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.

In line with advice received this section provides details of how Haringey's BCF plans will enable it to achieve the target attached to each metric, and how their attainment will be measured.

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 able to address the health and social care needs of individuals in the round (holistic provision). 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 which will make a particularly significant contribution to reducing the permanent admissions of older people as falls are a primary causes of these admissions. To monitor the benefits of these schemes all will be performance managed and work to SMART outcome orientated service specifications.

For the purposes of measuring overall 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.

Adult Social Care Outcomes framework http://www.hscic.gov.uk/article/2021/Website-Search?q=Measures+from+the+Adult+Social+Care+Outcomes+Framework&go=Go&area=both)

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 successful integrated reablement services. This will play an important role in equipping people with the skills and providing them with the confidence to manage independently, within their own homes, following a period of illness and/or hospitalisation. 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. 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.

The same approach will be taken to measuring outcomes as that described above and the following algorithm will be applied:

• 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.

Adult Social Care Outcomes framework (HSCIC: http://www.hscic.gov.uk/article/2021/Website-Search?q=Measures+from+the+Adult+Social+Care+Outcomes+Framework&go=Go&area=both)

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

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

For each metric the same assurance process applies. This is designed to deliver high achievemnet and performance through the use of the BCF 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 fore 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 CCG and the Health and Wellbeing Board.

4. The lessons arising from examination of the performance data will be learnt with under-performance being addressed with providers and good parctice shared across the provider community.

We want to use the assurance process as a learning, as well as, a performance to

We believe that the steps outlined above give confidence that Haringey's approach to assuring the process underpinning the agreements of the performance plans is both robust and accountable.

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	*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	446.0	431.0
	Numerator	38.4		35.9
	Denominator	27765		27765