

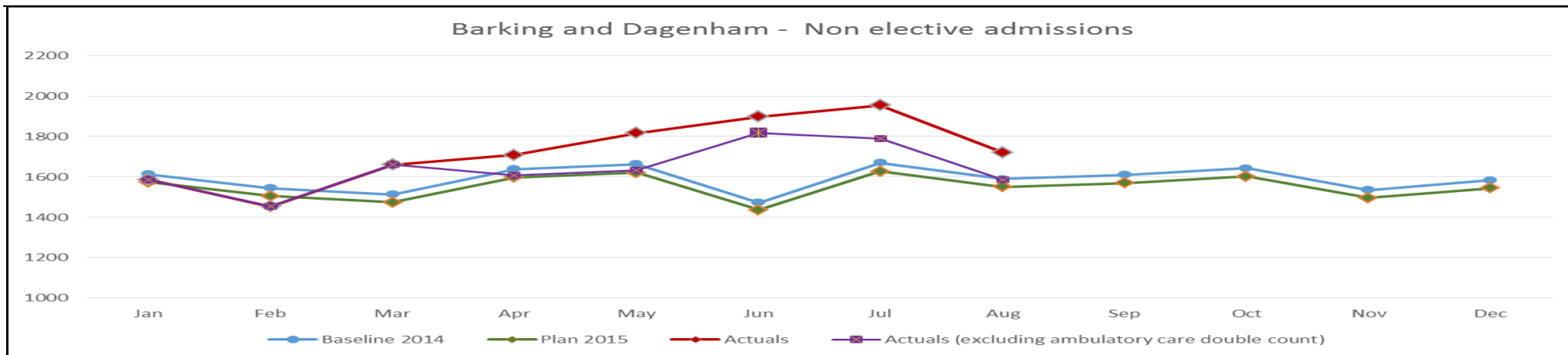
## Barking & Dagenham LA & CCG Better Care Fund Metrics Report

### 1. Non-elective Admissions to Hospital (General & Acute) April 2015

Source: SUS DATA

<b>Definition</b>	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.	<b>How this indicator works</b>	This indicator measures the total number of all non-elective admission (general & acute) of all ages in B&D.
<b>What good looks like</b>	Good performance is meeting the planned reduction actual monthly target with total annual reduction of <b>477</b>	<b>Why this indicator is important</b>	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.
<b>History with this indicator</b>	Monthly Baseline figure in 2014 below indicate 1472 as lowest in June and highest in July - 1668	<b>Any issues to consider</b>	<p>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.</p> <p>BHRUT has included the ambulatory care conditions under Non-elective admissions since April 2015. This has inflated the Non-elective admission numbers. This was raised in technical subgroup meeting and the trust was asked to resubmit the correct figures to SUS. Awaiting response from Trust</p>

	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	1708	1816	1898	1954	1721					13795
Actuals (excluding ambulatory care double count)	1586	1452	1660	1607	1633	1818	1789	1586					13131
% Planned reduction	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	70	154	426	286	132					1098
Variance from baseline %	-1.7%	-5.9%	9.8%	4.3%	9.2%	28.9%	17.1%	8.3%					8.6%
Variance from plan	13	-52	186	111	195	463	327	172					1415
Variance from plan %	0.8%	-3.5%	12.6%	7.0%	12.0%	32.2%	20.1%	11.1%					11.4%



<b>Performance Overview</b>	There has been a reduction in non-elective admissions in August when compared to June and July.	<b>Actions to sustain or improve performance</b>	
<b>RAG</b>			
<b>Benchmarking</b>	<ul style="list-style-type: none"> <li>Benchmarking information is the 2014 performance.</li> </ul>		

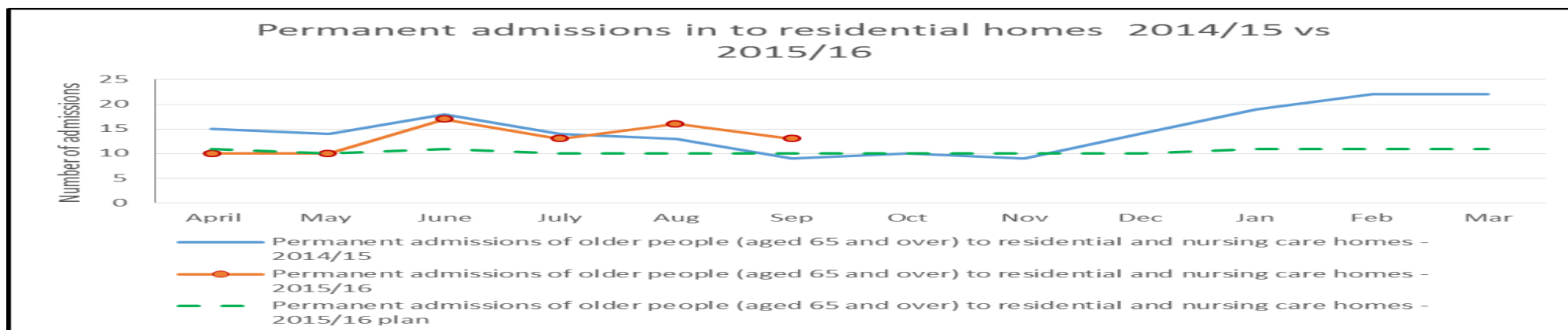
## 2. Permanent admissions into residential /nursing placements for older people (65) April 2015

Source: Social Care

<b>Definition</b>	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.	<b>How this indicator works</b>	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)
<b>What good looks like</b>	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	<b>Why this indicator is important</b>	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.

<b>History with this indicator</b>	In 2014/15, there were 179 admissions against the plan of 130 admissions. 40 more admissions when compared against plan	<b>Any issues to consider</b>	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.
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	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							79
Admissions (65 and over) -2015/16 plan	11	10	11	10	10	10	10	10	10	11	11	11	125



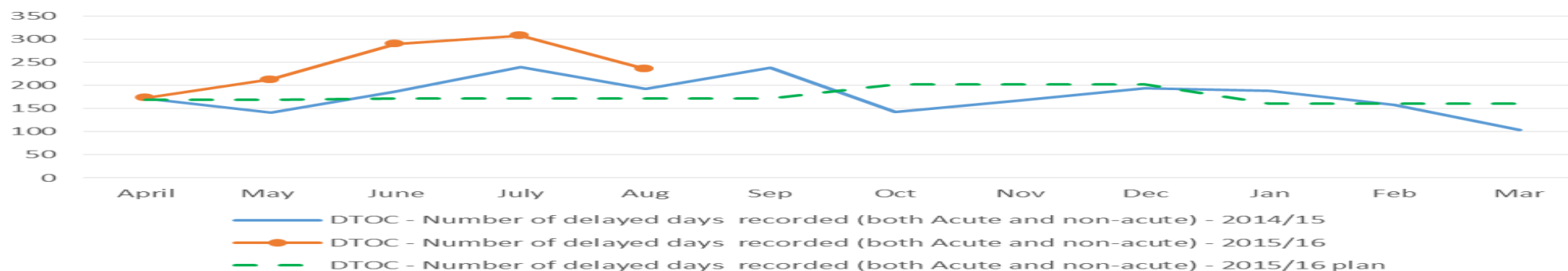
<b>Performance Overview</b>		<b>Actions to sustain or improve performance</b>	
<b>RAG</b>			
<b>Benchmarking</b>	<ul style="list-style-type: none"> <li>Number of permanent admissions in 2014/15 was 179.</li> </ul>		

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

Source: NHS England published

<b>Definition</b>	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.						<b>How this indicator works</b>	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 <b>142,593 for first 3 Quarters and 145,357 for Q4</b> ). (This is as per BCF submitted plan)					
<b>What good looks like</b>	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.						<b>Why this indicator is important</b>	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.					
<b>History with this indicator</b>	In 2014/15, Q1, Q3 and Q4 targets were met. In Q2, there were 669 delayed days reported against a plan of 504 days.						<b>Any issues to consider</b>	Please note that these figures are taken from the Department of Health website and have <b>not</b> been verified by Barking and Dagenham Social care, these figures will also include patients from Mental Health.					
	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>July</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	
DTOC - 2014/15	172	141	187	239	192	238	143	167	194	188	158	103	
DTOC - 2015/16	173	213	290	308	236								
DTOC - 2015/16 plan	169	169	171	171	171	171	202	202	202	161	161	161	

Delayed transfers of care (delayed days) -2014/15 vs 2015/16



<b>Performance Overview</b>	Of the 236 delayed days in August, 66 delays are due to NHS, 143 delays are due to Social care and 27 are due to both Health and social care. The main reasons for delayed days are due to public funding, patient or family choice and assessment not being completed	<b>Actions to sustain or improve performance</b>	
<b>RAG</b>			
<b>Benchmarking</b>	The number of delayed days in August 2014/15 was 192.		

4. Proportion of older people 65+ still at home 91 days after discharge 2015												
												Source: Social Service
<b>Definition</b>	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						<b>How this indicator works</b>	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 )				
<b>What good looks like</b>	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%						<b>Why this indicator is important</b>	This one of the metric for the BCF that LBBB & CCG have agreed to add to national metrics.				
<b>History with this indicator</b>	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						<b>Any issues to consider</b>	This is an annual indicator there is no data to report on a monthly basis.				
	<b>Apr-15</b>	<b>May-15</b>	<b>June-15</b>	<b>July-15</b>	<b>Aug-15</b>	<b>Sept-15</b>	<b>Oct-15</b>	<b>Nov-15</b>	<b>Dec-15</b>	<b>Jan-16</b>	<b>Feb-16</b>	<b>Mar-16</b>
<b>Reablement Metric</b>	In 2014/15 , the proportion of people (65 and above) who were still at home, 91 days after discharge is 67.2%											

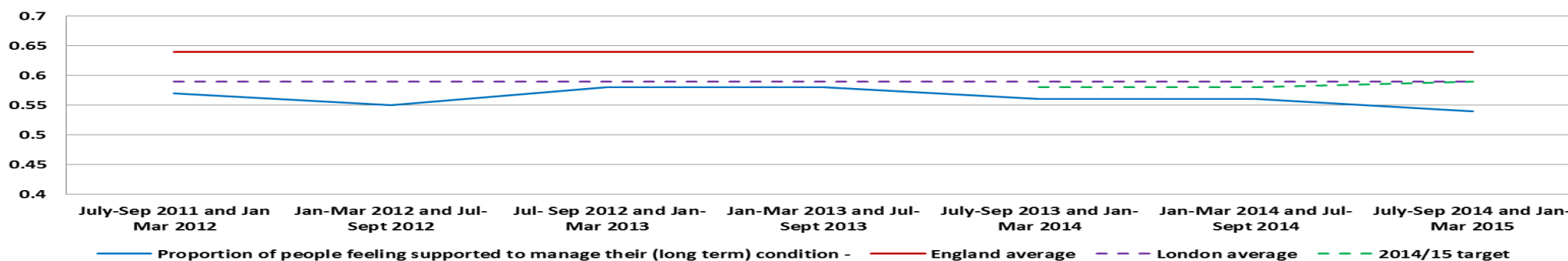
<b>Performance Overview</b>	<ul style="list-style-type: none"> <li>The target for 2014/15 is 89.3, the actual is 67.2 This is lower when compared to 88.3% in 2013/14</li> </ul>	<b>Actions to sustain or improve performance</b>	
<b>RAG</b>			
<b>Benchmarking</b>			

5. Proportion of people feeling supported to manage their (long term) condition December 2014

Source: GP Survey

<b>Definition</b>	A proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition.	<b>How this indicator works</b>	The indicator is based on responses to questions in the GP Patient Survey which is as follows: <b>In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)?</b> Responses will be weighted according to the following 0-100 scale: “No” = 0 , “Yes, to some extent” = 50 , “Yes, definitely” = 100	
<b>What good looks like</b>	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	<b>Why this indicator is important</b>	This one of the metric for the BCF that LBBD & CCG have agreed to add to national metrics.	
<b>History with this indicator</b>	<b>0.56</b> – 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	<b>Any issues to consider</b>	This publication uses aggregated data collected across two separate waves of fieldwork, from July –Sep 2014 and again from Jan-Mar 2015.	
	<b>Q4 14/15</b>	<b>Q1 15/16</b>	<b>Q2 15/16</b>	<b>Q3 15/16</b>
<b>Proportion of people feeling supported to manage their LTC</b>	.54			
<b>Plan</b>	.58		.61	

Patient experience



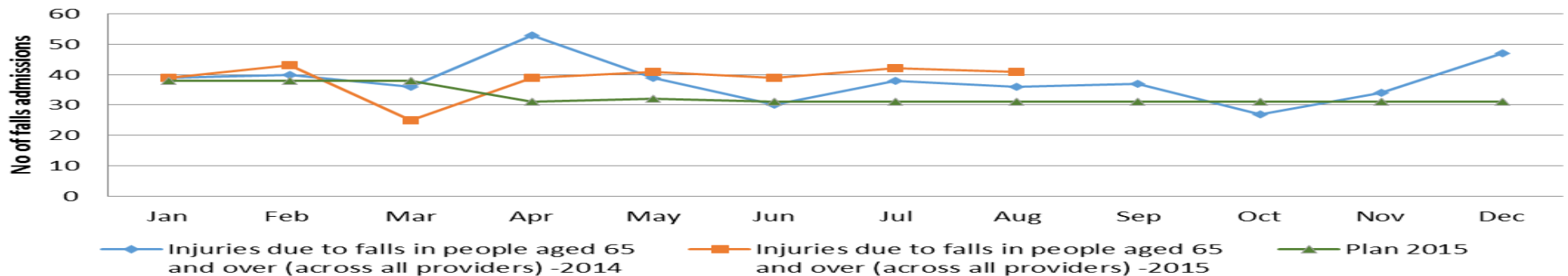
<b>Performance Overview</b>	<ul style="list-style-type: none"> <li>As per the latest released data this metric has fallen from 56% to 54%.</li> <li>The next data collection will be for July due to finish in September 2015 and will be published in December</li> </ul>	<b>Actions to sustain or improve performance</b>	<ul style="list-style-type: none"> <li>During the collection period there will be targeted work with PPGs to encourage.</li> </ul>
<b>RAG</b>			
<b>Benchmarking</b>	<ul style="list-style-type: none"> <li>England average is .64 and London average is .59</li> </ul>		

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

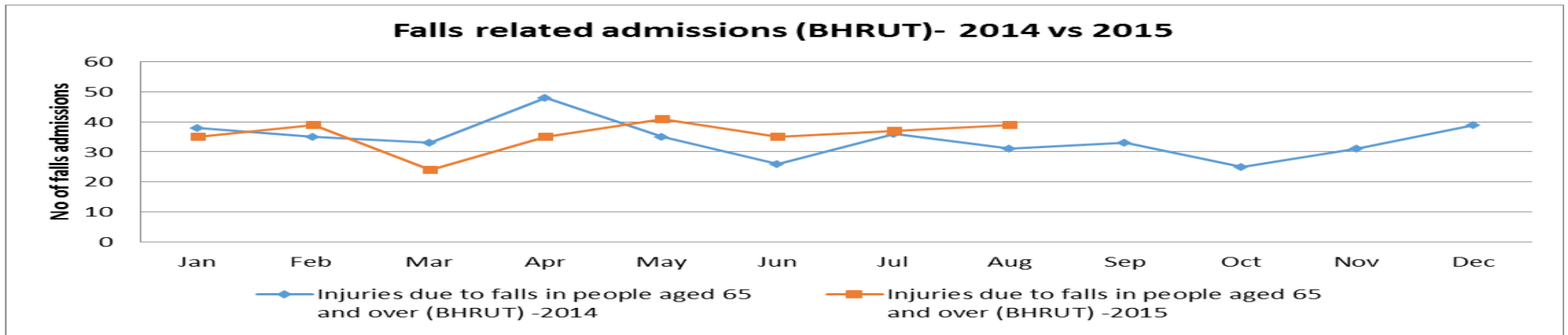
Source: SUS residence based data

<b>Definition</b>	Emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population						<b>How this indicator works</b>	This indicator measures the number of emergency admissions due to falls related injuries. (65+ population of <b>19,669</b> ). (This is as per BCF submitted plan). Reduction of 394 admissions in 2015 Calendar year					
<b>What good looks like</b>	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.						<b>Why this indicator is important</b>	This indicator is one of the metrics for BCF (local metric)					
<b>History with this indicator</b>	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						<b>Any issues to consider</b>	<b>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</b>					
	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	
<b>Falls admissions 65 and over (across all providers)- 2014</b>	39	40	36	53	39	30	38	36	37	27	34	47	
<b>Falls admissions 65 and over (across all providers)-2015</b>	39	43	25	39	41	39	42	41					
<b>2015 Plan</b>	38	38	38	31	32	31	31	31	31	31	31	31	

**Falls related admissions (across all providers)- 2014 vs 2015**



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Falls admissions 65 and over in BHRUT - 2014	39	40	36	53	39	30	38	36	37	27	34	47
Falls admissions 65 and over in BHRUT - 2015	39	43	25	35	39	35	37	39				



<b>Performance Overview</b>	<ul style="list-style-type: none"> <li>Falls admissions across all providers and BHRUT are on the rise when compared to same period last year</li> </ul>	<b>Actions to sustain or improve performance</b>	
<b>RAG</b>			
<b>Benchmarking</b>			