This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

The three tabs containing tables have been protected so that the structure can not be modified in a way that will impede the collation of all HWB plans. However, for the finance tables whole rows can still be inserted by right clicking on the row number to the left of the sheet and clicking 'insert'.

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# 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. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary*

| Organisation | Holds the pooled budget? (Y/N) | Spending on BCF schemes in 14/15 /£ | Minimum contribution (15/16) /£ | Actual contribution (15/16) /£ |
|---|---|---|---|---|
| Central Bedfordshire Council | | £ 3,821 | £ 1,190 | £ 4,607 |
| CCG #1 | | £ - | £ 14,100 | £ 14,100 |
| | | | | |
| | | | | |
| | | | | |
| **BCF Total** | | **£ 3,821** | **£ 15,290** | **£ 18,707** |

*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.*

Our submission is based on initial modelling work to understnd the potential impact of our Better Care Fund Plan, which is based on four programmes related to key points on the care pathway, from prevention and early intervention to ongoing support to main independence and to reduce reliance on institutional forms of care. Our modelling shows the best case scenario testing, developed within the time available and as such we will continue to test our assumptions as more detailed programme plans which will include further modelling and analysis emerge. Though the governance framework set out in Part One, we will continually monitor the BCF programme and through a performance management framework the joint accountable body for the Fund will receive real time data and regular updates on impact. The Health and Wellbeing Board will also be inv olved in this process. Through these processes we will manage risks and make adjustments as required. For both the CCG and the Council , the focus will be on intermediate care, rehabilitation and reablement; the role and impact of community health services, alignment with the programme of neighbouring authorities and continuing to look at efficiences, process redesign and procurement savings. We will continue to monitor the performance of the pooled budget ensuring that governance and accountability is strong. The Clinical Commissioning Group has agreed to top up the adjustment to reflect the initial sum of £15.290m. Underpinning all this is a continuing communications and engagement programme that covers both health and social care providers as well as key stakeholders in our four localities. Both the Clinical Commissioning Group and the Council are aligning this planning with the current contracting round.

| Contingency plan: | | 2015/16 | Ongoing |
|---|---|---|---|
| **Outcome 1** | Planned savings (if targets fully achieved) | 7.49 | 7.74 |
| | Maximum support needed for other services (if targets not achieved) | 14.37 | 14.85 |
| **Outcome 2** | Planned savings (if targets fully achieved) | 4.50 | 4.65 |
| | Maximum support needed for other services (if targets not achieved) | 8.63 | 8.92 |

*Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to 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 /£ |
| Reshaping our prevention and early intervention model | Council and Primary Care (in partnership with others including the voluntary and community sector) | £ 287,000 | | £ 260,000 | | £ 410,000 | | £ 980,000 | |
| Supporting people with long term conditions through multi-disciplinary working | Community Health Services and Primary Care (in partnership with Council) | £ 300,000 | £ 50,000 | £ 280,000 | | £ 300,000 | £ 56,000 | £ 1,090,000 | |
| Expanding the range of services which support older people with frailty and disabilities | Central Bedfordshire Council (in partnership with others including housing providers and the voluntary and community sector) | £ 867,000 | | £ 1,090,000 | | £ 3,989,000 | | £ 4,190,000 | |
| Restructuring urgent care pathways | Acute Trusts and Primary Care in conjunction with the Council | £ 2,317,000 | | £ 1,840,000 | | £ 13,952,000 | | £ 7,070,000 | |
| | | | | | | | | | |
| **Total** | | £ 3,771,000 | £ 50,000 | £ 3,470,000 | £ - | £ 18,651,000 | £ 56,000 | £ 13,330,000 | £ - |

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## Outcomes and metrics

*Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement*

1) Permanent admissions of older people (65+) to residential and nursing care homes, per 100,000 population
OUTCOME - reducing inappropriate admissions of older people (65+) into residential and nursing care, by reviewing the provisions of community based services and the expansion of the extra care market in Central Bedfordshire, as a alternative to residential care.
MONITORING - this metric will be monitored on a monthly basis, splitting the data by accommodation type and locality area.
2) Proportion of older people (65+) still at home 91 days after discharge from hospital into reablement/rehabilitation services
OUTCOME - to increase the likelihood of people remaining at home following the successful completion of reablement or rehabilitation.
MONITORING - For the Council's Reablement service, this metric will be monitored on a monthly basis, by locality area. Discussions will take place regarding the frequency of monitoring for commissioned services.
3) Delayed transfers of care from hospital per 100,000 population
OUTCOME - 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, by acting on the common causes for delayed discharges.
MONITORING - this metric will be monitored on a monthly basis, using the SITREP data. Data will be reported at a locality level, based on the hospital location.
4) Avoidable emergency admissions
OUTCOME - reduced emergency admissions, which can be influenced by effective collaboration across the health and care system
MONITORING - Further exploratory work is required to identify availability of the data.
The BCF target of 12% reduction in avoidable emergency admissions has been retained from the Initial submission to align with the CCG's Strategic Plan target.
5) Patient/service user experience
OUTCOME - To demonstrate that patient/service user and carer feedback has been collated and used to improve patient experience and 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. Central Bedforshire will use the national measure
MONITORING - whilst awaiting the national metric, Central Bedfordshire will monitor patient experience thorugh the Family and Friends Test and the Adult Social Care Survey. The national metric will be used to monitor performance, once the definitions are published.
6) LOCAL INDICATOR - Injuries due to falls in people aged 65 and over
OUTCOME - To reduce the number of admissions to hospital following a fall, by the increased use of interventions
MONITORING - Further exploratory work is required to identify availability of the data. Proxy measures may be developed

*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*

*Central Bedfordshire will use the national metric.*

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

*For all of the metrics used to measure the progress of our Better Care Fund plans, we have looked at historic local performance to establish trends. We have then applied the recommendations of the ready reckoner to establish the necessary impact our programmes need to exert in order to be statistically significant. We have also studied what has been achieved elsewhere to ensure that the expected outcomes of our BCF plans are credible. This is important to generate commitment to the programmes from across the local health*

*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*

*This plan covers only the Central Bedfordshire Health and Wellbeing Board.*

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# Outcomes and metrics

*Please complete all pink cells:*

| Metrics | | Baseline* | 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* | 602.9 | N/A | 518.4 |
| | *Numerator* | 256 | | 236 |
| | *Denominator* | 42465 | | 45525 |
| | | ( Apr 2012 - Mar 2013 ) | | ( Apr 2014 - Mar 2015 ) |
| **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**<br>*NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0* | *Metric Value* | 0.74 | N/A | 0.84 |
| | *Numerator* | 77 | | 87 |
| | *Denominator* | 104 | | 104 |
| | | ( Apr 2012 - Mar 2013 ) | | ( Apr 2014 - Mar 2015 ) |
| **Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)**<br>*NB. The numerator should either be the average monthly count or the appropriate total count for the time period* | *Metric Value* | 140.3 | 134.8 | 136.5 |
| | *Numerator* | 288 | 254 | 258 |
| | *Denominator* | 205296 | 208330 | 311310 |
| | | *Apr - Nov 2013 (Average)* | Apr - Dec 2014 (9 months) | Jan - Jun 2015 (6 months) |
| **Avoidable emergency admissions per 100,000 population (average per month)**<br>*NB. The numerator should either be the average monthly count or the appropriate total count for the time period* | *Metric Value* | 139.4 | 122.9 | 123.4 |
| | *Numerator* | 366 | [1] 7 | 332 |
| | *Denominator* | 262512 | 266041 | 269580 |
| | | *Apr - Sept 2013 (Average)* | Apr - Sep 2014 (6 months) | Oct 2014 - Mar 2015 (6 months) |
| **Patient / service user experience**<br>*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* | | *(State time period and select no. of months)* | [6] /A | *(State time period and select no. of months)* |
| **Emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population** | *Metric Value* | 1364.1 | | 1236.7 |
| | *Numerator* | 549 | | 563 |
| | *Denominator* | 40275 | | 45525 |
| | | *Apr 11 - Mar 12* | [1] *(S period and select no. of months)* | *Apr 13 -Mar 14* |