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

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. 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) /£
City of York Council	N	£ 3,354	£ 951	£ 951
NHS Vale of York CCG	Y	£ 1,311	£ 11,176	£ 11,176
BCF Total		**£ 4,665**	**£ 12,127**	**£ 12,127**

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.

A contingency plan requires, to an extent, an ability to implement an alternative strategy which is more effective at delivering what the plan sets out to achieve, since it has to deliver more quickly than the primary plan. Therefore, the contingency plan will be somewhat unwieldy, somewhat risky and certainly counter to the original intent. Early views on how this can be achieved centre on reverting to old processes, investment in additional capacity and cash bail-out to support over-stretched services

Contingency plans have not yet been defined in detail. There are risks inherent in the transformation of services which lead to the reduction of capacity of acute and secondary care settings instituted on the belief of reducing volumes. Reinstating this capacity at pace as a contingency response will not be quick and will not be easily achieved, especially where it concerns staffing.

To mitigate these risks, it is intended to plan for a phased introduction of our plan, with well-planned change management, robust evaluation and reporting, with carefully staged capacity release to ensure the risks are minimised and that corrective action is taken as early as possible.

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)		

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 /£
4 Respite(beds) for dementia	City of York Council	*82*		*130*		*82*		*130*	
Supporting carers assessments and direct payments to help carers at risk maintain their health and well being	City of York Council	*100*		*234*		*100*		*702*	
Increase telecare equipment, installation, monitoring and response capacity	Social Enterprise	*75*		*130*		*75*		*260*	
Additional care co-ordination capacity	City of York Council	*50*				*50*			
Placement Hub to free up care management time to focus on assessments and reviews	City of York Council	*70*				*70*			
Additional care management capacity to support assessment of needs	City of York Council	*137*				*137*			
Home Care provision to enable throughput from reablement service and thus offer support for hospital discharges	Private provider	*1,734*		*1,734*		*1,734*			
12 Transitional care and intermediate care beds	City of York Council	*300*		*438*		*300*		*438*	
Provision of reablement service to residents	Private provider	*915*		*1,170*		*915*		*1,170*	
Support to Carers	VoYCCG	*396*		*468*		*396*		*2,340*	
Data analyst expert developing data sharing protocols necessary to integrate health and social care services	CYC	*40*				*40*			
Community Facilitators to create community capacity and alternatives to "traditional" care provision	CYC	*40*		*120*		*40*		*120*	
Pilot Care Hub - Priory Medical Group	Priory Medical Group	*250*		*750*					
Emergency Care practitionersCPs	YAS	*216*		*648*		*216*		*648*	
Street Triage (part fund with NYCC)	NY Police	*100*		*300*		*100*		*300*	
Hospice at Home (part fund with NYCC)	St Leonards Hospice	*135*		*405*		*135*		*405*	
Pyschiatric Liaison (part fund with NYCC)	LYPT/YTHFT	*25*		*75*		*25*		*75*	
Further schemes to be developed and extension to existing schemes	VoYCCG					*6,320*		*18,960*	
Care Bill Implementation						*441*			
Disabilities Facilities Grant - grants to individuals to adapt home/install equipment enabling them to remain independent	CYC					*544*		*750*	
Social Care Capital Grant - contribution to Elderly Persons' home reprovision in York	CYC					*255*		*255*	
Social Care Capital Grant - investment in IT systems to implement the Care and Support Bill	CYC					*152*		*152*	
Total		£ 4,665	£ -	£ 6,602	£ -	£ 12,127	£ -	£ 26,705	£ -

Association

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

As part of our plan to deliver proactive care through local care hubs, we are working with 2 provider groups to implement our agreed approach. Specifically we intend our models to deliver the following performance outcomes:
* A reduction in the proportion of residents being admitted to care homes from both acute and community settings. We expect too see performance improvements in the range of 8-9% in year 1.
* A decrease in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge. We expect to see performance improvements in the range of 20% in year 1, increasing to around 35% by mid 2015.
* A reduction in the number of falls related injuries for residents over the age of 65. We expect to see performance improvements in the range of 6%.
* A shared care record for each individual accessing the Care Hub. We intend to work with providers to determine stretch targets for compliance.
* A named single contact point for each person accessing the Care Hub. We intend to work with providers to determine stretch targets for compliance.

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

We will initially use the national metric (under development) to measure patient experience but we intend to investigate additional measures of experience and service user well-being.

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

Joint Delivery Group

The Joint Delivery Group (JDG) will be responsible for ensuring the delivery of the proposed Care Hubs and other BCF related schemes and will hold providers to account for the delivery of their respective programme plans. This board will also design and implement the reporting and monitoring framework and will be accountable to the respective existing boards (ICB, CTB and HC&WB Board) for tracking and reporting progress. The JDG will also act as a forum to address shared issues across the Care Hubs and will manage the combined risk register, escalating as necessary.

The JDG is co-chaired by the Vale of York and City of York and membership includes suitably empowered representatives of City of York Council, North Yorkshire County Council and East Riding of York Council. A GP from the CCG sits onthe JDG to provide clinical oversight and scrutiny and a senior social worker is also a cor emember to provide specialist scrutiny and support to proposed schemes.

Care Hub Delivery Groups

The Delivery Groups (one in each Local Authority area in which Vale of York CCG works) will be responsible for the day to day management and delivery of their respective models. We do not intend to dictate to providers how they should manage the delivery of their projects, however we are clear that the levels of engagement and involvement highlighted earlier in this paper will form a crucial part of their success. We intend to work closely with our potential providers to help them establish these Delivery Groups and we will support these groups with specialist input (finance, modelling etc.) as required. We have already held a joint workshop with 2 of the hubs, supported by a team from NHS England, to build on the assurance processes we have put in place, and have put in a place a 6 weekly joint Action Learning Set which will complement the 2 weekly JDGs.

We will expect the Delivery Groups to work collaboratively to make sure we capture all the learning from their respective models and we are putting in place the required support network to make this happen. We will also develop the necessary reporting structure and processes we expect the Delivery Groups to follow, which will in turn give the necessary assurance to respective boards and accountability bodies.

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

NHS Vale of York CCG sits across the local authorities of City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council. Separate BCF plans have been submitted to cover these areas.

Please complete all pink cells:

	Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
1	**Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population**	*Metric Value*	617.7	N/A	525.3
		Numerator	215		197
		Denominator	34805		37500
			(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
2	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	69.8	N/A	83.3
		Numerator	30		40
		Denominator	45		48
			(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
3	**Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)** *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	18.3	14.9	11.5
		Numerator	30	25	19
		Denominator	163950	164934	165923
			april 2012 - march 2013	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
4	**Avoidable emergency admissions (average per month)** *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	2137.8	2113.1	2063.5
		Numerator	4276	4252	4177
		Denominator	200018	201218	202425
			(State time period and select no. of months)	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
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*		*(State time period and select no. of months)*	N/A	*(State time period and select no. of months)*
6	**Local measure** *Injuries due to falls in people aged 65 and over per 100,000 population*	*Metric Value*	2288.3	2106.3	1936.0
		Numerator	771	773	726
		Denominator	33693	36700	37500
			april 2012 - march 2013	*april 2014 - march 2015*	*oct 2014 - sept 2015*