**Appendix A**

# Better Care Fund – Technical Guidance

This document is designed as a reference to use in completing your Better Care Fund (BCF) planning template. It is not intended to be a complete guide to the Better Care Fund. In developing your plan for the Better Care Fund, you should also refer to:

- CCG Planning Guidance - which can be found on the NHS Planning page
- BCF Annex to Planning Guidance - which can be found on the NHS Planning page;
- BCF allocations – which can be found on the BCF Planning page
- "Guidance to local areas in England on pooling and aligning budgets"[1], DCLG;
- Planning FAQs - which can be found on the NHS Planning page

The document (i) discusses each section of the Better Care Fund Template in turn, (ii) sets out the detailed specification for each of the five national metrics underpinning the performance element of the Fund, (iii) provides further guidance on the choice of local metric, and (iv) provides further information for you in setting plans for each metric.

## The Better Care Fund Template

### Finance – Summary

The finance tabs of the template need only be filled out once for each Better Care Fund. This will normally mean that they are filled out by each Health and Wellbeing Board, but in some cases several Health and Wellbeing Boards may join together to make a single plan. Note that CCGs may appear in more than one BCF plan, if their population lies in multiple Health and Wellbeing Boards.

Contributions table

| Organisation | Spending on BCF schemes in 14/15 | Minimum contribution (15/16) | Actual contribution (15/16) |
|---|---|---|---|
| Local Authority #1 | | | |
| CCG #1 | | | |
| CCG #2 | | | |
| Local Authority #3 | | | |
| etc | | | |
| **BCF Total** | | | |

This table is intended to provide a summary of each participating body's contribution to the Better Care Fund in 2015/16, and of any spending on BCF schemes which is planned in 2014/15.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/8313/1508565.pdf

We will now describe the columns in more detail:

- **Organisation** – there should be a separate row for each organisation which is contributing some funds to the Better Care Fund. In many cases, the list will include an upper-tier local authority and a number of Clinical Commissioning Groups (CCGs) covering the same geographical area. Another organisation (e.g. a provider trust) may also choose to invest in the fund.

  In some cases, a group of multiple local authorities and CCGs may choose to plan together for the Better Care Fund. In such cases only one financial plan is needed, but each local authority and CCG should be listed separately in this table.

- **Spending on BCF schemes in 14/15** – some schemes to deliver the aims of the BCF will need investment in 14/15. There is £200m in the Better Care Fund in 2014/15, which will come as part of the s.256 transfer from NHS England to LAs. In addition, other partners may wish to invest early in order to realise benefits in 2015/16.

- **Minimum contribution (15/16) –** in this column, please record against each organisation the minimum amount which they must pay into the BCF in 2015/16. For local authorities, this will be the sum of the social care capital grant and the Disability Facilities Grant for 2015/16; for CCGs, this minimum will be given in the BCF allocations.

- **Actual contribution (15/16) –** CCGs and local authorities can choose to contribute more than the minimum. In this column, please record the actual amount which each organisation has contributed in 2015/16.

- **BCF total -** the total value of each column.

Contingency plans

| *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.* |
|---|
| |

The Better Care Fund is intended to provide a means for joint investment in integrated care, which ought to reduce the pressure on social care and hospitals by providing treatment before a crisis. CCGs will have to make significant efficiencies to generate the money to invest in the BCF, and there is a risk that if BCF plans do not deliver the anticipated results (e.g. reductions in residential care admissions or

reductions in emergency hospital admissions) resources will be needed to meet the demand (e.g. funding care packages or extra staff for A&E).

In this text box, please explain how you will meet any additional demand on health and care services if your BCF schemes do not deliver the anticipated reduction in demand.

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

This table gives some quantitative background to the contingency plan, allowing the reader to compare the scope of planned savings against the level of extra investment needed if the savings are not delivered. In more detail:

- **Outcome** – in this column, you should list the key metrics which you are using to measure the success of your BCF plan in reducing pressure on health and social care services. These are likely to include the national metrics, but may also include measures determined locally.

- **Planned savings (if target fully achieved) –** this row should give the level of savings expected if targets are achieved (e.g. if emergency admissions are reduced, reducing the amount of overtime required from A&E staff.)

- **Maximum support needed for other services (if targets not achieved) –** this row should give the amount of funding required to meet the additional need if the planned improvement in outcomes does not occur. E.g. if part of your BCF plans are that reablement means 100 fewer people need residential care, this would be the cost of putting those 100 people into residential care.

- Columns give the cost/benefit in 2015/16 and ongoing.

## Finance – Schemes

*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 |
| Scheme 1 | | | | | | | | | |
| Scheme 2 | | | | | | | | | |
| Scheme 3 | | | | | | | | | |
| Scheme 4 | | | | | | | | | |
| Scheme 5 | | | | | | | | | |
| Total | | | | | | | | | |

This table breaks down the financial implications of each element of your BCF plan across recurrent and non-recurrent, spending and benefits. In more detail:

- **BCF investment** – please use this column to list each scheme for using BCF spending. Please also include in this column the contributions paid from the BCF to district councils for the Disability Facilities Grant, unless they are included as part of another scheme. You may combine a number of small schemes into a single line, provided that the total value of that line is not greater than 10% of the BCF.

- **Lead provider –** this column should identify the primary provider for that scheme. Among other things, this might be an NHS provider, a charity, a council or a private company.

- **Spending –** these columns should match up to the total 14/15 and 15/16 spending listed in the Financial Summary sheet. This should be divided into recurrent and non-recurrent spending.

- **Benefits –** the Better Care Fund is intended to provide a better experience of care to patients and service users and by so doing reduce the pressure on residential care and acute hospitals. This column should capture any financial savings which are associated with the BCF initiatives, e.g. through reducing unplanned admissions.

## Outcomes & Metrics

You should provide details of the expected outcomes and benefits of the scheme and how these will be measured for each metric (other than patient experience) in the box provided (please expand the box as required).

| *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.* |
| --- |
| |

A patient/service user experience metric will be included for the 2nd (October 2015) payment and can be based on either an existing or newly developed local metric, or a national metric that is currently in development. If you are choosing a local metric for patient/service user experience, please provide details of how the local metric meets the following criteria:

- The metric should be meet SMART criteria (Specific, Measureable, Attainable, Realistic and Timely)
- The metric should target the population you are focussing on improving the health and well-being of. For example, the frail and more vulnerable elderly
- The metric should be centred around the core areas of improvement you are trying to make regarding patient experience. For example, understanding the extent to which people feel supported to manage their long term condition and have control over their daily lives
- The metric should look at patient experience across settings, considering how services work together.

If you are choosing the national metric, this is currently in development and details of payment will be confirmed once the national metric has been agreed.

*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*

Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand. To support this, for each metric you should provide details of the assurance process underpinning the agreement of the performance plans.

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

In addition to the local assurance the plans will also go through an assurance process involving NHS England and the LGA to assure Ministers.

Where it is agreed locally, you can work together with other HWBs to set a plan at a higher level – for example at county level. In this situation all HWBs within the area must sign up to the plan, and it should be clear what each HWB and each CCG is accountable within the plan.

*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*

Details should be provided in the template. In addition, plans should be submitted for each individual HWB, as well as the multiple-HWB combined (to allow reconciliation).

| 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* | | N/A | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | ( 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* | | N/A | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | ( April 2012 - March 2013 ) | | ( April 2014 - March 2015 ) |
| *Delayed transfers of care from hospital per 100,000 population (average per month)* | *Metric Value* | | | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | *( insert time period )* | ( April - December 2014 ) | ( January - June 2015 ) |
| *Avoidable emergency admissions (composite measure)* | *Metric Value* | | | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | *( 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 | |
| | | *( insert time period )* | | *( insert time period )* |
| *[local measure - please give full description ]* | *Metric Value* | | | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | *( insert time period )* | *( insert time period )* | *( insert time period )* |

You should provide a baseline for each metric, as well as a plan that will underpin each payment (April and October). We will now describe each column of the template in more detail:

- **Metrics** – this lists each individual metric, against which a baseline and plans need to be submitted. For the patient / service user experience measure, you should add the details of the metric that you propose to use here (if you do not provide these details then you will be agreeing that the as yet undetermined national metric for patient / service user experience). For the local measure, you need to provide details of the exact metric that you have chosen to contribute to the payment-for-performance element of the Fund.

- **Current Baseline** – To put performance plans in context, the template should set out a baseline level of performance for all of the metrics. For the permanent admissions to resident care and effectiveness of reablement metrics, the baseline should be 2012-13 data, which is available in the Operational Planning Atlas for CCGs. For delay transfers of care, data is available monthly and therefore you will want to choose the most appropriate period (in terms of representativeness of true underlying performance) to use as the baseline, although we recommend this should cover at least six months. For avoidable emergency admissions, historic data is not yet available at local authority level, and so NHS England will provide this data in January 2014. For the patient / service user experience measure you only need to enter a baseline if you have proposed a specific metric (as opposed to the as yet undetermined national metric). For the local measure, you will also need to provide a baseline figure. For all metrics you should provide the numerator and denominator as well as the overall metric value (typically a proportion or rate) to support the assurance process. For patient experience we'd anticipate that numerator and denominator data will not be available.

- **Performance underpinning April 2015 payment** – You should set out the level of ambition against which your performance will be assessed for the first payment of the performance element of the Fund here. The time period to which this should correspond has been stated in the template, although for the local metric you should specify this. A level of ambition is not required here for the permanent admissions to resident care and effectiveness of reablement metrics as these are annual metrics and will not underpin the April 2015 payment. Similarly we anticipate that any patient / service user experience metric will be annual, and so will not underpin the April 2015 payment. As with the baseline, you should provide the numerator and denominator (although typically this is based on ONS population estimates you may have to just assume no change) as well as the metric value.

- **Performance underpinning October 2015 payment** - You should set out the level of ambition against which your performance will be assessed for the second payment of the performance element of the Fund here. The time period to which this should correspond has been stated in the template, although for the local metric you should specify this. For the patient / service user experience measure you only need to complete this if you have

proposed a specific metric (as opposed to the as yet undetermined national metric).

## Specification of Metrics

| 1) Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population | |
|---|---|
| **Outcome sought** | Reducing inappropriate admissions of older people (65+) in to residential care |
| **Rationale** | Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. |
| **Definition** | **Description**: rate of council-supported permanent admissions of older people to residential and nursing care.<br>**Numerator**: Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey.<br>**Denominator**: Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate. |
| **Source** | Adult Social Care Outcomes framework (HSCIC: http://www.hscic.gov.uk/article/2021/Website-Search?q=Measures+from+the+Adult+Social+Care+Outcomes+Framework&go=Go&area=both )<br>Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html ) |
| **Reporting schedule for data source** | Frequency: annual (collected Apr-March)<br>Timing: Provisional data in 2012-13 was published July 2013 (4 month lag), final due early 2014 (9+ month lag)<br><br>Baseline:<br>This should be 2012-13 data available in the Operational Planning Atlas for CCGs.<br><br>Payment :<br>For this metric there will only be payment in October 2015 and this will be based on annual 2014-15 data. |
| **Historic** | Data first collected 2011-12 (currently two years data available – 2011-12 final, 2012-13 provisional) |

| 2) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | |
|---|---|
| **Outcome sought** | Increase in effectiveness of these services whilst ensuring that those offered service does not decrease |
| **Rationale** | Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal. |
| **Definition** | The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.<br>**Numerator:** The number of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. This excludes those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months. Collected 1 January to 31 March of relevant year for all cases in denominator.<br>**Denominator:** The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Collected 1 October to 31 December for the relevant year.<br>Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) discharged alive from hospitals in England between 1 October 2012 and 31 December 2012 (including all specialities and zero-length stays) that are offered this service. |
| **Source** | Adult Social Care Outcomes framework (HSCIC: http://www.hscic.gov.uk/article/2021/Website-Search?q=Measures+from+the+Adult+Social+Care+Outcomes+Framework&go=Go&area=both ) |
| **Reporting schedule for data source** | Frequency: annual (although based on 2x3 months data – see definition above)<br>Timing: Provisional data in 2012-13 was published July 2013 (4 month lag), final due early 2014 (9+ month lag)<br><br>Baseline:<br>This should be 2012-13 data available in the Operational Planning Atlas for CCGs. For the proportion offered reablement the baseline should be 2013-14 data (since this data is not required now to set this part of the level of ambition)<br><br>Payment :<br>For this metric there will only be payment in October 2015 and this will be based on 2014-15 data. |
| **Historic** | Data first collected 2011-12 (currently two years data available – 2011-12 final, 2012-13 provisional) |

| 3) Delayed transfers of care from hospital per 100,000 population | |
|---|---|
| **Outcome sought** | Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. |
| **Rationale** | This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. |
| **Definition** | Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month.<br>A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.<br>A patient is ready for transfer when:<br>(a) a clinical decision has been made that the patient is ready for transfer AND<br>(b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND<br>(c) the patient is safe to discharge/transfer.<br>**Numerator:** The total number of delayed transfers of care (for those aged 18 and over) for each month included*<br>**Denominator:** ONS mid-year population estimate<br>This rate should be divided by number of months included in numerator in order to give average total monthly delayed discharges (this is important in order to allow comparison of rates across the different payment periods – see *Reporting schedule for data source* below)<br>*Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'monthly snapshot' collected for one day each month. |
| **Source** | Delayed Transfers of Care (NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/ )<br>Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html ) |
| **Reporting schedule for data source** | Frequency: Numerator collected monthly. (Denominator annual)<br>Timing: 2 month lag. (ONS population denominator available for previous year in July - updated September. Where more appropriate ONS population projections can be used)<br><br>Baseline<br>Monthly data is available in the Operational Planning Atlas for CCGs for the period April 2012 to September 2013. Alternatively, the total monthly delayed transfers of care data is also available from NHS England (http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2013-14/) although the most up to date ONS population figures should be used to calculate rates. HWBs can choose an appropriate period to use although it is recommended that this covers at least six months and should be the latest available data.<br><br>Payment<br>Apr 2015 payment to be based on Apr-Dec 2014 (Q1-Q3 2014-15)<br>Oct 2015 payment based on Jan-Jun 2015 (Q4 2014-15 and Q1 2015-16) |
| **Historic** | Data first collected Aug 2010 (39 months currently available) |

| 4) Avoidable emergency admissions | |
|---|---|
| **Outcome sought** | Reduce emergency admissions which can be influenced by effective collaboration across the health and care system. |
| **Rationale** | Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the NHS improve the quality of care and reduce the frequency and necessity for emergency admissions.<br>About a third of avoidable admissions are for people with a secondary diagnosis relating to mental health. Progress in reducing emergency admissions is likely to need a strong focus on improving the physical health of people with mental health conditions. |
| **Definition** | Composite measure of:<br>• unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)<br>• unplanned hospitalisation for asthma, diabetes and epilepsy in children<br>• emergency admissions for acute conditions that should not usually require hospital admission (all ages)<br>• emergency admissions for children with lower respiratory tract infection.<br><br>Details of each of these separate indicators can be found in the NHS Outcomes Framework:<br>https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014<br><br>The composite measure will match that used in the Quality Premium except it will be based on Local authority (using resident population) rather than CCG geography (GP registered population).<br>http://www.england.nhs.uk/wp-content/uploads/2013/05/qual-premium.pdf<br><br>Numerator: emergency admissions for primary diagnoses covering those in all 4 metrics above for all ages, by local authority of residence<br>Denominator: Local authority mid-year population estimate/projected estimate (ONS)<br>This will be used to give the crude rate of avoidable emergency admissions per 100,000 population |
| **Source** | Hospital Episode Statistics |
| **Reporting schedule for data source** | Frequency: Quarterly<br>Timing: 4 month lag<br><br>Baseline<br>Historic data will not available to HWBs so NHS England will provide baseline data in January 2014.<br><br>Payment<br>April 2015 payment will be based on Apr 2014-Sep 2015 data<br>October 2015 payment will be based on Oct 2014-Mar 2015 data. |
| **Historic** | Quarterly data will be produced from January 2014 but historic data will be available to extract for last 5 years |

| 5) Patient/service user experience | |
|---|---|
| **Outcome sought** | To demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem. (Details of patient/service user engagement in development of BCF Plan should be included in Part 1 of the BCF Planning template) |
| **Rationale** | Effective engagement of patients, the public and wider partners in the design, delivery and monitoring of services:<br>• Improves communication between communities, service users, commissioners and providers<br>• Gives patients, carers & their families a better understanding of their conditions and treatment plans to achieve better outcomes<br>• Increases understanding of patients and the public about health and social care services<br>• Empowers communities to have a say in the delivery of local services<br>• Encourages better decision-making and leads to more effective service delivery; by involving communities in the design/delivery of services they are more likely to be successful in terms of their relevance, usage levels and, therefore, their impact. |
| **Definition** | Payment can be based on either an existing or a newly developed local metric or on a national metric. Please note that it is not possible to provide details of a national metric at this stage. Analysis of potential existing measures has identified a number of shortcomings in these measures, particularly in their ability to reflect experience across entire journeys of care and sectors. Therefore, a new national metric is currently being developed. For those choosing to use the national metric details of payment will be confirmed once the national metric has been agreed.<br><br>The following criteria should be applied by those choosing to use a local metric:<br>• The metric should be meet SMART criteria (Specific, Measureable, Attainable, Realistic and Timely)<br>• The metric should target the population you are focussing on improving the health and well-being of. For example, the frail and more vulnerable elderly<br>• The metric should be centred around the core areas of improvement you are trying to make regarding patient experience. For example, understanding the extent to which people feel supported to manage their long term condition and have control over their daily lives<br>The metric should look at patient experience across settings, considering how services work together. |
| **Source** | To be determined at a local level (national metric currently being developed) |
| **Reporting schedule for data source** | October 2015 data to be provided through an agreed local metric or a national metric. No single national measure of integration currently exists. Work is currently being undertaken to provide an appropriate |

| | |
|---|---|
| | initial national data source for reporting in October 2015. |
| **Historical comparisons** | Data for October 2015 submission based on a local or national metric. Historical comparisons will not be available unless local metrics have been used previously. A national metric is currently being devised for reporting in October 2015. |

## Local Metric

In addition to the five national metrics, you should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. You are required to either select one of the following metrics or another suitable local metric to underpin both the April 2015 and the October 2015 payment.

| | |
|---|---|
| **NHS Outcomes Framework** | |
| 2.1 | Proportion of people feeling supported to manage their (long term) condition |
| 2.6i | Estimated diagnosis rate for people with dementia |
| 3.5 | Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days |
| **Adult Social Care Outcomes Framework** | |
| 1A | Social care-related quality of life |
| 1H | Proportion of adults in contact with secondary mental health services living independently with or without support |
| 1D | Carer-reported quality of life |
| **Public Health Outcomes Framework** | |
| 1.18i | Proportion of adult social care users who have as much social contact as they would like |
| 2.13ii | Proportion of adults classified as "inactive" |
| 2.24i | Injuries due to falls in people aged 65 and over |

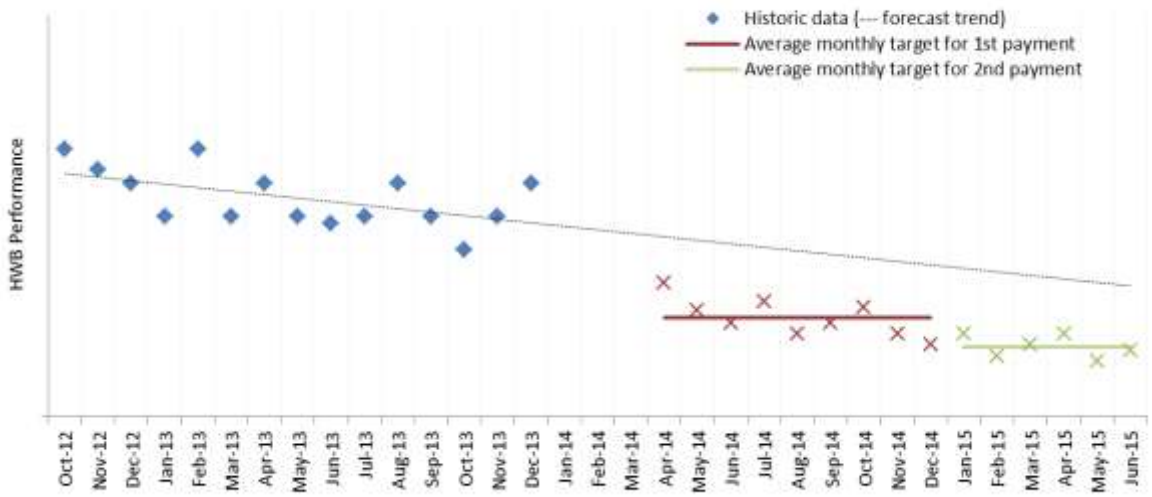
Whatever metric is selected (including those listed above), you must ensure that:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers – see "statistical significance" in next section);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance – this means that baseline data must be available in 2013-14 and that the data must be collected more frequently than annually;
- A numerator and a meaningful denominator should be available to allow the metric to be produced as a meaningful proportion or a rate;
- the achievement of the locally set plan is suitably challenging; and
- the metric creates the right incentives.

## Setting plans for each metric

For the avoidable emergency admissions and delayed transfers of care metrics (and potentially the local selected metric) there should be sufficient historic data available to allow you to be able to use forecasting as a tool in setting your levels of ambition. This could involve plotting historic data, assessing the trend over time and using this to set a target which is "better" than that predicted by the current trend – *see chart 1* (preferably taking in to account statistical significance – see below).

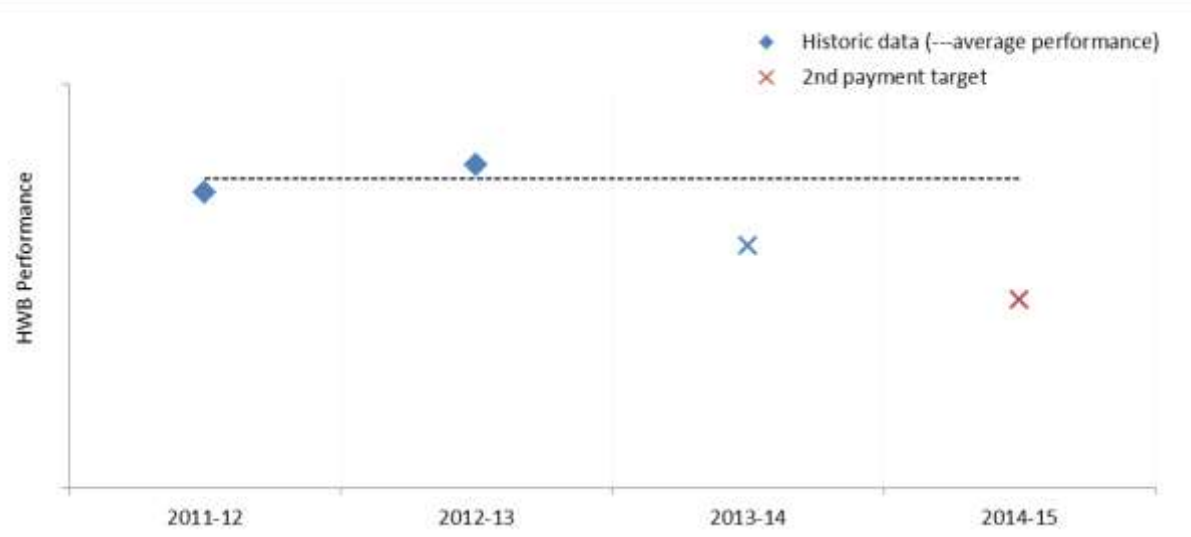
Chart 1: example of forecasting approach to setting targets for delayed transfer of care. The average monthly target for each payment could be set using the historic trend, and then the data collected from each month (red and green crosses) can be used to measure actual performance.




Any locally understood seasonal trends (periodic peaks or troughs) apparent in the data can also be taken in to account although it is anticipated that these variations will be marginal in most localities.

For the other metrics there will be insufficient historic data to allow this kind of forecasting. Instead the average historic performance may be a suitable starting point from which to base the level of ambition – *see chart 2.* Alternatively, the recent England 'trend' could be used as a means of forecasting.

Chart 2: example of average performance approach to setting targets for residential admissions.




It is important that you can provide assurance that detailed consideration has been given to the levels of ambition you set. Levels of ambition should:

- provide an overall goal and sense of purpose
- be related to actions known to be effective
- be achievable over a specified time
- be realistic but challenging
- be measurable and be able to be monitored
- be agreed by those who have a part to play in their achievement
- be expressed in terms of health improvements or reductions in risk factors in the population.

Clearly you will need to identify the key actions that can be taken to improve health and social care integration and link these predicted effects to a realistic level of ambition.

**Statistical significance**

Alongside the above considerations, you should be aware that improvements below a certain threshold will not be differentiable from year-to-year random fluctuations and therefore may not provide sufficient assurance that 'real' improvement has been made. It is recognised however that the size of a local authority (or more precisely the size of the relevant population to a given metric) will have an impact on the threshold required to reach statistical significance and therefore this will tend to be tougher for smaller local authorities. Therefore it is important that this is considered when setting targets although for some localities it may not be realistic to set a target on the basis of statistically significant improvement within the timeframe of the Better Care Fund.

The table below gives an indication, for each metric, of the magnitude of relative improvements that would be required to show statistically significant improvement for half of all localities (the median) within the timeframes of interest in the Better Care Fund. For all localities to statistically significantly improve these would need to be markedly higher.

| National metric | Relative improvement for half of localities to significantly improve |
|---|---|
| **Residential care admissions** | -13% |
| **Reablement effectiveness** | 6% |
| **Delayed transfers of care** | -4% |
| **Avoidable emergency admissions** | Data not yet available |
| **Patient experience** | Data not yet available |

In addition we have produced a “ready reckoner” that allows you to enter your baseline figures and the tool will show the approximate change required for it to be statistically significant. You may want to use this in setting your plans for the Fund. This tool uses a log-transform methodology to derive approximate confidence intervals around the rate/risk ratio between the baseline and the relevant payment period. To use this you will require:

- Your baseline numerator and denominator data (e.g. delayed transfers of care count and ONS local authority population),
- the expected target denominator for the particular payment period (this could be a forecast figure or, if expected to change little the same as the baseline denominator)
- The baseline and target periods used. These will be the same for some metrics (e.g. 12 months for reablement and residential admissions) but for others they may be different (e.g. delayed transfers of care). If different then the baseline and target numerators in the tool will represent figures for different time periods and will have to be divided through by the relevant periods in order to compare e.g. average monthly rate.
- There are also two dropdowns to choose the required direction of travel (e.g. target should be for delayed transfers of care to decrease) and the level of confidence in the statistical significance calculation. In many cases the 95% confidence level will be the appropriate level to use but a lower confidence level may be more appropriate, for example for smaller areas where it is harder to demonstrate statistical significance.

The tool will provide the target numerator that will be required for areas to show statistically significant improvement along with the relative percentage improvement required.