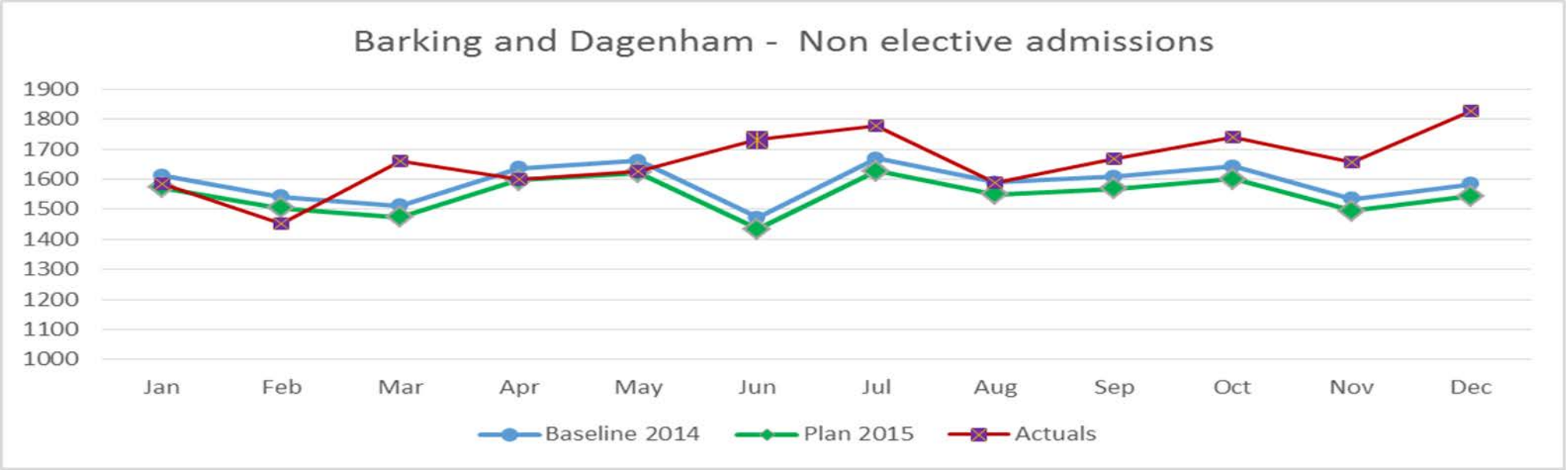
APPENDIX B

Barking & Dagenham LA & CCG Better Care Fund Metrics Report

1. Non-elective Admissions to Hospital (General & Acute) April 2015			Source: SUS DATA
Definition	The national definition is non-elective admissions general and acute into hospital of all ages in the borough. The aim being to reduce non-elective admissions which can be done by collaboration of health and social system.	**How this indicator works**	This indicator measures the total number of all non-elective admission (general & acute) of all ages in B&D.
What good looks like	Good performance is meeting the planned reduction actual monthly target with total annual reduction of **477**	**Why this indicator is important**	This indicator is a 'Payment for Performance' metric. This is monitored against a target reduction of 2.5% which has a financial implication if not achieved.
History with this indicator	Monthly Baseline figure in 2014 below indicate 1472 as lowest in June and highest in July - 1668	**Any issues to consider**	The Metric is monitored by Calendar year rather than Financial year. This indicator was reported on MAR data up until last month. NHSE has revised this and the metric will be reported based on SUS data . The data however includes children, Maternity and Hospital transfers where there were no schemes planned to reduce activity. BHRUT has identified the ambulatory care records and has flagged them.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Baseline 2014	1613	1543	1512	1638	1662	1472	1668	1589	1609	1643	1534	1583	19066
Planned reduction	40	39	38	41	42	37	42	40	40	41	38	40	477
Plan 2015	1573	1504	1474	1597	1621	1435	1627	1549	1569	1601	1496	1543	18589
Actuals	1586	1452	1660	1600	1627	1731	1778	1589	1667	1740	1655	1826	19911
% Planned reduction(from baseline)	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Variance from baseline	-27	-91	148	-38	-35	259	110	0	58	97	121	243	845
Variance from baseline %	-1.7%	-5.9%	9.8%	-2.3%	-2.1%	17.6%	6.6%	0.0%	3.6%	5.9%	7.9%	15.4%	4.4%
Variance from plan	13	-52	186	3	6	296	151	40	98	139	159	283	1321
Variance from plan %	0.8%	-3.5%	12.6%	0.2%	0.4%	20.6%	9.3%	2.6%	6.3%	8.7%	10.7%	18.3%	7.1%



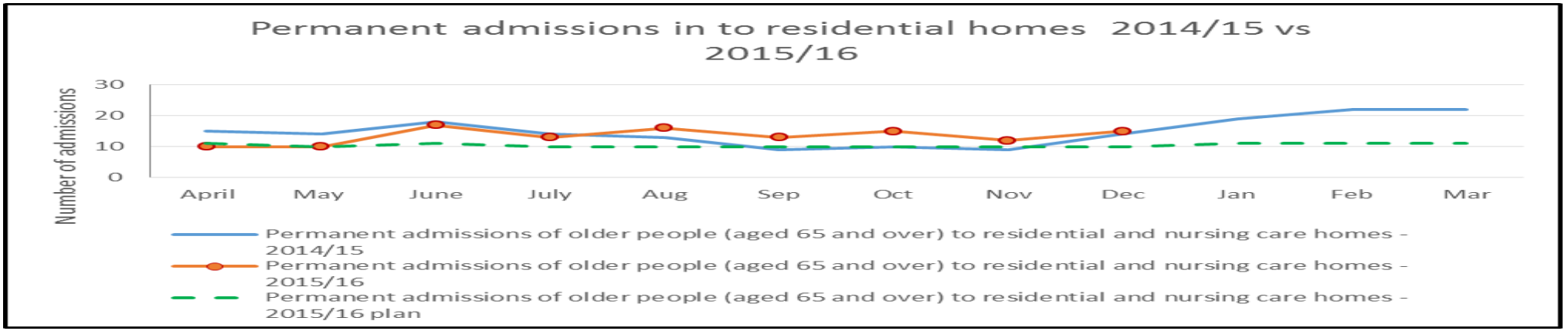
Performance Overview **RAG**	• Oct to Nov 2015 is the last quarter of the BCF 2015.Although October was slight higher than baseline and plan in November the performance was not far off from the baseline and plan. November was also one of the lowest overall number of admissions throughout the year. • There has been an increase in non-elective admissions in December when compared to previous months.	**Actions to sustain or improve performance**	This metric will not be monitored in 2016/17 by the BCF but will form part of the overall CCG performance monitoring which will bring in line with other strategies that are in place to impact on admissions.
Benchmarking	• Benchmarking information is the 2014 performance.		

2. Permanent admissions into residential /nursing placements for older people (65) April 2015

Source: Social Care

Definition	The national definition is admissions into care(residential/nursing) for older people 65+ in the borough. The aim being to reduce inappropriate admissions of older people (65+) into care.	**How this indicator works**	This indicator measures the total number of permanent admission into residential and care for older people 65+ in B&D. (ONS estimated population figure for 2015/16 is 19,669
What good looks like	BCF target is 125 admissions in total in 2015/16. The target for rate per 100,000 population is 635.5 for the year. Good performance would be under the annual target of 125 admissions or 635.5 rate per 100,000 population	**Why this indicator is important**	The number of permanent admissions to residential and nursing care homes is a good measure of the effectiveness of care and support in delaying dependency on care and support services, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions where appropriate. This includes placements made through the Older People Mental Health team.
History with this indicator	In 2014/15, there were 179 admissions against the plan of 130 admissions. 40 more admissions when compared against plan	**Any issues to consider**	Please note that admissions encompass both those agreed by the Councils Divisional Director (and delegates) and admissions outside of these such as those within Mental Health. Figures below are actual numbers of admissions and not rate per 100,000.

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Whole year
Admissions (65 and over)-2014/15	15	14	18	14	13	9	10	9	14	19	22	22	179
Admissions (65 and over) -2015/16	10	10	17	13	16	13	15	12	15				121
Admissions (65 and over) -2015/16 plan	11	10	11	10	10	10	10	10	10	11	11	11	125



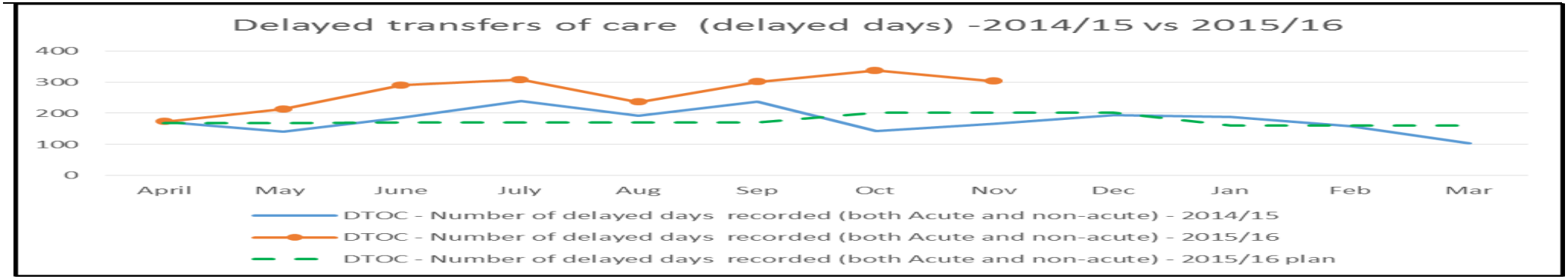
Performance Overview **RAG**	• Q3 Oct – Dec 2015 actual of 42 has overall been above plan and baseline. Plan was for 30admissions in a quarter which was 3 down from the baseline of 33admissions in 2014/15. • It has been note there has been increasing in people being admitted in care homes this year that in the past. • Our target was 125 for 2015/16 we currently expect performance to be much higher than this in the region of ?180 admissions. • Reviewing the last performance over the last 4year(11/12 – 200, 12/13 – 170, 13/14 – 135, 14/15 – 179) has been on average has been 171 admissions.	**Actions to sustain or improve performance**	A number of actions have been taken by Adult social care team to manage and monitor the number of admissions. A review of the target for 2016/17 needs to be based on the average 171 admissions per year than anything lower than 125.
Benchmarking	• Number of permanent admissions in 2014/15 was 179.		

3. DTOC – Total Delayed Days in the Month April 2015

Source: NHS England published

Definition	The national definition of a delayed transfer of care is when a patient is ready for transfer from acute care, but is still occupying an acute bed.	**How this indicator works**	This indicator measures the total number of delayed days recorded in the month regardless of the responsible organisation (social care/ NHS). The figures shown are number of delayed days (18+ population of **142,593 for first 3 Quarters and 145,357 for Q4**). (This is as per BCF submitted plan)
What good looks like	Good performance would be under 509 delayed days for Q1, under 513 delayed days for Q2, under 618 delayed days for Q3 and 491 delayed days for Q4.	**Why this indicator is important**	This indicator is important to measure as the average number of delayed days per month (per 100,000 pop) is included in the Better Care Fund performance monitoring.
History with this indicator	In 2014/15, Q1, Q3 and Q4 targets were met. In Q2, there were 669 delayed days reported against a plan of 504 days.	**Any issues to consider**	Please note that these figures are taken from the Department of Health website and have **not** been verified by Barking and Dagenham Social care, these figures will also include patients from Mental Health.

	Apr	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
DTOC - 2014/15	172	141	187	239	192	238	143	167	194	188	158	103
DTOC - 2015/16	173	213	290	308	236	301	337	303				
DTOC - 2015/16 plan	169	169	171	171	171	171	202	202	202	161	161	161



Performance Overview **RAG**	• Of the 303 delayed days in November, 138 delays are due to NHS, 157 delays are due to Social care and 8 are due to both Health and Social care. The main reasons for delayed days are due to public funding, assessment not being completed and awaiting nursing home placement or availability. • Most of the DTOC are inpatient mental health due to embargo.	**Actions to sustain or improve performance**	The causes are known and are being discussed at senior level. Once these are resolved performance will return to trajectory.
Benchmarking	The number of delayed days in November 2014/15 was 167.		

4. Proportion of older people 65+ still at home 91 days after discharge 2015

Source: Social Service

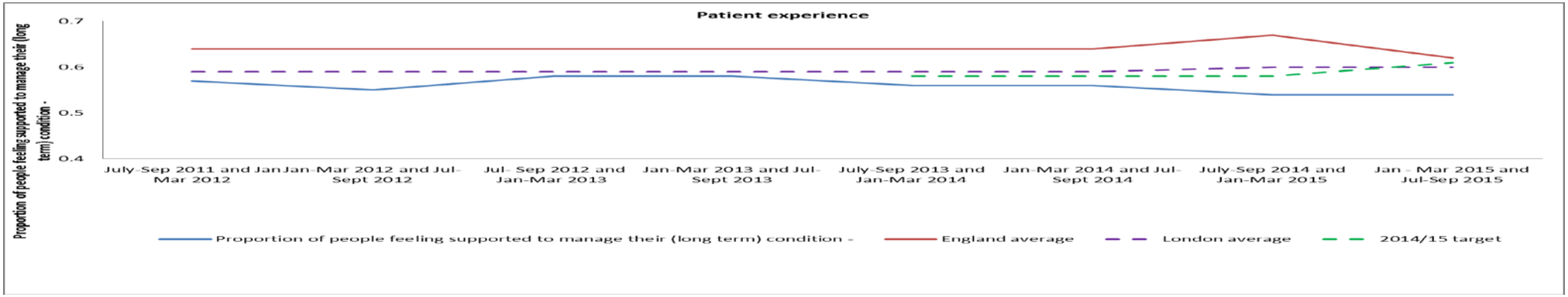
Definition	Older people still at home 91 days after discharge from hospital into reablement/rehabilitation services. The aim is to increase in effectiveness of reablement/rehabilitation services whilst ensuring those offered service does not decrease	**How this indicator works**	This indicator measures the total number of older people 65+ in B&D offered reablement services remaining at home 91 days after discharge. The figures shown below are. (ONS 12-13 estimate population of 198,409)
What good looks like	Increase in the number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital remaining in their homes 91 days after discharge. The target in 2014/15 – 89.3% . Target in 2015/16 – 90%	**Why this indicator is important**	This one of the metric for the BCF that LBBD & CCG have agreed to add to national metrics.
History with this indicator	In 2013/14 88.3 % of older people are reported to be still at home 91 days after discharge from hospital in to reablement/ rehabilitation services	**Any issues to consider**	This is an annual indicator there is no data to report on a monthly basis.

	Apr-15	May-15	June-15	July-15	Aug-15	Sept-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Reablement Metric	In 2014/15 , the proportion of people (65 and above) who were still at home, 91 days after discharge is 89.3%											

Performance Overview **RAG**	• The target for 2015/16 is 90%, the actual is 67.2% This is lower when compared to 88.3% in 2014/15 • Part of the review has shown there were significantly more deaths in 15/16 which explains why the figure dropped from 88.3% in 2013/14 to 67.2%	**Actions to sustain or improve performance**	We are reviewing our data collection methods to ensure its in line with other others and we are comparing unfavourable to similar boroughs.
Benchmarking			

5. Proportion of people feeling supported to manage their (long term) condition December 2014				**Source: GP Survey**
Definition	A proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition.	**How this indicator works**	The indicator is based on responses to questions in the GP Patient Survey which is as follows: **In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)?** Responses will be weighted according to the following 0-100 scale: "No" = 0 ,"Yes, to some extent" = 50 ,"Yes, definitely" = 100	
What good looks like	A greater proportion of people with long-term condition feeling supported to manage their condition. 2014/15 target is .58. The target for 2015/16 is .61	**Why this indicator is important**	This one of the metric for the BCF that LBBD & CCG have agreed to add to national metrics.	
History with this indicator	**0.56 –** based on the aggregated data collected from July-Sep 2013 and Jan- Mar 2014. In other words 56% of people(aged 18 and over)suffering from long-term condition felt supported to manage their condition	**Any issues to consider**	This publication uses aggregated data collected across two separate waves of fieldwork, from July –Sep 2014 and again from Jan-Mar 2015.	

	Q4 14/15	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**
Proportion of people feeling supported to manage their LTC	.54		.54	
Plan	.58		.61	



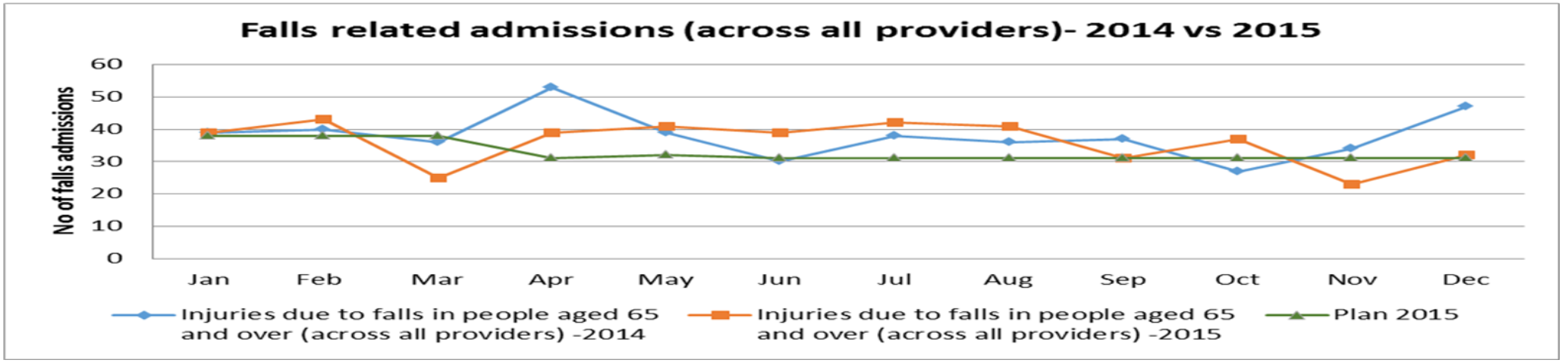
Performance Overview **RAG**	• As per the latest released data this metric has remained at .54% • The last data collection Jul-Sept 2015 which was published in December 2015 and has remained the same as in the previous collection of Jan-Mar 2015	**Actions to sustain or improve performance**	There is further work planned with local Patient Participation Groups and Health watch to understand patient experience.
Benchmarking	• England average is **.63** and London average is **.59**		

6. Injuries due to falls in people aged 65 April 2015

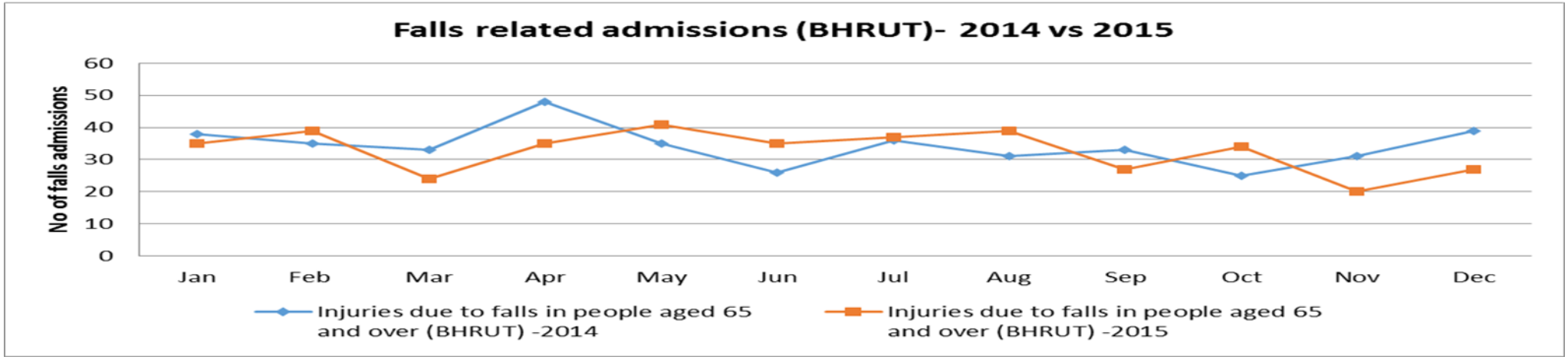
Source: SUS residence based data

Definition	Emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population	**How this indicator works**	This indicator measures the number of emergency admissions due to falls related injuries. (65+ population of **19,669**). (This is as per BCF submitted plan). Reduction of 394 admissions in 2015 Calendar year
What good looks like	A reduction in rate when compared to previous year will reflect the success of services in preventing falls which will give an indication of how the NHS, public health and social care are working together to tackle issues locally.	**Why this indicator is important**	This indicator is one of the metrics for BCF (local metric)
History with this indicator	The average admission rate for injuries due to falls across all providers for B&D resident population (per 100,000) in 2013/14 is 211.4 The average admission rate for injuries due to falls in BHRUT for B&D resident population (per 100,000) in 2013/14 is 198.1	**Any issues to consider**	**According to latest NHSE submission, this metric will be monitored on a calendar year (similar to Non-elective admissions) rather than the Financial year. The table below shows the actual number of admissions rather than the rate**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Falls admissions 65 and over (across all providers)- 2014	39	40	36	53	39	30	38	36	37	27	34	47
Falls admissions 65 and over (across all providers)-2015	39	43	25	39	41	39	42	41	31	37	23	32
2015 Plan	38	38	38	31	32	31	31	31	31	31	31	31



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Falls admissions 65 and over in BHRUT- 2014	38	35	33	48	35	26	36	31	33	25	31	39
Falls admissions 65 and over in BHRUT - 2015	35	39	24	35	41	35	37	39	27	34	20	27



Performance Overview **RAG (Q3 Position)**	• There is a reduction in Falls admissions in November 15/16 when compared to same period last year. • Q2 (July – Sep) 15/16 Plan (across all providers) is 93 where the actual is 114. This is 21 admissions more than what was planned for Q2. • Q3 (Oct-Dec) 15/16 Plan (across all Providers) is 93 whereas the actual is 92. • There has been an increase in the number of falls related admissions for over 85 age group in Q2 and Q3 . • 65-74 and 75-84 age group shows reduction in falls	**Actions to sustain or improve performance**	• Handyperson's service commenced in Nov, the referral criteria is being reviewed and would take into account the over 85 age group which have had significant number of admissions related to falls.
Benchmarking			