Public Document Pack

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14 March 2014

Dear Councillor

I am now able to enclose, for consideration at the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** on Tuesday 18 March 2014 at 4.00 pm, the following reports that were unavailable when the agenda was printed.

4 **BETTER CARE FUND** (Pages 2 - 31)

To receive an update on the Better Care Fund.

Yours sincerely

Chief Executive

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Kent County Council**
Clinical Commissioning Groups	**NHS South Kent Coast CCG**
Boundary Differences	
Date agreed at Health and Well-Being Board:	**12 February (1st draft)**
Date submitted:	**13 March**
Minimum required value of ITF pooled budget: 2014/15	**£3,884,000**
2015/16	**£13,283,000**
Total agreed value of pooled budget: 2014/15	**£3,884,000**
2015/16	**£13,283,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS South Kent Coast CCG
By	Hazel Carpenter
Position	Accountable Officer
Date	3 February 2014

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The South Kent Coast Integrated Commissioning Group has overseen the development of the Better Care Plan and has included representation from local providers to help shape the plan and the schemes within it during January and February. Details of each scheme has been shared and discussed with representatives from the local acute trust, community trust and the mental health trust through the discussions at the Integrated Commissioning Group. The local plans are aligned to the East Kent Federation of CCGs vision for integrated care which has been shared and developed at the East Kent Whole Systems Board which has providers on its membership.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

The Better Care Plan includes schemes already included in the CCGs operational plans for 2014/15. For these elements a range of local CCG engagement activities have been undertaken throughout 2013/14 in preparation for the 2014 plans. These include; • Public Events – including focus groups to develop and integrated Intermediate Care pathway; • Membership Council(s) – including the development of the Integrated Community Nursing model and Neighbourhood Care Teams; • Locality Meetings – to test plans on GP membership • Health Reference Groups - to test plans on patient group For elements of the Better Care Plan that are an enhancement or addition to the 2014/15 operational plans on-going engagement activities will be undertaken to ensure our clinically led plans are tested on the patients and service users the plans impact upon.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
High level description of each scheme	BCF Schemes summary and outcom
High level timetable of plans	SKC Better Care Fund Programme Plan HIGH

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision
The South Kent Coast vision for integrated health and social care is for patients to always be at the heart of their care and support, receiving coordinated services without organisational barriers that are easy to access 24/7, of high quality and that maximises their ability to live independently and safely in their community and in their own homes wherever possible. We will ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.

We will achieve this by building integrated health and social care teams around every patient. These teams, linked to every GP practice, will undertake integrated health and social care assessments and coordinated care planning to pro-actively manage patient's conditions and needs in the community helping people to stay out of hospital or to recover more quickly after a hospital stay.

Our plans for the Better Care Fund will be achieved by a number of schemes aimed at services working together to provide better support for people with long term conditions, older people and people with disabilities at home to maintain independence and earlier treatment in the community to prevent people needing emergency care in hospital or care homes and education and empowering people to make decisions about their own health and well-being. We will deliver this by:

- Building on and enhancing some of the local projects already implemented or planned and;
- Introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

Changes to service configuration
As set out in the CCGs five year strategy the overall vision to ensure the best health and care for our community will result in changes to current service configuration. Achieving the CCGs vision will require building sufficient capacity in the community, including the workforce, whilst reducing capacity in acute hospitals in order to deliver the following:

- Out of hospital services to be integrated and wrapped around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions;

- Acute hospital services will be specialist facilities whether for physical or mental health needs and will be highly expert to ensure high quality. Hospitals will act as hubs for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.

Patient and service user outcomes
By working in new and innovative ways we aim to achieve the following:
- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient's needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:
- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and objectives of an integrated system
With a high elderly population in South Kent Coast and increasing numbers of people who have one or more long-term condition we aim to focus the Better Care Fund on prevention, reducing the demand and making the most efficient and effective use of health and social care resources.
Our plans for the Better Care Fund support the delivery of the CCGs five year strategy which has a strong focus on the management of long term conditions and the subsequent impact long term conditions has on the local health systems. The plan will also support the delivery of the five year East Kent Strategic Plan (2014-2019).

Given the extent of integration set out in our plans there are considerable changes to the current ways of working and the existing workforce across multiple organisations. This will require us to undertake work to re-shape the supply of the market to enable delivery of our plans over time; this may take the form of an Integrated Care Organisation.
South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the local authority and both Dover and Shepway District Councils. This Strategy identified four shared aims which are working together toward:

- To improve the health and wellbeing of people in Dover and Shepway living with long term conditions, enabling as many people as possible to manage their own condition better;
- People with disabilities and older people will be supported to actively participate in the lives of their local communities, enabled by environments that are inclusive, accessible and safe for all;
- To support families and carers in their caring roles and enable them to actively

contribute to their local communities and;

- To ensure that the best possible care is provided at the end of people's lives.

Measuring improved outcomes

By delivering the above aims to will achieve the following outcomes:

- Reduced hospital admissions;
- Reduced length of stay in hospital;
- Timely access to local health and social care services;
- Improved access to information which allows people to make decision about their own lives;
- Thriving and self-reliant communities;
- Reduction in duplication;
- People will have access to local quality housing that meets their needs;
- People will be able to get around and access facilities in their local communities;
- People will have more choice and control over the health and social care services they use;
- After people are discharged from hospital they will return home to a safe and accessible environment as quickly as possible;
- Carers will have access to good quality information and advice;
- Carers will be supported to access services to support them in that role;
- Carers will be supported to stay mentally and physically well and treated with dignity;
- Improve end of life care for people living in residential, nursing and extra care housing;
- More people die in the place of their choice having received the care appropriate to their needs;
- Improved end of life care for people with dementia and long term conditions.
- Ensure services respond rapidly and more effectively;
- Support carers and empower individuals to do more for themselves;
- Improve the patient experience of the delivery of care

The above measures will be monitored using an integrated performance dashboard for the Better Care Fund, this will be developed and piloted during 2014/15.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

To achieve greater transformation to the integration of local services the current identified local priority schemes for the Better Care Fund are listed below:

- **Integrated Teams and Reablement**

Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide

enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.

SCHEME REQUIREMENTS

Integrated Intermediate Care Pathway & flexible use of community based beds

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points;
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite;
- Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
- The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

- **Enhance Neighbourhood Care Teams and Care Coordination**

This model builds a team around the patient who focus holistically on the patients overall

health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

SCHEME REQUIREMENTS:

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

- Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
- The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
- The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to asses a patients home environment;
- Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care;
- Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
- The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
- The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

- The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and

reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

- **Enhance Primary Care**

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

SCHEME REQUIREMENTS:

Develop primary care based services with improved access and integrated with other community and specialist services

- GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge;
- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
- Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital;
- GP practices to link with the support to care homes pathways to provide more intensive support

Primary care service will support and empower patients and carers to self manage their conditions

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
- The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of

care records with the patient and between health and social care professionals;

- Improved signposting and education and access to signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services
- Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.

- **Enhance support to Care Homes**

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory can plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

SCHEME REQUIREMENTS:

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes

- The integrated team can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
- The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes;
- Access to specialist services such as Dementia Crisis will be available to support care homes.

- **Integrated Health and Social Housing approaches**

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it’s used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment.

SCHEME REQUIREMENTS:

An integrated approach to local housing and accommodation provision to enable, supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.

- Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
- Promote developments of wheelchair accessible housing to support the reduction

of costly adaptations;
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
- Different types of supported accommodation for those with learning disabilities and mental health needs.

- **Falls prevention**

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

- Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Success factors and timeframes for delivery

Each of the above schemes has a range of outcome measures to demonstrate success. The key measurements of success are as follows:

- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia;
- Reduced length of stay;
- Improved transfers of care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment;
- Increase levels of patient self management of long term conditions;
- Reduction in falls and secondary falls;
- Reduction in hip fractures;

- Improve patient satisfaction and well-being;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services;
- Reduce unnecessary prescribing.

To ensure delivery of the above schemes in 2015/16 a programme plan setting out details of the key milestones is in development and will be refined during 2014/15 to ensure clarity of when the changes come into effect and the implications of these changes as well as the expected outcomes. The programme plan will also include contingencies if the plans are not delivered.

Alignment with local JSNA and local commissioning plans
The schemes outlined in this plan which have been developed in partnership with social care commissioners. The schemes, along with the CCGs overall commissioning plans, will support addressing the pressing needs identified through the local Joint Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them. These health priorities are as follows:

- Being ready to respond to the impact of our aging population;
- Tackling increasing inequalities;
- Improving access to primary care services;
- Managing patients mental health (including Dementia);
- Increasing access to care closer to home;
- Tackle patients' long term conditions;
- Tackle unnecessary and unfair variations in care;
- Improve management and identification of diabetes;
- Pro-active general practice (smoking, weight, alcohol, health checks etc.);
- Work closely with partners to tackle patients and carer wellbeing.

d) Implications for the acute sector
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The plans align with the delivery of the CCGs strategy, as outlined in section 2a above. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should enable the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement/rehabilitation services.

e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The local Better Care plans will be implemented and monitored using a commissioning project management framework. The delivery of the schemes will be supported by the local Integrated Commissioning Group which will report progress to the local Health and Well Being Board. Delivery of the plans will ultimately be the responsibility of the CCGs Governing Board. All defined milestones and outcomes of the plan will be monitored at a CCG's Governing Body committee level via the Performance and Delivery Committee and reported for assurance purposes to the Governing Body. The Better Care Fund schemes and metrics will be included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Performance and Delivery Committee. The committee feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee. Whilst many of the metrics are nationally defined and officially reported annually, proxy measures will be used to monitor them in year, including the Levels of Ambition Tool, Atlas of Variation and SUS data.

3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

The Better Care Fund plans set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact the care on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

Please explain how local social care services will be protected within your plans.

By managing to reable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services.

Development of a Self Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

- Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
- Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

All schemes within the local CCG plan require accessible 7 day a week service to support patients being discharged from hospital and prevent unnecessary admissions at weekends.

In South Kent Coast the enhanced multidisciplinary Neighbourhood Care Team is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The prime identifier across health and social care in Kent is the NHS number.

NHS
At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations.

The NHS standard contract states:
"Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user."

Social Care
A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT. Monthly batches of client records are sent to the NHS matching service (MACS) and if they can match to a single record on their system they return the NHS number which is uploaded into SWIFT.

The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.

KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource.
The MACS service is due to close at some point (no date given yet) so KCC are in the process of transferring to the Personal Demographics Service (PDS).

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Not applicable.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

South Kent Coast CCG, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will

also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Please see previous response for Governance arrangements around data sharing with regards to the MIG.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In South Kent Coast the accountable lead professional for people at high risk of hospital admission is their GP. Risk stratification is undertaken by practices and shared with community nursing teams to identify those patients most at risk. These patients are recommended for Proactive Care to ensure coordination of all their health and social care needs to prevent hospital admissions. If the patients are under the care of the community nursing or intermediate care teams they are informed on how to contact a member of these teams 24/7 if they need to. All patients at high risk or hospital admission and put forward for Proactive Care have a joint care plan in place.

Risk Profiling (Pro-Active Care)

South Kent Coast CCG has been running a programme called Pro-Active Care which almost all practices are participating in. Pro-Active Care is a 12 week intervention by a multi-disciplinary health and social care team for risk stratified patients with multiple co-morbidities. The aim is to improve patient's self-management, their quality of life, medicines compliance and reduce A&E and associated hospital admissions.

Through risk stratification Pro-Active Care targets the patients at highest risk of hospital admission and then works its way through the lower risk patients. This is something that, over a year on, the first practices to run pro-active care are now starting to achieve after having seen all of their highest risk long term condition patients. In turn this means that the amount of clinical time and intervention decreases with lower risk patients and there is an expectation that such intervention will go some way to preventing these lower risk patients from deteriorating as fast thus prolonging their health and quality of life over the long term.

Pro-Active Care is delivered by a multi-disciplinary health and social care teams undertaking joint assessments, clinically led by a GP, and jointly agreeing anticipatory care plans for every patients going through the programme. A pharmacist offers a review of their medicines, a health trainer supports them to develop a healthier lifestyle and signposts the patient to other services in the community. Physiotherapists and Occupational Therapists review the patient's needs. Social Services and Mental Health services also visit to offer advice and services if required. The GP remains the accountable professional for their patients.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
The investment required into primary care for the full benefits of the plan falls outside the remit of the pooled budget and sits with NHS England.	High	To be discussed with NHS England.
Cultural change – significant shift in how	High	Ensure whole health and

systems need to work in the future requirement large culture change		social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.
Regulatory and legislative environment – current arrangements not always looking at how the overall system works	High	Provide feedback to NHS England on this issue via the Kent Pioneer Programme.

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High Level Better Care Fund Plan
NHS South Kent Coast Clinical Commissioning Group

No	Scheme	Description of Scheme	Outcome Measures	High Risks
1	**INTEGRATED TEAMS, RAPID RESPONSE & REABLEMENT**	Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and will coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector. **SCHEME REQUIREMENTS:** **Integrated Intermediate Care Pathway & flexible use of community based beds** • Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points; • Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home); • Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;	• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia; • Improve patient experience; • Improve health outcomes; • Reduced length of stay; • Improved transfers of care; • Reduced long term	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability. • Flexibility of community based beds requires constant monitoring to ensure system copes with changing demand; • Integrated performance monitoring of pathways needs to support the level of integration required;

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21		• Community hospital beds only to be used for comprehensive assessments , for patients needing 24/7 nursing care and for carer respite; • Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand. **Enhanced Rapid Response – supporting acute discharge/preventing readmission** • Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals; • The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home; • The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home; • The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions; • The teams will integrate with the Mental Health Crisis Service which provides support 24/7. **Integrated rehabilitation & Non Weight Bearing Pathway** • Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients; • Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community; • Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.	placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment	• IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

No	Scheme	Description of Scheme	Outcome Measures	High Risks
2	**ENHANCE NEIGHBOURHOOD CARE TEAMS AND CARE COORDINATION**	This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients. **SCHEME REQUIREMENTS:** **Risk Profiling to enable proactive care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community** • Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support and care in the community, including within care homes, and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of end of life care; • The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient experience; • Increase levels of patient self management of long term conditions; • Improve health outcomes; • Reduced spend on drugs; • Reduced duplications across the health and social care system; • Reduce the needs for long term placements in residential and nursing homes.	• Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability; • Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes;

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23		interventions and will be integrated with pathways to assess a patients home environment; • Access into and out of the Neighbourhood Care Teams will be coordinated through a clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care; • Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach; • The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health; • The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required. **Specialists to integrate into community based generalist roles** • The enhanced Neighbourhood Care Team model requires specialist input from the acute trust in the community to enable the integrated assessment and management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.		• Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
3	**ENHANCE PRIMARY CARE**	Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus. **SCHEME REQUIREMENTS:** **Develop primary care based services with improved access and integrated with other community and specialist services** • GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis, and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge; • GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision; • Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will be co-produced in tandem with public engagement. This will require stronger integration with the Neighbourhood Care Teams and the Intermediate Care Teams and ensuring that all community pathways signpost people as appropriate to the voluntary sector; • Integrated primary care provision will have greater support from specialist hospital teams and stronger links with rapid response services to enable	• Reduced emergency admissions; • Reduced A&E attendances; • Improve patient satisfaction and well-being; • Increase levels of patient self management of long term conditions; • Increase levels of patients with personal health budgets and integrated budgets; • Improve health outcomes by better use of prevention services.	• Extensive workforce reconfiguration in the community to ensure the workforce has the required skills and training to deliver all elements of the scheme; • Large scale organisational change to ensure the whole health and social care system has shared vision and values to enable the delivery of required changes. This includes ensuring the voluntary sector are aware of the direction of travel; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and

25		patients to remain out of hospital; • GP practices to link with the support to care homes pathways to provide more intensive support. **Primary care service will support and empower patients and carers to self manage their conditions** • Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community; • The Neighbourhood Care Teams will educate patients about preventative services such as weight management, alcohol services and community mental health prevention services as part of the multidisciplinary assessment; • Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans and anticipatory care plans this includes electronic sharing of care records and plans with the patient and between health and social care professionals; • Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services; • Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.		support integrated outcome measurement and monitoring.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
4	**ENHANCE SUPPORT TO CARE HOMES**	This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions. **SCHEME REQUIREMENTS:** **An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes** • The integrated team can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers; • The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes. • Access to specialist services such as Dementia Crisis will be available to support care homes; • Care homes will be given access to additional skills development to support improving quality of care and outcomes for the management of residents with long term conditions, compassionate care needs, mental health and wellbeing and management of End of Life care.	• Reduced emergency admissions; • Reduced A&E attendances; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning.	• Workforce capacity to deliver the scheme is limited considering the large number of care home beds (approximately 3,000) in South Kent Coast; • Integrated performance monitoring of pathways needs to support the level of integration required; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring. • Workforce in care homes needs support to increase skills to support more complex patients.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
5	**INTEGRTAED HEALTH AND SOCIAL HOUSING APPROACH**	To develop and improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment. **SCHEME REQUIREMENTS:** **An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.** • Current bed based facilities (both step up and step down) to be flexible and broadened to use housing schemes; • Promote developments of wheelchair accessible housing to support the reduction of costly adaptations; • Responsive timely adaptations to housing; • Preventative pathways to enable patients and service users to return to, following admissions to hospital or care homes, or remain in their homes safely including full holistic home safety checks; • Flexible housing schemes locally; • Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities; • Different types of supported accommodation for those with learning disabilities and mental health needs.	• Reduction in emergency hospital admissions; • Reduced A&E attendances; • Reduced residential care admissions; • Reduced care packages; • Increased personalisation; • Reduced delayed transfers of care; • Increased patient experience as more people maintain level of independence in their own home.	• Policy and legislation for housing and Disabled Facilities Grants need to support the level of integration required.

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No	Scheme	Description of Scheme	Outcome Measures	High Risks
6	**FALLS MANAGEMENT AND PREVENTION**	Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues. **SCHEME REQUIREMENTS:** **Development of a local specialist falls and fracture prevention service** • This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches. **Local integrated falls prevention pathways** • Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists; • Develop an Integrated Ambulance Falls Response Service; • Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes, domiciliary based and within care homes.	• Reduction in falls and secondary falls; • Reduction in hip fractures; • Improve patient experience and levels of self management; • Reduced emergency admissions; • Reduced A&E attendances.	• Different skills and training required across multiple professionals and organisations; • Integrated performance monitoring of pathways needs to support the level of integration required as will be challenging to monitor improvements linked to falls prevention; • IT systems need to enable shared care plans between organisations and support integrated outcome measurement and monitoring.

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)
South Kent Coast		3,884,000	13,283,000	13,283,000
BCF Total		3,884,000	13,283,000	13,283,000

Section 256 monies

Require further details from KCC to show how the 2014/15 s256 monies align to the schemes in the local plan and how the monies will support transformational step change in 2015/16

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
Admissions to residential and care homes	Planned savings (if targets fully achieved)	468,000	468,000
	Maximum support needed for other services (if targets not achieved)	468,000	468,000
Effectiveness of reablement	Planned savings (if targets fully achieved)	42,000	42,000
	Maximum support needed for other services (if targets not achieved)	42,000	42,000
Delayed Transfers of care	Planned savings (if targets fully achieved)	0	0
	Maximum support needed for other services (if targets not achieved)	0	0
Avoidable emergency admissions	Planned savings (if targets fully achieved)	19,650	19,650
	Maximum support needed for other services (if targets not achieved)	19,650	19,650
Patient and service user experience	Planned savings (if targets fully achieved)	0	0
	Maximum support needed for other services (if targets not achieved)	0	0

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
Integrated Teams, Rapid Response and Reablement		2,692,336		-129,506		6,313,704		-129,506	
Enhanced Neighbourhood Care Teams and Care Coordination		441,210		-88,828		5,633,624		-88,828	
Enhance Primary Care		544,957		-87,464		720,718		-87,464	
Enhance Support to Care Homes		0		-168,498		259,457		-168,498	
Integrated Health and Social Care Housing Approach		179,435		-42,042		179,435		-42,042	
Falls Prevention		26,062		-77,135		176,062		-77,135	
Total		3,884,000	0	-593,473	0	13,283,000	0	-593,473	0

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
Permanent admissions of older people to residential and care homes - reduced number of those 65+ admitted to care homes
Effectiveness of Reablement - those 65+ still as home 91 days after discharge, ranging from 88.10-90%
Delayed Transfers of Care - reduction in total number of delayed transfers of care each month
Avoidable Emergency Admissions - reduction in admissions to be reported via the Levels of Ambition Atlas as provided by NHS England
Proportion of people feeling supported to manage their condition (local metric) - to be measured from the GP Survey every six months

Local Outcomes
Reduced A&E attendances
Reduced hospital admissions for patients with chronic long term conditions and dementia
Reduced re-admissions for patients with chronic long term conditions and dementia
Reduced Length of Stay
Reduced long term placements in residential and nursing packages
Reduce the need for long term support packages
Increase patients returning to previous level of functionality in usual environment
Increase levels of patient self management of long term conditions
Reduction in falls and secondary falls
Improve patient satisfaction and well being
Increase levels of patients with personal health budgets and integrated budgets
Improve health outcomes by better use of prevention services
Reduce unnecessary prescribing

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

Local patient / service user experience metric: Average EQ-5D score for people reporting having one or more long-term condition - to be reported via the Levels of Ambition Atlas as provided by NHS England

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

An integrated performance dashboard to be developed and made available monthly. This will be monitored through the CCGs existing assurance framework and made available to the local Health and well being Board and its Integrated Commissioning sub committee.

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*	156.2	N/A	154
	Numerator	358		346
	Denominator	43636		44552
		(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*	88.10%	N/A	90%
	Numerator	1401		1431
	Denominator	1590		1590
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	38.5		36.4
	Numerator	13		11
	Denominator	200382		202306
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1774.9	N/A	1759.7
	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-term condition		72.4	N/A	72.6
		(April 2012 - March 2013)		(April 2014 - March 2015)
(Local Metric) Proportion of People feeling supported to manage their condition. Expressed as a percentage and reflects the number of 'Yes, definitely', and 'Yes to some extent', response in the GP patient survey as a proportion of the total answers.	*Metric Value*	64.8%	N/A	70.0%
	Numerator	1176		1271
	Denominator	1815		1815
		(July 2013 to September 2013)		(January 2015 to March 2015

	£	
Reduction of 12 people Over 52 weeks	468,000	£750 - Nursing care cost per week as per CHC Team , Lisa Blackledge 11-3-14 (Ami Court is £111 per day - see tab)
Reduction of 30 People	42,000	Avoid readmission. Look at Urgent Care HCOOP, Gen Med, A&E tariffs Ave tariff Resp, genito Urinary etc (without CC) - £1,400 - see tab
Reduce delayed transfer of care - Assume that beds will be filled by additional patients, therefore no savings		
Reduction of 30 people	19,650	Avoid Emergency admissions Ave short stay cost - £655 see tab
N/A		
Links to Pro Active Care. No direct savings since this is effectively the start point for the metrics above		
	529,650	