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)
Thanet CCG	Various	**9,595,941**	**9,595,941**	**9,595,941**
Kent County Council	Various	**2,810,000**	**2,810,000**	**2,810,000**
BCF Total		**12,405,941**	**12,405,941**	**12,405,941**

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.

Performance indicators will be monitored to identify early warnings of risk and service non-delivery. The Integrated Commissioning Group (ICG) will oversee this process and will report directly to the Thanet Health and Well Being Board and to the system organisations senior management teams. This approach will provide multi-organisational management and responsibility.

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)	525,000	525,000
	Maximum support needed for other services (if targets not achieved)	1,052,000	1,052,000
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)	unable to quantify	
	Maximum support needed for other services (if targets not achieved)	unable to quantify	
Outcome 3 Delayed transfers of care from hospital per 100,000 population (average per	Planned savings (if targets fully achieved)	unable to quantify	

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
THANET CCG									
Delayed Transfer of Care	Various	1,013,000				1,013,000			
Avoidance of Emergency Admissions & Enhanced Integrated Community Teams & Care Coordination	Various	3,290,000		- 500,000		3,290,000		- 500,000	
Effectiveness of Reablement	Various	706,000				706,000			
Admissions to Residential Nursing Homes & Enhanced Support to Care Homes	Various	2,981,000		- 100,000		2,981,000		- 100,000	
Childrens Services	Various	262,500				262,500			
Admission Avoidance (inc Dementia)	Various	300,000		- 58,000		300,000		- 58,000	
GP Over 75s £5 Per Head Contribution & Enhanced Primary Care	GPs	700,000				700,000			
Volunteer Orgs	Various	87,441				87,441			
Mental Health	Various	255,000		- 125,000		255,000			
KENT COUNTY COUNCIL 256 Work Streams.									
Enabling People to return to/or remain in the community	Various	1,647,000				1,647,000			
Ease of access to services	Various	171,000				171,000			
Self Care & Prevention	Various	335,000				335,000			
Postural Stability	Various	18,000				18,000			
Supporting Implementation of Integration	Various	33,000				33,000			
Expand integrated commissioning of schemes that produce joint outcomes	Various	63,000				63,000			
Share of £200m national pot	Various	544,000				544,000			
TOTAL		**12,405,941**	-	**- 783,000**	-	**12,405,941**	-	**- 658,000**	-

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 (aged 65 and over) to residential and nursing care homes, per 100,000 population

Our aim is to achieve an 11% reduction in admissions. This will be achieved through our integrated reablement/rehabilitation schemes which will combine both health and Local Authority services to offer more proactive approaches to developing and promoting independence in the community. We will improve reablement services into all provision, e.g. domiciliary care, nursing and residential homes. Our locality integrated teams will target those people most at risk through robust risk stratification and analysis of pooled information across health and social care ensuring that individuals receive coordinated care services.

2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Our aim is to achieve an increase of 4.5% above current baseline. We will be extending the reach of our reablement services and focussing on more complex patients in the community. The main schemes focussing on this metric will be through our integrated reablement/rehabilitation services.

3. Delayed transfers of care from hospital per 100,000 population (average per month)

Our aim is to reduce the average number of delayed transfers by 10% This will be achieved through improving discharge processes within the hospital, eg. our investment in the intermediate care team which operates 7 days per week.

4. Avoidable emergency admissions

We aim is to reduce our number of avoidable emergency admissions by 5% This will be achieved through a series of programmes which will include primary care schemes to manage the care of over 75's, GP step up beds used to avoi

5. Reduction in falls and secondary falls

Our aim is to reduce the number of falls per year by 6% (allowing for population increase). This will be achieved through the development of falls and fracture prevention services for older people to undertake screening and comprehen

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.

6. (Local Metric) Proportion of People feeling supported to manage their condition. Expressed as a peicentage and reflects the number of 'Yes, definitely', and 'Yes to some extent',

The outcome will be achieved through improved cooperation between GP Practices, Community and Social Care teams. The continued development of multidisciplinary team working, the improved use of Risk Analysis tools and community information systems will support this initiative. The Enhanced Primary Care and Integrated Community Teams and Care Coordination schemes are designed to underpin this process.

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

The performance plans were set by reviewing historical trends and benchmarking our performance nationally and with local comparators. We have consulted with Heads of Service whose services impact on performance in all the areas and have also mapped the schemes in our local plan against the key factors impacting on the indicators.
We intend to apply rigorous and appropriate assurance processes to all the metrics. We will continue to use both national and local data which inform the metrics. As well as the nationally published data we will have access to local figures and information produced by our commissioning support organisation. This is further under-pinned by the development of state-of-the-art Community Information System by our local Community Trust, The CIS not only will provide data and information regarding the daily management of patients, but will also allow this data to be shared with GPs and Social Care partners. The day to day exchange of information and data will help to support significantly improved outcomes such as patients remaining in their own homes, avoiding inappropriate admissions and enabling enhanced care at home.
Specific actions include the achievement of more timely discharges from hospital using a detailed whole system review of our emergency care system that was undertaken last year. This review was carried out by external experts (ECIS
All performance indicators will be monitored to identify early warnings of risk and failures of service delivery. The Integrated Commissioning Group will oversee this process and will report directly to both the local Health and Wellbeing B

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*	901	N/A	804
	Numerator (number of admissions)	274		251
	Denominator (population aged 65+)	30422		31222
		(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*	84.76%	N/A	87.36%
	Numerator (of the discharges, those still at home at 91 days)	684		705
	Denominator (all discharges - including those that werent still at home)	807		807
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	6.04	N/A	5.41
	Numerator (number of DTOC)	102		92
	Denominator (total population)	140614		141809
		(April 2012 - March 2013)		(April 2014 - March 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2003.5	N/A	1903.5
	Numerator	not supplied		
	Denominator	not supplied		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Patient / service user experience: Average EQ-5D score for people reporting having one or more long-trm condition		70	N/A	70.2
		(April 2012 - March 2013)		(April 2014 - March 2015)
(Local Metric) Proportion of People feeling supported to manage their their condition. Expressed as a percentage and reflects the number of 'Yes, definitiely', and 'Yes to some extent', response in the GP patient survey as a proportion of the total answers.	*Metric Value*	59.8%	N/A	65.0%
	Numerator	772		840
	Denominator	1292		1292
		(July 2013 to September 2013)		(January 2015 to March 2015
Reduction in falls and secondary falls (ICD S7200, S7201, S721, S7210 and R29.6 for ages 65+)		263	N/A	240