Adults, Health & Public Protection Policy & Scrutiny Committee

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Classification:	General Release
Title:	**Reviewing the Community Independence Service -one year on**.
Report of:	Professor Tim Orchard- Imperial NHS Trust Jukes Martin- Managing Director Central London CCG
Cabinet Member Portfolio	Cabinet member for Adults and Public Health
Wards Involved:	All
Policy Context:	City for Choice
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1. Executive Summary

This report was commissioned asking health colleagues to update committee members on the performance of the Community Independence Service one year in.

The authors were also asked to include personalised budgets and relevant Key Performance Indicators.

This integrated report comes in two parts;

- Imperial providing the review and
- NHS Central, West and Hammersmith and Fulham CCG's providing an update on the procurement of the new service. The report highlights the successes of the service to date but acknowledges that there have been some challenges and that the service will continue to develop throughout the next phase.

2. Key Matters for the Committee's Consideration

Committee are asked to:

- To receive the update and recognise the challenges associated with delivering a complex service.
- Note the progress of the Community Independence Service (CIS) procurement process (paragraph 5)
- Identify when they may want to receive a report back on the performance of the new service

3. Executive summary

The Community Independence Service provides integrated community and social care through one multidisciplinary team in each borough. The service operates seven days a week enabling people to regain their independence and remain in their own homes following illness and/or injury. The service provides a patient-centric experience with as few separate interactions or home visits as possible. Services are currently delivered by a multidisciplinary team of community nurses, social workers, occupational therapists, GPs, geriatricians, mental health workers, reablement officers and others providing a range of functions which aim to:

- Avoid hospital admissions where clinically appropriate care can be provided in the community;
- Facilitate early supported discharge from hospital;
- Maximise independence; and
- Reduce dependency on longer term services.

A Case for change was put forward and agreed in 2014 setting out plans to develop an integrated health and social care intermediate care service using a phased approach. The first stage was to develop lead health and social care providers to shape the service during a transiton year, whilst a fully integrated model was designed and procured.

Following a restricted tender process, Imperial College Healthcare Trust were appointed as Lead Health Provider(LHP) and have been working with Adult Social Care (led by LBHF) to deliver services.

In February 2016 CCG Governing Bodies approved the joint reprocurement of the Community Independence Service with Adult Social Care.

4. Report from Imperial College Healthcare NHS Trust to Westminster City Council Adults, Health and Public Protection Policy & Scrutiny Committee

4.1 Imperial College Healthcare NHS Trust overview

The Trust provides acute and specialist healthcare for a population of approximately two million people in North West London, and more beyond. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – as well as a growing number of community services.

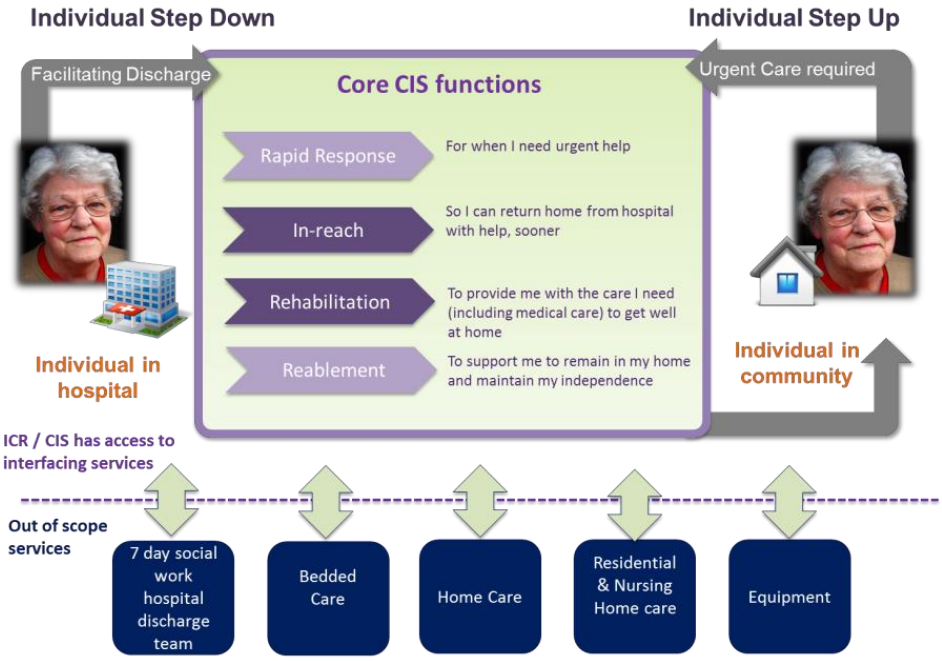
The main responsibilities of the Trust as the Lead Health Provider include:

- Designing and implementing an **integrated Community Independence Service**, amongst the three inner London boroughs, which aligns with commissioner expectations;
- Maintaining a **cohesive way of working** that is followed by all providers;
- Ensuring that **quality and care outcomes** are maintained in accordance to the contract;
- Ensuring that **savings targets** expected of the CIS are achieved;
- **Reporting regularly to commissioners** to assure that the agreed outcomes and targets are met against agreed KPIs and the Benefits Tracker.

4.2 Community Independence Service

The CIS provides:

- **Rapid Response** – providing a two hour response to those patients at imminent risk of admission to hospital, with nurses, social workers, occupational therapists and geriatric consultants working together to review the patient at home, agree a care plan and provide on-going support;
- **In-reach** – working alongside ward teams within hospitals to identify patients who would be better cared for in their own home and supporting them to do so via a supported discharge to the CIS home care team, working with the patient's GP;
- **Rehabilitation and Reablement** – either following a rapid response referral or a discharge from hospital, helping patients to regain their independence after an episode of ill health, providing occupational health, physiotherapy and medical input to support a recovery.



The aims of the service are:

- To enable people to be as healthy and independent as possible maintaining / or regaining / or improving their quality of life and wellbeing;
- To support people's choice to live in the most appropriate place for them, according to their needs and to have control over their lives;
- To ensure that people's experiences are positive by ensuring the service is personalised and seamless within the system;
- To ensure that the treatment, care and support that is provided is right for the person's needs, in the right setting and respects their individuality and dignity;
- To increase integration and efficiencies across health and social care to ensure strategic investment of funds and resources to maximise value for money.

4.3 Service Developments and Financial Flows

Designing and implementing an integrated CIS has been a primary focus of the programme over the twelve-month contract. The diagram below highlights key areas of achievement:

Summary of integrated CIS programme achievements throughout 2015/16 (page 1 of 2)

- ✓ Establishment of hybrid care workforce (with upskilling of Community Independent Assessors commenced)
- ✓ Integrated Occupational Therapist job role agreed
- ✓ Rehab investment and wait list reduction meeting key performance indicators

- ✓ Aligning CIS care and management with Whole Systems Integrated Care
- ✓ Integrated Multi-disciplinary team working
- ✓ Clear authorisation and escalation routes

- ✓ Integrated assessment and care planning
- ✓ Core Health and Social Care assessment

- ✓ Single referral process
- ✓ Consistent eligibility criteria
- ✓ Single point of access in H&F; aligned in West (WL) and Central London (CL)
- ✓ Clinically-led and consistent triage criteria implemented
- ✓ London Ambulance Service direct referral pathway (from July)
- ✓ Appropriately skilled and resourced Single Point of Referral

- ✓ Integrated InReach Pathway
- ✓ Early supported discharge and appropriate admission avoidance pathway
- ✓ Expansion of InReach Assessors' role in delivering a hybrid Health and Adult Social Care function

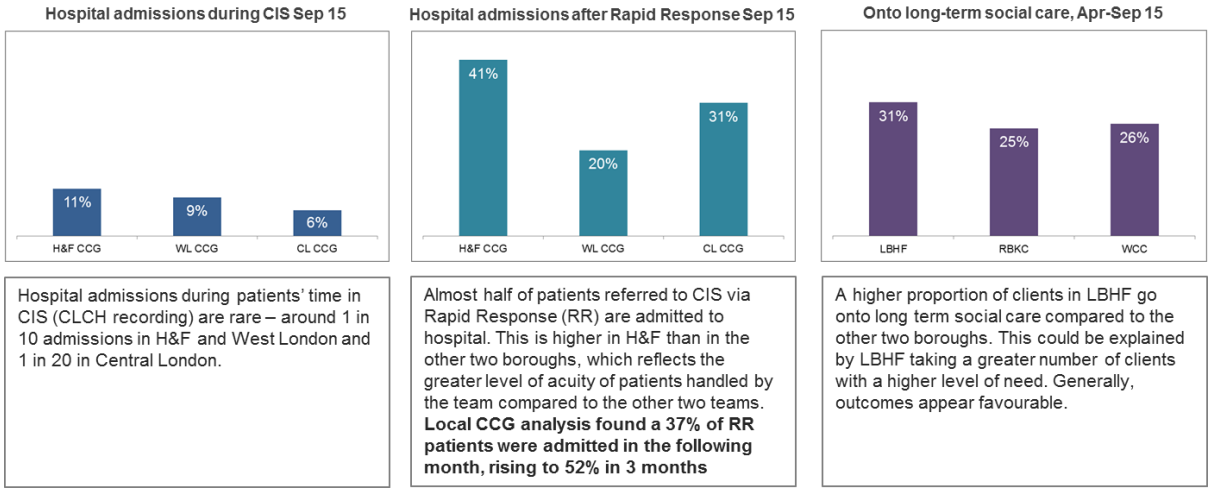
- ✓ Responsive 2 hour rapid pathway
- ✓ Multi-disciplinary team working
- ✓ Medical cover established across the TriBorough (with specialist Consultant cover in H&F and CL from July)
- ✓ QPP referral and medical cover process rationalised
- ✓ Planned rollout of prescribing pathway across in H&F and CL
- ✓ Pharmacy support identified for WL
- ✓ Planned expansion of Mental Health support for the service in WL and CL
- ✓ SystmOne integrated patient record, starting with H&F in July
- ✓ Adult Social Care recording of incidents on CLCH DATIX system agreed; Kensington & Chelsea pilot planned in Q1 2016/17
- ✓ Access to mobile specialist community equipment

There have been service enhancements achieved over the past year driven by the Lead Health and Social Care Providers and their shared delivery programme.

- The activity targets for the CIS were generated by the tri-borough CCGs from a starting ambition of reduced non-elective hospital utilisation by 5%;
- The required uplift in activity has not been achieved, although year-on-year analysis has been confounded by providers changing reporting systems between 2014/15 and 2015/16, which invalidated the baseline. See appendix 3 for referral volume over time;
- Financial targets were, in the main, reliant on increased activity in the Rapid Response pathway, which has not been realised. In reality, the In-reach activity has reached double its target and Rapid Response half its target;
- The activity uplift has not been achieved for several reasons:
    - The target was overly ambitious (approximately 200% activity increase for Rapid Response);
    - Despite significant engagement work, GP referral behaviours have not changed in proportion to targets during the relatively short timescales of the contract;
    - Team capacity has not increased in line with targets because:
        - It has not been possible to shift the high proportion of agency staffing to permanent staffing due to a sector-wide scarcity of senior nurses and therapists;

- The cost per episode may have been underestimated due to the perceived increase in caseload complexity, although this theory has not been evidenced;
- Staffing had been uplifted with winter pressures funding in 2014/15, which changed the baseline. Additional investment has become a continuation of that baseline.

It was assumed originally that 70% of CIS Rapid Response interventions would convert to an avoided acute admission. Recent analysis of matched data is shown below. It shows that the majority of care episodes in CIS do not end in a hospital admission. However, it indicates that there are significant numbers of admissions from that patient cohort in later months. As many CIS patients are highly complex, this may be expected. The data requires further validation and clinical scrutiny but provides us with a promising new approach to setting more outcome-based baselines and targets.



4.4 Non-Financial Benefits

There have been significant non-financial benefits achieved by the programme. These include:

- Benefits to patients from the service, which receives consistently high satisfaction ratings from patients and GPs. GP surveys between April and October 2015 showed an increase in GPs who felt that "CIS input had improved patient care" from 70% to 85%.
- Service user's rating their experience of the service as "good" or "excellent" has been consistently above 94% against an 80% target, based on a population size of 188. See appendix 5 for details;
- The establishment of the Clinical Reference Group as a forum bringing together clinical leads from all professions and organisations[1] (1) involved

[1] CRG membership includes senior clinical representation from:
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster NHS Foundation Trust
- London, Central & West Unscheduled Care Collaborative
- Central London Community Healthcare NHS Trust
- West London Mental Health NHS Trust
- Central & North West London NHS Foundation Trust

in the delivery of CIS and empowering them to deliver combined recommendations for service design; this is considered a key achievement by all health and LA partners.

- The establishment of the CIS Partnership Board as a forum of provider executives from across North West London, which has provided a strategic forum and escalation point for the effective delivery of local collaborative working. For example, the Partnership Board elected to re-invest a small underspend from the organisational development budget to increase in-reach bridging capacity to support system-wide benefits.

4.5 Key Challenges – Lead Health Provider 2015/16 transition year

The year has not been without significant challenges, some of which are summarised below:

- A lack of direct contractual relationship with CLCH, ASC and other providers has, to some extent, reduced the Trust's ability to influence performance through contract levers. Mechanisms were in place to implement contract variations via the commissioners;
- By the same token, the Lead Health Provider has had limited ability to apply incentives to in situations where provider partners have lacked the internal capability to make an agreed service change (e.g. recruitment of mental health staff into multi-disciplinary teams);
- Lack of inclusion of intermediate care beds creates pressure on CIS to support early discharges for clients not ready to receive re-enabling care from day one of the pathway, with downstream effects on social care costs;
- Staffing retention and recruitment has proven extremely challenging with the short term nature of commissioning contracts and the competitive nature of the London employment market;
- Due to the wider ASC Customer Journey transformation programme, the Health and ASC integrated workforce consultation was not launched in August 2015 as planned. The delays to consultation impacted on workforce stability and use of agency staff has resulted in minimal workforce uplift in comparison to the winter period last year. This has also resulted in the de-coupling of the joint health and ASC investment plan to service the assurance needs of the separate health and LA commissioners;
- The divergent incentives between health and social care have made meaningful integration difficult and have been hard to reconcile. Health providers are incentivised to discharge patients once they are medically fit but this creates a downstream pressure on long term ASC packages. Aligning incentives will be a key feature of the development of accountable care partnerships in North West London, underpinned by the exploration of shared health and social care budgets where possible and appropriate;
- Data Quality issues have resulted from the use of different recording tools. The integrated patient record on SystmOne launching in Hammersmith & Fulham in June will support the resolution of this challenge;

- The Lead Health Provider contract originally included 67 outcome measures (KPIs). Over the past year the Lead Health Provider has worked with the CCG to reduce this to more manageable data sets. Appendix 2 for KPIs Please see appendix 4 for high level outcome data;
- It was acknowledged that it would always be challenging to measure an avoided hospital admission or deterioration in independence, as a result of this joint work has commenced to explore and measure this in the new contract.

The health system alignment between commissioners, acute and social care services to shift resource has at times not been in alignment and this has been taken forward as a "lessons learned" for the procurement.

4.6 Summary of the last 12 months

The above successes and challenges have been discussed at length with the CCGs and it is hoped the new CIS Lead Provider contract will support the continued enhancement of the service to support benefits to patients and the wider health and social care system.

Despite Imperial's decision not to bid for the new Lead Provider contract, the Trust remains fully committed to supporting the delivery of this critical service and of the direction of travel towards integrated health and social care in North West London through Accountable Care Partnerships.

5. Procurement of the new Community Independence Service

5.1 Background

Intermediate care and re-enablement services are a key plan of government healthcare policy to provide health and care closer to home. Intermediate care services are key to reducing the financial, quality and activity pressures being experienced in secondary care and the care service sector. The National Audit of Intermediate Care (2015) provides a comprehensive analysis of models and performance of services which support, typically older, frail people with high levels of need and complex comorbidities, after leaving hospital or at risk of being sent to hospital or long term care. Evidence from this audit (to which CLCH and Central London CCG are contributors) indicates that CI services improve the independence of frail, older people and that reduces the cost of delivering care.

The CIS delivers the following key functions:

- A Single Point of Referral, Assessment & Rapid Response
- In-Reach/Supported Discharge
- Rehabilitation & Re-ablement

The Community Independence Service Business Case (Nov 2014) presented the case for an integrated Community Independence Service to be managed by lead providers from health and social care. The procurement was undertaken as a restricted tender between existing providers delivering services to tri-borough CCGs. The advertised restricted tender was for a one-year contract with no extension as

with the intention of using the transition year to procuring a full lead provider model for 2016.

The timescale for procurement was delayed to allow an evaluation of the current model in October 2015. The evaluation process included 1:1 and group meetings with commissioners, provider teams, GPs and Clinical leads for the service as well as patient feedback and surveys. Following the evaluation commissioners agreed to move to procurement of an integrated CIS under a partnership of providers using either a lead provider or alliance model. Learning from the evaluation has been discussed during Market Engagement and taken into consideration when developing the service specification.

5.2 Procurement Process

Phase 1 – Market Engagement

In December 2015 Triborough Health commissioners authorised a three month extension of the Lead Health Provider Contract to cover the anticipated procurement timeline.

A Memorandum of Information was published on the EU Portal on 13th January 2016 to advertise that a potential health & social care procurement of a fully integrated community independence service was being considered. The advertisement offered providers the opportunity to comment on the proposed service design and timescale for procurement through i) written response to a series of questions regarding future development of the Community Independence Service and ii) an opportunity to participate in 1:1 interviews with commissioners.

Commissioners received 11 expressions of interest, 8 written responses and undertook 7 provider meetings. Responses were positive and all provider written responses contained confirmation of ability to bid and mobilize services within the timeframes indicated in the Memorandum of Information.

Following a review of the market engagement exercise commissioners agreed to proceed to Phase 2 of this project, an open tender process.

Phase 2 - Procurement

Following completion of the market engagement exercises commissioners across health and social care jointly revised the CIS service specification. The intention was to strengthen the service model, building upon the first 12 months of the development of the CIS and enhance delivery to patients and residents across the three boroughs. The key service lines within the CIS model remain unchanged and areas identified for immediate improvement and development included:

- Single lead provider, responsible for delivery of health and social care elements of the service under one contract;
- Service overseen by Consultant/Elderly Care Specialist;
- Requirement to co-locate with Whole Systems Primary Care models in each area, as these develop;

- Increased emphasis on partnership working across health sectors (acute, mental health and primary care);
- Expansion of In-Reach cover to CL CCG out of area hospitals e.g. Royal Free and University College Hospitals London;
- Requirement to increase links with voluntary sector;
- Key Performance Indicators will focus on outcomes achieved for our patients and residents;
- Partnership Delivery Group meetings will focus on increasing shared learning from performance and outcomes to drive further improvements for the benefit of patients and residents.

Phase 3 - Advertising the Opportunity

Following development and agreement of a joint service specification, finance and procurement documentation, an advertisement was placed on Contract Finder (EU Procurement Portal) on 4th March 2016. Interested parties were given 6 weeks to provide a written submission to bid for delivery of the service with final deadline of noon on 15th April 2016.

5.3 Outcomes of Tender Process

Following development and agreement of a joint service specification, finance and procurement documentation, an advertisement was placed on Contract Finder (EU Procurement Portal) on 4th March 2016. Interested parties were given 6 weeks to provide a written submission to bid for delivery of the service with final deadline of noon on 15th April 2016.

A number of bids were received and marked by a multi-commissioner evaluation team. Commissioners hope to be in a position to appoint a lead provider in the near future with phased service commencement beginning in July 2016.

The intention is to consolidate and improve the current service delivered by integrated community and social care by creating multidisciplinary health and social care teams to work across the boroughs, which operate seven days a week, enabling people to regain their independence following illness and/or injury and remain in their own homes. Healthcare teams must have the ability to flex across borough boundaries for delivery of services to ensure the ability to meet fluctuations in demand.

The new service procured will be contracted for an interim period of a maximum of 21 months (July 2016-March 2018) which will:

- Provide an opportunity to further develop the service whilst commissioners develop and procure Accountable Care Partnerships (as set out in Commissioning Intentions 2015).
- Allow the existing provider network to develop to a suitable level of competence for involvement in Accountable Care Partnerships.

Appendix 2: CIS KPI Master List

N	Indicator	Detailed Descriptor	Service collecting	Threshold/Target (Total)	Threshold/Target (H&F - LBHF)	Threshold/Target (WL-RBKC)	Threshold/Target (CL - WCC)	Monitoring Frequency	Phasing (metric collected from)
SECTION A: CIS ACTIVITY									
3	Number of Primary referrals accepted into the CIS Service HC	Total number of Primary referrals accepted into the CIS HC	CLCH	To be confirmed				Monthly	Start of Q1 (1st April)
4	Number of service-users accepted into the CIS service	Total number of service-users accepted into the CIS	ASC	To be confirmed				Monthly	Start of Q1 (1st April)
5	The characteristics of patients accepted into the CIS	The characteristics of patients accepted into the CIS	CLCH	NA	NA	NA	NA	Quarterly audit	Start of Q2
6	Referral refused	Total number of patients refused with reason for refusal (drop down)	CLCH	NA	NA	NA	NA	Quarterly audit	Start of Q2
7	% of patients with a personalised care plan in CIS	100% of Patients identified as CIS patients should have a personalised CIS Care plan completed (or their prior plan amended) within 48 hours. This is the responsibility of CIS staff.	CLCH	100% of patients in CIS	100% of patients in CIS	100% of patients in CIS	100% of patients in CIS	Quarterly audit	Start of Q2

8	Rapid Response times: % attendance at patient's location within 2 hours of referral	Length of time from referral accepted as an urgent case to intervention- % of patients attended to within two hour threshold	CLCH	Response time to visit request from GP for patients in CIS will be 2 hours for urgent patients: 98%	Response time to visit request from GP for patients in CIS will be 2 hours for urgent patients: 98%	Response time to visit request from GP for patients in CIS will be 2 hours for urgent patients: 98%	Response time to visit request from GP for patients in CIS will be 2 hours for urgent patients: 98%	Monthly and report by exception	1st April
9	Rehab response times: Average length of time from referral to rehab intervention	Average length of time from referral acceptance to intervention	CLCH	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	Monthly	Start of Q1 (1st April)
10	Reablement response times: Average length of time from referral to reablement intervention	Average length of time from referral acceptance to intervention	ASC	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	Monthly	Start of Q1 (1st April)
11	In-Reach response times: Average length of time from referral to In-Reach intervention	Average length of time from referral acceptance to intervention	CLCH	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	48 hours to commencement of care: % to be confirmed	Monthly	Start of Q1 (1st April)
15	Number of PRIMARY referrals accepted and allocated to Reablement	Number of referrals accepted and tasked to a Reablement worker and actioned	ASC	4993 (+1846)	1676 (+522)	1656 (+587)	1661 (+738)	Monthly	Start of Q1 (1st April)

17	Average Length of Stay (LOS) of patients in the CIS: Rapid Response	Average duration of time spent within the CIS: Rapid Response	CLCH	To be confirmed	To be confirmed	To be confirmed	To be confirmed	Quarterly audit	Start of Q2
18	Average Length of Stay (LOS) of patients in the CIS: Rehabilitation	Average duration of time spent within the CIS: Rehabilitation	CLCH	To be confirmed	To be confirmed	To be confirmed	To be confirmed	Quarterly audit	Start of Q2
19	Average Length of Stay (LOS) of patients in the CIS: Reablement	Average duration of time spent within the CIS: Reablement	ASC	To be confirmed	To be confirmed	To be confirmed	To be confirmed	Quarterly audit	Start of Q2
20	% of cases where medical input was received by patient	Indication by 'tick box' where medical input has been made by a GP, Geriatrician etc.	CLCH	NA	NA	NA	NA	Quarterly audit	Start of Q1 (1st April)
21	Discharge summary provided to the GP within 24 hours of discharge	Evidence that the CIS has provided discharge summary information to the GP following discharge from the CIS.	CLCH	100% as per statutory indicator	100% as per statutory indicator	100% as per statutory indicator	100% as per statutory indicator	Quarterly audit	1st April (H&F) TBC CL/WCC & WL/RBKC to be confirmed
22	Number of customers who receive a service and are discharged from the CIS	Number of customers who receive a service from any or a combination of CIS services and are discharged from the CIS	CLCH					Quarterly audit	Start of Q1 (1st April)
23	Numbers and % of people seen by CIS who are still at home after 91 days	To be confirmed. More work required to develop this indicator.	TBC				.	Quarterly audit	Review at the end of Q2
SECTION B: Reducing non-elective admissions									

24	% of patients in CIS with a hospital admission during their period of care in CIS	Any patient identified that has an unplanned admission to hospital prior to discharge from CIS.	CLCH	NA	NA	NA	NA	Quarterly audit	Start of Q3
25	Number of NEL admissions avoided from CIS admissions	All GP referrers into Spoor to be asked what action they would have taken had they not referred into the CIS (inputted via multiple choice). Responses logged. A&E attendance (and calling an ambulance) included in the multiple choice tick box options.	CLCH	2235	734	772	729	Monthly	1st April
26	Number of A&E attendances avoided from CIS admissions:	All non-GP referrals into Spoor to be asked what action they would have taken had they not referred into the CIS (inputted via multiple choice). Responses logged. A&E attendance (and calling an ambulance) included in the multiple choice the tick box options.	CLCH	3800	1247	1313	1240	Monthly	1st April
27	Number of people with NEL admission to hospital 3 months after CIS admission	SUS data linked to CIS records. To be collected through DSCRO if possible.	Acutes	No threshold/ financial penalties will be attached to this metric. Ian Riley has provided a steer that tracking of patients through the system in this way is possible using the Hitachi programme. Commissioners and provider will have to work together	Quarterly audit				Start of Q3
28	Number of people with NEL admission to hospital 6 months after CIS admission	SUS data linked to CIS records	Acutes		Quarterly audit				Start of Q3
29	Number of people with NEL admission to hospital 12 months after CIS admission	SUS data linked to CIS records	Acutes		Quarterly audit				Start of Q1 2016/17
30	Number of people attending A&E 3 months after	SUS data linked to CIS records	Acutes		Quarterly audit				Start of Q3

	CIS admission								
31	Number of people attending A&E 6 months after CIS admission	SUS data linked to CIS records	Acutes		Quarterly audit				Start of Q3
32	Number of people attending A&E 12 months after CIS admission	SUS data linked to CIS records	Acutes		Quarterly audit				Start of Q1 2016/17
SECTION C: Reducing admission to residential and nursing placements									
34	Number of service-users permanently admitted to Nursing and Residential Care	LA already measure this outcome.	ASC	279 (per year)	120 (per year)	44 (per year)	115 (per year)	Monthly	Start of Q1 (1st April)
35	Number of service-users permanently admitted to Nursing and Residential Care (directly from CIS)	Link required to CIS records.	ASC					Quarterly audit	Start of Q1 (1st April)
36	Reduction in Length of stay in Nursing and Residential Care	Measuring reduction in care home placement weeks against last year's activity.	ASC	2425	1081	404	940	Quarterly audit	TBC
SECTION D: Effectiveness of reablement									
37	Reductions to home care spend due to reablement effectiveness	Measures the volume of additional ASC Reablement episodes per month and applies a saving cost per episode on homecare spend (assumption that people who go through reablement will get better or don't deteriorate so quickly)	ASC	Ongoing work on this metric. Threshold to be indicated upon completion	Ongoing work on this metric. Threshold to be indicated upon completion	Ongoing work on this metric. Threshold to be indicated upon completion	Ongoing work on this metric. Threshold to be indicated upon completion	Quarterly audit	Start of Q1 (1st April)

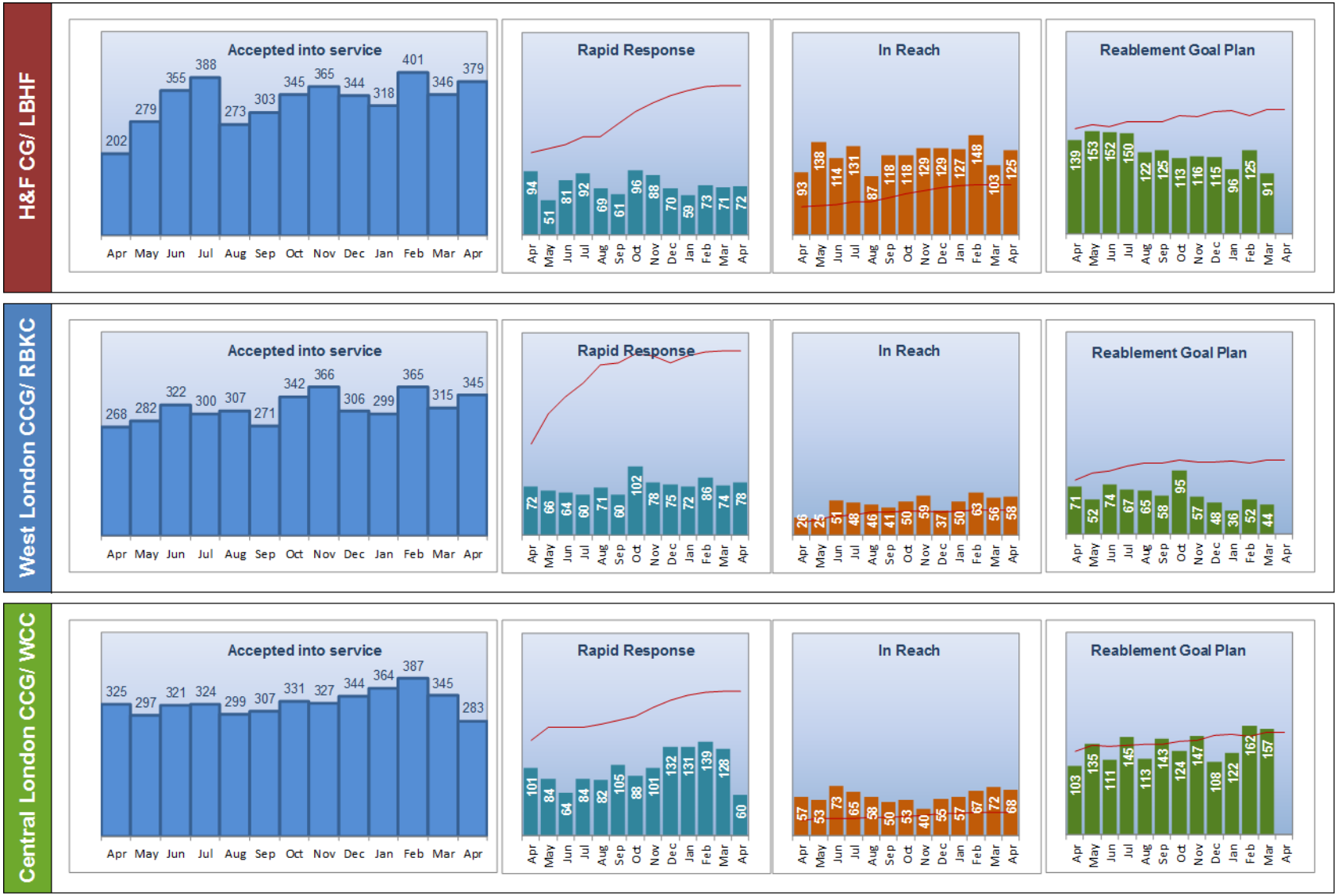
38	Number of people completing reablement	ASC Business Analysis already collects numbers completing reablement per month, via FWI. Note: reablement 'episodes' mean different things to different boroughs. For example, LBHF figures include minor adaptations/ equipment. It may be useful to monitor quarterly the activity around minor adaptations and 'kit' put into people's homes. It may also be useful to measure reablement spend (staffing? budget codes?) and total number of reablement hours provided, to get a fuller picture of provision. However, systems are not currently in place to do this consistently across all three boroughs.	ASC	2510	967	617	926	Monthly	Review at start of Q2
41	% of people requiring Long term care post reablement	Destination after reablement.	ASC	Meeting or exceeding the target set out in the BCF plan and agreed in implementation plan				Quarterly audit	Review at start of Q2
42	People who have completed reablement, what number are re-referred within 6 months (and with what outcome)		ASC	NA	NA	NA	NA	Quarterly audit	Start of Q1 (1st April)
43	People who have completed reablement, what number are re-referred within 12 months (and with what outcome)		ASC	NA	NA	NA	NA	Quarterly audit	Start of Q1 (1st April)
44	Reablement spend	To be determined- likely to be budget or staffing. This measure should also include a method for capturing what equipment/ kit/ minor adaptations are involved in each intervention.	ASC	£1,899,768	£536,785	£603,982	£759,001	Quarterly audit	Start of Q1 (1st April)

45	Reablement hours	Total reablement hours delivered through CIS	ASC	NA	NA	NA	NA	Quarterly audit	Review at the end of Q2
SECTION E: Reducing length of stay in hospital/ Reducing Delayed Transfer of Care (Excess bed days)									
46	Reduction in length of stay in hospital for patients with Long Term Conditions	Number of bed days saved from Early Supported Discharge to CIS. Comparison of length of stay of patients with LTCs that are discharged directly into CIS vs. baseline average length of stay for patients with LTCs pre-CIS (or based upon HRG trim-points)	Acutes	To be confirmed Downwards trajectory	To be confirmed Downwards trajectory	To be confirmed Downwards trajectory	To be confirmed Downwards trajectory	Quarterly audit	Start of Q1 (1st April) ICHT only; Chelwest to be confirmed
47	Number of DTOCs that could have been attributed to CIS	Number of DTOCs that could/ should have been a referral into CIS rather than a DTOC. This will be produced by evaluating a sample of DTOC case files (to be confirmed) and assessing whether a CIS referral could have been an alternative outcome to the resulting DTOC. This defines the slack within the system and shows the increment by which acute discharge processes could further improve in the following period.	Acutes	NA	NA	NA	NA	Bi-annual (6 month) audit	Start of Q1 (1st April) ICHT only; Chelwest to be confirmed
SECTION F: Patient Experience									
48	CIS patient satisfaction and experience	Existing CLCH & ASC surveys will be used. Group B are currently working on service-focused patient experience survey which will fit into this section when completed.	CLCH	? % of patients satisfied with the service Others to be confirmed				Bi-annual (6 month) audit	Start of Q1 (1st April)
50	CIS service-user satisfaction and experience	Existing CLCH & ASC surveys will be used. Group B are currently working on service-focused patient experience survey which will fit into this section when completed.	ASC	? % of service-users satisfied with the service Others to be confirmed				Bi-annual (6 month) audit	Start of Q1 (1st April)
51	CIS carer satisfaction and experience	Existing CLCH & ASC surveys will be used. Group B are currently working on service-focused patient experience survey which will fit into this section when completed.	ASC	? % of carers satisfied with the service Others to be confirmed				Bi-annual (6 month) audit	Start of Q1 (1st April)
52	Friends and family test (Would you recommend this service to friends & family?)	Standard 'Friends and Family' survey questions (5 plus 1). This will also provide a pre-'go live' Baseline which will aid comparison.	CLCH & ASC	To be confirmed				Quarterly audit	Start of Q1 (1st April)
SECTION G: GP participation, perception and experience									

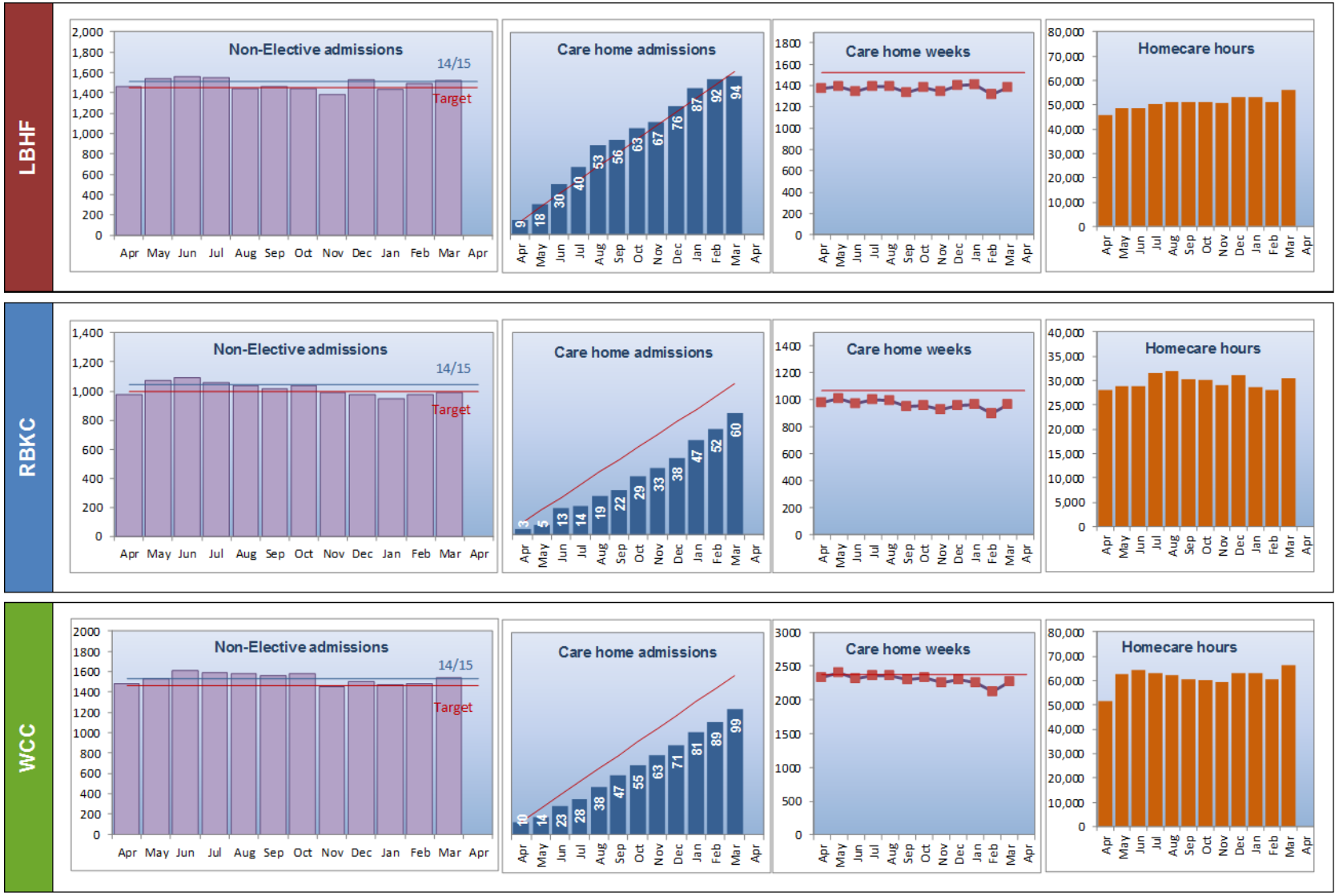
53	GP satisfaction with the service	Dr Rob McLaren as developed a GP survey for H&F GP Fed only. Lead Provides and commissioner need to decide whether this is an appropriate survey to be used as a GP satisfaction measurement tool across the three boroughs.	LHP					Quarterly audit	Start of Q1 (1st April)
54	% of cases where prior notice of discharge from hospital was provided to the GP	Tracking of existing cases and discharges expected in next 3-5 day. CIS sends daily report on Tracking of existing cases and discharges expected in next 3-5 days to the Care Navigator / Case Manager. This is a key piece of information to communicate to the GP and enables the GP's active participation in the care planning process.						Quarterly audit	Start of Q2
SECTION H: Staff perception and experience									
56	Staff satisfaction and CIS perceptions survey (CLCH)	Current CLCH staff satisfaction survey for staff working within the CIS.	CLCH	To be confirmed				6 monthly	Start of Q1 (1st April)
57	Staff satisfaction and CIS perceptions survey (ASC)	Current ASC Triborough staff satisfaction survey for staff working within the CIS.	ASC	To be confirmed				6 monthly	Start of Q1 (1st April)
SECTION I: Management indicators									
58	Achievement of key milestones agreed in investment plan related to recruitment, training and induction	Comparison of actual performance vs. performance milestones agreed with commissioners and signed off in the investment plan	LHP	To be confirmed				Quarterly audit	Start of Q1 (1st April)
59	Evidence that CIS is meeting the RAPID RESPONSE & IN-REACH activity uplift requirements set out in the Financial model across	Comparison of actual performance vs. performance milestones agreed with commissioners and signed off in the investment plan. Rehab excluded as activity uplift figures for Rehab not included in the financial model (financial figures included only).	LHP	3193	1048	1103	1042	Quarterly audit	Start of Q1 (1st April)

	all three boroughs								
60	Number of complaints	No of complaints	CLCH & ASC					Quarterly audit	Start of Q1 (1st April)
61	Complaints detail	Detail of complaints and action taken	CLCH & ASC					Quarterly audit	Start of Q1 (1st April)
62	Incidents (including SIs)	No of incidents with detail of incident and action taken	CLCH & ASC					Quarterly audit	Start of Q1 (1st April)
65	Staff turnover %	% who have left in the quarter and breakdown of which component i.e., RR, In Reach, Rehab or Reablement	CLCH & ASC					Monthly	Start of Q1 (1st April)
66	Current vacancies - per CCG	Number of positions vacant at end of quarter	CLCH & ASC					Quarterly audit	Start of Q1 (1st April)
67	Sickness Levels		CLCH & ASC					Quarterly audit	Start of Q1 (1st April)

Appendix 3: CIS referral volumes over time



Appendix 4: CIS outcomes over time



Appendix 5: CLCH patient satisfaction and experience

6. - Patient experience - CLCH (1 of 2)

Community Independence Service

KPI 52	Friends and family test (Would you recommend this service to friends & family?)

CBU	Service	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely unlikely	Grand Total	Net Promoter Score
Community Independence Services	(CRT) Community Rehabilitation Team	17	4	0	0	0	21	
	(ICT) Intermediate Care Team	1	1	0	0	0	2	
	(IR) In Reach	2		0	0	0	2	
	(RRT) Rapid Response Team	2	1	0	0	0	3	
	CL Community Falls Prevention Service	2	1	0	0	0	3	
	CRT: Occupational Therapist		1	0	0	0	1	
	CRT: Physiotherapist	1	1	0			2	
	CRT: Rehabilitation Assistant	2		0			2	
	Falls Prevention Service	9	2	1	0	0	12	
	Falls: Rehabilitation Assistant	1	0	0	0	0	1	
	Rehab Strength & Balance	2	0	0	0	0	2	
Community Independence Services Total		**39**	**11**	**1**	**0**	**0**	**51**	98

This is the March 2016 survey result

98% are likely or extremely likely to recommend CIS to friends and family

Patient experience - CLCH (2 of 2)

Community Independence Service

KPI 48	CIS patient satisfaction and experience

These services collected PREMS from 188 service users in March 2016.

PREMS Question	Yes	Sort of	No	Not Sure	(blank)	Grand Total	RAG Rating
Involvement in decisions about care and treatment.	37	7	1	4	0	49	75%
Treated with dignity and respect	49	1	1	0	0	51	96%
Treatment explained in a way that could be understood	48	3	0	0	0	51	94%
Satisfied with how quickly you were seen.	31	3	1	0	5	37	83%

Question	Excellent	Good	Ok	Poor	Very Poor	(blank)	Grand Total	RAG Rating
Overall Experience of Care	33	13	1	0	1	1	49	94%

Comments:

The data was taken from the March 2016 survey.

- For KPI 48: 94% Services users rate their overall experience as 'Excellent' or 'Good'. **(Target: 80%)**
- For KPI 48: 75% Services users 'definitely' involved in decisions about their care or treatment. **(Target: 80%)**
- For KPI 48: 96% The staff 'definitely' treated service users with dignity and respect. **(Target: 95%)**
- For KPI 48: 83% Service user was 'definitely' satisfied with how quickly they were seen. **(Target: 80%)**
- For KPI 48: 94% Service users' care and treatment was 'definitely' explained in a way that they could understand. **(Target: 90%)**