HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8 JUNE 2016

REPORT OF THE CHIEF EXECUTIVE AND COMMISSIONING SUPPORT PERFORMANCE SERVICE

PERFORMANCE UPDATE AT END OF QUARTER 4 2015/16

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on health performance issues based on the available data at the end of quarter 4 of 2015/16.

Background

2. The Committee currently receives a joint report on performance from the County Council's Chief Executive's Department and the Arden/GEM Commissioning Support Performance Service. This particular report encompasses:

   a. Performance against key metrics and priorities set out in the Better Care Fund plan;
   b. An update on key provider performance issues and performance priorities; and
   c. An update on wider public health metrics and performance.

3. The Health Performance Framework and reporting will be refreshed from Autumn 2016 to reflect changes in national health performance reporting as well as new priority areas and metrics emerging from a refresh of the local Health and Wellbeing Strategy, which is underway.

Better Care Fund and Integration Projects

4. The following section of the report summarises final performance against the targets within the previous Better Care Fund (BCF) plan. See table below. Three of the targets have been achieved whilst three didn't achieve the level of improvement sought (though two did improve overall). An outline of some of the wider achievements and delivery from the first BCF Plan is set out in **Appendix 1**.

BCF Metric	Plan Target 2015/16	Actual 2015/16	Status
Metric 1 - permanent admissions of older people to residential and nursing care homes, per 100K pop per year	670.39	642	Achieved
Metric 2 - proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation	82.01%	87.50%	Achieved
Metric 3 - delayed transfers of care from hospital per 100K pop	275.60, 256.00, 350.79, 350.48 for Q1 - Q4 respectively	238.74, 233.81, 216.28, 314.98	Achieved
Metric 4 - total non-elective admissions into hospital per 100K pop, per month (2015)	717.44	738.07	Not achieved – see para 5-9
Metric 5 - patient/service user experience - patients satisfied with support to manage long term conditions	66.4%	61.6%	Not achieved - improvement on baseline of 60.9%
Metric 6 - emergency admissions for injuries due to falls people aged 65+, rate per 100K pop per month	140.47	147.34	Not achieved; improvement on 2014/15

5. In relation to **emergency admissions reduction** a number of schemes have been funded through the Better Care Fund plan to help reduce the increasing number of admissions. The schemes achieved 1,581 avoided admissions between 1st January 2015 and 31st December 2015, against a target of 2,041. The schemes involved are 7 day GP services, the Older Persons' Unit at Loughborough, Integrated Crisis Response Service and Loughborough Urgent Care Centre additional pathways.

6. Some of the progress on reducing emergency admissions from the previous BCF Plan activity includes -

- ✓ Implemented the frail older people's assessment unit at Loughborough Hospital with 540 people referred and 377 avoided admissions between January to December 2015.
- ✓ Trained 81% of paramedics in the falls risk assessment tool so that an average of 37% people per month are now not conveyed to hospital; but receive care and support at home instead.
- ✓ Implemented Night Nursing so that the existing Integrated Crisis Response Service can operate 24/7, with 470 referrals and 437 avoided admissions achieved in the Night Nursing Service during 2015.

- ✓ Piloted seven day services in primary care across both Clinical Commissioning Groups (CCGs) with evaluation findings informing models and admissions avoidance assumptions for 2016 onwards.

7. The Leicestershire BCF plan during 2015/16 had a strong focus on admissions avoidance, with the admission avoidance schemes implemented and performance managed intensively throughout the year. These schemes have had demonstrable impact, albeit the overall rise in emergency admissions across Leicester, Leicestershire and Rutland (LLR) has remained extremely challenging. Four BCF schemes were formally evaluated as part of the BCF refresh. Two new admissions avoidance schemes are also being incorporated within the 2016/17 plan. Driving down the number of admissions and readmissions continues to be an important feature of the approach.

8. It can be demonstrated that three of the four emergency admissions avoidance schemes in Leicestershire (GP seven day services pilots were the fourth) have delivered measurable impact in 2015/16 in terms of admissions avoidance in the BCF target cohort (older people). This is evidenced in falls non-conveyance figures for example, data from the new Care and Healthtrak system, clinical audit and independent academic evaluation outputs which support/triangulate these findings. A more rigorous implementation plan for falls prevention is being implemented in 2016/17 as part of a new LLR wide Falls Strategy.

9. Despite the schemes contributing to the achievement of reducing the increase in emergency admissions they have yet to achieve the full target trajectory. An action plan to address and improve the utilisation of the schemes continues and is being monitored by the Step Up/Step Down Programme Board in order to continually assess the confidence level of the schemes meeting the required targets.

10. In relation to **delayed transfers of care** included in the BCF is a metric relating to the number of *days* people are delayed in hospital awaiting discharge. The BCF had four quarterly targets for 2015/16, each of which has been met. Delayed Transfer of Care (DToCs) *attributable to adult social care* are calculated by taking an average of the number of delays on the last Thursday of each month. There has been significant improvement during 2015/16 such that the average of 5.6 is a marked improvement on 11.5 during the previous year.

11. Overall the number of days lost due to a delayed transfer of care has fallen during 2015/16 compared to the previous year. For NHS attributable delays the number of days has fallen by a third to 12,400. For adult social care attributable delays there has been a 44% reduction down to 1,800 days in 2015/16.

12. **Comparing performance in Leicestershire to other similar and regional authorities** - For this group of councils the average of all delays, regardless of who they were attributable to has remained similar to the previous year whilst the average for Leicestershire has reduced from 15.9 delays per 100K population in 14/15 to 9.0 delays in 2015/16. For the same group of authorities the average number of people delayed attributable to adult social care has increased from 2.9

per 100k in 2014/15 to 3.6 in 2015/16. In contrast during the same period Leicestershire's delays have dropped from 2.2 per 100k pop in 14/15 to 1.0 per 100k in 2015/16.

13. **Appendix 2** contains more information on the **new BCF Plan indicators and targets** applying from April 2016. Future reporting to the Committee will be against these new targets. These are all 2016/17 targets.

    1. Metric 1 – residential and nursing home admissions – 630.1 per 100k per year
    2. Metric 2 – reablement – 84.2% for each rolling 3 month period
    3. Metric 3 – DTOC quarterly targets - 238.03, 233.25, 215.90, 220.69 per 100k
    4. Metric 4 – non-elective admissions – 726.38 per 100K per month
    5. Metric 5 – patient experience – 63.5%
    6. Metric 6 – falls – 145.24 per 100K per month

Provider and CCG Dashboard - Appendix 3

14. Attached as Appendix 3 is a dashboard that summarises information on provider and CCG performance. The Everyone Counts Dashboard sets out the rights and pledges that patients are entitled to through the NHS. The indicators within the dashboard are reported at CCG level. Data reported at provider level does differ, and delivery actions indicate where this is a risk.

15. In March NHS England published a new **Improvement and Assessment Framework (IAF) for CCGs**. From 2016/17 this will replace the existing CCG Assurance Framework. The Framework includes a set of 57 indicators across 29 areas. In the Government's Mandate to NHS England the new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS. The IAF has been designed to supply indicators for adoption in Sustainability and Transformation Plans as markers of success. Future reports will look to include relevant indicators from the new Framework, taking into account contents of the local Sustainability and Transformation Plan and revised Health and Wellbeing Strategy. In the meantime the contents of this report are based on the performance framework in place for 2015/16.

University Hospitals of Leicester (UHL) Emergency Department (ED). Waiting Time < 4 Hours

16. Concerns about emergency care continue. UHL have seen a slight increase in performance in April 2016, although performance remains much worse than this time last year. Due to ward reconfiguration work, medicine has access to 28 fewer beds now at the LRI than the same time last year. UHL problems continue to be driven primarily by high attendance and admissions, although admissions in the first three weeks of this financial year are similar to last year. Key updates include that UHL have now recruited to the vacant Head of Nursing and Head of Operations posts in the Emergency Department (ED) and are trialling all ward admissions being reviewed by an ED senior decision maker or Acute Physician. The Clinical Management Group (CMG) is also increasing its management presence within ED to support and push performance improvements in May.

17. The following remain the three most important areas for the health system to focus on: Admission avoidance – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department. Preventative care – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs. Discharge processes across the whole system - ensuring there are simple discharge pathways with swift and efficient transfers of care.

Ambulance Response Times, Handovers between UHL ED and Ambulance and Ambulance Crew Clear

18. East Midlands Ambulance Service (EMAS) and UHL continue to have weekly conference calls to manage improvements in ambulance handovers. The team has continued to improve internal processes and an escalation process for patients on ambulances (POAs) has been introduced to support early decision making and management of flow, decreasing long waits for handover. The trial of using minors as majors to increase capacity by 9 cubicles in April made a significant difference to ambulance handovers and as such an expansion of the trial is being planned. Improvement is still required as UHL remains an outlier for long ambulance handovers, and as such this is a priority for the Group to improve.

Cancelled Operations - non re-admitted in 28 days

19. The availability of beds, particularly those in ITU, is monitored daily and interventions will be made where necessary. The planned opening of an additional 6 ITU beds at the LRI is anticipated by the end of April. Theatre Managers have increased theatre capacity for the increased cancer demand by making additional lists available. Theatre capacity planning for 2016/17 is well underway and incorporates the increased demand. The day ward has now been allocated exclusively for surgical patients in order to try to increase the elective throughput.

52 Week waiters at UHL. *(This relates to 227 Orthodontic patients (all CCGs), this service is commissioned by NHS England)*

20. With the Trust Development Authority and NHS England, UHL have identified treatment opportunities from across the regional health economy for the majority of the patients on the orthodontics waiting list and are in talks with two further providers, which would guarantee capacity for all patients to be treated in the East Midlands area either in a community provider or a secondary care trust. The service team are in the process of transferring patients to these providers, explaining the drop in reported numbers from the end of February (261).The Trust is reporting weekly to the Trust Development Authority.

Diagnostic Waiting Times < 6 weeks

21. Imaging-machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. Some extra sessions continue that run up to midnight. Endoscopy - twice-weekly phone calls are taking place between

the performance function and the Endoscopy service team to ensure momentum and help problem solving. While Imaging-machine stability capacity is now being scaled back, there will be 2 Medinet and one 'Your World' list in April to ensure that the capacity lost through the junior doctor strikes is accounted for. The extra capacity is complemented by a robust action plan addressing general performance issues in the service, with particular focus on ensuring that all lists are fully booked and efforts to improve cancer performance via access to Endoscopy tests.

Cancer

22. Current cancer performance is an area of concern across UHL and focus on recovery is one of the Trust's highest priorities. The weekly cancer action board chaired by the Director of Performance and Information, with mandatory attendance by all tumour site leads ensures that corrective actions are taken. The Trust has initiated a programme, 'Next Steps' for cancer patients in 3 key tumour sites. The pilot started in the Prostate pathway in early April.

Improved Access to Psychological Therapies

23. Performance in March has improved significantly with both CCGs falling just short of the national target of 15% (WL – 14.6% and ELR – 14%). Examples of actions to address performance include increasing the number of agency staff, introducing 2 evening assessment clinics run by staff on overtime, ensuring that all cancellations through the service are filled with assessments and one of the high intensity agency staff will be undertaking extra work to undertake an assessment clinic.

Unplanned Hospitalisation and Emergency admissions

24. In relation to West Leicestershire CCG examples of schemes aimed at reducing emergency admissions include weekly real time data review providing feedback to practices; on the day access schemes, acute visiting service (AVS), weekend Access Service: On Call GP/Emergency Care Practitioner (ECP) and care home weekend AVS. ELR actions are to include extended GP services, implementing the primary care weekend access scheme targeting 2% at risk/end of life/ moderate-frequent flyer patients; maximising appropriate use of increased specialist medical cover to allow increased referrals from GPs, Acute Visiting Service (AVS) and EMAS. Deploying LHIS support to access GP care plans for ED clinicians and upskilling ED ward clerks in accessing primary care information via LHIS.

Estimated diagnosis rate of people with dementia

25. In relation to West Leicestershire the March 16 dementia diagnosis rate figures shows the CCG has achieved 66.4% diagnosis rate narrowly missing the national 67% target by 25 patients. The CCG will be looking to continue the momentum in 2016/17 by running the Dementia Quality Toolkit in those practices with Care Homes. ELR are working with LPT to look at ELR waiting list times for the Memory Access Clinic. A full afternoon educational session focussed on GPs/Nurses/HCAs/Practice Managers and admin staff is being arranged for June

2016 to increase clinical knowledge and general awareness and understanding of dementia. The first BCT Dementia delivery group meeting took place on the 22nd of March with ELR Clinical Lead Dr Girish Purohit as Chair and Caroline Kirkpatrick (ELR) managerial lead.

Incidence of health associated infection CDIFF

26. As previously reported the maximum number of CDiff cases across West Leicestershire was exceeded in 2015/16 by 28 cases. Across ELR the national standard was exceeded by 1 case in 2015/16. The standard remains the same in 2016/17 for all CCGs and Providers. Work will continue to review cases to identify any common themes.

Public Health Outcomes Performance – Appendix 4

27. Appendix 4 sets out current performance against targets set in the current performance framework for public health. In February 2016 Public Health England published an update to the public health outcomes framework (PHOF). In terms of high level outcomes 14 indicators are presented and Leicestershire is better than the England average for six of these. No indicators perform significantly worse than the England average.

28. The PHOF also summarises a range of other performance indicators grouped under four domains. Overall Leicestershire performs well for a wide range of indicators (Better 96, Similar 52). However, there are a small number of areas where Leicestershire performs below average. These are summarised below for information:-
    - Wider Determinants of Health – school readiness, social isolation;
    - Health Improvement – newborn bloodspot screening coverage, NHS health checks take-up;
    - Health Protection – chlamydia detection, flu vaccination coverage;
    - Health Care – preventable sight loss, excess winter deaths - males aged 85+.

29. In relation to newborn bloodspot screening coverage the indicator measures the timeliness in getting results rather than actual coverage. Performance is dependent on the performance of relevant specialist centres rather than the County Council Public Health function. In relation to flu vaccination this is commissioned by Public Health England. However the public health team is working to improve the role of the Health Protection Board across the County in addressing these issues. The Council is also encouraging people to have seasonal flu vaccination, with free vaccines offered to those considered to be at risk. In relation to excess winter deaths the council is working closely with other agencies to provide advice and support to help people stay warm and healthy in the home. Also encouraging individuals and communities to play there part in checking on family, friends and neighbours and encouraging people to have seasonal flu vaccination. The Warm Homes, Healthy Homes scheme funded by the Council also offers advice.

30. A number of the PHOF indicators were updated in a data release in May 2016 and Appendix 4 summarises the latest position. A number of issues flagged

include take up of the NHS Health Check Programme, completions of drug treatment - non-opiate users, smoking quitters and mental health – excess mortality and suicide rates. In relation to drug treatment - for opiates the completion and non-representation in six months data for the latest quarter 3 is 8.5% which is in the top quartile though below the baseline period. 62.2% are estimated to be in treatment compared with 52% nationally. For non-opiate clients it is 36.2% for completion and non-representation, which is below the national average.

31. Further consideration will be given to actions to tackle these areas as part of the new Health and Wellbeing Strategy and public health service plan development process.

Recommendations

32. The Board is asked to:

a) note the performance summary and issues identified this quarter and actions planned in response to improve performance; and

b) comment on any recommendations or other issues with regard to the report.

List of Appendices

Appendix 1– Better Care Fund Track Record of Delivery

Appendix 2 – BCF – New Metrics and Targets 2016/17

Appendix 3 – Provider and CCG Dashboard

Appendix 4 – Public Heath Performance Dashboard.

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

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APPENDIX 1 - BCF TRACK RECORD OF DELIVERY IN 2015/16

Progress Achieved by the 2015/16 BCF Plan

The Leicestershire BCF Plan is delivered under four themes. The themes are designed to group together related activity/projects so that:

- These are managed and governed effectively within the local integration programme.
- Their contribution and outputs are connected effectively to LLR-wide governance, where applicable.

BCF THEME 1: Unified Prevention Offer	**BCF THEME 2: Long Term Conditions**
• Integration of prevention services in Leicestershire's communities into one consistent wrap-around offer for professionals and services users. • Improved, systematic, targeting, access and coordination of the offer.	• Integrated, proactive case management from multidisciplinary teams for those with complex conditions and/or the over 75s. • Integrated data sharing and records, for risk stratification, care planning and care coordination.
BCF THEME 3: Integrated Urgent Response	**BCF THEME 4: Hospital Discharge and Reablement**
• Integrated, rapid response community and primary care services 24/7 • Working together to avoid unnecessary hospital admissions, supporting people at home wherever possible.	• Safe, timely and effective discharge from hospital, via consistent pathways, reducing length of stay • "Home First" philosophy, focused on reablement and maintaining independence.

Progress by Theme

Implementation of the integration programme in Leicestershire continues at pace. The following table is a summary of our achievements to date:

Unified Prevention Offer ✓ Launched Local Area Coordinators in eight localities to support vulnerable people and extend the availability and uptake of our community based assets. ✓ Implemented the Lightbulb Housing Offer with pilots operating across three localities targeted to improving health and wellbeing. ✓ Redesigning adaptation processes with district council partners and designing a new "housing MOT."	**Integrated, Proactive Care for those with Long Term Conditions** ✓ Rolled out integrated locality working between community nursing and social workers so that they jointly respond and manage their caseloads using shared operational practices and procedures – organised to support both planned care and urgent care cases in each locality. ✓ Adopted NHS number onto 94% of adult social care records.
Integrated Urgent Response ✓ Implemented the frail older people's assessment unit at Loughborough Hospital with 540 people referred and 377 avoided admissions between January to December 2015. ✓ Trained 81% of paramedics in the falls risk assessment tool so that an average of 37% people per month are now not conveyed to hospital; but receive care and support at home instead. ✓ Implemented Night Nursing so that our existing Integrated Crisis Response Service can operate 24/7, with 470 referrals and 437 avoided admissions achieved in the Night Nursing service during 2015. ✓ Piloted seven day services in primary care across both CCGs with evaluation findings informing models and admissions avoidance assumptions for 2016 onwards. ✓ Achieved 1,581 avoided admissions from the above schemes between 1st January 2015 and 31st December 2015, against a target of 2,041.	**Hospital Discharge and Reablement** ✓ High impact interventions prioritised for 2015/16 BCF funding for improving DTOC, which ensured we achieved the DTOC target in Q1 (for the first time since 2011) and sustained good performance throughout 2015/16. ✓ Introduced dedicated housing support to acute and mental health inpatient settings to support hospital discharge, (featured in the HSJ in October). ✓ Redesigned domiciliary care service resulting in business case and joint specification for NHS and LA partners to commission a new service with effect from 2016/17.

Progress with BCF Enablers in 2015

Progress with BCF Enablers in 2015
• Implemented Care and Healthtrak – the new data integration tool for LLR. Care and Healthtrak is now a business as usual tool for measuring the impact of Better Care Together and BCF/integration developments in LLR. • Introduced the safe minimum transfer data set for hospital discharge. • Individual trajectories developed for each of the emergency admissions avoidance schemes with ongoing performance management. • Evaluated the emergency admissions avoidance schemes in conjunction with Loughborough University, Healthwatch Leicestershire and SIMUL8 to inform commissioning intentions for 2016, and with a view to publishing and disseminating our findings and methodology regionally and nationally in 2016. • Emma's story animation published (https://youtu.be/AU8CK-LT3dU) highlighting the approach to emergency admissions avoidance in Leicestershire, featured in the national Better Care Exchange Bulletin. • Social isolation campaign being launched in early 2016. • Integration Stakeholder Bulletins published quarterly featuring our progress and case studies (www.leics.gov.uk/healthwellbeingboardnews#hcibulletins). • Work of the Integration Programme promoted via @leicshwb twitter feed.

Appendix 2 - Better Care Fund Metrics – Targets for 2016/17

The following table explains the definition of each metric, and the rate of improvement we are aiming for in each case.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target for 2016/17 has been set at 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0%. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16 this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of 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. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 238.0, 233.3, 215.9, 220.7 for quarters 1 to 4 of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the

		results reflected in the development of a trajectory of 1,517 avoided admissions from these schemes in 2016/17.

National Metric (5)	Definition	Trajectory of improvement
Improved Patient Experience	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health." The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	It is proposed that this target is set at 1742.9, based on holding the number of admissions for injuries due to falls steady for the 65-79 age group (a reduction in the rate per 100,000 from 678.9 to 664.0) while lowering the rate per 100,000 for the 80+ age group from 7,919.1 to 7,523.1 (this equates to 25 fewer admissions in the year despite the increase in population) The latest published data (2014/15) shows Leicestershire as having a directly standardised rate significantly better than the England average for the whole age 65+ cohort and for the separate 65-79 age group and the 80+ age group.

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