Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Hampshire County Council	Y		*7,942,000*	*7,942,000*
West Hampshire CCG	N	8,774,000	*29,845,000*	*29,845,000*
North Hampshrie CCG	N	3,588,000	*11,391,000*	*11,391,000*
South Eastern Hampshire CCG	N	3,483,000	*11,617,000*	*11,617,000*
Fareham & Gosport CCG	N	3,300,000	*10,876,000*	*10,876,000*
North East Hampshire & Farnham CCG	N	2,613,380	*9,005,150*	*9,086,000*
BCF Total		**21,758,380**	**80,676,150**	**80,757,000**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Service Integration		*21,758,380*				*21,758,380*			
Adult Services						*963,725*			
Community Enablement						*120,000*			
Day Care Services						*30,707*			
Welcome Home Support						*50,638*			
Palliative Care						*224,274*			
Dementia Advisors						*144,728*			
Dementia Days						*29,939*			
ICES						*1,839,189*			
Community Occupational Therapists	Southern Health NHSFT					*2,072,000*			
Community Phyios	Southern Health NHSFT					*2,537,000*			
Community Nursing	Southern Health NHSFT					*28,690,000*			
OPMH Community Teams	Southern Health NHSFT					*12,453,020*			
Disability Grant						*5,295,000*			
Social Care Capital Grant						*2,647,000*			
Further Service to be Identified						*1,820,550*			
Total		***21,758,380***	**-**	**-**	**-**	***80,676,150***	**-**	**-**	**-**

Association England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Our aims and allied outcomes will have a suite of metrics attached to them. Full details of the aims and outcomes are provided in the part 1 of this plan. These will be used locally for tracking progress. For the BCF performance related outcomes, details are below. We will be focussing on older people with long term conditions including people with dementia and carers in 2014/15-2015/16.

Outcome: Increased proportion of people with complex and long-term health and social care needs receiving planned and coordinated care in, or close to home

Metric 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population. This metric will enable us to measure our success at identifying those at risk of incurring high health and care costs, providing coordinated care to prevent people reaching crisis and our ability to provide 7 day, coordinated care to enable people to stay supported in their own homes for as long as possible, including timely discharge from hospital to prevent functional deterioration. Achieving success in this objective will also have financial benefits as overall costs to health and social care will be lower. Hampshire currently peforms well compared to the rates for England, the South-East and comparator local authorities on this metric (2012/13 data). We expect to see 93 fewer permanent admission to residential and nursing care homes in 2014/15. a statistically signficant improvement from the 2012/13 baseline. This will be measured using social care datasets and is available nationally.

Outcome: Improved independence and recovery for people with long-term health and care needs

Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services This metric will enable us to measure our success at providing timely, high quality reablement services, that are integrated with wider support services for people who have been admitted to hospital thus enabling people to stay at home for as long as possible. We expect to see an improvement of 2% in the proportion of people who are still at home 91 days after discharge. Hampshire is currently in the 3rd quartile of the CIPFA comparator local authorities, this target is near to the 2nd quartle mean (83.1%) and stastistically signficant at 85% level, therefore representing a realistic improvement. The smaller denominator reflects our plan to provide reablement prior to hospital admission. This metric will be measured using social care datasets and is available nationally.

Outcome: People have their health and care needs met seamlessly in the most appropriate setting **Metric 3:**

Delayed transfers of care from hospital per 100,000 population (average per month) This metric will enable us to track progress on improving the interface between acute and community health and social care organisations; and the improvements we have planned in step-down provision. Hospital discharge has been highlighted as an area for improvement by older people in Hampshire and delayed discharge alos has cost implications for services. Comparing the performance of Hampshire using the ASCOF metric, Hampshire performs better than the England and South-East averages and this peformance in statistically significant. In addition it is the 3rd best amongst its 15 comparator Local Authorities (2012/13 data). for the BCF we propose to maintain our current, high peformance.

Outcome: Increased proportion of people with complex and long-term health and social care needs receiving planned and coordinated care in, or close to home

Metric 4: Avoidable emergency admissions (composite measure): Emergency admissions can be clinically unecessary, destabilising for the patient and costly to the system. By providing coordinated care in the community we hope to reduce the likelihood of conditions esculating so patients require admission and improve our capacity to provide appropriate care out of the hospital setting. As this is a composite measure our plans for the first two years of the BCF will only have a direct impact on two of four elements. Hampshire is in the top quartile of performance nationally for the rate of unplanned hospital admission for chronic ambulatory sensitive conditions and for acute conditions that should not usually require hospitalisation (2012/13 data).

Outcome: Improve satisfaction with health and social care services.

Metric 5: TBC - national indicator. Whilst overall satisfaction with health and social care services is high, we know that some elements of our services can be improved, especially for people with complex health and social care needs. **Local measure**:

Metric 6 TBC. The planning guidance gives some options for local measures. Potential indicators are: social care related quality of life, proportion of adult social care users who have as much social contact as they like and injuries due to falls in people aged 50 and over. We will explore a number of other options for the local measure for example: Health related quality of life for people with long term conditions and emergency admissions in over 65 year age group for acute ACSC conditions

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We will use the national metric for patient experience.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The assurance process is the same for all the metrics. We are using five nationally defined metrics and one locally defined metric. The performance has been calculated by analysing (a) historic trends (b) statistical analysis (c) scope for improvement (d) performance related to comparator local authorities. The peformance plans have been approved by (a) Hampshire Health and Wellbeing Board and (b) the Governing Bodies of the five Hamsphire Clinical Commissioning Groups.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	648.9	N/A	612.7
	Numerator	1,670		1,577
	Denominator	257,370		257,370
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	81.3	N/A	83.3
	Numerator	925		700
	Denominator	1,135		840
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	164.3	164.3	164.3
	Numerator	2,315	2,315	2,315
	Denominator	1,408,725	1,408,725	1,408,725
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	DATA NOT AVAILABLE		
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		NATIONAL METRIC DATA TBC	N/A	
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

Metrics	Description	Availability/Validity/numbers etc	Cause and effect
2.1 Proportion of people feeilng supported to manage their (long term) condition	Data from GP Patient survey (2011/12 onwards) Response rate variable, weighted. Unit: CCG 2013/14 published Sept 14. Standardisation methodology is being revised (1).	HSCIC quality statement: https://indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Specification/CCG_2.2_I00782_Q_V1.pdf Available 3 months after completion 12mo fieldwork. Weighted data not aggregated to LA level.	Direct - SE and F&G - LTC target population. ITC in NH - most vunerable targetted not whole population with LTC, NEH & F element primary care improvement (elderly)
2.6i Estimated diagnosis rate for people with dementia	Data from QOF and estimates of prevalence. Numerator: Number diagnosed on GP register, denominatorThe Dementia UK report (2007) contains estimates of late onset dementia prevalence rates (ie how many people have dementia as a proportion of the population in that age band) by five year age bands from age 30 to 95+. These rates are available by gender and as a weighted average for all persons. Local data not currently available.	HSCIC quality statement https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_2.6.i_I00744_Q_V2.pdf. Data is not sufficiently robust at local level and DH are reviewing current estimates of dementia. May release data for the PHOF in the future	Not possible to calculate local baseline at the moment. May be feasible in 2014.
3.5 Proportion of people with fragility fractures recovering to their previous levles of mobility /walking ability at 30/120 days	Data not available. Under investigation to see if available locally.	Small numbers	Not feasible
1A Social care-related quality of life	This measure is calculated using a combination of responses to the Adult Social Care Survey, which asks how satisfied or dissatisfied users are with indicators of quality of life, such as personal cleanliness and safety.2012/13 denominator 1260	The social care-related quality of life measure tells us about outcomes for social care users but does not isolate the impact that care and support services have on those outcomes.	Indirect impact, though older users of social care are part of the targetted population groups
1H Proportion of adults in contact with secondary mental health services living independently with or without support	Collected annually (from quaterly returns), from Mental Health Minimum Data Set v4 (MHMDS) denominator - 2,650	Care planning meetings include assessments, formal reviews or other multi-disciplinary care planning meetings. Some people currently captured in this measure may be appropriate to exclude, for example those who are detained under the Mental Health Act for a significant portion of the year. The measure only includes those on the Care	This population group are to be included in the ITF from 2016/17
1.18i Proportion of adult social care users who have as much social contact as they would like	This indicator is presented as the percentage of respondents who answered A) to question 8a from the Adult Social Care Survey:	Measure of social isolation rather than health and care services per se.	Indirect impact
2.24i Injuries due to falls in people aged 65 and over	Numerator: Number of hospital admissions for falls classified by first diagnosis code (ICD10 primary diagnosis in the range S00 through T98X) and external cause (ICD10 code W00-W19) and with an emergency admission code in people aged 65 and over. Counted by first finished episode in the respective financial year, Denominator: Number of people aged 65 and over based on ONS mid-year population estimates		Older population, do not necessarily need integration to effect change, indirect impact

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213057/121109-Technical-Appendix.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261281/Handbook_of_definitions_v8_0__2_.pdf
http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-tech-guid.pdf

Aims	Program Objectives/outcomes	National metrics	Local metrics
Provide the right care in the right place at the right time	To increase the proportion of people benefitting from evidence based prevention and early intervention		Injuries due to falls in people aged 65 and over
	To increase the proportion of people with complex and long-term health and social care needs receiving planned and coordinated care in, or close to home	Admissions to residential and care homes Avoidable emergency admissions	Admissions for acute ASCS in over 65s.
	To ensure people have their health and care needs met seamlessly in the most appropriate setting	Delayed transfers of care	
Maximise health, wellbeing and quality of life	To improve the health related quality of life and wellbeing of people with long-term conditions		Health related quality of life for people with long-term conditions
	To maintain or improve independence and recovery for people with long-term health and care needs	Effectiveness of reablement	Social care-related quality of life
	To reduce the difference between those with the best and worst health		
Place the person at the centre of care	To empower key population groups to maximise their capabilities and to manage their health and wellbeing	Patient / service user experience	
	To increase the proportion of people with health and social care needs that have choice and control of their care		
	To improve satisfaction with health and social care services		

Goal	Program Objectives
Provide the right care in the right place at the right time	To increase the proportion of people benefitting from evidence based prevention and early intervention
	To increase the proportion of people with complex and long-term health and social care needs receiving planned and coordinated care in, or close to home
	To ensure people have their health and care needs met seamlessly in the most appropriate setting
Maximise health, wellbeing and quality of life	To improve the health related quality of life and wellbeing of people with long-term conditions
	To maintain or improve independence and recovery for people with long-term health and care needs
	To reduce the difference between those with the best and worst health
Place the person at the centre of care	To empower key population groups to maximise their capabilities and to manage their health and wellbeing
	To increase the proportion of people with health and social care needs that have choice and control of their care
	To improve satisfaction with health and social care services