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)
Oxfordshire County Council - Adult Social Care Capital Grant and Disabled Facilities Grant	Y		*3,677,000*	
NHS Oxfordshire Clinical Commissioning Group	N		*33,120,000*	
NHS Swindon Clinical Commissioning Group	N		*356,000*	
NHS Aylesbury Vale Clinical Commissioning Group	N		*415,000*	
BCF Total			***37,568,000***	

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.

This will be managed through the joint management groups / use of the pooled budget, with reference back to appropriate risk share arrangements - currently these are proportionate to the level of funding contributed to the pool, with overspends / underspends being taken back to each organisation accordingly

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 (£'000)	Non-recurrent	Recurrent	Non-recurrent
Alert Service		300				300		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Long term Care Packages		4352				4352		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Equipment		750				750		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Crisis response		500				500		*Reduced emergency admissions*	
Existing Protection of ASC		2300				2300		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Increased transfer in 2014/15 - Intermediate care		391				391		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Protecting ASC - discharge to assess, investment in equipment		1910				1910		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Carers Breaks						1300		*Reduced carer brekadown, more people supported at home for longer, reduced admissions to care homes or emergency admissions*	
Existing Investment in reablement						3000		*More people supported to stay at home, less admissions to care homes and emergency admissions, reduce delays*	
Capital Funding - Disabled Facilities Grants						2401		*More people supported to stay at home, less admissions to care homes and emergency admissions*	
Capital funding - Oxfordshire County Council						1267		*Additional ECH sche,mes, alternative to Care Home admissions*	
Capital Funding - care bill						500		*IT system able to deliver Care Bill functionality*	
Other Care Bill Implementation costs						1350		*Successful implementation of Care Bill*	
Create a more personalised approach to home support which will include removing short visits for personal care for older people						4000		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Equipment and assistive technology						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Support for people to die at home / in residential care						500		*Fewer emergency admissions, better patient experience*	
Information and advice						500		*Savings in customer service Centre, through reduced assessments and income from site advertising and revenue fees*	
Discharge to assess care service						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Improving performance of reablement and rehabilitation						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Increased investment in Carers Breaks jointly funded and accessed via GPs						200		*Reduced carer brekadown, more people supported at home for longer, reduced admissions to care homes or emergency admissions*	
Support to people with dementia						500		*More people supported to stay at home, fewer admissions to care homes, reduced emergency admissions, better patient experience*	
Investment in support for people to die at home / in residential care						500		*Fewer emergency admissions, better patient experience*	
Shared data						100		*Better patient experience and joined up care*	
Shared care coordination - particularly for dementia and comorbidities						200		*Better patient experience and joined up care*	
7 day working (including management costs)						500		*Better patient experience, more people supported to stay at home, fewer emergency admissions, reduced delays*	
Investment to meet increased demand for Funded Nursing Care and Continuing Healthcare						1100		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Integrated Support for hospital admission avoidance						1500		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Contingency (approx 1%)						4647			
Total		10503				37568			

Total BCF	37568.00
Balance to allocate	0.00

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.

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. Delayed transfers of care should average no more than 90 across the year (140 in 2012/13 and 144 in the first 9 months of 2013/14). This reflects a 37.5% improvement next year. The increase in performance will be shared equally across all 3 responsiblities (NHS; Social Care and both) with an expectation of no more than 43 NHS delays 30 social care and 17 both. 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

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. 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

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 and for the multiple-HWB combined

N/A

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*	534	N/A	473
	Numerator	582		546
	Denominator	109000		115000
		(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*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	26.9	21.8	17.0
	Numerator	140	115	90
	Denominator	521000	528000	528000
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)

Avoidable emergency admissions (composite measure)	*Metric Value*	1471.7	N/A	1414.1
	Numerator	N/A		N/A
	Denominator			
		2012-13		*2014-15*
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	
Achieve above the national average of people very satisfied with the care and support they receive from adult social care	*Metric Value*	62.7%	N/A	64.1%
	Numerator	4236.8		n/a
	Denominator	6760.6		n/a
Achieve above the national average of people satisfied with their experience of hospital care	*Metric Value*	149.7	N/A	149.6
	Numerator	N/A		N/A
	Denominator			
		2012		*2014-15*
Achieve above the national average of people 'very satisfied' with their experience of their GP surgery	*Metric Value*	4.8	N/A	4.81
	Numerator	N/A		N/A
	Denominator			
		2012		*2014-15*
		Metric value relates to E.A.7 (Outcomes Template) which includes OOH & encorporates "Very Good" & "Fairly Good".		
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%	N/A	TBC
	Numerator	2122		TBC
	Denominator	3537		TBC
		Mar-13	*(insert time period)*	*Mar-15*
increase the proportion of older people (aged 65 and over) with an on-going care package supported to live at home	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)		