APPENDIX 3

BETTER CARE FUND IMPACT ANALYSIS

1. INTRODUCTION

The Leicestershire Better Care Fund (BCF) Plan for 2014/15 and 2015/16 will be submitted on 4 April 2014. This will compromise an updated BCF plan with a supporting financial and performance outcome template submission. The aim of this paper is to present the findings of an impact analysis of the thirty-seven components of the BCF plan against the plans of the six outcome metrics. NHS England provided technical guidance for the preparation of baselines and trajectories for each metric, including an indication of what would constitute a statistically significant improvement based on the population size.

2. FINDINGS FROM METRIC REVIEWS

Since the original BCF submission on 14 February 2014 a detailed impact analysis has been undertaken of the (five) national and (one) local metrics against which delivery of the BCF plan will be assessed. This initial impact assessment was presented for discussion at a multiagency workshop held on 12 March 2014. The findings are presented below.

2.1. METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care. Chart 1 shows a bar chart illustrating the proposed trajectory detailed in Table 1 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 1.1

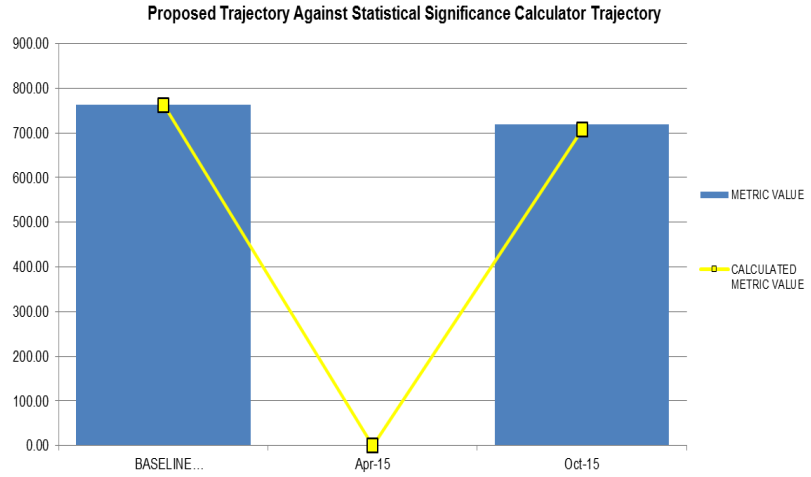

Chart 1.2

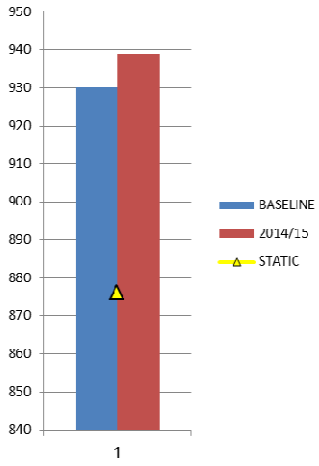

Table 1

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	930		939
DENOMINTOR	121,930		130,645
METRIC VALUE	762.73		718.74

The proposed trajectory is for a reduction from 762.73 permanent admissions per 100,000 population per year to 718.74 (or 5.77%) by 31 March 2015 (this is against a national benchmark of a reduction of 13%). It is noted that the numerator for the October 2015 payment is 939 which is an increase of 9 (0.97%) against the baseline of 930. Chart 1.2 illustrates this increase in the numerator. This chart also shows the effect of discounting population growth which would result in 54 fewer permanent admissions to residential or nursing care.

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

This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge. Chart 2 shows a bar chart illustrating the proposed trajectory detailed in Table 2 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 2.1

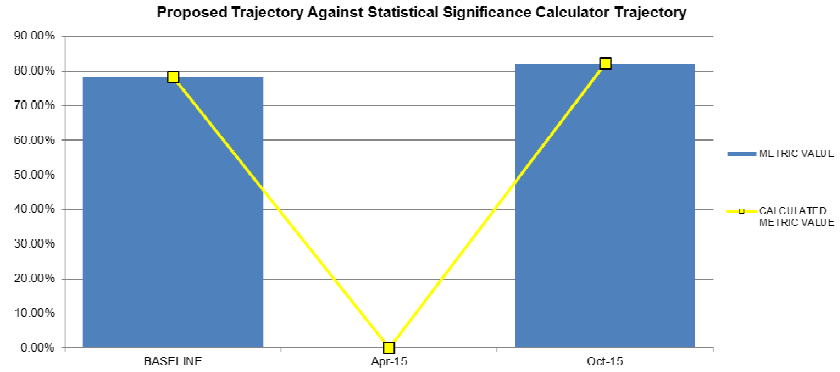

Chart 2.2

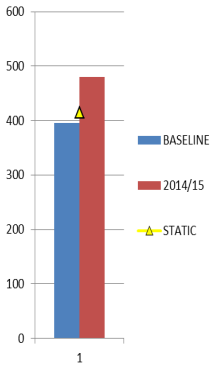

Table 2

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	395		480
DENOMINTOR	505		584
METRIC VALUE	78.22%		82.19%

The proposed trajectory is for an increase from 78.22% of service users still at home 91 days after discharge to 82.19% (or 5.08%) by 31 March 2015 (this is against a national benchmark of an increase of 6%). It is noted that an action plan is being developed to improve the data quality to more accurately measure the 91-day period from discharge. Chart 2.2 shows the effect of discounting population growth on the number of older people who were still at home 91 days after discharge. It is noted however, that the percentage delivery against this indicator remains the same.

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

This is a nationally defined metric measuring delivery of the outcome of 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. The aim is therefore to reduce the rate of delayed bed days per 100,000 population. Chart 3.1 shows the cumulative monthly rate of delayed bed days per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 3.2 shows the reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Chart 3.1

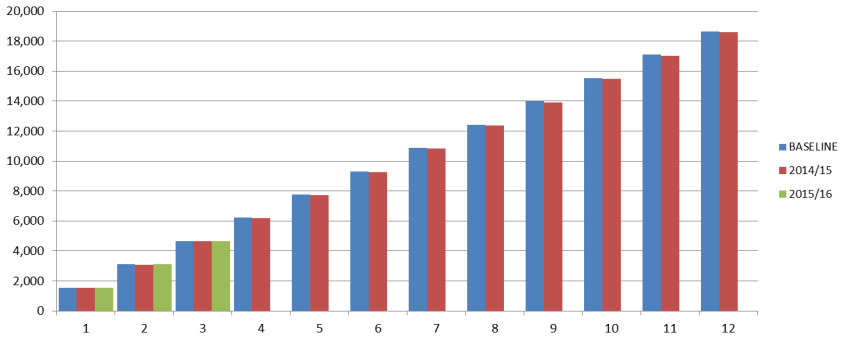

Chart 3.2

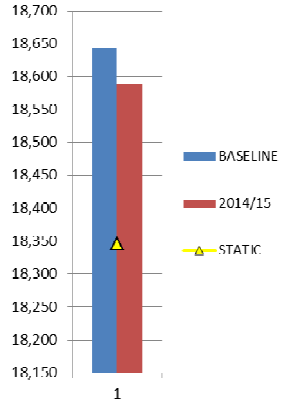

Table 3

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Dec-14)	Oct-15 PAYMENT (Jan-15 – Jun-15)
NUMERATOR	12,429	13,915	9,348
DENOMINTOR	530,769	536,515	541,600
METRIC VALUE	292.71	288,18	287.67

Table 3 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 292.71 delayed bed days per 100,000 per month to 288.18 (1.55%) by 31 December 2014 followed by a further reduction to 287.67 (0.18%) by 30 June 2015. This is against a national benchmark of a reduction of 4%. Chart 3.2 also shows the effect of discounting population growth which would result in a further reduction of 242 delayed bed days at the end of 2014/15.

2.4. METRIC 4: Avoidable emergency admissions (composite measure)

This is a nationally defined metric measuring delivery of the outcome to reduce avoidable emergency admissions which can be influenced by effective collaboration across the health and care system. This is a composite measure of:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in children
- Emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- Emergency admissions for children with lower respiratory tract infections

Chart 4.1

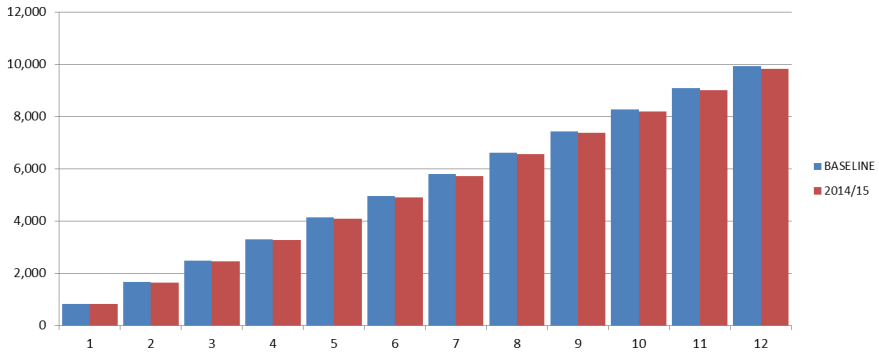

Chart 4.2

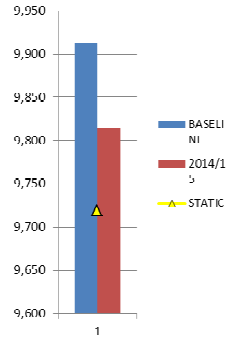

Chart 4.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 4.2 shows the reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Table 4

	BASELINE (Apr-12 – Mar-13)	**Apr-15 PAYMENT (Apr-14 – Sep-14)**	**Oct-15 PAYMENT (Oct-14 – Mar-15)**
NUMERATOR	9,913	4,907	4,907
DENOMINTOR	665,557	672,049	672,049
METRIC VALUE	124.12	121.69	121.69

Table 4 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 124.12 emergency admissions per 100,000 per month to 121.69 (1.96%) by 30 September 2014 and then remaining the same at 121.69 until 31 March 2015. Chart 4.2 also shows the effect of discounting population growth which

would result in a further reduction of 99 avoidable emergency admissions at the end of 2014/15

2.5. METRIC 5: 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]

This will be a nationally defined metric however, at the time of writing this paper the guidance confirming the definition of the metric has not be released. The outcome will be 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.

In the absence of this clarity this metric was reviewed as part of the BCF workshop held on 12 March 2014.

2.6. METRIC 6: Injuries due to falls in people aged 65 and over

This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions due to falls in people aged 65 and over. Chart 5.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 the period October 2014 to September 2015. Chart 5.2 shows the increase in cumulative emergency admissions comparing the end of the baseline period with 2014/15 and the period October 2014 to September 2015.

Chart 5.1

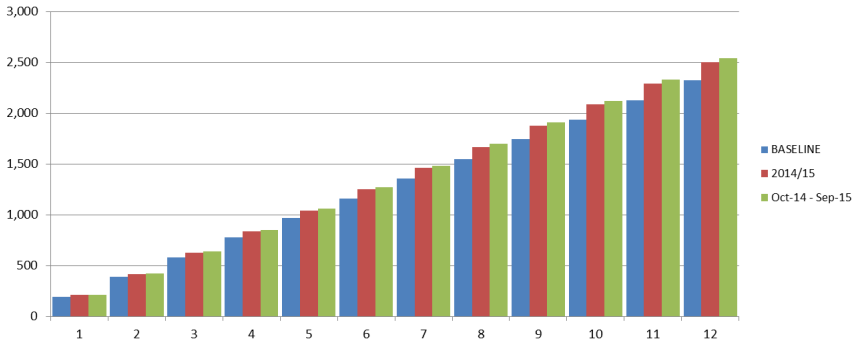

Chart 5.2

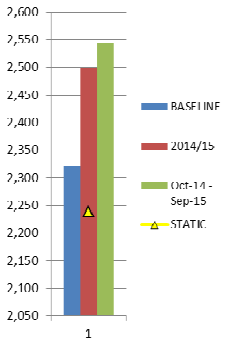

Table 5

	BASELINE (Apr-10 – Mar-11)	Apr-15 PAYMENT (Apr-14 – Mar-15)	Oct-15 PAYMENT (Oct-14 – Sep-15)
NUMERATOR	2,322	2,500	2,543
DENOMINTOR	115,044	128,466	130,645
METRIC VALUE	168.20	162.17	162.21

Table 5 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 168.20 emergency admissions per 100,000 per month to 162.17 (3.58%) by 31 March 2015 followed by a slight increase to 162.21 (0.02%) by 30 September 2015. Chart 5.2 also shows the effect of discounting population growth which would result in a further reduction of 83 emergency admissions due to falls at the end of 2014/15 in comparison to the baseline.

3. OUTCOME OF WORKSHOP/RECOMMENDATIONS

A multi-agency BCF Impact Assessment Workshop was held on 12 March 2014. The aim of the workshop was to jointly assess the achievability of the six BCF metrics and the impact on the health and care system. In light of the assessment, the workshop would propose any material changes to the BCF submission on 4 April 2014 and associated recommendations.

The proposed trajectories for each of the six metrics in section 2 reflect the output of analysis and validation undertaken up to and following the workshop. During the course of the workshop, the team made an assessment of which of the BCF schemes would make the most directly measurable contribution to the delivery of each metric. The workshop also assessed the overall risks to deliver each metric and created a product showing the top three risks in each case for immediate prioritisation, along with suggested mitigation.

Products from this work are:

- An updated BCF Scheme Impact Analysis (included as Appendix A)
- An updated BCF Metric Impact Analysis (included as Appendix B)

- Appendix C shows updated tables which illustrate how each of the 37 schemes contribute to the delivery of the six metrics
- A prioritised list of risks and associated mitigations to deliver each of the six metrics (included as Appendix D)

3.1. RESIDUAL RISKS REQUIRING MITIGATION PRIOR TO 4 APRIL SUBMISSION

With reference to Appendix D the following table highlights a list of risks and associated mitigations which will be addressed as part of the work to finalise the submission for 4 April.

METRIC	RISK	MITIGATION	STATUS
3	Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the DToC metric and those schemes which make a minimal contribution	Schemes currently identified against the DToC metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed **ACTION**: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	COMPLETE (Appendix C)
	The current DToC metric needs to be amended prior to resubmission so that it has a negative gradient in line with the national benchmark	**ACTION**: It was agreed that GEM would send SR revised numerators for the DToC metric by close of play Friday 14 March. This revision would be aligned to the CCGs' 5-year Strategy. GEM will also confirm that the baseline includes DToC for both UHL and LPT	COMPLETE
	Need to identify schemes outside of the BCF that directly impact on the DToC metric for Adult	The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery of	IN PROGRESS

METRIC	RISK	MITIGATION	STATUS
	Mental Health DToC	the DToC metric. These will be included toward evidencing delivery of the DToC metric	
4	Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the metric and those schemes which make a minimal contribution	Schemes currently identified against the metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed **ACTION**: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	COMPLETE (Appendix C)
	The current metric needs to be reviewed and amended prior to resubmission so that it is inline with CCG plans and 2014/15 contracts	**ACTION**: It was agreed that GEM would review the metric and if necessary send SR revised numerators for the metric by close of play Friday 14 March.	IN PROGRES
	Are all providers (i.e. UHL, LPT and out-of-county) included in the current submission?	**ACTION**: It was agreed that GEM would review and send confirmation to SR by close of play Friday 14 March.	COMPLETE
	Need to identify childrens schemes outside of the BCF that directly impact on the metric	The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery metric. These will be included toward evidencing delivery of the DToC metric	IN PROGRESS
6	EMAS service – a proven scheme which is likely to deliver	Propose the addition of the EMAS non conveyance/falls service and cost into the BCF,	IN PROGRESS

METRIC	RISK	MITIGATION	STATUS
	against the metric quickly is not within the BCF plan (or therefore linked to this metric)	adjust other schemes as needed to find the resource required. Ensure this is a joint scheme between EMAS/LA and NHS so that operational protocols and local pathways are aligned to support non conveyance	

3.2. RESIDUAL RISKS TO BE CAPTURED IN BCF PROJECT PLAN FOR 2014/15

METRIC	RISK	MITIGATION
1	Capacity in Dom Care market – workforce risks	Better care together (LLR wide strategy) will include a workforce strategy Help to Live at Home project group is also tackling this issue in Leicestershire However we need to understand the pace and milestones for these improvements to ensure we meet the metric
	Limited staff pool to develop new areas of service	Action plan to include plans to develop generic workers. How contract terms for Dom care workers can be addressed
	Mobilisation, resource and capacity are concerns	Clear agreement of model asap Data baseline required asap
2	Normally bottom quartile for this metric	Immediate feasibility work to change the approach to data capture and cost the implications of these changes – need to capture where people actually end up after reablement – across all settings of care.
6	Number of the schemes are about future delivery (prevention) and will not see	Longer term prevention schemes still need to be prioritised and developed but clarity is needed in presentation of these schemes

METRIC	RISK	MITIGATION
	results/impact on metrics immediately in year 1	against this metric that they will deliver later and need measurables

4. CONCLUSIONS AND RECOMMENDATIONS

I. Gaps remain in the impact analysis, including where evidence is missing or incomplete, where governance or project resources are unclear, or where there is insufficient detail in the measurement of the interventions/data capture. It is recommended that the impact analysis is subject to further work in Q1 2014/15, with a progress update at the April meeting of the Integration Executive.

II. That KPIs be further validated (where they exist) or developed as necessary for each of the BCF component schemes, so that their contribution to the 6 headline metrics is clear and the impact can be tracked by scheme.

III. The risk analysis and mitigation plan by metric should be incorporated into the project plan and risk register of the relevant component of the integration programme.

IV. The Integration Executive is recommended to approve the submission of the metrics per the analysis in this paper with the following caveats:

a. Further work is required to improve data quality for metric 2 (reablement 91 days)

b. That the DTOC metric may be subject to further national development in 2014/15

c. That the avoidable emergency admissions trajectory should be expressed over a 5 year period with supporting narrative indicating the improved pace of delivery (stretch to be applied) from 2015/16 onwards in line with CCG operating plan/5 year plan intentions.

d. In the absence of a national metric for capturing patient experience the Integration Executive should ask quality leads to consider the feasibility of using a local proxy metric or metrics which can be applied to the 4 themes of the BCF.

e. That the numerator for the falls metric currently increases over the course of the proposed trajectory. Due to this further analysis is needed on the impact of the schemes to deliver against this metric – see V below

V. The Integration Executive should include a new scheme in the BCF to address the falls metric, as the findings of the workshop the schemes currently in the plan will not deliver in the first 18 months but are valid for prevention in the longer

term. The addition of the EMAS falls prevention scheme is recommended as this has good evidence from elsewhere in the East Midlands and analysis is currently underway to assess the financial requirements for this scheme in 2014/15.

VI. The papers for the Health and Wellbeing Board on April 1st should include a short cover paper outlining the decisions of the integration executive with supporting Appendix B, so that assurance can be given on the validation undertaken of the metrics prior to BCF approval.

5. APPENDIX A: BCF Scheme Impact Analysis

BCF Schemes Impact Analysis (V2.4).xls

6. APPENDIX B: BCF Metric Impact Analysis

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METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

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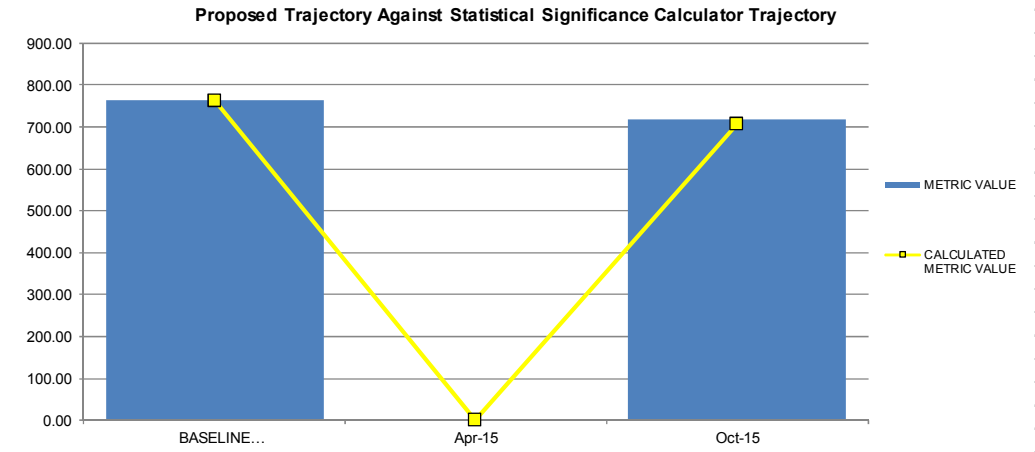

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
			(Apr-14 - Mar-15)
SUBMITTED TRAJECTORY			
NUMERATOR	930		939
Variance against previous milestone			9
DENOMINATOR	121,930		130,645
METRIC VALUE	762.73		718.74
Improvement			-5.77%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	930		924
Variance against previous milestone			-6
Variance	0		15
Percentage variance	0.00%		1.62%
CALCULATED METRIC VALUE	762.73		707.26
Variance	0.00		11.48
Percentage variance	0.00%		1.62%
Improvement			-7.27%

Matches BCF base data

Matches BCF base data

Matches BCF base data

Matt Williams confirmed this was calculated using the Statistical Significance Calculator with a 90% confidence level

Calculated using the BCF Statistical Significance Calculator

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because the submitted metric has a) a numerator for Oct-15 greater than he baseline and although the metric shows an improvement, the absolute volume of admission increases to 939 for the submitted trajectory (using a 90% confidence level) b) the submitted trajectory has an improvement of -5.77% whereas the calculated trajectory (using a 95% confidence level) has a greater improvement of -7.27% (the national benchmark is -13%) - Amber Performance RAG given due to the current performance against this metric - Amber/Red Risk RAG given because delivery against this metric has been assessed to be very challenging

DEFINITIONS	
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.
DENOMINATOR:	Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate.
METRIC:	rate of council-supported permanent admissions of older people to residential and nursing care.

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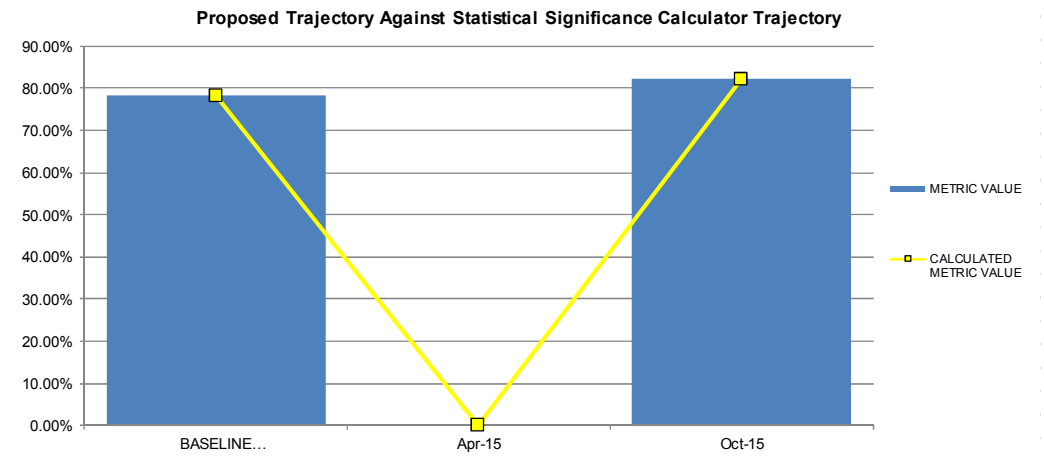
METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

(back)



	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	395		480
Variance against previous milestone			85
DENOMINATOR	505		584
METRIC VALUE	78.22%		82.19%
Improvement			5.08%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	395		480
Variance against previous milestone			85
Variance	0		0
Percentage variance	0.00%		0.00%
CALCULATED METRIC VALUE	78.22%		82.19%
Variance	0.00		0.00
Percentage variance	0.00%		0.00%
Improvement			5.08%

Apr-14 - Mar-15

Matches BCF base data

Calculated using the BCF Statistical Significance Calculator

Matches BCF base data

Matt Williams advised that the Oct-15 denominator value has been modelled locally

INFORMATION RAG	**A**
PERFORMANCE RAG	**A**
RISK RAG	**A**
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the data quality of the numerator is not good due to the monitoirng of the 91-day window following discharge from reablement **(ACTION:** Matt Williams and Sandy McMillan to write a summary of issue and remedial solutions). It is noted that the submitted improvement is 5.08% against a national benchmark of 6% - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult due to the data quality issues

DEFINITIONS	
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.
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. 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.
METRIC:	The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.

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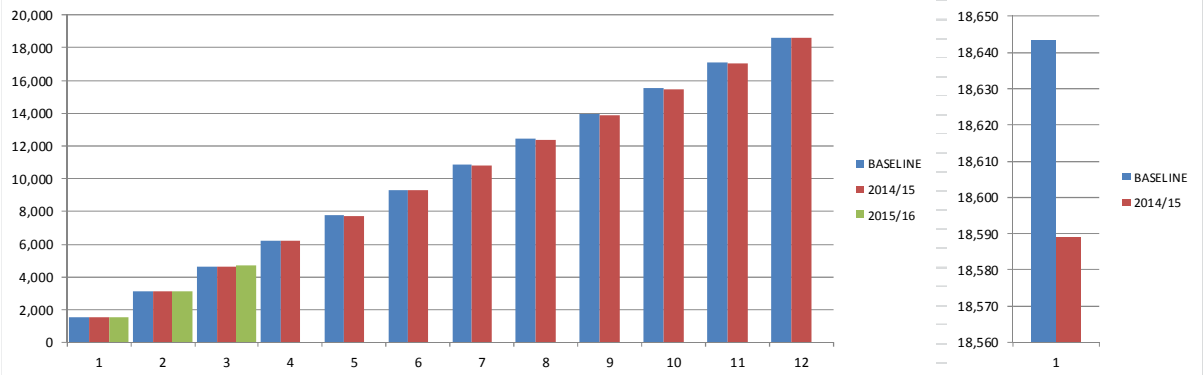
METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month)

(back)



	BASELINE	Apr-15	Oct-15
NUMERATOR	12,429	13,915	9,348
DENOMINATOR	530,769	536,515	541,600
Number of months	8	9	6
Monthly rate	1,553.63	1,546.11	1,558.00
METRIC VALUE	292.71	288.18	287.67
		-1.55%	-0.18%
			-1.72%

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
Combined annual activity	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
2014/15	1	2	3	4	5	6	7	8	9	1	2	3
Cumulative activity per month	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	1,558	3,116	4,674
Combined annual activity	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	15,473	17,031	18,589
2015/16	1	2	3									
Cumulative activity per month	1,558	3,116	4,674									
Combined annual activity	1,558	3,116	4,674									
												-55
												-0.29%

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Red Information RAG given because a) the revised trajectory has a negative gradient against a national benchmark of -4%. The trajectory using the calculated numerators with a 95% confidence level shows a decrease of -5.89% for Apr-15 and a continued decrease of -12.66% for Oct-15. The trajectory using the calculated numerators with a 75% confidence level shows a decrease of -2.41% for Apr-15 and a continued decrease of -5.22% for Oct-15 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	The total number of delayed transfers of care (for those aged 18 and over) for each month included
DENOMINATOR:	ONS mid-year population estimate 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)
METRIC:	Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.

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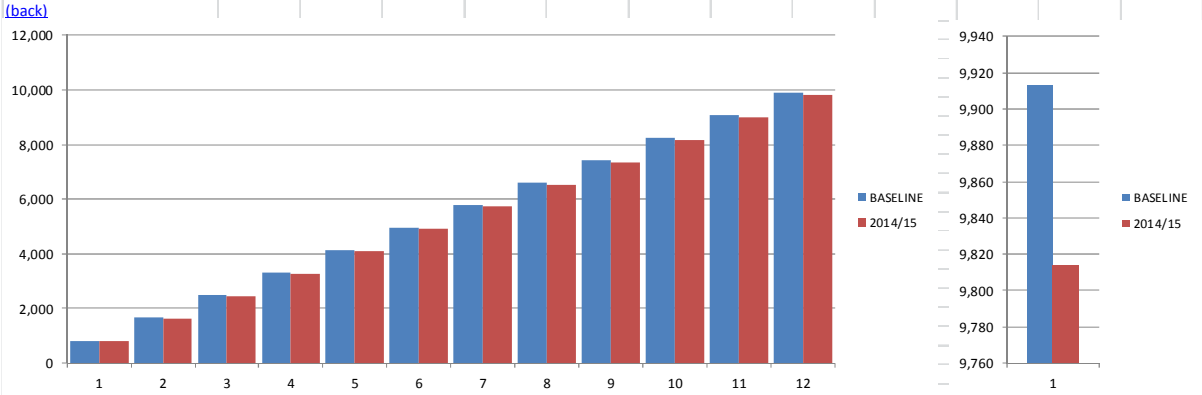
METRIC 4: Avoidable emergency admissions (composite measure)

(back)



	BASELINE	Apr-15	Oct-15
NUMERATOR	9,913	4,907	4,907
DENOMINATOR	665,557	672,049	672,049
Number of months	12	6	6
Monthly rate	826.08	817.83	817.83
METRIC VALUE	124.12	121.69	121.69
		-1.96%	

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
Combined annual activity	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
2014/15	1	2	3	4	5	6	1	2	3	4	5	6
Cumulative activity per month	818	1,636	2,454	3,271	4,089	4,907	818	1,636	2,454	3,271	4,089	4,907
Combined annual activity	818	1,636	2,454	3,271	4,089	4,907	5,725	6,543	7,361	8,178	8,996	9,814

INFORMATION RAG	A
PERFORMANCE RAG	G
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the source of the numerator for Apr-15 and Oct-15 can not be replicated using the statistical significance calculator (the baseline numerator using the historic data would be 4,698) b) the submitted trajectory results in a different reduction in admissions than trajectories calculated using the statistical significance calculator with either a 75% or 95% confidence level (a national benchmark is not currently available) and c) the reduction in admissions from the baseline to the first and subsequent milestones are significant and is this reflected in 2014/15 contracts? It is noted that the sum of the two milestones for the submitted trajectory is 8,620 (a variance of 95 against the baseline) and the modelled trajectories are 8,446 and 8,677 respectively (variances of 269 and 38 respectively) - Green Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	Emergency admissions for primary diagnoses covering those in all 4 metrics above for all ages, by local authority of residence
DENOMINATOR:	Local authority mid-year population estimate/projected estimate (ONS) This will be used to give the crude rate of avoidable emergency admissions per 100,000 population
METRIC:	Composite measure of: □ unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) □ unplanned hospitalisation for asthma, diabetes and epilepsy in children □ emergency admissions for acute conditions that should not usually require hospital admission (all ages) □ emergency admissions for children with lower respiratory tract infection. Details of each of these separate indicators can be found in the NHS Outcomes Framework: https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014 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). http://www.england.nhs.uk/wp-content/uploads/2013/05/qual-premium.pdf

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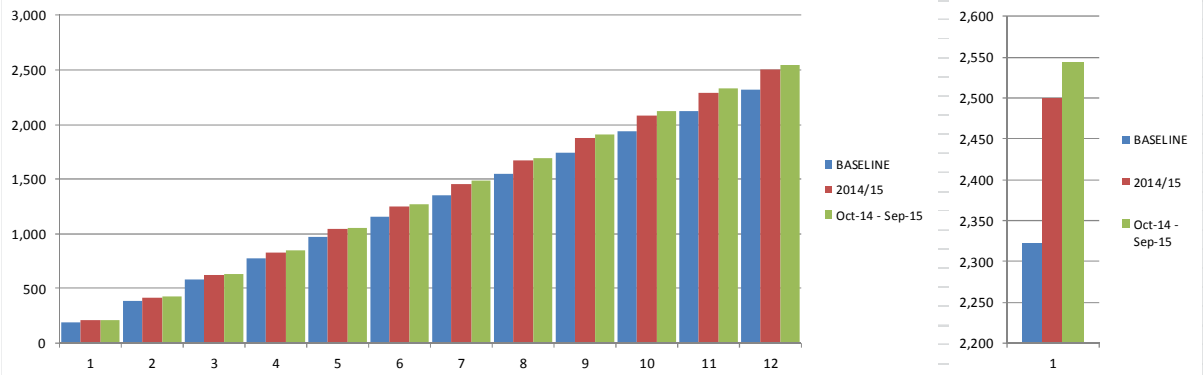
METRIC 6: Injuries due to falls in people aged 65 and over

(back)



	2018.3582	1946.0402	1946.4962
	BASELINE	**Apr-15**	**Oct-15**
NUMERATOR	2,322	2,500	2,543
DENOMINATOR	115,044	128,466	130,645
Number of months	12	12	12
Monthly rate	193.50	208.33	211.92
METRIC VALUE	168.20	162.17	162.21
		-3.58%	0.02%

	MONTH											
BASELINE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
Combined annual activity	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
2014/15	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Combined annual activity	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Oct-14 - Sep-15	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543
Combined annual activity	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543

INFORMATION RAG	**A**
PERFORMANCE RAG	**A**
RISK RAG	**A**
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) no milestone has been included for Apr-15 b) is there a benchmark to appraise the submitted improvement? c) although the metric shows an improvement, the absolute volume of falls increases to 2,543 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	This is measured by the number of emergency admissions due to falls
DENOMINATOR:	The denominator is the ONS mid-year population estimate provided by NHS England as part of the BCF toolkit. This is the estimated 65+ population of Leicestershire
METRIC:	This is our local measure which will enable us to monitor the effectiveness of the prevention programme of work in particular with our frail older population. This links with the improved housing offer which will enable a more rapid response to patients identified that require adaptations or alternative options that ensure that they are safe and independent within their homes. Furthermore the proactive and integrated care model involves risk stratification and proactive care planning for patients who can be supported to manage their long term conditions using the MDT approach - measuring the injuries due to falls will enable us to monitor the effectiveness of these plans.

7. APPENDIX C: BCF Scheme Impact Analysis Pivot Table

METRIC 1: Residential & Nursing Care Admissions	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
LTCs	SC - protection of community care packages
	SC - Sustainable community services
Prevention	Assistive Technology
	Carers Assessment
	Carers Service
	Disabled Facilities Grants
Urgent Response	Integrated Crisis Response Service

METRIC 2: Rehabilitation / Reablement	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
	HART Reablement
	Hospital to Home
	Integrated Residential Reablement
	Intermediate Care
Urgent Response	Integrated Crisis Response Service

METRIC 3: Delayed Bed Days	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
	HART Reablement
	Hospital to Home
	Integrated Residential Reablement
	Intermediate Care
	NHS - Assertive In Reach
	NHS - Intensive Community Service
	NHS - Reablement
	NHS - Step Down
	Strengthening Mental Health Discharge Provision
Urgent Response	Integrated Crisis Response Service

METRIC 4: Avoidable Emergency Admissions	
THEME	**SCHEME**
Discharge Reablement	Intermediate Care
	NHS - Intensive Community Service
	SC - Residential Care Respite
LTCs	Improving Quality in Care Homes
	Integration Model for LTCs (ELRCCG)
	Proactive Care (WLCCG)
	SC - Increasing demographic pressures

	SC - Nursing care package
	SC - protection of community care packages
	SC - Sustainable community services
Prevention	First Contact
	Local Area Coordination
Urgent Response	Elderly Frail Service
	Expanded role of Primary Medical Care
	Integrated Crisis Response Service

METRIC 5: Patient / Service User Experience	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
	HART Reablement
	Hospital to Home
	Integrated Residential Reablement
	Intermediate Care
	NHS - Assertive In Reach
	NHS - Intensive Community Service
	NHS - Reablement
	NHS - Step Down
	Patient Transfer Minimum Data Set
	Strengthening Mental Health Discharge Provision

LTCs	Improving Quality in Care Homes
	Integration Model for LTCs (ELRCCG)
	IT Enablers - data sharing, care plans , t/health & t/care
	Pathway to Housing
	Proactive Care (WLCCG)
Prevention	Assistive Technology
	Carers Assessment
	Carers Service
	Disabled Facilities Grants
	First Contact
	Local Area Coordination
	NHS - LD Short Breaks
	Specialist Support to People with Dementia & Carers
	Time Banking (Non-recurrent funding)
Urgent Response	Elderly Frail Service
	Expanded role of Primary Medical Care
	Integrated Crisis Response Service

METRIC 5: Falls	
THEME	**SCHEME**
LTCs	Integration Model for LTCs (ELRCCG)
	Proactive Care (WLCCG)
Prevention	Assistive Technology
	Disabled Facilities Grants
	Local Area Coordination

It is noted that the schemes below may be enabling overall rather than relate in a measurable way to a specific metric

THEME	**SCHEME**
Discharge_Reablement	HART Scheduling System
	SC - cost pressures linked to new models of working
Prevention	Assistive Technology (replacement equipment) (Non-recurrent funding)
	Strengthening Autism Pathway

8. APPENDIX C: prioritised list of risks and associated mitigations to deliver each of the six metrics

Metric Name: One – Residential/Nursing Care

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
GP communications on available services	ALL	Communications plan/support tools for GPs so they have the most up to date information on care pathways and have details of when new elements of service come on stream via the BCF plan.			
First Contact in GP surgeries may not be well developed	First Contact	As above but to include ensuring the GPs role in First Contact is communicated.			
Cultural risk on Assistive Technology adoption – staff and citizens seem not to favour it in LLR, and so this presents a risk in the BCF plan, where we are aiming to get greater uptake of AT to avoid use of other services	Assistive Technology	Educating GPs / nursing staff / public about the benefits of AT, evaluate knowledge and confidence of AT before and after awareness campaign			
Mobilisation, resource and capacity are concerns	Bridging Service	Clear agreement of model asap Data baseline required asap	3		
Capacity in Dom Care market – workforce risks		Better care together (LLR wide strategy) will include a workforce strategy Help to Live at Home project group is also tackling this issue in leicestershire	1		

Metric Name: One – Residential/Nursing Care

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
Limited staff pool to develop new areas of service		Action plan to include Plans to develop generic workers. How contract terms for Dom care workers can be addressed	2		
Financial risks in changing profile of workforce		For discussion with the LLR-wide strategy group – how can the workforce strategy influence T&Cs to support BCF priority workforce changes/ groups			
Housing offer to Health – "light bulb"	Unified Prevention	Project plan needed to deliver consolidated service as soon as possible. Procurement timeline needs factoring in District buy in and agreement to Pooling of DFGs is a key factor –need to factor in time required to reach agreement			
Lack of prioritisation and coordination of schemes across the metric	All metrics	Too many priorities and lack of clarity about which scheme best serves which metric(s) will lead to a confused and ineffective programme of work			
Risks to change in carer assessments as a result of the Care Bill		Modelling the costs of these changes, and comparing to the figures currently in the BCF			
Schemes that are about improving hospital discharge are not featuring in this metric and are potentially applicable.	Discharge	Consider the impact on the trajectory for this metric that can be achieved via improved discharge – confirm and challenge with CCGs and UHL			

Metric Name: One – Residential/Nursing Care

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1 Group 2 Group 3
Carers service - difficult to measure the contribution	Carers	More work needed on how we will measure effectiveness of carers service – may need to link to patient experience metric	☐ ☐ ☐
We may not be capturing data that tracks the impact of reablement on mitigating admissions to residential and nursing care	Reablement/ IC	Look at the feasibility of capturing this data and calculate the trends in activity /outcomes from reablement service in avoiding residential/nursing care. Will help with future pathway development and BCF costings	☐ ☐ ☐
Continence management/care not featuring in the BCF but is a key risk factor for admissions to nursing and residential homes		Triggers for admission to residential care needs considering, emphasis in the BCF plan may need revisiting	☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐

Metric Name: Two – 91 Days

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1 Group 2 Group 3
Current problems exist with the baseline data which could be exacerbated with the move to the new ASC data system	All reablement	Action plan to improve data capture/quality and mitigate the impact of the IT changes	☐ ☐ ☐
The Metric as defined nationally is a blunt instrument and does not look at all aspects of the patient experience pathway and how this can be improved via the BCF plan	All reablement	Measure readmission via use of NHS number Agree definition of what we mean by readmission With agreement on evidence base and capturing the timing of readmission	☐ ☐ ☐
Residential reablement discharge to assess pathway needs improving	All reablement	Plan in place to re-commission the model	☐ ☐ ☐
Normally bottom quartile for this metric	All reablement	Immediate feasibility work to change the approach to data capture and cost the implications of these changes – need to capture where people actually end up after reablement – across all settings of care.	1 ☐ ☐
Risk that when the reablement pathway ends we are not signposting to other services effectively such as low level support in communities	All reablement	Identify the hand off points between reablement and other services and have a product suitable for professionals and public per locality.(link to LAC)	☐ ☐ ☐
Need to make the link between speed of hospital discharge and effectiveness of reablement		Correlate data between speed of hospital discharge and end point of reablement (e.g. measure to span length of stay through to outcome of reablement)	☐ ☐ ☐

Metric Name: Three – Delayed Transfers of Care (DToC)

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the DToC metric and those schemes which make a minimal contribution		Schemes currently identified against the DToC metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed ACTION: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	1		
Need to identify schemes outside of the BCF that directly impact on the DToC metric for Adult Mental Health DToC		The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery of the DToC metric. These will be included toward evidencing delivery of the DToC metric	3		
To identify schemes outside of the BCF Programme which make a contribution to the delivery of the DToC metric		The revised version of the BCF submission to include a caveat noting that other, non-BCF schemes contribute to the delivery of the DToC metric. However, due to complexity and pragmatism these scheme will be noted and not discretely included in monitoring delivery of the DToC metric (e.g. EMAS workstream)			
The current DToC metric needs to be amended prior to resubmission so that it has a negative gradient in line with the national benchmark		ACTION: It was agreed that GEM would send SR revised numerators for the DToC metric by close of play Friday 14 March. This revision would be aligned to the CCGs' 5-year Strategy. GEM will also confirm that the baseline includes DToC for both UHL and LPT	2		
Need to develop local metrics for: • DToC across all Providers (i.e. UHL, LPT and out-of-county) • Delayed days (rather than delays) *(note: since the workshop on 12/3/2014, revised BCF guidance has changed the metric from delays to delayed days)* • To split out health and mental health delays *(note: since the workshop on*		ACTION: It was agreed that GEM would work with SR and CCG colleagues to develop these metrics			

Metric Name: Four – Avoidable Emergency Admissions

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
The current metric needs to be reviewed and amended prior to resubmission so that it is inline with CCG plans and 2014/15 contracts		ACTION: It was agreed that GBM would review the metric and if necessary send SR revised numerators for the metric by close of play Friday 14 March.	2		
Are all providers (i.e. UHL, LPT and out-of-county) included in the current submission?		ACTION: It was agreed that GBM would review and send confirmation to SR by close of play Friday 14 March.	2		
Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the metric and those schemes which make a minimal contribution		Schemes currently identified against the metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed ACTION: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	1		
Need to identify childrens schemes outside of the BCF that directly impact on the metric		The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery metric. These will be included toward evidencing delivery of the DToC metric	3		
To identify schemes outside of the BCF Programme which make a contribution to the delivery of the metric		The revised version of the BCF submission to include a caveat noting that other, non-BCF schemes contribute to the delivery of the metric. However, due to complexity and pragmatism these scheme will be noted and not discretely included in monitoring delivery of the metric			

Metric Name: Five – Patient / Service User Experience

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1 Group 2 Group 3
In the absence of a national metric Outcomes Framework submissions to be reviewed to identify appropriate measures		Outcome Framework submissions to be reviewed	☐ ☐ ☐
In the absence of a national metric National Voices submissions (40 key statements) to be reviewed to identify commonality between LPT and LCC		National Voices submissions to be reviewed	☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐

Metric Name: Six – Falls

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
Number of the schemes are about future delivery (prevention) and will not see results/impact on metrics immediately in year 1	First Contact Housing offer LAC	Longer term prevention schemes still need to be prioritised and developed but clarity is needed in presentation of these schemes against this metric that they will deliver later and need measurables	2		
EMAS service – a proven scheme which is likely to deliver against the metric quickly is not within the BCF plan/or therefore linked to this metric)	Urgent response Falls	Propose the addition of the EMAS non conveyance/falls service and cost into the BCF, adjust other schemes as needed to find the resource required. Ensure this is a joint scheme between EMAS/LA and NHS so that operational protocols and local pathways are aligned to support non conveyance	1		
Elderly frailty service business case	Elderly frailty service	Needs to show alignment to falls prevention			
There should be a link in the falls prevention section of the BCF to Medicines Use Reviews and their role in preventing falls	Case management of over 75s LTC Hospital discharge	change of medication or a medicines review should prompt consideration of impact on risk factors for falls.			
Case finding through implementing a number of better prevention services across the BCF could lead to greater demand on certain services e.g. carers support, equipment, assistive technology	All areas but esp. unified prevention and LTCs	Assessing the impact of case finding on other elements of the BCF/other aspects of the health and care system should be factored into the impact assessment action plan.			