SCHEDULE 5(A)– PERFORMANCE ARRANGMENTS 2017/18

1. Introduction:

The Better Care Fund plan prided within schedule 6 establishes a range of performance measures which encompass both national conditions and local priorities. All parties recognise the need for a robust performance framework for delivery against the Better Care Fund Plan (BCF). The performance framework will ensure that parties have visibility and assurance relating to local progress in delivering iBCF priorities and the impact on national metrics and local Key Performance Indicators (KPIs). The framework will also provide assurance to any regional or national scrutiny.

Key outcomes for the BCF are:

- Reductions in emergency admissions (total non-elective admissions to hospital general and acute per 100,000 population) by 2.5 %
- Continued reduction of Delayed Transfers of Care against target trajectory as required by NHS England as part of our improved BCF plan submission
- Reduction in permanent admissions to permanent residential care
- Increasing the effectiveness of reablement services

Delayed Transfers of Care have, within the life of the iBCF, become an increasing priority nationally, with both a desired reduction in acute beds and specific attribution of delayed days and targets to the BCF partners.

It is recognised that whilst iBCF is a key system component it is not the only set of contributors to performance outcomes, which will be influenced, not least by other service activity, actions by partners and other factors. Within the iBCF Individual schemes will l have a differential impact upon the agreed targets and each scheme therefore establishes specific outcomes and KPIs against which progress will be considered. These are set out within the Better Care Fund plan submission.

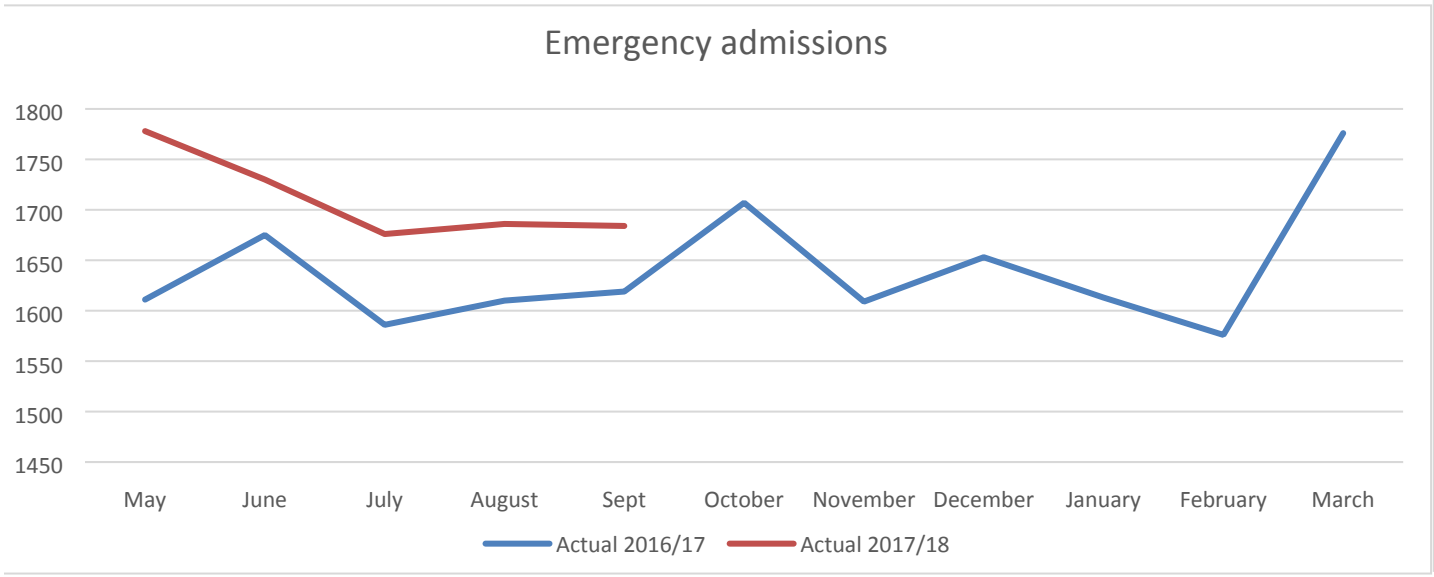
The JEMC will receive monthly reports setting out the progress made through our Better Care Fund in achieving the targets. Such progress is reported through the iBCF Dashboard a copy of which is provided below:

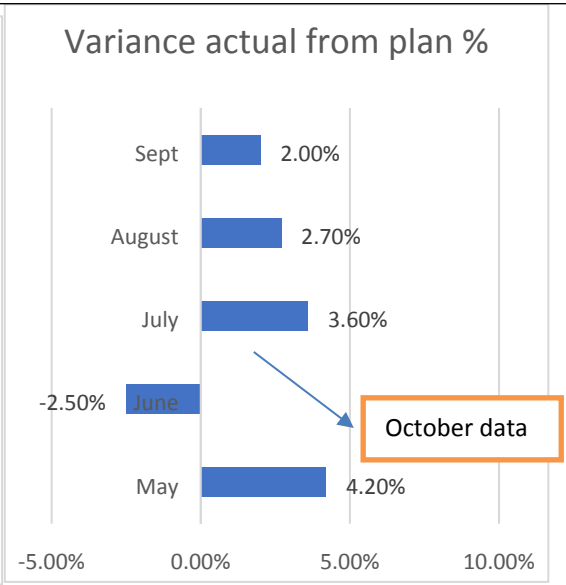
Sample iBCF dashboard:

Barking & Dagenham LA & CCG integration and Better Care Fund metrics report to the Joint Executive Management Committee

1. Emergency admissions to Hospital (General and Acute), all age per 100,000 population												Date : October 2017 Source:
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 sought 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. The figures shown below are per 100,000 resident population (ONS 12-13 estimate population of **198,409**)					
What good looks like	Good performance is meeting the plan metrics. Effective systems are deemed to be ones where there are a number of effective community based services which can provide an alternative solution, where appropriate, to acute admissions.					**Why this indicator is important**	This ids key performance metric for NHS England nationally and one which is a determinant of pressure upon costly acute services.					
History with this indicator	This indicator and its breadth (inclusion of all service user groups – incl maternity and children) has proved challenging. We have seen significant increases in presentations to hospital but which importantly haven't seen a pro rata translation into admissions.					**Any issues to consider**	Increased activity across the system as a whole. CCG are currently undertaking a management review of A & E attendances and this will be used to develop a demand management plan with GP Network.					

Emergency admissions (all ages) from SUS	**May**	**June**	**July**	**August**	**Sept**	**October**	**November**	**December**	**January**	**February**	**March**	**Grand Total**
Actual 2016/17	1611	1675	1586	1610	1619	1707	1609	1653	1613	1576	1776	19506
BCF OP Mapped(HWB)	1707	1775	1617	1641	1650	1724	1624	1669	1553	1517	1712	19746
Actual 2017/18	1778	1730	1676	1686	1684							10261
Actual 16/17 vs Actual 17/18	10.4%	3.3%	5.6%	4.7%	4.0%							7.2%
Variance Actual from plan	72	-45	59	44	33							313
Variance Actual from plan %	4.2%	-2.5%	3.6%	2.7%	2.0%							3.1%

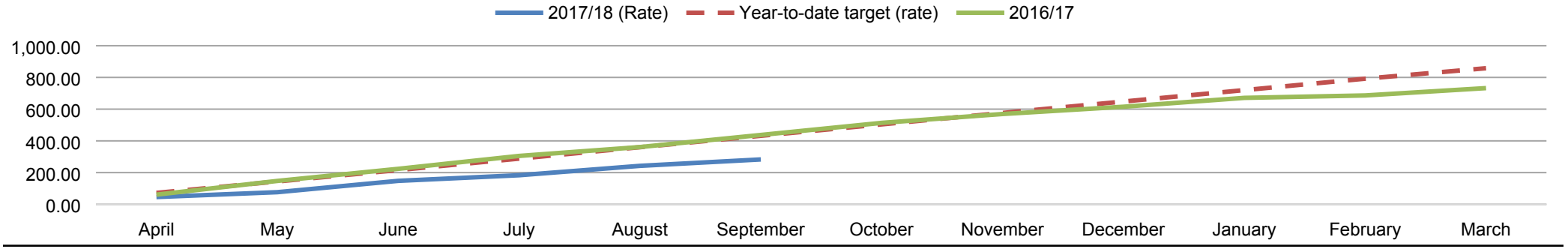




Performance Overview **RAG**		**Actions to sustain or improve performance**	Health and Social Care Service work with at risk of admission patient groups. Operational resilience plans
Benchmarking	• Benchmarking information will be made available in the future reports		

2. Permanent admissions into residential /nursing placements for older people (65+) per 100,000				Date: October 2017 Source: Adult Social Care
Definition	The national definition is admissions into care(residential/nursing) for older people 65+ in the borough. The aim is 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. The figures shown below are per 100,000 of all residents.	
What good looks like	Good performance is below the target of 170 admissions per year, equivalent to 858.89 per 100,000.	**Why this indicator is important**	This indicator is one of the national metrics and supports local health and social care services to work together to reduce avoidable admissions	
History with this indicator	There was a significant reduction in admissions during 2016-17, when the rate fell to 732.6 from 913.0.	**Any issues to consider**	Residents who fund their own care are excluded from the measure.	

Admissions per 100,000 older people	April	May	June	July	August	Sept	October	November	December	January	February	March
2016-17	61.01	147.44	223.70	305.05	360.97	437.24	513.50	569.42	615.18	671.11	686.36	732.60
2017-18	**45.90**	**76.51**	**147.91**	**183.28**	**242.51**	**282.93**						



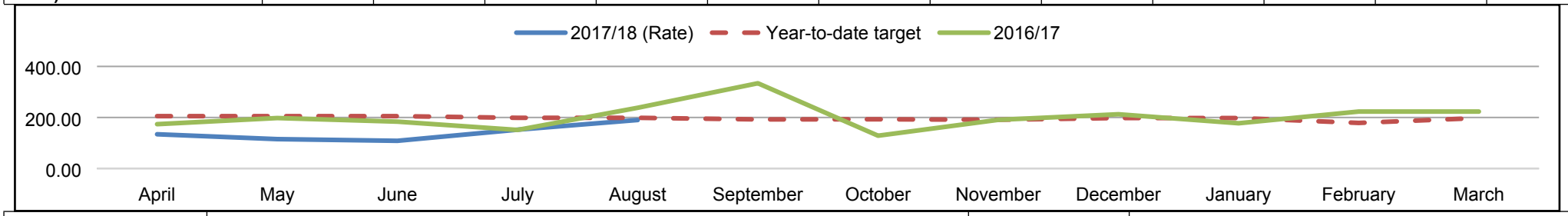
Performance Overview **RAG**	• Performance in the year to date is better than the target and is significantly lower than the same period last year. The long-term trend remains positive.	**Actions to sustain or improve performance**	Crisis Intervention and long-term community based care packages that enable people to remain in their homes.
Benchmarking	2016-17 • Adult Social Care Outcomes Framework comparator group average - 460.9 per 100,000 • London average - 438.1 per 100,000		

2. DTOC – Total Delayed Days in the Month (per 100,000 pop)

Date: October 2017
Source: NHS England

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 below are per 100,000 18+ residents. (18+ population of 144,677).
What good looks like	Good performance is below the monthly target.	**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	During 2016-17 the average number of delayed days per month was 202.7 per 100,000 people.	**Any issues to consider**	These figures are taken from NHS England and have not been

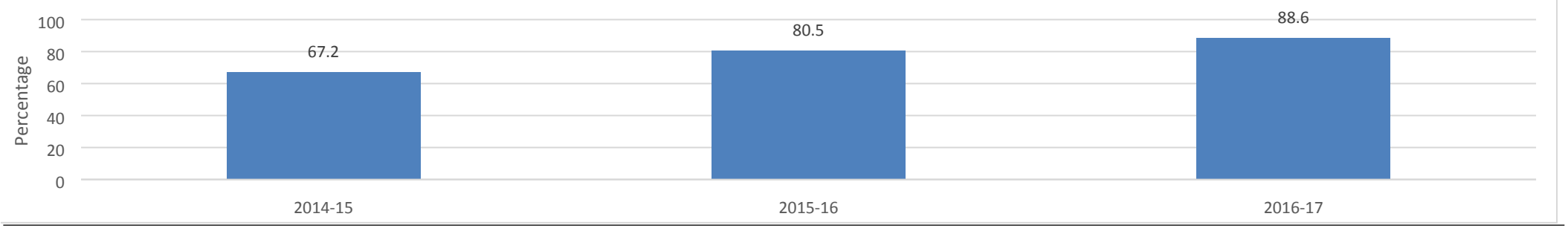
Delayed days (acute and non-acute)	**April**	**May**	**June**	**July**	**August**	**Sept**	**October**	**Nov**	**December**	**January**	**February**	**March**
2016-17	173.72	197.73	183.61	151.12	237.99	334.03	128.53	190.67	212.56	177.25	223.16	223.16
2017-18	**134.18**	**115.11**	**108.52**	**152.06**	**190.08**							
Target (those set by NHS England are shown in bold)	205.16	205.16	205.16	**198.62**	**198.62**	**192.35**	**192.88**	**190.97**	**197.72**	**197.72**	**178.60**	**197.72**



Performance Overview **RAG**	• In the year to date our delayed delays have been consistently within the targets set by NHS England. The metric continues to be rated green, however there are a few areas of focused work that are being under taken to improve delays attributed to some providers.	**Actions to sustain or improve performance**	• Daily bed monitoring and performance reporting • Improved communications with providers to facilitate safe and timely discharge
Benchmarking	Last year for performance.		

3. Proportion of older people 65+ still at home 91 days after discharge			Date: October 2017 Source: Adult Social Care
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 per 100,000. (ONS 2016 population estimate of 144,677)
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. A target of 85% has been set in order to ensure continued improvement in the metric.	**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	During the reporting period in 2015-16 60.5% of older people remained at home following their discharge from hospital	**Any issues to consider**	This is an annual indicator.

Year	**2014/15**	**2015/16**	**2016/17**
Outturn	67.2	80.5	88.6



Performance Overview **RAG**	• The metric's performance for 2016-17 exceeded the target of 85%. The indicator has improved significantly for the second year in a row.	**Actions to sustain or improve performance**	• To improve communications with patients and their families to manage expectations around discharge • Strengthening pathways out of hospital through Discharge 2 Assess
Benchmarking	2016-17 • Adult Social Care Outcomes Framework comparator group average - 87.3% • London average - 85.5%		

3. Process:

The BCF dashboard shall be reviewed by the nominated officer and officers of the CCG and the Council through the BCF delivery group (or alternative) who will ensure timely submission to the JEMC with any recommendations for consideration and actions on a monthly basis.