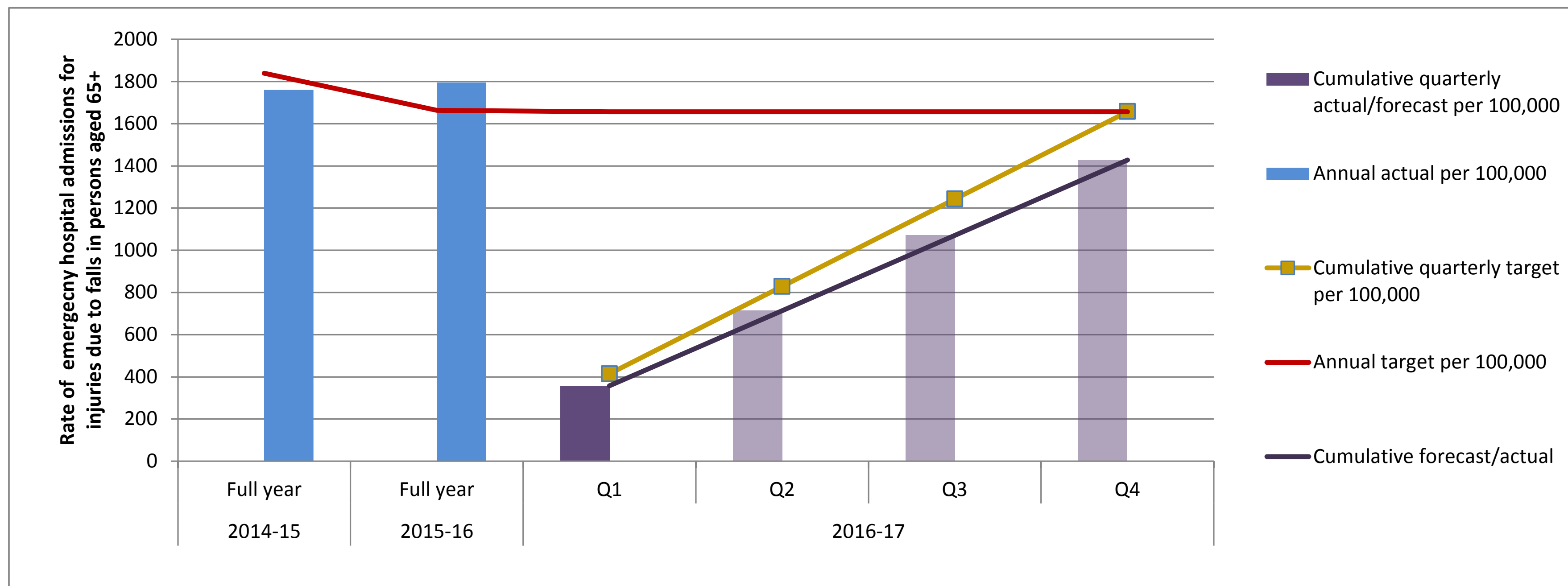
Definition:
Based on the percentage who responded yes to survey Adult Social Care survey question 2b. " Do Care and Support Services help you to have a better quality of life".

Reporting Schedule:
Data reported from annual Adult Social Care users survey. Next update will be March/April 2017.

Metric 6 - Local Metric - Over 65s Falls

GREEN: GEM CSU figures for 2015-16 indicate that last year's falls target was not met, although, without the programme, this level of falls would almost certainly have been higher. Falls prevention interventions were commissioned during 2015-16 following the Falls Summit, and are being progressed during the current programming period. Levels of falls are currently on track: the pro rata falls target per quarter is 414 falls per 100,000 over 65 population. This target was met in Q1 of 2016-17, with 357 falls admissions per 100,000 over 65s. However, given the high variability that characterises an area of small population, there is no case at this early stage in the year to assume that overall targets will be met and to reduce the focus on falls prevention interventions.

Rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population (annual targets/totals only shown)



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 GEM CSU data processed by Leicestershire County Council Public Health analysts.

Delayed Transfers of Care (DTOCs) involving Rutland Patients - Detailed view to July 2016