

Appendix four – Cheshire East Better Care Fund Year End Position (2017/18)* Cheshire East & Q4 performance

Outcome description	Baseline 2016/17	2017/18 Plan	2017/18 Performance				Outturn	Variance from Plan
			Q1	Q2	Q3	Q4		
Non-elective admissions	40,199	39,768	10,218	9,993	10,663	10,901 (forecast)	41,775 (forecast)	+ 2,007 (forecast)
Delayed transfers of care from hospital per day	58 (Mar 2017)	43 (Mar 2018)	47 (Jun 2017)	42 (Sep 2017)	26 (Dec 2017)	Data not yet available	Data not yet available	
Injuries due to falls, persons 65+								
People who feel supported managing long term conditions								
Admissions to residential and nursing homes 65+	610	616	Cumulative Admissions: 188 (Q1 - 188)	Cumulative Admissions: 355 (Q2 – 167)	Cumulative Admissions: 479 (Q3 – 124)	Data not yet available	Data not yet available	
Admissions to residential and nursing homes 65+ per 100,000 population	723	717	Cumulative Rate: 219	Cumulative Rate: 413	Cumulative Rate: 557	Data not yet available	Data not yet available	
Effectiveness of reablement (at home 91 days after discharge to reablement / rehabilitation **	82.3%	88.4%	82.0%	77.0%	72.3%	Data not yet available	Data not yet available	

* These are provisional figures and may change as final data returns are compiled. The population figure used to calculate the 2017/18 rate is based on ONS population projections.

** The figures up to Quarter 3 only include Intermediate Care and do not include reablement due to data not being available. Quarter 4 data, which is the period used for the BCF and national Adult Social Care Outcomes Framework (ASCOF) measure, will include the reablement element.

Cheshire East Better Care Fund Year End Position (2017/18)*

Eastern Cheshire CCG

Outcome description	Baseline 2016/17	2017/18 Plan	2017/18 Performance				Outturn	Variance from Plan
			Q1	Q2	Q3	Q4		
Non-elective admissions	17,602	-	4,480	4,297	4,604	Data not yet available	Data not yet available	-
Injuries due to falls, persons 65+								
People who feel supported managing long term conditions								
Admissions to residential and nursing homes 65+	292	-	Cumulative Admissions: 115 (Q1 - 115)	Cumulative Admissions: 187 (Q2 – 72)	Cumulative Admissions: 248 (Q3 – 61)	Data not yet available	Data not yet available	-
Admissions to residential and nursing homes 65+ per 100,000 population	622	-	Cumulative Rate: 240	Cumulative Rate: 391	Cumulative Rate: 518	Data not yet available	Data not yet available	-

* These are provisional figures and may change as final data returns are compiled. The population figure used to calculate the 2017/18 rate is based on ONS population projections.

Cheshire East Better Care Fund Year End Position (2017/18)*

South Cheshire CCG

Outcome description	Baseline 2016/17	2017/18 Plan	2017/18 Performance				Outturn	Variance from Plan
			Q1	Q2	Q3	Q4		
Non-elective admissions	22,597	-	5,738	5,696	6,059	Data not yet available	Data not yet available	-
Injuries due to falls, persons 65+								
People who feel supported managing long term conditions								
Admissions to residential and nursing homes 65+	318	-	Cumulative Admissions: 73 (Q1 - 73)	Cumulative Admissions: 168 (Q2 – 95)	Cumulative Admissions: 231 (Q3 – 63)	Data not yet available	Data not yet available	-
Admissions to residential and nursing homes 65+ per 100,000 population	851	-	Cumulative Rate: 192	Cumulative Rate: 442	Cumulative Rate: 607	Data not yet available	Data not yet available	-

* These are provisional figures and may change as final data returns are compiled. The population figure used to calculate the 2017/18 rate is based on ONS population projections.

Data descriptions

Non-elective admissions

- Description: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.
- Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.

- Rationale: Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
- Outcome sought: A reduction in the number of unplanned acute admissions to hospital.

Delayed transfers of care from hospital per day

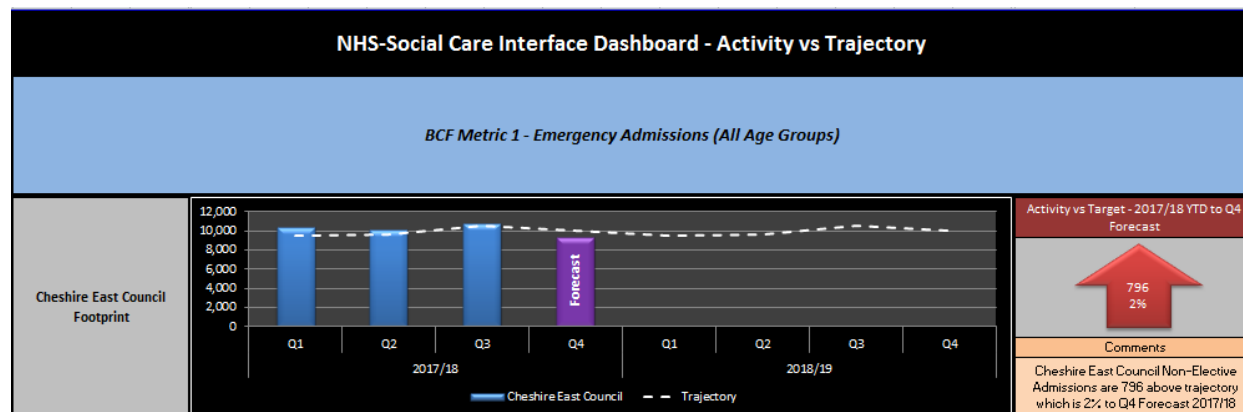
- Description: Delayed transfers of care from hospital per 100,000 population
- Data definition: Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)*
 - A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
 - A patient is ready for transfer when:
 - a clinical decision has been made that the patient is ready for transfer AND
 - a multi-disciplinary team decision has been made that the patient is ready for transfer AND
 - the patient is safe to discharge/transfer.
- 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 (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
- 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.

Admissions to residential and nursing homes 65+

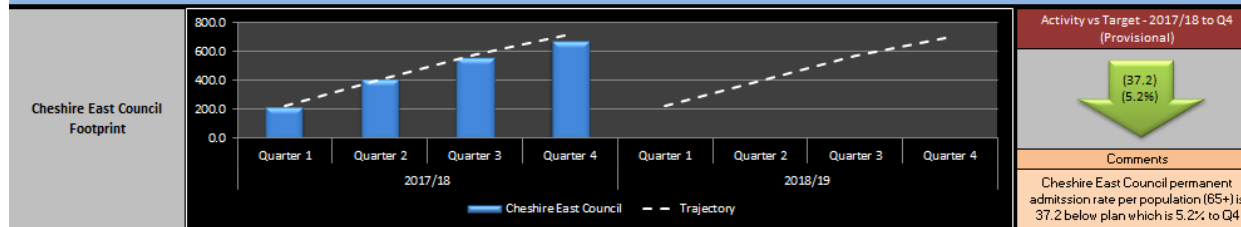
- Description: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
- Data definition: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
- Rationale: Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework 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. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
- Outcome sought: Reducing inappropriate admissions of older people (65+) in to residential care

Effectiveness of reablement (at home 91 days after discharge to reablement / rehabilitation)

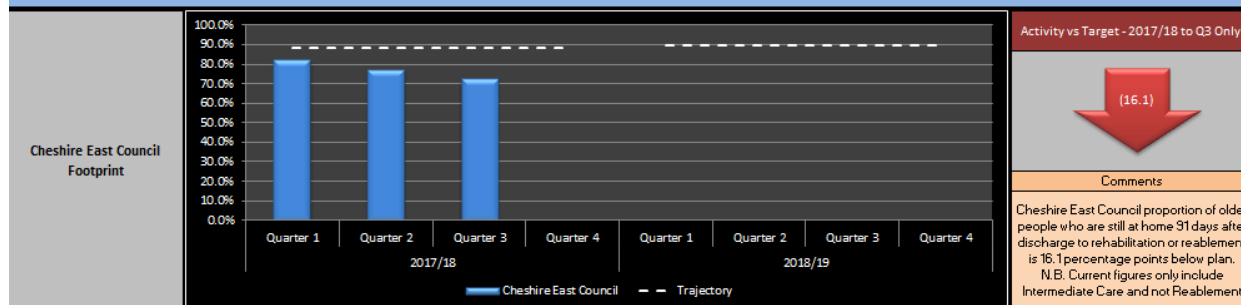
- Description: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Data definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
- 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.
- Outcome sought: Increase in effectiveness of these services whilst ensuring that those offered service does not decrease



BCF Metric 2 - Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (per 100,000)



BCF Metric 3 - Proportion of older people (65 and over) who are still at home 91 days after discharge



BCF Metric 4 - DTOCs

Delayed transfers of care - DTOCs per day

