Report

Agenda No.:	

Report To:	**Cheshire East Overview and Scrutiny Committee**
Report Title:	**SRG non-recurrent funding Impact Assessment**
Meeting Date:	**14th January 2016**

Report Author(s)		**Governing Body Lead**	
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CCG Strategic Priorities (5+1) supported by this paper	
Transforming Primary Care	✓
Transforming Mental Health	
Transforming Urgent Care	✓
Integration	✓
Person Centred Care	✓
NHS Constitution Targets	✓

Outcome Required	**Approval**		**Assurance**		**Discussion**		**Information**	✓

Recommendations:

The Overview and Scrutiny Committee are asked to:

1. Note the content of the paper.

Executive Summary (key points, purpose, outcomes)

Through the delegated authority of the Central Cheshire Strategic System Resilience Group (SRG) the Central Cheshire Operational System Resilience Group (ORG) produced and implemented the SRG plans to support system resilience in 2014/2015 and 2015/2016.

This report highlights the impact of the 2014/15 initiatives and the process for the implementation of the 2015/16 plans

Reviewed by (e.g. committee/team/director)	
Name (Individual or Group)	**Date**

Have the following areas been considered whilst producing this report?	Yes	N/A
Other resource implications		✓
Equality Impact Assessment (EIA)		✓
Health Inequalities (JSNA, ISNA)		✓
Risks relating to the paper		✓
Quality & Safeguarding (6 C's +1, CASE)		✓
Stakeholder engagement/involvement (member practices/GP Federations, patients & public, providers, LAs etc.)	✓	
Regulatory, legal, governance & assurance implications	✓	
Procurement processes	✓	

Glossary/Acronyms	
BRC	British Red Cross
CCG	Clinical Commissioning Group
CEC	Cheshire East Council Local Authority
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CWAC	Cheshire West and Chester Local Authority
ECT	East Cheshire Hospitals NHS Trust
KPI	Key Performance Indicator
MCHFT	Mid Cheshire Hospitals NHS Foundation Trust
NHS	National Health Service
NHSE	NHS England
NWAS	North West Ambulance Service
PES	Paramedic Emergency Services
PTS	Patient Transport Services
REACT	Rapid Emergency Assessment and Community Therapies Team
SCCCG	NHS South Cheshire Clinical Commissioning Group
VRCCG	NHS Vale Royal Clinical Commissioning Group

1. Introduction

1.1. In 2014/2015 the System Resilience Group (SRG) for Central Cheshire, which covers the geographic area of NHS South Cheshire CCG (SCCCG) and NHS Vale Royal CCG (VRCCG), was allocated £3M in SRG Non-recurrent funding to support winter pressures.

1.2. In 2015/2016 the SRG was allocated £1.7M, of which NHS England mandated that funding should be used in April 2015 to support pressures over Easter. The funding remaining to develop plans for winter 2015/2016 was £1.4M.

1.3. This paper outlines the SRG's approach to reviewing the outcomes and impact of the 2014/2015 initiatives and how this supported the development of robust plans for 2015/2016.

2. Review of 2014/2015 SRG Initiatives

2.1. 33 initiatives were implemented by the Central Cheshire SRG in 2014/2015 (see appendix 1) from two NHSE funding announcements. Phase one was announced in July 2014, with Central Cheshire being awarded £1.7M, allowing time to plan and implement initiatives in advance of winter. Unprecedented demand and failure of the A&E 4 Hour Target across England and the UK led to a further allocation to SRGs in December 2014. For Central Cheshire SRG, this equated to £1.3M. Processes and governance developed for phase one were also used in deciding priorities for the phase two funding.

2.2. The initiatives put in place in 2014/2015 were given four areas to measure their success against, these were agreed by the ORG group as follows:

1. Recognised Impact on system
2. Cost for Impact
3. KPIs and outcomes
4. Avoided activity and costs

2.2.1. Recognised Impact on system

As a group, the ORG assessed each initiative against six key areas of impact, with a score of 1 (one) for each area, the six areas were:

- Delivers care closer to home
- Supports integrated working
- Improves patient experience
- Protects core hospital services
- Improves patient flow
- Supports 18 weeks elective activity

The maximum scored by any of the initiatives was 5 out of the 6, the only initiatives achieving this were the British Red Cross supported discharge, the Rapid Emergency Assessment and Community Therapies (REACT) Team and the YMCA Homeless support with Liaison Mental Health. Those scoring 4 were; Urgent Care Centre (UCC) weekend opening, additional Out Of Hours (OOH) Service capacity and Acute Visiting scheme, additional ambulance transport and the Rapid Care Service and additional social workers provided by the Local Authorities.

2.2.2. Cost for Impact

In 2014/15, the average investment per patient seen by an SRG initiative was £120. It is difficult to compare the costs per patient across different services and sectors of care, as a bed based service will cost fundamentally more than support delivered in a patient's own home by third sector partners with volunteers.

To allow comparisons on a more "like for like" basis, 3 graphs were used to group similar areas of service delivery to compare the cost per patient to the impact achieved (see 2.1.1).

The key used is as follows:

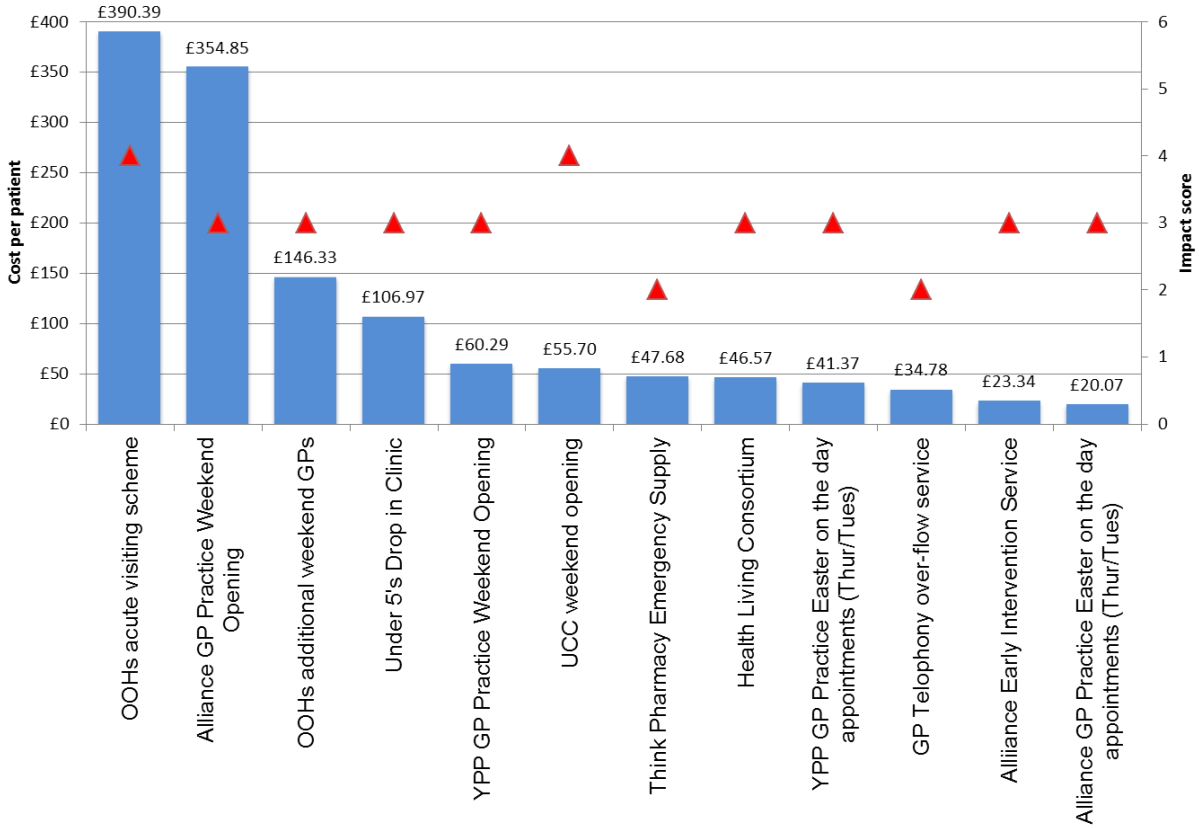
Cost per patient Impact

Admission avoidance/Emergency Department (ED) deflection

The 12 SRG initiatives reviewed for this area of the system have been included in Graph 1 (see below) were based either in the community, in primary care or on the front door of the ED at MCHFT.

The initiatives that stood out as being the most cost effective, delivering the greatest impact on reducing, or better management of ED attendances were:
the GP Alliance Early Intervention scheme (weekdays), the Healthy Living Consortium Home Support for at risk groups and the UCC weekend opening.

Graph 1: Admission avoidance/ED deflection



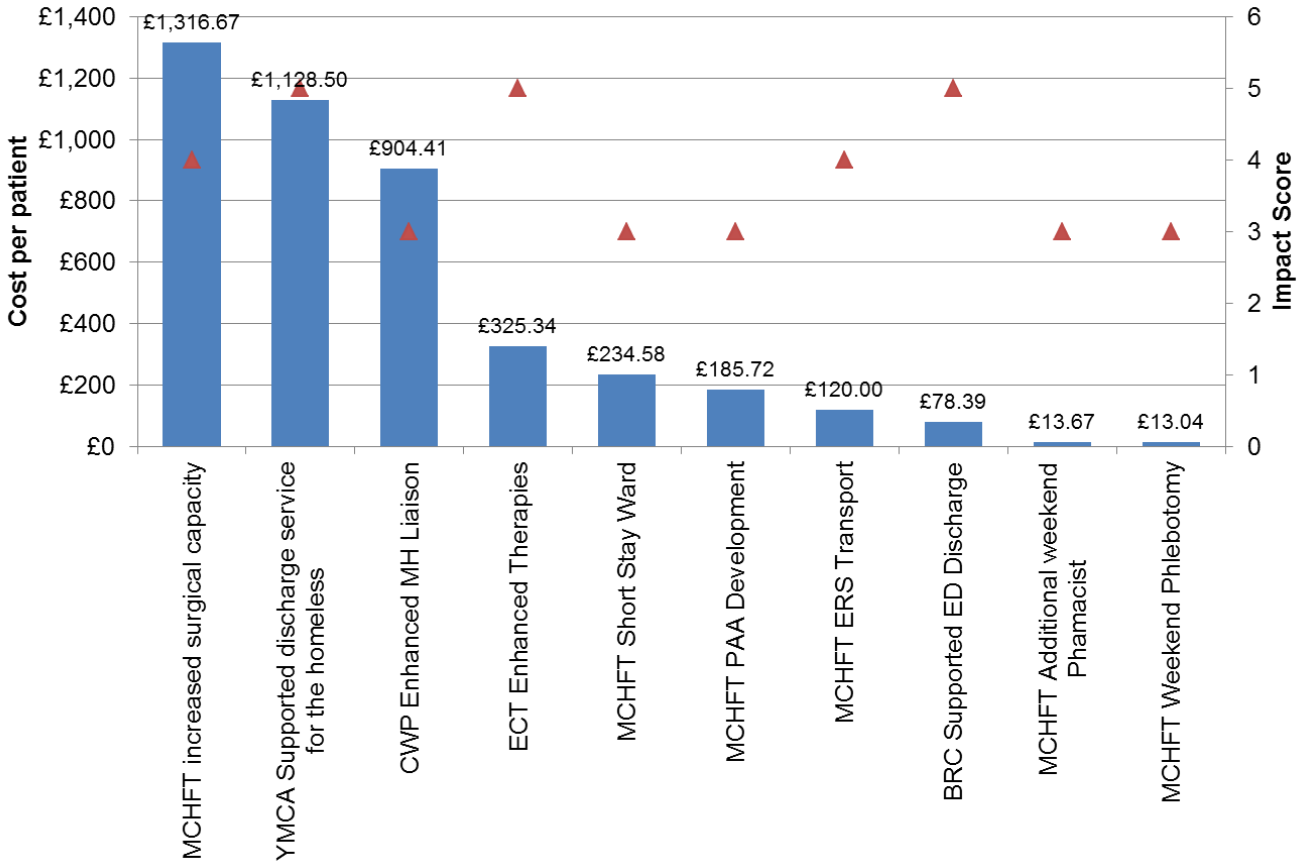
Hospital Patient Flow

The 10 SRG initiatives reviewed for this area of the system have been included in Graph 2 (see below) based on initiatives delivered within the ED and through the patient episode at the Trust.

The initiatives that stood out as being most cost effective and delivering the greatest impact on improving patient flow were: the YMCA Homeless support with Liaison MH, Rapid Emergency Assessment and Community Therapies (REACT) Team, the Short Stay Ward and Primary Assessment Area at MCHFT, British Red Cross Supported Discharge.

The additional pharmacists and phlebotomy, that both had a positive impact, have since been mainstreamed by MCHFT

Graph 2: Hospital Patient Flow

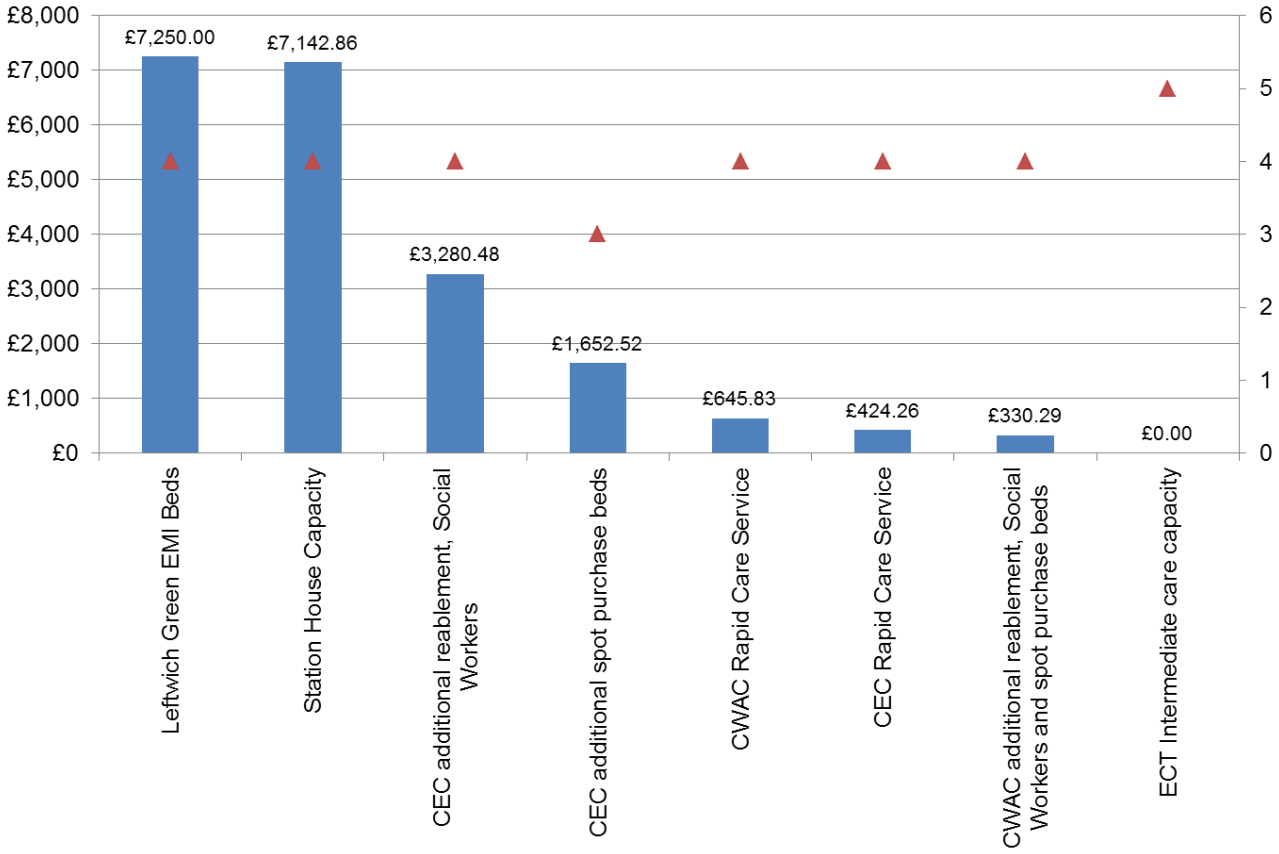


Discharge and Community Care

The 8 SRG initiatives reviewed for this area of the system have been included in Graph 3 (see below) and cover initiatives that delivered care within the community - the majority of which are bed based, or support patients at home who wouldn't otherwise have been able to be discharged home.

The initiatives that stood out as being the most cost effective and delivering the greatest impact on providing bed based care outside the Trust were:
the additional social workers, reablement beds and the Rapid Care Service provided by the Local Authorities. The Intermediate Care beds did not open in 2014/15.

Graph 3: Discharge and Community Beds



2.2.3. KPIs and Outcomes

Data was collated monthly from all providers to allow the ORG to measure:
where patients were seen by each of the initiatives
where they would have been referred to if the initiative had not been in place.

Across the 33 initiatives the following outcomes were achieved for our residents:

25,000 – People received additional care & support
4000 – People stayed at home or treated locally
1000 – People were supported home from the ED
3500 – People went home earlier

The initiatives that achieved the best outcomes for our patients were judged to be those that supported 500 people or more to either remain in their usual place of residence, or that helped then get home from hospital more quickly.

The initiatives showing the highest impact in these areas were:
The British Red Cross supported discharge, the Rapid Emergency Assessment and Community Therapies (REACT) Team, additional OOHs capacity, the GP Early Visiting scheme, additional social workers in the ED and Discharge team, additional pharmacist capacity, Short Stay Ward and PAA at MCHFT.

2.2.4. Avoided activity and costs

Costs avoided for each area were apportioned after some debate, but as all providers were reporting against the same criteria, if was felt the following criteria would ensure a fair review when comparing avoided costs across services and providers - the agreed costs can be seen in table one below:

Table 1: Agreed avoided costs by type

1	ED attendance avoided – minors	£57
2	ED attendance avoided – majors (of which 30% would be admitted)	£130
3	Admissions avoided (= av. 3 bed days)	£1500
4	Reduced LoS (= av. 3 excess bed days)	£900
5	Day of discharge – home support (= av. 1 excess bed day)	£300
6	Day of discharge – expedited prescribing (= av. 0.5 days)	£150

Based on the measures agreed above, it is estimated that 4155 Bed days were saved (over 20 a day) across all the initiatives and total avoided costs were estimated as c£5.5M against an investment by the SRG of £2.7M

The initiatives that achieved the highest level of avoided costs and reduced length of stay in the hospital, were judged to be those that supported 100 or more early discharges or avoided admissions from the Trust, the initiatives showing the highest impact in these areas were:
the British Red Cross supported discharge, the Rapid Emergency Assessment and Community Therapies (REACT) Team, the additional pharmacist in the Trust, OOHs Acute Visiting Scheme and the Rapid Care Service provided by the Local Authorities. The Short Stay Ward and PAA at MCHFT also had a positive impact

It was also agreed that the British Red Cross Supported Discharge initiative reduced a number of readmissions, many of the patients were referred into the Charity's Support At Home service who would not have previously been able to access it.

In addition, the Ambulance Trust Pathways initiative, which was not funded by SRG monies, was also seen as a success. Although the SRG chose not to continue the Acute Visiting Scheme with recurrent funding, it was agreed that GP practices and OOHs would continue to take calls from the ambulance crews to maintain "See and Treat" and the subsequent reduction in conveyancing of patients to the ED with a Primary Care need.

2.2.5. Summary by Impact

The following table (table two) indicates the initiatives with a recognised impact across the 4 areas as identified above:

Table 2: Initiatives and impact

Initiative	Recognised Impact on system	Cost for Impact	KPIs and outcomes	Avoided activity & costs	Comment
British Red Cross supported discharge	✓(5)	✓	✓	✓	Achieved an impact in all four areas. The ORG believe this should be mainstreamed
Rapid Emergency Assessment and Community Therapies (REACT) Team	✓(5)	✓	✓	✓	Achieved an impact in all four areas. The ORG believe this should be mainstreamed
Rapid Care Service provided by the Local Authorities.	✓(4)	✓	✓	✓	Achieved an impact in all four areas. The ORG believe this should be mainstreamed
Additional OOHs capacity and Acute visiting scheme	✓(4)	✓ if no AVS	✓	✓	Additional OOHs GP cost effective in own right and repeated in 15/16, but without the Acute Visiting Scheme (AVS). ORG added the AVS role to the GP early intervention scheme for 15/16.
GP early visiting scheme	✓ if inc. AVS	✓	✓	✓ if inc. AVS	
Trust Short Stay Ward		✓	✓	✓	Setting up and mainstreaming of the “fit to sit” ambulatory care area replaced this initiative in 2015/2016
Trust PAA		✓	✓	✓	GPs speak to the acute physician first. Trust mainstreamed in 15/16 with additional 1 WTE physician
Trust additional pharmacists		✓	✓	✓	Implemented recurrently by MCHFT
YMCA Homeless support with Liaison MH	✓(5)	✓			Achieved an impact in two areas as a niche service, should be repeated in 15/16, but ORG believe this should not be mainstreamed
UCC weekend opening.	✓	✓			Achieved an impact within the ED, should be repeated in 15/16, but ORG believe this should not be mainstreamed
Additional in hours ambulances	✓				
Trust extended Phlebotomy hours		✓			Implemented recurrently by MCHFT
Healthy Living Consortium home support		✓			Although cost per patient is low the service does not give the impact that BRC service is able to, the ORG believe this should not be mainstreamed

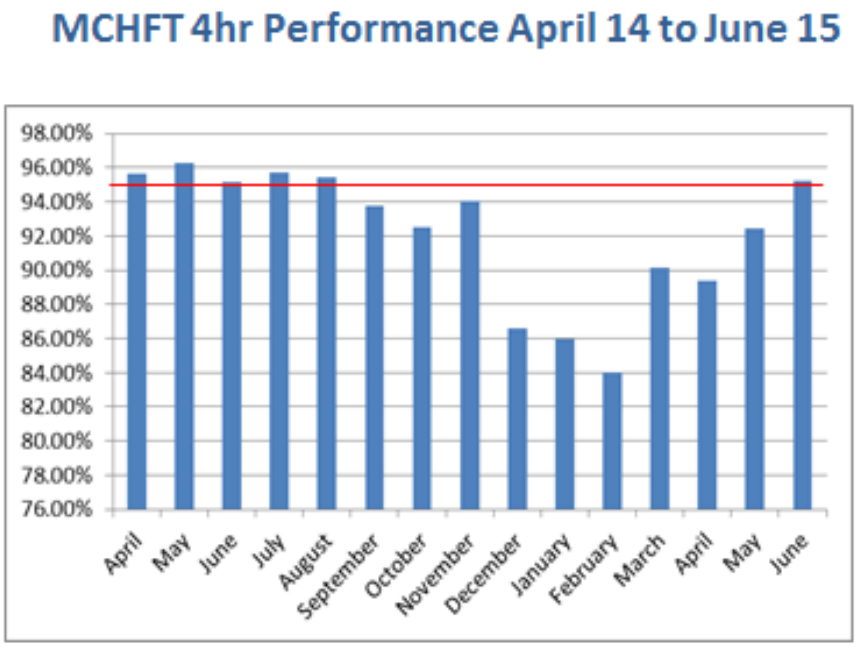
3. Review of 2014/2015 Performance

3.1. A&E performance

3.1.1. The A&E 4 hour target is the measure that is used by NHSE to benchmark the performance of individual SRG areas.

3.1.2. Performance in A&E across the UK in 2014/15 failed, across England A and E performance was 93%, for MCHFT, their performance was 92.26%. Attendances were up by 9% on 2009/10. However analysis of attendances shows that 50% of attendances in the UK either, had no treatment, or only required guidance and advice. Graph 4, below, indicates MCHFT performance by month between 1st April 2014 and 30th June 2015

Graph 4



3.2. Ambulance performance

3.2.1. Ambulance Trust performance is measured at a regional level, for North West Ambulance Service (NWAS), this covers a population of 7 million and 33 CCGs. NWAS failed the 8 minute performance target for both “Red 1” (where the call is immediately classed as a Red) and “Red 2” (where the call is classed as Red during the call) at regional level, Significantly, there is no statistical difference in patient outcomes between the attendance of an ambulance within 8 minutes and attendance in 19 minutes. Locally, NWAS attendance was achieved within an average of 8 minutes and 43 seconds.

3.2.2. SRG continue to work with NWAS to mainstream the referral of patients with a primary care need to the most appropriate service and also to develop further areas of support to help improve performance in Cheshire.

3.3. Winter deaths 2014/15

3.3.1. Excess Winter Deaths (EWD) is a marker of outcomes for patients over winter. The number of daily deaths in 2014/15 was above the five-year average throughout most of

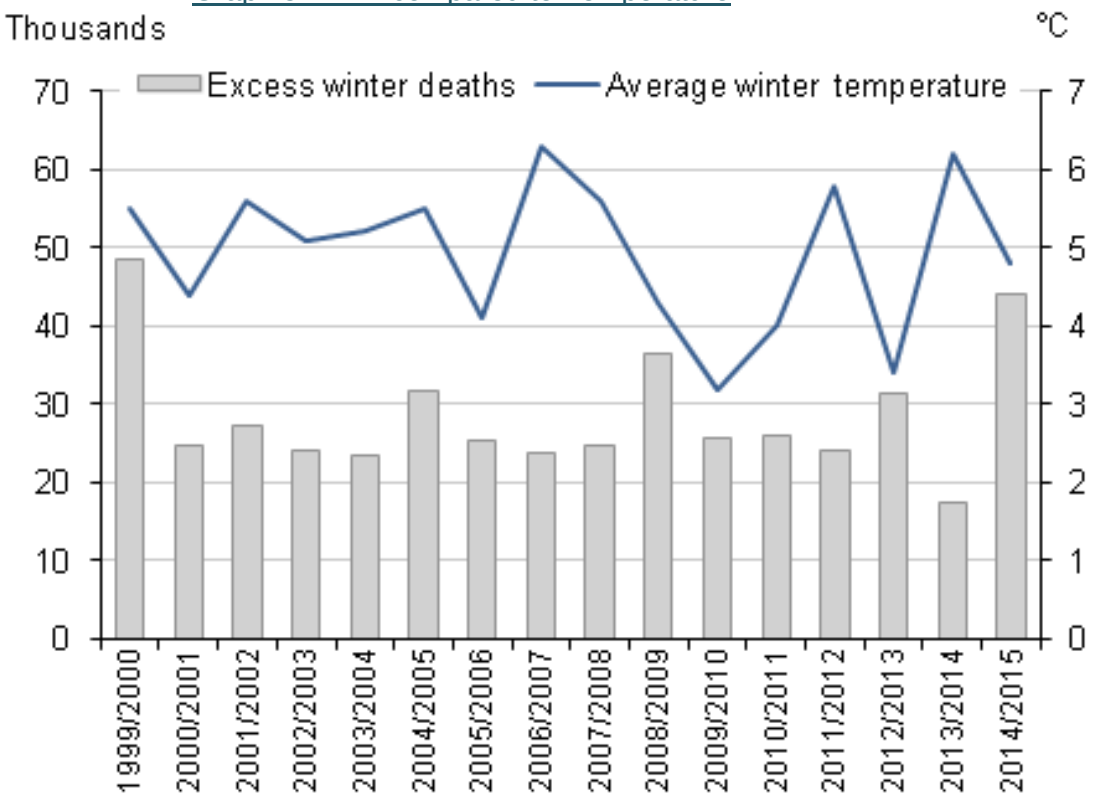
the year (on 304 out of 365 days). During the winter period, there were only 2 days where the number of daily deaths was below the five-year average.

3.3.2. In early December, the number of daily deaths began to climb noticeably higher than the five-year average. The number of daily deaths peaked on 1st January 2015, and remained about 30% above average until 10th January, and around 10% above average until early March.

3.3.3. Winter deaths in Cheshire East are 26% higher among people over the age of 85, compared to 17.2% for those aged 65 - 84 and 9.8% for those aged under 65. The equivalent figures for England are 24.4% for people over the age of 85, 15.1% for those aged 65 - 84, and 7.1% for under 65's.

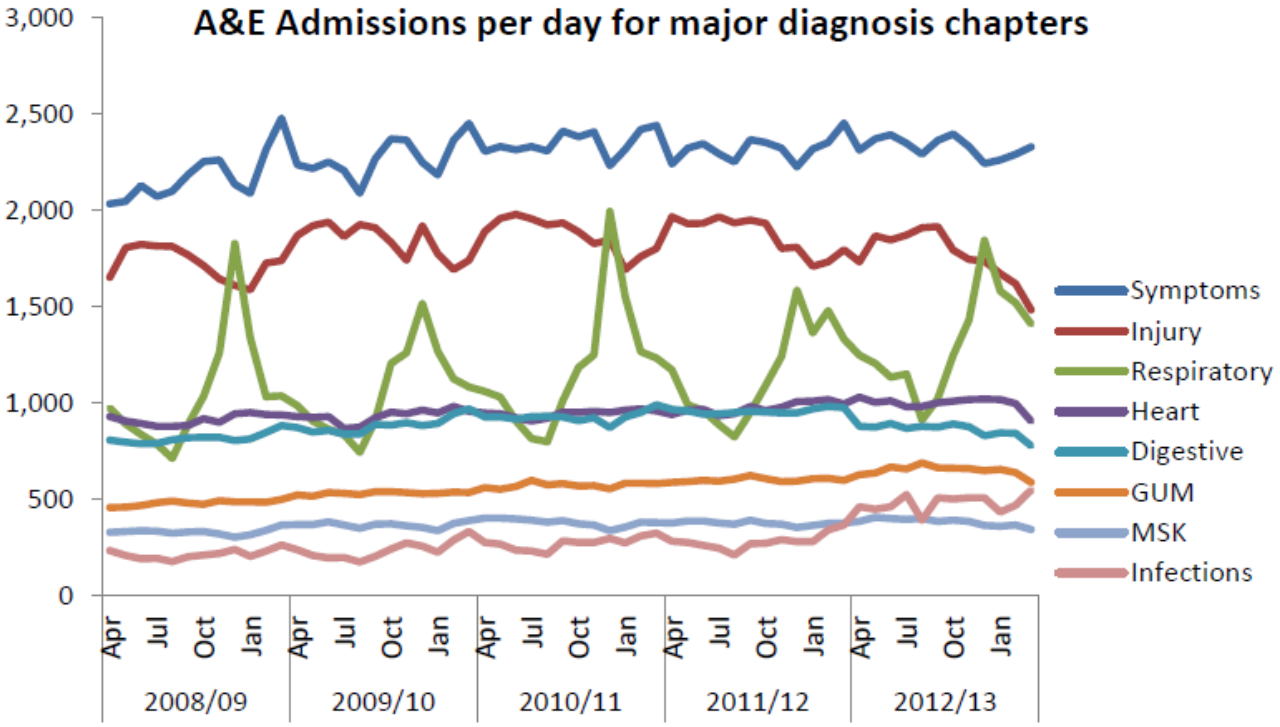
3.3.4. Although it is often thought the main cause of excess winter deaths is climate temperature, it is not the only factor affecting levels of mortality. Though climate temperature clearly is a factor, the link between average winter temperature and EWDs is very unclear in some years. For example, winter 2009/10 was exceptionally cold, but excess winter mortality (EWM) was similar to years with mild winters. In contrast, the higher number of EWDs in 2012/13 was likely to be due to cold weather, but it was the unusual pattern of a sustained cold from mid-January until early April, rather than just a cold January period, that influenced mortality. Graph 5 below compares temperature and EWDs.

Graph 5: EWD compared to Temperature



3.3.5. The risk of EWD is 55.9% higher locally for people who have respiratory disease and 22.3% higher for cardiovascular disease. As can be seen from the chart below, respiratory admissions peaks noticeably in winter.

Graph 6:NHS England data to 2012/13



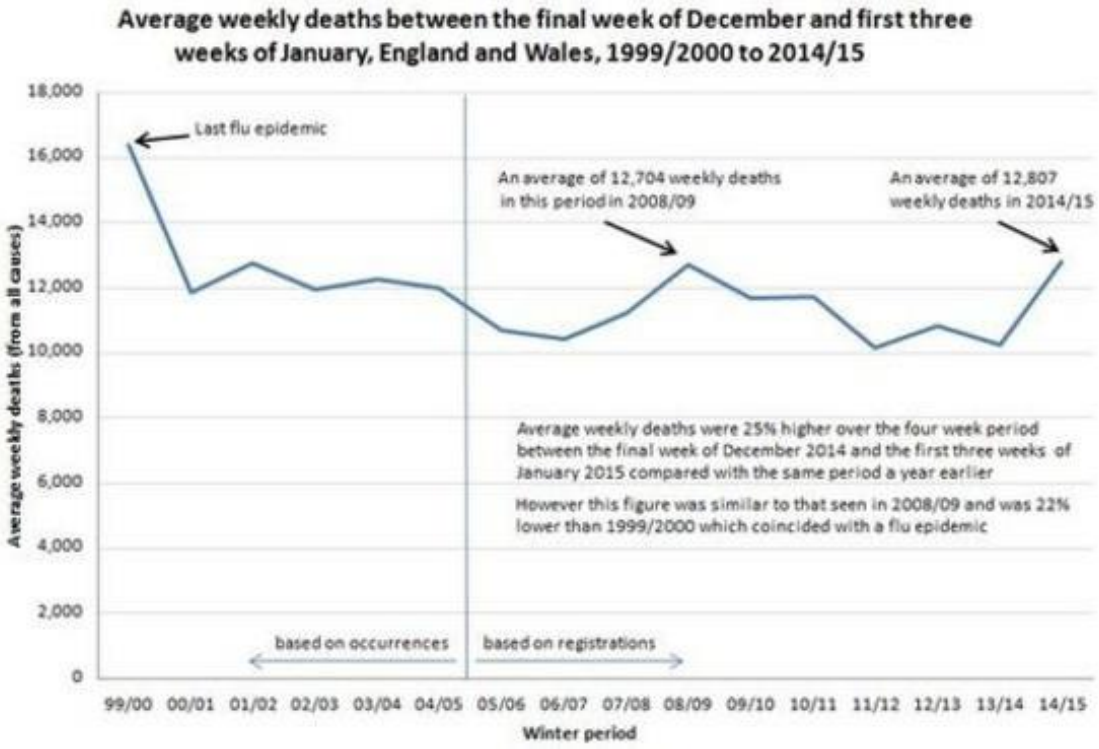
3.3.6. Admissions and deaths from respiratory disease peak when the UK has increased Influenza rates. Influenza infection is associated with potentially life threatening complications, such as bacterial pneumonia. The elderly, and those with underlying health conditions, are particularly at risk of developing complications (Public Health England, 2014b), which can result in hospitalisation and death (Public Health England, 2014c).

3.3.7. Respiratory disease is known to be one of the main causes of excess winter deaths (EWDs); for example in 2014/15, respiratory disease was listed the underlying cause of death for 36% of all excess winter deaths, with the majority of these deaths occurring in the 75+ age group. Pneumonia was the underlying cause in 19% of all excess winter deaths in 2014/15.

3.3.8. The predominant influenza virus in winter 2014/15 was influenza A(H3N2). This strain of flu had a particularly noticeable effect on the elderly, resulting in numerous care homes outbreaks and far higher levels of excess mortality than the last notable H3N2 season of 2008/09 (Public Health England, 2015). By comparison, in the previous winter of 2013/14 the predominant influenza virus was influenza A(H1N1), which was particularly virulent in younger people (Public Health England, 2014).

3.3.9. High levels of influenza occurred in 1999/2000 and were associated with a high level of mortality. In 2014/15 influenza-like illness rates rose above the epidemic threshold in week 50 and remained above or at that threshold until week 14 (Public Health England, 2015).

Graph 7: NHS England data to 2014/15



3.3.10. In conclusion, EWD were higher than average in 2014/2015; however they were in line with levels expected when there are high Influenza rates.

4. Post winter planning

4.1. The ORG have put in place an action plan to address areas of pressure in services that occur throughout the year, these areas of work support the ongoing delivery of the 8 high impact areas identified by NHS England, ADASS (Association of Directors of Adult Social Care), Monitor and the Trust Development Authority, the recommendations from the Tripartite visit to MCHFT in 2015 and other areas of best practice identified both regionally and nationally.

4.2. MCHFT have implemented initiatives that will support them in planning for these surges in demand, this included enhancing A&E, Short Stay and PAA protocols and processes and also the following actions have been implemented:

4.2.1. Senior decision making: additional consultants in A&E (5.0 whole time equivalent (wte) to 8.5wte) moving to 14 wte in future. This now provides A&E consultant cover 8.00am to 10.00pm every day. In addition, there are now 5.00 wte acute physicians who are able to provide cover over the same period 7 days a week.

4.2.2. Clinical support: the workforce review also increased nurse staffing on all medical wards and increased the number of nurse practitioners enabling cover in A&E to be extended to midnight every night , soon to be extended again to 2.00am every night.

4.2.3. New “Fit to Sit” Primary Ambulatory Care unit: opened on 1st October with 16 “beds”, to be extended in Jan by a further 16 beds. This is used for patients for up to 72 hrs with rapid discharge. This has a double impact : ensuring fast turnaround i.e. waiting for assessments after admission, all in one location within the hospital. It also minimises medical outliers e.g. in December 2015, week 2 - 1 medical outlier, this time last year circa 30. Impact is that zero length of Stay (LOS) has increased and current conversion rate in A&E is very high (40%) but A&E 4 hr standard is delivered.

4.2.4. Review of all long waiters: Clinical Peer review of all over 28 day stays. Formal review of all “over 14 day” LOS patients.

4.2.5. Admission avoidance: due to having additional acute physicians, no patient can be admitted to the Primary Ambulatory Unit (PAU) by a GP, unless the GP speaks to the acute physician first; this saves at least 3 admissions per day. This is the portal for all GP referrals

4.3. Availability of beds and care packages in the community to support discharges has also been a main area of issue throughout the year. Delayed Transfers of Care (DToCs) are currently running at 8% for the year against a national target of 2.5%. The level of delayed transfers of care indicates the performance of the health and social care discharge functions and community bed capacity.

4.3.1. Timely discharge of patients, particularly those over 75 is important for their outcomes. About 75% of patients who are ≥ 75 and functionally independent at admission are not functionally independent when they are discharged. Acute hospital care should last only long enough to allow patients to become medically fit for discharge. The outcome of hospitalisation is poorer with increasing age, although physiologic age is a more important predictor of outcome than is chronologic age. Outcomes are better for patients hospitalised because of elective procedures (eg, joint replacement) than for those hospitalised due to an emergency admission.

4.3.2. NHS England have provided the SRGs in Cheshire and Mersey with standardized score cards that compare Local Authority averages, As can be seen from the charts below the proportion of spend on residential and nursing care in Cheshire East (Chart 1) is lower than average, and the level of DToCs higher than average, while in Cheshire West and Chester (Chart 2) the opposite is evident, with a higher proportional spend and a lower level of DToCs.

Chart 1: Cheshire East Council

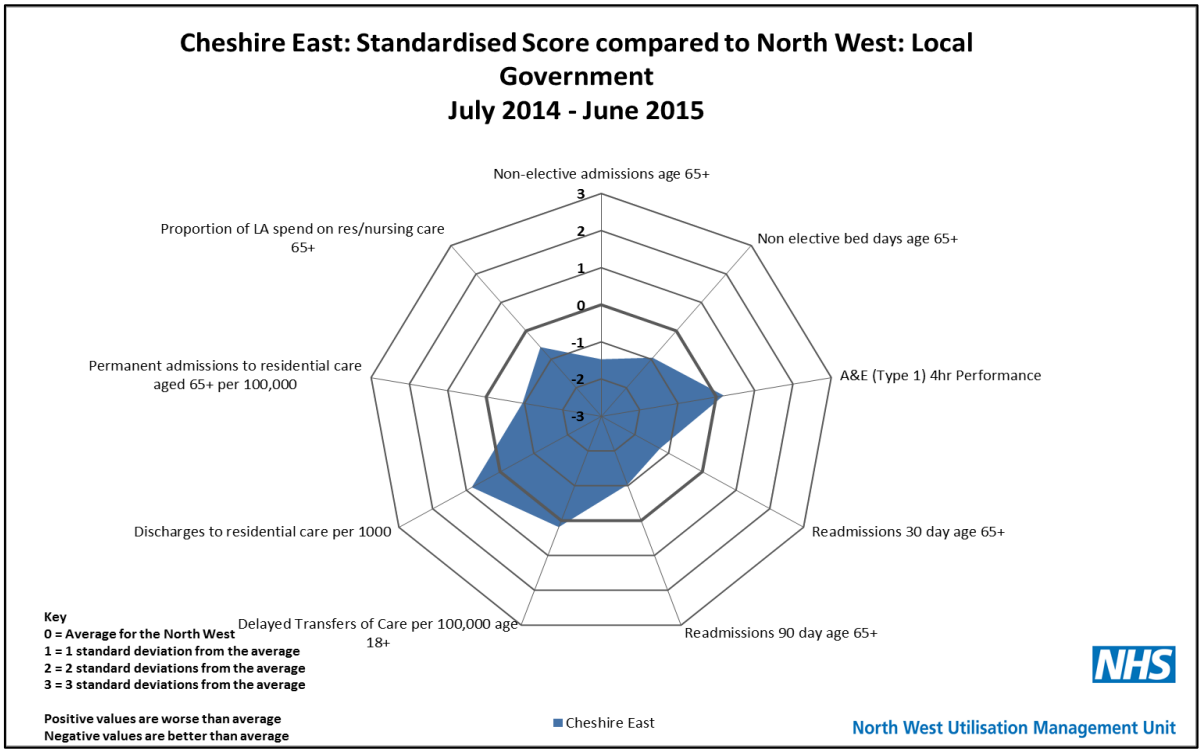
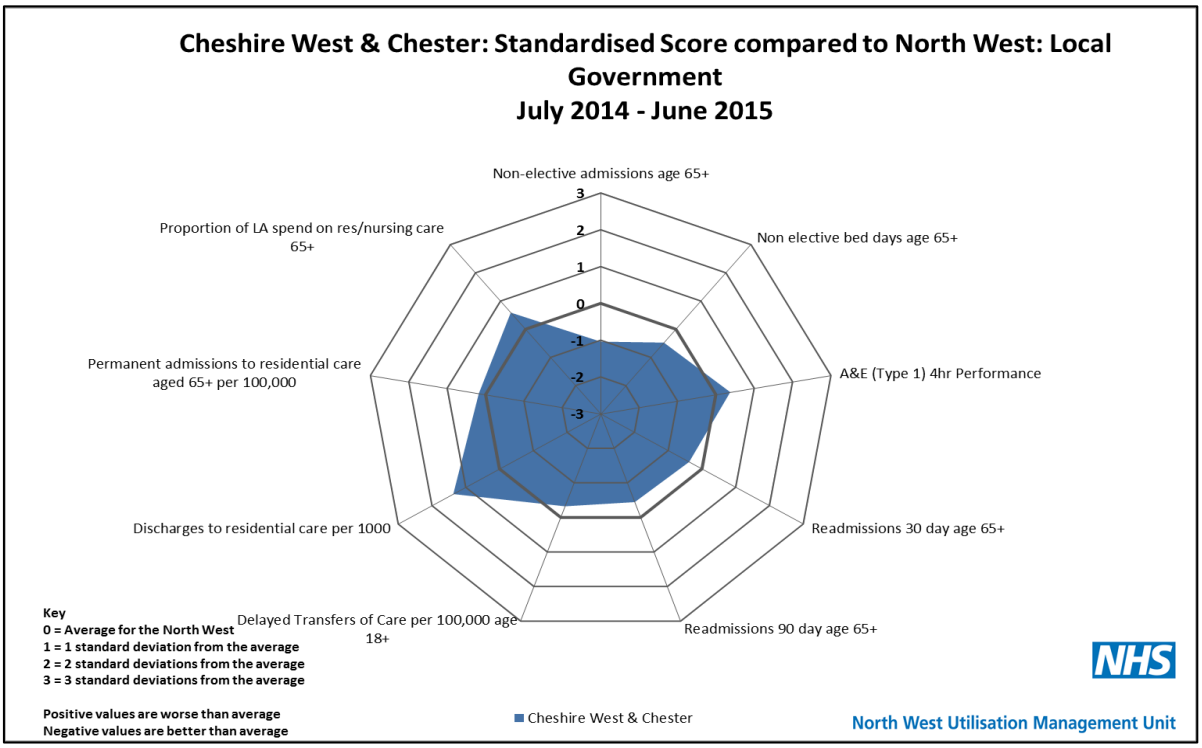


Chart 2: Cheshire West and Chester Council



5. Approach to SRG Planning 2015/2016

5.1. The SRG was allocated £1.7m by NHSE for 2016/2015.

5.2. However, due to the pressures that continued within the system during Quarter 1 2015/16, NHSE mandated that the SRGs should fund the successful 14/15 winter initiatives to the end of April 2015. This requirement took £287k of funds from the SRG budget for winter 15/16, (see breakdown below):

Table 3: Mandated investment April 2015/2016

Organisation	Initiatives	£
MCHFT	Additional ED Staffing	£38.3K
MCHFT	16 beds - ward 12	£71.5K
MCHFT	PAA overnight & weekends	£61.1K
MCHFT	ST3 Discharge Dr at weekends	£4.0K
MCHFT	SAU	£26.9K
MCHFT	Pharmacy TTOs	£0.5K
MCHFT	Reduced Medicine capacity	£4.8K
MCHFT	UCC	£2.4K
ECT	GP OOHs additional weekends	£16.5K
ECT	Enhanced Therapies	£43.2K
ECT	Station House IC staffing	£14.1K
CEC	Social Worker	£2.0K

CWAC	Social workers	£2.0K
TOTAL		**£287.3K**

5.3. To mitigate against the shortfall of funding in 15/16, the ORG developed an approach to developing plans in 2015/2016 - three task and finish groups were established to work jointly on three specific work streams.

- Avoidance of attendances and admissions to hospital
- Improved flow within the acute trust
- Integrated supported discharge and community care

Each group was allocated £400k and a lead from the providers was identified for each group, stakeholders from all SRG partner organisations were members of each group.

5.4. Each group was asked to address:

- The key areas of development discussed for each work stream at the June ORG (based on the performance of the previous winter initiatives)
- The areas of work identified for their group within the eight high impact areas as highlighted by NHSE
- The areas of work identified for their group from the report produced by Ian Sturgess for UHNM (University Hospital of North Midlands).
- Identify initiatives and solutions that could be delivered at no cost
- Not to include any bed based services. An additional SRG Task and Finish group had already been established earlier in the year to review community bed provision and develop proposals for the local health and social care economy

5.5. All local organisations were involved in the decisions for which initiatives would be implemented in 2015/2016 and developed balanced proposals that were ratified by the SRG.

5.6. Table four below shows the initiatives agreed for 2015/2016:

Table 4: 2015/2016 Initiatives

	Organisation	Initiatives	£
Group 1 Attendance and Admission Avoidance	GP Alliance	Rapid response from Primary care	£330k
	OOHs	OOHs enhanced capacity	£60k
	NWAS	NWAS Pathfinder/direct conveyancing	£0
	CCG	Implementation of MIG for EPACCS/EOL	£25k
	BRC	Patient Transport to support Primary Care	£25k
Group 2 Hospital Patient Flow	MCHFT	ED additional Staffing	£195k
	ECT & MCHFT	Enhanced therapy provision (REACT)	£214k
	MCHFT	UCC Weekend and evening opening	£78k
	MCHFT	Additional weekend medical cover	£27k
	CEC	Acute Social Workers	£66k
	CWaC	Acute Social Workers	£44k
	CCG	Community Bed Bureau	£50k

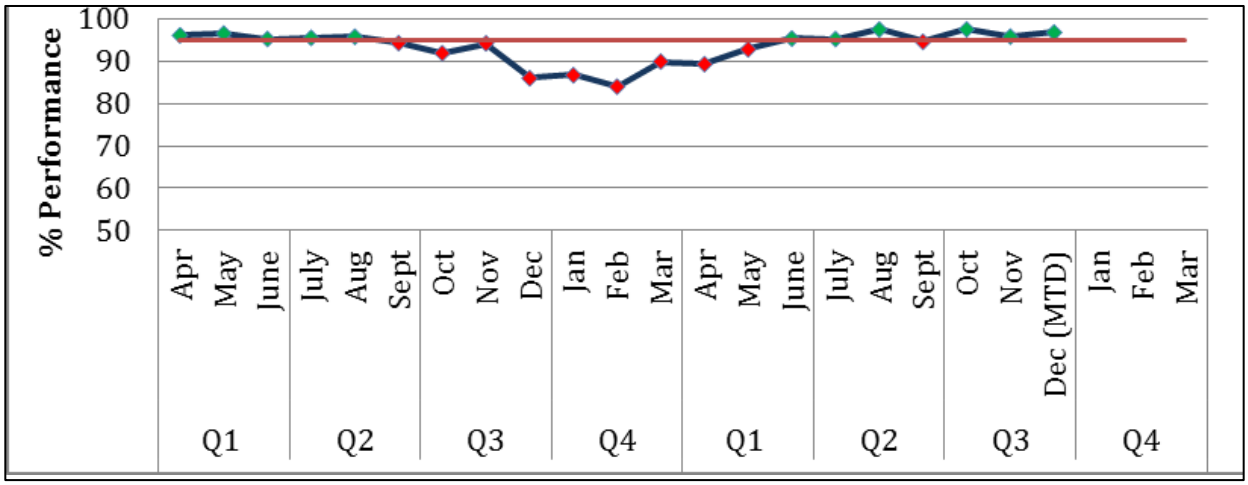
Group 3 Supported Discharge and Community Care	BRC	Enhanced discharge from wards and ED	£130k
	BRC	Enhanced home support	£35k
	ECT & MCHFT	Enhanced therapy provision	£45k
	CEC	Rapid Care Service	£162k
	CWaC	Rapid Care Service	£108k
TOTAL			**£1595K**

6. Current performance

6.1. MCHFT met the four hour access standard in 6 of the last 9 month and all three months in Quarter 3 (Q3) with December reporting 96.3%, November 95.72% and October 97.41% giving a Q3 position of 96.4%. The trust are currently the highest performing acute trust in Cheshire and Mersey.

6.2. Overall performance year to date currently stands at 94.89%, narrowly missing the target due to poor performance in April and May 2015 and a dip, marginally under at 94.6%, in September.

Graph 8: MCHFT 4hr performance as at 8th Dec 2015



6.3. It is felt that the SRG initiatives put in place during October and November have gone some way to achieve the improved performance; however the additional beds and the fit to sit area implemented by MCHFT, which are not funded by the SRG, have also ensured that the target is met by increasing bed capacity at the trust.

6.4. Additional community capacity was not implemented through SRG funding. An SRG Task and Finish Group have looked at community capacity and opportunities for increasing bed numbers in the community to reduce the number of DToCs, which will be key to freeing up beds within the trust and the achievement of the p4hr target in Quarter 4 (Q4) 2015/2016.

7. Summary

7.1. The processes undertaken in developing plans for both non-recurrent SRG funding in 2015/2016 and in year development work are seen as being innovative by NHS England. NHSE are

following the work of our SRG closely and have shared some of the initiatives and work undertaken as best practice across the North West.

7.2. Functionally this has been achieved by the setting up groups at two levels; the Strategic SRG, meets monthly and is attended at Chief Executive and Executive Director level and the Operational SRG which is attended at Director and Senior Manager level meets two weeks after allow rapid escalation or delegation of issues between the two groups, in summary:

- The Strategic SRG provides a clear direction of travel and fully supports and engages with any issues that are escalated by the Operational SRG.

- The Operational SRG has a hands-on approach to developing plans and addressing issues that can be quickly escalated to the Strategic group, which provides access to senior support to enable implement and

7.3. Overall the Central Cheshire SRG is recognised by NHS England as a high performing SRG that proactively and successfully manages the challenges and surges in demand through effective partnership working - partner organisations should acknowledge and recognise the contribution that their representative members have made to achieving this recognition.

8. Appendices

APPENDIX 1: 2014/15 Initiative Summary

Bid No	Initiative	Actual cost of initiative £	Total No Patients supported	Actual Cost per patient	Avoided cost (see full performance reports for detail)	Diff between actual cost and avoided costs
001	Health Living Consortium	£60,540	1300	£46.57	£111,608	-£51,068
004	BRC Supported Discharge	£68,903	879	£78.39	£380,950	-£312,047
005	CEC Rapid Care Service	£28,850	68	£424.26	£71,400	-£42,550
019	OOHs Acute Visiting Scheme	£144,835	371	£390.39	£977,250	-£832,415
020	Additional OOHs weekend cover	£59,997	410	£146.33	£108,507	-£48,510
025	ECT Enhanced Therapies	£203,987	627	£325.34	£745,041	-£541,054
036	MCHFT Weekend Phlebotomy	£3,600	276	£13.04	Difficult to Quantify	N/A
037	MCHFT Enhanced ED Staffing	£20,700	?	?	Difficult to Quantify	N/A
038	MCHFT Short Stay Ward	£194,000	827	£234.58	£193,900	£100
039	MCHFT PAA Development (16 beds)	£463,000	2493	£185.72	£1,062,500	-£599,500
040a	MCHFT ST3 at Weekends	£0	0	£0.00		N/A
040b	MCHFT Additional weekend Pharmacist	£9,200	673	£13.67	£235,550	-£226,350
041	MCHFT increased surgical capacity	£158,000	120	£1,316.67	£0	£158,000
042	UCC weekend opening	£31,636	568	£55.70	£47,895	-£16,259
044	Think Pharmacy Emergency Supply	£3,528	74	£47.68	£2,590	£938
049	Leftwich Green EMI Beds	£116,000	16	£7,250.00	£166,400	-£50,400
051	CWAC Rapid Care Service	£62,000	96	£645.83	£101,500	-£39,500
100	CWAC additional reablement, Social Workers and spot purchase beds	£196,192	594	£330.29	£259,750	-£63,558
101	CEC additional reablement, Social Workers	£68,890	21	£3,280.48	£22,050	£46,840
102	CEC additional spot purchase beds	£38,008	23	£1,652.52	£33,600	£4,408
200	Under 5's Drop in Clinic	£29,630	277	£106.97	£83,649	-£54,019
201	Alliance Early Intervention Service	£330,400	14157	£23.34	£439,738	-£109,338
205	GP Telephony over-flow service	£3,617	104	£34.78	Not reported	N/A
301	NWAS Green Care	£45,474	??	??	Not reported	N/A
400	CWP Enhanced MH Liaison	£123,000	136	£904.41	£87,380	£35,620
401	YMCA Supported discharge service for the homeless	£9,028	8	£1,128.50	£19,472	-£10,444
501	Proactive Comms Newspapers/radio	£6,851	??	??	Difficult to Quantify	??

502	Station House Capacity	£50,000	7	£7,142.86	£7,350	£42,650
505	MCHFT ERS Transport	£3,600	30	£120.00	£10,500	-£6,900
999a	Alliance GP Practice Easter Weekend Opening	£35,840	101	£354.85	£6,060	£29,780
999b	Alliance GP Practice Easter on the day appointments (Thur/Tues)	£22,400	1116	£20.07	£270,327	-£247,927
999c	YPP GP Practice Easter Opening	£4,160	69	£60.29	£4,140	£20
999d	YPP GP Practice Easter on the day appointments (Thur/Tues)	£9,680	234	£41.37	£54,952	-£45,272