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)
Southend Borough Council		687,000	*1,153,000*	*#REF!*
Southend CCG			*11,619,000*	*#REF!*
NHS England				
BCF Total		**687,000**	**12,772,000**	**#REF!**

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.

System leaders in Southend University Hospital Trust, Southend East Essex Partnership Trust, Southend Borough Council and Southend CCG have agreed a the Acute, Community and Mental Health Services, Southend CCG have formed a Strategic Alliance to support integration and radical system change. This will be achieved by commitment to the vision and supported by a willingness to see radical change in services to achieve better outcomes through integration and an agreement to manage risk collectively.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	To be developed	To be developed
	Maximum support needed for other services (if targets not achieved)	To be developed	To be developed
Outcome 2	Planned savings (if targets fully achieved)	To be developed	To be developed
	Maximum support needed for other services (if targets not achieved)	To be developed	To be developed

The table below shows how the BCF has been complied. It lists where reources are currently allocated. It does not set out where funds will be spent.

Current Service	Lead provider	2014/15 spend		2015/16 spend
		Recurrent	Non-recurrent	Recurrent
Pilot 7 Day working of Social worker in A&E		*50,000*		*50,000*
Falls Pathway			*30,000*	
Pilot Integrated Care record in SPOR		*25,000*	*100,000*	*25,000*
Care Trak risk stratification		*50,000*		*50,000*
Hospital Discharge (Timely assessment in most appropriate setting		*60,000*	*140,000*	*60,000*
GP Hub Pilot		*50,000*	*32,000*	*50,000*
Single Point of Referral	Southend Borough Council	*150,000*		*252,941*
CICC Intermediated Care bedded capacity				*304,438*
Dementia Intensive Support Team	South Essex Partnership Trust			*203,000*
Reablement				*976,000*
Community Geriatrician	South Essex Partnership Trust TBC			*102,500*
Care Home admission avoidance				*48,000*
RAID	South Essex Partnership Trust			*50,000*
DAU	Southend University Hospital Foundation Trust			
COPD Psychology Service	South Essex Partnership Trust			*50,000*
Integrated Community Teams	South Essex Partnership Trust			*3,536,848*
Collaborative Care Team	South Essex Partnership Trust			*255,296*
Intermediate Care Service	South Essex Partnership Trust			*800,000*
Continence service	South Essex Partnership Trust			*374,831*
Pressure releving equipment	South Essex Partnership Trust			*118,679*
Leg Ulcer	South Essex Partnership Trust			*97,169*
tissue viability service	South Essex Partnership Trust			*45,604*
old peoples Mental Health Service	South Essex Partnership Trust			*819,456*
Stroke Early Supported Discharge	SUHFT			*65,000*
Shaarc Car	EoE			*256,000*
Everyone counts	Essex AT			*900,000*
Personnel Health Budgets	CCG			
Carers Grant				*389,000*
Social Care Transfer				*3,100,000*
Disability Facilities Grant				*694,000*
Social Care Capital Grant				*459,000*
Total		*385,000*	*302,000*	*14,132,762*

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.

METRICS
The Better Care Fund schemes have been aligned to specific metrics within the plan, however there is recognition that individual schemes will impact on more than one area and that there are also interdependencies between the schemes.

	1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
1	The Frailty service will facilitate a reduction in the number of permanent admissions to residential and Nursing care homes for people over the age of 65 years through early assessment and proactive case management to support people enabling patients to remain independent. Health and social care professionals will be able to gain same day access to a Comprehensive Geriatric and wider MDT Assessment, together with a range of diagnostics as appropriate. Scheme Benefits □ Following the assessment patients will be able to access services appropriate to their needs that will aim to support people maximise their independence through. □ Individualised care plans □ Reablement □ Care Packages □ Social care □ Third sector support □ Community Intermediate care bed □ Rehabilitation □ Community Dementia Services Outcomes □ Patients will be supported to maintain their independence A reduction in the number of older people (aged 65 and over) admitted inappropriately to residential settings. Measure □ % reduction per 100,000 population in the number of permanent admissions to residential settings. 2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services □ Increased access to Reablement and Rehabilitation are key to achieving and sustaining improvements in people's capacity to be independent and cared for in their own homes. Reablement capacity has been increased by 30% and community Intermediate Care beds at the Cumberledge Intermediate Care Centre (CICC) support rehabilitation following a hospital admission Scheme Benefits
	2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
2	□ Increased access to Reablement and Rehabilitation are key to achieving and sustaining improvements in people's capacity to be independent and cared for in their own homes. Reablement capacity has been increased by 30% and community Intermediate Care beds at the Cumberledge Intermediate Care Centre (CICC) support rehabilitation following a hospital admission Scheme Benefits □ Access to a 'Discharge to Assess model □ Patients have swift and timely access to reablement support □ Access to bedded rehabilitation for appropriate patients. □ Carers enabled to support the cared for return to independence Outcomes □ % increase in the number of patients supported to remain in their homes 91 days following discharge from hospital Measurement □ % reduction in the number of patients readmitted to hospital within 91 days for the same HRG
	3 Delayed transfers of care from hospital per 100,000 population (average per month)
3	□ A significant amount of work has been undertaken in this area, the hospital have direct access to an integrated health and social care supported discharge pathway through the a Single Point of Referral (SPOR) This scheme will be enhanced through the Better Care Fund with plans to extend the working hours to 8 pm each day and full 7 day, there is currently a skeleton service at the weekends. Benefits □ Improved access to supported discharge 7 days a week □ Effective utilisation of Acute Hospital bedded capacity □ Improved patient experience for patients discharged at the weekends Outcomes □ Effective utilisation of acute hospital beds Improved □ Effective utilisation of emergency ambulances. Measurement □ %Reduction in delayed transfers of care per 100,000 population □ % Reduction in ambulance delays as a result of reduced bed capacity in the hospital

4. Avoidable emergency admissions (composite measure)

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There are a number of scheme which contribute to supporting avoidable admissions from hospital. There is a multimodal approach which includes schemes that aim to offer health and social care professionals, working in primary and community care, access to a rapid response to an integrated health and social care assessment and intervention for their patients. Schemes that will support this approach include:

o SPOR admission avoidance pathway
o Rapid Assessment Intervention and Discharge Mental health pathway collocated in A&E
o Dementia Intensive Support Team, collocated in A&E

Schemes that focus on admission avoidance through a proactive approach include.

- Integrated Community Locality Teams
- Primary Care Practice level MDT
- Psychology support for patients with COPD & Stroke.

Benefits

- Proactive early intervention reducing the number of patients reaching crisis that requires an admission to hospital.
- A reduction in the independence of an individual will be identified at an early stage and action taken
- Increase in the number of people
- Patients' empowered to manage their own conditions.
- Improved patient experience
- Swift access to integrated assessment and intervention supporting more people to remain at home

Outcomes

- More patients treated and cared for in community settings closer to home.

Measurement (National Composite Measure)

- A reduction in the number of patients admitted to hospital with an ambulatory care condition amenable to community intervention.
- % reduction in unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- % reduction in unplanned hospitalisation for asthma, diabetes and epilepsy in children
- % reduction in emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- % reduction in emergency admissions for children with lower respiratory tract infection.

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

Southend CCG is intending to work with the National patient experience metric which is currently underdevelopent with NHS England and the Department of Health.

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

Assurance Process
The system chief Officers strategic alliance through the Joint Operational Group will agree system plans and performance manage delivery against metrics and outcomes.
To provide further assurance and to support planning across the system the partnership commissioned an external evaluation of all legacy schemes that aimed to both prevent inappropriate admissions to hospital and improve discharge processes to reduce readmissions. The final evaluation report clearly identified schemes that could be strengthened to maximise their potential and others that were unlikely to achieve the outcomes required and were therefore recommended for

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

Not appropriate for Southend CCG.

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*	**888.8**	N/A	Under development
	Numerator	**285**		Under development
	Denominator	**31955**		Under development
		(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*	**79.9**	N/A	Under development
	Numerator	**185**		Under development
	Denominator	**230**		Under development
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	**4.7**		Under development
	Numerator	**6**		Under development
	Denominator	**136830**		Under development
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	**1830.60**		Under development
	Numerator	**3586.00**		Under development
	Denominator	**184290.00**		Under development
		(TBC)	(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]			N/A	Under development
				Under development
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			Under development
	Numerator			Under development
	Denominator			Under development
		(insert time period)	*(insert time period)*	*(insert time period)*