Better Care Fund – Technical Guidance

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1. This document is designed as a reference to use in completing the Better Care Fund (BCF) planning templates. 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:

   - The covering letter accompanying the guidance and template documents
   - The revised Better Care Fund planning guidance
   - The planning templates (parts one and two)

2. The document
   i. provides information to support the completion of the part 1 and part 2 planning templates
   ii. explains the revised Payment for Performance framework, including payment schedule
   iii. sets out the detailed specification for the Payment for Performance metric, and the specification for the national metrics not linked to payment
   iv. provides further information in setting plans for each metric.

The BCF Plan Template Part 1 – what 'good' looks like

3. Part 1 of the template has been revised to ensure that the questions are as clear as possible and provide space for sufficiently detailed information about local plans. For a summary of the changes to Part 1 of the template, please see the revised Better Care Fund planning guidance.

4. Below you will find detailed guidance for each of the sections and sub sections of the revised Part 1 template, highlighting the primary issues to consider and the key pieces of information to provide.

Section 1) Please complete the summary information as requested.

Section 2) Vision for health and social care services	**A good vision for health and social care services will:** • Give a high level but realistic picture of how your health and social care services will look in five years'

	time • Give a clear comparison between current and 2018/19 state • Reference your JSNA and JHWS, and any other locally relevant strategic plans • Describe this difference in terms of changes to patient and service user experience and outcomes. • Evidence the input of service users and public engagement • Make it clear how these changes effectively respond to changes to the local public health needs and the broader demographic, and socio-economic changes in your local area • Describe a set of concrete changes to service delivery that will help to bring about this vision for the future. E.g. • Who is delivering the care and support, and who is receiving the care and support? o Where is the care and support being delivered? o When is the care and support being delivered? o How is the care and support being delivered? • Describe which precise aspects of this change you are intending to deliver using the Better Care Fund o Which aspects of service change would not otherwise be delivered without the BCF?

Section 3) Case for change	**A good case for change will:** • Provide a clear and quantified understanding of the precise issues that the BCF will be used to address in your local area • Include risk stratification of entire population and segmentation of opportunity to improve quality and reduce costs • Be bespoke to your area, i.e. not a generic narrative about the need for integration that could be relevant to any local area • Be supported by data– e.g. data that quantifies levels of unmet need, issues of service quality, or inefficiencies in service delivery • Provide visualisations of data if appropriate – do you have any graphs or diagrams that illustrate these issues? • Articulate at a high level how integration (of systems, processes, teams, budgets) could be used to improve this issue – i.e. set out in broad terms the theory of change or logic that supports your BCF plan

Section 4) Plan of action	**A good plan of action will:**
	
	• Describe the specifics of the overarching governance and accountability structures in place locally to support integrated care:
	  o How do these support joint accountability?
	  o At what level will strategic issues be dealt with?
	• Describe the specifics of the management and oversight in place to support the delivery of the Better Care Fund plan:
	  o At what level will operational issues be dealt with and how will these be escalated
	• You may find putting in diagrams helpful to explain structures for decision making and governance
	• Articulate the arrangements in place to support joint working, especially where there has been little precedent for joint delivery
	• Set out the key milestones associated with delivery of your plan of action

Section 4 c) Planned BCF Schemes – please list the schemes which you will provide further detail on in Annex 1

Section 5a) Risk log	**In addition to answering all of the prompts, a good risk log will:** • Be developed in partnership with all stakeholders • Cross reference with all risks raised elsewhere within the template, e.g. issues raised through the stakeholder engagement exercises (Cross ref. Section 7) • Use a consistent scale to describe the likelihood of the risk arising • Articulate the potential impact in quantified terms as far as possible – how many people would it affect? What would be the knock on implications? • Set out a precise and tangible list of mitigating actions, each of which have an agreed owner and timeline

Section 5 b) Financial risk sharing and contingency.	**A good risk sharing and contingency plan will:** • Quantify the amount of the pooled funding that is 'at risk' • Demonstrate that this has been calculated using clear analytics and modelling. Link to Payment for Performance tab, Part 2 plan template • Articulate an agreed plan for how this funding will be spent o What services or development will this be used to fund?

	○ In which quarter will you receive this, and what are the implications for financial management? • Confirm that the Health and Wellbeing Board has been consulted on this plan of action and that they are aware of the spend • Articulate any other risks associated with not meeting the target for reduction in unplanned emergency admissions – will this have any knock on implications? How far can these be mitigated through pre-emptive actions? • Articulate what proportion of the financial risk will be born by each party, and how these are reflected in contracting and payment arrangements

Section 6) Alignment a) with other initiatives related to care and support underway in your area.	**A well aligned plan will:** • Make reference to the links with initiatives, such as (but not limited to): ○ Challenged health economies ○ Implementation of personal budgets ○ The Local Vision programme • Articulate how these initiatives can support the delivery of the Better Care Fund? Is there any shared resource? • Identify any inter-dependencies – how does one initiative impact or depend on the other? • State who will be responsible for bringing together and ensuring ongoing communications between the related initiatives • Consider and articulate how well aligned the plan is with local plans for housing and plans for the use of technology
b) with existing 2 year operating and 5 year strategic plans, as well as local government planning documents	• Confirm that the schemes described in this BCF plan are all included as part of the 2 year operating plans for 2014-2016 and aligned with 5 year strategic plans • Highlight any schemes that are not part of the 2 year plans – how will this be managed? How will these plans be included in any refreshed CCG plans or in CCG plans for 16-18? ○ Are there any risks that emerge as a result of differences or discrepancies between the BCF plans and the 2 year plans? How can these be addressed?
c) with your plans for primary co-commissioning • For those areas which have not applied for primary co-	• Describe the arrangements in place for primary co-commissioning in your local area - how can these support the delivery of the BCF schemes? • Describe how you've engaged your primary providers if co-commissioning arrangements are not in place. ○ At what stage were they brought in?

commissioning status, please confirm that you have discussed the plan with primary care leads.	○ Did you engage with individual providers or area wide forums? ○ What issues did stakeholders from primary care raise, and how were these addressed? • Demonstrate links with the enhanced GP service to be delivered through "Transforming Primary care" support Better Care Fund plans? • Highlight any risks relating to the involvement or role of primary care – how could these impact on the delivery of the BCF schemes? Ensure these risks are cross referenced in the risk log alongside appropriate mitigating actions

Section 7) a) Protecting social care services	**A good plan will:** • Articulate what protecting adult social care services will look like in practical terms in your area, i.e. indicate own local definition. • To be described in a way that could be understood by either a commissioner, provider, service user or carer. ○ What is the level of eligibility that is being maintained? ○ What other service criteria are you expecting to maintain? • Articulate a rationale for any planned changes • Explain how the proposed local schemes and spending will support this commitment ○ How will these achieve the desired outcome of the protection of social care services? • Describe an increased focus on preventative services and explain how this will link to benefits for health services • Demonstrate consideration of how local demographic change will impact upon social care demand • Indicate the total amount from the BCF that has been allocated for the protection of adult social care services • Confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties • Quantify the allocation within BCF which is for the implementation of the Care Act • Articulate what the requirements of the Care Act mean in terms of changes to the delivery of local services ○ How are these changes overseen – what are the groups and forums with oversight and accountability? • Articulate any interdependencies between this work stream and the delivery of the BCF • Set out the amount of funding that will be dedicated to carer-specific support from within the BCF pool • Articulate how this funding will be used to support improved outcomes for carers ○ What types of services are being commissioned How will the experience be different from the perspective of a carer? • Demonstrate an evidence based consideration of how carer support will impact on patient level outcomes

	• Highlight any risks relating to the delivery of carer-specific support and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions • Attach any support documents that evidence the approach to carer-specific support • Set out the amount of funding that has been affected within the local government budget, if any • Set out any further implications to local authority services as a result of the change

Section 7 b) day services to support discharge	**A good plan will:** • Evidence engagement with the Action Plan to deliver clinical standards for 7 day services (7DS) contained in the Service Development and Improvement Plan section of NHS local contracts between CCG and providers • Indicate how local partners will work together to ensure that NHS providers meet the milestones for inclusion of the Clinical Standards for 7DS in 2014/15, 2015/16 and 2016/17? E.g: • Year 1 (2014/15) – do local contracts include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section? • Year 2 (2015/16) – should those clinical standards which will have the greatest impact move into the national quality requirements section of the NHS Standard Contract? • Year 3 (2016/17) – are all clinical standards incorporated into the national quality requirements section of the NHS Standard • Contract? • Set out the delivery plan associated with the move to seven-day services o What are the key milestones associated with this? o What are the priority actions – what needs to happen before any further progress can be made? • Describe how this will impact on admission prevention and discharge • Highlight any risks relating to the move to seven day services and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions

Section 7 c) Data sharing	**A good plan will:** • Articulate the progress made to date in relation to the use of the NHS number as the primary identifier, based on either real time retrieval or timely batch processing • Demonstrate plans to use the NHS number as early as possible in the clinical process / care pathway as opposed to solely at end for payment purposes • Describe how these changes will impact upon integration of services • Set out the remaining key phases of work required to ensure that this becomes part of business as usual o What are the key milestones associated with this?

	○ What are the priority actions – what needs to happen before any further progress can be made? • Highlight any risks relating to using move to the use of the NHS number as the primary identifier ensure that these are cross referenced in the risk log alongside appropriate mitigating actions • Evidence progress made to date in adopting Open APIs and Open Standards ○ How close to delivery is this? • Set out the remaining key phases of work required to ensure that this becomes part of business as usual ○ What are the key milestones associated with this? ○ What are the priority actions – what needs to happen before any further progress can be made? • Highlight any risks relating to using Open APIs and Open Standards and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions • Demonstrate commitment within the scope of the plan (be it procured/developed) that systems will provide interfaces that are accessible to those that need to use them • Demonstrate commitment within the scope of the plan (be it procured/developed) that all significant business functionality provided by the host system should be available via an API • Demonstrate commitment within the scope of the plan (be it procured/ developed) to clearly publish and document their provided interfaces? • Articulate the progress made to date in developing and implementing appropriate IG controls • Include documentation demonstrating local IG protocols and agreements in place • Highlight the remaining phases of work (particularly in relation to procurement of technical systems, development of guidance and protocols, delivery of training) to ensure IG controls are observed • Highlight any risks relating to IG controls and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions • Be compliant with NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise Caldicott 2

Section 7 d) Joint assessment and accountable lead professionals for high risk populations	**A good plan will:** • Describe plans for health and social care teams to use a joint process to assess risk and plan care • Describe any action being taken to remove barriers to joint assessments and planning • Describe the role of accountable lead professional as it is envisaged, such that the patient knows who to contact when they need to and can get timely decisions about their care • Set out how GPs will be supported in being accountable for co-ordinating patient centred care for older people and those with complex needs • Demonstrate consideration of the impact of these systems for

	people with Dementia and mental health problems

Section 8) Engagement **a) Patient, service user and public engagement**	**A good quality record of engagement will include:** • Involvement of the local Healthwatch as a route to public engagement • A description of how patients, service users and the pubic have been engagement in the development of the plan and how you will continue to involve your local population in shaping and supporting the delivery of your plans going forward • Mentions of specific meetings, forums and representative groups • Evidence of a clear "you said, we did" framework to show those engaged how their perspective and feedback has been included • Evidence of best practice in engagement such as user led events, user led representation on decision making boards, user feedback on plans and commissioning documents • Evidence of service user and patient voice embedded within the performance metrics mentioned in Annex 1 Scheme descriptions • Evidence of approaches taken to engage harder to reach groups
b) Service provider engagement	• A clear description of who the main providers are across o NHS Trusts and FTs o Primary care providers o Social care and the voluntary and community sector • A description of how the organisations have been engaged in the development of the plan and how they will be engaged on an ongoing basis, mentioning specific meetings, forums and representative groups • Confirmation that the implications of the BCF delivery have been reflected in their operational plans
c) Implications for acute providers	**A good response will include:** • Evidence that it has been produced in consultation with the acute providers. Cross ref with Annex 2 – Provider Commentary • Evidence of basic modelling to show potential impact of the BCF on the acute sector • Evidence of moderation that has been done to ensure that the BCF plans have not duplicated QIPP planning • An assessment of future capacity and workforce

	issues across providers • Evidence of modelling to show the impact of not delivering the BCF activity on the acute sector, e.g. ability to deal with potential increase in demand • Confirmation, in line with the Mandate requirements on achieving parity of esteem for mental health, that plans do not have a negative impact on the level and quality of mental health services

Part 1 - Annex 1 : Detailed Scheme Description

Annex 1 is a new section of the planning template designed to provide local areas with a space to articulate in more detail the individual projects being funded by the BCF, and in particular the evidence to support assumptions about their proposed impact.

A good scheme description will:

- Have a clearly articulated **strategic objective** that links to and cross references both the Vision for health and care services and the Case for change
    - How does this scheme help to achieve the vision for health and care services and how does it respond to the case for change?
- Provide an **overview of the scheme**, identifying the model of care and support, with reference to:
    - What is the service? Who will deliver it?
    - Who will receive the service? Identify the target audience for the service, in terms of the proposed profile and the projected volume of service users for the scheme
    - Where and when will it be delivered?
- Provide evidence of a delivery chain, i.e.
    - Articulate which organisations are commissioning which services from which providers
    - Provide evidence that there are clearly assigned roles and responsibilities for delivery and implementation of the scheme
- Describe the **evidence base** used to identify the scheme and model future impact
    - What research and evidence did you consult as part of your decision to implement this scheme?
    - Have you done any local evaluation to support/ inform this?
    - Articulate where the evidence base may be relatively weak in support of the scheme
    - NB - If you are not able to articulate an evidence base in support of each individual scheme, please articulate what evidence you have consulted to plan your approach to integrated care overall
- Include detail on **investment requirements**, cross referencing to Tab 3- HWB Expenditure, Plan 2
- Outline the anticipated **impact of the scheme** , cross referencing with Tab 4, HWB Benefits Plan, Part 2. And as part of this:
    - Consider impact on all Better Care Fund metrics, patient experience and

any other locally important metrics
    - What research and evidence have you consulted to generate a set of assumptions about future outcomes?
- Describe the **feedback loop** in place to understand where services are working well and well
    - What is your approach to impact measurement for this scheme?
    - What measures and metrics will you use? And how will you demonstrate that the contribution of that scheme to your overall objectives? Can you set up a counterfactual or control?
    - Will data be generated automatically or does it require a new survey / data collection approach?
- Demonstrate an understanding of the **key success factors** for the scheme that you are proposing. E.g. expertise, staff, demographics, history of partnership working?
    - Do these also exist within your area?
    - If not - what action is required to put those in place?
    - Or what impact will the absence of those supporting factors have on the outcomes that can be achieved?
    - Outline a stepped approach to implementation which draws on i) learning from either local evaluation or other areas where this has been implemented, and ii) engagement with partners about the deliverability of the proposal

Part 1 – Annex 2 : Provider commentary

One of the key changes is that we are asking all areas to ensure they have shared their planned non-elective activity reductions with their relevant providers. In particular, we are looking for acute providers to submit commentary explicitly stating whether they recognise the emergency admissions activity reductions and agree with them. We do not expect providers to sign-off BCF plans, but we do expect to see evidence of provider engagement. A template is provided in annex 2 which should be shared with acute providers for commentary and should be submitted alongside the BCF plans in September.

Although we only require explicit written commentary from acute providers to be submitted alongside the BCF plans, you may wish to conduct a similar exercise with out-of-hospital providers to ensure they are prepared for any impact of planned emergency admissions reductions.

A good provider commentary will:

- Confirm detailed and meaningful provider involvement in the development of the plans, from the major acute providers locally
- Demonstrate clear alignment between the overarching BCF plan and the provider plans
- Provide triangulation to provide reassurance that the projected reductions in planned emergency activity are feasible
- Confirm that providers are implementing their own risk management and action plans to respond to the planned change in activity
- Demonstrate a shared understanding of the critical path to successful delivery
- Articulate local risks and cross reference with the risk log in Section 4

The BCF Plan Template Part 2 (Excel Spreadsheet)

5. The purpose of this template is to clarify data from earlier BCF plan submissions and to collect further information from CCGs and HWBs in order to ensure that the assurance process ahead of any BCF plans being recommended for sign-off is as rigorous as possible. This includes providing a more detailed breakdown of planned investments and savings, and clarification of the impact of the BCF.

6. Below you will find:

   a. Further detail on the revised Payment for Performance framework and associated payment schedule
   b. Detailed guidance for each of the sections and sub sections of the revised part 2 plan template, highlighting the primary issues to consider and the key pieces of information to provide.

Revised Payment for Performance framework

7. The previous £1bn Payment for Performance element of the pooled fund is now split into:

   i. **Payment for performance on total emergency admissions (general and acute non-elective admissions)**
   There is a national expectation that areas will set a target to reduce their total emergency admissions by at least 3.5% during the period Q4 2014/15 to Q3 2015/16, against a baseline of Q4 2013/14 to Q3 2014/15. The planning assumption is that the 3.5% reduction equates to c.190,000 fewer admissions. The size of this performance fund is dependent on local target setting and is calculated by multiplying the activity reduction by the national average reported provider cost for non-electives from the latest NHS reference costs. The assumed 3.5% therefore equates to c.£300m nationally. However, we are asking HWBs to determine their own levels of ambition for reducing emergency admissions, which must be suitably challenging but realistic for the local area. Thus the size of the fund that is linked to performance at a local level will be dependent on the scale of ambition set out in plans.

   ii. **NHS commissioned out-of-hospital services**
   The size of this element of the fund will be dependent on the size of the performance fund relating to reduced emergency admissions above. As the national planning assumption is a minimum of a 3.5% reduction, which equates to a £300m performance fund, the size of this element of the fund for NHS commissioned services will be around £700m (depending on the aggregate of individual plans agreed at local level). The local proportion of this will be the amount that CCGs will need to transfer into the BCF pooled fund at the beginning of 2015/16 for investment in NHS commissioned out-of-hospital services.

Payment schedule for emergency admissions performance

8. The performance-related funding will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 2015/16, against the trajectory as set out in the plans. HWBs are therefore required to set an annual target (from Q4 2014/15 until end of Q3 2015/16), with quarterly milestones, in the finance and activity plan template.

9. Assessments of how suitable the locally set targets are will be made by NHS England Area Teams, in consultation with local government peers and HWBs themselves. Payments will be made in arrears as set out below:

   i. May 2015 (based on Q4 2014/15 performance)
   ii. August 2015 (based on Q1 2015/16 performance)
   iii. November 2015 (based on Q2 2015/16 performance)
   iv. February 2016 (based on Q3 2015/16 performance)

10. At each 'payment point', CCGs will release money into the BCF pooled fund on the basis of performance to date, against plan. Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned full-year reduction against the baseline). The relationship between payment and progress toward target will be directly linear (e.g. achieving 30% of the target will release 30% of the funding). There will be no additional payment for performing beyond the target.

11. The steps to calculating the quarterly payment are:

    a. Take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction
    b. Multiply that by the size of the performance pot available
    c. Subtract any performance payments made for the year to date.

12. Note: The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

13. Annex 1 sets out various worked examples to demonstrate how performance will be assessed against plans to release an area's performance payments.

Investment in NHS commissioned out of hospital services

14. The element of the £1bn for NHS commissioned out of hospital services should be transferred by the CCG into the pooled fund at the beginning of 15/16 for investment. HWBs should include a breakdown of spend, including the amount they identify as NHS-commissioned spend in the revised templates. It is important that the breakdown of spend in the templates can distinguish between how much NHS commissioned spend is coming from the HWB minimum pooled fund, versus the actual pooled fund which may include additional voluntary contributions in areas where CCGs or Councils have chosen to pool additional funds.

Non-elective admissions (general and acute) baseline

15. Note that although we are asking areas to plan on the basis of the baseline being actual Q4 13/14 outturn, and planned Q1, Q2, Q3 14/15 outturn, for the purposes of assessing performance in 15/16, for quarters 1-3 in 14/15 areas will be assessed against their actual outturn. We ask areas to ensure any financial risk associated with this is managed appropriately and articulated in plans. Annex 1 includes worked examples of how the planned targets will be used to generate targets from the actual data, when available.

Sections of the BCF Plan Template Part 2

16. Throughout the template, cells which are open for input have a white background and cells which contain description, calculations or auto-fills have a grey background.

Tab: Authorisation

17. Please select the HWB this plan relates to on this worksheet. This will populate subsequent worksheets in the template.

18. Please also supply a contact name and email address here.

Finance sheets

Tab: Payment for Performance

19. This sheet is entirely pre-populated and contains two sections:

    a. Reduction in non-elective activity (general and acute): This information feeds from 5.HWB P4P metric sheet and is assessing the level of change in non-elective admissions between Q4 14/15 – Q3 15/16 and the planned baseline submitted for Q4 13/14 – Q3 14/15. Reductions greater than 3.5% will be RAG rated green; increases will be RAG rated red and values in between will be RAG rated amber.

    b. Calculation of Performance and NHS Commissioned Out of Hospital Funds. This brings in the value of non-elective savings anticipated (from 5. HWB P4P metric sheet) and compares that with the funding subject to payment for performance measures the HWB received. The difference needs to be evidenced as investment in NHS commissioned out of hospital services as shown in cell B23. Cell B25 examines the HWB expenditure plan and compares the amount commissioned by the NHS for non-acute services which was funded from the minimum CCG contribution to the HWB. Where there is a shortfall in the contribution to NHS commissioned services cell B27 will be highlighted red.

Tab: HWB Funding Sources

20. This sheet will be pre-populated with the minimum CCG contributions to the Fund in 2015/16.

21. Please enter additional contributions to the Fund by selecting a Local Authority or CCG from the drop down boxes in column A and enter the values of the contributions in columns B and C.

Tab: Summary

22. This sheet summarises the planned expenditure for the HWB by area of spend and as a subset of that the planned expenditure that is being funded by the NHS commissioned out of hospital services minimum BCF pool.

23. Please confirm the level of expenditure being committed to the protection of adult social care services and explain any discrepancy with the figures reported on the HWB Expenditure Plan.

24. A summary of HWB benefits is also listed on the bottom of the sheet.

Tab: HWB Expenditure plan

25. This tab breaks down the planned BCF spending by scheme and provider. **Note that you may need to fill out several lines to fully describe a single scheme.**

26. To complete it:
    - Enter a scheme name in column A;
    - Select the area of spending the scheme is directed at using the drop-down box in column B; if the area of spending is not adequately described by one of the drop down options please choose 'Other' and give further explanation in column E.
    - Select the commissioner for the scheme using the drop-down box in column F, **if the scheme is jointly commissioned please select 'joint' and apportion the percentage that is NHS and Local Authority** in columns G and H.
    - In column I please select the provider that will deliver the scheme from the drop down options available.
    - In Column J state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines.
    - Complete the cells in columns K and L to give the planned spending on the scheme in 2014/15 and 2015/16;
    - Repeat for other elements of the scheme if required, then repeat for other schemes.

27. This information is important to establish the impact of the Better Care Fund on NHS and local government spending nationally in 2014/15 and 2015/16 to inform broader planning work.

Tab: HWB Benefits Plan

28. This tab is designed to give a more detailed view of the benefits planned from the Better Care Fund: in particular, to describe how they are distributed across the local health and care economy and to explain how they have been calculated. We are asking for this information in order to help us to understand the impact of the BCF on the financial challenges facing both health and social care in 2015/16.

29. Please note that there are two tables to complete: one table describing the benefits in 2014/15 and another, below that, outlining the benefits in 2015/16. The instructions below refer to the 2014/15 table, but the instructions apply equally to 2015/16 benefits.

30. Please see the note at the top of the sheet which explains the options you have in how to present the estimated benefits. We are asking you to select the category of benefit and then state which schemes will contribute to that benefit. We expect there will be a number of schemes that in aggregate will have an impact on each category of benefit. Where it is possible to determine, you can disaggregate the benefits linked to each specific scheme. We realise that this is likely to be challenging and therefore you are able to list a number of schemes that will contribute to each category of benefit and estimate the impact in aggregate.

31. To complete this tab, please:
    - The drop-down box in column A should be used to indicate the source of the financial benefit
    - If you select 'Other' for the above, please specify the category of benefit in column B
    - Input the schemes that will contribute to the benefit in column C – you are able to input a number of schemes using multiple lines
    - Select the category of organisation who will benefit using the drop-down box in column D;
    - In column F please enter the planned change in activity due to Better Care Fund schemes being implemented, relative to what you would have expected it to be without the Better Care Fund. You may wish to refer to tab '7. Metric Trends' which provides projected figures which crudely estimate the activity for 2014/15 and 2015/16 based on historic trends. Please enter all reductions in activity as negative numbers. (For 'Other' schemes please enter -1 if the change in activity measure is not applicable.)
    - In column G enter the unit price of the activity being changed. Where the change in activity measure is not applicable please enter the whole value of the saving in this column.
    - Column H will calculate the saving by multiplying the change in activity (column F) with the unit price (column G).
    - In column I please state how the saving was calculated, and in column J state how savings will be monitored.
    - If you choose to estimate the savings for each category of benefit in aggregate rather than at individual scheme level, then please do this as a

separate row entitled “Aggregated benefit of schemes for [X category of benefit]”, completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the “aggregated benefit” line. This is to avoid double counting the benefits. However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

Outcomes & Metrics Sheets

Tab: HWB P4P Metric

32. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund. You should provide details of your plans for this metric on a quarterly basis.

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions

Metric		Baseline (from CCG plans)				Pay for performance period				
		Q4 (Jan 13 - Mar 13)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	2,766	2,623	2,490	2,506	-	-	-	-	-
	Numerator	5,375	5,205	4,941	4,972					
	Denominator	194,352	198,409	198,409	198,409	202,358	202,358	202,358	202,358	206,395
					P4P annual change in admissions		*0*			
					P4P annual change in admissions (%)		*0.0%*			
					P4P annual saving		*£0*		£1,490	National average

33. The baseline for performance is based on Q4 13/14 actual outturn and Q1-Q3 14/15 CCG operational plans as submitted through UNIFY. CCG operational plan figures are based on the CCG registered (GP) population and the mapping used directly maps between this population and the associated Health and Wellbeing board resident population. Because the CCG registered population will not fall within clear geographical boundaries then this means that in some cases the HWB resident activity is mapped from a large number of CCG plans. However this can be simplified by removing mappings from CCGs that contribute only a small proportion of a HWB resident population and then rescaling the remainder of mappings to 100%. A cut-off of approximately 0.1% was found to have minimal impact on the resulting mapping of non-elective admissions. The resulting CCGs that contribute to each HWB are shown in the ‘HWB P4P metric’ tab:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in HWB	% HWB resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 13 - Mar 13)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 13 - Mar 13)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
CCG1	5,336	5,208	4,941	4,975	89.9%	89.2%	4,799	4,684	4,444	4,475
CCG2	6,776	6,055	5,788	5,754	6.2%	7.7%	418	373	357	355
CCG3	7,845	7,424	7,560	7,968	0.2%	0.3%	13	12	13	13
CCG4	7,248	6,755	6,417	6,459	2.0%	2.8%	145	135	128	129

34. The CCG plans are expected to be updated for some CCGs following the release of this guidance and the template. The CCG plan figures are therefore

'white' cells indicating that the figures can be overwritten if the plans are updated.

35. It should be noted that a mapping methodology such as this will only give an approximation of true activity as it assumes that non-elective activity is 'smoothed out' across registered CCG populations before being mapped to HWB level. It should also be noted that this is not the same mapping as used for the financial contributions from CCGs to HWBs which is based on CCG 'of residence' mapped to HWB 'of residence'.

36. The performance element of the Fund is based on performance in Q4 of 2014-15 and Q1-3 of 2015/16. You should therefore provide details of your plans for this metric on a quarterly basis. Only numerators (the total non-elective FFCEs in general and acute specialties for the period, by HWB) need to be submitted as quarterly rates are calculated automatically from the numerator and pre-populated denominator. A RAG rating is included to indicate if plans are valid (i.e. no text, counts not below 0, numerators not bigger than denominators) and whether or not they meet the expected 3.5% improvement. To note, HWBs are able to set their own levels of ambition and local considerations should be taken in to account in setting plans. For example, population increases could result in higher levels of non-elective admissions and therefore make plans harder to achieve - at a national level there is a projected all-age population increase of approximately 0.7% but there will be variation between HWBs. A rationale box should be completed to explain why levels of ambition may not demonstrate the expected 3.5% improvement.

37. In order to establish the balance of the £1bn element of the fund available for NHS commissioned spend, the amount of savings a local HWB aims to achieve from reducing non-elective admissions has to be calculated. The template will estimate the annual savings based on the planned change, based on an assumption about the average unit cost for the activity saved (taken from latest Reference Costs). The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Tab: HWB Supporting Metrics

38. In addition to the non-elective admissions metric underpinning payment for performance, there are a number of national metrics that support delivery of the BCF, namely:

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

- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population

39. In addition there is a local metric, and a patient/service user experience metric, where organisations can either use an existing or a newly developed local metric or a readily available national metric.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**944.0**	**-**	**-**
	Numerator	345		
	Denominator	36,440	37,850	38,423
		Annual change	*0*	*0*
		Annual change (%)	*0.0%*	*0.0%*

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**86.0**	**-**	**-**
	Numerator	255		
	Denominator	300		
		Annual change	*0*	*0*
		Annual change (%)	*0.0%*	*0.0%*

40. For residential care admissions, and the reablement metrics, the baseline (2013/14 data) are taken from published ASCOF figures. The figures previously underpinning the October 2015 pay-for-performance plan submitted in April this year have not been pre-populated as a newer baseline period (2013-14) is now available. Only the numerator is required for the residential admissions metric (as the population denominator is pre-populated and the rate is calculated automatically). Plans are required for both 2014/15 and 2015/16. NB. The denominator for the residential care admissions is 2012-13 population estimate rather than 2013-14 as this reflects what is in the ASCOF provisional publication.

Delayed transfers of care

Metric		14/15 plans				15-16 plans			
		Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Rate*	-	-	-	-	-	-	-	-
	Numerator								
	Denominator	139,942	139,942	139,942	142,593	142,593	142,593	142,593	145,357

41. For the delayed transfers of care metric, plans should be submitted quarterly for 2014/15 and 2015/16. Only numerator data needs to be submitted as rates are calculated automatically from the numerator and pre-populated denominator.

Patient / Service User Experience Metric

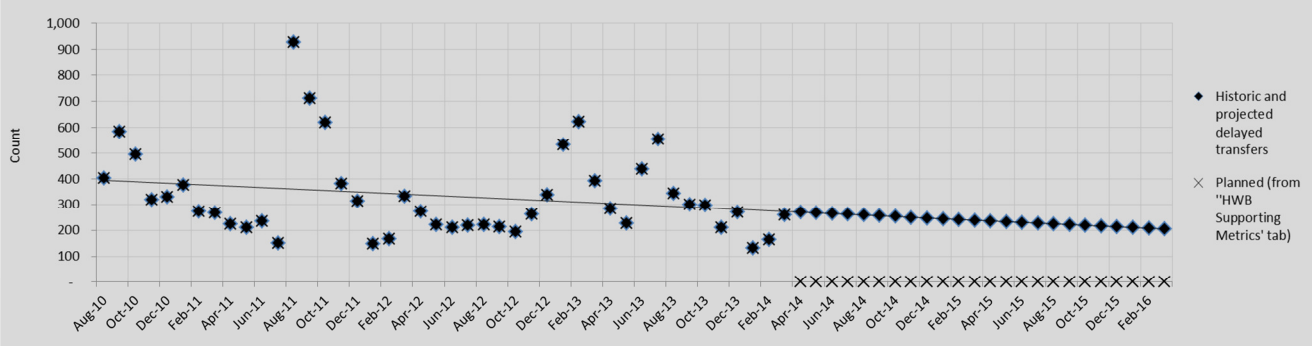
Metric		Baseline [enter time period]	Planned 14/15 (if available)	Planned 15/16
[please insert metric description]	*Metric Value*			
	Numerator			
	Denominator			
Improvement indicated by:	<Please select>			

42. For both the patient/service user experience and the local metrics, baseline data and a 15-16 plan must be submitted. In each case, if the baseline is 13-14 data then a 14-15 plan should also be submitted. Additionally, information on the chosen metric should be completed as well as confirmation of whether an *increase* or *decrease* in the chosen metric is deemed 'an improvement'.

Tab: Metric trends

43. Projecting in to the future from past and current data can be helpful in setting your levels of ambition. To support finalisation of plans, we have provided *estimates* of future performance, based on historical figures using a simple 'straight line' projection approach. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2015/16. Although linear projections do not account for seasonal variations, the plans should take this into account where applicable (the baseline figures which will reflect previous seasonality can be used to account for this). The effect of this means that the projected-trend figures at quarterly level may poorly mirror the true expected trend although these should be 'ironed out' annually.

44. The charts in this tab also show the plan figures from the earlier tabs so that areas can see how their plans align against their historic data and the simple projections.



45. 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.

46. 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.

47. The next section of the guidance provides detailed specifications for the metrics.

Specification of Pay for Performance Metric

Non-Elective Admissions (general and acute)	
Outcome sought	Reduce non-elective 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 health and care system improve the quality of care and reduce the frequency and necessity for non-elective admissions.
Definition	Non-Elective admission data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected from providers (both NHS and IS) who provide the data broken down by Commissioner. Number of first finished consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which: • patient classification = ordinary admission; • admission method = emergency admission, maternity admission, other admission (codes 21-83); • episode number = 1. Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care. General & Acute specialties; • include: 100-192, 300-460, 502, 504, 800-834, 900 and 901 • exclude: 501, 700-715. Monthly Activity Return guidance is available here: http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/ **Numerator** Total non-elective FFCEs in general and acute specialties for the period, by local authority of residence. For the baseline CCG plans have been “mapped” across to HWB **Denominator** This should be the appropriate mid-year ONS population estimate or projection

	(all ages) – these have been pre-populated in the template
Source	NHS England statistics on monthly activity data (http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/) 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: Monthly Timing: 6 week lag Baseline Based on mapping (to HWB) of actual CCG activity for Quarter 4 2013-14 (Jan 14 - Mar 14) and CCG operational plan data for Quarters 1-3 of 2014-15 (April 14 – Dec 14) Payment Based on Quarter 4 of 2014-15 HWB plan (Jan 15 – Mar 15) and Quarters 1-3 of 15-16 HWB plans (Apr 15 – Dec 15). We are additionally requesting a HWB plan for Q4 of 2015-16 in order to give complete 2015-16 plans.
Historic	Monthly non-elective FFCEs in general and acute available back to April 2008 on NHS England website (http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/)

Specification of Supporting 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**: annual rate of council-supported permanent admissions of older people to residential and nursing care. **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 should be the appropriate ONS mid-year population estimate or projection.
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) 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) Timing: Provisional data for 2013-14 was published in July 2014 Baseline: This will be 2013-14 data as published by the HSCIC (note that for the published data the 2012, not the 2013 ONS population estimate has been used for the population denominator)
Historic	Data first collected 2011-12 (currently two years data final available (2011-12 and 2012-13) and one year's draft (2013-14).

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. **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) offered rehabilitation services following discharge from acute or community hospital.
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) Timing: Provisional data for 2013-14 was published in July 2014. Baseline: This should be 2013-14 data as published by the HSCIC.
Historic	Data first collected 2011-12 (currently two years data final available (2011-12 and 2012-13) and one year's provisional (2013-14).

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 (delayed days) 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. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate/mprojection for 18+ population. *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient 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/) 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) Timing: 2 month lag. Baseline: 2013/14 quarterly rates
Historic	Data first collected Aug 2010

4) Patient/service user experience	
Outcome sought	- To take steps to begin to understand patient experience in relation to the delivery of integrated care. - To develop a system which measures patient experience of integration over time, allowing any improvements to be demonstrated. - To embed a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.
Rationale	Effective engagement of patients, the public and wider partners in the design, delivery and monitoring of services: • Improves communication between communities, service users, commissioners and providers • Allows performance to be monitored over time and improvements demonstrated • Gives patients, carers and their families a better understanding of their conditions and treatment plans to achieve better outcomes • Increases understanding of patients and the public about health and social care services • Empowers communities to have a say in the delivery of local services • 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	Organisations are strongly encouraged to consider how patient/service user experience metrics can support the initial and ongoing development of integrated care models as well as monitor their effectiveness. Organisations may want to use an existing or a newly developed local metric or a national metric. Use of an existing or newly developed local metric The following criteria should be applied by those choosing this option: • The metric should 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 provide a baseline for levels of experience to be monitored over time • The metric should look at patient experience across settings, considering how services work together Those choosing to develop a new local metric may want to give consideration to the development of a new local survey, the inclusion of additional questions on existing local surveys, such as the Friends and Family Test, or the voluntary inclusion of additional questions on the Adult Social Care Users Survey and/or the Personal Social Services Survey of Adult Carers. Further information on the Social Care Surveys can be found at the following link: http://www.hscic.gov.uk/socialcare/usersurveys

	Those aiming to develop a new local survey, to include additional questions on an existing local survey or to voluntarily include additional questions on the Adult Social Care Users Survey and/or Survey of Adult Carers, may want to give consideration to the inclusion of questions from the 18 developed by the Picker Institute and Oxford University. Consideration may also be given to newly developed local questions. The Picker Institute and Oxford University questions can be found at the following link: http://www.pickereurope.org/assets/content/pdf/News%20releases/Developing%20measures%20of%20IC%20report_final_07012014.pdf Attention should be given to the areas of particular importance at a local level in relation to integration, such as information sharing or involvement in decision making. The following link provides a useful reference to PIRU's indicator report, which has a section on user/carer experience: http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf Use of an existing national metric 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. However, a number of the national surveys can be argued to provide some insight into experiences of integrated care within the setting or for the condition to which the survey relates. There are a number of themes which can be seen to relate to integrated care. Some of these themes are given in Annex 2, with related questions from existing surveys. Some of the themes and questions will relate more to some populations than others. The themes and related questions are broadly based around the National Voices narrative for person centred, coordinated ('integrated') care. This list of questions is intended to provide some examples of the information available within the national surveys. It is not intended to be exhaustive. It should also be noted that some of the questions listed span more than one theme.
Source	Data source determined at a local level for those developing/utilising existing local metrics OR questions from any of the national surveys could help to form a picture of patient/service user experience of integrated care, including: CQC Community Mental Health Survey CQC Inpatients Survey Cancer Patient Experience Survey GP Patient Survey Adult Social Care Users Survey Personal Social Services Survey of Adult Carers
Reporting schedule for data source	Data reporting determined at a local level OR data reporting schedule for national surveys used
Historical	Historical comparisons will not be available unless local metrics have been used previously. For the national survey questions historic comparisons will be available with the exception of the community mental health survey which has been redeveloped for 2014.

Local Metric

In addition to the national metrics, you should choose one additional indicator that will be used to support delivery of the BCF. You are required to either select one of the following metrics or another suitable local metric.

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;
- 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.

Annex 1: Payment for performance worked examples

This annex sets out worked examples of how targets will be adjusted to account for actual data on non-elective admissions and of how performance will be assessed against plans to release an area's performance payments. In all scenarios that following context applies:

- Area X share of the £1bn payment for performance fund is £8.7m (figure available from allocations – see http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/)
- Their baseline (Q4 2013/14 – Q3 2014/15) for total emergency admissions is 50,000 (taken from CCG plans mapped to HWB)
- Their target reduction is 3.5% - therefore, they are projecting a maximum total outturn of 48,250 by the end of Q3 in 2015/16
- The size of their performance fund is therefore £2,607.5k (the 1,750 reductions multiplied by the average unit cost per emergency admission of £1,490)
- The size of the fund within the minimum BCF pool that must be spent on NHS commissioned out-of-hospital services is therefore £6.1m (£8.7m minus the £2.6m payment for performance pot).

Calculating Payment for Performance targets from actuals

In September, each HWB will set out a plan for non-elective admissions (general and acute only) based against planned non-elective admissions in the baseline period. The table below shows the plan used in our worked examples:

		A	B	C	D	E
		Q4	Q1	Q2	Q3	Total
1	Baseline Q4 13/14-Q3 14/15 (Q4 actual, Q1-3 plans)	10,000	11,000	12,000	17,000	50,000
2	Q4 14/15-Q3 15/16 Plan (as submitted 19 Sept 2014)	9,500	10,750	11,750	16,250	48,250
3	Planned reduction on baseline (cumulative)	1.00%	1.50%	2.00%	3.50%	3.50%

Note that the percentage reductions are cumulative. That is to say, the planned reduction for Q2 is the total reduction planned in Q4, Q1 and Q2 together: 500 + 250 + 250 = 1,000, 2% of the 50,000 baseline.

Once the actual baseline performance is known, revised targets will be calculated by subtracting the planned percentage reduction from the new baseline. In this case, imagine that the actual baseline performance was as shown below:

		A	B	C	D	E
		Q4	Q1	Q2	Q3	Total
1	Baseline Q4 13/14-Q3 14/15 (Q4 actual, Q1-3 plans)	10,000	11,000	12,000	17,000	50,000
2	Q4 14/15-Q3 15/16 Plan (as submitted 19 Sept 2014)	9,500	10,750	11,750	16,250	48,250
3	Planned reduction on baseline (cumulative)	1.00%	1.50%	2.00%	3.50%	3.50%
4	***Actual*** Baseline Q4 13/14-Q3 14/15	10,000	11,200	12,200	17,200	50,600

The new targets will be calculated by using the same percentage targets for each quarter. Note that these percentages are applied to a higher cumulative baseline

(the total for the year – 50,600 instead of 50,000) so more admissions will need to be avoided to achieve a 3.5% reduction. Working this through for Q4:

- The new baseline for Q4 is 10,000 non-elective admissions.
- The new annual baseline is 50,600 non-elective admissions.
- The planned reduction for Q4 is 1% of the cumulative baseline, which is 506 non-elective admissions.
- Thus the target for Q4 is 10,000 – 506 = 9494 non-elective admissions.

It appears counter-intuitive that the target for emergency admissions in Q4 becomes harder as a result of worse performance than planned over the baseline period. However, this is simply because the target reduction is set as a percentage of the full year total. The full year total is larger than planned, so the same percentage reduction means a larger number of avoided admissions. This is only apparent in Q4 because the baseline performance is the same as planned: in the remaining three quarters, the increase in the baseline is larger than the increase in the target number of avoided admissions, so the new target is higher than the previous target (e.g. in Q2, below, the revised target is 10,947 admissions vs a plan of 10,750 admissions).

As the targets are cumulative, you must calculate the target for each quarter in turn. So to calculate the new target for Q1:

- The new cumulative baseline for Q1 is 10,000 + 11,200 = 21,200 non-elective admissions.
- The cumulative target for Q1 is a 1.5% reduction in the baseline.
- Thus the combined target for Q4 and Q1 is 21,200 – 1.5% * 50,600 = 20,441.
- To determine the target for Q1, we subtract the target for Q4 from the new cumulative target: 20,441 – 9,494 = 10,947

<u>Baseline Higher Than Planned</u>

The table below shows the results of working through the calculations described above for an area which has a higher level of non-elective admissions than planned in the baseline period.

		A	B	C	D	E
		Q4	Q1	Q2	Q3	Total
1	Baseline Q4 13/14-Q3 14/15 (Q4 actual, Q1-3 plans)	10,000	11,000	12,000	17,000	50,000
2	Q4 14/15-Q3 15/16 Plan (as submitted 19 Sept 2014)	9,500	10,750	11,750	16,250	48,250
3	Planned reduction on baseline (cumulative)	1.00%	1.50%	2.00%	3.50%	3.50%
4	***Actual*** Baseline Q4 13/14-Q3 14/15	10,000	11,200	12,200	17,200	50,600
5	Submitted BCF plan against ***actual*** baseline (cumulative)	1.00%	1.90%	2.80%	4.70%	4.70%
6	Revised Q4 14/15-Q3 15/16 Plan	9,494	10,947	11,947	16,441	48,829
7	Revised targets against actual baseline (cumulative)	1.0%	1.5%	2.0%	3.5%	3.5%

As discussed above, note that targets for Q1-Q3 have been relaxed in absolute terms (i.e. the target number of admissions is higher), while the target for Q4 is harder in absolute terms. In all four cases, however, these targets represent the same percentage improvement on the actual baseline as had been planned against the original baseline.

Baseline Lower Than Planned

The table below shows the results of working through the calculations described above for an area which has a lower level of non-elective admissions than planned in the baseline period.

		A	B	C	D	E
		Q4	Q1	Q2	Q3	Total
1	Baseline Q4 13/14-Q3 14/15 (Q4 actual, Q1-3 plans)	10,000	11,000	12,000	17,000	50,000
2	Q4 14/15-Q3 15/16 Plan (as submitted 19 Sept 2014)	9,500	10,750	11,750	16,250	48,250
3	Planned reduction on baseline (cumulative)	1.00%	1.50%	2.00%	3.50%	3.50%
4	***Actual*** Baseline Q4 13/14-Q3 14/15	10,000	10,800	11,800	16,800	49,400
5	Submitted BCF plan against ***actual*** baseline (cumulative)	1.00%	1.10%	1.20%	2.30%	2.30%
6	Revised Q4 14/15-Q3 15/16 Plan	9,506	10,553	11,553	16,059	47,671
7	Revised targets against actual baseline (cumulative)	1.0%	1.5%	2.0%	3.5%	3.5%

Note that as before, the first quarter changes counter-intuitively (i.e. the reduction required is lower than previously planned.) This is again a result of the change to the annual baseline: as the annual baseline is now lower, a 1% reduction is a smaller number in absolute terms. This is subtracted from the baseline figure, which has not changed.

The following three quarters all change as you would expect, making the target more challenging in absolute terms but maintaining the same percentage decrease as planned.

Payment Examples

The following three scenarios illustrate how performance will be compared to the baseline in 2015/16 to determine payment by performance. For each of these scenarios, it is assumed that performance in the baseline period matched the planned performance.

Scenario 1 – area meets targets

Below sets out how the quarterly payment for performance schedule will work on the basis that Area X meets their quarterly milestones for reduced emergency admissions:

		A	B	C	D	E
		Q4	**Q1**	**Q2**	**Q3**	**Total**
1	Baseline Q4 13/14 - Q3 14/15	10,000	11,000	12,000	17,000	50,000
2	Baseline Q4 13/14 - Q3 14/15 (cumulative)	10,000	21,000	33,000	50,000	50,000
3	Plan Q4 14/15 - Q3 15/16	9,500	10,750	11,750	16,250	48,250
4	Plan Q4 14/15 - Q3 15/16 (cumulative)	9,500	20,250	32,000	48,250	48,250
5	Planned reduction on full-year baseline (cumulative)	1%	1.5%	2%	3.5%	3.5%
6	Actual total activity to date	9,500	20,250	32,000	48,250	48,250
7	Actual activity reduction achieved (cumulative)	500	750	1,000	1,750	1,750
8	Performance payment made	£745k	£372.5k	£372.5k	£1,117.5k	£2,607.5k

May 2015 Payment (on basis of Q4 14/15 performance)

- Cumulative activity reduction of 500 by end Q4 2014/15 *(A2 – A6 = A7)*
- Cumulative target reduction by end Q3 2015/16 of 1,750 *(D2 – D4)*
- 28.6% of progress made towards full year target reduction *(500 / 1,750 = 28.6%)*
- Payment in Q4 of £745k *(28.6% * Performance Fund of £2,607.50)*

August 2015 Payment (on basis of Q1 15/16 performance)

- Cumulative activity reduction of 750 by end Q1 *(B2 – B6 = B7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 42.9% of progress made towards full year target reduction *(750 / 1,750 = 42.9%)*
- Cumulative payment by Q1 of £1,117.5k *(42.9% * Performance Fund of £2,607.5k)*
- £745k released in Q4 so additional £372.5k released in Q1 *(£1,117.5k - £372.5k)*

November 2015 Payment (on basis of Q2 15/16 performance)

- Cumulative activity reduction of 1,000 by end Q2 *(C2 – C6 = C7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 57.1% of progress made towards full year target reduction *(1,000 / 1,750 = 57.1%)*

- Cumulative payment by Q2 of £1,490k *(57.1% * Performance Fund of £2,607.5k)*
- £1,117.5k released to date so additional £372.5k released in Q2 *(£1,490k - £1,117.5k)*

February 2015 Payment (on basis of Q3 15/16 performance)

- Cumulative activity reduction of 1,750 by end Q3 *(D2 – D6 = D7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 100% of progress made towards full year target reduction (1,750 / 1,750 = 100%)
- Cumulative payment by Q3 of £2,607.5k *(100% * Performance Fund of £2,607.5k)*
- £1,490k released to date so additional £1,117.5k released in Q3 *(£2,607.5k - £1,490k)*

In this example, Area X meets their planned targets exactly and achieves their full-year target reduction of 3.5%. As a result they achieve their full performance related fund of £2,607.5k at the end of Q3, and there will be no money held back for remedial reallocation.

Payment for Performance
Scenario 2 – area does not fully achieve quarterly milestones

Below sets out how the quarterly payment for performance schedule will work on the basis that Area X does not fully meet their quarterly milestones for reduced emergency admissions:

		A	B	C	D	E
		Q4	**Q1**	**Q2**	**Q3**	**Total**
1	Baseline Q4 13/14 - Q3 14/15	10,000	11,000	12,000	17,000	50,000
2	Baseline Q4 13/14 - Q3 14/15 (cumulative)	10,000	21,000	33,000	50,000	50,000
3	Plan Q4 14/15 - Q3 15/16	9,500	10,750	11,750	16,250	48,250
4	Plan Q4 14/15 - Q3 15/16 (cumulative)	9,500	20,250	32,000	48,250	48,250
5	Planned reduction on full-year baseline (cumulative)	1%	1.5%	2%	3.5%	3.5%
6	Actual total activity to date	9,750	20,500	32,125	48,500	48,500
7	Actual activity reduction achieved (cumulative)	250	500	875	1,500	1,500
8	Performance payment made	£372.5k	£372.5k	£558.75k	£931.25k	£2,235k

May 2015 Payment (on basis of Q4 14/15 performance)

- Cumulative activity reduction of 250 by end Q4 2014/15 *(A2 – A6 = A7)*
- Cumulative target reduction by end Q3 2015/16 of 1,750 *(D2 – D4)*
- 14.3% of progress made towards full year target reduction *(250 / 1,750 = 14.3%)*
- Payment in Q4 of £372.5k *(14.3% * Performance Fund of £2,607.5k)*

August 2015 Payment (on basis of Q1 15/16 performance)

- Cumulative activity reduction of 500 by end Q1 *(B2 – B6 = B7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 42.9% of progress made towards full year target reduction *(500 / 1,750 = 28.6%)*
- Cumulative payment by Q1 of £745k *(28.6% * Performance Fund of £2,607.5k)*
- £372.5k released in Q4 so additional £372.5k released in Q1 *(£745k - £372.5k)*

November 2015 Payment (on basis of Q2 15/16 performance)

- Cumulative activity reduction of 875 by end Q2 *(C2 – C6 = C7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 50% of progress made towards full year target reduction (785 / 1,750 = 50%)
- Cumulative payment by Q2 of £1,303.75k *(50% * Performance Fund of £2,607.5k)*
- £745k released to date so additional £558.75k released in Q2 *(£1,303.75k - £745k)*

February 2015 Payment (on basis of Q3 15/16 performance)

- Cumulative activity reduction of 1,500 by end Q3 *(D2 – D6 = D7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 85.7% of progress made towards full year target reduction (1,500 / 1,750 = 85.7%)
- Cumulative payment by Q3 of £2,235k *(85.7% * Performance Fund of £2,607.5k)*
- £1,303.75k released to date so additional £931.25k released in Q3 *(£2,235k - £1,303.75k)*

In this example, Area X does not fully meet their planned full-year target, and as a result only achieves 87.5% of the available performance related fund of £2,607.5k at the end of Q3. This means that the balance of c.£375k will be held back for remedial reallocation. CCGs will decide how this fund should be spent, in agreement with the HWB. The HWB should also implement their contingency plan developed in the event that they do not meet their target reductions in emergency admissions.

Payment for Performance
Scenario 3 – area exceeds quarterly milestone in Q4, performs in Q1, sees increase in activity in Q2, but back on track by Q3

Below sets out how the quarterly payment for performance schedule will work on the basis that Area X has performance that fluctuates around their quarterly milestones for reduced emergency admissions:

		A	B	C	D	E
		Q4	**Q1**	**Q2**	**Q3**	**Total**
1	Baseline Q4 13/14 - Q3 14/15	10,000	11,000	12,000	17,000	50,000
2	Baseline Q4 13/14 - Q3 14/15 (cumulative)	10,000	21,000	33,000	50,000	50,000
3	Plan Q4 14/15 - Q3 15/16	9,500	10,750	11,750	16,250	48,250
4	Plan Q4 14/15 - Q3 15/16 (cumulative)	9,500	20,250	32,000	48,250	48,250
5	Planned reduction on full-year baseline (cumulative)	1%	1.5%	2%	3.5%	3.5%
6	Actual total activity to date	8,000	20,250	33,000	48,200	48,200
7	Actual activity reduction achieved (cumulative)	2,000	750	0	1,800	1,800
8	Performance payment made	£745k	£372.5k	£0	£1,490k	£2,607.5k

May 2015 Payment (on basis of Q4 14/15 performance)

- Cumulative activity reduction of 2,000 by end Q4 2014/15 *(A2 – A6 = A7)*
- Cumulative target reduction by end Q3 2015/16 of 1,750 *(D2 – D4)*
- Over 100% of progress made towards full year target reduction *(2,000 / 1,750 = 114.3%)*
- Payment therefore restricted to planned reduction in Q4 as a proportion of the full-year plan (A5 / D5 = 1% / 3.5% = 28.6%)
- Payment in Q4 of £745k *(28.6% * Performance Fund of £2,607.5k)*

August 2015 Payment (on basis on Q1 15/16 performance)

- Cumulative activity reduction of 750 by end Q1 *(B2 – B6 = B7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- 42.9% of progress made towards full year target reduction *(750 / 1,750 = 42.9%)*
- Cumulative payment by Q1 of £1,117.5k *(42.9% * Performance Fund of £2,607.5k)*
- £745k released in Q4 so additional £372.5k released in Q1 *(£1,117.5k - £372.5k)*

November 2015 Payment (on basis of Q2 15/16 performance)

- Cumulative activity reduction of 0 by end Q2 *(C2 – C6 = C7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*

- 0% of progress made towards full year target reduction (0 / 1,750 = 0%)
- Cumulative payment by Q2 of £0 *(0% * Performance Fund of £2,607.5k)*
- The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism), so therefore no payment in Q2

February 2015 Payment (on basis of Q3 15/16 performance)

- Cumulative activity reduction of 1,800 by end Q3 *(D2 – D6 = D7)*
- Cumulative target reduction by end Q3 of 1,750 *(D2 – D4)*
- Over 100% of progress made towards full year target reduction *(1,800 / 1,750 = 102.9%)*
- Cumulative payment therefore restricted to size of available fund (£2,607.5k)
- £1,117.5k released to date so additional £1,490k released in Q3 *(£2,607.5k - £1,117.5k)*

In this example, Area X exceeds their planned full-year target reduction of 3.5% by the end of Q3 2015/16. As a result they achieve their full performance related fund of £2,607.5k at the end of Q3, and there will be no money held back for remedial reallocation.

In either of the scenarios set out above, the amount that must be spent in NHS commissioned services is £6.1m.

Annex 2: Patient/service user experience

Communication – this might include evidence as to whether respondents feel that the professionals involved in their care worked together as a team, knew who was in charge of their care, knew who their first point of contact was for questions at any time, and whether they received help getting other services.	
CQC Inpatients survey	Q31. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?
CQC Inpatients survey	Q62. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
CQC Inpatients survey	Q63. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?
CQC Inpatients survey	Q64. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)
CQC Community Mental Health survey	Q8. Have you been told who is in charge of organising your care and services? (This person can be anyone providing you care and may be called a "care coordinator" or "lead professional".)
CQC Community Mental Health survey	Q10. Do you know how to contact this person if you have a concern about your care?
CQC Community Mental Health survey	Q11. How well does this person organise the care and services you need?
CQC Community Mental Health survey	Q20. Did you know who was in charge of your care while this change was taking place?
GP Patient survey	Q40. Do you know how to contact an out of hours GP service when the surgery is closed?
Cancer Patient Experience Survey	Q21. Were you given the name of a Clinical Nurse Specialist who would be in charge of your care?
Cancer Patient Experience Survey	Q22. How easy is it for you to contact your Clinical Nurse Specialist?
Cancer Patient Experience Survey	Q54. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
Cancer Patient Experience Survey	Q46. While you were in hospital, did it ever happen that one doctor or nurse said one thing about your condition or treatment, and another said something different?
Cancer Patient	Q63. As far as you know, was your GP given enough information

Experience Survey	about your condition and the treatment you had at the hospital?
Cancer Patient Experience Survey	Q65. Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?
VOICES	For those cared for at home in last 3 months of life Q3. When he was at home in the last three months of life, did he get any help from any of the services listed below? These may be provided by different organisations, such as voluntary organisations, a private agency or social services
VOICES	For those cared for at home in last three months of life Q4. When he was at home in the last three months of life, did all these services work well together?
VOICES	Q27. Did the hospital services work well together with his GP and other services outside of the hospital?
Decision making – this might include evidence as to whether respondents feel that they were involved in decisions about their care and treatment as much as they wanted to be and that their families or carers were involved as much they wanted them to be.	
CQC Inpatients survey	Q 32. Were you involved as much as you wanted to be in decisions about your care and treatment?
CQC Inpatients survey	Q 48. Did you feel you were involved in decisions about your discharge from hospital?
CQC Community Mental Health survey	Q. 13 Were you involved as much as you wanted to be in agreeing what care you will receive?
CQC Community Mental Health survey	Q16. Were you involved as much as you wanted to be in discussing how your care is working?
CQC Community Mental Health survey	Q17. Did you feel that decisions were made together by you and the person you saw during this discussion?
CQC Community Mental Health survey	Q25. Were you involved as much as you wanted to be in decision about which medicines you receive?
CQC Community Mental Health survey	Q31. Were you involved as much as you wanted to be in deciding what treatments or therapies to use?
GP Patient survey	Last GP appointment Q21 Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following? Involving you in decisions about your care
GP Patient survey	Last nurse appointment Q21 Last time you saw or spoke to a nurse from your GP surgery,

	how good was that nurse at each of the following? Involving you in decisions about your care
Cancer Patient Experience Survey	Q16. Do you think your views were taken into account when the team of doctors and nurses caring for you were discussing which treatment you should have?
Cancer Patient Experience Survey	Q20. Were you involved as much as you wanted to be in decisions about your care and treatment?
VOICES	Q48. Looking back over the last 3 months of his life, was he involved in decisions about his care as much as he would have wanted?
VOICES	Q49. Looking back over the last 3 months of his life, were you involved in decisions about his care as much as you would have wanted?
Information - this might include evidence as to whether respondents have been given appropriate information in a way they could understand, whether their family or carer had been given appropriate information, and whether they have been given information about other services or support organisations that are available to someone in their circumstances.	
CQC Inpatients survey	Q8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?
CQC Inpatients survey	Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?
CQC Inpatients survey	Q38. Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?
CQC Inpatients survey	Q54. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?
CQC Inpatients survey	Q 61. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?
CQC Inpatients survey	Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?
CQC Community Mental Health survey	Q27. The last time you had a new medicine prescribed for your mental health needs, were you given information about it in a way that you were able to understand?
CQC Community Mental Health survey	Q32. In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?
CQC Community Mental Health	Q33. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

survey	
CQC Community Mental Health survey	Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?
Cancer Patient Experience Survey	Q25. Did hospital staff give you information about support or self-help groups for people with cancer?
Cancer Patient Experience Survey	Q26. Did hospital staff discuss with you or give you any information about the impact the cancer could have on our work life or education?
Cancer Patient Experience Survey	Q27. Did hospital staff give you information about how to get financial help or any benefits you might be entitled to?
Cancer Patient Experience Survey	Q53. Were you given clear written information about what you should or should not do after leaving hospital?
Cancer Patient Experience Survey	Q55. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you at home?
Personal Social Services Survey of Adult Carers	Q13. In the last 12 months, have you found it easy or difficult to find information and advice about support, services or benefits? Please include information and advice from difference sources, such as voluntary organisations and private agencies as well as social services
Adult Social Care Users Survey	12. In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits?
Transitions/changes – this might include evidence as to whether respondents experienced delays in moving between services or being discharged and whether the respondent feels that changes in service provision have had an impact on their care.	
CQC Inpatients survey	Q51. On the day you left hospital, was your discharge delayed for any reason?
CQC Inpatients survey	Q52. What was the MAIN reason for the delay?
CQC Community Mental Health survey	Q18. In the last 12 months, have the people you see for your care or services changed? Q19. What impact has this had on the care you receive?
My goals and outcomes – this might include evidence as to whether respondents felt that their needs were assessed and taken into account, that their family or carers needs were taken into account, that they received enough help, support and follow up care to live the life they want to the best of their ability.	
CQC Inpatients survey	Q 60. Did hospital staff take your family or home situation into account when planning your discharge?
CQC Inpatients survey	Q71. Since leaving hospital, have you received enough follow up care and assistance from health or social care services (e.g. from a GP, physiotherapist, community nurse, or from social services?

CQC Community Mental Health survey	Q7. Did the person or people you saw understand how your mental health needs affect other areas of your life?
CQC Community Mental Health survey	Q14. Does this agreement on what care you will receive take your personal circumstances into account?
CQC Community Mental Health survey	Q40. Do the people you see through NHS mental health services help you with what is important to you?
GP Patient survey	For respondents with a long-standing health condition Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health
Cancer Patient Experience Survey	Q56. After leaving hospital, were you given enough care and help from health or social services (for example, district nurses, home helps or physiotherapists)?
Cancer Patient Experience Survey	Q63. Do you think the GPs and nurses at your general practice did everything they could to support you while you were having cancer treatment?
VOICES	Q5. Overall, do you feel that you got as much help and support from health and social services as you needed when caring for him?
VOICES	Q35 Please look at the following statements and tick the answer box that corresponds with your opinion about the help he receives in the last two days of his life: a)There was enough help available to meet his personal care needs (such as toileting needs) b) there was enough help with nursing care, such as giving medicine and helping him find a comfortable position in bed
Adult Social Care Users Survey	2b. Do care and support services help you to have a better quality of life?
Adult Social Care Users Survey	3a. Which of the following statements best describes how much control you have over your daily life?
Care planning - This might include evidence as to whether a care or support plan has been agreed, an understanding of how much control the respondent feels that they have over their care planning and whether their care plan is regularly reviewed	
CQC Community Mental Health survey	Q12. Have you agreed with someone from NHS mental health services what care you will receive?
GP Patient survey	Q36. Do you have a written care plan?
GP Patient	Q37. Did you help put your written care plan together?

survey	By 'helping' we mean setting goals for yourself or choosing how you want to manage your health
GP Patient survey	Q39. Does your GP, nurse or other health professional review your written care plan with your regularly?
Cancer Patient Experience Survey	Q68. Have you been offered a written assessment and care plan? *A care plan is a document that sets out your needs and goals for caring for your cancer. It is an agreement or plan between you and your health professionals to help meet those goals*
Emergencies – this might include evidence as to whether respondents know who to contact in a crisis and whether they got the help they needed from that person.	
CQC Community Mental Health survey	Q21. Do you know who to contact out of office hours if you have a crisis?
CQC Community Mental Health survey	Q22. In the last 12 months, have you tried to contact this person or team because your condition was getting worse?
CQC Community Mental Health survey	Q23. When you tried to contact them, did you get the help you needed?
VOICES	Q8 The last time this happened, who did he contact or who was contacted on his behalf? (urgent care need)
VOICES	Q9. What happened as a result?
VOICES	Q10. In your opinion, was this the right thing to do?