Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

1. Reduce permanent care home admissions to 10.5 per week; or 546 in the year - a rate of 473. This would be the 17th lowest in the country last year based on last year's figures; lower than any point in the last 5 years and reflects a 17% increase on the expected 2014/15 value. This will be supported by additional investment in community based service and additional personalised home support.

2. Increase the number of older people supported to leave hospital with reablement to 500 between October and December. The current contract expects around 450 episodes. (3750 episodes; 50% from hospital for ¼ of a year). The present estimate for this year is 437 (all ages). 500 would imply 4000 episodes per year at current rate. It will be over 15% increase on this year. Increase the proportion of people still at home 90 days after leaving the service to 80%. This would place us close to the national average. So far this year at the point of leaving the service 18% of people have gone back into hospital; 3% of people have gone into a care home and 2% die. The clear issue is the level of people returning to hospital and reflects the levels of dependency people have when leaving hospital and the entrance criteria for the service. These measures will be supported by additional investment in rehabilitation and reablement and additional personalised home support.

3. The number of days people are delayed in hospital will drop by 37.5% from the baseline 15 months from April 2012. The increase in performance will be shared equally across all 3 responsiblities (NHS; Social Care and both) with an expectation across the 15 month performance period of 1458 days or less lost per month to NHS delays; 1064 to social care and 408 to both organisations. Many of the investments support improved patient flow including reducing hospital admissions by high intensity users; increased 7 day working including pick up for providers; improved information flows; improved co-ordination of shared care and increased market capacity and a consequent drop in the number of people delayed and the number of days lost to delayed patients

4. Avoidable emergency admissions: the aggregate measure includes emergency admissions for ambulatory care sensitive conditions, admissions for acute conditions not normally requiring hospitalisation, and two measures of preventable admissions for the under 19 years old.
i. Our integration and LTC Improvement Interventions will deliver integrated health and social care close to home for the elderly and those with LTCs and integrated physical and mental health care in year 1 of the plan
ii. Our primary care development programme will ensure we can deliver the evolution required in primary care to ensure general practice is contributing fully to this priority from the beginning of year 2.
iii. Our urgent and emergency care improvement intervention will remodel our emergency and sub-acute pathway so that it delivers :
☐ Primary care assessment at ED to improve referral straight to community based services
☐ A dedicated Clinical Decision Unit for Paediatrics, co-located with the Emergency Department at the JR
☐ Enhanced MIU provision
☐ Access to urgent ambulatory care pathways in the acute
☐ Roll out of Emergency multidisciplinary units to provide 1 stop shop alternatives to A&E for those needing a speedy assessment and same day package of community health and social care in order to remain at home.

5.Patient experience. Improving patient experience is a current health and wellbeing priority and is measured by 3 indicators on satisfaction with social care; hospital care and GP care. We will continue to use these measure until the new national metric is developed and will review the existing measure once the new metric is agreed

6. The local measure is to increase the proportion of older people with an on-going care package supported to live at home. This is monitored via reports to the Department of Health in the national RAP and ASC-CAR submission. The scheme will assist the delivery of this objective by increasing the numbers of people supported via home care (or direct payments) as an alternative to care homes

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.

Patient expericence is currently measured in the health and wellbeing strategy vis 3 separate national measures. These are:
Achieve above the national average of people very satisfied with the care and support they receive from adult social care (Health and Wellbeing Strategy indicator 7.3)

Achieve above the national average of people satisfied with their experience of hospital care (Health and Wellbeing Strategy indicator 7.4)

Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (Health and Wellbeing Strategy indicator 7.5)

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

Assurance of the performance plans for the Better Care Fund plan will be provided by the Older People's Joint Management Group, reporting to the Health and Wellbeing Board. The Older People's Joint Management Group meets in public bi-monthly, and has a key role contributing to the delivery of the priorities in the Joint Health and Wellbeing Strategy by monitoring and managing the implementation of the Joint Older People's Commissioning Strategy through the Older People's Pooled Budget, including performance indicators, activity and spending. It reports regularly and by exception to the Health and Wellbeing Board and Clinical Commissioning Group and County Council.

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

N/A

Outcomes and metrics

Please complete all pink cells:

Metrics		Baseline*	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*	534	N/A	473
	Numerator	582		546
	Denominator	109000		115000
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	13497.9	4896.4	3427.8
	Numerator	70324	25853	18099
	Denominator	521000	528000	528000
		Time period April 2012 to June 2013 15	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	1471.7	1334	
	Numerator	10181	9092	
	Denominator	691785	681559	
		(State time period and select no. of months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
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*			N/A	
		(State time period and select no. of months) 1		*(State time period and select no. of months)* 1
Local measure *Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home* *Numerator: Number of people receiving home care or an on-going direct payment from an older person's budget* *Numerator + people funded Number of people funded in a permanent care home place from a council budget*	*Metric Value*	60.0	61.9	62.4
	Numerator	2122	2301	2348
	Denominator	3537	3716	3763
		Snapshot figure for end of 2012/13 12	*Snapshot figure for end of 2014/15* 12	*Snapshot figure for end of Sept 2015* 6

* Baseline figures for the four national metrics figures are available on the NHS England BCF webpage (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/)