ENCLOSURE: P

Agenda Item: 64/14

NHS Bexley Clinical Commissioning Group

Governing Body (public) meeting

DATE: 29 May 2014

Title	Better Care Fund
Recommended action for the Governing Body	That the Governing Body: **NOTE** the Better Care Fund submission to NHSE on behalf of Bexley CCG and London Borough of Bexley.
Executive summary	The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced as part of the June 2013 Spending Round. The first cut of the Better Care Plan was submitted in February 2014 and following feedback from NHS England further work was undertaken to finalise the plan by 4 April 2014. The draft plan was considered by the Bexley Health and Wellbeing Board at their meeting in January 2014 and the final plan was subsequently circulated to the Health and Wellbeing Board for approval, prior to submission. In line with National Planning Guidance, a review of all BCF plans has been carried out by NHS England (London Region) with local authority input provided by the London Social Care Partnership and London Councils. In carrying out their review, NHS England recognise that BCF plans are beginning to set out a shared vision for transformational improvement; delivering sustainable services, driving closer integration and improving outcomes for patients and service users. There is also recognition that changing services and spending patterns to deliver this change will undoubtedly take time and the plan for 2015/16 will need to be subject to on-going refinement to ensure alignment with the ambitions detailed in longer-term five year strategic plans for health, and care and provider plans.

	The regional review is now complete and NHS England have submitted their recommendations, with a national process now underway to determine any further requirements or areas for clarification. Bexley's final submission is attached as Appendix 1		
Which objective does this paper support?	**Patients:** Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders		✓
	People: Empower our staff to make NHS Bexley CCG the most successful CCG in (south) London		
	Pounds: Delivering on all of our statutory duties and become an effective, efficient and economical organisation		✓
	Process: Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience		✓
Organisational implications	Key risks (corporate and/or clinical)	• That acuity of patients continues to rise • That acute trusts will continue to admit people so commissioners will "pay twice" • That reducing budgets will undermine partnerships • That Primary Care does not have the capacity to deal with increased demand • Managing patient / carer expectations	
	Equality and diversity	The Better care Fund is intended to improve care and treatment of the most vulnerable people	
	Patient impact	The Better care Fund is intended to secure seamless services for patients and to eliminate the risk of falling between the services of health and social care	
	Financial	Minimum required value of ITF pooled budget: 2014/15 - **£774,000** 2015/16 - **£13,708,000** Total agreed value of pooled budget: 2014/15: **£774,000** 2015/16: **£15,301,000**	
	Legal issues	The Better Care Fund will be covered by a	

		Section 75 Agreement
	NHS constitution	The proposal is in line with the principles of the NHS Constitution in particular principle 5, by working across organisational boundaries.
Audit (considered/approved by other committees/groups)	The draft plan was considered by the Bexley Health and Wellbeing Board at their meeting in January 2014 and the final plan was subsequently circulated to the Health and Wellbeing Board for approval, prior to submission.	
Communications plan	To be developed as part of implementation plans	
Author	Alison Rogers Assistant Director for Integrated Commissioning	
	Clinical lead Nikki Kanani	Executive sponsor Sarah Valentine
Date	16 May 2014	

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Bexley**
Clinical Commissioning Groups	**Bexley Clinical Commissioning Group**
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**3 April 2014**
Date submitted:	**4 April 2014**
Minimum required value of ITF pooled budget: 2014/15	**£774,000**
2015/16	**£13,708,000**
Total agreed value of pooled budget: 2014/15	**£774,000**
2015/16	**£15,301,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Sarah Blow
Position	Chief Officer – Bexley CCG
Date	3.4.14

Signed on behalf of the Council	
By	Mark Charters
Position	Director of Education and Social Care
Date	3.4.14

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Teresa O'Neill
Date	3.4.14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There has been engagement with NHS providers through discussions at the Bexley Integrated Care Collaborative and Bexley's Integrated Commissioning Board. The planned initiatives are all building on existing projects that partners are fully signed up to.

The Integrated Care Collaborative focuses on the integration of health and social care services for older people and people with long term conditions with the overriding objective of delivering improved experience and outcomes for Bexley residents and efficiencies for the health and social care system. The Collaborative provides operational oversight to the various work streams with the Programme, ensuring that the work streams are aligned, and that all opportunities to develop improved and more efficient models of care are realised and implemented. Membership includes representation from all partner organisations, including health and acute sector, and the voluntary sector.

Discussions have been initiated with major acute providers to discuss and identify the required improvements for the local health economy. This is being done in partnership with neighbouring CCGs who commission from the same health providers.

The following officers have already been engaged in the process through a series of one to one discussions:

- Chief Executive and Leader of London Borough of Bexley
- Director of Education and Social Care at London Borough of Bexley
- Cabinet Member and Chairs of OSC
  Chief Executive Officer and Deputy Chief Executive Officer of Oxleas,
- Chief Executive Officer and Deputy Chief Executive Officer of Darent Valley Hospital
- Director of Nursing at Lewisham and Greenwich Hospitals
- South East London CCG's Programme Office
- Bexley Voluntary Services Council

Common themes are emerging and feedback from these initial interviews is set out in appendix A. True ownership of integrated care will be based on a platform of trust between CCG, the Council and the acute. There is an agreement that integration of health and social care, strengthened in community settings is the right thing to do and Bexley CCG and the London Borough of Bexley are well placed to lead this together as alignment has already been established through the development of an integrated care system. Further work is required to develop integration across the whole system but it is recognised that this will take time and a transition plan will be developed that will align with the new Southeast London strategy and its timetable. Enclosed is a summary report of the work completed todate.

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MOVING FORWARD I

In addition to direct engagement in the process by the third sector through BVSC, there has been extensive engagement with the voluntary and community sector over the last year around integrated commissioning of preventative and early intervention services. The BCF plans are very much in line with this direction of travel.

Within the social care market there has been some targeted engagement with a number of providers, with the development of Market Position Statement for Dementia and services for people with a learning disability.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

To ensure that patients/carers inform the service redesign, the following existing patient engagement structures are available to support the work of the Care Collaborative:

- Patient Council- this represents the diverse communities in the borough with most reps coming from other networks or community/voluntary groups. It could seek feedback from their members and these could be collated through the Patient council and reported at the ICC meetings.
- Database of 300 older residents – can be sought for views
- Patient Participation Groups – most GP practices within the borough have one
- Regular Pensioners Forum
- Quarterly case studies from people accessing Prevention and Early Intervention Services
- Short questionnaire completed on patient experience at time of discharge different elements of the Integrated Health and Social Care pathway.

The Integrated Care Collaborative will then receive regular patient feedback updates, which will be used to shape and further improve service delivery. Mechanisms to provide timely updates to GP practices about their patients are also included in this work stream.

Bexley is in the process of implementing Friends and Family Test solution across Bexley practices, and this will provide feedback from across Integrated Care at each stage of the experience to be measured against actual patient expectation of the experience. This starts with the patient, listening to their needs and responding appropriately, so that meeting needs are achievable and result in an environment where individual patients feel cared for and supported. This will include further coordinated engagement of the Patient Networks, including Healthwatch Bexley. Enclosed commentary demonstrates approach to patient engagement through 'I' Statements.

I Statements Commentary.pdf

Our Integrated Care Teams are currently finalising the detail and method of collating patient feedback both from the acute and community settings.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
LD Market Position Statement	**http://www.bexley.gov.uk/CHttpHandler.ashx?id=12485&p=0**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The Bexley Health and Wellbeing Strategy spells out the aspirations for residents of the borough. The vision is summarised below:

'Healthy, Active Bexley'

"We will work with communities, families and individuals to provide opportunities that help everyone make the right choices, stay healthy and feel positive about their wellbeing".

We want people in Bexley to be healthy, happy and resilient and we believe that everyone has the right to access good health and care opportunities. We want our health and care services to be joined up, high quality and safe, and when services are used we want residents to have a positive experience of the care they receive.

We believe that good health is everyone's responsibility and requires everyone to play their part. Individuals need to take good care of their own health and that of their families and friends by choosing healthy options and healthy lifestyles. The Council and partners can support this by developing preventative, wellbeing focused services and creating an environment so that people can make informed choices about their health and the way in which they live.

Although health outcomes for people in Bexley are better than in many parts of London, there is still an over-reliance on institutional care, both in hospitals and care homes.

Our strategic vision centres around a redesigned whole systems, population health based approach, which will result in an integrated health and social care delivery model that can:

- respond to the individual needs and wishes of Bexley residents
- promote independence, whilst facilitating choice and control, and dignity
- promote care in the community as the default position, rather than acute or institutional settings
- reduce areas of health inequities ensuring that integrated services are accessible to all borough wide
- develop and establish single point access and shared IT platforms

There are no acute health providers within the borough of Bexley. Integrated Teams operate from two acute settings on the borough's borders (Darenth Valley Hospital and Queen Elizabeth Hospital) managed by two different Trusts. There are established plans for the continued development of Queen Marys Hospital. A new hub and spoke model of Urgent Care Centres will ensure consistent delivery of Urgent Care Services for the whole borough, this will also be an integrated system of Out of Hour GP provision. This will provide a wraparound health and community care model that is accessible and able to respond to the needs of Bexley residents.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Bexley CCG with the London Borough of Bexley has faced and overcome significant challenges over the past 3 years, from:

1. The sub optimal performance of the main provider and then the dissolution of that provider (the South London Healthcare Trust) to 3 new receiver organisations (acute Trusts);
2. The financially challenged situation within the Primary Care Trust (which at its dissolution in March 2013 it was £12.5m in the red);
3. Strained relationships that historically existed between the London Borough of Bexley and the Primary Care Trust
4. That there is no one acute provider / hospital within Bexley – we have a disaggregated spend across 3 main providers. This results in:

- The reductions in admissions (or reductions in length of stay) for Bexley residents alone are not enough for an acute provider to shut down capacity (beds or consultant) at a scale that would allow them to reduce their costs (e.g. a ward for example)
- Rather than building services that focus on one acute hospital (front and back door) our teams need to focus primarily on two sites (Queen Elizabeth at Woolwich and also Darent Valley in Kent) a third site is now also gaining more prominence in admissions (Princess Royal at Bromley). Therefore we cannot benefit from economies of scale in staffing these services due to the need to cover multiple sites.
- The potential for a risk share with one acute provider is not really a reality for Bexley on its own.

In the past 18 months we have developed a strong relationship that is mutually supportive and understanding of each other's challenges. This has allowed us to build the trust between the organisations to establish new integrated services for the benefit of our population and to also build an integrated commissioning unit, where staffing is shared, and initiatives developed and then implemented.

We have established a successful Integrated Care Service (the CCG, London Borough of Bexley and Oxleas NHS Foundation Trust) across social and community care that already offers 7 days a week and extended hours services with Rapid Access & Support. The funding for this unit was provided by the CCG with the express aim of reducing hospital admissions, speeding and aiding earlier discharge and improving the services to our population. This investment was to be balanced against savings to the CCG from the acute sector (through avoiding the cost of admissions). An investment of £2.1 M was intended to release £4.02M from acute and £537K from council spend on care homes, emergency placements and home based care.

In addition to this, shared CCG and Council investment in reablement has been in place for 3 years. This has made a significant contribution to the management of costs in adult social care over that time (evaluations suggest this is approximately £1.25m a year of avoided costs).

Together these services have had a marked impact on avoiding hospital admissions & delivering effective health & social care closer to home and promoting independence "home is best". It is highly regarded by one of our acute providers as the model that all CCGs should follow, it is therefore disappointing to note that although the hospital admissions have reduced significantly and the numbers of in-patients being referred to adult social care for discharge planning is falling, the spend on admissions has increased significantly. This is counter intuitive and the CCG is trying to uncover the underlying cause(s) of this increase (as this has had significant and detrimental impact on the CCG's financial position in 2013/14). As we are "financially challenged" it results in the need for any investment to be set against an at least equal and opposite reduction in acute spend in the same financial year, or the need for the acute sector to engage with Bexley in a risk sharing arrangement (see later).

In order to deal with the increases in demand for care and support in the borough and in the face of reducing resources available and significant change within the local NHS - in particular acute hospital services - there has been a strategic decision to integrate health and social care services where possible in order to deliver more effective care closer to home.

Our aim through the Better Care Fund is to expand the range of services offered within the Integrated Care Service, but we need careful balance and alignment financially to enable this.

Specifically we aim to:

- Ensure that service users and patients are at the centre of service provision and have optimal control over their lives.
- Create opportunities for people to remain or regain independence
- Ensure that we develop local, accessible, flexible and responsive high quality community based services.
- Work in partnership with carers in order to support them in their vital role
- Work in partnership with our providers to ensure that investments in the community are cost neutral and off-set by the reductions in the acute sector spend.

Over the last 18 months, adult social care and Oxleas adult community and intermediate care services, with support from the CCG have been developing more integrated care for vulnerable adults – particularly (but not exclusively) for older people. Local acute trusts have been fully engaged in the Integrated Care Collaborative which helped design the model and continues to drive this initiative.
The first elements of Bexley's Integrated Care went live in August 2013 with 7 days a week, extended hours integrated intermediate care provision, providing a range of interventions such as "Rapid Response" and integrated rehabilitation. We also expanded our intermediate care bed provision to facilitate this new service and developed an innovative community geriatrician service to support the new services and primary care to look after patients with higher acuity levels in the community.

Our integrated health and social care teams are fully engaged, co-located teams and this workforce has been instrumental in the development and design of the new integrated care pathways. The voluntary sector has also been key in shaping the model of prevention and early intervention services in Bexley that complement and support the integrated care pathways. New Prevention and Early Intervention services were implemented from the beginning of October, following a re-commissioning process that was very much a piece of co-production with the voluntary sector and concentrated on the following key outcomes:

- Ensuring people have a positive experience of care
- Delaying and reducing the need for care, support and admission to hospital
- Enhancing quality of life for people with long term conditions
- Help people recover from adverse events, illness or injury
- Enhancing quality of life for people with care and support needs

Mental Health services for working age adults have been integrated for many years in Bexley and are managed within Oxleas NHS Foundation Trust. This approach will see further integration of the mental health services with the integrated health and social care services, so to enable a 'one story one time ' experience for patients, in that multi-disciplinary teams are able to better respond and gather crucial information in the first instance.

Running in parallel to this, we have had a small number of "GP Pilot" schemes aimed at early identification and intervention for people with complex needs at risk of non-elective admissions or premature admissions to care homes and the associated 'care navigation' support mechanism that will facilitate care closer to home. This model was built upon risk-stratification and multi-disciplinary working. Work is now underway to evaluate the outcomes from the pilots and test

and learn from further MDT developments in advance of roll out to all GP practices and also utilise the opportunities afforded by a more robust risk management tool that has recently been deployed across GP practices in the borough.

Our vision is that the whole system, population based approach will result in:

- care co-ordination; through the creation of a unified record, accessible (as appropriate) by all to all and use of IT to create a shared platform for integrated care (including patient access to bookings, records and development of care plans). Partners have agreed to seek to build upon work being undertaken by Lewisham and Greenwich Trust that will create a clinical portal across the partnership to securely and appropriately share relevant information.
- medicines management; more proactive use of medicine management such as group consultations for people with long term conditions (reflecting complex cycles of care, not episodes) as well as utilising medicines management as a core function of integrated care
- improved social value; by unlocking of community assets through social prescribing, integration of the voluntary sector in case management and signposting and other initiatives which support community wellbeing.
- falls prevention; using evidence based approaches such as strength and balance training, home hazard assessment and intervention (with the voluntary sector), vision assessment and referral and medicine review with modification / withdrawal (in the form of, for example, medicine management at integrated care meetings and early identification of risk of UTI through regular testing)

Over 2014 we are looking to expand the range of services and conditions treated within these services, to ensure that services will provide greater support for dementia, for carers, and for patients who are in their last year of life (all diseases) to enable them to avoid hospital admissions and to die with dignity in their place of choice. We will also be looking at building on the virtual ward principle wrapping service teams around our GP localities (social, voluntary, community, mental health services) these will provide a one stop shop approach to services, but also ensure that these services are fully integrated.

However, this must be seen against the risk to both the CCG and the London Borough of Bexley in their expenditure.

Bexley has a small population, with no one acute provider. We have a disaggregated spend across multiple acute providers. This results in:

- The reductions in admissions (or reductions in length of stay) for Bexley residents alone are not enough for an acute provider to shut down capacity (beds or consultant) at a scale that would allow them to reduce their costs (e.g. a ward for example)
- Rather than building services that focus on one acute hospital (front and back door) our teams need to focus primarily on two sites (Queen Elizabeth at Woolwich and also Darent Valley in Kent) a third site is now also gaining more prominence in admissions (Princess Royal at Bromley). Therefore we cannot benefit from economies of scale in staffing one services as these services need to be able to cover multiple sites, with the need for staff to often travel between the sites.
- The potential for a risk share with one acute provider is not really a reality for Bexley on its own and is having to be done in collaboration with neighbours.

Over the past months we have undertaken a series of in-depth interviews with senior executives within our main providers, and whilst they support the work that Bexley has undertaken to reduce admissions (and recognise those reductions) we are not at a stage in those discussions that might enable them to enter into risk shares with the economy. We are therefore looking at consolidating the schemes of admission avoidance with our neighbouring main CCGs (particularly Greenwich) to look at the opportunity of more global capacity reductions that will

bring greater gains to the acute sector, to enable cost and capacity to be removed. On this basis we may be more likely to achieve reductions in acute expenditure or to see the benefits of a collective risk sharing arrangement.

Our intention and commitment is still to build the expanded services in 2014/15 as defined above, must it must be recognised that these could introduce further financial risks to Bexley. We will continue to carefully monitor this during 2014/15 and onwards, but also to try and unravel why there have been significant increases in expenditure with our acute partners.

Financial pressures for the coming years are significant for both the Council and the CCG and this is in advance of the disproportionate additional pressures that the Care Bill implementation will bring to Bexley because of the ageing, home-owning population. Currently the Council has projected deficit of £40m over the coming three years, having already made savings of £35m over the last three years (and adult social care is the biggest single budget area within the Council). The CCG has QIPP savings to achieve of £13.7m in 2014/15 (£38.797 over a 5 year period) to address the historical financial pressures and the needs of its population.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

In order to take “care close to home” to the next level, it is imperative that services are aligned and have shared objectives in managing the care and support needs of people with more complex conditions. This means that rather than just intervening to prevent people being admitted to hospital, we need to identify and target those most at risk of increasing dependency or deterioration. In order to do this effectively this needs to be undertaken through a proactive multi-disciplinary approach.
Currently there are three GP localities and it is proposed that we build multi-disciplinary “virtual ward” type models around each of these localities. This will enable the teams to build up closer working relationships and also be of sufficient size to have “critical mass”. The voluntary sector will be key partners in much of this work too.

These teams will function as cohesive units, working with GP practices in the localities to identify and manage people with a range of complex, long term conditions and co-morbidities such as diabetes, neurological conditions and dementia. Together with a strong patient / service user centred focus on self-management, use of technology and a combined risk-stratification modelling, it is expected that there will be reductions in the numbers of people whose needs are exacerbated and consequently need higher level interventions (including hospital admission or long term care).

A key to this model working well is effective early identification, communication and information sharing around the care and support needs of those people with the most complex needs to enable consistency and co-ordination of care. They will also work closely with existing integrated community teams and the Community Consultant Geriatrician, who will be able to give specific support to GPs and the MDTs.

The proposal is that the teams will deal with all aspects of need, comprising of social care and clinical health care staff (physical and mental health) and working with GPs and practice staff within the localities aligning to the community hub model in primary care described below. In line with the aspirations of the BCF, it is proposed that the shift from in-patient care to community

care is funded by incentivising all partners to support care close to home. This will mean investment in a range of community provision (including GP, community health and social care) through disinvestment in hospital activity.

Specifically we will:

- Reduce spend on bedded health and social care provision and increase investment in community based care and support
- Extend existing 7 day working to better support acute hospitals and also better able to respond flexibly for people who experience crises
- Develop a single point of access to community health and social care services
- Ensure that we continue to build systems and processes around individuals in order to optimise both effectiveness and also their choice and control (including use of Personal Budgets and Personal Health Budgets)
- Development and implementation of a shared IT platform
- Extend co-ordinated care management for those people most at risk of hospital admission or admission into long term care
- Share information appropriately and effectively using the NHS number as the unique identifier
- Extend opportunities for use of self-care and technology to promote wellbeing and independence
- Invest in services that are able to work with people with more complex needs in the community

Although there have been a number of effective projects that have been developed over recent years, changes made in August 2013 to invest in enhanced community based services for frail older people - in order to reduce acute hospital activity - appear to be demonstrating savings for both the CCG and the council, both through reduced admissions to hospital and continued downward trends in admissions to care homes.

Further, through proactive engagement with the Voluntary and Community Sector, investment has been targeted at “upstream” prevention initiatives that support the vision of the Health and Wellbeing Strategy.

In planning for further developments we have had consideration both of areas highlighted in the JSNA and also the priorities of the Health and Wellbeing Strategy. Although much good progress has been made to support people with physical health needs (and we need to continue these developments), we have identified gaps in community provision for mental health (both functional and organic). This is evidenced by high levels of hospital admission and long term care for people in these groups.

Dementia is one of the key priorities identified in the Health and Wellbeing Strategy, but it is also a key issue in increased cost pressures to both the CCG and the Council. The demographic make-up of this borough is such that the demands on health and social care arising from dementia are going to increase markedly in coming years.

Outcomes in Bexley for adults with serious and enduring mental health needs are not as good as they could be. Recent work done by LG Futures for the LGA identified that Bexley is below average in supporting adults with MH needs to live independently. NHS data also shows that there is a higher level of hospital admissions for this group of individuals.
Work that is underway through the council’s Prevention Strategy will enable some improvements in outcomes, there is evidence to suggest that if we can provide improved “Crisis Support”, including access to social care assessment and services to this group of people, especially outside of normal working hours, then we may be able to reduce hospital admissions and thus keep more people living independently.

d) Implications for the acute sector
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Providers are being involved in the discussions to agree priorities and also in the identification of opportunities for further improvements in outcomes. This will continue as we move ahead into further implementation of integrated care.

We have commissioned a specific piece of work to engage with the major acute providers serving the residents of Bexley, recognising the complexity of the financial picture in the immediate aftermath of the SLHT TSA process. Financial pressures for the coming years are significant for both the Council and the CCG and this is in advance of the disproportionate additional pressures that the Care Bill implementation will bring to Bexley because of the ageing, home-owning population. Currently the Council has a projected funding gap of £40m over the coming three years, having already made savings of £35m over the last three years (and adult social care is the biggest single budget area within the Council). The CCG has QIPP savings to achieve next year of 13.7million in 2014/15 (£38.797m over a five year period) to address historical financial pressures and the needs of its population.

We intend to make better use of the system as a whole, ensuring decisions of care, treatment and support are made in a timely way and in the correct place. We will explore further the increased use of Ambulatory Care as we know the acuity of our residents needs is increasing in complexity and intensity. We will still require the use of our acute colleagues but in a radically different way to traditional methods currently used. The Queen Elizabeth Hospital, Woolwich was praised by the Intensive Support Team for their delivery of Ambulatory Care and we intend to build on that with QE and our other local acute Hospitals. This will enable the system as a whole to be more efficient.

e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Our Integrated Commissioning Board (ICB) will have strategic oversight of the work undertaken within the remit of the BCF. The ICB reports into the Bexley HWBB who will both sign off the strategic plan and receive regular updates on delivery.

As part of our current operational governance arrangements we have a local Integrated Care Collaborative comprised of a range of commissioners, providers and other stakeholders. It is anticipated that this will continue to have an operational and performance oversight of the BCF projects, agreeing how resources are deployed to achieve agreed outcomes within the projects.

Reports will also continue to be given to both the CCG Governing Body and the Cabinet on progress made against predicted outcomes.

Enclosed is the ICB Structure Chart.

ICB Structure.pdf

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Eligibility Criteria will remain the same

Please explain how local social care services will be protected within your plans

Protecting social care services is seen as ensuring that vulnerable adults are supported to be as healthy and independent as possible within the limits of the council's Fair Access to Care Services criteria. This includes ensuring that we work with partners to reduce the need for admission to hospital or ensure timely discharge when this is necessary. Work currently undertaken with NHS colleagues is already making an impact on this both through integrated commissioning and integrated service delivery. Further developments are planned around LTCs in preparation for the BCF.

The council is committed to maintaining FACS at the current level while at the same time continue investing in a range of early intervention and preventative strategies that will further reduce dependency on the statutory sector. This in turn will reduce the numbers of people presenting in crisis to health or social care services.

JD Pathway triangle for 2012-13.pdf

Whilst evidence demonstrates increased inquiry / demand for services through initial contact via the Council's front door, there is a comprehensive screening and signposting function that assists with demand management and reduces the volume of those coming through.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

The Integrated Health and Social Care teams **already offer an extended hours / 7 day service** to avoid unnecessary admission and some weekend discharges are already being facilitated. This is supported in the community by Twilight and the District Nursing team. Work is under way with acute trusts to support them to extend the current arrangements. As we further integrate health and social care provision, we anticipate that 7 day working will be further extended.
In addition to this, there is access to GPs 7 days a week through Urgent Care**.**

Furthermore Bexley CCG is in the process of re-procuring the whole urgent care system for the borough including the development of a hub and spoke model, providing an additional UCC in the more deprived north of the borough and OOH GP services from the same provider resulting in an integrated approach to unscheduled care with enhanced accessibility.

In response to the Prime Minister's Challenge Fund, local GPs have begun to prepare for extended hours and weekend access through the development of locality based community hubs which will provide integrated access to health and social care services.

Bexley already has a comprehensive telecare and emergency link line service, with initial

discussions taking place around extension of this to include telehealth. Telecare is well embedded in local social care provision. Local evaluations suggest that this has already made savings for the council of more than £250k p.a. Integrated working offers opportunities for this to be more widely explored and extended.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

N/A see below for explanation

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The Council have commissioned and are planning to implement a new case management system in the summer. Initial requirements for a single access platform, which will have the opportunity to be accessed by the Council, CCG and health partners (subject to strict information governance) have been identified and are being discussed. The new system will have the facility to use the NHS number as the primary identifier.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems as detailed above.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott 2.

We confirm that we are committed to ensuring that the appropriate IG controls will be in place as detailed above.

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In Bexley health and social care professionals attend monthly integrated team meetings in GP practices to actively case manage patients that are at increasing risk of hospital admission or of their care needs escalating. This joint approach to care planning helps ensure that robust management plans are in place that anticipate and prevent a crisis situation arising – the team involves GPs, practice staff, social workers and district nurses and we are working with the voluntary sector to utilise their expertise to aid signposting. Currently both health and social care professionals have mechanisms to identify those deemed most at risk of hospital admission and who would most benefit from an integrated care plan. A risk profiling tool is in the process of being implemented which will provide a consistent and robust method for assessing risk. The risk profiling tool works by applying a risk score to patients based upon a range of clinical indicators. This will enable earlier identification of those patients across the system so that a proactive and preventative approach to their care can keep them well managed in a community setting. There are around 1,800 patients in Bexley that have a joint care plan in place with an accountable professional identified.

4) RISKS

Over the past months we have undertaken a series of in-depth interviews with senior executives within our main providers, and whilst they support the work that Bexley has undertaken to reduce admissions (and recognise those reductions) they are not willing to enter into risk shares with the economy. We are therefore looking at consolidating the schemes of admission avoidance with our neighbouring main CCGs (particularly Greenwich) to look at the opportunity of more global capacity reductions that will bring greater gains to the acute sector, to enable cost and capacity to be removed. On this basis we may be more likely to achieve reductions in acute expenditure or to see the benefits of a collective risk sharing arrangement.

Our intention and commitment is still to build the expanded services in 2014/15 as defined above, must it must be recognised that these could introduce further financial risks to Bexley. We will continue to carefully monitor this during 2014/15 and onwards, but also to try and unravel why there have been significant increases in expenditure with our acute partners.

Other risks are highlighted in the table below:

Risk	**Risk rating**	**Mitigating Actions**
Acuity of patients continues to rise	High	Use of Community Geriatrician to support Primary Care, effective multi-disciplinary case management meetings in the GP practices
That Acute Trusts will continue to admit people so commissioners will "pay twice"	High	Work with acute to manage their 'front door' in order to stop unnecessary admissions, identify people at trim point and target people with higher priced HRGs
Reducing budgets will undermine partnerships	Medium	Commitment to working together and transparently over pressures
Delivering change without parallel funding	High	Partners working closely and avoiding cost shunting, rather agreeing to share risk to deliver improved outcomes
Primary Care does not have the capacity to deal with increased demand	Medium	CCG is working with GPs to develop skills and ensure appropriate access to clinicians
Managing patient / carer expectations	Medium	Effective communications through accessible material and signposting access points. Including Bexley's Healthwatch programme

Actual admissions will be of a more complex / higher need	Medium	Developing local hubs and more effective use risk stratification will help raise awareness of cases before exacerbation and enable more timely intervention

5) Additional Narrative to Financial Metrics

Due to time constraints and shortage of analytical capacity, the expected benefits could range from £201,129 to £926,711. The submission is therefore based on the median.

6) Appendix

- Letter from Chairman and Vice Chairman of Health and Well Being Board

Better Care Fund Submission april14.pd

NHS
Bexley
Clinical Commissioning Group

Better Care Fund

Summary

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced as part of the June 2013 Spending Round.

The first cut of the Better Care Plan was submitted in February 2014 and following feedback from NHS England further work was undertaken to finalise the plan by 4 April 2014. The draft plan was considered by the Bexley Health and Wellbeing Board at their meeting in January 2014 and the final plan was subsequently circulated to the Health and Wellbeing Board for approval, prior to submission.

In line with National Planning Guidance, a review of all BCF plans has been carried out by NHS England (London Region) with local authority input provided by the London Social Care Partnership and London Councils.

In carrying out their review, NHS England recognise that BCF plans are beginning to set out a shared vision for transformational improvement; delivering sustainable services, driving closer integration and improving outcomes for patients and service users.

There is also recognition that changing services and spending patterns to deliver this change will undoubtedly take time and the plan for 2015/16 will need to be subject to on-going refinement to ensure alignment with the ambitions detailed in longer-term five year strategic plans for health, and care and provider plans.

The regional review is now complete and NHS England have submitted their recommendations, with a national process now underway to determine any further requirements or areas for clarification.

Bexley's final submission is attached for information at **Appendix 1**.

Recommendations

1. Provided for information and discussion.

BETTER CARE FUND

1. Introduction

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced as part of the June 2013 Spending Round. The BCF is a single pooled budget to support health and social care services to work more closely together in response to growing demand and constrained resources across the health and social care system. It aims to support the transformation of local services so that people are provided with better integrated care and support.

A common template, devised by the LGA and NHS England, was used to assist the H&WBB in developing, agreeing and publishing Bexley's Better Care Plan. The template and accompanying guidance set out the key information and metrics that were needed to address the conditions of the Fund.

The Bexley Health and Wellbeing Board was required to sign off the plan on behalf of the Council and NHS Bexley CCG. The first cut of the Better Care Plan was submitted in February 2014 and following feedback from NHS England further work was undertaken to finalise the plan by 4 April 2014. The draft plan was considered by the Bexley Health and Wellbeing Board at their meeting in January 2014 and the final plan was subsequently circulated to the Health and Wellbeing Board for approval, prior to submission.

2. Performance Indicators

The Plan includes five mandatory performance indicators plus one local indicator; the latter to be chosen from a selection of performance indicators. The six performance indicators are as follows:

- Delayed transfers of care
- Avoidable emergency admissions
- Admissions to Residential and Nursing care
- Effectiveness of reablement
- Patient and service users experience (exact measure yet to be determined)
- Injuries due to falls in people aged 65 and over

Our proposed targets against these indicators take into account the level of improvement in the Better Care Fund technical guidance, alongside analysis of local baselines and trends.

3. Regional Assurance Process

In line with National Planning Guidance, a review of all BCF plans has been carried out by NHS England (London Region) with local authority input provided by the London Social Care Partnership and London Councils.

In carrying out their review, NHS England recognise that BCF plans are beginning to set out a shared vision for transformational improvement; delivering sustainable services, driving closer integration and improving outcomes for patients and service users.

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The regional review is now complete and NHS England have submitted their recommendations, with a national process now underway to determine any further requirements or areas for clarification.

Local Government Act 1972 – section 100d

List of background documents

Better Care Fund Planning. Links to online documents, including Technical Guidance and baselines: http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Report to Bexley Health and Wellbeing Board, 21 January 2014, Agenda Item 11:

http://democracy.bexley.gov.uk/ieListDocuments.aspx?CId=1744&MId=27264&Ver=4

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Appendices: Appendix 1 – Bexley's Better Care Fund Planning Template