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)
Local Authority #1	Yes	5,066,000	6,654,000	9,079,200
CCG #1	Yes	1,371,430	11,407,000	12,996,723
BCF Total		**6,437,430**	**18,061,000**	**22,075,923**

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 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	527,862	527,862
	Maximum support needed for other services (if targets not achieved)	527,862	527,862
Outcome 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	177,476	177,476
	Maximum support needed for other services (if targets not achieved)	177,476	177,476
Outcome 3 Delayed transfers of care from hospital per 100,000 population	Planned savings (if targets fully achieved)	94,110	94,110

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
Older People and Dementia Pathway	London Borough of Haringey	**475,000**		131,966		**475,000**		*263,931*	
Mental Health Recovery Pathway	London Borough of Haringey	**580,000**				**580,000**			
Winterbourne Response	London Borough of Haringey	**50,000**				**50,000**			
Joint Commissioning	London Borough of Haringey/CCG	**135,000**				**200,000**			
Development and Enabling (Programme Management, Facilitating Integrated Locality Team Development, Initiating Integrated Care Planning, Staff Development, Scoping of Single Point of Access)	London Borough of Haringey/CCG		**225,000**			**150,000**	*335,000*		
Integrated Locality Teams (Re-ablement, District Nursing, Community Matrons, Locality based social work teams)	London Borough of Haringey/Whittington Health			61,230		**10,744,200**		*61,230*	
Rapid Response - 7 days/wk	Whittington Health	**340,000**		158,178		**500,000**		*206,141*	
Step Down Care	London Borough of Haringey	**625,000**							
Reablement	London Borough of Haringey	**2,450,000**		88,738				*177,476*	
Reducing Delayed Discharges from hospital (Step-Down Care, Integrated Hospital Discharge Teams, Home from Hospital, Social Workers based in Hospitals 7 days/wk)	London Borough of Haringey	**150,000**		58,580		**3,857,904**		*94,110*	
GP Case Management and 7 day access	CCG	**1,371,430**		158,178		**1,371,430**		*206,141*	
Integrated End of Life Care Service	Whittington Health					**1,379,389**			
Additional Third Sector Investment	London Borough of Haringey	**26,067**				75,000			
Promotion of self management, measurement of patient engagement/activition, community development (Community Development Workers and Good Neighbours)	London Borough of Haringey	**120,000**		131,966		**770,000**		*263,931*	
Community Capacity Grant Schemes	London Borough of Haringey					*639,000*			
Promoting independence for people with disabilities	London Borough of Haringey					949,000			
Total		**6,322,497**	***225000***	***788835***	***0***	***21,740,923***	***335000***	***1,272,960***	**0**

Note: benefits are put against the main contributor, but all schemes benefit

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.

1. Permanent Admissions of Older People: This target will be achieved through increased and enhanced reablement services, the development of Integrated Health and Social Care Community Teams (holistic provision), which will be aligned to and work with Haringey's GP Collaboratives, and developing our dementia pathway. In addition, investment in building community capacity will surround frail older people with local networks of support that will help sustain their independence, thereby, delaying or preventing the need for institutional care. We also intend to investment in falls prevention and Rapid Response to, respectively, address a major cause of permanent admissions and ensure older people have the help they need when they need it.

To measure measuring performance against this metric we will apply the following algorithm:

• Description: rate of council-supported permanent admissions of older people to residential and nursing care.

• Numerator: Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey.

• Denominator: Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate.

2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services: Haringey's BFC Plan proposes a significant additional investment in our already successful Integrated Reablement Services. Our experience of reablement shows that most people who receive this service require less support than otherwise would have been the case. Supplementing reablement services will be arranged of other supports purchased through the BCF. For example, our Home From Hospital service ensures that the homes of older people living alone are ready to receive them on discharge from hospital, whilst our use of the third sector will be expanded to provide a range of flexible and highly personalised support that will help people maintain their independence as long as possible.

To measure measuring performance against this metric we will apply the following algorithm:

• Description: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.

• Numerator: The number 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 three months after the date of their discharge from hospital. This excludes those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months.

• Denominator: The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) discharged alive from hospitals in England between 1 October 2012 and 31 December 2012 (including all specialities and zero-length stays) that are offered this service.

3. Delayed transfers of care from hospital per 100,000 population (average per month): Reducing delayed transfers of care represents a challenge and we will use the BCF to enhance our Rapid Response service, invest in step down and Integrated Hospital Discharge Teams to ensure that the discharge processes works smoothly, that patients are provided with a much better experience and delays are reduced to a minimum. The Integrated Hospital Discharge Teams will be responsible for ensuring that all parts of the discharge process work together. Once again the Home From Hospital service has an important part to play in realising our ambitions for the BCF; it will support discharge by making sure that people's homes are ready to receive them.

To measure measuring performance against this metric we will apply the following algorithm:

• Numerator: The total number of delayed transfers of care (for those aged 18 and over) for each month included

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

Using national metric

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

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1. Permanent admissions to care homes: data collected as part of national ASCOF framework.
2. Proportion of older people still at home 91 days after discharge: data collected as part of national ASCOF framework
3. Delayed transfers of care: data collected as part of national ASCOF framework
4. Avoidable emergency admissions: data collated as part of NHSOF
5. Injuries due to falls: data collected as part of the Public Health Outcome Framework

For each metric the same assurance process applies and consists of the following:

1, The development of a commissioning strategy which encompasses contracting. All contracts will contain SMART specifications whose delivery will be monitored and measured.

2, The appointment to joint commissioning and data analyst posts that will be responsible for developing quality assurance and performance measurement tools. These posts will work with providers to ensure that they have in place the processes required to gather required performance data. Our expectation is that providers will return reports on, at least, a quarterly basis.

3. The joint commissioning and data analyst posts will aggregate this information to produce performance reports. Performance monitoring reports will be fed into the governance structure (see Part 1 of Haringey's BCF Plan) where it will be presented to the Operational Management Board, the Integrated Programme Management Board, Haringey's Cabinet, the Governing Body of our

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*	458.2	N/A	396
	Numerator	106		95
	Denominator	23,134		23,967
		(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 RL to look into to get basic numbers	*Metric Value*	88.4	N/A	94
	Numerator	76		81
	Denominator	86		86
		(April 2012 - March 2013)		(April 2014-March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	255	246	238
	Numerator	4182 (over 8 months)	4,612	2,967
	Denominator	204,609	207,901	207,901
		(April 2013 - November 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1564.2	1501.7	1447
	Numerator	4050	3942 (full year effect)	3848 (full Year effect)
	Denominator	258912	262506	265929
		(April 2012 - March 2013)	(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 to be used (currently under development)	N/A	
Social care related quality of life				
Proportion of people who use services who have control over their daily life				
Injuries due to falls in people aged 65 and over	*Metric Value*	461		431.0
	Numerator	38.4		35.9
	Denominator	27765		27765
		(April 2012 - March 2013)		(April 2014-March 2015)

Note: DETOCs based on miod-point of bed day costs beyond the trim point

Note: We will continue to refine our figures as more guidance and data is released