Open Agenda

Southwark Council

Health and Wellbeing Board

Thursday 2 October 2014
10.00 am
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Peter John (Chair)	Leader of the Council
Andrew Bland	NHS Southwark Clinical Commissioning Group
Jim Crook	Strategic Director of Children's and Adults Services
Councillor Dora Dixon-Fyle MBE	Cabinet Member for Adult Care, Arts and Culture
Councillor Barrie Hargrove	Cabinet Member for Public Health, Parks and Leisure
Dr Jonty Heaversedge	NHS Southwark Clinical Commissioning Group
Eleanor Kelly	Chief Executive
Gordon McCullough	Community Action Southwark
Professor John Moxham	King's Health Partners
Dr Yvonneke Roe	NHS Southwark Clinical Commissioning Group
Dr Ruth Wallis	Director of Public Health
Southwark Healthwatch Representative	Vacancy
Metropolitan Police Service	Vacancy

INFORMATION FOR MEMBERS OF THE PUBLIC

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Contact

Everton Roberts on 020 7525 7221 or email: everton.roberts@southwark.gov.uk
Webpage: http://www.southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 24 September 2014

Southwark Council

Health and Wellbeing Board

Thursday 2 October 2014
10.00 am
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES** To receive any apologies for absence.	
2.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
5.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 28 July 2014.	1 - 5
6.	**HEALTH AND WELLBEING BOARD GOVERNANCE REVIEW** To consider the outcome of the governance review.	6 - 18
7.	**HEALTH IN SOUTHWARK - IMPROVING SEXUAL HEALTH PRESENTATION** To receive a presentation from the Director of Public Health on improving sexual health in Southwark.	

Item No.	Title	Page No.
8.	**HEALTH AND WELLBEING STRATEGY UPDATE PRESENTATION** To receive a presentation from the Director of Public Health on the Health and Wellbeing Strategy.	
9.	**DIRECTOR OF PUBLIC HEALTH REPORT - LAMBETH & SOUTHWARK** To note the Director of Public Health report covering the period July to September 2014.	19 - 29
10.	**INTEGRATION UPDATE - BETTER CARE FUND (BCF)** To note the Better Care Fund plan re-submission of 19 September 2014 and next steps.	30 - 168
11.	**ACCESS TO HEALTH SERVICES IN SOUTHWARK (HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE)** To note the health, adult social care, communities and citizenship scrutiny sub-committee review report ‘Access to Health Services in Southwark’ and to provide a response to the relevant recommendations at the November health and wellbeing board meeting.	169 - 212

Date: 24 September 2014

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Monday 28 July 2014 at 12.00 pm at Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Peter John (Chair)
Andrew Bland
Jim Crook
Councillor Dora Dixon-Fyle MBE
Councillor Barrie Hargrove
Jonty Heaversedge
Eleanor Kelly
Alvin Kinch
Gordon McCullough
Professor John Moxham
Dr Ruth Wallis

OBSERVERS: Jane Fryer, NHS England
Rob Harper, Metropolitan Police Service

OFFICER SUPPORT: Kerry Crichlow, Director of Strategy and Commissioning

1. APOLOGIES

There were no apologies for absence.

2. CONFIRMATION OF VOTING MEMBERS

Those members listed as present were confirmed as the voting members for the meeting.

3. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

There were no late items.

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

RESOLVED:

That the Minutes of the meetings held on 19 December 2013 and 24 March 2014 be approved as correct records and signed by the Chair.

Matters Arising

Minutes – 19 December 2013

In respect of item 14, Pharmaceutical Needs Assessment (PNA), Andrew Bland reported that the Pharmaceutical Needs Assessment Steering Group had begun meeting. The first draft of the PNA would be completed in October prior to a 60-day consultation period on the document.

Minutes – 24 March 2014

In respect of item 7, Director of Public Health Report, Kerry Crichlow reported that the reports on issues and actions to address the problem of gambling venues and off licence premises in the borough would be submitted to a subsequent board meeting.

6. COUNCIL PLAN 2014/15 - 2017/18

The board received a presentation from the Leader of the Council on the Council Plan.

RESOLVED:

1. That the Leader's presentation on the Council Plan 2014/15 – 2017/18 be noted.
2. That the annual report on the Council Plan 2014/15 be submitted to the health and wellbeing board for information.

7. INTEGRATION UPDATE - INCLUDING BETTER CARE FUND (BCF) PROGRESS REPORT

Tamsin Hooton, Director of Service Re-design and Alex Laidler, Director of Adult Social Care introduced the report. The board also heard from Mark Kewley, Director of Strategy and Design, Southwark and Lambeth Integrated Care.

RESOLVED:

1. That the progress on integration, in particular plans for integrated commissioning and pooled budgets be noted.

2. That the proposals to support the development of integrated neighbourhood teams as a way of pursuing greater operational service integration be noted.

3. That the progress on the Better Care Fund as at Quarter 1 2014/15 be noted.

4. That the need to resubmit Better Care Fund plans for 2015/16 as a result of national changes be noted and the proposed process for agreement of the Better Care Fund re-submission for 2015/16 as set out in paragraph 31 of the report be agreed.

8. SOUTHWARK AND LAMBETH INTEGRATED CARE (SLIC) - DELIVERING THE INTEGRATED CARE VISION

RESOLVED:

1. That support be given to the CCG and Council to work collaboratively with other commissioners and providers, through SLIC, in order to take practical steps to change the commissioning and provision of services, beginning with new arrangements from April 2015.

2. That the ongoing work, facilitated by SLIC, which is bringing providers of health, social care and other services (including housing) together to identify and commit to the delivery of some specific integrated working practices that can be delivered at scale be noted; and the very close alignment between this work and the development of neighbourhood working and integrated teams within Southwark also be noted.

3. That options to develop joint budget arrangements for this new approach to integrated commissioning be submitted to the next board meeting.

9. EARLY ACTION COMMISSION

Gordon McCullough, Chief Executive of Community Action Southwark introduced the report.

RESOLVED:

1. That an independent Early Action Commission for Southwark be established.

2. That it be noted that the Commission will formally commence work in September 2014 and report back to the Health and Wellbeing Board in March 2015.

Note: In agreeing this decision, the issue relating to the commissions focus to be taken in account.

10. HEALTH AND WELLBEING STRATEGY UPDATE

Dr Ruth Wallis, Director of Public Health introduced the report.

RESOLVED:

1. That the update on the actions to implement the health and wellbeing strategy for 2013/14 be noted.

2. That the refreshed Southwark Joint Strategic Needs Assessment (JSNA) process and health issues identified in the JSNA for Southwark www.southwark.gov.uk/jsna be noted.

3. That the emerging issues highlighted by local people through the 1,000 Lives community engagement exercise be noted.

4. That the refreshed health and wellbeing strategy priorities 2014/15 which are informed by the JSNA and the 1,000 Lives community engagement exercise be agreed.

5. That the health and wellbeing strategy steering group oversee the development and implementation of an action plan for 2014/15, reporting back to the board on progress at the next meeting and in March 2015.

11. HEALTH AND WELLBEING BOARD GOVERNANCE REVIEW

Kerry Crichlow, Director of Strategy and Commissioning introduced the report.

RESOLVED:

1. That the progress made on taking forward the review of governance arrangements for the Health and Wellbeing Board be noted.

2. That the terms of reference for the review agreed across the partners, set out at Appendix 1 of the report be noted.

12. DIRECTOR OF PUBLIC HEALTH REPORT - LAMBETH & SOUTHWARK

Dr Ruth Wallis, Director of Public Health introduced the report.

RESOLVED:

That the Director of Public Health Report covering the period April to June 2014 attached as Appendix 1 to the report be noted.

13. HEALTHWATCH SOUTHWARK ANNUAL REPORT 2013/14

Ms Alvin Kinch, Healthwatch Southwark Manager introduced the report.

RESOLVED:

That the report be noted.

It was noted that this would be Alvin Kinch's last meeting as a member of the health and wellbeing board. On behalf of the board, the chair thanked Alvin for her work and contributions over the past year.

14. DRAFT SEXUAL HEALTH STRATEGY FOR LAMBETH, SOUTHWARK, LEWISHAM

The item was not considered at this meeting.

The meeting ended at 1.50pm

CHAIR:

DATED:

Item No. 6.	Classification: Open	Date: 2 October 2014	Meeting Name: Health and Wellbeing Board
Report title:		Health and Wellbeing Board Governance Review	
Wards or groups affected:		All	
From:		Kerry Crichlow, Director of Strategy and Commissioning, Children's and Adults' Services	

RECOMMENDATION

1. The Board is requested to:

   - Accept the recommendations of the Health and Wellbeing Board Governance Review attached at Appendix 2.

   - Agree the appointment of a Vice Chair for the Health and Wellbeing Board and establish a planning sub-group as at paragraph 6 (section II).

   - Agree the priority work areas for the Board at paragraph 7.

   - Note the protocol between the Health and Wellbeing Board, the Southwark Safeguarding Children Board and the Southwark Safeguarding Adults Board attached at Appendix 3.

BACKGROUND INFORMATION

2. At the last meeting of the Health and Wellbeing Board on 28th July 2014, members agreed the Terms of Reference for a review of governance, attached at Appendix 1.

3. Since that meeting, the expert adviser, Gayle Curry of Mills and Reeve, has carried out a desk based review of the operation of the Health and Wellbeing Board in Southwark in the light of statutory requirements and best practice and spoken to members of the Health and Wellbeing Board to get their views.

4. The Health and Wellbeing Board governance review panel met with the expert adviser on Monday 8th September to discuss her findings.

5. A summary of the review's findings and recommendations is attached at Appendix 2.

KEY ISSUES FOR CONSIDERATION

6. The key recommendations at Appendix 2 centre around the following:

   I. Agreeing clear key priorities to drive the Joint Health and Wellbeing Strategy and deliver the Board's vision.
   II. Developing a published forward work programme based on the agreed

key priorities, which will form the basis of the Board's agenda, with a small planning subgroup to manage the process.

III. Greater clarity in the reports received by the Health and Wellbeing Board to enable members to come to meetings empowered to fully contribute in decision making.

IV. Holding informal meetings of Board members and/or subgroups of the Board between formal Board meetings to drive action forward.

V. Mapping the relationships and planning links with other groups with influence on and interest in the health and wellbeing of people in Southwark.

7. Based on evidence of where the greatest impact can be made, the following priority areas are proposed as a starting point for the Board's forward work plan.

- Sexual health
- Mental wellbeing
- Alcohol/substance misuse
- Smoking
- Obesity, diabetes and other long-term conditions
- Early years and children's health and wellbeing

8. With Board members' agreement, officers will work up a forward work plan that allows time for topic based deep dives relating to the above key priorities, alongside the regular business of the Board in the discharge of its statutory responsibilities.

Protocol between the Health and Wellbeing Board and Southwark's Safeguarding Boards

9. A protocol has been developed to clarify the roles and responsibilities of the Health and Wellbeing Board (HWB), with regard to the Southwark Safeguarding Children Board (SSCB) and the Southwark Safeguarding Adults Board (SSAB).

10. These three Boards have a common purpose to promote joint working and co-operation between partners to improve the wellbeing of children and adults at risk of abuse or neglect in Southwark, support and develop areas of mutual interest through integrated multi-agency practice in prevention and early intervention.

11. The protocol attached at Appendix 3 has been agreed by the three independent chairs of the HWB, the SSCB and SSAB and sets out how the three Board's will inform each other's work.

12. The protocol is attached at Appendix 3 and Board members are asked to agree this document.

Policy implications

13. The recommendations of the Health and Wellbeing Board review of governance allow an opportunity for the Board to strengthen its effectiveness and as a partnership, to deliver better health and wellbeing outcomes for people in Southwark.

14. The recommendations of the Health and Wellbeing Board review of governance do not necessitate the delegation of executive powers from the Council.

Community and equalities impact statement

15. Improving the effectiveness of the Health and Wellbeing Board through the recommendations of the review, will contribute to achieving the vision set out in the Joint Health and Wellbeing Strategy – to reduce health inequalities by working together to create a borough where everyone can realise their potential and have the best possible life chances.

Legal implications

16. The Board will have due regard to the statutory responsibilities of the Health and Wellbeing Board as set out in the Health and Social Care Act 2012 and the legal duties of its constituent bodies in setting priorities for the Board and its forward work plan.

Financial implications

17. The financial implications of the recommendations of the review will be met within existing resources.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Health and Social Care Act	http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/category/public-health/hwb/	

APPENDICES

No.	Title
Appendix 1	Review panel terms of reference
Appendix 2	Summary of findings and recommendations
Appendix 3	Protocol between Health and Wellbeing Board and Southwark Safeguarding Boards

AUDIT TRAIL

Lead Officer	Kerry Crichlow, Director of Strategy and Commissioning Children's and Adults' Services
Report Author	Rachel Flagg, Principal Strategy Officer, Children's and Adults' Services
Version	Final
Dated	19 September 2014
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER

Officer Title	Comments Sought	Comments Included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		24 September 2014

APPENDIX 1

Health and Wellbeing Board Governance Review

REVIEW PANEL TERMS OF REFERENCE

Objectives

1. The review panel has been established to undertake an independent review of the governance arrangements in the health and wellbeing landscape, including the Health and Wellbeing Board and wider partnership infrastructure. The review will consider current capacity and the future developments required to deliver the local health and wellbeing agenda, in particular making a tangible difference to residents' lives through delivering the integration agenda.

Function and activity

2. The function of the review panel is to ensure that current ways of working are robust enough to deliver the Health and Wellbeing Board's ambitions around improving health and wellbeing outcomes for local people, in particular in relation to the integration of services.

3. In order to achieve this, it will:

   - Assess the current partnership arrangements within the context of current and anticipated requirements on the Health and Wellbeing Board, including the oversight of safeguarding procedures for children and vulnerable adults;

   - Examine the totality of the local partnership infrastructure (see Appendix 3) and identify strengths and opportunities, duplication, and where the local partnership structure needs clarity or would benefit from change or new ways of working;

   - Test current arrangements against best practice governance models and learning, to identify what it may mean for future arrangements in particular reporting, processes and delegated authority including relevant links to local health scrutiny responsibilities as appropriate.

4. In carrying out these activities, the review panel will consider and test the following:

   - The capacity of current arrangements against the range of responsibilities and expectations that have been placed upon it by national government (see Appendix 2 for further details).

   - The effectiveness and efficiency of current arrangements and whether the delegation of additional functions from the Council to the Board would be beneficial.

   - The relationships between the board and:

     i. other partnership bodies, such as Safer Southwark Partnership, children and adult safeguarding boards and the Children and Families' Trust;
     ii. working groups, such as Southwark and Lambeth Integrated Care governance

and delivery boards, primary and community care delivery working groups and local commissioning boards; and

iii. statutory bodies, such as the Healthy Communities scrutiny committee.

These relationships will need to be considered against the expectations formally set out in the Health and Social Care Act 2012 and the Care Act 2014; the statutory responsibilities of Clinical Commissioning Groups, Directors of Children's Services and Directors of Adults' Services; and around any policy expectations such as safeguarding responsibilities, the Winterbourne Concordat and Better Care Fund.

Accountability and timeframe

5. The review panel will meet on 25th July to discuss parameters and set expectations for the review.

6. A desk based audit will be carried out over the summer and recommendations will be fed back to the review panel in September.

7. The recommendations will be reported at the next relevant Health and Wellbeing Board, which will determine actions and next steps.

Membership

8. The following panel membership is proposed:

Alex Laidler	Director, Adult Social Care, Southwark Council
Tamsin Hooton	Director of Service Redesign, NHS Southwark CCG
Graeme Gordon	Director, Corporate Strategy, Southwark Council
Kerry Crichlow	Director, Strategy and Commissioning, Southwark Council
Dr Ruth Wallis	Director of Public Health for Lambeth and Southwark
Dr Jonty Heaversedge	Chair, NHS Southwark CCG
Gordon McCullough	Chief Officer, Community Action Southwark
Jonathon Toy	Head of Community Safety and Enforcements, Southwark Council
Andrew Bland	Chief Officer, NHS Southwark CCG
Mark Kewley	Director of Strategy, SLIC
Sarah Feasey	Head of Safeguarding & Community Services, Finance and Corporate Services, Southwark Council

Expert advice and challenge

9. An expert adviser, Gayle Curry of Mills and Reeve, will provide independent challenge to stimulate thinking and discussion, provide evidence-based advice on the powers and duties of each organisation and the Health and Well-Being Board Terms of Reference and associated agreements, as well as to benchmark local arrangements against national best practice and experience.

APPENDIX 2

London Borough of Southwark Health and Wellbeing Board Governance Review

Summary of findings and recommendations

The statutory responsibilities of the Health and Wellbeing Board are to:

a) Encourage health and social care to work in an integrated manner
b) Provide assistance for the making of arrangements for pooled budgets/integrated management of provision
c) Produce the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy
d) Produce the Pharmaceutical Needs Assessment
e) Sign off the Better Care Fund plans
f) Approve governance arrangements for holding the pooled budget

Southwark's Health and Wellbeing Board has been established correctly and is meeting its statutory objectives. The Board is able to fulfil its obligations relating to the Better Care Fund without the delegation of executive functions, unless the Council wishes the Board to be responsible for commissioning of services using Better Care Funding, as opposed to advising strategically on how the funding could best be used.

The review found that all members understood the purpose of the Board - to establish a strategic framework within which member organisations work across their boundaries to deliver shared desired outcomes.

The Joint Health and Wellbeing Strategy should guide the strategic direction of its member organisations and therefore the commissioning plans of the Clinical Commissioning Group and the Council must reflect the strategic intentions of the Joint Health and Wellbeing Strategy. However, it is not the role of the Board to performance manage the organisations of its members.

The core purpose of the Health and Wellbeing Board is to encourage health and social care to work together in an integrated manner. Therefore the Board should establish a strategic framework within which the resources of health and care in Southwark can be applied to deliver the outcomes set out in its Joint Health and Wellbeing Strategy.

The Health and Wellbeing Board has a clear vision, but needs to develop its priorities in order to deliver an effective Joint Health and Wellbeing Strategy.

The Board could have a wider remit to include housing, planning leisure and culture services where they have an impact on health and wellbeing, however a focus on health and care is advised at this stage in the Board's life.

Recommendations

The efficiency and effectiveness of the Health and Wellbeing Board could be improved through addressing the following:

1. Clarify the membership of the Board so that it matches the requirements of the Council's constitution.

2. Consider having a co-chair/vice chair, so that the Chair is joined by a non-Council member of the Health and Wellbeing Board.

3. Be clear on any given issue whether the Board's role is to take a decision on an issue, or to discuss an issue and have members go back to their own organisation for it to take a decision.

4. Ensure papers going to the Board are succinct and always include an executive summary. A cover sheet should accompany each paper and make clear what is required of the Board. If the Board is simply to receive a report, why is it necessary for the report to come to the Board? If it is to make a decision, what are the implications of the decision? If it is discuss and make recommendations, then what are the implications of the recommendations?

5. Ensure members of the HWB come to meetings empowered by their own organisations to discuss issues and, if appropriate to the issue, to make commitments, assisted by papers as described above.

6. Work towards a Joint Health and Wellbeing Strategy with less broad, more detailed priorities. Rigorous prioritisation work should be done with the assistance of public health professionals, so that the HWB ends up with a list of key priority outcomes with realistic costings for their implementation, so that clear recommendations can be made to health and social care to inform their commissioning.

7. Consider having sub-committees or task and finish groups to progress particular work streams outside of HWB meetings. These should not duplicate the work of existing committees/board (e.g. the Safer Southwark Partnership Board and Safeguarding Boards).

8. Prepare and publish a clear published forward programme of work and set clear agendas for its meetings. It could consider an "executive team" from amongst the members of the HWB to work with the Chair on this. Some HWBs do this and find it particularly effective. If Southwark adopts this approach, it will need to ensure that the "executive" works very transparently and inclusively to avoid distancing members of the HWB who are not included in the "executive".

9. Continue to hold HWB public meetings quarterly, but in between these public meetings HWB should meet informally in private in seminar sessions to discuss and debate issues relevant to forthcoming agenda items.

10. Consider whether the Board is doing enough to engage members of the public. Some HWBs nationally hold public engagement events once or twice each year.

11. Be clear as to how the Board relates to other bodies/boards/committees in Southwark without duplicating work done there. For example:
    (i) NHS England's guidance requires that Safeguarding Boards must link with, but must not be subordinate to or subsumed within the HWB, and;
    (ii) The Health Overview and Scrutiny Committee has the statutory responsibility for scrutinising local health services and must be consulted on changes to local health services. The HOSC can be a valuable critical friend to the HWB.

12. Look at other groups, including those who may not have any specific statutory function, but whose work will be of interest to the HWB. The HWB should map those groups and plan whether and how they will link with them.

APPENDIX 3

A Protocol between Southwark Health and Wellbeing Board, Southwark Safeguarding Children Board and Southwark Safeguarding Adults Board

Introduction

This document sets out the expectations of the relationship and working arrangements between Southwark's Health and Wellbeing Board (HWB), Southwark Safeguarding Children Board (SCB) and the Safeguarding Adults Board (SAB). It covers their respective roles and functions, membership of the three boards, arrangements for challenge, oversight and scrutiny and performance management.

The chair of the HWB and the independent chairs of the SCB and SAB have formally agreed to the arrangements set out in this document, which will be subject to review annually.

The Health & Wellbeing Board (HWB)

The HWB has strategic influence over commissioning decisions across health, public health and social care through the development of a Joint Health and Wellbeing Strategy.

The HWB is intended to strengthen democratic legitimacy by involving democratically elected representatives and patient (Healthwatch) representatives in commissioning decisions alongside commissioners across health and social care. The board also provides a forum for challenge and discussion.

The HWB brings together the clinical commissioning group (CCG) and council to develop a shared understanding of the health and wellbeing needs of communities. It undertakes a Joint Strategic Needs Assessment (JSNA) and develops a Joint Health and Wellbeing Strategy for how these needs can best be addressed in a coordinated, planned and measurable way.

Through undertaking the JSNA, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing, such as housing and employment can also be addressed.

The HWB's key priorities for 2014/15 are:

- Wider determinants of health
- Early years
- Prevention including screening
- Long term conditions
- Integration for better health and wellbeing outcomes
- Tackling neglect and vulnerabilities for children and adults

Southwark Safeguarding Children Board (SCB)

The SCB is a statutory partnership with responsibility for agreeing how relevant local organisations will co-operate to safeguard and promote the welfare of children. The SCB's role is to monitor and evaluate the effectiveness of local arrangements to safeguard all children.

The SCB's key responsibilities are to:

- Develop policies and procedures for safeguarding and promoting welfare of children in the area of the authority, including policies and procedures in relation to the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention, ensuring safe recruitment and working practice, investigating allegations and concerns and training provision.
- Monitor and evaluate the effectiveness of what is done by the local authority and board partners, individually and collectively, to safeguard and promote the welfare of children and advise them on ways to improve.
- Communicate and raise awareness of the need to safeguard children and promote the welfare of children to those who work with children including volunteers and members of the public.
- Collect and analyse information about child deaths with a view to learning from experience and safeguarding and promoting the welfare of children.
- Participate in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account.
- Undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern about the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child.
- Lead on or contribute to specific safeguarding initiatives e.g. sexual exploitation, e-safety, substance misuse, licensing.

<u>Southwark Safeguarding Adults Board (SAB)</u>

The Safeguarding Adults Board will become statutory on 1st April 2015 , following implementation of the Care Act. Currently the board operates within the framework promoted by 'No Secrets' which was published by the Department for Health and the Home Office in March 2000 and by 'Safeguarding Adults' which was published by the then Association of Directors of Social Services in October 2005.

The focus of the work of the SAB is adults at risk of abuse or neglect who are unable to protect themselves. The forms of abuse which the board aims to prevent and address are: physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect or acts of omission, discriminatory abuse.

The role of the SAB is to ensure effective safeguarding arrangements are in place in both the commissioning and provision of services to adults at risk of abuse or neglect by individual agencies and to ensure effective inter-agency working in this respect.

The SAB has identified agreed objectives and priorities for its work which include clear policy, procedural and practice arrangements, mechanisms to secure coordination of activities between agencies, the provision of training and workforce development in support of safeguarding and quality assurance and performance management arrangements to test the effectiveness of safeguarding and the impact of the Board.

<u>The relationships between the SCB, the SAB and the HWB</u>

The roles and responsibilities of the respective bodies are different and complementary. They have a common purpose to promote joint working and co-operation between partners to improve the wellbeing of children and adults at risk of

abuse or neglect in Southwark, support and develop areas of mutual interest through integrated multi-agency practice in prevention and early intervention.

Whilst the SCB contributes to that wider goal of improving the wellbeing of all children, of necessity, it has a narrower focus on safeguarding and promoting welfare. The SCB is a statutory body in its own right. In order to ensure that its separate identity and independent voice is not compromised, the SCB must not be subordinated to or subsumed within other board structures. Through its case review, evaluation and audit programmes of work, the SCB must be able to form a view of the quality of local activity, to challenge organisations as necessary, and to speak with an independent voice. For that reason, the SCB and HWB must be chaired by different people. Similar considerations apply to the SAB, as it moves on to a statutory footing.

In Southwark, the SCB and SAB are chaired by independent persons, while the HWB is chaired by the Leader of the Council.

The independent chairs of the SCB and SAB will be invited to attend HWB meetings, as and when necessary, in order to present reports and assist or advise on the development of effective plans and service delivery arrangements for safeguarding Southwark children and adults at risk of abuse or neglect. Similarly, representatives of the HWB will be invited to attend SCB or SAB when there are issues of common interest and purpose.

The SCB and SAB will work with the HWB, informing and drawing on the JSNA. Within the wider Health and Social Care environment, the HWB will seek to advise, inform and consider issues referred to it by, and in conjunction with, the SCB and SAB. The HWB may request the SCB or SAB to consider issues for development, action or scrutiny.

Given the SCB's remit (as set out above), its role in relation to HWB is:

- to focus on ensuring that key people and organisations that have a duty under s11 of the Children Act 2004 are fulfilling their statutory obligations to safeguard and promote the welfare of children and that the arrangements made by the HWB are effective in supporting this;
- to offer support, guidance, advice, challenge and scrutiny to HWB to enable the partner organisations to discharge their safeguarding responsibilities effectively;
- to produce and publish an annual report which comments on the effectiveness of safeguarding in Southwark and provides information and challenge to the work of the HWB in order to drive improvements.

The SAB's role in relation to the HWB is:

- to oversee how organisations across Southwark work together to prevent harm and reduce the risk of abuse or neglect to adults with care and support needs and to ensure that the arrangements made by the HWB are effective in supporting this;
- to offer support, guidance, advice, challenge and scrutiny to HWB to enable the partner organisations to discharge their safeguarding adults' responsibilities effectively;
- to produce and publish an annual report which comments on the effectiveness of safeguarding adults in Southwark and provides information and challenge to the work of the HWB in order to drive improvements.

The annual reports of the SCB and SAB will be submitted to the chair of the HWB (as well as the chief executive of the council).

The HWB will work with the SCB and SAB:

- to develop and interpret the Joint Strategic Needs Assessment with respect to safeguarding and promoting the welfare of Southwark's children and adults at risk of abuse or neglect;
- to develop a clear understanding of the effectiveness of current services, including where services might need to be improved, reshaped or developed;
- to ensure priorities for change are delivered.

The HWB will consider within its remit any Community, Health and Social Care services the provision of which is the responsibility of its members; this will include (among other things) safeguarding children services and safeguarding adults services.

In general, the SCB and SAB are not operational bodies or ones which directly commission or deliver services. The HWB provides expert advice around all issues of health to the HWB. It supports the shaping of the health strategy and priorities for the borough to reduce health inequalities and improve outcomes service users. Commissioning decisions remain the remit of the commissioning groups.

<u>Relationships with other strategic bodies</u>

Other strategic bodies within Southwark include:

- The Children's Trust
- The Safer Southwark Partnership
- Southwark Clinical Commissioning Group

The purposes of these bodies are consistent with and complementary to those of the HWB, SCB and SAB. The principles which underlie this protocol, in relation to consultation, joint and inter-agency working, apply equally to these bodies. There are members within each of these bodies who are also members of the HWB, SCB and SAB.

<u>Arrangements to secure co-ordination between the Boards</u>

In order to secure the opportunities identified above, it is proposed that the following arrangements are put in place to ensure effective co-ordination and coherence in the work of the three Boards.

1) Between September and November each year the chairs of the two safeguarding boards will present to the HWB their Annual Reports outlining performance against Business Plan objectives in the previous financial year. This would be supplemented by a position statement on the boards' performance in the current financial year. This would provide the opportunity for the HWB to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in the refresh of the Health and Wellbeing Strategy.

2) Between October and February the HWB to present to the safeguarding boards the review of the Health and Wellbeing Strategy, the refreshed JSNA and the

proposed priorities and objectives for the refreshed Health and Wellbeing Strategy to enable the safeguarding boards to ensure that their refreshed business plans appropriately reflect relevant priorities set in the refreshed HWB work programme.

3) In May the boards will share their refreshed plans for the coming financial year to ensure co-ordination and coherence.

…………………………… .... Date __ / __ / 2014.

Chair of the Health and Wellbeing Board

…………………………… .... Date __ / __ / 2014.

Chair of the Southwark Safeguarding Children Board

…………………………… .... Date __ / __ / 2014.

Chair of the Safeguarding Adults Board

Item No. 9.	Classification: Open	Date: 2 October 2014	Meeting Name: Health and Wellbeing Board
Report title:		Director of Public Health Report – Lambeth & Southwark	
Ward(s) or groups affected:		All wards	
From:		Director of Public Health	

RECOMMENDATION(S)

1. That the Board note the Director of Public Health Report covering the period July to September 2014 attached as Appendix 1 to the report.

BACKGROUND INFORMATION

2. The Director of Public Health reports periodically on health issues in the borough.

KEY ISSUES FOR CONSIDERATION

3. This report is a quarterly report of the Joint Director of Public Health to the Lambeth & Southwark Health and Wellbeing Boards and the Lambeth & Southwark clinical commissioning groups. This report covers current health protection issues:

- Ebola
- Flu Immunisation Campaign and pandemic planning
- Cancer Screening and other screening programmes
- Infection control
- Sexual health/SH24 update

Policy implications

4. This is an overview document and any implications for policy will be subject to a more detailed report.

Resource implications

5. Any resource implications are set out in the Appendix attached.

Legal implications

6. Any legal implications are set out in the Appendix Attached.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Director of Public Health Report – Lambeth & Southwark

AUDIT TRAIL

Lead Officer	Dr Ruth Wallis, Director of Public Health – Lambeth & Southwark	
Report Author	Dr Ruth Wallis, Director of Public Health – Lambeth & Southwark	
Version	Final	
Dated	23 September 2014	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team/Community Council/Scrutiny Team		23 September 2014

APPENDIX 1

Public Health in Lambeth and Southwark

Director of Public Health Report

July - September 2014

Lambeth and Southwark Public Health

Director of Public Health: Dr Ruth Wallis

Introduction

This is the quarterly report of the Director of Public Health for Lambeth and Southwark for the second quarter of 2014-15. The report is for the London boroughs of Lambeth and Southwark and Lambeth and Southwark Clinical Commissioning Groups as well as for all Health and Wellbeing Boards partners.

The aim of the quarterly reports is to update partners on the activities of the Lambeth and Southwark specialist public health team and work being done in partnership; and to provide information about current public health issues relevant to Lambeth and Southwark, including alerting people to areas of concern or risk.

This quarter summaries are health protection work streams including the local response to Ebola in West Africa, Pandemic Flu planning, Flu Immunisation Campaign, an first year update on the L&S immunisation programmes, infection control across Lambeth, Southwark and Lewisham, Cancer Screening and SH24 update.

Comments and ideas for future topics are welcome. Please contact PHadmin@southwark.gov.uk

1. Ebola

Background

Ebola virus disease is a severe infection, which occurs in humans and other primates. The disease emerged in 1976 in central African countries – Democratic Republic of Congo, Uganda and Sudan. The natural reservoir has not been identified.

The largest outbreak to date is currently occurring in West Africa – Liberia, Sierra Leone, Guinea and Nigeria.

The first human case in an outbreak of Ebola is acquired through contact with blood, secretions or other bodily fluids from an infected animal. People can also be infected through contact with objects such as needles or soiled clothing that has been contaminated with infected secretions. Outbreaks have been extended by traditional burial practices where mourners have direct contact with the bodies of the deceased. Acquisition through sexual contact of a convalescent case is also possible as the virus remains in the semen for up to 7 weeks after recovery.

Diagnosis and Management

The incubation period is between 2 and 21 days and the disease is manifest with sudden onset of

fever, headache, joint and muscle pains, sore throat and intense weakness. This is followed by diarrhoea, vomiting, rash and impaired kidney and liver function. Some patients develop a rash, red eyes, internal and external bleeding. Ebola is fatal in between 50-90% of clinically ill cases. Diagnosis of Ebola at the early stage is difficult due to the non-specific symptoms which are similar to many other diseases, e.g malaria.

There is no specific treatment or vaccine currently available for Ebola. Patients require intensive support including rehydration, and monitoring of oxygen and blood pressure.

Prevention of Ebola requires great care during nursing of an Ebola patient to avoid contact with bodily fluids. Isolation and strict barrier nursing with personal protective equipment is essential. Those that have died from Ebola must be buried safely and promptly.

Local Arrangements

Lambeth and Southwark have the largest resident West African communities in London. Many of these residents will have family and friends in affected countries. The risk of cases in the UK is extremely low, however Public Health has undertaken preparation in the unlikely event of local transmission.

In Lambeth and Southwark, the Public Health Team have been responding to queries and communicating with local colleagues to allay anxieties, including the following:

1. Information to the public via the Southwark Council Website. Lambeth Council do not include advice to the public on their site.
2. Letters to Head Teachers, Child Care Providers, and Further Education Establishments with links to national guidance on where exclusion is required.
3. Development of awareness display boards for display in public spaces across the two boroughs.
4. Development of Workplace algorithm for employers to assess risk which has been circulated within both local authorities and CCGs (contact Lambeth and Southwark Public Health for a copy).
5. Considering plans for a helpline should it be required locally.

In the UK, case management and containment will be led by Public Health England and acute trusts. Existing isolation facilities are being reviewed in order that expansion will be possible if required.

Locally, response plans will be based on existing pandemic arrangements:

- Encouraging patients to remain at home and contact services by telephone, and not by visiting their local GP surgery or A&E.
- Ensuring GPs refer patients into hospital through appropriate routes e.g. not via A&E. PHE have

developed information for primary care that summarises guidance for General Practice, including referring patients to hospital, infection control, personal protective equipment and decontamination. This is detailed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/349981/Information_for_primary_care_01092014.pdf

- Access existing supplies of personal protective equipment (PPE) from the NHS England stockpile
- Rolling out PPE specific infection control training
- Working closely with CCG and NHSE colleagues to ensure primary care services can respond

2. Pandemic Influenza Planning

The most recent meeting of Lambeth and Southwark Pandemic Flu Planning Group was on Monday 15th September. It focused on those aspects of planning pertinent to Ebola e.g. raising public awareness, infection control (including availability of personal protective equipment - PPE), assurance of business continuity plans in all local providers. This group includes members from Lambeth and Southwark councils and both CCGs to develop a coordinated local pandemic flu plan in line with NHS England (London) requirements. The Lambeth and Southwark Public Health Service are currently supporting both CCGs to develop their own plan ahead of a recent request by an NHS England to have a Pandemic Flu Plan in place. This CCG specific plan has been drafted to enable it to be slotted in to the multiagency one already being developed locally.

3. Lambeth and Southwark Immunisation Annual Report 2013/14

Lambeth and Southwark Immunisation Steering Group has produced it's first annual report to provide local stakeholders with a summary of local programmes. This report will soon be available on the Southwark Council website.

Immunisation service delivery and commissioning responsibilities:

- NHS England is responsible for commissioning the delivery of immunisation programmes. However their role is very contractual and not strategic.
- GSTT Community Services Support the local Lambeth and Southwark Immunisation Programmes by providing support to GPs, the delivery of a local helpline, verifying data and chasing up where immunisations have been missed.
- CCGs are responsible for ensuring quality of services is appropriate.

- Local authority Directors of Public Health are responsible for assuring themselves that immunisation services are being delivered and address gaps where possible.

Lambeth and Southwark stakeholders have made remarkable progress with improving immunisation uptake.

4. Local Flu Immunisation Campaign

The responsibility for ensuring flu immunisation delivery sits with NHS England. Directors of Public Health have a responsibility to assure themselves that local immunisation services are being delivered effectively and efficiently. Where they feel they are not, they should work with stakeholders to address the gaps. Locally uptake has not reached the national target and needs to be improved. In particular the uptake by people with long term conditions is about half the national target rate of 75%.

Therefore this year in Lambeth and Southwark, we have set aside some Public Health resource to support a two-borough flu immunisation campaign. The target groups will be people 65 years old and over, those in at risk groups (long term conditions e.g. chronic heart and lung disease), and health and social care staff. The campaign includes:

- Posters in Bus Shelters and on Buses
- Leaflets in pharmacy bags
- Council website information for staff and the public
- Immunisation of senior health and social care leaders
- Messages to health and social care staff

Immunisation of front line staff protects them, their family and protects those who they look after.

5. Infection Control

Responsibility for infection control is the responsibility of providers (delivery) and CCGs to ensure (quality). The Lambeth and Southwark Specialist Public Health Services deliver the CCGs' responsibilities locally. This includes ensuring the following services:

- Audits and training for General and Dental Practices
- Post Infection Reviews for MRSA (Meticillin Resistant Staphylococcus Aureus) bacteraemias attributed to the community

- Review of all community *Clostridium difficile (CDI)* cases to address learning
- Management of the Lambeth Southwark and Lewisham Infection Control Committee, which reports to both CCGs.
- Support community policy development where required.

Following transition to local government, the infection control team are working more closely with social care commissioners and care home commissioners in LAs and CCGs. This includes joining up local work streams through SLIC (Southwark and Lambeth Integrated Care). Infection control is now being included in local training for care homes. Statements about legal requirements for infection control need to be included in all contracts with providers. This work will aim to reduce the spread of infectious diseases (e.g. Norovirus, influenza, MRSA, CDI) in the community and between organisations. Some challenges have arisen as a result of the transfer to local government. Public health infection control staff require access to patient notes as part of their responsibilities reviewing MRSA and CDI. Some NHS organisations have not provided this access on the grounds of information governance and have insisted on getting patient consent before allowing access. This consent is often not possible as a consequence of the nature of the patients concerned. However this is a national health protection requirement. The Lambeth and Southwark Director of Infection Prevention Control has raised this at the national, regional and local level and is awaiting a resolution.

6. Cancer Screening

There are three cancer screening programmes currently running in England:

- Breast cancer screening (women aged 50-70 every 3 years)
- Cervical cancer screening (women aged 25-49 every 3 years and 50-64 every 5 years)
- Bowel cancer screening (people aged 60-69 every 2 years)

Attendance at these helps detect cancers or abnormal changes so they can be treated early. Further information about all the programmes can be found at http://cancerscreening.nhs.uk

Performance in the cancer screening programmes

One way of measuring performance in the cancer screening programmes is to look at uptake (the proportion of people invited for screening for whom a test result is recorded) or coverage (the proportion of people eligible for a particular screening programme who have had a test).

Table 1 shows coverage data for the cervical and breast screening programmes and uptake for bowel screening. Uptake in bowel cancer screening is particularly low in Lambeth and Southwark.

Table 1: Coverage and Uptake in the Cancer Screening Programmes

	% Cervical Screening Coverage in last 3.5/5.5 yrs (25-64 yr olds) Nov 13	% Breast Screening Coverage in last 3 year period (50-70 yr olds)* Nov 13	% Uptake in Bowel Screening (60-69 yr olds) Feb 14
National target	80%	70%	60%
Lambeth	71.0%	58.3%	38.7%
Southwark	72.3%	60.5%	35.0%
London total	69.1%	63.4%	47.9%

Source: NHS England London Cancer Screening Coverage & Uptake July 2014

* might include open episodes

Some of the challenges for the screening programmes include:

- High population mobility leading to incorrect patient contact details on GP records
- Low uptake and coverage, leading to inequalities in outcomes for screening.
- Unlike the cervical screening programme, the programme structure for breast and bowel is not embedded within primary care
- Ensuring all cervical sample takers undertake regular update training.

Changes to the National Programmes

- Bowel cancer screening is being extended to include 70-74 year olds. This is being rolled out in stages and so far about 40% of the new age group in South East London have been invited. By the end of 2015 all 70-74 year olds will be included in the programme.
- Bowel Scope Screening (BSS) is being introduced across the country. This involves a one-off test at age 55, with 56-60 year olds being able to opt in if they wish. In Lambeth and Southwark this is expected to be implemented in 2016.
- The age range for breast screening is being extended to include all women between 47 and 73. A

random sample of women aged between 47-49 and 71-73 are being invited and full roll-out of the age extension is expected to be completed after 2016.

Current local activity

We are working closely with local CCG leads in Lambeth and Southwark to try and improve performance, coverage and uptake in all the cancer screening programmes, including:

- An audit of cervical sample takers in primary care and their training history, with a view to targeting specific practices and putting on further update training.
- Following on from a telephone intervention pilot conducted recently, we are proposing to undertake a project to improve bowel cancer screening uptake by asking volunteer GPs to invite those patients who do not return their bowel test kit to come into the practice to discuss screening. There is evidence to suggest that people are more likely to return the test if they have a conversation with their GP about it.
- Holding some BSS workshops for general practice during 2015 to ensure GPs are aware and fully informed of the new programme.

7. Sexual Health 24 (SH24) Update

SH24 has now established a multi-disciplinary team to develop its first minimum viable product (MVP) – a website residents will be able to use to order a sexually transmitted infection (STI) test online, return samples, receive their results and be referred to relevant services if they are positive. The team includes SH24's digital partner (Unboxed Consulting) and branding partner (MultiAdapter) who were commissioned during the spring.

Following the identification of a laboratory (TDL) to support MVP1 and an N3 host, the alpha phase of SH24 (the first stage of software development) has been completed. This created a prototype allowing a small number of individuals to complete the end-to-end testing experience online. An approach to information governance (IG) has also been developed through consultation with IG and information security leads in the trusts, and a paper is due to be considered at the relevant IG boards. Most recently, SH24 has moved into its beta phase which will further develop the website for testing with real users at the two specialist health clinics it is working in partnership with.

Other elements of SH24 have been progressing well. SH24 submitted its first monitoring report to Guy's and St Thomas' trust charity and has held its fourth advisory board, securing the release of all planned instalments of grant funding. SH24 has continued to extend its stakeholder community

through a series of events, including one for the Lambeth, Southwark and Lewisham (LSL) local pharmaceutical committee, and a Made in Lambeth hack day. A blog documenting SH24 from day one has also recently been setup.

To ensure that SH24 is a long term financial proposition and releases savings to the local sexual health economy, it is working closely with the LSL integrated commissioning team to agree an online tariff and come to a commissioning agreement. Two SH24 papers setting out its business model have been approved by the LSL sexual health commissioning board and a finance working group has been established to drive forward this piece of work.

The SH24 evaluation team is currently setting-up its first randomised control trial, analysing and writing up its theory of change research and undertaking safeguarding research that will inform the development of an online safeguarding policy for SH24; a paper has been submitted to Southwark's Safeguarding Children's Board.

8. Other

Infection disease remains an important local health issue and improving uptake of immunisation is important in reducing its impact. In addition to work detailed here the Public Health team is also developing work on hepatitis C and London-wide work on TB.

Agenda Item 10

Item No. 10.	Classification: Open	Date: 2 October 2014	Meeting Name: Health and Wellbeing Board
Report title:		Integration Update – Better Care Fund (BCF)	
Ward(s) or groups affected:		All	
From:		Alex Laidler, Acting Director of Adult Care, Southwark Council Paul Jenkins, Interim Director of Integrated Commissioning, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. That the Board note the Better Care Fund plan re-submission of 19th September 2014, and next steps, as set out in paragraphs 13 to 18.

BACKGROUND INFORMATION

Better Care Fund

2. The Better Care Fund (BCF) plan sets out a range of community based health and care schemes to be funded from a pooled budget of £22m in 2015/16 to help deliver the local vision for integrated services. A key objective of the plan is to shift the balance of investment from acute care to community based care and health services that are more focussed on supporting people in a co-ordinated and effective way, preventing the need for more intensive health and social care support. The BCF is a national policy initiative intended to increase the pace of integration.

3. On 24th March 2014 the Health and Wellbeing Board considered a report on the draft BCF plan prior to its submission to the national validation process on 4th April. The Board agreed the approach to the fund as set out and the associated vision for integration "Better Care, Better Quality of Life", and requested a regular update on progress.

4. On 24th July 2014 the Health and Wellbeing Board considered a further report setting out progress on the BCF since the submission. The report set out that as a result of recent national developments all Health and Wellbeing Boards would be required to re-submit their BCF plans in line with stricter planning guidance. The changes resulted from national concerns over whether the resources invested in the BCF would deliver on key objectives, including an increased focus on reducing emergency admissions in order to reduce financial pressure on the acute sector.

5. Health and Wellbeing Boards are required to approve the resubmitted plan. As the re-submission was due to be before the next Health and Wellbeing Board meeting, and major changes to the Southwark plan were not expected, it was agreed at the 24th July meeting to delegate the final sign off of the revised BCF

submission to the Chair of the Board following agreement by the Chief Officer of the CCG and the Director of Adult Social Services.

6. This report updates the Board on the re-submission requirements and the changes required to the revised BCF plan submitted on 19th September, and the expected next steps before full implementation can be progressed.

KEY ISSUES FOR CONSIDERATION

7. Key changes to the national Better Care Fund and re-submission requirements were as follows;

   - An increased focus on reducing all emergency admissions, including the introduction of a performance related payment linked to meeting a reduction target expected to be at least 3.5% over 2015. If the performance target is not delivered £1.3m in Southwark will not be released by the NHS into the Better Care Fund, but will be available to CCGs to pay for the excess admissions.

   - Input from acute providers is to be demonstrated through a “Provider Commentary” agreeing the plans for admissions reduction arising from the BCF are consistent with their own plans.

   - A minimum amount of the fund must support NHS commissioned community based health services, £4.6m in Southwark’s case.

   - More details about the “case for change” in the local health and social care economy, providing a robust analysis of key issues and supporting the approach to integration.

   - More detail is required on each scheme, its evidence base and likely impact on a range of measures and objectives related to the BCF

   - Plans must explicitly show how the BCF;

     a. supports the funding of Care Act implementation by local authorities
     b. supports carers, and
     c. protects social care services across the board

   - alignment with existing plans across health and social care to be demonstrated

   - A more robust national assurance process has been produced.

8. Following analysis of the new requirements and discussions with partners it was agreed that in high level terms the overall approach of the original BCF plan was sufficiently robust to meet these new requirements. Although there was a need to provide more details on the individual plans there was no need to alter the proposed schemes for investment through the pooled budget or the approach to integration as previously agreed by the Board.

9. For example;

   - The plan was already focussed on a target of a 3.5% reduction in avoidable emergency admissions and the new minimum target (which applies to all

admissions) is broadly in line with CCG Operating Plan and QIPP assumptions.

- Our main acute providers, Guy's and St Thomas' and King's College Hospital have confirmed the target is consistent with their plans as required in the new Provider Commentary.

- The new requirement for a minimum sum to be invested in NHS commissioned community health care (£4.6m for Southwark) was also met by existing plans.

- The BCF approach was already well grounded in an evidence based case for change that has been developed through the SLIC work, and we have provided details of this in the resubmission.

- Each scheme has a clear link to the delivery of national BCF objectives and measures. The areas of investment have an established evidence base in terms of effective integrated approaches, e.g. carers support, self-care, re-ablement and intermediate care.

- Provisions for the implementation of the Care Act were already explicitly made and are in line with government indications of costs that should be met from the BCF.

- Services for carers already receive a significant level of funding from the BCF with £1.1m identified.

- Protection for social care was already substantial in the initial plan, with a high proportion of the fund allocated to social care (£15.5m or 70%) which is easily compliant with requirements.

10. There was however a requirement to provide a lot more detail and background analysis to support the selection of schemes and that has been provided. The revised BCF plan submission is attached in Appendix 1.

11. It is anticipated that the assurance process will be robust and it has been indicated that most plans will only be accepted on a conditional basis, highlighting further assurance required.

Pay for performance risk

12. The new Payment for Performance element (based on the 3.5% emergency admissions reduction target) potentially creates a £1.3m risk for the Better Care Fund. If the target is not met this money would instead be withheld by the NHS and diverted to the CCG to meet the costs of excess acute activity. For the BCF this requires an agreed risk sharing approach which could take the form of agreeing disinvestment in schemes during 2015/16 if the quarterly performance payments are not delivered, or establishing a contingency within the BCF. However, in order to give the plan a stable footing and ensure maximum investment in community based schemes that may prevent admissions, in principle agreement has been given to establishing a joint risk reserve between the council and CCG that can be used to fund the full plan if the £1.3m performance payment is not received. The final approach will be written into the Section 75 agreement that underpins the pooled budget. The BCF submission sets out this position.

Next steps

13. The assurance process includes an interview with the BCF planning team on 24th September.

14. It is anticipated that following submission the assurance process will either approve plans or indicate the further action required during October, and all plans will be agreed before commencing in 2015/16.

15. At the point of approval detailed planning would be undertaken for the proposed services, including the development of Section 75 agreements that will underpin the governance of the Better Care Fund, including service specifications, risk sharing, performance monitoring etc as previously advised. This will include an agreement on the hosting arrangements for the pooled budget, as this can be held by either the Local Authority or the CCG.

16. It has been agreed that during the detailed planning of the pooled budget Section 75 agreements there will be opportunities to identify further budgets that could be added to the BCF minimum pool where this makes sense. An example may be where additional funding for a service is in the BCF but the core funding for the same or a similar service is held by the local authority or the CCG. Bringing all related funding into one pooled budget would clearly be an option in such cases. Any such plans will be subject to agreement by the Board.

17. During the detailed planning stage there will be a consideration of how best to align the BCF programme with the much broader integration programme across acute, primary health and social care being led by SLIC. For example, the pooling of budgets in 2015/16 will be a useful first step towards developing outcomes based commissioning from capitated pooled budgets as being considered in the SLIC programme. Also, the SLIC programme is developing best practice in a number of areas that BCF funded services should benefit from. The BCF also provides funding to specific admissions avoidance workstreams overseen by SLIC (Enhanced Rapid Response and ERR, and discharge related workstreams). It is hence important that the SLIC programme and the BCF are closely aligned. (See SLIC update in para 19).

18. A further report will be bought to the next Health and Wellbeing Board confirming the outcome of the assurance process. This will provide an update on the 14/15 BCF preparatory programme for Quarter 2, including performance on key outcomes, and progress being made on planning the 15/16 schemes, and any key decisions the Board needs to take as a result.

SLIC update (Southwark and Lambeth Integrated Care)

19. Southwark Council and Southwark CCG are partners within Southwark and Lambeth Integrated Care (SLIC). This partnership of councils, CCGs, care providers and citizens is a mechanism to deliver the Health & Wellbeing Board's integration strategy. As part of the SLIC programme partners have worked together to identify important principles and actions to deliver integrated care across the Borough. These relate to changes in both the commissioning and provision of health and care services.

20. In terms of commissioning, the Council and CCG have identified that, to support the delivery of integrated care in Southwark, a clearer description of the

desirable outcomes and attributes of care is needed, and a range of existing funding and contractual barriers need to be removed. By doing this care providers will be given more flexibility to move resources from where they are currently used (e.g. dealing with emergency admissions to hospital) to areas that are more preventative and cost-effective (e.g. investing more in proactive primary and community care).

21. Progress to date in redesigning the commissioning approach includes:

- ***Finalising the funding arrangements to allow health and social care funds to be brought together*** – this is to bring together health and care budgets to enable joint commissioning of services (a vital part of developing a holistic approach to care); the arrangement for doing this could include an expansion of the BCF as described in paragraph 16 and 17.

- ***Consulting with citizens and professionals to identify suitable contracting outcomes*** – supported by the council, CCG and public health colleagues, public workshops have been held in January and September to define the outcome measures that matter to people; and processes are being developed to engage care professionals in this exercise (working through the SLIC Programme 'Provider Group').

- ***Quantifying the funding that could be included within a contract*** – a technical working group of commissioning and provider finance leads has been established to identify the amount of expenditure that could be 'in scope' as part of a new contract for integrated care.

- ***Identifying suitable contractual forms to underpin outcomes-based contracting*** – commissioners recently arranged a 'contracting masterclass' which included presentations from external advisers about the legal and practical considerations associated with different contract options. This event will inform decision-making by council and CCG commissioners about the best way to develop contracts with the various health and care providers, each of which plays a vital role in coordinating the delivery of genuinely integrated care.

Policy implications

22. Integration of services and the Better Care Fund plan involves agreeing shared policy goals with partners as set out in the draft vision, developing neighbourhood multi-disciplinary team models with care co-ordinated by a lead professional, and jointly agreeing how pooled resources will be invested under the Section 75 pooled budget arrangements. Specific policy implications will be identified during the detailed design phase and agreed through integrated governance arrangements.

Community impact statement

23. The health and care related services covered by the Better Care Fund and the goals set out in the vision have a positive impact on the community as a whole. In particular it will impact on older people and people with long term conditions (many of whom have disabilities or mental health problems) who are most at risk

of admission to hospital or needing intensive social care support. The plan aims to promote the health and wellbeing, independence and quality of life of these groups who are recognised groups with protected characteristics under Equalities legislation. The informal carers of these groups will also benefit, who are disproportionately female. The draft vision will also contribute to the wider prevention and public health agenda benefitting the population as a whole in the longer term, and reducing health inequalities.

24. As individual schemes are further developed for implementation in 2015/16 they will be subject to a more detailed community impact analysis.

Staffing implications

25. There is a significant workforce development agenda that needs to be addressed to effectively deliver integrated working. The workforce will need to be well-informed, appropriately skilled and clear of its common purpose in delivering person-centred care. Some staff will need to work increasingly flexibly in integrated neighbourhood teams.

26. The specific development of 7 day working to support hospital discharge will have staffing implications that will be assessed as detailed arrangements are proposed.

Financial implications

27. The BCF totals £1.3m in 2014/15, increasing to £22m in 2015/16. The majority of the BCF represents existing budgets transferred directly from the NHS, where there are existing commitments from both the CCG and the council. The BCF is now included in the council's overall settlement and spending power calculation.

28. The BCF schemes proposed include a mix of existing funding, recognising the financial pressures experienced by the Council and CCG, as well as investment in new schemes. In 2015/16, a total of £2m is explicitly labelled as contributing to maintain social care services, an increase of £500k from the 2014/15 level. In total £15.5m is to be used for funding social care services. It is hoped that the impact of integration across the Council and CCG, including investment in schemes to reduce length and number of hospital and residential homes stays, will result in enduring savings for both organisations.

29. As set out in para 12 there is a payment for performance risk of £1.3m which it is proposed will be mitigated by establishing a joint BCF risk reserve.

30. The pooled governance and financial arrangements for the BCF remain under discussion and will be agreed over the coming year.

Consultation

31. The plan is underpinned by a vision for improving services in the community through better integrated working that has been developed over several years and shaped by a range of engagement activity.

32. SLIC has developed much of the thinking behind our approach and has actively consulted with the public through the Citizen's Forum over the past 18 months. Southwark and Lambeth commissioners, working with the SLIC team, held an engagement event with residents on the 28th January 2014 to identify what

people wanted as outcomes from integration and to help us articulate those outcomes from a resident's perspective. This work supports our vision document, but will also help us as we work to further develop our local outcome measures for integrated care. This event included over 50 participants, including Healthwatch and the representatives of other engagement groups linked to the CCG and LA.

33. There has not been a consultation on the re-submitted plan as the initial proposals agreed by the Health and Wellbeing Board have not materially changed.

34. There will be further engagement activity as detailed implementation plans for 2015/16 are developed.

BACKGROUND DOCUMENTS

Background Documents	Held At	Contact
Better Care Fund –supporting documents Health and Wellbeing Board BCF report 24/3/14 and 27/7/14	160 Tooley St	Adrian Ward 020 7525 3345
SLIC programme		Mark Kewley 020 7188 7188 Ext. 55184

APPENDICES

No	Title
Appendix 1	Better Care Fund – resubmission of 19th September

AUDIT TRAIL

Lead Officer	Paul Jenkins, Interim Director of Integrated Commissioning, NHS Southwark Clinical Commissioning Group Alex Laidler, Director of Adult Social Care, Southwark Council
Report Author	Adrian Ward, Programme Manager – Integration and Better Care Fund (BCF update) Mark Kewley, SLIC (SLIC update)
Version	Final
Dated	24 September 2014
Key Decision?	No
Previous relevant reports	Better Care Fund Plan to HWB 24/3/14, and BCF update report 24/07/14
Date final report sent to Constitutional Team	24 September 2014

APPENDIX 1

Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.ukas well as to the relevant NHS England Area Team and Local government representative.

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 Southwark**
Clinical Commissioning Groups	**NHS Southwark CCG**
Boundary Differences	**No boundary difference**
Date agreed at Health and Well-Being Board:	Board of 28/7/14 agreed update report on the BCF and process for delegated sign off by the Chair for resubmission by 19/9/14.
Date submitted:	**19/09/14**
Minimum required value of BCF pooled budget: 2014/15	**£1.309m**
2015/16	**£21.967m**
Total agreed value of pooled budget: 2014/15	**£8.957m** (Notes: 1) this will not be in the form of a formal pooled budget in 2014/15. Pooled budget arrangements will be developed for introduction when the Better Care Fund

	formally starts on 1/4/2015, in line with the planning guidance. 2) This value includes £1.309m BCF allocation, plus £5.835m existing NHS transfer, plus £1.813m re-ablement grant rolled forward from 13/14
Total agreed value of pooled budget: 2015/16	**£21.967m** The CCG and the local authority will be evaluating options for extending the range of service budgets incorporated within the pool during 2014/15 prior to the finalisation of 2015/16 plans.

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Andrew Bland
Position	Chief Officer, NHS Southwark CCG
Date	19/9/14

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Jim Crook
Position	Strategic Director of Children's and Adults Services, Southwark Council
Date	19/9/14

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Peter John
Date	19/9/14

Nb. Signed copy of this page available on separate PDF.

c) 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
1. Vision document	*Attached appendix 1*
2. Health and wellbeing strategy	*http://www.southwark.gov.uk/info/100010/health_and_social_care/2663/health_and_wellbeing_board*
3. JSNA	*http://www.southwark.gov.uk/jsna*
4. CCG Primary and Community Care Strategy	*http://www.southwarkccg.nhs.uk/Pages/Home.aspx*
5. Southwark CCG 2yr plans	*http://www.southwarkccg.nhs.uk/Pages/Home.aspx*
6. South East London NHS 5 yr Plans	*http://www.southwarkccg.nhs.uk/Pages/Home.aspx*
7. Local Account – Adult Social Care	*http://www.southwark.gov.uk/localaccount*
8. SLIC website and project plans and reports	*http://slicare.org/*
9. Carers Strategy	*http://moderngov.southwark.gov.uk/documents/s45096/Background%20document%20Carers%20strategy.pdf*
10. HWB report on BCF 28th July	*http://moderngov.southwark.gov.uk/ieListDocuments.aspx?CId=365&MId=4664&Ver=4*

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our shared vision for integrated care and support for our local population through the provision of well co-ordinated, personalised health and care services **"Better Care, Better Quality of Life in Southwark"** is set out in full in **appendix 1**. It is a vision for the whole system, not just health and social care, based on evidence of need and the views of our population. In particular it links to Southwark's Health and Wellbeing Strategy, NHS Southwark CCG's Primary and Community Care Strategy, Operating Plan and 5 year plan, Southwark's Housing Strategy and the Council's Fairer Future priorities.

We want people to live healthy, independent and fulfilling lives, based on choices that are important to them.

Our vision for integrated care in Southwark is for people to stay healthier at home for longer by supporting people to manage their own heath and well-being, by doing more to prevent ill health and by providing more services in people's homes and in the community. We want people to feel in control of their lives and their care, with the services they receive co-ordinated and planned with them around their individual needs.

We will build upon our existing locality and neighbourhood work to integrate services around people's needs, but recognise that we now need to transform the way we work together across health and care to really achieve this.

Our ambition for integrated care in Southwark is to deliver:

- More care in people's homes and in their local neighbourhoods
- Person-centred care, organised in collaboration with the individual and their carers
- Better value care and support at home, with less reliance on care homes and hospital based care
- Better experience of care for people and their carers
- Population based care that is pro-active and preventative
- Less duplication and a more efficient system overall
- Improved outcomes for people's health and wellbeing
- Enabling stronger and more resilient communities
- Southwark as a great place to live and work,

We will know we have achieved our ambition for integrated health and care in Southwark when we need to rely less on hospital-based care and care homes, because more care will be delivered in people's homes and in their local neighbourhoods. People will be admitted to hospital quickly when they need to be, to access our local world class facilities and services. Hospitals will be able to discharge people quicker, because effective and pro active services at home and in the community will help people get back on their feet and stay healthy and independent for longer.

This vision will deliver improved outcomes for the people of Southwark in areas where we know from benchmarking that improvements can be delivered, as set out in our JSNA, for example in premature mortality linked to long term conditions.

The Better Care Fund (BCF) will play a key enabling role in driving forward this vision by creating a substantial £22m pooled budget between the Council and CCG for the delivery of community based services that are strongly focused on shared aspirations. This will provide a strong platform for developing more integrated approaches to services delivery and integrated governance, and already the preparatory work in 2014/15 is helping develop joined up thinking about whole system investment and multi-disciplinary working.

At present the BCF in Southwark is limited to the national allocation, but as we progress these discussions, there is potential to expand the pooled budget to cover a larger proportion of our shared expenditure.

The vision is also aligned with our neighbouring borough Lambeth through the work of Southwark and Lambeth Integrated Care (SLIC) programme. SLIC is a multi agency federation of commissioners, acute and mental health providers, social services and the voluntary sector working together to integrate care. The SLIC programme has been a critical enabling vehicle for agreeing a programme of integration work across Lambeth & Southwark and supporting a shift of resources to support our priorities for the BCF. This is particularly reflected through specific jointly commissioned admissions avoidance services that operate across both boroughs that will be funded through BCF arrangements, and a shared approach to key enablers of integration including the development of an appropriate workforce and information sharing arrangements.
Over the past few months we have been working with our SLIC partners on options for further progressing wider integration, including developing a framework for outcome based integrated commissioning and exploring different financial and contractual mechanisms for integrated care, including capitated approaches to pooled budgets.

Integration in Southwark is focused on the key role of primary care to provide a co-ordinated, effective, person centred approach to working with people with complex needs through the development of a neighbourhood model.

The plan is underpinned by a vision for improving services in the community through better integrated working that has been developed over several years and shaped by a range of engagement activity.

b) What difference will this make to patient and service user outcomes?

The vision and ambition set out in (a) above will be measured as follows.

Expansion of integrated community support to reduce need for intensive health and social care support will be measured by:

- Increases in the numbers of people benefitting from the community multi disciplinary team approach, and activity levels in the BCF funded services such as home ward, admissions avoidance and re-ablement.
- reductions in the rate of avoidable emergency admissions

- shifting the balance of care away from care homes, including reduced admissions
- impact of re-ablement in reducing the care needs of clients using the service
- delayed transfers of care
- length of stay in hospital and emergency bed days for older people
- people reporting they feel supported to manage their long term conditions

All BCF schemes directly contribute to these goals.

A key underlying principle of our BCF plan enabled through the SLIC programme is for integrated care to help achieve financial sustainability for the whole health and social care system, as well as to improve population health, improving key health and life outcomes. The success of this will be evaluated with reference to the financial position of all commissioners and providers. We are developing a 'balanced scorecard' tracking outcomes and costs across the health and social care economy, which will help us to assess our impact on delivering better value care. As part of this, we are working to define a set of outcome measures that assess the impact on the health and wellbeing of our target population, which will include outcome measures defined by residents and measured through local surveys. These measures will be built into new integrated contractual mechanism enabling integrated approaches to provision and a focus on prevention.

In addition to the BCF outcome metrics, we have worked with the SLIC Citizen's Board and user groups in Southwark and Lambeth as well as Public Health to articulate a wider set of outcome indicators that reflect local people's priorities and aspirations for their health and wellbeing.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The focus for the Southwark whole system is to enable people to live independently and well for as long as possible, using the widest range of mechanisms and support options possible. Some of the key aspects of change we want to see are:

- more care for older people and people with long term conditions will be delivered through locality based community multi-disciplinary teams with a lead professional responsible for co-ordinating the care of individuals, ensuring an integrated and personalised approach to case management by all services working with each person - GPs, Community Health, Social Care, Housing, Mental Health workers and hospital services.
- there will be less care needed in acute settings. A&E attendance and avoidable emergency admissions will reduce by 3.5% across our 2 main acute hospitals as community teams provide more targeted support to those at risk.
- when people do need acute care they will stay in hospital for shorter periods, returning home safely with the help of services such as @Home (Home Ward) and enhanced discharge support.
- re-ablement and intermediate care will increasingly provide effective short term interventions that rehabilitate people, restoring health and independence
- the balance of social care will shift away from care homes towards support in people's own homes and supported housing schemes including Extra Care.
- home care services will be funded with a view to radically improving quality and

outcomes, with home carers linked in with other health and care professionals through the multi-disciplinary team approach
- there will be enhanced support for carers in line with our Carers Strategy and the Care Act
- there will be a greater role for technology through telecare to help people live safely at home and investigating opportunities for telemedicine.
- a more integrated and coherent approach to preventative services including the voluntary sector tackling issues such as social isolation
- through BCF and whole systems funding services will be responsive and accessible 7 days a week, including improvements to weekend discharge planning with social care, admissions avoidance community services, as well as primary care
- new focus on developing dementia related services
- developing a neighbourhood model

The BCF will contribute to this vision by funding key community based services on a pooled budget basis using a person centred approach, co-ordinating the input of different support services that need to work together through multi-disciplinary neighbourhood based working.

The "golden thread" that unites the range of BCF schemes in this plan is that they all help people with health and care needs to live independent, healthy lives in their own homes by providing an integrated approach to meet each persons individual set of needs.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Our work as partners of Southwark and Lambeth Integrated Care (SLIC) has included a detailed programme that has examined the case for change. This work has been supported by all the key local commissioners and providers of acute, primary and community based care services who were involved as the business case has developed. This work has shaped the approach to the pooling of budgets in the BCF which is very much the first step in a wider integration agenda. The analysis was based on detailed data on the population needs, current services, demographic projections of need and finance and evidence about what models work.

In **appendix 2** there is a summary of some of the **case for change** work including graphical representations of the findings.

The analysis shows that despite the existing configuration of world class health services available in the borough, outcomes remain poor for many local people. An outcomes based approach to integrated commissioning and provision will be developed, including a greater focus on prevention, of which BCF funded services will be one part.

The challenges are also clearly set out in the Health and Wellbeing Strategy. Southwark has an aging population, with an extra 900 people aged 85 or over expected by 2020, which is an increase of nearly 30% on current levels. The number of people with disabilities and learning difficulties is also rising steadily, with those under 65 years predicted to increase to around 20,000 by 2025. There are high levels of deprivation, with almost half of over-65s claiming pension credits, which is higher than the London average. The ageing population brings health challenges, with the estimated 12,500 over-65s in Southwark living with a long term illness rising to over 17,000 by 2025. The borough has a higher prevalence of long term conditions for older people than national or London figures. In addition, there are estimated to be around 1,800 people living with dementia, a figure that is predicted to rise by around 300 by 2020. Emergency admission rates for the over 75s, however, are among the worst in the country, and overall satisfaction levels with social care support services are below national benchmarks

A key conclusion of the case for change work is that the current system is financially unsustainable without transformative change, with a potential financial gap of £171m across entire system of health and care by 2018/19 in Southwark. The evidence shows that integration can help bridge that gap by shifting the balance of care towards more preventative community based care, and in so doing improve outcomes. All partners agree that there is scope to improve services and reduce costs by better integrating services. Our risk stratification and population segmentation approach has led to an initial focus on older people and long term conditions, and this has informed the focus of the BCF.

The BCF is one part of the integrated response to making the required changes to achieve sustainability and improve outcomes.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Key Milestones:

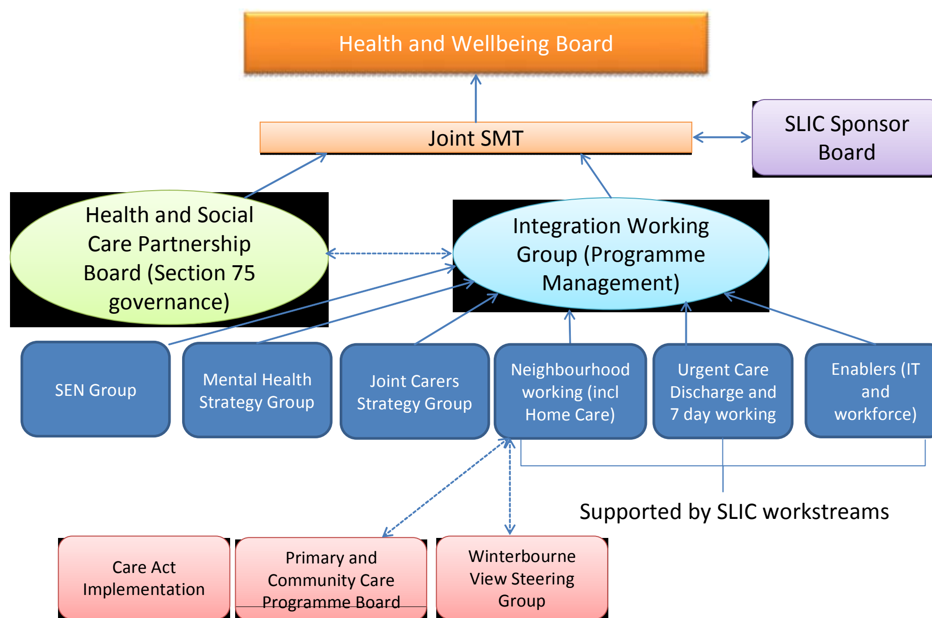
Health and Wellbeing Board workshop agrees focus of BCF schemes, prioritising ideas emerging from previous multi agency consultations	**28/01/14**
Agreement of initial Better Care Fund plan by Health and Wellbeing Board	**24/3/14**
Submit Better Care Fund plan to NHS (initial national process)	**4/4/14**
Implement detailed plans for 2014/15 new expenditure (£1.3m) following approval of initial submission and release of BCF integration grant	**1/5/14**
Develop and implement the 2014/15 BCF preparatory investments, including agreeing and sign relevant Sec 75 and Sec 256 agreements for 2014/15 BCF	**1/6/14**
Commence review of existing services funded by NHS transfers rolling into Better Care Fund in 2015/16	**1/7/14**
Appoint programme manager for BCF	**1/08/14**
Establish Integration Working Group meetings and other governance arrangements to drive BCF progress	**Monthly**
Health and Wellbeing Board quarterly update	**28/7/14 +** quarterly
Joint Senior Management Team: agree re-submission details	**10/9/14**
CCG Governing body agrees paper on re-submission	**11/9/14**
Finalise BCF re-submission (revised national process per 25th July letter)	**19/09/14**
Receive NHS agreement to revised plan / make required amendments	**Oct. 2014**
Develop and agree detailed plans for 2015/16 schemes, informed by review of existing schemes, and reflect in a signed Section 75 agreement for whole Better Care Fund pooled budget arrangement	**Dec. 2015**
Agree any wider pooling of budgets above BCF minimum level in BCF	**Dec. 2015**
Development of commissioning for outcomes framework, contracting, funding and provider mechanism – link to wider SLIC integration workstreams	**Jan 2015**
Establish detailed 15/16 project plans and monitoring mechanisms:	**Jan- Mar 2015**
Formal revision of HWB governance arrangements to reflect governance requirements for integration in line with governance review:	**March 15**
Implement Better Care Fund Plans 2015/16, funding invested in poll and services commence	**April 2015**
Determine payment for performance to be received on basis of quarterly monitoring, and invoke contingency plans if BCF not fully funded:	**May 2015 for Q1**
Ongoing monitoring and improvement of BCF schemes by HWB	**July 2015**

Each individual area will have more detailed plans covering specific actions and milestones including staff and user engagement.

Key interdependencies relate to the overall SLIC programme, including the workstreams for data sharing and workforce development. The neighbourhood working workstream and primary care development are also key links.

b) Please articulate the overarching governance arrangements for integrated care locally

Governance arrangements for BCF and integrated working in Southwark



The Health and Wellbeing Board will be responsible for agreeing the Better Care Fund plan and overseeing its successful delivery through the quarterly report process. The terms of reference of the Board and appropriate underlying support and governance structures to be reviewed to ensure they are fit for this purpose, with an independent review due to report in October 2014.

Although jointly responsible for delivering on the objectives of the fund through the Health and Wellbeing Board individual organisations will remain formally accountable for their own expenditure pooled within the BCF through their existing governance arrangements. The accountable officers will be the council and CCG lead directors.

For different schemes within the fund, management responsibility for delivery will be delegated to different bodies that will be accountable to the Health and Wellbeing Board via relevant CCG and Local Authority management arrangements.

Roles, responsibilities and risk share arrangements will be clearly set out in a Section 75 agreement(s) under which the pooled funding will be managed.

A system of quarterly reporting to the HWB will be in place from 2014/15 covering all key schemes expenditures, milestones, activity and performance. An initial Quarter 1 report has been provided on 28th July. A Health and Social Care Partnership Board has been established as a sub-group of the Board to ensure there is capacity to do this effectively, and an Integration Working Group is developing the programme of work to implement it. The Partnership Board will model a fresh approach to performance monitoring of integrated provision over 14/15 in preparation for the BCF in 15/16.

The SLIC programme management structure will feed into BCF monitoring arrangements for those projects it directly manages (including @home and Enhanced Rapid Response) following allocation of lead responsibilities at the detailed planning stage. The sponsor Board includes BCF lead directors of the CCG and council.

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

The BCF will be managed through Programme Board and delivery group strictures. Each BCF scheme has a clear plan setting out the service details, key deliverables in terms of activity and outcomes, named lead organisations and managers, risks, dependencies, milestones and reporting arrangements. These requirements will be reflected in the Section 75 agreement underpinning the governance of the pooled budget. Quarterly exception reporting on all schemes will be required, although care will be taken not to add unnecessary or duplicated reporting burdens. Collated reports will be discussed initially at the Integrated Working Group and the Section 75 review meetings of the Health and Social Care Partnership Board, with an overview and exception report discussed at Joint SMT. This will feed into a quarterly report for the Health and Wellbeing Board to assess progress and discuss any areas that need unblocking. Although early in the programme the first quarterly update report on the BCF was provided to the HWB on July 28th.

Individual schemes will be overseen by delivery groups reporting up to the IWG as set out in the diagram above, including Carer, Neighbourhood working and Urgent Care.

For any scheme element that is not on track a recovery plan will be provided. Particular focus will be given to spending and any variance on plans will be addressed, including consideration of reinvestment of any slippage.

Outcomes will be managed at scheme level and whole system level, with close performance management of key measures undertaken on a monthly basis, including analysis of avoidable admissions, care home placements and delayed transfers of care.

A jointly funded senior programme manager has been recruited to support the delivery of the Better Care Fund and the wider integration agenda. The BCF programme manager reports to the Director of Integrated Commissioning of the CCG and the Director of Adult Social Services.

A number of schemes will be managed through the SLIC programme management structure, including the cross borough admissions avoidance and hospital @home services.

d) **List of planned BCF schemes**

The list below sets out the individual projects we are planning as part of the Better Care Fund. See the *Detailed Scheme Description* templates (Annex 1) for each of these schemes, and how they will address the issues in our case for change and vision.

Ref no.	Scheme	2015/16 £000
1	**Existing NHS transfers**: range of social care services that support health care, with a focus on discharge support. To be reviewed along with other schemes to ensure best integrated approach.	**5,621**
2	**Winter pressure grant funded services:** additional social work input to support 7 day discharge & admissions avoidance, mental health re-ablement, enhanced rapid response, care home support, OT, reablement 7 day working, & Nightowls overnight care.	**1,048**
3	**Re-ablement**: grant rolled forward, services to be reviewed and further integrated with discharge support, admissions avoidance and enhanced rapid response.	**1,813**
4	**Service development**: Change management capacity for the BCF programme.	**100**
5	**Self management including expert patient programme**: enhance quality of life and independence of people with long term conditions.	**307**
6	**Home care quality improvement:** improving quality and effectiveness of home care to help support people to remain at home as part of approach to integrated community support services.	**1,900**
7	**Psychiatric liaison** and related services: aimed at responding to people with mental health problems in the acute hospital sector including A &E at King's College Hospital and Guys' and St Thomas' Hospital.	**300**
8	**Mental health**: strengthen multi-disciplinary working in the community to prevent crisis admissions, and integrating physical/mental health. Includes enhanced psychological support for people with learning disabilities in line with Winterbourne View programme.	**870**
9	**Telecare expansion**: supporting people to live at home through assistive technology.	**566**
10	**Carers**: investment to support implementing the agreed multi-agency joint carers strategy to help people continue in their caring roles.	**450**

Ref no.	Scheme	2015/16 £000
11	**Admissions avoidance services**: existing programme including enhanced rapid response services.	**2,200**
12	**@home -** Hospital at home service: full year effect of extension to home ward	**1,200**
13	**Care Act Implementation:** amount of BCF identified by government as contributing to implementation of Care Bill, including additional assessments, safeguarding and Care Accounts for the care cost cap system.	**1,000**
14	**Social Services Capital**: existing grant rolled into BCF 15/16. Includes investment in centre of excellence for dementia and supported accommodation for people with a learning disability.	**875**
15	**Disabled Facilities Grant:** existing grant for residents not in council housing, enabling disabled people to live at home.	**614**
16	**Protecting Adult Social Care of benefit to health services:** further support in line with BCF conditions to maintain key service levels in context of council funding cuts.	**500**
17	**Seven day working:** programme to support seven day hospital discharge across primary, community and social care.	**1,493**
18	**Voluntary sector preventative services**: existing grants, to be reviewed as part of an integrated approach to prevention.	**910**
19	**End of life care:** additional spend relating to end of life care co-ordination to integrate and improve overall approach, to include medicines management.	**200**
		21,967

These individual schemes are all closely related aspects of community based support and will be managed in the context of our integrated approaches to multi-disciplinary assessment and care management.

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Non-delivery of acute emergency demand reductions results in CCG deficit, non-delivery of community investment and capacity problems in the acute sector	4	3	12	Progress on impact on acute demand reductions will be monitored closely as part of the BCF governance arrangements and recovery plans put in place promptly where necessary. If targets not met, contingency plans to set out how any excess acute demand will be funded whilst protecting the development of community based services. Plans to be considered in context of South East London sector wide approach to sustainability of acute expenditure.
Non-delivery of targets to reduce care homes and community demand lead to social care financial unsustainability.	2	2	4	Progress on care home demand and the effectiveness of re-ablement and other services at reducing long term care needs in the community will be monitored closely and recovery plans put in place promptly where necessary.

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
				If targets not met, contingency plans to set out how any excess social care costs will be funded whilst protecting the development of community based services.
Non-delivery of targets results in loss of performance related portion of BCF allocation	3	2 (£1.3m performance risk)	6	Close monitoring of targets as part of overall programme management and governance. Agree risk share based on a joint reserve to protect BCF schemes at risk
Acute provider financial stability if shift to community achieved (and freed up acute capacity not taken up by specialised activity, fixed costs not reduced in line with reduced activity)	2	3	6	Close liaison with providers joint planning group, SEL sector planning groups, SLIC and contract monitoring to identify issues early.
Data sharing and information governance issues hold up the development of multi-disciplinary working	3	3	9	Existing IT/IS and data sharing strategy – progress and milestones to be closely monitored. Unblock problems at HWB level if necessary.
Project milestones not delivered due to change management / capacity issues/ other demands on the system deflecting resources from delivering programme	2	4	8	Governance and monitoring to underpin programme management, identifying any slippage and addressing underlying reasons.

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
Better Care Fund overspends / underspends	2	2	4	Close monitoring of expenditure through the governance framework, rapid identification of problems and prompt recovery planning. Risk share arrangements set out in Sec 75 agreement specify arrangements for funding overspends by individual agencies or from with BCF as appropriate.
Workforce development across all agencies does not keep pace with requirements for integrated working	2	3	6	Workforce development issues identified for all schemes and overall requirements captured in programme.
Demographic pressures exceed overall public sector resources available after net reductions in 15/16 and beyond despite improvements in effectiveness arising from integration.	3	3	9	Contingency plans will include evaluation of value for money and continual review and re-commissioning of services within affordability envelope.
Improvements in health and wellbeing required to reduce demand on health and social care not forthcoming at sufficient pace	3	3	9	Review the Health and Wellbeing Strategy
Funding settlement for Adult Social Care requires a level of reduction that the Better Care Fund can not mitigate resulting in loss of access to	3	3	9	Ensuring effective integrated use of resources in the community.

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions
community based support and undermining Care Act implementation.				
Insufficient input from key partners in the development of integrated approaches, e.g. from GPs in CMDT roll out, as a result of complex commissioning structures.	3	3	9	Use HWB and SLIC sponsor board to help unblock problems. NHSE dialogue.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

We have set a reduction target of 3.5% in the number of emergency admissions over the calendar year 2015 in line with the national expectation for the BCF.

This is an ambitious target given the historic growth in local and London-wide emergency activity. It is recognised that there is a risk it will not be achieved, particularly as many BCF schemes will not fully impact until later in 2015. We can not be certain of the precise impact of any particular scheme and the impact of wider pressures such as the growth of need in the older population. However, reducing emergency admissions is a shared target across a wide range of service initiatives outside the BCF and, as set out in the case for change, we are ambitious to achieve the transformation necessary to achieve sustainability across the health and care system.

Should the target not be achieved there is a specific risk in relation to the payment for performance system underlying the BCF framework, which will put up to £1.3m at risk for Southwark if a decrease is not achieved. If that is the case the money will be withheld from the pooled budget and redirected towards the CCG, who will be able to use it to meet the costs of excess acute activity above plan. This will mitigate the risk to financial balance in the CCG and acute sector.

During 2014/15 and beyond the risk of under performance will be managed through a range of service initiatives that will help reduce demand on acute, including the System Resilience investments which are closely aligned with the BCF approach and our

ambitious primary care transformation programme. Delivery of BCF and related schemes against targets will be closely monitored and recovery plans put in place at the earliest sign of targets not being met.

In terms of the risk to the BCF from the potential loss of £1.3m during 2015, it has been recognised it would be damaging to the overall success of the long term integration strategy if an approach of disinvesting from BCF schemes were taken to balance the fund. It has therefore been agreed locally by the Integration Working Group and Heath and Wellbeing Board to work towards a risk management approach that is based on establishing a reserve that can be called upon in the event of short term under performance. This will enable services to be planned with a stable footing and will be reflected in the Section 75 agreement underpinning the pooled budget. A reserve is being established in 2014-15 which will mitigate any under performance, ensuring that a full year's funding is available for all projects.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

We have positioned our response to the BCF as a key enabling element of a wider transformational change in health and care services in Southwark. The Health and Wellbeing Strategy articulates the overall goals of the system and the Vision for integration "Better Care, better quality of life" (**annex 1)** sets out the ambition that the integration agenda has in achieving this.

The Health and Wellbeing Strategy highlights specific priorities under the themes of a) building healthier and more resilient communities, and tackling the root causes of ill health, and b) improving the experience and outcomes for our most vulnerable residents, and enabling them to live more independent lives, that the BCF has a key role in delivering, specifically:

- Provide more services in community settings, reducing the need for specialist or acute support across a range of needs and areas
- Enable more residents with complex and chronic conditions to lead independent and fulfilling lives for longer and enjoy good mental wellbeing
- Give users and carers a seamless, personalised experience, enabling them to have more choice and control over their life, death and support services

There is strong alignment and understanding between the BCF programme and the Social Services vision and associated transformation programme, which has a clear focus on providing personalised services in the community that help people live safely and independently at home, working in an integrated way with all services that support an individual. The key objectives of the social care system include promoting quality of life and preventing, delaying and reducing the need for intensive health and care support.

Key shared targets with the BCF include care home admissions reductions, re-ablement effectiveness, user experience and minimising delayed transfers of care.

The local authority budget round for 2015/16 currently underway is based upon a consideration of the impact BCF resources on the overall delivery strategy.

In addition to social care, the Council Plan is well aligned with BCF priorities through the "Age Friendly Borough" strategy which will seek to ensure a multi-agency approach including Housing, public health prevention strategies and a specific commitment to improve the quality of home care services.

As set out in b) below the BCF is an integral part of the NHS planning at local and regional level, which includes plans for challenged health economies, the primary and community care strategy and development of the neighbourhood model which is the key building block for integrated services.

The SLIC programme is closely linked to the BCF, with certain key schemes funded directly by the BCF in 2015/16 (@home, admissions avoidance, enhanced rapid response) and other enabling workstreams that are closely related to BCF objectives including Holistic Health Assessments, Integrated Care Management and CMDT development, homecare workforce development, care home support, consultant community hotline, simplified discharge, falls, infection, nutrition and dementia.

The Carers funding element of the BCF is targeted on funding the recently agreed multi-agency carers strategy.

The programme manager for the Better Care Fund is expected to help identify all related workstreams and ensure that there is good alignment between these and the BCF.

b)Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The core schemes included in the Southwark BCF plan are reflected in the CCG's 2 year Operating Plan for 2014 to 2016. The Operating Plan forms the initial phase of the CCG's 5 year strategic plan (completed as part of the south east London SPG), which has also therefore been developed to align with the shared approach to the BCF. Our BCF plan reflects the core part of Southwark CCG's current operational and strategic plans as all are centred on enhancing integration, neighbourhood working, reducing unplanned admissions to hospital, enabling community resilience and promoting prevention in line with BCF priorities.

The impact of the Better Care Fund has informed the development of the CCG's financial model and our current QIPP and activity assumptions for the next two years.

The budget and service planning processes of the local authority reflect the BCF resources available to support integration and wider adult care objectives as set out in the Local Account and the adult care business plan.

c)Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Both the BCF plan and our wider vision for integration have been discussed with the full range of providers including Primary Care. The CCG's Primary and Community Care Strategy, approved by the CCGs membership and Governing body relates the transformation of primary care directly to the goals and implementation of our Better Care Fund plans. Our engagement has extended to full discussions with the Local Medical Committee who are represented at the key decision making forums of both the CCG and the wider partnership focused upon the delivery of Integration through the Lambeth and Southwark Integrated Care (SLIC) programme.

Whilst the model for co-commissioning of primary care services remains under discussion locally, the CCG enjoys a productive interaction with NHS England as the direct commissioners of primary care services for the borough and this has supported the development of commissioning strategies, aligned to the BCF.

As the details of the national approach to co-commissioning become clearer, and as we develop our local response to those further, we will seek to optimise the role of primary care within the integration agenda through the aligned commissioning of those services, recognising that patient experience and the quality of primary care is key to successful integration.

Integration in Southwark is focused on the key role of primary care to provide a co-ordinated, effective, person centred approach to working with people with complex needs through the development of a neighbourhood model.

Southwark CCG has submitted a combined expression of interest with SE London CCGs, outlining our commitment to explore co-commissioning based upon a set of principles and assumptions. An initial review suggests that co-commissioning may be beneficial by:

- aligning the commissioning of services more directly to the CCG and South east London SPG five year strategies;
- harnessing local knowledge of member practices and involving the communities they serve in commissioning decisions;
- aligning commissioning intentions directly to commissioning investment decisions.

Primary care representatives and commissioners have been closely involved in the development of the integration agenda throughout, including GP representation at BCF and integration workshops, SLIC workstreams etc.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting social services means ensuring that there are sufficient resources for social services that promote health and wellbeing and reduce demand on health services, in particular those at the interface of health and social care where seamless services are required to improve user experience and promote efficient use of resources.

This means focussing Better Care Funding on areas that would otherwise be vulnerable under current funding reductions facing local authorities, combined with rising demand for services due to demographic factors. This includes maintaining current levels of eligibility criteria at substantial and critical needs, provision of assessment, care packages and personal budgets for home based care, re-ablement, intermediate care and hospital discharge and support to carers, and signposting to prevention and community support services for those below the eligibility threshold.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The Better Care Fund directly funds a range of adult care services, with around 75% (£15.5m) of the fund being invested in this way. In particular, discharge support services, re-ablement and Intermediate Care Services have assisted social services in providing a level of assessment and care management services, and care packages that is consistent with existing eligibility criteria, and this will continue and expand in 2015/16.

The additional BCF service proposals generally all have an impact in terms of reducing, delaying or preventing the need for more intensive health and social care services, and hence assist the financial sustainability of the social care as well as health. For example:

- support to carers helps prevent the breakdown of informal care arrangements and so reduces the pressure on statutory services
- self management support to enable people to keep themselves well and increase their levels of independence
- funding quality improvements in home care
- funding 7 day working in hospital social care teams
- funding telecare expansion

The BCF will also help the local authority meet a proportion of the costs associated with implementing the Care Act (£1m, in line with national allocations). In addition there are sums specifically earmarked for the protection of social care (£2m) to help meet budget reduction targets without withdrawing services of benefit to health.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total sum invested in social care services comes to £15.5m as set out in template 2, allocated to a range of services, all of which can be considered as protecting social care. Of this £0.5m has been allocated in 2015/16 specifically as a contribution to the Social Care budget reduction requirement, which will be allocated to specific services at risk in the forthcoming budget round. This adds to the use of £1.5m of the existing NHS transfer previously used in the same way. Without this contribution of £2m Social Care would need to reduce base budgets accordingly and this savings requirement would necessitate a material reduction in access to social services that would have a significant impact on health services.

A sum of £1m has been set in the BCF for the implementation of the Care Act. This is in line with the national guidelines stating the BCF should meet these costs. The Carers strategy funding of £400k within the BCF will also potentially assist with Care Act implementation.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

There is a comprehensive change management programme in place to deliver the Care Act requirements. This is managed through a project steering group chaired by the Director of Adult Social Care. The CCG is represented on this group through the Integration Programme Manager who oversees the BCF to ensure an integrated approach is taken.

For details see Care Act implementation scheme in annex 1.13.

The BCF will play a role not just in terms of funding the cost of the changes, but also in facilitating the integrated working required to deliver the agenda.

v) Please specify the level of resource that will be dedicated to carer-specific support

£1.13m (including estimate of Care Act implementation funding costs)

Within the BCF there is a specific sum of £450k in 2015/16 for rolling out the Carers Strategy (see scheme details in annex 1.10) which adds to £400k funding for Carers already in place in 14/15 from the existing NHS transfer. In addition to this £850k there is also a potentially significant element of funding within the Care Act implementation budget (to be finalised, but potentially £280k based on national estimates)

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change to the level of social care related investment in the revised submission hence the revenue budget assumptions are unchanged. However the Pay for Performance element has introduced a risk that around £1.3m of funding may be withdrawn subject to performance on emergency admissions. As set out in section 5(b) we are seeking to mitigate this by establishing a shared risk reserve which will impact on the resource position of the council, particularly if the reserve needs to be applied in the event of a performance shortfall.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Within Southwark we already have a range of services working 7 days a week to support discharge and prevent admission, including our admission avoidance service (@Home). Across the health economy, we are moving towards 7 day working, and are currently piloting improved weekend discharge support within the Supported Discharge Team, along with a pilot of a simplified discharge pathway led by SLIC, which operates 7 days a week interfacing with the @Home service and Enhanced Rapid Response.

Our local acute Trusts are also moving to 7 day working, and we will need to bring together all these plans and reach agreement on how we fund any additional costs in community based services to support these - through redistributing savings from acute bed day reductions, or making new investment across the system. The BCF is aligned to winter planning and targeted plans on 7 day working. This is aligned to the Prime Minister's Challenge Fund for which Southwark's application was successful.

Southwark CCG plans to commission extended primary care working on a 7 day basis from November 2014, which would increase the capacity of primary care to offer both planned and urgent care. Increasing accessibility of GP services is expected to reduce the demand for urgent care services elsewhere on the system, avoid pressure surges on particular days of the week, and improve continuity of care for people who have ongoing care needs. By April 2015, primary health care will be accessible from 8am to 8pm, 7 days a week.

Our Better Care Funding plans include additional investment to increase the capacity of discharge support services (admission avoidance and other social care support), as well as a contribution towards the costs of extended access to primary care.

Reflecting this strategic commitment to 7 day working, a budget of £1.5m has been set

aside in 2015/16 BCF plans specifically for delivering on this priority, supporting developments underway in specific areas. These will be seed funded from winter resilience funding where possible in 14/15 to ensure early progress is made.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is being rolled out as the primary identifier across health and social care services and good progress is being made. Agreement from all partners is in place, and the recording of NHS number in all care records is improving.

The NHS Number has always been identified as the preferred unique identifier for patients / users. All health providers use the NHS Number with excellent progress having been made to maintain data quality. The council went through a NHS number cleansing process during 2012/13 with very good results. Due to the inception of the CCG there has been a delay in re-instating this process. Plans are being developed for South London CSU to support the PDS batch processing for the councils.

Work is to be undertaken to explore and enable the Council to become PDS compliant and bought within the N3 network.

The Council is to replace its current adult and children's system. The pre-implementation phase is capturing the requirements for health and social care sharing of information (Phase 2 of the Local Unified Care Record project – see below).

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We have made progress on information sharing within the SLIC programme, including the 'Collaborator' service, which allows members of Community Multi-Disciplinary Teams to share data on case management patients in a secure way, which is compliant with information governance requirements. The next phase of our work is to develop solutions which will allow more routine data sharing. The SLIC programme are leading work to develop an Information Sharing Strategy that will enable data sharing across health and social care, working to ITK standards.

A vital challenge remains, to make key clinical information available to primary care clinicians, other care providers and ultimately patients. LUCR (Local Unified Care Record) will enable the real time sharing of clinical information between Kings Health Partners and with primary care across the boroughs of Lambeth and Southwark. It recognises the complexity of the various information needs and the technical difficulty of developing integrated systems.

The main health providers are committed to their EPR systems and developing a clinical portal (across acute, community and mental health). With only two practices not using EMIS Web this is an ideal opportunity to make the 'link'.

LUCR will allow Primary Care clinicians to view all KHP vital clinical information, including community services from within their EMIS Web.

It builds upon local IM&T strategies. It will be a portal, based on NHS numbers, follows IG, is fully auditable, ITK compliant, easily accessed from the existing partner EPRs.

The intention is to extend into Social Care in the future. With common goals of patient centric care and patient empowerment, the final stage would look to integrate into local patient / public portal.

Approved in principle, LUCR is in the early stages of pre-implementation and planning. Data Sharing agreements with all partners are being approved. LUCR aligns to the work underway with the MIG (Medical Interoperability Gateway) for the viewing of primary care records across the patch.

Each partner organisation has already committed capital funding to the project and this via SLIC (hosted by GSTT).

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Work has continued in developing an overarching Data Sharing Agreement (DSA). This has been via a Local Unified Care Record Data Sharing working group, comprising of Caldicott leads, LMC GP leads, and IG leads.

Key principles are:

- A framework to share between the organisations who are subject to the agreement (in accordance to the DPA and Caldicott principles)
- An agreement to share clinical information. The actual data set of information shared will be constrained by the system design and capability.
- A programme of communication to inform patients that in the course of their care data will be shared between clinicians with a legitimate reason to access their records
- Mechanisms to establish and record patient opt out preferences
- Appropriate system logic to exclude patient information on the basis of expressed opt out.

The patient choice not to share their record, expressed to any one or all of the partner organisations (King's, Guy's, SLAM or Primary Care), will be recorded in the partner organisation system and will exclude ALL record sharing for the patient between the partners.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Currently 3,340 adults have been identified through risk stratification as being at high risk of hospital admission, representing 1.4% of the adult population.

For risk stratification we use the HealthNumerics-RISC system which is a risk identification and stratification tool provided by United Health which identifies patients at risk of a future unplanned hospitalisation due to chronic conditions within the next 12 months. The source of data for the predictive modelling is GP data (register, activity and medications) and Secondary Care (inpatient, outpatient and A&E). The system produces monthly reports with patient level risk scorings for clinicians.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Currently, our approach to care co-ordination and accountable lead professional has been implemented for older adults and led by Primary Care. We have an integrated approach to risk stratification and identification of high risk patients in primary care. In addition to the HealthNumerics risk data, older people will be offered proactive, Holistic Health Assessments (HHAs) by their GP practice to help identify issues and risks early. People will be supported by Integrated Care Managers (ICMs) and GPs where it is deemed appropriate (adding to the support being implemented by NHSE in the national admission avoidance schemes). This care management and co-ordination will aim to ensure people are engaged in their own care and that a full range of support is made available to someone in a proactive way to improve overall wellbeing and outcomes and reduce the need for unplanned hospital admissions. ICMs and GPs will be supported by Community Multi-Disciplinary Teams (CMDTs) who will support complex care management, offer additional advice and support, help to unblock service issues and problems and ensure holistic care is being offered. These CMDT meetings are already established and supporting complex care in each locality. They consist of professionals from acute trusts, mental health, social care and community healthcare.

In 2014/15 GP practices and providers in Southwark are expecting 3324 to have had a HHA and 900 will be supported by Case Management with an Integrated Care Manager. A further 360 people will be discussed at CMDT meetings.

Our intention is to roll this model out to cover younger adults with Long Term Conditions or complex needs.

We recognise that we have further work to do to establish joint comprehensive assessment processes between health and social care and in developing the role of care coordinators or accountable lead professional across Southwark services. We will take this work forward building on what has already been done at a CMDT level to establish trust and relationships, and moving forward our work on neighbourhood level integrated care over the course of the next twelve months. One barrier to joint assessments being undertaken is joint data system and having a shared care record, which professionals

can contribute to, being addressed through the data sharing workstream.

As part of the NHSE admission avoidance over 75s will now have a named GP and where appropriate a care co-ordinator. Additionally, as part of the local integrated care programme, all over 80s, those that are over 65 and housebound or haven't seen their GP for 15 months or more, will also be offered a Holistic Health Assessment and care plan. This assessment and care plan also shows the name of the professional undertaking the work and their contact details. On top of this anyone with more complex care, if they fall outside of the NHSE framework, will be supported by an Integrated Care Manager under the local Integrated Care Programme work.

GPs are at the centre of the local and national initiatives, supported to identify, assess and manage the needs of older and more complex people. In doing so they will be offered help, tools and guidance by the CCGs, local provider organisations and the local SLIC Integrated Care Programme. There are now contracts in place for the work, activity and outcomes expected, which have been jointly agreed by all parties. These targets and expectations are reported to a Governance Board each month which contains GPs, providers and commissioners.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

27% of high risk people (900) are subject to case management with a community multi-disciplinary team.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The plan is underpinned by a vision for improving services in the community through better integrated working that has been developed over several years and shaped by a range of engagement activity.

Our integration project (SLIC), which has developed much of the thinking behind our approach has actively consulted with the public through its Citizen's Forum over the past 18 months. For example, Southwark and Lambeth commissioners, working with the SLIC team, held an engagement event with residents on the 28th January to identify what people wanted as outcomes from integration and to help us articulate those outcomes from a resident's perspective. This work supports our vision document, but will also help us as we work to further develop our local outcome measures for integrated care. This event included over 50 participants, including Healthwatch and the representatives of other engagement groups linked to the CCG and LA. The selection of our local metric (people feeling supported to manage their long term conditions) was informed by this engagement event.

Healthwatch have been closely involved through the various BCF and integration discussions at HWB, HWB workshops and CCG Boards and other events. The Director of Adult Care recently addressed a Healthwatch event on social services and integration plans.

There will be further engagement activity as detailed implementation plans for 2015/16 are developed.

The BCF has been discussed at the Older People's Partnership Board which includes strong user and voluntary sector representation, and the re-submission will be further discussed at its meeting on 24th September.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Our local acute trusts are key members of the Southwark and Lambeth Integrated Care (SLIC) programme and have been closely involved in producing and delivering the integrated care strategy to date, as well being involved in delivering some of the new integrated service models, for instance the admission avoidance programme. A workshop on integration was held in November 2013 including representatives of our main health providers, which helped us establish the vision and narrative for integration

which underpins our plans for the Better Care Fund (BCF).

Representatives of our main health providers were invited to the HWB seminar in February which agreed the vision for integration and priorities for investment from the fund.

Our detailed proposals for integration in Southwark, including the schemes to be funded from the BCF, have been shared and discussed with acute providers in a number of fora including; the Health and Well Being Board integration and BCF workshop on the 6th February, SLIC meetings and a Southwark and Lambeth joint planning meeting which includes CCG and Local Authority commissioners as well as representatives from our local providers (GST, KCH and SLAM).

Assumptions about acute activity reductions resulting from integrated care are also being agreed as part of the contracting round for 2014/2015. These reductions underpin Southwark CCG's overall acute QIPP requirements and have been shared with providers, both in the CCG's commissioning intentions and in more specific contractual negotiations.

Service providers have also been active participants in a number of change programmes and consultations that together help form our local integration programme. For instance, Social Care providers have been involved in My Home Life and other quality initiatives that form part of this wider plan, including the development of the re-ablement service model and home care redesign.

There will be further engagement activity as detailed implementation plans for 2015/16 are developed.

Our commissioning intentions document highlights the impact of BCF.

The provider commentary in **Annex 2** shows that King's College Hospital and Guy's and St Thomas' Hospital agree to the emergency admissions reductions targeted by the BCF plan.

ii) primary care providers

As per acute providers as set out above, our primary care providers are CCG council members and key members of the SLIC programme which has shaped our approach to integration which has shaped the BCF.

See also 6(c) on alignment with primary care plans.

iii) social care and providers from the voluntary and community sector

Social Care has been closely involved in the BCF preparations and the wider integration agenda from the outset. The SLIC Sponsor Board includes the Strategic Director of Children's and Adults services. The SLIC Operations Board is jointly chaired by the Director of Adult Care and there is a provider group workstream which includes the Director of Adult Care representing social care from the provider perspective.

Community Action Southwark, representing the voluntary sector, are represented on the Health and Wellbeing Board and have been involved in the development of the BCF as a result. Partnership Boards all include voluntary sector representation and integration is frequently on the agenda. The Older People's Partnership Board received a report on the April submission and are due to received an update on the re-submission on the 25th September.

We have engaged with providers and the community sector in a focussed way on specific BCF themes, for example a detailed consultation on the carers strategy, home care quality etc, and will continue to do so as plans are implemented.

In Southwark there is an Early Action commission looking at the role of the voluntary sector in the prevention and care agenda. This will include the services funded from the £910k BCF budget for community support services delivered by the voluntary sector for info and advice/befriending services and how we need to ensure these fully contribute to the overall outcomes for the BCF.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The impact of our plan on NHS services will mean:

1. Expanded community based admission avoidance and discharge support services, preventing emergency admissions and reducing length of stay
2. Support for 7 day working from integrated social care and community services, which will enable more efficient discharge processes and shorter hospital stays
3. Extended access to primary care, 7 days a week, supporting improved health outcomes for local people and reduced reliance on urgent care services/A&E
4. More support to keep people living independently in their own homes, including self management support, telecare, increased community mental health services and better quality home care

Savings will be realised in acute hospital services, largely at Kings College Hospital and Guys and St Thomas NHS Foundation Trusts. Savings will come, primarily from

reductions in emergency admissions and readmissions and shorter length of stays, as well as lower A&E attendances and reduced elective cancelations. The details of these savings are being agreed with providers both as part of our contractual negotiations and QIPP plans, but also through the SLIC programme, in terms of agreeing financial shifts across the health economy to support integrated care.

It should be noted that Southwark and Lambeth's main acute providers, Guys and St Thomas NHS Foundation Trust, and Kings College Hospital NHS Foundation Trust, are tertiary providers covering a large geographical catchment area, and the proportion of their work relating to the two boroughs is less than 50%. Although Southwark is an important local referrer and partner to the two hospitals in the integration programme, the impact on our providers of changes to local demand is not as significant as it would be for district general type hospitals.

Within our local acute providers, capacity will be rebalanced to reflect the reduced use of emergency services by Southwark people. This will be through a combination of increasing the amount of tertiary work undertaken, through specialised services growth and consolidation, as well as bed reductions in some acute medical and older people's wards. This rebalancing of capacity will be agreed and tracked through the SLIC programme.

There are two key risks for acute providers:

1) That the bed savings do not materialise, in which case there would be a cost pressure within the local health economy. We are seeking to mitigate this in a number of ways:

- Proactively taking acute capacity out of service as the new integrated capacity is developed, or redeploying capacity in the community
- Performance managing the integration programme to deliver agreed benefits, and holding partners in the system to account through the SLIC structures
- Entering into risk management agreements between commissioners and providers
- Evaluating the impact of the overall integration and admission avoidance programme, and amending components of the programme where there is shown to be low impact or less value for money

2) That the programme does release acute capacity, but this is not taken up by more profitable specialised activity. In this case there would need to be rationalisation of total acute capacity and reductions in fixed costs to create efficiencies.

The impact on service delivery targets if savings and activity reductions do not materialise would include pressures on emergency capacity, leading to pressures on A&E performance and possibly also referral to treatment times for elective work. However, the comment re the proportion of our FTs' activity which relates to Southwark patients means that this impact is diluted by other demand and volume of activity from other commissioners, including other boroughs and NHS England specialist work

In **Annex 2** there is a copy of the signed agreement from King's College Hospital and Guy's and St Thomas' Hospital to the emergency admissions reductions targeted by the BCF plan.

ANNEX 1.1 Detailed Scheme Description - scheme 1 - Existing NHS transfers:

Scheme ref no.

1

Scheme name

Existing NHS transfers: range of social care services that support health. Includes protection of adult social care services that have a health benefit. To be reviewed over 2014/15 along with other existing schemes to ensure best integrated approach

What is the strategic objective of this scheme?

This scheme covers a range of services currently funded by historic NHS transfers which were all invested with the aim of protecting social care services of benefit to health - with a particular focus on discharge support, intermediate care, carer support, maintaining eligibility, reablement, mental health, community equipment and telecare. The overarching objective is to help ensure that people are supported to live safely at home, preventing admission to hospital or care homes, and if admitted are well supported following discharge from hospital, avoiding re-admission to hospital.

As these resources are pooled in the Better Care Fund in 2015/16 there is an opportunity to review and rationalise these services during 2014/15 guided by the overarching objectives of the Better Care Fund and the local vision for integration.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The current services funded in this way are as follows:

Service	**Cost**
1. Hospital Discharge Teams North and South – contribution to core costs	£1,200,000
2. Re-ablement – contribution in addition to re-ablement grant	£300,000
3. Carers – contribution to overall costs of Carers services	£400,000
4. Intermediate Care - Home Care Package costs – contribution to costs	£900,000
5. Mental Health – personal budgets for CMHT clients	£600,000
6. Learning Disabilities – contribution to home care / personal budgets costs	£211,000
7. Community equipment – ICES	£400,000
8. Telecare – contribution to cost	£100,000
9. Protect Adult Social Care – contribution to budget reduction target enabling services to be protected and eligibility maintained	£1,510,610
Total (per BCF plan)	**£5,621,000**

1.1 Hospital Discharge Teams – contribution to core costs - £1.2m

The 2 Hospital Discharge Teams, based at King's College and St. Thomas hospitals, offer a vital frontline service facilitating safe discharge for residents who are eligible for social care and are inpatients within a hospital ward. They provide multidisciplinary assessment screenings for adults requiring support on discharge from hospital including ICT, Re-ablement and Care home placements, CHC and advice and information regarding universal and voluntary sector services and undertake safeguarding alerts and investigations.

As well as ensuring continued low rates of delayed discharge the service plays a key role in reducing emergency re-admissions by supporting safe discharge processes, and reducing the need for care home placements.

1.2 Re-ablement: £0.3m

This is a further contribution to the total cost of re-ablement alongside the main re-ablement grant – see scheme 3 for details.

1.3 Carers services: £0.4m

A contribution to cost of carers services (respite breaks etc) which will be used to take forward the Carers Strategy alongside new investment in 2015/16 from the BCF (see scheme 10 and 13).

1.4 Intermediate Care - Home Care Packages – contribution to costs £0.9m

This is the cost of care packages commissioned via the Intermediate Care service.

1.5 Mental Health personal budgets for CMHT clients £0.6m

Personal budgets for community mental health team service users on CPA to obtain tailored support services to help them live safely and independently at home. May be used to obtain diverse range of support including personal assistants, peer support, day activities as well as traditional services such as home care. Approach being developed alongside Personal Budgets for health – national pilot site.

1.6 Learning Disabilities home care £0.211m

Contribution to funding support for people with learning disabilities via personal budgets to enable them to live safely at home and avoid admissions.

1.7 ICES: £0.4m

Contribution to funding of ICES contract providing equipment that helps people live safely at home etc. e.g. wheel chairs. Essential service for supporting hospital discharge.

1.8 Telecare: £0.1m

Contribution to cost of alarms scheme and specialist equipment such as sensors to enable people to live safely at home. Will be expanding in 2015/16 so that more partners agencies can access the service directly (see scheme 9 for new telecare investment).

1.9 Protect Adult Social Care – maintaining eligibility - £1.5m

Contribution to previous year's budget reduction target enabling services to be protected and eligibility maintained.

The way these current services will work in a more integrated model under the Better Care Fund is being developed as part of the SLIC programme. The guiding principles behind the model are:

- Integrated discharge support, re-ablement, intermediate care, joined up with admissions avoidance and enhanced rapid response service model.
- Integrated multi-disciplinary teams organised on a neighbourhood basis assessing need and accessing the services funded in pooled budgets, including case management and care co-ordination
- Personalised assessment and support planning process to deliver individual outcomes
- Whole system outcomes improved including BCF and wider measures
- Enhanced support to carers in line with Southwark's Carers Strategy

The main cohorts being targeted are a) vulnerable older people and people with disabilities and/or long term conditions discharged from hospital or at risk of admission. b) carers, c) all people eligible for social care services d) people with mental health issues.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The local authority employs staff in the provision of social work and other services, or commissions providers of community based support including re-ablement/ ICT home care, carers support and ICES/ telecare services. A number of services are delivered by personal budgets in which the service user exercises choice and control over the provider delivering the support plan, including personal assistants and home carers.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National evidence of effectiveness of social services in following areas, as well as existing performance data on current services for:

- Hospital discharge
- Re-ablement and Intermediate Care
- Carers
- Mental health and learning disability personal budgets
- Community equipment
- Telecare
- Maintaining eligibility criteria

These services are in place and delivering outcomes at present, for example strong

delayed transfers perfromance. By taking a more integrated approach to these services through the BCF it is anticipated that effectiveness can be increased in line with national evidence.
Investment requirements £5.621m (see above) Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
These schemes play a key role in driving good performance on non-elective acute admissions and re-admissions, delayed transfers of care, enhancing effectiveness of reablement/ICT, promoting independence and quality of life of people eligible for social services, improving user feedback and preventing people needing more intensive services. For example: Delayed discharges are currently a strong area of performance, with a firm top quartile position. Care home admissions are declining in line with targets in 14/15. Growing numbers receiving intermediate care or re-ablement upon discharge from hospital (105 in August), and measures of effectiveness are improving in terms of people staying at home for longer. See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The Adult Social Care performance framework provides range of information on outcomes from services, including activity and performance, which will be drawn into the BCF monitoring reports. CCG emergency admissions and re-admissions monitoring reports will be used in the BCF reporting.
What are the key success factors for implementation of this scheme?
Current schemes already implemented. Review of schemes as part of wider BCF to be completed to further integrate and rationalise approach in line with overall vision, in particular by developing simplified discharge and multi-disciplinary working at the neighbourhood level.

ANNEX 1.2 – Detailed Scheme Description: Winter pressures grant funded services

Scheme ref no.

2

Scheme name

Winter pressures grant funded services: additional social work input to support discharge & admissions avoidance: mental health re-ablement, enhanced rapid response, care home support, OT, re-ablement 7 day working, & Nightowls overnight care. Previously funded from Winter Pressures funding.

What is the strategic objective of this scheme?

To relieve the pressure on the acute sector through provision of additional discharge support social services and management support, intermediate care, mental health re-ablement, enhanced brokerage support and 7 day working for intermediate care. The largest area of expenditure is on the Night Owl service which provides intensive over-night home care support to prevent the need for hospital or care home admission.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The schemes under this heading were funded from Winter Pressures funding that ceased in 2012/13, then funded in 2013/14 from reserves. These are now being funded from the Better Care Fund as a long term source of funding.

Service area – Winter Pressures	£
2.1 Mental Health Re-ablement (team 1)	£151,632
2.2a Hospital Discharge (team 2)	£187,336
2.2 b Broker to support hospital discharge	£53,117
2.3 Enhanced Rapid Response (team 3)	£230,606
2.4a Supported Discharge (team 4)	£186,450
2.4b Supported Discharge – intermediate care weekend working	£51,113
2.5 Night Owl Service	£322,453
2.6 Age UK Foot and Nail Care Services (Happy Feet)	£10,000
2.7 Consultancy support – system redesign	£12,947
Total	**£1,192,707**

(Adjusted for contribution from reserves = £1,048,000)

2.1 Mental Health Re-ablement (team 1) : £151,632

One team manager and 3 social workers supporting the mental health re-ablement function, restoring people's independence with short term rehabilitative services (link to scheme 1.7). There were 224 clients 13/14 completing re-ablement (13 week rehab service). Good evidence of effectiveness. (see also scheme 1.7)

2.2a Hospital Discharge (team 2): £187,336

Additional social work and management capacity to support the KCH and St Thomas's

hospital discharge teams. Consisting of 1 team manager and 3 social workers. Objective to support the 2 hospital team managers to focus on designated priorities including the development of integrated working.

2.2b Broker to support hospital discharge: £53,117

Expansion of the brokerage service with dedicated capacity to provide priority and speedier response to hospital discharge requirements (packages and placements).

2.3 Team 3 – Enhanced Rapid Response - £230,606

Social work contribution to enhanced rapid response service - **see scheme 11**

2.4a Supported Discharge – team 4: £186,450

The team works with clients in their home to improve their functioning and mobility to support them remaining in the community, reduce hospital admissions and reduce dependence upon long term care. Supported Discharge supported 572 users in 2013/14 at home. Of this, 88% in 2013/14 were at home 91days after discharge. 75% of users on 2013/14 finished their time on the scheme with less or nil ongoing care services.

2.4b Supported Discharge – intermediate care weekend working: £51,113

Support the discharge home from hospital clients on the weekend who have already been assessed and agreed for weekend discharge. Part of wider 7 day working investment (see scheme 18).

2.5 Night Owl Service: £322,453

The night owl service is delivered through two pairs of mobile night-time homecare workers working across Southwark from 22:00 to 07:00, seven nights per week 365 nights of the year. Scheme expanded following successful pilot in 2013, viewed as contributing effectively to admissions avoidance (hospital and care home).

2.6 Age UK Foot and Nail Care Services (Happy Feet) : £10,000

Toe-nail cutting service for older people providing home and clinic appointments in order to maintain mobility and reduce falls to avoid acute and more costly interventions. Reduces pressure on formal Podiatry services. Approx 850 toe nails cutting appointments annually

2.7 Change management support – £12,947

Following up on discharge consultancy work, focus on continuing care.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The local authority employs staff in the provision of social work and other services for the assessment and care management process to access services, and commissions direct providers of community based support.

The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
These services are in place and delivering outcomes at present. By taking a more integrated approach to these services through the BCF it is anticipated that effectiveness can be increased in line with national evidence. The Mental health re-ablement team is an innovative model with strong indications of good outcomes. The Night Owl services is established and considered locally to be a useful resource for admission avoidance. Demand for the service has led to an increase in volume.
Investment requirements : £1.048m Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
These schemes play a key role in driving good performance on delayed transfers of care, non-elective acute admissions and re-admissions, enhancing effectiveness of reablement/ICT, promoting independence and quality of life of people eligible for social services, improving user feedback and preventing people needing more intensive services. For example: Delayed discharges are currently a strong area of performance, with a firm top quartile position. Care home admissions are declining in line with targets in 14/15. The schemes also make a contribution to 7 days working, e.g. Intermediate Care scheme 2.4. See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Adult Social Care Performance framework provides range of information on outcomes from services. Emergency admissions monitoring. Night owl contract monitoring.
What are the key success factors for implementation of this scheme?
Current schemes already implemented. Review of schemes as part of wider BCF to be completed to further integrate and rationalise approach in line with overall vision, in particular by developing simplified discharge and multi-disciplinary working at the neighbourhood level.

ANNEX 1.3 – Detailed Scheme Description - Re-ablement

Scheme ref no.
3.
Scheme name
Re-ablement: grant rolled forward, services to be reviewed and further integrated with discharge support, admissions avoidance and enhanced rapid response. Used to expand reablement in line with council plan targets.
What is the strategic objective of this scheme?
To support people to regain their independence and minimise their long term care needs.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Re-ablement team work to support an individual to regain skills, confidence and independence, often following a specific period of illness or injury and hospital admission. It is a key service for supporting safe discharge from hospital and preventing admissions or re-admissions to hospital of people at risk, and reducing the need to use care homes. The services is provided as a short-term, intensive alternative in the persons home, usually for up to 6 weeks (although can be less, dependent on goals achieved or appropriateness to the service). The team can provide short term care and support or assistive equipment to increase independence/safety with activities of daily living, transfers, and improving confidence. The team receive referrals from the community support teams as well as hospital discharge services. The model of care of care is well established nationally and expanding re-ablement services is a key strategy nationally and locally to improve outcomes for people with care needs. Following re-ablement an assessment of long term care needs is made. If there are eligible long term needs these are subject to a support planning process and personal budget allocation, enabling people to exercise choice and control over the long term services they receive. The Occupational Therapists and Social Care workers within the team assess the users at home, and set goals to improve their independence and functioning, and draw up a package of care including input from specialist reablement homecare providers. The current provider BS Homecare is co-located with the team to enhance effective communications. The Southwark Re-ablement Team consists of 9 Social Workers, 6 Occupational Therapists, and 3 Assistant Practitioners.

The service is also the default assessment service for Southwark, and combined with the Supported Discharge Team facilitates 70% of all discharge from hospital.

In 2013-2014 Southwark Re-ablement supported approximately 1200 Southwark residents. Of these, approximately 89% of the hospital discharges have been supported to remain at home 91days after discharge into re-ablement.

69% of people receiving Re-ablement exit the service with a lower or zero care package.

Prior to the full commencement of the Better Care Fund there will be a review of how best to deliver re-ablement services in a way that is more integrated in line with the development of the overall integrated service model. Integration with related services such as Intermediate Care and Enhanced Rapid Response, and linkages with the neighbourhood multi disciplinary team approach will be considered. Taking into account the SLIC projects, Neighbourhood model and Integration Agenda – we will be looking at ways that the Re-ablement service (with Supported Discharge) could support discharges from hospital sooner, and provide additional support to higher acuity patients.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Adult Social Care services are responsible for providing the re-ablement service. The social work and OT assessment and care management input is provided by directly employed social workers whilst specialist independent reablement home care providers are commissioned by the local authority. In addition to the existing key provider (BS Homecare) there is an ongoing procurement process for the Re-ablement/Intermediate Care/Neuro Rehab services to appoint 2 new providers in 2015.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is a growing national and local evidence base for the effectiveness of re-ablement services. The local model of services is in line with best practice approaches as set out, for example, in Social Care Institute for Excellence research and guidance on re-ablement. Further refinements to the model will be made on an ongoing basis.

http://www.scie.org.uk/publications/guides/guide49/

Investment requirements £1.8m (from re-ablement grant)
Note: the re-ablement grant is supplemented by £0.3m of the s256 funding in scheme 1.

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The re-ablement service is anticipated to have a major impact contributing to the system

wide targets to reduce delayed transfers of care, reduce care home admissions and reduce hospital admissions and re-admissions. There are specific targets on re-ablement effectiveness in the BCF which the service is directly responsible for. In 2013-2014 Southwark Reablement supported approximately 1200 Southwark residents (1800 total Reablement/ICT). Approximately 89% of the hospital discharges into re-ablement have been supported to remain at home 91days after discharge. 69% of people receiving Re-ablement exit the service with a lower or zero care package. See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
There is an established performance monitoring scorecard for the re-ablement service which highlights activity in term of referrals, service users, duration, completions and outcomes. This will feed into BCF monitoring.
What are the key success factors for implementation of this scheme?
The scheme is operating successfully. Continued success will be dependent on maintaining assessment capacity and provider capacity to meet demand from referrals in a timely way, and developing services in a more integrated way in line with the integration programme.

ANNEX 1.4 – Detailed Scheme Description – service development

Scheme ref no.
4
Scheme name
Service development: Change management capacity. (2014/15 and 2015/16)
What is the strategic objective of this scheme?
To ensure programme management resources support the delivery of the BCF.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The CCG is to recruit programme management support to help deliver the Better Care Fund plan. The employee will be employed and line managed within the CCG but jointly accountable to the Director of Social Care. Key workplan goals to be agreed by Director of Service Redesign of CCG, and Director of Adult Care of the Council. The role includes making an effective link between the BCF and the wider integration agenda.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The CCG will establish, recruit to and manage a new senior post "Programme Manager – Integration and Better Care Fund". The budget includes an element for related costs.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
n/a – enabler for BCF implementation
Investment requirements £100k Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
This change management capacity is an essential enabler for the programme of schemes and its associated benefits.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Through the line management process monitoring against workplan goals will be undertaken. A brief quarterly report on progress against the planned goals to be provided by the programme manager and any issues regarding the effectiveness of the role can be discussed between the CCG and council if any concerns are raised.
What are the key success factors for implementation of this scheme?
Successful recruitment of programme manager and ongoing management support from partners to enable the role to be effective.

ANNEX 1.5 – Detailed Scheme Description – Self-management

Scheme ref no.
5
Scheme name
Self-Management Support
What is the strategic objective of this scheme?
To enable Southwark residents with long term health conditions to keep themselves well and increase their levels of independence.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
For Southwark residents living with long term health conditions contacts with health and social care services make up only a very small proportion of their daily life. The larger part is spent managing their condition(s), drawing on their own resources and those available in the wider community. **2014/15 (£107,000)** Funding focuses predominantly on commissioning self-management support to ensure that patients in Southwark living with a long term condition(s) have the knowledge, skills and confidence to manage their condition effectively in the context of their everyday life. Projects include: • **Face to face generic & Carer Self-Management Courses** Lay led self-management courses help anyone living with any long-term condition to learn new skills to better manage their condition. Courses will also be adapted for adults who care for someone with a long term condition, and for people living with, or in recovery from, a mental health condition. 13 courses to be delivered in 14/15 (8 generic course, 3 adapted mental health courses, 2 carers courses) • **Online Self-Management Course** Pilot an internet based self-management programme for people with long term conditions in Southwark. This will provide choice to patients to either attend a face to face programme or an online course. • **Living with Diabetes Self-Management Course** 6 week programme which enables people living with diabetes to develop and improve their skills and knowledge to manage their own health. (4 courses to be delivered in 14/15, each course 6 weeks with capacity of 15 places per course). • **Printing of Diabetic Self-management Pack** Self-management pack was developed by the Diabetes Modernisation Initiative (DMI) and co-produced by local diabetes teams and patient groups. The initiative aims to give everyone living with diabetes in Southwark information about what care they need and how to access it locally. 12,000 packs to be printed in 14/15 and distributed to GP practices via the Diabetes Community Service.

- **COPD Patient Passports**
  The passport empowers patients them to engage in self-care interventions that can release value. The British Lung Foundation promotes use of the passport to support self-care. 4,000 to be printed in 14/15 and distributed to practices to provide to patients on the COPD register.

- **Inhaled Corticosteroid Safety (ICS) Information**
  Developed by the London Respiratory Team and aims to enhance the ability of patients with respiratory conditions to manage their intake of Inhaled corticosteroid agents. 5,000 cards to be distributed to GP practices to provide to patients on inhalers.

2015/16 (£307,000)
2015/16 funding will be used to continue to fund the self-management courses where evaluation has shown demand for the service and effectiveness. Additionally, gaps in self-management provision, for example, support for COPD patients in early stages of their disease will be the focus of funding. The second year of funding would build on this by taking a community asset based approach to support individuals to feel more confident and motivated to manage their condition(s). Community and self-help groups can often provide the type of support required by people with long term conditions. Examples include cookery classes to help those struggling to eat a healthy diet, gardening projects to encourage physical exercise, volunteering befriending schemes to combat social isolation and loneliness, peer-led self-help groups and locality/neighbourhood community champions.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Integrated Commissioning Directorate of Southwark CCG will lead on commissioning.

The face to face self-management courses (generic/carers/mental health) will be delivered by Self-Management UK. The pilot online course will be delivered by Self-Management UK. Living with Diabetes is provided by Guys and St Thomas's Community Services (GSTT)

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base for the face to face self-management programmes, including courses commissioned from Self-Management UK and GSTT comes from the national evaluation of the Expert Patient Programme which showed that self-management courses significantly improve the quality of life for people on the course and that an average cost saving of around £1800 per person is achieved.

The evidence base for running an internet based self-management programme for people with long term conditions in Southwark comes from the evaluation of an online self-management programme (EPP online) for England residents with long term conditions (Lorig et al, 2008). The study found that the peer-led online programme appears to decrease symptom, improve health behaviours, self-efficacy and satisfaction

with the healthcare system and reduce health care utilisation up to 1 year post intervention.
Investment requirements: £107k in 14/15, £307k in 15/16 Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Reduction in emergency department visits and admission avoidance due to improved health behaviours and increase in confidence to manage own condition(s) appropriately. • More appropriate healthcare utilisation • Decreases in symptoms and improvements in health related behaviour • Increase in patients confidence, skill and knowledge to manage their condition • Increase in satisfaction with health care services • Improved quality of life See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Self-Management courses commissioned from Self-Management UK will be reported on using the HeiQ (Health Education Impact Questionnaire). The HeiQ is the name of a questionnaire that is handed out to participants before they start a course, and again once they have completed a course. The data collected then allows for a comprehensive evaluation to be produced and reported on. The following areas will be reported on: • Positive and active engagement in life • Health directed behaviour • Emotional well-being • Self-monitoring and insight • Constructive attitudes and approaches • Skill and technique acquisition • Social integration and support • Health service navigation Both patient reported satisfaction and patient reported outcomes, i.e how support patient feels in managing their condition and/or how confident a patient feels in managing their condition, will be collected for the Living with Diabetes service.
What are the key success factors for implementation of this scheme?
GPs signposting patients to the self-management programmes available. Action required to ensure that health care professionals and practice managers are aware of the service and are committed to directing patients to self-refer to the programmes. Ensure that referral processes are accessible and simple for patients to navigate.

ANNEX 1.6 – Detailed Scheme Description – home care quality

Scheme ref no.
1.6
Scheme name
Home Care Quality Improvement - Transforming home care into a new integrated community support offer: improving quality and effectiveness of home care, with links to clinical and medical support – ensuring a strong local community offer, tailored to the overall health and social care needs of individuals.
What is the strategic objective of this scheme?
To improve the quality and effectiveness of homecare services by investing in the workforce and improved levels of provision that will better enable people to live safely and healthily at home.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Southwark Council and NHS Southwark CCG will commission an integrated community support service from July 2015. This service will supersede the current homecare approach. The service will provide high quality care and support for those with a care need. The service will also be able to draw on clinical and health expertise to meet whole-person health and care needs, support a reduction in hospital and care home admissions and support independent living for those in receipt of the service. **Model of care and support** Southwark integrated community support (ICS) will be commissioned on the basis of the following strategic commissioning principles. The commissioning strategy principles are set out within the partnership framework of the Southwark Health and Wellbeing Board's *Better Care, Better Quality of Life* vision for the integration of health and social care services. More care in people's homes and in their local neighbourhoods • The ICS will be commissioned on a *neighbourhood basis*, enabling care and other support workers to be better linked into the communities in which they work. Person-centred care, organised in collaboration with the individual and their carers • The ICS will place *those who are in receipt of care at the heart of the commissioning and procurement process* – helping to shape and design the service that they will receive, and to assess its effectiveness in meeting individual needs Better experience of care for people and their carers • The ICS will have *safety as its core*, ensuring at all times that a high quality service is commissioned that provides continuity of care and helps people to stay safe from

harm.

- The ICS will be underpinned by the *Southwark ethical care charter*.

Population based care that is pro-active and preventative, rather than reactive

- The ICS will be a core part of, and link with, *wider community based support*, that combats social isolation and promotes community engagement

Better value care and support at home, with less reliance on care homes and hospital based care

- The ICS will support and *further enable the shift in the balance of care* in Southwark from residential settings to community based support and independent living.

Less duplication and 'hand-offs' and a more efficient system overall

- The ICS will ensure there are *links across to other services* and expertise, including primary care, reablement and intermediate care. In doing this the service will avoid a situation where those in receipt of care can have multiple visits from different organisations from across the health and social care system.
- The ICS will connect and collaborate with *community health services*, linking with the local health neighbourhood model.

Improvements to key outcomes for people's health and wellbeing

- The ICS be focused and monitored on the *basis of real outcomes* of those who receive care, with wellbeing as well as health and care outcomes at its core. This will help ensure that people leading fulfilled lives, connected to their own communities, and not prohibited from leading independent lives, is a key part of the service.
- The ICS will be commissioned on a *long-term basis, creating a strategic relationship* with the future service providers. It will provide greater certainty to those who receive care - whilst, at all times, ensuring providers are held to account, and share the risk, of any contracting issues.
- The ICS will also embed the following cross-cutting issues, that is support of stronger, more resilient communities and Southwark as a great place to live and work at the heart of the service.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The current homecare service is commissioned by Southwark Council. The two core contracted providers of this service are LondonCare and MiHomecare.

The ICS will be commissioned by Southwark Council, with input and support by NHS Southwark CCG.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Council and CCG in Southwark have drawn on local social care and health demographic, performance and other information, including the statistical and technical work on the opportunities from integration in this area led by the Southwark and Lambeth Integrated Care (SLIC) pilot. Feedback from those in receipt of services has also consistently expressed a desire that the support and care that they require should be based in their own homes and communities. All of this work, setting out the scale of joint health and social care need in the community, underlies the model that has been developed. User satisfaction with home care as reflected in the national user survey is lower in Southwark than comparable London boroughs, which adds support to the view that home care quality is a key issue in Southwark.
Investment requirements £1.9m Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Improved quality and effectiveness of homecare in the context of an integrated approach to community support is expected is expected to have an impact on the full range of Adult Social Care Outcomes Framework measures as well as health measures such as A&E attendance and emergency admissions and re-admissions. In particular, positive benefits are anticipated in user satisfaction with services, and other user reported outcomes from the social care user survey and GP survey. Improved support to help people live independently at home will help achieve the objective of preventing, reducing and delaying the need for more intensive care and support and promote a personalised approach. See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The council's performance data, including user survey results, will enable key outcomes to be monitored. Southwark Councils' contract monitoring team will measure key metrics, including both health and social care outcomes. Individual service user reviews will enable the council to monitor the extent to which services are helping them deliver their support plan objectives.
What are the key success factors for implementation of this scheme?
It is recognised that to increase the quality of current home care services more needs to be invested in the workforce, including tackling basic issues like building in and being paid for travel time, sickness pay, training and living wages - as well as allowing for more intensive homecare packages where necessary. This is a potentially large investment at a time when resources are reducing. The contribution from the BCF is therefore crucial, as will be identification of council resources in the budget process.

ANNEX 1.7a (14/15) – Detailed Scheme Description – mental health (psychiatric liaison)

Scheme ref no.
7. (2014/15)
Scheme name
Psychiatric Liaison : Reablement expansion in acute and mental health inpatient services
What is the strategic objective of this scheme?
Integrated reablement care pathway across acute and mental health inpatient services to facilitate earlier discharge and redirecting demand from urgent and unplanned care to community based services improving service user experience of the care and support they receive and to facilitate and maintain recovery and independence.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Currently a community based reablement service is offered to mental health service users following an episode of severe ill health or hospital admissions to regain skills which enable recovery and staying well. The programme is currently offered at the point of discharge, however the new model will extend this into acute and inpatients services to begin reablement earlier and increase the number of people offered reablement as part of their recovery plan. The service will be specifically aimed at those individuals who may otherwise require residential care or supported accommodation in order to be discharged from hospital. The scheme will provide the foundations for further enhancement of the reablement model across specialist mental and physical health services as part of the 15/16 BCF programme. The remainder of the 14/15 year will be spent integrating the model into existing services, developing processes and working with health professionals to include reablement as part of individuals recovery plans in preparation for 15/16 services becoming available.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Local Authority will be accountable for the implementation and delivery of the scheme working in partnership with SLaM (our mental health trust) and the acute trusts to ensure effective implementation and integration of the resource.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes

The independent evaluation of the reablement service shows a positive impact on the reduction of clients' needs as a result of the intervention with significant improvement in six of the outcome domains which are measured. Financial cost of care immediately after reablement decreases from an average of £104,378 to £61,997 with 65% of service users no longer FACS eligible following the intervention. Additionally, clients satisfaction is mostly positive with clients reporting they are happy about the care and support they received.

Proactive promotion and active consultation with health professionals has had a positive effect on identifying appropriate individuals to benefit from reablement with referrals increasing as a result of this approach. Service development reviews have also identified an opportunity to start reablement earlier to discharge people from hospital sooner. Integrating a reablement worker into hospital based inpatient services will further support increase in referrals and access to the service with support starting earlier to reduce delay in the transfer of care and support.

Investment requirements £54k 2014/15 (2 reablement workers from September, seed funding £300k 2015/16 proposals)
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Increase in number of people referred to reablement service
- Reduction in levels of need
- Reduced transfer of care
- Improved patient experience of the care and support they receive
- Reduction in Occupied Bed Days
- Reduced re-admissions to hospital and care homes.
-

See annex 1.20 on contribution to non-elective admissions target

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Service user outcome data will be used to understand the impact of the service
Existing data mechanisms will identify the numbers and length of delayed discharge and reduction in OBDs.

On-going service evaluation and development with health and social care staff and service users to identify further opportunities or barriers to integrated mental health and social care

What are the key success factors for implementation of this scheme?

- Effective partnership working
- Clear understanding of the Social Care roles
- Clear reporting and supervision line for Social Care practitioners
- Recruitment of high quality staff able to work flexibly and in partnership with other professionals

ANNEX 1.7b (15/16) – Detailed Scheme Description – mental health (psychiatric liaison)

Scheme ref no.
1.7b (2015/16)
Scheme name
Psychiatric Liaison: Integrated AMHP/SC professionals in psychiatric liaison and crisis care pathway
What is the strategic objective of this scheme?
Integration of social care expertise within the mental health crisis care pathway (Home Treatment Team and Psychiatric Liaison) to reduce unplanned admissions and facilitate earlier discharge reducing reliance on hospital based services. Enhancing the in ward mental health liaison across acute inpatient wards supports parity of esteem through integrating physical and mental health which is further strengthened by social care input delivering stronger person centred approach to care and support and improving people's experience of the care and support they receive.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrate 6 AMHP/SC professionals across the Home Treatment Team and Psychiatric Liaison Service Currently, the Psychiatric Liaison service gate keeps all mental health hospital admissions through responsive assessment, care planning and diversion offered 24/7 in A&E and during core hours for inward liaison across acute and mental health inpatient services.4439 referrals were accepted by the Psychiatric Liaison Team during 13/14 with 92% from A&E. Wherever possible the service diverts people away from hospital based services and facilitates earlier discharge through engagement with community based services for example the Home Treatment Team (HTT) which provides specialist community based intervention for people in acute mental distress reducing the demand on urgent and unplanned hospital based care. The Home Treatment Team provided 774 episodes of care during 13/14. Further investment to the Psychiatric Liaison Service will support the delivery of the evidence based RAID model (Rapid Assessment, Intervention and Diversion) across urgent care and inpatient services. The inclusion of social care professionals, funded via BCF monies will support the delivery of more holistic, single assessments and discharge planning in A&E and increased in reach capacity across acute hospitals and inpatients. In addition a specific reablement worker (funded through the 14/15 investment) integrated into inpatient services will begin reablement during inpatient stay supporting smoother transition and earlier impact of the intervention. Integrating AMHP/SC professionals into psychiatric liaison and Home Treatment Team

will expand the current health focused model to include a multidisciplinary approach to assessment, care and support planning for people in mental health crisis. Furthermore, SC professionals will provide care coordination for service users with significant social care needs ensuring appropriate Recovery and Support Planning across health and care pathways. Specifically the service will continue to focus on people at risk of crisis or in crisis reducing escalation of need wherever possible.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Local Authority will be accountable for the implementation and delivery of the scheme working in partnership with SLaM and the Acute Trusts to ensure effective implementation and integration of the resource.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The integrated approach is directly in line with the principles of the Mental Health Crisis Concordat to provide early intervention to reduce the likelihood of crisis, sufficient and high quality response for when someone is in crisis and services to support people to recover and stay well. The concordat recognises the high correlation between poor mental health and broader social factors for example family and relationships, housing and living environment, education and employment status and therefore encourages a systemic approach to ensuring not only the presenting behaviour but the underlying issues impacting on people's poor health are identified and addressed resulting in more people recovering and stay well for longer.

The Emergency and Unscheduled Care Mental Health Sub Group continues to address the increasing MH presentations at A&E (target assessment rate of 200 exceeded every month), ensuring the most appropriate and streamlined pathway is followed for patients in crisis. (90% of admissions to SLaM inpatients come through A&E).

A number of interventions have impacted upon the numbers of mental health patients being seen in A&E such as enhanced Psychiatric Liaison input at the front desk at A&E which resulted in 40% of patients being re-directed to more appropriate services. In addition Winter Pressures monies was also used to support London Quality Standards to ensure Specialist Clinician availability in A&E departments and test the impact of senior psychiatry presence in busiest times to provider better leadership across the department and ensure patient flow is directed in the most risk averse, clinically appropriate way. Increased specialist assessments which are therapeutically orientated were adopted resulting in increased numbers of direct discharge from Emergency Departments. The outcome of both interventions has resulted in a local commitment to provide on-going CCG investment to fund psychiatric input into Psychiatric Liaison duplicating the Birmingham RAID Model which has showed positive outcomes in reducing reliance on hospital based services, earlier identification of mental illness and earlier discharge from Acute and inpatient services. The increased investment from both the CCG and the BCF will also support increased in-reach across Acute hospital wards to further support early identification and discharge of people with physical and mental ill-health. By expanding the health model to also include a social systems approach delivering single assessment and discharge planning across the full spectrum of individuals needs it is predicted that more people can be diverted away of hospital based services and discharged earlier to

community based services.

To provide an effective alternative to accident and emergency departments and support earlier discharge, investment in the community based Home Treatment Team to expand the breadth of the current health based service to include specialist social care consideration, more people will be diverted away from urgent, unplanned and inpatient care. The Flash bed Audit undertook in May 2014 identified 40% of avoidable admissions could have been diverted via the HTT and 7% of service users who could have been discharged on the day of the audit home with HTT input. The additional investment will therefore support the individuals who could have otherwise be diverted from or discharged from inpatient care.

The scheme aligns to the second mental health focused scheme to provide multidisciplinary working in community based services supporting a strategic shift across all care pathways for integrated health and social care working around people with mental illness.

Investment requirements £300k
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Improved recovery and staying well
Reduction in unplanned and emergency admissions
Reduced demand on hospital based services
Earlier discharge
Improve service user experience of the care and support they receive

See annex 1.20 on contribution to non-elective admissions target.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Data currently provided through core contract reporting will be used to understand the impact of the scheme on the above areas including number of referrals successfully gate kept by psychiatric liaison, number and length of delayed discharge and reduction in OBDs.
Data gathered through the Unplanned and Emergency Care Mental Health Subgroup including the recently developed single scorecard of mental health activity across both EDs in the borough to provide greater understanding of activity across the wider system. This will continue to be used to understand the impact of the investment.
On-going service evaluation and development with health and social care staff and service users will support qualitative review and evaluation of the scheme and support identification of further opportunities or barriers to improve the offer.

What are the key success factors for implementation of this scheme?

Effective partnership working, clear “memorandum of understanding” of the Social Care roles. Clear reporting and supervision line for SC practitioners
Recruitment of high quality staff able to work flexibly and in partnership.

ANNEX 1.8a – Detailed Scheme Description

Scheme ref no.
1.8a Mental Health
Scheme name
Multidisciplinary, community based mental health services
What is the strategic objective of this scheme?
Strengthen community based, multi-disciplinary working to reduce escalation of need and prevent crisis admissions through integrating, person centred services which foster a culture of recovery and staying well. The approach will provide joint health and social care assessments and single 'accountable professional' co-ordinating care of individuals improving people's experience of the care and support they receive. Targeted at complex care groups including those who would otherwise require residential care, the reablement focused approach will support more people to live independently, reducing reliance on residential and nursing care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model will embed social care professionals, principles and evidence based practice across Community Mental Health Services to provide an integrated approach to care and support shifting the balance from hospital based services. Locally, the transformation of Adult Mental Health (AMH) Services is taking place over the next year providing more intensive, community based support for people out of hospital, moving from long term tracking to focused intervention, recovery and staying well. The BCF monies will be used to ensure a multidisciplinary approach through integrating social care into the new AMH model. The enhanced, integrated community teams will provide effective care pathways for the Psychiatric Liaison and Home Treatment Team as part of BCF Scheme providing a strategic shift in the balance from hospital based services. **Home care reablement:** providing a practical element to reablement to support earlier discharge from hospital and staying at home for longer **Dual Diagnosis worker and data analyst :** interfacing with all parts of the system including criminal justice, social care, drug and alcohol and the Multi Agency Safeguarding Hub(MASH) the analyst and worker will identify complex cases and provide targeted input ensuring appropriate wrap around packages of care which engage and sustain recovery and staying well. **Dialectical Behaviour Therapy (DBT) for vulnerable and at risk young people:** Integrated into Specialist Family Focus Team (SFFT) the resource will provide an evidence based intervention for vulnerable and at risk young adults who have had historical and on-going contact with the social care system. The resource will provide a trainer and practitioner to support building capacity across the social care system.

OT and reablement: two OTs for the Residential Care Transition Team (part funded by CCG and charitable trust funding for management capacity) focused on driving a culture change from the current residential care model to personalised packages of care and support using personal health and social care budgets for people in their own homes supporting more people to move on and live independently. Two OT/reablement workers integrated into the MAP treatment team and re-ablement service providing focused integrated into community mental health teams.

MH Housing Link Worker: To ensure appropriate accommodation is available, accessed and maintained for the people enableed to move on and live interdependently, including those with personal health and social care budgets or as an outcome of the PIE programme.

Primary Care Advanced Practitioners: an Advanced Practitioner for each of the localities (north and south) to provide mental health social workers and advanced practitioner as part of the locality model. To be developed with the locality model developments.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Home care reablement: additional resource into the already commissioned home care provider by the LA

Dual Diagnosis worker and data analyst: LA delivered resource integrating into the MASH

Dialectical Behaviour Therapy (DBT) for vulnerable and at risk young people: CCG commission SLaM as part of the CAMHS contract, integrated into the LA delivered SFFT working alongside, managed and supervised by the Functional Family Therapy manager (part of SFFT)

OT and reablement: Delivered by the LA integrated into the residential Care Transition Team, Reablement Service (both managed by the LA and integrated into the MAP Treatment (SLaM)

MH Housing Link Worker: LA delivered service

Primary Care Advanced Practitioners: LA delivered service interfacing with the locality teams

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is a large body of evidence which recognises the impact of social, economic and environmental factors on people's health and wellbeing. Adopting a recovery focus model requires focusing care on building the resilience of people with mental health problems, not just treating or managing their symptoms. An integrated health and social care model providing a fully personalised service provides a strong

foundation to implement a recovery focused model.

Embedding personalisation across the system supports the national and local agenda to provide choice and control to individuals over the care and support they received. Predominantly in the learning disability sector, but increasingly in mental health, there is an increasing evidence base that offering personal health and social care budgets provides maximum impact of the personalisation policy for individuals. Adopting personal health and social care budgets for people who would have otherwise required residential care provides a more efficient model of support significantly reducing the cost of care and ensures care and support is wrapped around the individual in their own home providing stability and responsiveness.

The reablement model has been adopted in Southwark for the last 2 years, with an independent evaluation showing a positive impact on the reduction of clients' needs as a result of the intervention with significant improvement in six of the outcome domains which are measured. Financial cost of care immediately after Reablement decreases from an average of £104k to £62k with 65% of service users no longer FACS eligible following the intervention. Additionally, clients satisfaction is mostly positive with clients reporting they are happy about the care and support they received. Further integrating the reablement approach into Community Mental Health Teams will support the delivery of person centred care and support.

Investment requirements £700k
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved recovery and staying well
- Reduction in unplanned and emergency admissions
- Reduced demand on hospital based services
- Earlier identification and prevention of escalating mental illhealth
- Reduction in use of residential and nursing care
- Increase in people with mental health issues living independently
- Earlier discharge
- Improve service user experience of the care and support they receive

See annex 1.20 on contribution to non-elective admissions target.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Data currently provided through core contract reporting will be used to understand the impact of the scheme on the above areas. In addition the new dashboard which is being developed and adopted to monitor the impact of the Adult Mental Health transformation will provide insight into the impact and outcomes of the investment.

On-going service evaluation and development with health and social care staff and service users will support qualitative review and evaluation of the scheme and support identification of further opportunities or barriers to improve the offer.

What are the key success factors for implementation of this scheme?
▪ Effective partnership working ▪ Clear "memorandum of understanding" of the Social Care roles ▪ Clear reporting and supervision line for SC practitioners ▪ Recruitment of high quality staff able to work flexibly and in partnership with other professions

ANNEX 1.8b – Detailed Scheme Description - Enhanced Intervention Service for people with learning disabilities

Scheme ref no.
1.8b Mental health (learning disability)
Scheme name
Enhanced Intervention Service for people with learning disabilities
What is the strategic objective of this scheme?
To provide additional community based support to people with learning disabilities and challenging behaviour, enabling them to live in the community rather than more intensive care settings. This scheme forms part of Southwark's strategic response to *Transforming Care: A national response to Winterbourne View Hospital*, DH, (2012), which includes a clear transformational agenda that: • Services will be developed and strengthened locally so that individuals with learning disabilities displaying significant challenging behaviour can expect to be supported locally: and • There is a reduction in the use of unnecessary out of area assessment and treatment unit placements, both in terms of numbers of admissions and length of stay.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme builds on a Enhanced Intervention Service pilot scheme commissioned from the South London and Maudsley NHS Foundation Trust (SLaM). The key objectives are to: • Work preventatively with local services to increase their capacity to create capable environments; • Provide rapid, flexible, intensive assessment and intervention at the point of crisis or potential service / family breakdown; and • Provide clinical leadership for planning and strengthening services for people returning to Southwark as well as additional clinical expertise to support step-down back from more restrictive environments. Eligibility criteria for the service: • Meeting the eligibility criteria for the MHLD service; i.e. presence of significant learning disabilities and mental health problems / and or significant challenging behaviour and over 18 years old. (Consideration is being given to the benefits of MHLD's involvement in

service planning with young people who are under 18 years old. This longer lead in time would strengthen the service planning process).

- At significant risk of placement breakdown, exclusion from services, admission to A&T unit and / or specialist out of area placement.
- Requires a significantly more intensive / rapid assessment and intervention in the community to enable them to maintain living locally.
- With presentations of co-morbidity, a predominant presentation of challenging behaviour to the crisis is identified.
- There is an expectation of cross agency support and commitment towards a multi-agency approach to managing crises.

The fast tracked referral process is through the MHLD referral route, with the aim to accept and respond to referrals within 24 hours (standard working days) aiming to hold a multi-agency network meeting held within 48 hours of the referral being accepted (where possible) to enable a co-ordination risk management plan, alongside intensive assessment and intervention.

The Enhanced Intervention Service input is time limited, has clear contracting and expected outcomes, and a pathway for step down to the existing MHLD for continuation of input once the crisis is over.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The permanent team will be jointly commissioned by Southwark CCG and Southwark Council. As with the pilot, the service will be co-ordinated by SLaM and will be provided by staff in SLaM, GSTT and Southwark Council's Learning Disability Team.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The pilot has been identified by the National Winterbourne View Joint Improvement Board as being an area of good practice.

Demand for the service has exceeded supply.

Out of area placements cost annual average of £84,750 compared with £67,100 for in borough residential care placements and £41,950 for supported living placements. However, specialist placements for people with behaviour that challenges services can range from £140,000 p.a. for a residential service with 1:1 support and £208,000 p.a. for a residential service providing 2:1 support and £230,000 for an in-patient bed.

Good practice reports highlight that in addition to financial savings, they are accompanied with improved outcomes for the individual in terms of quality of life and wellbeing.

The pilot has been clinically evaluated using:

- HoNOS-LD (clinical wellbeing measure)
- Behaviour Problems Inventory (BPI)
- WHO-QOL (Mini MANS-LD) (Quality of life measure)
- GCPLA (Quality of life measure)
- Professional Quality of Life Scale (Pro QoL)
- Brief Family Distress Scale (FDS)
- Qualitative questionnaire

Feedback from those involved both in developing services for individuals and in the strengthening of local services has been overwhelmingly positive, as have the clinical outcomes and improvements in quality of life for service users and their families.

The pilot has shown the positive impact of the intervention in diverting people with challenging behaviour from more expensive specialist inpatient and residential services and has produced significant savings in placement costs across the health and social care economy totalling £8,563 p.w.; (£445,276 per year).

Investment requirements £135k (50% funding, from BCF)
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The service will contribute to the following metrics:

- The scheme will support people in assessment and treatment services to step down into local community services as quickly as is appropriate.

- Delayed Transfers - Effective joint working of hospital and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

- Reduce emergency admissions which can be influenced by effective collaboration across the health and care system.

- Reduce the numbers of people with learning disabilities and / or autism in inpatient beds or specialist residential services.

The scheme will continue to divert people from more expensive, specialist inpatient and residential services and it is anticipated that this action will continue to produce significant savings costs across the health and social

care economy.

The scheme has already been identified by the National Winterbourne View JIP as good practice and will enhance Southwark's reputation as an innovative and proactive area.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The measures from the pilot will continue to be used in the scheme. These include:

- HoNOS-LD (clinical wellbeing measure)
- Behaviour Problems Inventory (BPI)
- WHO-QOL (Mini MANS-LD) (Quality of life measure)
- GCPLA (Quality of life measure)
- Professional Quality of Life Scale (Pro QoL)
- Brief Family Distress Scale (FDS)
- Qualitative questionnaire

Numbers of service users worked with and outcomes. i.e. supported to remain in the community / diverted from inpatient / specialist care; supported to step down from inpatient services / specialist care.

What are the key success factors for implementation of this scheme?

The pilot has shown the following as being key success factors for the service:

- Partnership with:
  - Service users and families
  - Local authority
  - Service providers
  - Commissioners
- Accountability to the multi agency Winterbourne View Steering Group
- Use of positive behaviour support to understand behaviour and develop preventative strategies and crisis planning.
- Systemic approaches
  - Solution focussed
  - Co-creation
  - Building relationships
- Combination of clinical work and strengthening services
- Flexible working and creative solutions.

These were achieved in the pilot and are expected to continue in the permanent team which will involve many of the same staff.

ANNEX 1.9 – Detailed Scheme Description

Scheme ref no.
9
Scheme name
Telecare expansion: supporting people to live at home through assistive technology.
What is the strategic objective of this scheme?
Telecare expansion underpins the prevention offer in the borough and supports the delivery of the health and well-being strategy in that it can help to reduce the admissions to hospital and residential care and enable vulnerable adults to live independently and safely in the community for longer.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The telecare expansion intends to provide free telecare including monitored equipment such as pendant alarms as well as more complex equipment for identified cohorts as follows: • People who are FACs eligible • People over the age of 85 • People identified as having moderate needs following reablement • People with a diagnosis of dementia The target is to reach 1,000 additional service users during 15/16.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The telecare expansion project has a clear governance structure with a project board with ultimate oversight for the delivery. Representatives from adult social care, commissioning, housing and the CCG are members of the board. The responsibility for the operational delivery of the programme sits jointly between housing (where the monitoring and response service sit) and ASC who have the primary role in identifying and assessing need. Performance reports are provided to the senior management team in order that they are able to track delivery against projections.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Studies throughout the UK and overseas over the last decade have demonstrated the capacity of telecare to achieve the following outcomes at low cost: • Enabling people to remain at home who would otherwise need to be placed in residential or nursing care establishments; • Reducing the number of preventable injuries, accidents or risks encountered by sick, disabled or vulnerable people living at home; • Supporting unpaid carers to care without experiencing such intense pressure or

stress that they themselves become ill or have to give up their caring role;
- Improving the efficiency of home care services, especially by reducing those costs (e.g. travel costs and time; checking visits, overnight sleepovers) which deliver no direct benefit to the person cared for;

Evidence supporting the development of telecare from Essex county council has indicated that the financial benefits of telecare are for every £1 spent on telecare £3.80 is saved on traditional care. Hillingdon council saw the number of admissions to residential care reduce by half within 18 months of the implementation of their telecare offer.

A number of key groups have been identified as being at particular risk and where the telecare offer can have the most beneficial impact. This has informed the commitment to expand the telecare offer to adult social care clients as follows:
- Adults with critical and substantial needs
- Adults diagnosed with dementia
- Adults aged 85+
- Adults with moderate needs following reablement

Investment requirements: £566,000 (in addition to £100k within existing NHS transfers
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1. Reduction in avoidable hospital admissions
2. Reduction in delayed transfers of care
3. Reduction in avoidable nursing/residential care admissions
4. Prevention of avoidable accident and emergency presentations
5. Prevention of readmission to hospital
6. Prevention of falls, and the effect of falls, on the independence of vulnerable people
7. Supporting more older people with dementia and mental health problems in the community
8. Enabling more older people, and people with identifiable vulnerabilities, to continue living in the community
9. Enabling more people with physical and learning disabilities to continue living in the community
10. Supporting more people with long term health related conditions to live in the community
11. Providing a safer working environment for lone workers
12. Reducing pressure on informal carers and the need for respite services
13. Improving carers reported levels of confidence and quality of life
14. Reducing the pressure on statutory and other emergency services

See annex 1.20 on contribution to non-elective admissions target

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?
We will be commissioning bespoke research in order to track the effectiveness of the programme. The nature of the outcomes we are intending to achieve through the scheme will require a detailed analysis on a range of metrics including hospital admissions, admissions for falls and referrals to the falls clinic, admissions to care homes, etc. We will also carry out surveys of service users and carers as part of our usual survey process with questions that specifically capture the issue of telecare.
What are the key success factors for implementation of this scheme?
• The migration of the monitoring and response service in to customer experience • Increased staffing levels within SMART and ASC to support the delivery • Funding to support the expansion of SMART to respond to the increased demand • Embedding of telecare across all teams within ASC and health • Awareness raising amongst key cohorts • Clear pathways for all customer groups

ANNEX 1.10 – Detailed Scheme Description - Carers

Scheme ref no.
10
Scheme name
Carers: investment to support the implementation of the joint carers strategy to help people continue in their caring roles.
What is the strategic objective of this scheme?
The joint carers strategy recognises that carers are key partners in the delivery of care and support to adults and children in the borough and, not only should they have the skills and resources to take control of their caring role but they should also be able to lead their own lives, following their own aspirations, outside of that role. The investment in the strategy will ensure that these objectives are delivered
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The strategy sets outs a series of pledges which form the basis of our delivery model as follows: **1. Developing an outreach programme** To ensure that carers are reached at an early stage so they know about the services and support available and are able to make choices about what help they receive **2. Ensuring carers have access to information and advice** To provide carers with the necessary information and advice so that they are fully informed about the caring role and their rights as a carer **3. Health and wellbeing programme** To support carers to look after their own health and wellbeing **4. Emergency response services** To ensure that carers are able to access the support that they need in an emergency **5. Young carers programme** To support young carers so that they can have the same life experiences as their peers **6. Short breaks provision** To ensure carers are able to take a break from their caring role through the provision of short breaks **7. Policy development and alignment** To work to align the policies of the council and the NHS to reflect the needs and aspirations of carers For the purposes of the strategy, carers are defined as people who support members of their family, friends or neighbours on an informal basis and without financial reward. As an all-age strategy the aim is to ensure that the both young and adult carers receive the support that they need and choose in the ways that they choose and that the detrimental impact of caring is minimised as well is inappropriate caring (in the case of young carers) is prevented.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The council will jointly commission services with the CCG and drive forward the overall programme of changes through the project structure. The project sponsor is the Director of Adult Care.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In September 2011 Carers UK was commissioned to undertake a review of carers and support for carers in Southwark. The work has enabled Southwark Council and its health partners to develop a better understanding of the Southwark carer population and carers' support in Southwark which will lead to:

- Improved strategic planning and commissioning of support for carers
- Identification of opportunities to improve operational, systems level performance within service delivery, particularly carers' assessments
- Whole system transformation in which the needs of carers are identified and promoted

Some of the highlights within the report include:

- There are approximately 21,000 carers in Southwark
- Around 4 in 10 carers belong to ethnic minority groups
- Between 40% and 50% of carers in Southwark provide more than 20 hours of care per week
- 1 in 4 carers in Southwark provide care for more than 50 hours per week
- Majority of carers in the borough are aged 35-64
- The population of older carers in Southwark is increasing and they are more likely to report poor health than those of working age

The evidence gathered during the Carers UK project has also been complemented by the Personal Social Services Survey of Adult Carers in England - 2012-13, which was completed in November 2012. All carers who had received a carers' assessment in the previous year were surveyed across a variety of domains covering quality of life and overall satisfaction with services.

The census of 2011 indicated that there are almost 21,000 people in Southwark[1] who care on an unpaid basis for friends and members of their family who are ill, frail or disabled. The contribution that carers make to the borough of Southwark is enormous. In financial terms alone, the care that they provide is estimated to save the health and social care system, in Southwark, £471 million a year.

Investment requirements £450,000 (in addition to investment from scheme 1 and 13)

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The outcomes identified that are expected from this programme are that carers: ▪ Report better physical, mental and emotional health. ▪ Feel supported in their caring role. ▪ Are supported to access housing, transport, leisure, information, life-long learning and support that promotes wellbeing. ▪ Are involved in planning and decision making about the direction of their support and delivery of the services they receive. ▪ Are supported to live in a safe environment and are assisted to action against any disruption to it, as appropriate. ▪ Have the opportunity to achieve economic wellbeing and have access to work/ and or benefits as appropriate. ▪ Feel recognised as a carer, understand the implications of their role and how they can receive support when needed ▪ Feel that they are treated with respect and are listened to, have a sense of self worth and are valued by others including healthcare professionals. Carers are expected to have a role to play in the healthcare, living and care decisions for the person they care for. The impact of this is that the people they care for will be better supported, leading to improvements in wide range of measures, including ASCOF measures and health measures such as A&E attendance/ emergency admissions. See annex 1.20 on contribution to non-elective admissions targets.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A significant proportion of the programme will be delivered through commissioned services which will be specified against the outcomes identified above. Therefore we will ensure that the contract management and monitoring captures these outcomes and the degree to which services are delivering them. In addition we will be overseeing the delivery of the strategy and pledges including the outcomes through the carers strategic partnership. There will also be ongoing and regular performance reports submitted to the senior management team. The Carers Survey (national bi-annual survey administered locally) will also be a key feedback tool locally for benchmarking performance, as will carer related questions in health care surveys.
What are the key success factors for implementation of this scheme?
• Procurement of the carers services that respond to the pledges • Development of the carers personal budget programme including clear and transparent criteria • Investment in the carers services and personal budgets • Review and development of policies that respond to the strategy and the additional responsibilities relating to carers in the Care Act • Close joint working with CCG

ANNEX 1.11 – Detailed Scheme Description - Admissions avoidance: enhanced rapid response

Scheme ref no.
11
Scheme name
Enhanced Rapid Response (ERR)
What is the strategic objective of this scheme?
Overall the service will: • Promote independence and, where possible, enable older people and adults to continue to live in their own homes • Prevent unnecessary admissions to acute care • Facilitate discharge for patients • Provide a specialist intermediate care assessment of the adult/older person (and their carer) in an appropriate environment, ideally in their own home.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
ERR provides home based rehabilitation and support targeted at adults and older people with a physical or sensory disability, with the aim of them regaining or maintaining independent living within the community and preventing unnecessary hospital admission. The service is able to respond rapidly (within two hours if needed) to carry out a holistic assessment of needs and put support in place to prevent unnecessary hospital admission. Referrals are accepted from a range of areas including GPs, Community Matrons, District Nurses, community therapists, London Ambulance Service, A&E and other acute wards and acute assessment units where the patient's length of stay is under 48-72 hours. The service provides short term outcome focused interventions in patient's homes, through multidisciplinary assessment and interventions co-ordinated by a nurse, physiotherapist or occupational therapist, and delivered by Rehabilitation Support Workers (RSW's). The service can implement care, support, therapy or assistive equipment to: • Increase independence/safety with activities of daily living (ADL) such as washing, dressing and meal preparation • Improving independence and safety with transfers, mobility and stairs • Assess and take action to reduce the risk of falls including provision of home exercise plans • Improve community access such as shopping and attending GP clinics • Basic nursing interventions such as medication management, monitoring skin integrity, simple dressings, self-management/education, continence assessment and support

- Assess for and prescribe adaptive equipment to improve safety with mobility and activi of daily living such as walking aids, bedside commodes, and chair raisers.

Patients may require and receive support from a single clinician or two or more clinicians working together, depending on their needs.

A specialist medical consultant is aligned to the service to provide medical support and advice; however the medical responsibility for the patient remains with their GP.

The maximum anticipated episode of care is usually six weeks, with many patients needing only one to two weeks to achieve their goals.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lambeth and Southwark CCG both commission GSTT to provide the ERR service.

The Clinical Lead, who is also the operational manager, has line management responsibility of the Therapy Leads. The operational manager is a dedicated leadership and development role that reports into the Head of Rehabilitation and Therapy.

There are close working relationships with social care, GPs, acute medical colleagues, @home, Reablement and the Supported Discharge Team.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Model based on best practice including:

Department of Health Policy documents:
- Transforming Community Services
- High Quality Care for All
- Care Quality Commission (CQC) Regulations
- National Service Frameworks (NSFs, including for Older People, Long Term Conditions)
- Our Health, Our Care, Our Say
- Intermediate Care – Halfway Home
- End of Life Care Strategy

Regulatory Documents:
- CQC regulations
- Health and Care Professions Council (HCPC) Regulations/Standards
- Nursing & Midwifery Council Regulations/Standards
- Professional Standards (College of Occupational Therapy, Chartered Society of Physiotherapy, Nursing and Midwifery Council)
- All nationally unregulated staff within the team work to organisational and local policies, procedures and competency frameworks

National Guidance:

- National Institute of Clinical Excellence e.g. Falls, Osteoarthritis, Parkinson's Disease.

Local drivers:

- Joint Health & Social Care Strategy for Older People
- Urgent and unscheduled care network
- GSTT Adult Community Business Plan
- Southwark and Lambeth Integrated Care (SLIC)
- GSTT Local Services Programme
- Winter planning and pressure surge management.

Investment requirements £2.2m 15/16 (£0.214m in 14/15 for social work support element only)
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme makes a key contribution to minimising emergency admissions, delayed transfers, reablement effectiveness, user experience and care home admissions. The scheme is already established.

See annex 1.20 on contribution to non-elective admissions target

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Existing comprehensive reporting mechanism are in place as part of the SLIC programme management structure and this will be incorporated into the BCF monitoring process.

What are the key success factors for implementation of this scheme?

Scheme is already implemented. For continued successful development referral volumes and capacity need to be aligned through effective planning.

ANNEX 1.12 – Detailed Scheme Description - @home

Scheme ref no.
12
Scheme name
@home: Hospital at home services: existing service including full year effect of extension of home ward, investing in an acute clinic team to care for patients at home and avoid unplanned admissions
What is the strategic objective of this scheme?
The **@home** service is an important part of the admission avoidance strategy in the Boroughs of Lambeth and Southwark/. Avoiding an admission or the early discharge from a hospital admission contributes to releasing capacity in acute beds to support elective and necessary admissions **@home Strategic objectives** a) To develop an innovative service that provides integrated, acute, complex and intensive clinical care at home, with optimum safeguarding for people who access this service. b) To provide an equitable and responsive service on a scale that meets local need, maximises service outcomes and improves the patient experience. c) To improve clinical outcomes and patient satisfaction. d) To develop a service that gives confidence to GPs, hospital consultants and other acute partners in referring, and confidence to staff, patients and carers for timely discharge and admission avoidance decisions. e) To create a major building block, in the redesign of community nursing and other community services. To increase community nursing's confidence in offering acute care and to up-skill clinical staff in the community. f) To relieve pressure on acute services, reduce patient length of stay, and facilitate better use of inpatient beds for elective and other patients.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The **@home** service provides acute clinical care at home that would otherwise be carried out in hospital. Interventions are delivered in the usual place of residence in order to provide the best possible patient experience and outcome, and enable the patient to benefit from holistic integrated care. The concept of providing healthcare **@home** means that instead of patients being admitted to hospital, a multi-disciplinary team works collaboratively with GPs, hospital staff and other organisations to deliver safe, quality healthcare within the

patient's own home. This care also supports advanced discharge from hospital so that people can complete their episode of treatment at home.The @home team includes Nurses, Practice Development Nurses, Therapists, Pharmacists and Social Workers, who are all involved in visiting patients in their own home and administering the care required.

The service has three main aims:
- Identifying people at risk of a hospital admission through risk stratification and providing care which prevents their condition getting worse.
- Allowing people to be given a high level of care in their own homes instead of being admitted unnecessarily to hospital.
- Allowing for advanced discharge out of hospital, so patients can recuperate in the comfort of their home while receiving high quality care.

Referrals can be made between 08:00 – 23:00hrs (by 19:00hrs for same day admission) 7 days per week.

How does the @home service work?
Once a referral has been made, a member of the **@home** team will visit the patient at home for an initial assessment and explain the care that will be given. An **@home** clinician will be appointed and they are responsible for making sure the right care is given by the right professional in the team at the right time. Patients will be discharged from the **@home** team once their course of care is complete.

Referral Criteria:
- Patients aged 18 or above with acute episodes of medical illness who would otherwise require hospitalisation for stabilisation and management. Who require the following interventions:
  - Intensive support and monitoring by highly train clinicians for an acute episode of illness
  - IV Therapy including PICC & Hickman Lines
  - Complex Wound Management including VAC Dressing
  - Blood Monitoring and Anticoagulation Therapy in an acute episode of illness
  - Clinical support and monitoring for an acute exacerbation of Chronic condition such as LVF, COPD
  - Clinical support and monitoring to facilitate early discharge i.e post operatively, A&E, MAU in order to reduce hospital stay

Who Can Refer:
- GPs, SELDO, London Ambulance Service, Hospital Consultants and Other Health Professional.
-

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lambeth and Southwark CCG both commission GSTT to provide the **@home** service.

See attached **@home** professional leadership structure.

A Deputy Head of Nursing/Clinical Lead has operational line management of four **@home** Matrons who lead the multidisciplinary teams, and two Clinical Nurse Practitioners liaising with acute colleagues and case finding within the hospitals. This operational manager is a dedicated leadership and development role reporting to the Head of Community Nursing and Nursing Practice

There are close working relationships with acute medical colleagues, Enhanced Rapid Response and Supported Discharge Team, GPs and social care.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Similar services have already been introduced successfully in several parts of the UK, which informed the design of the pilot.

Pilot

A pilot 'Home Ward'service was initiated in January 2012 by a joint commissioner, provider and social care programme board (the Admission Avoidance Programme Board).

The pilot led to a compelling strategic, clinical and financial case for the full implementation of an **@home**service across Lambeth and Southwark. Wide stakeholder consultation and service observation took place in preparing the business case, achieving significant engagement across GSTT, KHP (Kings Health Partnership) and primary care, to support the expansion of the scheme.Those who had referred patients to Home Ward - GPs, hospital Consultants, District Nurses etc - expressed appreciation of the service and were keen that it should continue and expand. They were eager for it to be available across both boroughs.

The business case built on a number of previous analyses and evaluations of Home Ward (HW) and related developments, notably:

- an external evaluation of the Home Ward pilot by Virginia Morley Associates in September 2012 including user feedback;
- the original business case for the Home Ward Pilot as part of the transformation of community services;
- the new older people's pathway developed by Southwark and Lambeth Integrated Care (SLIC);
- scoping work on the future of Home Ward in November 2012;
- work on the Intermediate Care Pathway;
- the operational policy and medical model options papers;
- patient and referrer feedback

The business case also incorporateda review of other NHS and commercial models of acute home-based provision including Medihome, Hospital at Home Ltd, Orla, other NHS models and contact with virtual ward related services in three other trusts in addition to Virtual Wards visited in the original Pilot start-up and awareness of

PACE (Post Acute Care Enablement Service) provided by Bromley Health Care (a social enterprise).

Early evaluation conclusions by Virginia Morley Associates included

- Patient feedback about the service was overwhelmingly positive.
- The scheme experienced a number of initial teething problems, but most had been overcome by the five month mark.
- A preliminary internal analysis of costs at month five suggested that the Home Ward scheme was no less costly than acute care, but this reflected that the scheme had not been working at full capacity (the pilot had suffered from a lack of GP endorsement and a small catchment area), which pushed up bed costs and length of stay.

The evaluators summarised feedback and operational problems that were highlighted during the qualitative interviews with clinicians and others involved in the programme. This provided the community services management team with an opportunity to resolve outstanding problems where possible. In light of the above, it is evident that the admission avoidance programme should be viewed as a longer term strategic piece of work that is developed and implemented over a 3 to 5 year period of time, aligned with the integrated care programme. This is expected to give the service a chance to learn from the set up, improve any operational difficulties, provide an opportunity to adjust and change referral patterns if required and for more robust quantitative and qualitative evaluation to be completed as part of larger externally commissioned evaluation of integrated care. Lambeth and Southwark commissioners believe that the schemes that have been funded can make inroads into acute pressures but that they need to be given time to achieve this.

Patient choice
In addition to the high cost associated with hospital admission, prolonged length of stay - especially in the frail elderly and those with long term conditions - can lead to a higher risk of acquired infection and other complications, loss of confidence, function and social networks. Increasingly, given the choice, patients and their carers show a preference for receiving care at home, when they have confidence that it will be provided by skilled practitioners offering continuity of care and working collaboratively.

Investment requirements : £1.2m
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Admission avoidance and early discharge, reduced bed days, user experience

Although scheme is established it is expected that throughput should increase as the approach matures.

See annex 1.20 on contribution to non-elective admissions target

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Integrated metrics are reported monthly which track referrals/ impact on length of stay and admission avoidance across primary, community and acute. Evaluation commissioned that will include: • Patient satisfaction • Impact on family/informal carers • Impact on other community and social services • Bed occupancy on the **@Home** wards • Length of stay • Number of unplanned admissions to hospital • Incidences of cognate clinical complications (health care related infection, pressure sores, other condition specific complications) • Staff satisfaction in terms of readiness for working on the **@Home** wards and rotational opportunities and sharing of skills between nurses and therapists. • Effectiveness of the generic support worker roles
What are the key success factors for implementation of this scheme?
Based on the evaluation of the 'Home Ward' Pilot, experience of services elsewhere and stakeholder consultation, the conditions for successful expansion of the service were identified and incorporated into the service design and implementation of **@home**during 2013/14, including: 1) Strong dedicated developmental and operational **leadership**, with effective business support. 2) HW serving **all GP practices** in Lambeth and Southwark, who have regular contact with representatives of the service. 3) An integrated **IT and telecommunications** system that is fit for purpose in a mobile, rapid, geographically distributed service, including teleconferencing capability for MDTs, and a business continuity plan to overcome any interruption to critical IT information. 4) A **scalable model** of service delivery providing for a minimum 80 o 100 beds, sustaining occupancy levels that demonstrate cost effectiveness and relief of pressure on in-patient beds. 5) Clear **patient pathways** for referral and expectations for length of stay in Home Ward, with timescales for discharge regularly monitored. 6) A **single point of access**, with a streamlined and integrated referral process for Home Ward and ERR, i.e. a single phone number and a single route for e-referral, including 'out of hours' cover. 7) Excellent **clinical nursing** care combining best practice of acute and community nursing, with confidence to treat more patients traditionally cared for in acute settings. 8) Integrated multi-disciplinary and **inter-disciplinary working**, with clarity about **medical responsibility**.

9) A consistent service presence in local acute hospitals (**Guy's and St Thomas'and King's College Hospital)**at the rightlevel and background, working with hospital teams, MDTs etc. This will be crucial to the visibility and effective take-up of Home Ward as an alternative to in-patient care.

10) Clear protocols for case managed patients, with **Community Matrons** included in Home Ward multi-disciplinary team meetings.

11) A 'ready use' **equipment store**, with a small number of key items e.g. portable bladder scanner, home ADL and mobility equipment, IV stands, for short term loan when existing equipment arrangements cannot meet service needs.

12) A new **career pathway** for community nursing, supported by tailored class-leading HW training, to develop senior community practitioners with advanced clinical reasoning, practice and decision-making skills.

ANNEX 1.13 – Detailed Scheme Description - Care Act implementation

Scheme ref no.
13
Scheme name
Care Act Implementation: amount of BCF identified by government as contributing to implementation of the Care Act
What is the strategic objective of this scheme?
To ensure that the Care Act is successfully implemented in Southwark by; - providing funding for Care Act implementation costs from the Better Care Fund in line with national guidance - maximising benefits from the considerable opportunities the Act presents for the whole health and care system and addressing the significant challenges successful implementation presents. - ensuring an integrated approach to the implementation of the Care Act that is co-ordinated with BCF schemes and the wider integration programme - focussing on the requirements for health, social care and housing and other agencies to work together in an integrated way to promote health and wellbeing and prevent and delay the onset of intensive care and support needs. The key strategic opportunities presented by the Act include: • Improving rights for carers, and giving them the right to have an assessment of support needs, and be offered local authority support for their eligible needs • A focus on the promotion of wellbeing (both adults and carers) when providing support • Increased focus on personalised services to meet people's overall needs • Greater clarity on safeguarding responsibilities and how the local authority and partners across sectors work to protect our most vulnerable residents • Engagement with those currently paying for the cost of care and support, who will benefit from financial support from 2016, including assessments of needs • Giving our residents better information and advice • Duties that reinforce work on integrating adult social care services with health, housing and children's services in order to maintain wellbeing and prevent and delay care and support needs.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The £1m funding will contribute to the costs of the implementation of the Care Act incurred by the Local Authority that are expected to be funded from the BCF in line with national requirements. The Care Act implementation programme involves a complex range of changes to the adult care system. A Southwark Council Cabinet report on the Care Act indicating the range of changes involved in the programme can be viewed through this link: http://moderngov.southwarksites.com/ieListDocuments.aspx?CId=302&MId=4862&Ver=4

The exact model of adult care involved varies between services but is characterised by a personalised and integrated approach to care which puts people in control of the support they receive to achieve the goals they want to reach, with an emphasis on prevention and short term support to maximise people's ability to live independently at home before considering long term care options.

The cohort who will benefit from the changes includes all people eligible for social care and their carers, and people in contact with social care but below the eligibility threshold who may benefit from preventative services to promote their wellbeing.

The precise breakdown of implementation costs will be establish during the implementation period from 1st April 2015, and will also depend on actual demand for support, such as enhanced access to carers services.

Based on national estimates an indicative allocation of the costs to be funded from the BCF would be £1.131m as follows:

Care Act implementation costs area allocated to BCF	£
Carers – new assessment duties	£130,000
Carers – new duties to provide services	£281,000
Assessments – implement national eligibility criteria	£167,000
Information advice and support	£86,000
Safeguarding Board requirements	£32,000
Other	£108,000
Total revenue	**£804,000**
IT capital (new systems required to meet Act requirements)	£327,000
Total Care Act costs	**£1,131,000**

The Southwark BCF specific allocation for the Care Act is £1m, however the additional scheme on Carers (scheme 10) will also contribute to the implementation costs to bring the total funding into line with the indicative allocation.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Adult Social Care division will lead on the delivery of the Care Act requirements, including the provision of assessment and care management services provided through the directly managed social care workforce, and through externally commissioned services such as carer support from the voluntary sector.

While key elements of the Care Act are the responsibility of local authorities there is recognition in the Act of the responsibility that health services in particular (and also areas like employment services such as JobCentre plus) play in relation to successful delivery of the key outcomes and the requirements of the Act (particularly linked to areas such as information and advice, preventing, reducing and delaying care and support needs, specific responsibilities around Continuing Health Care, reducing delayed hospital

discharge, etc).
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The scheme relates to local implementation of national policy on the transformation of adult care and support as set out in the Act and related detailed guidance, which have all been developed using a robust evidence based approach. Local implementation will be in line with guidance.
Investment requirements: £1m Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
As the implementation of the Care Act relates to a whole system transformation it is expected to contribute to the full range of outcome measures set out in the **Adult Social Care Outcomes Framework (ASCOF)** as well as broader Public Health and NHS outcome measures.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The CCG BCF programme lead will sit on the Care Act implementation group to help ensure a high level of integration with the BCF programme requirements. The Care Act programme management arrangements will include regular exception reports indicating progress, and these report will be used within the proposed BCF governance arrangements, including confirmation of costs incurred.
What are the key success factors for implementation of this scheme?
As set out in the detailed Care Act programme management arrangements, key success factors include: - sufficiency of funding to meet actual costs generated by new arrangements e.g. demand for carers services, new national eligibility criteria, numbers of self funders seeking an assessment and newly eligible for council support - rigorous programme management - effective joint working between agencies involved - workforce training and development - market development to support personalised approach to services - implementation of new assessment systems - implementing IT/IS systems - effective communications, including information and advice on the changes for the public and professionals

ANNEX 1.14 – Detailed Scheme Description – Social Services Capital

Scheme ref no.
14
Scheme name
Social Services Capital: existing grant rolled into BCF 15/16 funding. Includes investment in centre of excellence for dementia
What is the strategic objective of this scheme?
The social services capital programme includes a range of projects aimed at improving accommodation and buildings for people with social care needs, enabling them to live independently in their own homes in the community. As a result of national funding changes the grant will be paid into the BCF. This creates the strategic opportunity to take a more integrated approach to capital investment between partners on estates and other capital investments.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The current capital programme includes major investments in a new centre of excellence for people with dementia, providing facilities for day support, respite, extra care. It will be a hub for multidisciplinary work in line with the dementia strategy. It also includes a significant capital programme to enhance supported accommodation and respite facilities for people with learning disabilities.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The local authority commission the capital works.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Individual capital schemes require a business case
Investment requirements: £875,000 Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Individual capital schemes business cases set out expected impact.

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
As the capital programme funded from this source becomes part of the BCF it will be covered within the Section 75 agreement and joint governance arrangements which will include monitoring of the programme.
What are the key success factors for implementation of this scheme?
Each capital project has associated success factors identified, with procurement delay risks being a key area.

ANNEX 1.15 – Detailed Scheme Description – Disabled Facilities Grant

Scheme ref no.
15
Scheme name
Disabled Facilities Grant: existing grant enabling disabled people to live at home being channelled into the BCF (non-council accommodation).
What is the strategic objective of this scheme?
Prevention of care home admission and hospital admissions / delayed discharges for disabled people by funding major adaptations to people's homes. Promotion of overall health and well-being and quality of life of disabled people.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Direct support in terms of home improvements, falls prevention interventions, minor and major adaptations. 80 major adaptations due to be completed in 2014/15.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Council commissions the service and employs staff to administer the scheme. Referrals made from Occupational Therapists (OTs), then the Financial counsellor (FC) visits the client within 2 weeks to carry out assessment, they have 1 week to pass case on to surveyor. The surveyor must visit within 2 weeks of receiving the referral from FC, surveyor has 3 weeks to complete schedule of works, then 4 weeks to go out to tender, on receipt of tenders and awarding job, surveyor has 2-3 weeks to prepare cost report. On average jobs from initial referral to completion take 1 year. Some works such as stairlifts and automated door opening systems can be completed in much faster timescales where costs are under £5k don't need to go out to tender. However, if scope of works includes other repair work then DFG process can take a lot longer to complete depending on the nature of additional enabling works required.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Housing Grants, Construction and Regeneration Act 1996 sets out provisions for the mandatory DFG. Housing Health Cost Calculator – BRE 2014 Assessment & Prevention of falls in Older people – NICE guidance 2014

Investment requirements :£614k grant in BCF (total cost includes an additional £800k from council capital budget) Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
A range of health and care related targets are impacted upon by enabling people to live more safely in their home. See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Performance reporting on referrals processed, waiting times and numbers benefitting to be incorporated into BCF monitoring.
What are the key success factors for implementation of this scheme?
Availability of OT's to carry out assessments in timely fashion. This is an issue that will be addressed as part of the BCF.

ANNEX 1.16 – Detailed Scheme Description – Protecting Social Care (to be allocated in 15/16 budget process)

Scheme ref no.
16
Scheme name
Protecting Adult Social Care of benefit to health services: further support in line with BCF conditions to maintain key service levels in context of LA funding cuts: assessment, care management and maintaining eligibility levels
What is the strategic objective of this scheme?
To protect social care services that are of benefit to health in the context of year on year budget reductions faced by adult social care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
£0.5m has been set aside in the 2015/16 BCF to protect adult care services that would be cut in the 2015/16 budget round (for which up to 10% cuts are anticipated). This will be aimed at supporting social services that are essential for supporting integrated working with health, but for which access may need to be reduced, possibly via a tightening of eligibility criteria. The precise allocation of this sum will not be determined until the 2015/16 budget settlement for Southwark's Adult Care, and key budget reductions are known. However it will be likely to be used to help support services that prevent hospital admission. The sum will be used directly to help the department meet its budget target without cutting key services. Note: The sum is in addition to £1.5m of previous NHS sec 256 funding already used to contribute to the social care budget target to protect services.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Adult Social Care will use the resources to maintain funding for existing services.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
NHS funding to support social care of benefit to health is an established practice nationally and locally, and a requirement of the BCF.
Investment requirements: £0.5m 2015/16 Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
By protecting social care and enabling eligibility criteria to be maintained a range of health and social care outcome measures will be supported. Hospital admissions, delayed transfers and the full range of ASCOF measures may be impacted, depending on the precise allocation to particular schemes. See annex 1.20 on contribution to non-elective admissions target.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The impact of protecting social care will be monitored as part of overall BCF monitoring.
What are the key success factors for implementation of this scheme?
It is important that during budget discussions this resource is targeted at the most effective social care services that are otherwise under threat, and that the resources are transparently allocated to social care for the agreed purposes.

ANNEX 1.17 – Detailed Scheme Description - 7 day working

Scheme ref no.
17
Scheme name
Seven day working: programme to fund seven day working across primary, community and social care to support seven day discharge
What is the strategic objective of this scheme?
To support patients to be discharged at weekends, and prevent unnecessary admissions at weekends, by providing effective co-ordinated 7 day discharge support from social services and primary care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
1) **Additional ERR capacity (£400k)** Local services have reported increases in the number of complex patients requiring double-handed support three to four times a day in addition to social care support. Winter monies have been allocated to seed fund additional capacity in advance of the BCF in 2015/16. This will be used to manage a combination of both double handed and single handed patients and also fund the associated social care support required to ensure the rapid transfer of patients to re-ablement or standard packages of care. 2) **Extended Primary Care Access (£743k)** Southwark CCG has agreed to commission extended primary care access to be delivered through 2 to 4 access points, 8am - 8pm, 7 days a week. This represents approximately 106000 additional appointments per annum. Patients will access the service through their general practice or the Out of Hours service, and those requiring same day or next day care will receive rapid clinical assessment through telephone management. If it is deemed that they need to be seen they will be either booked into their own practice or booked an appointment in the 'Access clinic' which will be staffed by GPs and nurses and have access to consultation diagnostics. This will act as an extension of general practice, with clinicians having access to patient records to support continuity of care, and will be fully integrated with GP out of hours provision. The first site will be live in November 2014 followed by a second in January 2015. The CCG have also been successful in securing nearly £1million from the Prime Ministers Challenge Fund which will be used to support the implementation of this service. This work forms part of the broader CCG Primary Care & Community Strategy aiming to improve access, outcomes, integrate services and provide more care out of hospital

The service does not seek to target any specific patient cohorts, but care will be taken to support equity of access for high risk groups.

3) **Integrated weekend working (£350k)**
   Whilst a number of hospital and community services operate seven days a week to support discharge of patients, the lack of social care input at weekends has been a limitation. Lambeth & Southwark winter monies have been allocated to seed fund this scheme in 14/15. It will include social work input and appropriate support services to facilitate increased discharges at weekends. This proposal will facilitate a multi disciplinary team approach and support. The scheme will fund 4 social workers per borough to be placed across both GSTT and KCH, with 2 to be based in A&E and the assessment unit and four on the elderly care wards. Social workers will:
   - meet patients in order to complete assessment/support plan sign off
   - Meet with relatives\support networks
   - follow up outstanding referrals to relevant departments
   - Liaise with Discharge Co-ordinators(Ward Staff) and engage in completion of check lists/HNA
   - Prepare paperwork and complete case management tasks to facilitate discharge
   - Work closely with other Health and social care teams to ensure good practice and effective use of limited weekend resources
   - Follow up discharges made on Fridays
   - Work with ERR and A&E/Admission wards to offer assessment.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

1) Enhanced ERR 7 day capacity
   Commissioned by CCG and provided by GSTT Community services working with social care across both local authorities in relation to onward support

2) Extended Primary Care Access
   Commissioned by CCG and provided by two primary care umbrella organisations: Improving Health Ltd and Quay Health Solutions

3) Integrated working at weekends
   Commissioned by CCG and provided by social care across both local authorities

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1) Acute seven day working
   - London wide standards for urgent & emergency care

2) ERR – see scheme 11

3) Extended Primary Care Access
   - The RCGP has suggested that the contact rate for Scottish practices provided the closest available benchmark for total capacity (GP and nursing). This is approximately 83 face to face contacts per 1,000 patients per week, (62 of these being GP contacts) for an average standardised practice. The additional capacity requirements have been calculated using this and current service activity (core contract, extended hours DES, total SELDOC, Lister Walk-in centre).
   - The service principles have been developed through a programme of engagement with both patients and practices and informed by the review of urgent care services within Southwark.
   - We are participating in both the national Prime Ministers Challenge Fund evaluation and commissioning a local evaluation to more fully understand the impact.

4) Integrated working at weekends
   - Clinical standards for seven day working
   - Small scale pilots have been undertaken at both King's and GSTT to understand the potential impact of this type of intervention and this scheme will build upon this including the evaluation measures.

Investment requirements £1.5m
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1) Additional ERR
   - Reduced length of stay
     Double handed patients: it is estimated that this could lead to a length of stay reduction of between 7 and 21 days, allowing patients to integrate back into their home environment far earlier.

2) Extended Primary Care Access
   - Increased capacity within primary care - demand and capacity measures to be confirmed
   - Increased patient satisfaction in relation to access, consistency of message and treatment
   - Greater staff satisfaction
   - Support a reduction in A&E activity

3) Integrated weekend working
   - preventing admission of patients in A&E (or Assessment Unit) thereby reducing emergency admissions
   - increase the number of earlier/weekend discharges thereby reducing length of stay

See annex 1.20 on contribution to non-elective admissions target

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Alongside high level measures such as delayed transfers and emergency admissions, more detailed analysis will be undertaken of the adequacy of the extent of 7 day working. Specific cases where discharge is delayed at the weekend due to lack of social care or primary care support will be examined in detail.

What are the key success factors for implementation of this scheme?

1) ERR
    - Appropriate support services in place for double handed patients
    - Onward support

2) Extended Primary Care Access
    - Promoting positive health seeking behaviours and patient education
    - Cultural change within general practice – working in a new and collaborative way
    - Workforce
    - Robust systems/infrastructure to support i.e. telephony

3) Integrated working at weekends
    - cultural change amongst clinical and social care staff: working in an new way, referring and discharging patients
    - effective support services in place to discharge patients
    - workforce/recruitment
    - patient choice and support
    - systems/infrastructure to support i.e. access to appropriate patient information etc

ANNEX 1.18 – Detailed Scheme Description – voluntary sector prevention

Scheme ref no.
18
Scheme name
Voluntary sector preventative services: existing grant funded services which will be used to take an integrated approach to prevention and protect CCG and ASC funded services
What is the strategic objective of this scheme?
The vision for adult social care sets out the framework for delivering objectives within the council plan. It identifies the need to develop a sustainable system that puts people in control of their own care and support, make sure that the most vulnerable people are supported and also deliver value for money for local residents. With this in mind, the vision sets out to re-shape the universal offer (open access discretionary services) that cover areas such as befriending, information and advice. The community support model represents a key element of the service redesign aimed at achieving the vision.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Between August and October 2011 consultation with stakeholders was undertaken to develop a service model that would deliver the required structural and financial changes by creating efficiencies whilst protecting, as much as possible, the front-line services. The agreed model identified three specific service elements: • Information, advice and access • Well-being planning • Social interaction development and befriending **Information, Advice and Access** services are aimed at enabling vulnerable adults to find the help and support they need to maintain their independence and improve their engagement in the local community. The providers link closely with the council's information and advice portal and respond to the needs of customers either contacting them directly or referred by the council. They provide a broad range of information about access to services, welfare rights, debt advice, and access to training and employment opportunities. **Well Being Planning** services offer support to customers to take more responsibility for their own health through making lifestyle changes and through a better understanding of health issues. To achieve this they are supported to develop a well-being plan that sets out a clear set of objectives and how to achieve them. **Befriending – social interaction development** services have shifted the focus from one of constant unchanging volunteers visiting people in their own homes, to a model of creating social networks for people and connecting people so that they can move on from

services and achieve greater independence
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Project sponsor -Director of Adult Social Care Delivery team – Broad range of voluntary and community sector partners as follows: Age Concern, Alzheimer's Disease Society ,Blackfriars Settlement , Dulwich Helpline & Southwark Churches Care, Lambeth Family Link, Lambeth Mencap, Leonard Cheshire Disability, Riverside ECHG, Southwark Disablement Association, Southwark Pensioners Time and Talents Under the BCF these services will be jointly commissioned.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Making a strategic shift towards prevention and early intervention of one of the central objectives of Putting People First. In Southwark we appreciate that the current model of support and provision is more often than not based on a reactive approach where people are ‘done to’ or where things are ‘done for’ a person in need. By understanding this and working to shift to a model of enabling people to be able to ‘do for themselves’, before a time of crisis or significant deterioration in ability, Southwark is aiming to support and maintain our citizens ability to engage positivity in their own communities, manage their own health and social care needs and have a far greater emphasis on self directed support over traditional models of care as they encounter and engage with services and professionals. Developments in medicine and public health have meant that the population as a whole is living longer as people age or live longer with complex health conditions. Demographics in Southwark, particularly those relating to an aging population, socially excluded and deprived communities and people with complex needs, indicate that significantly more people will be accessing health and social care services over the coming years. This increase in service demand is occurring alongside reducing public resources as public sector spending comes under increasing pressure. We know that public sector finances will not increase in line with this demand and as such continuing with current models of service is unsustainable. The Community Support Model is one strand of the prevention approach highlighted above.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The aim of the model is to support the following outcomes: • Older and disabled people understand what choices they have and are able to

make informed decisions about how to support themselves; • Older and disabled people are able to access services and activities that they choose; • Older and disabled people take an active approach to supporting themselves within their means by planning their lives; • The health and well-being of older and disabled people is supported by the choices they make; • Older and disabled people are able to develop social networks that support their independence See annex 1.20 on contribution to non-elective admissions target
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
All of the services commissioned within the community support model are monitored against the outcomes identified. We have also carried out a strategic review of these services which will inform our commissioning activity going forward. Additionally we ask provider to carry out regular and ongoing service user engagement to capture the qualitative impact of services
What are the key success factors for implementation of this scheme?
• Clear and transparent customer pathways • Close integration between the voluntary and community sector and Adult Social Care • Clarity regarding roles of organisations within structure and clear channels of communication • Significant awareness raising amongst local population • High quality advice and information provided • Regular and ongoing monitoring and review • Investment in key services within structure

ANNEX 1.19 – Detailed Scheme Description – End of Life

Scheme ref no.
19
Scheme name
End of life care: development of an End of life Care Co-ordinator(s) based in social care but working across NHS and Social Care in Southwark to integrate, build on and improve the overall approach.
What is the strategic objective of this scheme?
Improved co-ordination of care for people at the end of their life to improve the quality and outcomes of services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Co-ordinators to be recruited to develop and improve the approach to end of life care strengthening the links between social care and health , ensuring multi-agency resources are well co-ordinated to support people to remain in their own home in a safe and dignified way in line with their personal plan, and informal carers are well supported. The Co-ordinators will support the link with community nursing and specialist palliative care teams to ensure that people's experience of care and support provision is seamless and to ensure advance care plans are developed to prevent avoidable crisis. The scheme will aim to prevent emergency admissions and unnecessary stays in hospital. The budget includes funding for training staff involved in end of life care. The co-ordinators will have a particular focus on the cohort of clients with a terminal diagnosis who are not yet in need of palliative care services to ensure that this client group have access to appropriate services to support advance care planning. The Co-ordiantors will also have a specific remit in working with the Nurse Consultant for End of Life Care and community nursing to explore how residential care can be supported to manage end of life care. Co-ordinators will work with health and social care professionals to explore and gather best practice evidence from around the country to further develop service provision, improve pathways and fast tracks in Southwark, linking with other work streams for example, Dementia care. With partners the Co-ordinators will further develop discharge pathways from acute hospital to a "preferred place", and thus allow more people die in a setting of their choice. The scheme will look to expand and develop out of hours/rapid response provision in terms of medical support, medication management, strengthening community pharmacy presence. The scheme seeks to strengthen the medicine management support to care

homes to support admission avoidance. This will be achieved by increasing the pharmacy input into care homes to ensure that prescribing reviews are in place for people identified as end of life to reduce poly pharmacy and ensure that anticipatory drugs are available both in and out of hours. (This includes £30k which will be of benefit to a wider cohort). A network of 4 co-ordinators will be developed, covering each neighbourhood.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The End of Life Care Co-ordinators will be recruited jointly and would work as part of an MDT and link in with key professionals including End of Life Nurse Consultant, GSTT Palliative Care End of Life Co-ordinator, St Christopher's, Marie Curie, SELDOC (Out of Hours Service) and social care partners. They would help develop ideas for smarter End of Life Care pathways and have a greater role around End of Life Care linked to residential and nursing care.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Around 20% of people in Southwark currently die in their own home and evidence from other areas is that more can be done through co-ordinated support to increase that in line with people's wishes. This may be at home or another place of their choice. Feedback from carers frequently indicates the quality of end of life care should be improved through better co-ordination. The extract below from **"Quality standard for end of life care for adults"** encapsulates Southwark's vision for End of Life Care provision. The End of Life BCF Scheme has been developed to support services in Southwark to meet the general quality measures that we should be judging End of Life care social care provision. "This quality standard describes high-quality care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for adults approaching the end of life and the experience of their families and carers. This will be done in the following ways, regardless of condition or setting: • Enhancing quality of life for people with long-term conditions. • Ensuring that people have a positive experience of (health) care. • Treating and caring for people in a safe environment and protecting them from avoidable (healthcare-related) harm. The quality standard is also expected to contribute to the following overarching outcome(s) for people approaching the end of life:

• The care that people approaching the end of life receive is aligned to their needs and preferences. • Increased length of time spent in preferred place of care during the last year of life. • Reduction in unscheduled care hospital admissions leading to death in hospital (where death in hospital is against their stated preference). • Reduction in deaths in inappropriate places such as on a trolley in hospital or in transit in an ambulance."
Investment requirements: £200k Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contributes to a range of key BCF metrics, including hospital admissions, admissions to care homes, delayed transfers of care and user experience. See annex 1.20 on contribution to non-elective admissions target
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
There will be an evaluation of the end of life care cases co-ordinated to determine the effectiveness of the approach, including use of carer feedback, unplanned admissions and compliance with end of life plans.
What are the key success factors for implementation of this scheme?
Effective engagement of different agencies in care co-ordination and end of life planning process. This will be facilitated by the co-ordinator role.

Annex 1.20

Note on contribution of individual schemes to the targets for non-elective reductions:

The target to reduce non-elective admissions by 3.5% (860) in 2015 has been accepted as challenging but realistic in the context of the extra BCF funding. This is based on benchmarking and other evidence that demonstrates that a reduction of this order should be possible if services are more effectively co-ordinated, as set out in the case for change.

The schemes in the BCF are all designed to make a contribution towards this target, and are highly inter-related as an overall programme of support. They are also operating alongside other admissions reduction initiatives funded outside the BCF. For example a service user at risk of admission could benefit from a package of care and interventions that could well include several of the BCF services (e.g. discharge support, re-ablement or intermediate care, home care, carer support, telecare, community equipment, enhanced rapid response and other services) as well as services such as the Falls service or GP initiatives such as holistic health assessments outside the BCF. Demonstrating the extent to which each of these may individually reduce emergency admissions is therefore extremely difficult.

Broad estimates have however been made to check the potential impact is in the right order of magnitude, based on estimated additional number benefitting, improved effectiveness under the integrated service model, and numbers possibly avoiding an admission as a result. These are not felt to be sufficiently robust to be used as scheme targets in the programme management of the BCF, although as the detailed schemes are implemented more robust impact monitoring arrangements will be established to maximise our understanding of the evidence of impact.

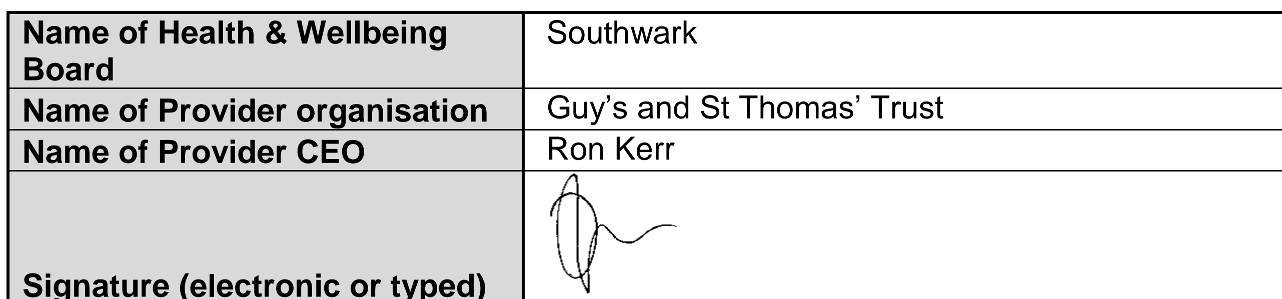
These estimates are set out in the table below:

Estimated impact of schemes on emergency hospital admissions

Ref no.	Scheme	Illustrative contribution to non-elective admissions target in 2015 (range)
1	Existing NHS transfers	50-70
2	Winter pressure grant funded services	30-50
3	Re-ablement	40-60
4	Service development	0
5	Self management	20-40
6	Home care quality improvement	80-120
7	Psychiatric liaison	30-40
8	Mental health	40-60
9	Telecare expansion	40-60
10	Carers	80-120
11	Admissions avoidance services	70-80
12	@home	100-150
13	Care Bill Implementation	0
14	Social Services Capital	10-25
15	Disabled Facilities Grant	5-15
16	Protecting Adult Social Care	25-50
17	Seven day working	15-25
18	Voluntary sector preventative services	15-25
19	End of life care	50-70
	Total	**700-1060**

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.



Name of Health & Wellbeing Board	Southwark
Name of Provider organisation	Guy's and St Thomas' Trust
Name of Provider CEO	Ron Kerr
Signature (electronic or typed)	

For HWB to populate:

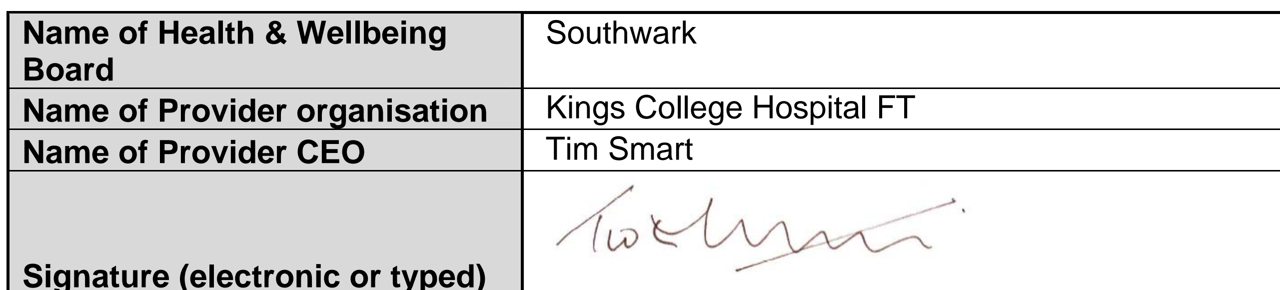
Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10,203
	2014/15 Plan	9,842
	2015/16 Plan	9,498
	14/15 Change compared to 13/14 outturn	-3.5%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	361 (not solely BCF)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	344 (not solely BCF)

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust supports the planned reductions of non-elective admissions targeted through the BCF, integrated in a wider programme of pathway change aimed to keep people out of hospital.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agreewith the projected impact?**	*n/a*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust is working with partners to reduce demand on A&E and inpatient admissions and this reduction in non-elective admissions is entirely consistent with out own service objectives.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.



Name of Health & Wellbeing Board	Southwark
Name of Provider organisation	Kings College Hospital FT
Name of Provider CEO	Tim Smart
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10,203
	2014/15 Plan	9,615
	2015/16 Plan	9,278
	14/15 Change compared to 13/14 outturn	-5.8%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	588 (not solely BCF)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	337 (not solely BCF)

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust supports the planned reduction in non-elective admissions targeted through the BCF, integrated in a wider programme of pathway change aimed to keep people out of hospital.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*n/a*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust is working with partners to reduce demand on A&E and inpatient admissions and this reduction in non-elective admissions is entirely consistent with our own service objectives.

Appendix 1

Better Care, better quality of life in Southwark:

Our vision for integrated care and support for our local population through well co-ordinated, personalised health and care services.

This is a vision for the whole system, not just health and social care. It links key themes in Southwark's Health and Wellbeing Strategy and other key strategies across the CCG and Council to support people to live independent, safe and healthy lives by giving them more choice and control over their care.

We want people to live healthy, independent and fulfilling lives, based on choices that are important to them.

Our vision for integrated care in Southwark is for people to stay healthier at home for longer by doing more to prevent ill health, by supporting people to manage their own heath and well-being and by providing more services in people's homes and in the community. We want people to feel in control of their lives and their care, with the services they receive co-ordinated and planned with them around their individual needs.

We will build upon our existing work to integrate services around people's needs, but recognise that we now need to transform the way we work together across health and care to really achieve this.

Our key aspirations for integrated care in Southwark are to deliver:

- More care in people's homes and in their local neighbourhoods
- Person-centred care, organised in collaboration with the individual and their carers
- Better experience of care for people and their carers
- Population based care that is pro-active and preventative, rather than reactive and episodic
- Better value care and support at home, with less reliance on care homes and hospital based care
- Less duplication and 'hand-offs' and a more efficient system overall
- Improvements to key outcomes for people's health and wellbeing
- Stronger, more resilient communities
- Southwark as a great place to live and work

We will know we have achieved our ambition for integrated health and care in Southwark when we need to rely less on hospital-based care and care homes, because more care that is better value will be delivered in people's homes and in their local neighbourhoods. People will be admitted to hospital quickly when they need to be, to access to the world class facilities and services. Hospitals will be able to

discharge people quicker, because effective and pro active services at home and in the community will help people get back on their feet and stay healthy and independent for longer.

We will take a population based approach to health, so that rather than just treating sickness, we recognise and address the wider determinants of ill-health across Southwark and the role of different services in promoting the public's health. This is set out in Southwark's Health and Wellbeing Strategy.

Why do we need to transform and integrate services?

There is a strong national and local drive towards integration, supported by new funding arrangements which necessitate joint working. The Care Bill will place a statutory requirement upon local authorities to carry out their care and support functions with the aim of integrating services with health and housing, and the Health and Social Care Act requires the NHS to ensure organisations work together to improve outcomes.

The way services are currently commissioned and organised does not always achieve our aims and our ambition is to work together to achieve better outcomes for our population and improved quality of life for individuals.

Southwark is a richly diverse borough with a significant asset base in terms of its people, its public services, its business communities, local economy and its social capital. The challenges we face are however significant. We have some world class services and yet we know we can do more to improve individual experiences, to improve the health of our local population and tackle health inequalities.

Our aspiration to improve the experience of local people, the challenges of our changing population, the increasing demands on our system and the economic challenge all mean we need to change.

Experience of patients and public: People in Southwark have told us they want care and support delivered in, or close to, their own homes. They want a response that is integrated and personalised, as expressed by the definition created by people who contributed to the 'National Voices' work:

> ***"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me"****

**This is an agreed national definition of integration from "Integration: Our Shared Commitment". It goes on to list a range of similar statements from the user perspective about what good integrated care should feel like.*

Population and demographic challenges: Southwark's population is younger, more transient, more ethnically diverse and more benefit dependent than is the case nationally and in many London boroughs. Although the older population is not increasing as quickly as in some regions, the over 85s population is rising. The

number of hospital admissions and use of A&E has increased much more rapidly than the growth in population. People are living longer but in Southwark people's 'healthy life expectancy' is below the London average and poorer people continue to have lower life expectancy and lower healthy life expectancy. A very high proportion of older people in Southwark live in social housing, presenting an opportunity for valuable co-operation between health, social care and housing services.

Economic challenge: The unprecedented economic challenge means the need for health and social care to deliver better value is greater than ever. A significant proportion of the demand on our local health system and the council comes from increasing numbers of frail older people and people with multiple long term conditions, including mental health. Integrated care is most effective when it is focussed on support for those people who are identified as being at greatest risk of poor health outcomes without early intervention and much improved co-ordination of services.

Building on progress so far:

As partners of Southwark and Lambeth Integrated Care (SLIC) we have already taken some significant steps towards integrating care in the borough, including establishing more community based support for frail elderly people to respond quickly to prevent admission or facilitate early discharge. Community Multi Disciplinary Teams are in operation across the borough, and primary care services are beginning to be organised on a neighbourhood basis.

We have also taken steps to re-direct finances to support these new models of care, However, there is still much to do to transform the way that care is organised, experienced by citizens, and funded across the borough. Our plans for the future of integrated services will build on these successes but go further, focussing on delivering personalised, pro-active care to local communities.

The changes we want to achieve:

We want to create a sustainable system that supports the most vulnerable and delivers value for money. To achieve this we need a significant cultural shift across the whole system. This means a different set of relationships between the NHS, the Council and the community, moving to a model where local citizens are seen as people who can contribute and exercise control over their own lives, improving their own health and well-being.

We want to tackle health inequalities and develop a more effective approach to preventing poor health and supporting people to better manage their own conditions. We need better integrated early interventions so that people get the right help when they need it and we need to ensure that people who have more complex conditions receive an integrated and personalised service.

We recognise the vital role that carers play both in delivering care and in helping prevent further deterioration, so that people do not need more intensive packages of support over time. This means we need to ensure that carers can access the right support to maintain their own health and well-being and to continue in their caring role, wherever they seek help.

We recognise we need to invest in the development of social capital across the borough, with a particular focus on enabling people to take control and giving them the tools to manage their conditions effectively. To help build community networks and a more personalised approach we will organise health and care services on a neighbourhood model around groups of primary care practices. This means that doctors, nurses, social workers, therapists, housing support workers and home carers will be able to build a strong set of relationships and work in a more integrated way, with common objectives to improve health outcomes for their local population and to offer a good experience that promotes better quality of life for local citizens.

The role of the third sector will be vital in driving forward the approach for building strong community engagement and the experience of the sector will be invaluable as we look to put the vision for effective prevention into practice.

We will mobilise our communities and recognise their assets, strengths and abilities, not just their needs. We will build on the assets in our community to support active self management by people, and support between peers, carers and families to take control of their own health and well being to address issues such as smoking, loneliness, exercise and eating.

Integrated care and support is about partnerships beyond the NHS and social care – involving individuals, communities, voluntary and private sectors and the Council's wider services, particularly employment and housing.

Healthwatch will help ensure that we are on track, and in particular that we provide services in a compassionate way that maintains people's dignity.

What does it mean for how we will commission services?

The Council and CCG are committed to using our joint resources to achieve our shared vision. The way that services are currently commissioned and organised does not always achieve these aims, and there are many 'hand offs' and differential incentives that work against our vision of services working together to support better health and more independence.

This will mean realigning finances to commission more pro-active support that offers continuity of care and is joined up around people's needs. Our plans, if successful, will mean less reliance on care in hospital or care homes, and more care in people's home or delivered in community based settings. We will work with partners in SLIC and the acute sector to enable this shift of resources to happen.

We will use our resources differently to remove organisational impediments to the provision of person-centred care and financially incentivising prevention, earlier intervention, recovery and re-ablement with our providers.

The pattern of services will be different in a number of ways:

The focus for the whole system is to enable people to live independently and well for as long as possible, using the widest range of mechanisms and support options possible. Some of the key aspects of change we want to see are:

- more care for older people and people with long term conditions will be delivered through locality based community multi-disciplinary teams with a lead professional responsible for co-ordinating the care of individuals, ensuring an integrated and personalised approach to case management by all services working with each person - GPs, Community Health, Social Care, Housing, Mental Health workers and hospital services.
- there will be less care needed in acute settings. A&E attendance and avoidable emergency admissions will reduce as community teams provide more targeted support to those at risk.
- When people do need acute care they will stay in hospital for shorter periods, returning home safely with the help of services such as @Home (Home Ward) and enhanced discharge support.
- re-ablement and intermediate care will increasingly provide effective short term interventions that rehabilitate people, restoring health and independence
- the balance of social care will shift away from care homes towards support in people's own homes and supported housing schemes including Extra Care.
- home care services will be funded with a view to radically improving quality and outcomes, with home carers linked in with other health and care professionals through the multi-disciplinary team approach
- there will be enhanced support for carers
- there will be a greater role for technology through using telecare to help people live safely at home
- a more integrated and coherent approach to preventative services including the voluntary sector tackling issues such as social isolation
- services will be responsive and accessible 7 days a week, including social care and admission avoidance community services as well as primary care
- new focus on developing dementia related services
- developing a neighbourhood health champions model

Achieving genuinely integrated care will have far reaching implications for the health and social care workforce and for the way that staff are trained and work together. Our **workforce** will need to be well-informed, appropriately skilled and clear of its common purpose in delivering person-centred care. We are committed to investing in the workforce so that they are appropriately skilled and trained for new ways of delivering care, and have a shared approach to coordinating care around people's needs.
Staff will need to work increasingly flexibly in integrated teams, with more staff working in the community and in people's homes. We will ensure that we have the right range of staff to respond flexibly to people's needs and that all staff across our system feel valued for their contribution to keeping Southwark people as healthy and independent as possible.

Better Care Fund - Southwark - appendix 2

Case for Change - Background documentation from SLIC integration business case research

Guy's and St Thomas'
NHS Foundation Trust

King's College Hospital
NHS Foundation Trust

South London and Maudsley
NHS Foundation Trust

We are all working together to increase the value of care we provide for the people of Lambeth and Southwark

Objectives of high value care

Issues in our current system

Quality

- The care people experience could and should be improved
- Commissioners are now looking to providers to focus on co-producing outcomes with patients through services that feel very different with an emphasis on being preventative, holistic and empowering

Cost

- If we carry on without change they system will go broke
- By working together to deliver preventative and coordinated care we can significantly reduce the gap
- But this will requires a fundamental shift in the way we work both clinically and operationally, underpinned by a new way of contracting with commissioners

The following slides provide more detail of the case for change within Southwark and Lambeth

Quality: commissioners are looking to us to work together differently to improve people's health and care outcomes

The care people experience could and should be improved

•In Lambeth and Southwark we have world-leading health and care institutions, yet our overall health outcomes are worse than average

•When asked, people describe a desire to have more control over their care, particularly with respect to those who live with long term conditions

•Evidence from local, national and international practice shows that different models of care can be used to help reduce people's need for unplanned care, reduce time spent in hospital and care home settings, to increase people's sense of empowerment, and to improve their overall health outcomes

- Local examples include pioneering work within the Diabetes Modernisation Initiative, The Lambeth Living Well Collaborative and the Older People's Programme

In response, commissioners are now looking to providers to:

•focus on improving the outcomes we co-produce with citizens, rather than the inputs we use or outputs we deliver, with an emphasis on reducing unplanned admissions (e.g. through the Better Care Fund)

•develop services which:

- Empower and activate people and communities, enabling people to be in control of their health and wellbeing
- Offer holistic and co-ordinated care and support
- Are equitable, proactive, preventative and focused on better outcomes

Cost: we need to ensure that the total costs of the system remain affordable – there is one system one budget!

If we carry on without change they system will go broke

•We estimate that in the 'do nothing scenario', health and social care spend in Southwark and Lambeth will increase by ~35%

•When compared against the funding allocations, the financial gap for social and health care in Southwark and Lambeth is projected to be ~£339m by 2018/19

By working together to deliver preventative and coordinated care we can significantly reduce the gap:

•Modelling work on our local data suggests that, through better care integration, the local system could reduce this gap by £163m, but this would require investment of £39m in new services (net saving £124m). This is the biggest opportunity we have for addressing the funding gap

•Taking this into account, integrated care could decrease the forecast social and health care spend across Southwark and Lambeth by ~11%

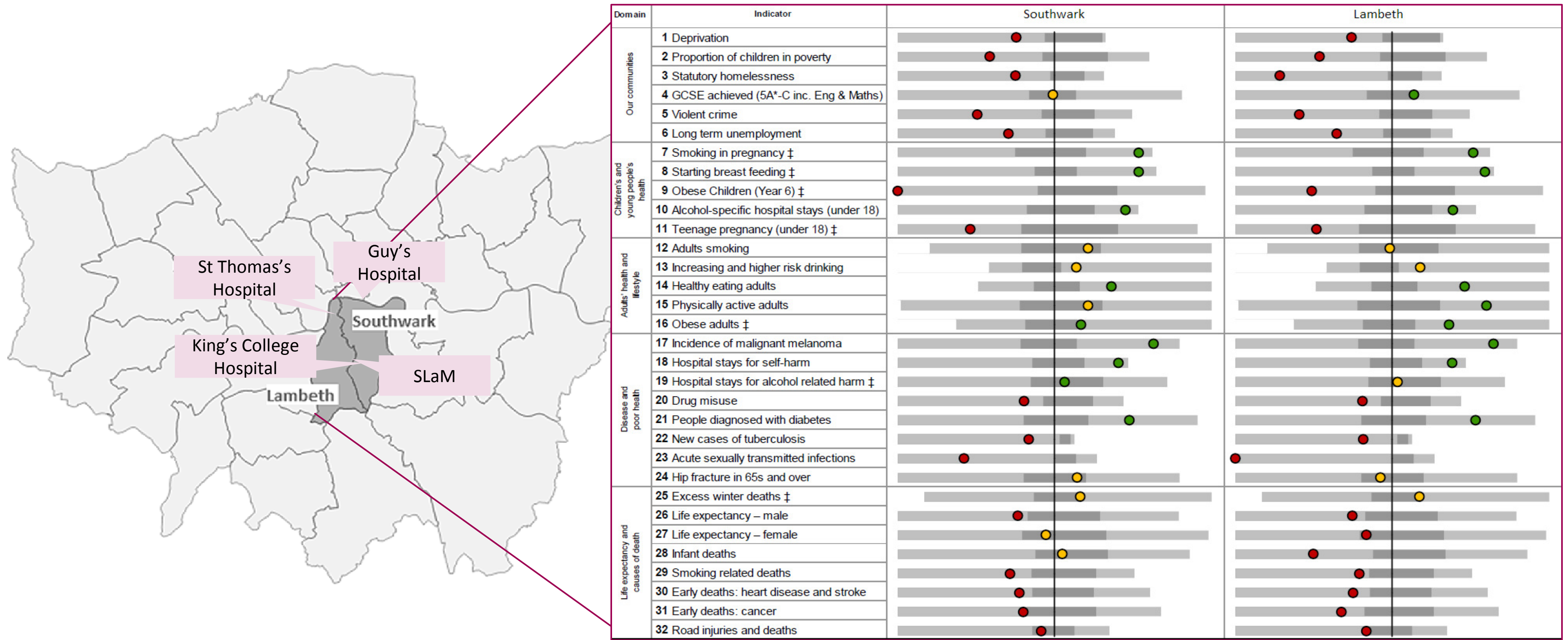
But this will requires a fundamental shift in the way we work both clinically and operationally, underpinned by a new way of contracting with commissioners

•The savings and investments associated with integrated care would change the balance of spend in health and social care

- For example funding into acute trusts would decrease by an estimated £19m, and funding into primary care would need to increase by £46m

Quality

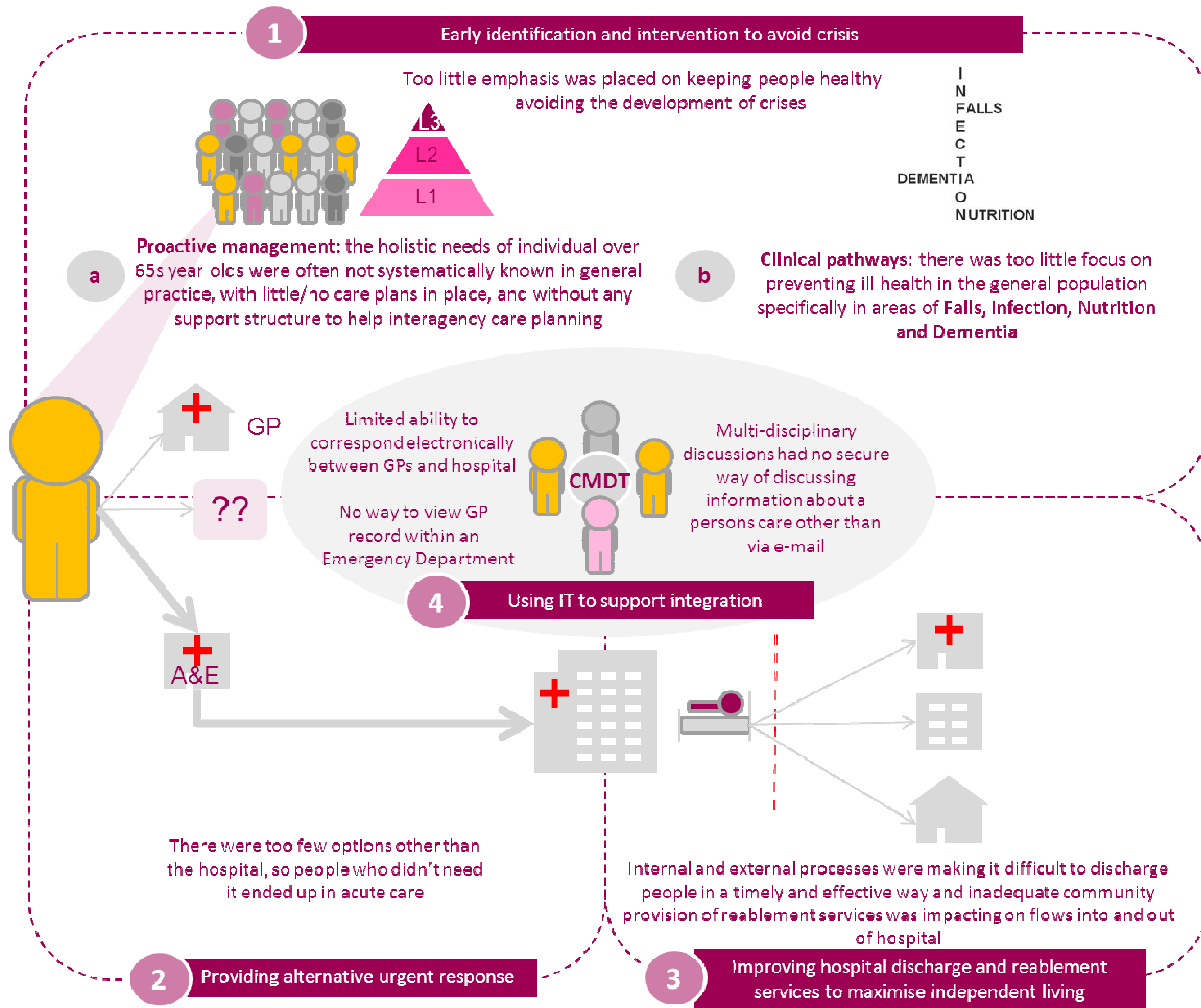
For our population of 600,000 people we have world-class medical institutions but worse than average outcomes and deprivation



Source: Health Profiles 2013

147

There is good local practical and theoretical evidence to show that new models of integrated care can improve outcomes for people



Anticipated benefits

By 2015/16:

Bed Reduction
(through reduced admissions & LOS)

- 23,500 bed days saved
- Equates to 32 beds for each acute

Social Care Reduction

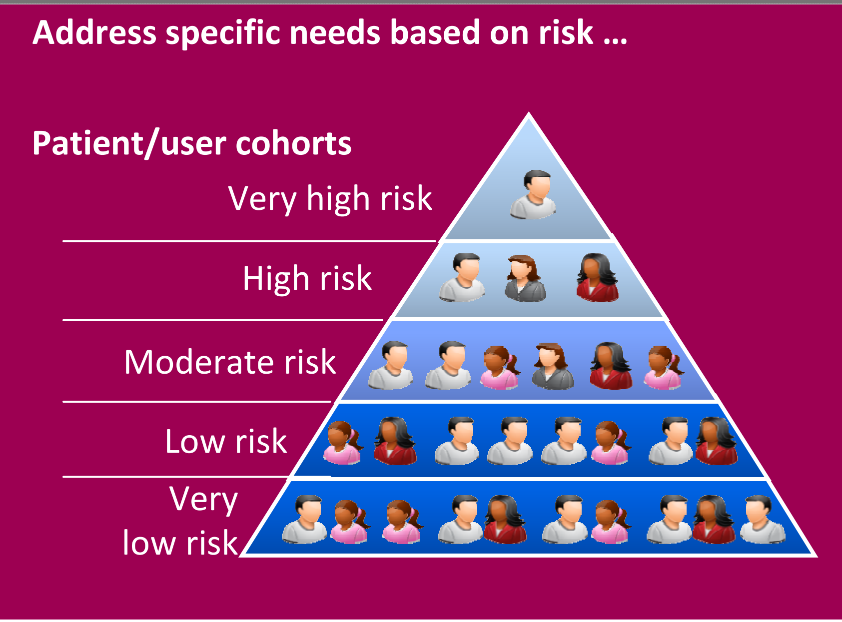
- 20% reduction in residential packages
- Equates to 133 less packages of care

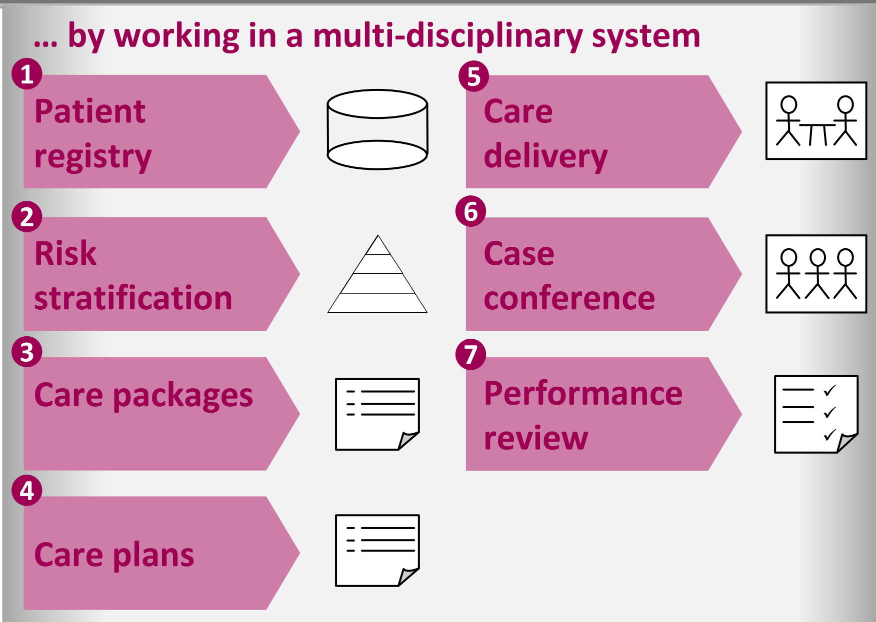
Improved patient experience

......Working together for healthier and happier lives

And global research shows successful integrated care systems require three core building blocks

Success in integrated care





… supported by key enablers

Aligned incentives and reimbursement models

Accountability and joint decision-making

Information transparency and decision support

Clinical leadership and team working

Patient engagement

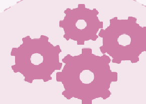
New services should feel different: people should experience services that are empowering, holistic and preventative

Attributes of integrated Care

SOUTHWARK & LAMBETH INTEGRATED CARE

Empowers and activates people and communities, enabling people to be in control of their health and wellbeing:

- Recognises, uses and develops all the assets available in our communities
- Empowers people to be active and in control of their own care, and supports the needs of carers
- Promotes choice for individuals, their families and carers
- Provides more care in people's homes, or supports them in community settings close to home, which enable them to stay as well and independent as possible



Offers holistic and co-ordinated care and support

- Works with people holistically across their physical, mental and social dimensions
- Meets the needs of all citizens, is easily understood and navigated by individuals
- Provides continuity of care over time, and co-ordinates care across settings and providers
- Ensures effective transition for individuals between services
- Removes duplication and feels seamless to individuals

Is proactive, preventative and focused on better outcomes

- Actively promotes good health and well being across communities, enabling people to live healthier, more independent lives, for longer
- Detects problems earlier and intervenes quicker
- Avoids crisis and the need to address avoidable complications
- Aids recovery and a return to independence
- Provides equitable access for

Cost

We estimate that in the 'do nothing scenario', health and social care spend in Southwark and Lambeth will increase by ~35%

Care setting	Spend 13/14, in £m			Projected spend 18/19 'do nothing scenario', in £m			Change, in %		
	Southwark	Lambeth	Sum	Southwark	Lambeth	Sum	Southwark	Lambeth	Sum
Acute	201	230	431	297	325	622	48%	41%	44%
CHS	30	45	75	38	42	80	29%	-7%	7%
MH	58	66	124	78	95	173	35%[3]	44%[3]	39%
Primary[1]	57	68	125	72	84	156	26%	23%	25%
Prescribing	32	36	67	42	44	87	34%	25%	29%
CC	6	11	18	10	12	22	67%	1%	25%
SC	112	92	204	144	112	255	28%	22%	25%
Other[2]	21	28	48	35	48	83	70%[3]	73%[3]	72%
Total	**517**	**575**	**1,092**	**717**	**761**	**1,478**	**39%**	**32%**	**35%**

For Lambeth **£10.3m** transferred from CHS into BCF

Note: numbers may not add up due to rounding. Specialist care excluded. BCF involves allocation transfers from Acute, CHS and CC into Other (set up of reserves)
1 Includes dentistry and eye health
2 Incl. free nursing care, contract reserves (e.g., BCF), reablement, corporate budgets and other budget items
3 Non-demographic growth of MH stimulated by high outturn
4 Change driven by increased reserves set up for BCF
SOURCE: Southwark (v. 28.2.2014) and Lambeth (v. 10.3.2014) CCG plans; LA budgets as latest available; Team analysis

Cost

The financial gap for social and health care in Southwark and Lambeth is projected to be ~£339m by 2018/19

Million £

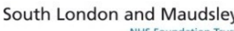
Council	Object	13/14	14/15	15/16	16/17	17/18	18/19
Southwark	CCG[1]	0	20	43	67	88	109
	Social care	0	11	28	39	50	62
	Total Southwark[2]	**0**	**31**	**71**	**106**	**138**	**171**
Lambeth	CCG[1]	0	25	53	79	102	124
	Social care	0	9	17	28	36	44
	Total Lambeth[2]	**0**	**34**	**70**	**107**	**138**	**168**
Total financial gap		**0**	**65**	**141**	**213**	**276**	**339**

The methodology used to calculate the financial gap is different to how CCGs report the gap in their strategic plans. We define it here to include the total gross QIPP requirement subtracting all investment costs, and adding back any projected savings. The rationale is that the gap as presented here reflects the total challenge under status quo conditions. The bridge between CCG QIPP and the CCG financial challenge as reported here, is set out in the appendix

1 CCG forecasted financial gap, including running cost allowance, and excluding BCF
2 Does not include the Public health budgets held jointly by CCG and Local Authorities
Note: Numbers may not add up due to rounding; numbers as presented in last ICG meeting

SOURCE: Southwark (v. 28.2.2014) and Lambeth (v. 10.3.2014) CCG plans; LA budgets; Team analysis

......Working together for healthier and happier lives



PRELIMINARY

The ICG has developed a population segmentation for Southwark and Lambeth

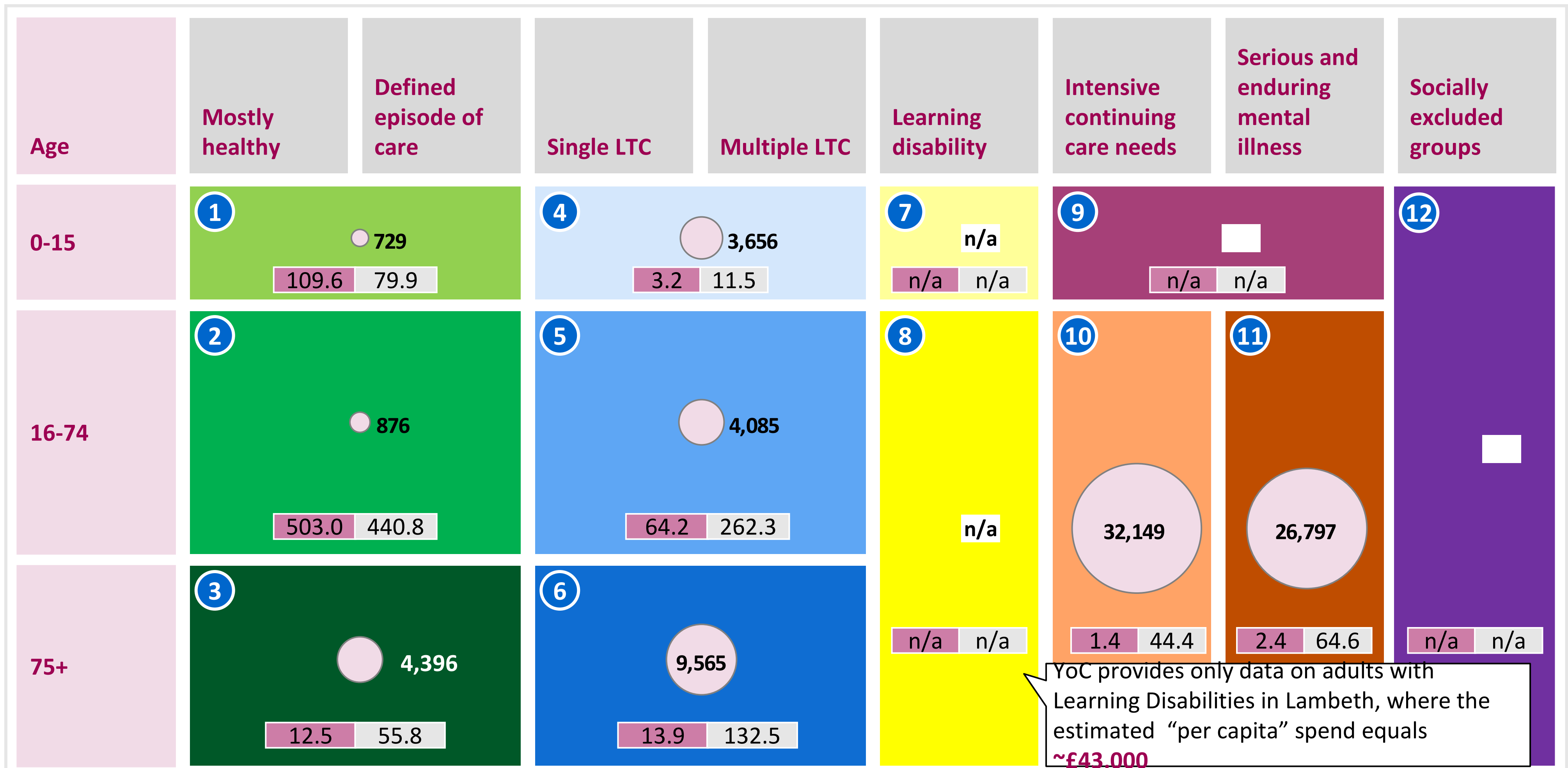
Age	Mostly healthy	Defined episode of care	Single LTC	Multiple LTC	Learning disability	Intensive continuing care needs	Serious and enduring mental illness	Socially excluded groups
0-15	1 Mostly healthy children		4 Children with one or more LTCs		7 Children with LDs	Children with intensive continuing care needs[1]		11 Homeless people, alcohol and drug dependencies
16-74	2 Mostly healthy adults		5 Adults with one or more long term conditions		8 Adults and elderly people with learning disabilities	9 Adults and elderly people with intensive continuing care needs	10 Adults and elderly people with SEMI	
75+	3 Mostly healthy elderly people		6 Elderly people with one or more long term conditions					

In addition there will be several **cross-cutting themes** that should be used to prioritise the particular approach within each grouping, e.g. frailty, deprivation, behaviour, social involvement, utilisation risk, presence of a carer, a person's own caring responsibilities

1 Small numbers of citizens in this category; ICG to confirm how to approach this group

B2 13/14 spend per capita by population segment

Average spend per capita (£)
Number of people (ths) | x | £ym | Total annual spend



Numbers represent estimates derived from the Year of Care (YoC) database. ~60% of total cost (~£660 mln out of ~£1,090 mln) has been linked to the segments. The remaining ~40% of CCG, NHSE and LA spending has been proportionally distributed across the segments. The YoC database includes spend for the following settings: Acute, MH, CHS, CC, Prescribing, SC and GPs. Other CCG spend e.g., contract reserves has been evenly allocated to each citizen. Specialist commissioning spend is excluded. Citizens in groups 7, 8, 9 and 12 cannot be identified in the YoC data

SOURCE: NWL Whole Systems work; SLIC Sponsor Board discussion July 2013; ICG discussions January-March, 2014

Cost

National and international case studies of integrated care identify a 15-25% savings potential

Group[1]	Relevant cases	Investment range	Impact range	Net savings[2] (%)
1 Mostly healthy children	▪ Colorado Children's Healthcare Access Program (CCHAP)	▪ ~25-35% increase of GP costs (preventive care)	▪ ~15-25% decrease of A&E spend ▪ ~20-25% decrease for non-elective inpatients spend	10-15
2 Mostly healthy adults	▪ Geisinger Health System ▪ Valencia's IC	▪ n/a	▪ 20% reduction in hospital admissions ▪ 7% savings in medical costs ▪ 76% increase in hospital productivity	10-20
3 Mostly healthy elderly	▪ NHS Torbay	▪ n/a	▪ Non-elective inpatient bed use in for 65+ patients reduced by 29% with LOS 19% lower	10-20
4 Children with LTCs	▪ Colorado Children's Healthcare Access Program (CCHAP)	▪ ~25-35% increase of GP costs (preventive care)	▪ ~5% decrease of A&E department utilisation ▪ ~25-35% decrease for non-elective inpatients spend	15-25
5 Adults with LTCs	▪ NHS Tower Hamlets	▪ Increase of GP spend by 40-50%	▪ 12-14% decrease of non-elective admissions spend	10-15
6 Elderly with LTCs	▪ ChenMed	▪ n/a	▪ 38% lower hospitalization rate ▪ 17% lower readmissions rates compared to national averages for patient group	20-30
10 Intensive continuing care needs	▪ n/a	▪ n/a	▪ n/a	n/a
11 SEMI	▪ NY Care Coordination Program ▪ Maricopa/Magellan	▪ n/a	▪ 29% reduction of annual per capita mental health costs	25-30
			Total	15-25

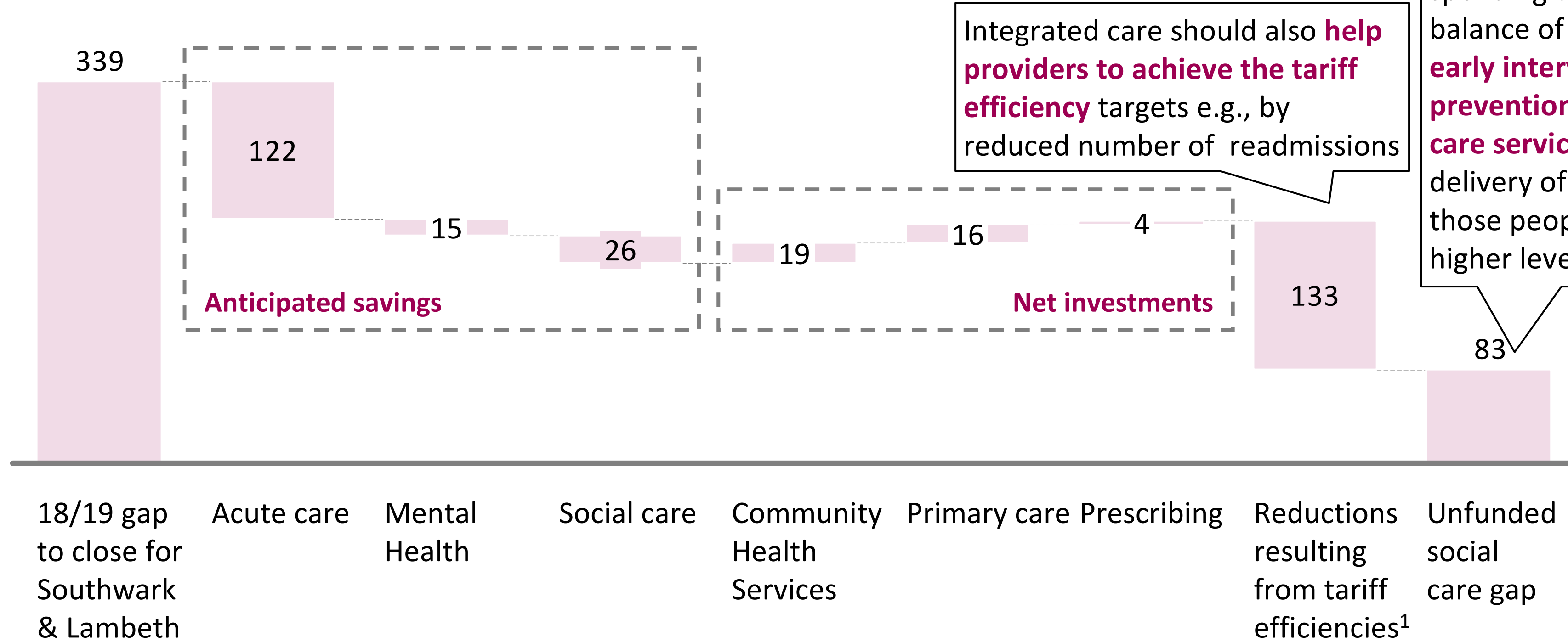
Each of the studied business cases and clinical papers **records actual savings** that have been observed during an adequate time span (i.e. mostly within 5 years)

1 Excludes groups 7, 8, 9 and 12, where no cost data is currently available

2 As part of total acute spend in segment; where no information on investment, savings reduced by 5-10%p

SOURCE: Expert interviews; Press search

Our modelling shows that investments of £39m are needed to release potential savings of £163m, a net saving of £124m



All savings and investments to be revised as plans for specific IC interventions are developed in more detail

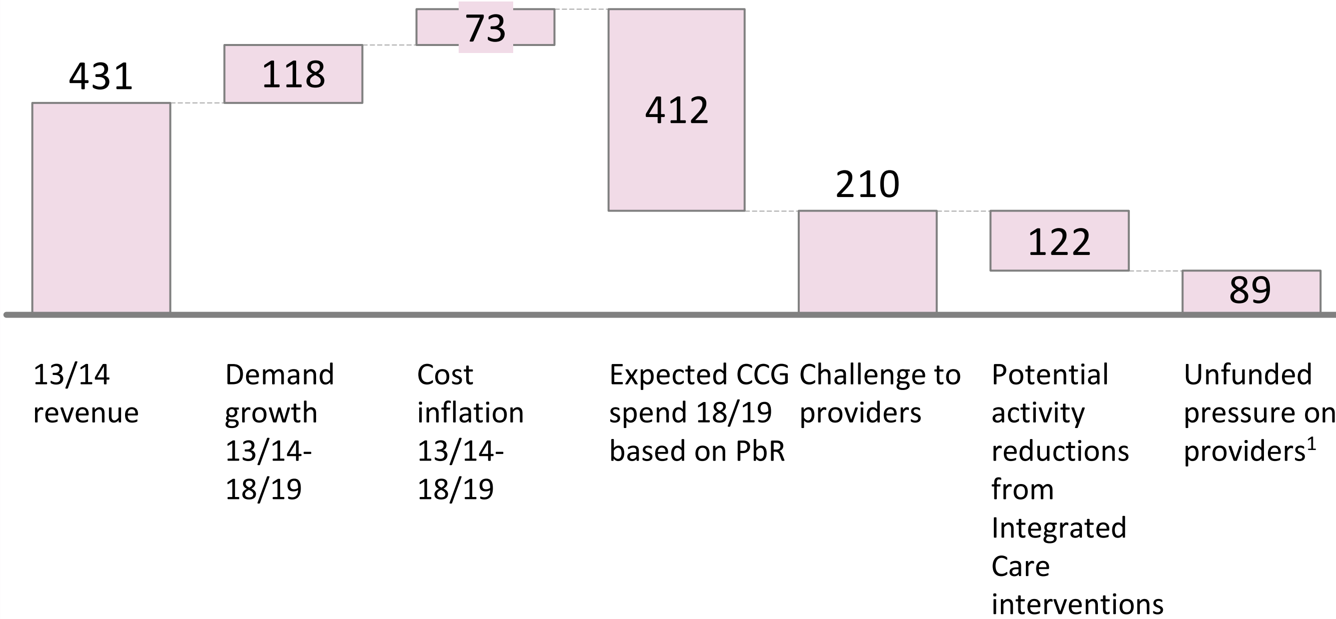
1 National planning guidance on 4%pa tariff efficiency for acute, mental health and community services

2 More details on LA approach regarding options available for the financial gap closure can be found in the appendix

SOURCE: YoC database, Southwark and Lambeth CCG plans

Commissioners' ability to invest in new services is based upon the ability to move resources from acute trusts…(1/2)

Financial challenge bridge for acute Trusts – only includes services at GSTT and KCHT for Southwark and Lambeth CCG



- Potential activity reductions through integrated care (based on case studies and benchmarking) approximately offsets demand growth (£122m vs. £118m), so the net change in Trust activity is small
- Remaining £89m is a large financial pressure on Trusts
- This analysis represents a small part of the larger financial challenge for the acute Trusts, as Lambeth and Southwark account for less than 20% of total Trust revenue[2]

1 This is equivalent to the 4% 'tariff efficiency' real reduction in prices that is embedded in Tariffs
2 Lambeth and Southwark CCG represent 16% total income (21% clinical income for KCH, and 19% total income (25% NHS clinical income) for GSTT. The total 5 year savings requirements for the Trusts when considering their full business (equivalent to the £210m challenge here), as reported by the Trusts, are approximately £350m (KCH) and £310m (GSTT) – this is beyond the scope of the SLIC work so has not been derived or tested here. The Trusts report that "The financial challenge to the Acute providers will be greater than the national efficiency factor of 4/4.5% due to additional cost pressures in the system such as a phased reduction of training & education funding, the loss of project diamond funding, Commissioner QIPP targets, cost pressures such as pension costs, medical locum and nursing agency costs due to staff shortages and an increased nursing requirement regarding patient acuity. In order to provide adequate capacity, there is an increased cost of debt service and associated PFI cost pressures." – Head of Financial Planning, King's College Hospital May 2014
SOURCE: SLIC financial modelling, based on CCG plans (Southwark (v.28.2.2014) and Lambeth (v.10.3.2014)) and comments provided by Trusts May 2014

…(2/2) but this is very difficult; unless activity falls, or risk is shared, trusts will face the cost of care without income to fund it

Acute providers	▪ On the current trajectory, 2018/19 would see the provision of £118m of acute activity that commissioners cannot afford given their future allocations and aspirations for spending on non-acute services ▪ Under this scenario, acute providers would be left with unrecoverable costs ▪ Halting this increase will take a heroic effort ▪ Cases studies and benchmarks indicate that integrated care can reduce activity by £122m offsetting this growth ▪ Doing this will require a significant increase in the resources in primary and community and their effectiveness ▪ Even with activity remaining flat, acute Trusts will need to achieve productivity savings that offset the £89m pressure from tariff efficiency
Out of hospital providers	▪ Out of hospital services, including community, mental health will also have to manage price reductions of 4 % below cost inflation (a total of £7m). ▪ However, there will be a need to invest additional resources in out of hospital services to deliver these improvements in health.

Cost

Implementing IC would change the balance of spend in health and social care away from acute hospitals

Million £

	13/14 Spend	Baseline 18/19	18/19 after IC interventions	Net change (Million £)
Total	1,092	1,336	1,212	+130
Other	4%	6%	6%	29
SC	19%	19%	19%	26
CC	2%	2%	2%	4
Prescribing	6%	6%	8%	24
GP	11%	11%	13%	46
MH	11%	11%	11%	8
CHS	7%	5%	7%	11
Acute	40%	40%	34%	-19

13/14 Spend → Baseline 18/19: +232, +22%

Baseline 18/19 → 18/19 after IC interventions: -144, -11%

Note: Numbers may not add up due to rounding

SOURCE: YoC database; Southwark and Lambeth CCG plans, team analysis

Cost

Overall, IC could decrease the forecast social and health care spend across Southwark and Lambeth by ~11%

For each setting we assumed the maximum net saving

Setting	Service line	13/14 spend	Baseline forecast: Activity	Baseline forecast: Price[1]	18/19 baseline spend	Applied net saving, in %	Net changes: Activity	Net changes: Price[1]	Net changes: Total	18/19 after IC interventions
Acute	Total acute	£431m	£118m	-£16m	£534m	-23%[2]	-£4m	-£16m	-£19m	412
	Non-elective	£110m	£30m	-£4m	£136m	-33%	-£15m	-£4m	-£19m	90
	Elective	£132m	£36m	-£5m	£164m	-30%	-£12m	-£5m	-£17m	115
	Outpatients	£105m	£29m	-£4m	£130m	-18%	£6m	-£4m	£2m	107
	A&E	£22m	£6m	-£1m	£28m	-18%	£1m	-£1m	£0m	23
	Non-PbR	£63m	£17m	-£2m	£77m	n.a.	£17m	-£2m	£14m	77
Primary		£125m	£31m	£0m	£156m	10%	£46m	£0m	£46m	172
Community		£75m	-£5m	-£2m	£67m	25%	£14m	-£2m	£11m	86
MH		£124m	£27m	-£5m	£147m	-10%	£13m	-£5m	£8m	132
Prescribing		£67m	£12m	£7m	£87m	5%	£17m	£7m	£24m	91
CC		£18m	£2m	£2m	£22m	n.a.	£2m	£2m	£4m	22
SC		£204m	£16m	£35m	£255m	-10%	-£9m	£35m	£26m	230
Other		£48m	£28m	£1m	£77m	n.a.	£28m	£1m	£29m	77
TOTAL		**£1,092m**	**£230m**	**£23m**	**£1,345m**	**11%**	**£107m**	**£23m**	**£130m**	**1,222**

Note: Numbers may not add up due to rounding

1 Includes tariff efficiencies

2 Lack in Non-PbR savingsresults in total for Acute of 23% vs.27% as proven by GP variation

SOURCE: YoC database; Southwark CCG plans

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Health and Wellbeing Board Details

ROCR approval applied for

Version 3

Please select Health and Wellbeing Board:

Southwark

Please provide:

Adrian Ward

adrian.ward@southwark.gov.uk

Health and Wellbeing Funding Sources

Southwark

Please complete white cells

	Gross Contribution (£000)	
	2014/15	2015/16
Local Authority Social Services		
Southwark	8,957	1,489
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
Total Local Authority Contribution	**8,957**	**1,489**
CCG Minimum Contribution		
NHS Southwark CCG		20,478
-		-
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**20,478**
Additional CCG Contribution		
<Please Select CCG>		
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Total Additional CCG Contribution	**-**	**-**
Total Contribution	**8,957**	**21,967**

Summary of Health and Wellbeing Board Schemes

Southwark

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	54	1,170			
Community Health	214	3,400			
Continuing Care	-	-			
Primary Care	207	1,900			
Social Care	8,482	15,497	8,482	15,497	Note: if "protecting social care" defined as all social care spend
Other	-	-			
Total	8,957	21,967		15,497	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		585
Community Health		3,400
Continuing Care		-
Primary Care		1,377
Social Care		310
Other		-
Total		5,672

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	(156)	(156)	
Increased effectiveness of reablement	-	(100)	
Reduction in delayed transfers of care	(47)	(33)	
Reduction in non-elective (general + acute only)	(1,819)	(1,271)	1,282
Other	-	(253)	
Total	(2,022)	(1,812)	1,282

note: P4P is based on calendar year 2015, this table is financial years

Southwark

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

Red triangles indicate comments
- Planned deterioration on baseline (or validity issue)
- Planned improvement on baseline of less than 3.5%
- Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	Quarterly rate	2,034	2,025	2,054	2,012	1,936	1,830	1,967	1,915	1,841
	Numerator	6,145	6,130	6,214	6,082	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Denominator	302,790	302,790	302,790	302,790	306,487	306,487	306,487	306,487	310,934

P4P annual change in admissions: -860

P4P annual change in admissions (%):

P4P annual saving: £1,281,534

Please enter the average cost of a non-elective admission[1]: £1,400

Rationale for change from £1,400:

Rationale for red/amber ratings:

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Southwark	% Southwark resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Camden CCG	4,379	4,580	4,601	4,678	0.6%	0.4%	21	22	22	23
NHS Central London (Westminster) CCG	3,630	4,004	3,912	3,805	1.6%	1.0%	57	64	63	63
NHS Lambeth CCG	7,461	8,070	7,432	7,128	6.6%	7.2%	476	492	492	472
NHS Lewisham CCG	5,807	6,339	6,473	6,408	2.0%	1.9%	118	126	129	129
NHS Southwark CCG	5,762	5,760	5,814	5,607	94.7%	89.1%	5,477	5,436	5,507	5,396
Total						100%	6,148	6,130	6,214	6,082

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Health and Wellbeing Board Financial Benefits Plan

Southwark

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

Benefit achieved from	If other please specify	Scheme Name	2014/15 Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
Reduction in permanent residential admissions		Aggregated benefits from permanent care home admissions from all schemes	Local Authority	(260)	600	(156,000)	av unit cost x weeks saved	Monthly monitoring of care home admissions, feeding in discussion from social services performance surgery which closely tracks admissions.
Reduction in non-elective (general + acute only)		Aggregated benefits from reduction in emergency admissions from all schemes (see annex 1.20)	NHS Commissioner	(1,221)	1,490	(1,819,290)	Av unit cost x admissions reduction	Monthly monitoring of NE admissions - detailed monthly analysis scorecard to be developed which shows avoidable admissions and GP practice.
Reduction in delayed transfers of care		Aggregated benefits from reduced delayed transfer of care all schemes	NHS Commissioner	(226)	206	(46,556)	bed days saved x av unit cost	Monthly DETOC data is analysed at patient level and trust levell. Issues usually discussed at bed management meetings.
Total						(2,021,846)		

Benefit achieved from		Scheme Name	Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
Reduction in permanent residential admissions		Aggregated benefits from permanent care home admissions from all schemes	Local Authority	(260)	600	(155,000)	av unit cost x weeks saved (not possible to disaggregate impact between range of related schemes that have similar impact on objective) Target based on benchmarking and analusis of known avoidable care home admissions from deep dive analysis	Monthly monitoring of care home admissions, feeding in discussion from social services performance surgery which closely tracks admissions.
Reduction in non-elective (general + acute only)		Aggregated benefits from reduction in emergency admissions from all schemes (see annex 1.20)	NHS Commissioner	(853)	1,490	(1,270,970)	Av unit cost x admissions reduction (not possible to disaggregate impact between range of related schemes that have similar impact on objective). Target based on benchmarking analysis of avoidable admissions.	Monthly monitoring of NE admissions - detailed monthly analysis scorecard to be developed which shows avoidable admissions and GP practice.
Reduction in delayed transfers of care		Aggregated benefits from reduced delayed transfer of care all schemes	NHS Commissioner	(160)	206	(32,960)	bed days saved x av unit cost	Monthly DETOC data is analysed at patient level and trust levell. Issues usually discussed at bed management meetings.
Other	bed days saved	The @ home service, ERR and reablement - improved impact 15/16	NHS Commissioner	(1,226)	206	(252,556)	bed days saved x av unit cost (SLIC benefits realisation analysis)	Bed day activity for referred clients
Increased effectiveness of reablement		Reablement	Local Authority	(6,250)	16	(100,000)	estimated reduction in home care hours for reablement clients	Monitoring outcomes of clients post reablement (care package reductions and people requiring no care, and still living at home after 91 days and re-admissions)
Total						(1,812,486)		

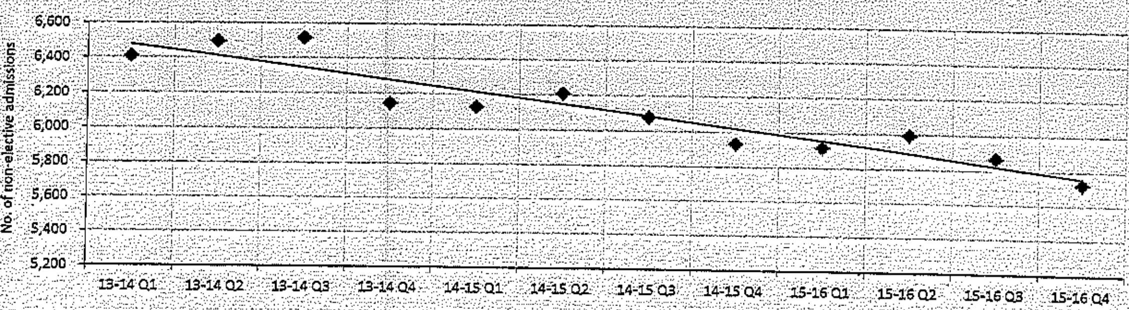
Southwark

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	6,413	6,499	6,520	6,148	6,130	6,214	6,082	5,933	5,915	5,997	5,869	5,725

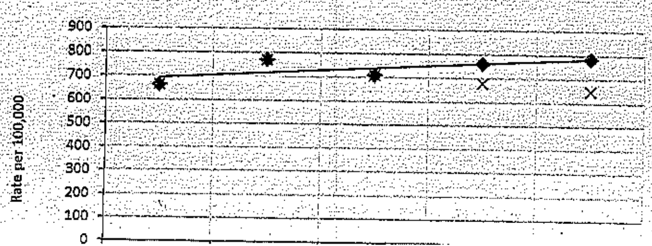


Metric		Projected				
		2014-2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*1,962.6*	*1,930.1*	*1,956.5*	*1,915.0*	*1,841.3*
	Numerator	*5,933*	*5,915*	*5,997*	*5,869*	*5,725*
	Denominator	*302,290*	*306,487*	*306,487*	*306,487*	*310,934*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	665	771	710	*760*	*783*
	Numerator	150	175	165	*179*	*187*
	Denominator	22,425	22,965	22,965	*23,527*	*23,843*



This is based on a simple projection of the metric proportion.

Reablement

Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Historic and projected annual %	90.7	77.2	88.1	82.7	81.4
	Numerator	100	110	185	174	171
	Denominator	110	145	210	210	210

This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	Historic and projected delayed transfers	81	161	222	110	134	132	190	195	134	132	251	311

Metric		Projected rates* 2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	377.1	385.3	393.5	395.6	403.7	411.7	419.7	421.6
	Numerator	909	929	949	968	988	1,008	1,027	1,047
	Denominator	241,087	241,087	241,087	244,755	244,755	244,755	244,755	248,374

* The projected rates are based on annual population projections and therefore will not change linearly

Agenda Item 11

Item No. 11.	Classification: Open	Date: 2 October 2014	Meeting Name: Health and Wellbeing Board
Report title:		Access to Health Services in Southwark (Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee)	
Ward(s) or groups affected:		All	
From:		Healthy Communities Scrutiny Sub-Committee	

RECOMMENDATIONS

1. That the Health and Wellbeing Board notes the contents of the review report: ‘Access to Health Services in Southwark’ and that the board provide a response to the relevant recommendations at the following board meeting on 20 November 2014, and convey that to the Healthy Communities scrutiny sub-committee.

BACKGROUND INFORMATION

2. Attached is the final report arising from the scrutiny review of Access to Health Services in Southwark, produced by the previous administration’s health scrutiny committee: ‘Health, Adult Social Care, Communities & Citizenship scrutiny sub-committee 2013/14’ – Appendix A.

3. Access to health services throughout Southwark is varied, with differing issues presenting at each access point. Each of these issues is interlinked, and an under-performance in one sector will necessarily impact on other health services. With increased, sustained pressure on the health service it is important, now more than ever, to have services which are truly delivering for our residents. The Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee therefore decided to consider the range of health services provided in the borough, and the ways in which our residents interact with these. In doing so, the sub-committee found a number of key issues which are leading to strains being placed on other health services

4. The scrutiny review focused on four areas of concern:

- Access to out of hours care – specifically the 111 Service and rollout in Southwark

- Understanding the reasons for increased use of A&Es over winter and how this could be reduced

- Access to individual GP surgeries and walk-in centres

- The implications of the Trust Special Administrator (TSA) and King’s Health Partners (KHP) merger on access to emergency and urgent care.

5. The 2013/14 Overview & Scrutiny Committee considered the sub-committee's report at its meeting on 10 March 2014. The committee welcomed the report and the valuable work of the sub-committee.

6. Southwark Council's cabinet provided a report responding to the review's recommendation for the local authority on 16 September 2014 - Appendix B.

7. The CCG, Hospital Acute Trusts and NHS England have been asked to provide a response to the Healthy Communities scrutiny sub-committee by 23 October and present at the committee meeting on 11 November.

HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE RECOMMENDATIONS

8. The sub-committee's recommendations are set out below in full, with those for consideration by the Health and Wellbeing Board set out in bold: recommendations 3, 8 & 13.

Recommendations

The 111 Service

1. We recommend that the Clinical Commissioning Group should report an update when there are next discussions on the potential rollout of the NHS 111 Service in Southwark.

2. We recommend that the Clinical Commissioning Group should provide clarity on the telephone numbers that residents can use to access out of hours healthcare services in the borough.

3. We recommend that the Health & Wellbeing Board and the Clinical Commissioning Group place signposting to healthcare services as a key priority for 2014/15, with key activities to reach all communities throughout the borough.

Accident and Emergency Departments

4. We recommend that the Trusts regularly report to the sub-committee on current staffing levels and the ways in which they are working to ensure that they are adequate.

5. The sub-committee recommends that Hospital Trusts should report quarterly on the number of beds available to A&E patients and how this compares to the number of beds needed, with particular reference to emergency admissions for older people and people in mental health crisis.

6. The sub-committee commends the 'Not Always A&E' campaign and recommends that it is rolled out throughout the year to help promote public awareness of the alternative healthcare services that residents can access.

7. We further recommend that Public Health supports the CCG in their campaign, ensuring that public awareness of the alternative healthcare services increases.

8. We recommend that the Health & Wellbeing Board and the Clinical Commissioning Group make raising the public awareness of the healthcare services available to Southwark residents a priority for the next year.

9. We recommend that the Clinical Commissioning Group continues its programmes working specifically with older people and that Public Health identifies the further support that we, as an authority, can be giving them.

10. This sub-committee commends the work of the CCG, jointly with the local authority and community services to help people stay well at home for longer. We would like to see further evidence of the work being done on the frail elderly pathway to ensure that we are offering our residents the best care services.

11. This sub-committee welcomes the work being taken forward by the Adult Social Care department. We recommend an update report on the services provided for older people with high needs to be made to the next sub-committee.

12. We recommend that further work is done by the Adult Social Care team within the council, looking specifically at the ways in which we can identify and support older people to prevent admissions to A&E.

13. We remain concerned however that there seems to be a lack of co-ordinated action by the health community to tackle the issue of increased acuity of patients. The subcommittee recommends that the Health & Wellbeing Board places this as a priority for 2014/15 and that Public Health carries out a piece of research into the reasons behind the increased acuity in Southwark.

14. We also recommend the establishment of a joint working group, led by the CCG and working alongside those involved in the JSNA and including the council, Hospital Trusts, Public Health and Healthwatch to look specifically at the ways in which we can support those people with long-term conditions in the community, and reduce presentations at A&E wards.

15. We recommend that the Mental Health sub-group of the Lambeth and Southwark Urgent Care Board presents its final Action Plan to the sub-committee for further comment.

16. We recommend that the final draft of the Joint Mental Health Strategy is presented to the sub-committee ahead of publication for further scrutiny.

17. We welcome the decision by SLAM to collate information on classifications of presentations to Emergency Departments and would recommend that this information is shared as part of the Joint Mental Health Strategy that is being developed.

18. We recommend that Kings College Hospital and Guy's and St Thomas' place the provision of safe, secure spaces for the treatment of patients presenting with mental health conditions as a key priority in their workplans for 2014.

19. The sub-committee welcomes the services that are currently provided by SLaM to support those with mental health conditions in Southwark. We recommend that priority is placed by SLaM on supporting people with mental health in the community, and intervening ahead of any admissions to A&E wards.

Access to GP Services

20. We recommend that the CCG and Hospital Trusts work together to reduce the time taken for GP surgeries to receive outpatient reports. We also recommend the CCG look into the ways in which they can provide template forms and support to GPs to

help them reduce the time taken on administrative tasks related to patient consultations.

21. We recommend that the Housing Options & Assessment and the Disabled Travel Team should carry out a review looking at the ways in which to influence customer signposting to ensure that residents are aware of the services that the council provides in terms of assessing residents for blue badges and receipt of benefits.

22. This sub-committee has actively followed and partaken in the consultation around the future provision of health services at the Dulwich Hospital site. We have welcomed the work done by the CCG, and the sub-committee recommends that the CCG provides an update as necessary.

23. We recommend that the CCG report back to the sub-committee on the Lister Urgent Care Centre once more work has been done on the preferred option for the provision of urgent care services in the south of the borough.

24. We recommend that GP services promote the SELDOC service within their local practices, to signpost patients to out of hours services.

25. We recommend that NHS England report to the sub-committee with an update on proposed opening hours of GP surgeries.

26. We recommend that NHS England, with the support of the Clinical Commissioning Group, undertake a study into the best method for providing appointments consistently across the borough and consider a Southwark offer that ensures minimum standards of access for patients in Southwark in regards to contact with a GP if appropriate following NHS England's Call for Action response.

The Kings Health Partners Merger

27. The sub-committee noted with interest that this process has now been delayed and recommends that when a Full Business Case is developed, King's Health Partners should return to the sub-committee for further scrutiny.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Overview & Scrutiny Committee Agenda 10 March 2014	Scrutiny Team 160 Tooley Street London SE1 2QH	Julie Timbrell 020 7525 0514

APPENDICES

No.	Title
Appendix A	Report of the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
Appendix B	Cabinet response to the review report

AUDIT TRAIL

Lead Officer	Shelley Burke, Head of Overview & Scrutiny	
Report Author	Julie Timbrell, Scrutiny Project Manager	
Version	Final	
Dated	17 September 2014	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Chief Officers	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		17 September 2014

APPENDIX A

Access to Health Services in Southwark

Report of the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

March 2014

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Introduction

1. Access to health services throughout the Borough of Southwark is varied, with differing issues presenting at each access point.

2. Each of these issues is interlinked, and an under-performance in one sector will necessarily impact on other health services.

3. With increased, sustained pressure on health service it is important, now, more than ever, to have services which are truly delivering for our residents.

4. This sub-committee therefore decided to consider the range of health services provided in Southwark, and the ways in which our residents interact with these. In doing so, we found a number of key issues which are leading to strains being placed on other health services.

5. In this report, we set out a number of recommendations to help alleviate some of this pressure and ensure that Southwark residents are able to access the highest quality of healthcare services.

Terms of the inquiry

6. The inquiry focused on four areas of concern:

    1. Access to out of hours care – specifically the 111 Service and rollout in Southwark
    2. Understanding the reasons for increased use of A&Es over winter and how this could be reduced
    3. Access to individual GP surgeries and walk-in centres
    4. The implications of the Trust Special Administrator (TSA) and King's Health Partners (KHP) merger on access to emergency and urgent care

Oral evidence session attendees

7. Evidence was received from:

    - Kings College Hospital
    - Guys and St Thomas' Hospital
    - South London and Maudsley (SLaM)
    - Southwark Clinical Commissioning Group (SCCG)
    - Public Health, Southwark & Lambeth
    - Healthwatch
    - Southwark Council Cabinet Member for Health
    - NHS England
    - London Ambulance Service
    - Local Medical Committee
    - Southwark Residents through an online survey

8. The following appeared in person before the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee:

- Harjinder Bahra, Equality and Human Rights Manager (SCCG)
- Andrew Bland, Chief Officer (SCCG)
- Kevin Brown, Assistant Director Operations for South London, London Ambulance Service
- Steve Davidson, Service Director, Mood Anxiety and Personality Clinical Academic Group, SLaM
- Angela Dawe - Director of Community Services, Guy's & St Thomas' NHS Foundation Trust (GST)
- Dr Roger Durston, GP Clinical Lead for Mental Health (SCCG)
- Dr Katherine Henderson, Clinical Lead (GST)
- James Hill, Head of Nursing for the Emergency Dept (GST)
- Dr Patrick Holden, Urgent Care Clinical Lead (SCCG)
- Tamsin Hooton, Director of Service Redesign (SCCG)
- Gwen Kennedy, Director of Client Group Commissioning (SCCG)
- Alvin Kinch, Healthwatch
- Sarah McClinton, Director of Adult Care, Southwark Council
- Cllr Catherine McDonald, Cabinet Member, Health, Adult Social care & Equalities
- Keith Miller, Ambulance Operations Manager at Waterloo, London Ambulance Service
- Hayley Sloan, 111 lead (SCCG
- Briony Sloper - Deputy Divisional Manager for Trauma and Emergency Medicine, King's College Hospital (KCH)
- Dr Ruth Wallis, Public Health Director, Southwark and Lambeth
- Jill Webb Deputy Head of Primary Care (South London) NHS England
- Nicola Wise, General Manager, Guy's and St Thomas'
- Dr Amr Zeineldine, Chair of the NHS Southwark Clinical Commissioning Group

Summary of recommendations

The 111 Service

1. We recommend that the Clinical Commissioning Group should report an update when there are next discussions on the potential rollout of the NHS 111 Service in Southwark.

2. We recommend that the Clinical Commissioning Group should provide clarity on the telephone numbers that residents can use to access out of hours healthcare services in the borough.

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7. We further recommend that Public Health supports the CCG in their campaign, ensuring that public awareness of the alternative healthcare services increases.

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The Kings Health Partners Merger

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The 111 Service

9. The NHS 111 Service was set out by the Secretary of State for Health as

   '[an] underlying concept...that everyone can agree with: it is a simple number that everyone can remember; the fact that you are connected directly to a clinician, if you need to speak to one, rather than being called back is something people like; the idea that you are triaged only once and do have to repeat your story lots and lots of times is a good one; and the fact you have a service that is broader than the old NHS Direct.' (House of Commons, Health Select Committee Report: Urgent and emergency services, 24 July 2013, p.41)

10. However, there have been a number of problems with its initial rollout. The initial provider of the 111 service, NHS Direct, was not financially sustainable, although it performed relatively well after initial teething problems. Performance in Southwark's surrounding boroughs - Bexley, Bromley and Greenwich - was below national standards for clinician referrals and call-backs.

11. In Southwark, the decision was taken to delay the rollout of the 111 Service in Southwark, Lambeth and Lewisham while the new provider, London Ambulance Service (LAS), became established. As the CCG highlighted in their report to this sub-committee, 'A stable, high standard of service is what we wish to be available for our patients across the whole area' (CCG Submission, South East London NHS 111 service update, July 2013).

12. At the same time the NHS Direct 111 service ended the NHS Direct number (0845 4647) was also switched off in March 2013. As the CCG set out in their evidence, a Southwark resident who calls the NHS Direct number will be advised to call 111. The call handler will be able to deal with the call, and redirect Southwark residents to the local out-of-hours provider (SELDOC) if they require GP out of hours services. This has obviously led to some complications, with residents having to phone multiple different telephone numbers in order to be able to access the right service. Southwark Healthwatch has been monitoring the feedback provided on the NHS 111 Service and highlighted in their evidence a number of key issues, including access and awareness of GP out of hours service (SELDOC) and the process by which residents are redirected to the NHS 111 Service. (NHS 111 Feedback Report, Healthwatch, 30 August 2013). It is reassuring that the new provider for South East London (SEL) of the 111 service is in the top 5 for 111 providers in the country.

Recommendations

1. We recommend that the Clinical Commissioning Group should report an update when there are next discussions on the potential rollout of the NHS 111 Service in Southwark.

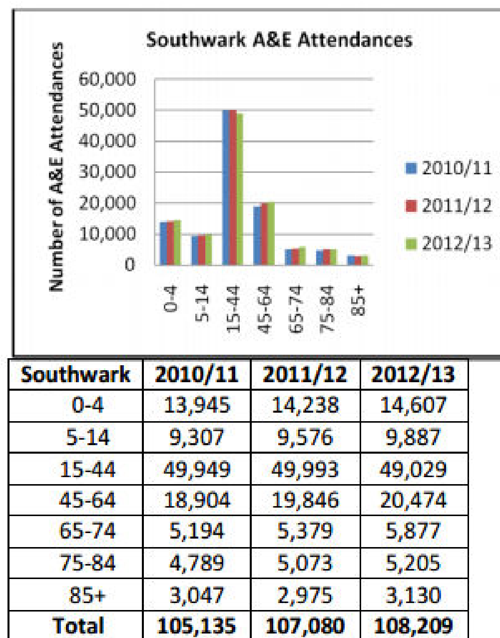
2. We recommend that the Clinical Commissioning Group should provide clarity on the telephone numbers that residents can use to access out of hours healthcare services in the borough.

3. We recommend that the Health & Wellbeing Board and the Clinical Commissioning Group places signposting to healthcare services as a key priority for 2014/15, with key activities to reach all communities throughout the borough.

Accident and Emergency Departments

Problems in Accident and Emergency Departments

13. It is fair to say that there is an increased pressure on Accident & Emergency (A&E) departments in Southwark. Whilst the number of attendees has not changed significantly over the past two years, there are a number of problems, which when combined together are affecting the way in which the service operates. There has been an increase in the volume and acuity of both older people presenting at A & E and in demand for emergency mental health services.



Southwark	2010/11	2011/12	2012/13
0-4	13,945	14,238	14,607
5-14	9,307	9,576	9,887
15-44	49,949	49,993	49,029
45-64	18,904	19,846	20,474
65-74	5,194	5,379	5,877
75-84	4,789	5,073	5,205
85+	3,047	2,975	3,130
Total	**105,135**	**107,080**	**108,209**

Figure 6. (Source: Local SUS data)

Figure 1: Trends in Acute Care Usage in Lambeth and Southwark: Public Health Analysis, Public Health Southwark, January 2014

14. As the Lambeth and Southwark Urgent Care Board noted in their evidence to the sub-committee, both Kings College Hospital and Guy's and St Thomas' have experienced issues with capacity.

15. Briony Sloper from Kings College Hospital said in her evidence that Denmark Hill A&E was not well set up for the volume and acuity of patients with mental health needs, and this was confirmed too by Guy's and St Thomas' who said that a lot of their overspend is around mental health issues. Both hospitals also raised the issue of increased economic pressures contributing to the rise in acuity of patients. Clinical staffing was also raised as an issue, with Kings College Hospital noting that there was a particular problem with approved social workers.

i. Staffing levels in hospital A&E departments

16. There have been increasing reports of the number of locum doctors that are being drafted in to support A&E departments. On 14 January 2014, the BBC reported that spending on locum doctors to plug the gaps in A&E units in England had risen by 60% in the last three years. Spending rose from £52million in 2009-10, to £83.3m last year. (Sharp rise in spending on A&E locum doctors, 14 January 2014, http://www.bbc.co.uk/news/health-25713374)

17. This same issue was raised as part of the sub-committee's inquiry. As a result, the Lambeth and Southwark Urgent Care Board, in their evidence to the sub-committee told us that both Hospital Trusts are implementing large scale emergency department developments over the next two years which will create additional physical capacity.

Recommendation

4. This sub-committee notes with concern that staffing levels are an issue in Accident & Emergency departments. We recommend that the Trusts regularly report to the sub-committee on current staffing levels and the ways in which they are working to ensure that they are adequate.

ii. Numbers of beds for admissions

18. The numbers of beds for hospital admissions has been reducing consistently over the past two and half decades. This is not a new problem. As The Guardian reported in January 2014 'successive governments have closed over 50% of NHS beds. In 2013/14 there were 135,000 NHS beds compared with 297,000 in 1987/88.' (Why A&E departments are fighting for their life, 14 January 2014, The Guardian). However reductions in bed capacity can be warranted by reductions in length of stay, which is the objective of the CCG admission avoidance programme and investment in community capacity.

19. The Lambeth and Southwark Urgent Care Board noted in their evidence that there were issues with numbers of beds. Sufficient bed capacity in acute hospitals is linked to A&E capacity and their ability to manage pressures. Guy's & St Thomas' bed capacity is historically less pressured than at King's College Hospital.

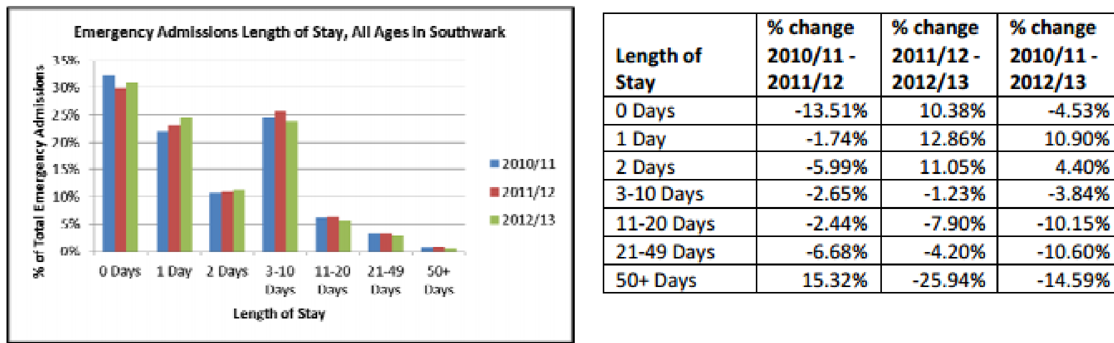
Recommendation

5. The issue of not having enough beds for patients is a worrying one. The sub-committee recommends that Hospital Trusts should report quarterly on the number of beds available for admissions from A&E and how this compares to the number of beds needed, with particular reference to emergency admissions for older people and people in mental health crisis.

iii. Length of stay and discharge processes

20. Matthew Cooke, an academic and clinical director of Heart of England Foundation Trust suggested in the Health Services Journal in October 2013, that the reason for increased pressure on A&E services was in fact down to delayed discharges from hospitals. (Delayed Hospital Discharge to blame for A&E pressure, October 2013, http://www.hsj.co.uk/acute-care/exclusive-delayed-hospital-discharge-to-blame-for-ae-pressure/5063876.article#.UwSNqPl_tnE)

21. Public Health in their evidence, told the sub-committee that the proportion of short (1-2 day) admissions had increased in Southwark, whilst the proportion of long-stay admissions had decreased. Dr Wallis suggested that one possible explanation for this was a lower number of delayed discharges.



Length of Stay	% change 2010/11 - 2011/12	% change 2011/12 - 2012/13	% change 2010/11 - 2012/13
0 Days	-13.51%	10.38%	-4.53%
1 Day	-1.74%	12.86%	10.90%
2 Days	-5.99%	11.05%	4.40%
3-10 Days	-2.65%	-1.23%	-3.84%
11-20 Days	-2.44%	-7.90%	-10.15%
21-49 Days	-6.68%	-4.20%	-10.60%
50+ Days	15.32%	-25.94%	-14.59%

Figure 17. (Source: Local SUS Data)

Figure 2: Emergency admissions length of stay, all ages in Southwark, Public Health, January 2014

22. However, she also noted that whilst hospital data suggested that delayed discharges have reduced, it is important to ensure that pressures in the system do not lead to premature discharges.

23. The Hospital Trusts addressed this in their evidence to the sub-committee. Kings College Hospital told the sub-committee that they had initiatives such as 'home for lunch' and a discharge suite, to help speed up the process.

24. And Guy's and St Thomas' told the sub-committee that they had plans to further improve discharge planning, looking at the ways in which they can use community support to help patients outside of hospitals. They also hoped that this would help to reduce readmissions in the future.

Type of people presenting at A&E departments

i. People presenting with non A&E conditions

25. Both Guy's & St Thomas and King's College Hospital emergency staff reported that around 20% of presentations at A&E are more minor ailments that could be treated outside of A&E or urgent care.

26. However, their concern was that it is hard to turn people away, especially when they are presenting in person at the A&E department. For those that present at an A&E department without an urgent medical condition, they will get streamed to a GP or emergency nurse. This has a cost implication for the hospitals, who said in their evidence that a hospital may get paid the lower tariff for providing care, but none of the emergency tariffs actually covers the cost of providing the service.

27. The London Ambulance Service also gave evidence as part of this review, explaining that the calls that they receive have been increasing by about 3% year on year. However, around half of all patients are not being taken to A&E.

28. London Ambulance Service suggested that there are people dialling 999 when it is not an emergency, because they do not know what to do and do not know how to access help and support from other parts of the healthcare system.

29. The sub-committee notes with interest the high proportion of people contacting, or presenting at A&E departments who do not have an immediate medical emergency. We believe that there is continued confusion about where residents can access minor care, versus urgent care.

30. The Clinical Commissioning Group in Southwark have taken steps to help educate residents about when to access A&E services through the 'Not Always A&E' campaign, launched in Winter 2013.

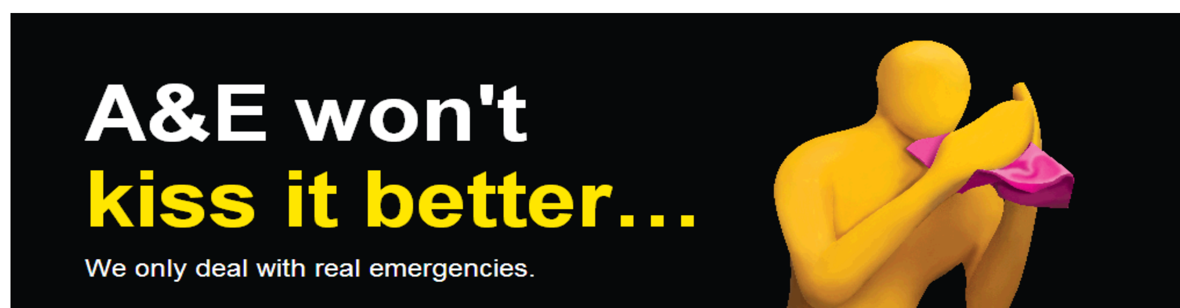


Figure 3: Not Always A&E Campaign

31. The NHS campaign explains that people should only go to A&E when it is absolutely necessary and reminds people of the alternative services that are available. The campaign is focused around yellow men, with different minor ailments, highlighting the alternative places that they can go to get expert advice and treatment if they need it.

Recommendations

6. The sub-committee commends this campaign and recommends that it is rolled out throughout the year to help promote public awareness of the alternative healthcare services that residents can access.

7. We further recommend that Public Health supports the CCG in their campaign, ensuring that public awareness of the alternative healthcare services increases.

8. We recommend that the Health & Wellbeing Board and the Clinical Commissioning Group make raising the public awareness of the healthcare services available to Southwark residents a priority for the next year

ii. High acuity patients

32. The Public Health function of the council has looked into the changing demographic of Southwark and found that GLA predictions indicate that the population of Southwark will grow by 15% by 2025, but the age structure will stay similar, with approx. 7% of the population between 65 and 84.

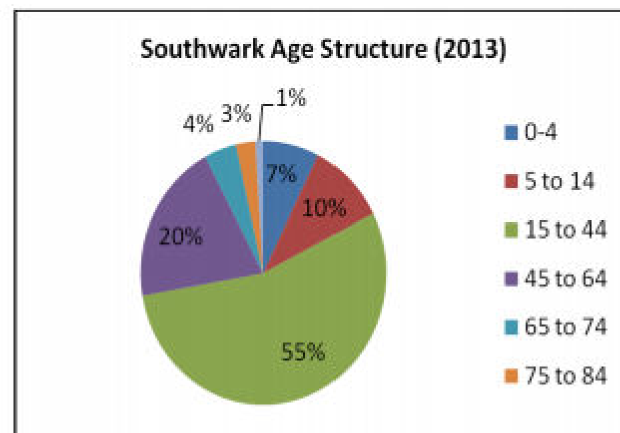


Figure 4: Southwark Age Structure, 2013, Public Health Southwark and Lambeth, January 2014

33. As part of their evidence, they suggest that A&E attendance and admission rates increased amongst 65 - 84 year olds, but fell amongst younger groups.

34. This was reinforced by the Lambeth and Southwark Urgent Care Board which noted that there is an increase in activity amongst the over 65 age group across Lambeth &

Southwark in accessing A&E services. (Lambeth and Southwark Urgent Care Board Briefing, September 2013)

35. The council took over responsibility for Public Health in April 2013, which means that we as an authority now have responsibility to ensure that the right services are available for our residents for public health related concerns.

36. Dr Ruth Wallis, Director of Public Health for Southwark & Lambeth set out in her evidence a number of ways in which the council should be focusing its efforts on public health concerns, especially for older people.

37. Focusing on issues that affect people as they become older may be one way in which increased older people A&E admissions can be combated. Dr Wallis suggested that long-term conditions need care and there should be an increased focus on diabetes and flu immunisation. In doing so, the causes of accessing A&E services by older people can be prevented through intervention by another part of the healthcare system.

Recommendation

9. The sub-committee notes with interest that public health drivers can play a part in reducing admittance to A&E's. We recommend that Public Health continues to support the work of the CCG in this and that the CCG, with Public Health support, undertakes a programme to look specifically at older people and the further support that we, as an authority, can be giving them.

38. Alongside an increase in the number of older people presenting at A&E departments, Hospital Trusts reported an increase in the acuity of these patients.

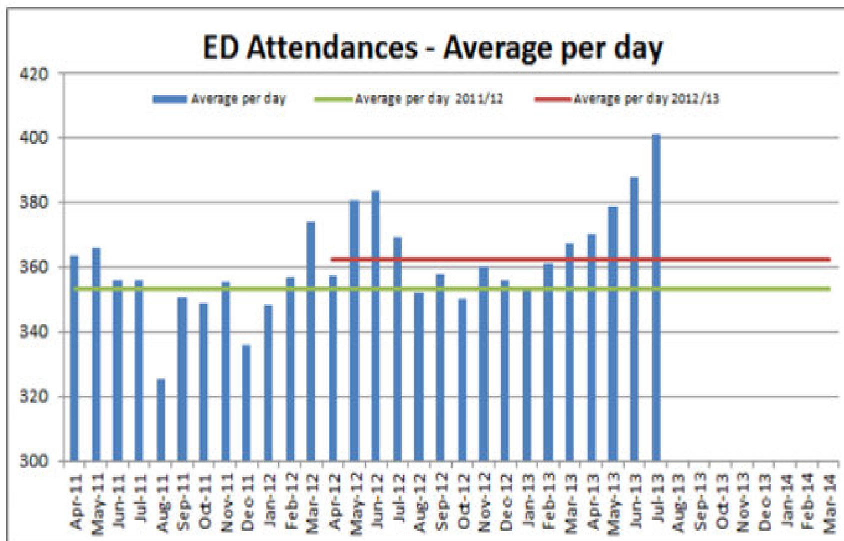
39. In Southwark, the number of emergency admissions in 2012/13 was 1.5% lower than in 2010/11, but the rate per 1,000 populations fell by a more significant 4.66%. However A&E attendance rate per 1,000 population had risen by around 10% in both 65-74 and 75-84 age groups since 2010/11, but the emergency admission rate per 1,000 population actually fell by 2.50% in the 65-74 age group, whilst rising 11.56% in the 75-84 age group.

40. This may indicate that the increase in attendances by 65-74 year olds is predominantly amongst less seriously ill individuals, whereas the increase in the older 75-84 year old age group consists of more seriously ill individuals who then require admission.

Age group	% change 2010/11-2011/12	% change 2011/12-2012/13	% change 2010/11-2012/13
0-4	-4.92%	0.18%	-4.74%
May-14	-3.45%	-0.31%	-3.75%
15-44	-3.39%	-6.58%	-9.74%
45-64	-4.79%	-5.36%	-9.90%
65-74	-1.37%	-1.15%	-2.50%
75-84	11.25%	0.28%	11.56%
85+	2.43%	-2.03%	0.35%
Overall	-1.47%	-3.24%	-4.66%

Figure 5:CCG data on older people and acuity February 2014

41. In their evidence, Kings College Hospital said that this increase in patients with acute conditions presenting at A&E departments meant that the number of people being admitted to the hospital was increasing, and they were staying longer. This necessarily puts more pressure on hospitals.



	A&E attendances	Average Daily
Jan-13	10944	353
Feb-13	10106	361
Mar-13	11400	368
April-13	11112	370
May-13	11747	379
Jun-13	11651	388
Jul-13	12443	401

Figure 6: Report to the Southwark Health and Adult Social Care Scrutiny Sub-Committee on Emergency Care, Emergency Department Attendances, Kings College Hospital, September 2013

42. As Public Health set out in their evidence, the proportional increase in attendance of patients of older age may mean a greater proportion of patients with co- morbidities as elderly patients are more likely to present with a number of conditions. Managing chronic conditions during an acute illness presents challenges, and this could be part of the explanation for the increased 'acuity' noted by local clinicians.

Providing support for those with high acuity in hospitals

43. Hospital Trusts however have set up a number of programmes to try and relieve the pressure caused by patients presenting with high acuity. The CCG in their evidence suggests that the provision of 'soft care' can help to keep people at home. They talked in their evidence to the sub-committee of an increased focus on community based admission avoidance schemes.

44. As part of the Southwark and Lambeth Integrated Care Programme's (SLIC) frail elderly pathway, the CCG has worked with the local authority and community services to keep people well and cared for in the home. This plan includes enhanced rapid response and home wards, which allow people to be discharged from hospital earlier.

45. However, when probed, the CCG admitted that whilst the use of 'rapid response' has been very good, the effectiveness of 'home wards' was less effective.

46. Guy's and St Thomas' further detailed their work as part of the frail elderly pathway, highlighting a focus on simplified discharge process, enhanced seven day working arrangements, redesign of the falls pathway, Community Multi-Disciplinary Team registers, holistic checks and case management.

Recommendation

10. This sub-committee commends the work of the CCG, jointly with the Local Authority and community services to help people stay well at home for longer. We would like to see further evidence of the work being done on the frail elderly pathway to ensure that we are offering our residents the best care services.

Providing support for those with high acuity conditions in the community

47. The Adult Social Care Department also presented evidence on their actions to support those older people with high needs in our community.

48. Sarah McClinton highlighted that 'risk of hospital admission is a key factor in assessing eligibility for social care, and services are put in place to minimise the risk.' (Adult Social Care, Access to Health Services, January 2014).

49. A key objective of the social services that the Authority provides is to prevent, delay or avoid the need for people to access more intensive health and care services including A&E, by helping people to live independently and safely in the community.

50. Sarah McClinton went on to say that:

    ‘for older people identified as at risk of admission we take a multi-disciplinary team approach with a single lead professional co-ordinating support from different agencies that should help prevent avoidable admissions through A&E. This priority is recognised nationally and will be taken forward in 2014/15 through the Better Care Fund which necessitates pooled funding and joint working in areas that will reduce pressure on health and care services.’(Adult Social Care, Access to Health Services, January 2014)

Recommendation

11. This sub-committee welcomes the work being taken forward by the Adult Social Care department. We recommend an update report on the services provided for older people with high needs to be made to the next sub-committee.

51. Southwark Council provides a large number of services as part of its social care package, which further helps to enable people to remain safely and independently in the community. This includes a 24 hour 7 day social care service, increased telecare resources, support for care homes to manage the health of residents, occupational therapy service and community equipment services.

52. Councillor Catherine McDonald, Cabinet Member for Health, in her annual scrutiny interview with the sub-committee also highlighted the work being done by GPs to provide assessments for older people to prevent demand at a later point in time - for example recommending the installation of grab rails to prevent falls in the home.

53. She also talked about the council’s work looking at housing policy, including the re-introduction of wardens and the plans for expansion of extra care, which would provide nursing on-site.

Recommendations

12. The sub-committee is pleased to know that the Adult Social Care teams within the Council are working hard to ensure that Southwark residents are receiving the best levels of care to help them stay safely and independently in the community. We recommend that further work is done to specifically look at the ways in which we can identify and support older people to prevent admissions to A&E.

13. We remain concerned however that there seems to be a lack of co-ordinated action by the health community to tackle the issue of increased acuity of patients. The sub-committee recommends that the Health & Wellbeing Board place this as a priority for

2014/15 and that Public Health carries out a piece of research into the reasons behind the increased acuity in Southwark.

14. We also recommend the establishment of a joint working group, led by the CCG and working alongside those involved in the JSNA and including the Council, Hospital Trusts, the Public Health and Healthwatch to look specifically at the ways in which we can support those people with long-term conditions in the community, and reduce presentations at A&E wards.

iii. Helping people with mental health conditions

54. In 2011, the Department for Health published ‘No Health without Mental Health’, a cross-government mental health outcomes strategy for people of all ages.

55. The report emphasised the importance of mental health, stating this: ‘Mental health is everyone’s business...good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.’ (No Health without Mental Health, February 2011, p.5)

56. The impact of mental health problems is estimated to continue to increase. As the CCG set out in their evidence, there are suggestions that the cost of treating mental health problems could double over the 20 years from the current estimated cost of £105billion per year. (NHS England statistics)

57. The sub-committee established that there are two distinct working groups looking at addressing the issues around mental health in Southwark.

58. First, a sub-group of the Lambeth and Southwark Urgent Care Board has recently been formed, which includes Gwen Kennedy, Director of Client Group Commissioning at the Clinical Commissioning Group, with representatives from the hospital trusts. This group is looking directly at supporting patients who present with mental health conditions at A&E. The group is currently working on an Action Plan, which sets out the activities the Trusts will be undertaking to help relieve the pressures.

Recommendation

15. We recommend that the Mental Health sub-group of the Lambeth & Southwark Urgent Care Board presents its final Action Plan to the sub-committee for further comment.

59. Secondly, the Council and the Clinical Commissioning Group commissioned a review of the partnership arrangements that were in place for delivering mental health services in the borough. The review made a number of recommendations, including the developments of a new Mental Health Strategy for Southwark.

60. The initial thoughts on this document were presented to the sub-committee by the Clinical Commissioning Group in October 2013.

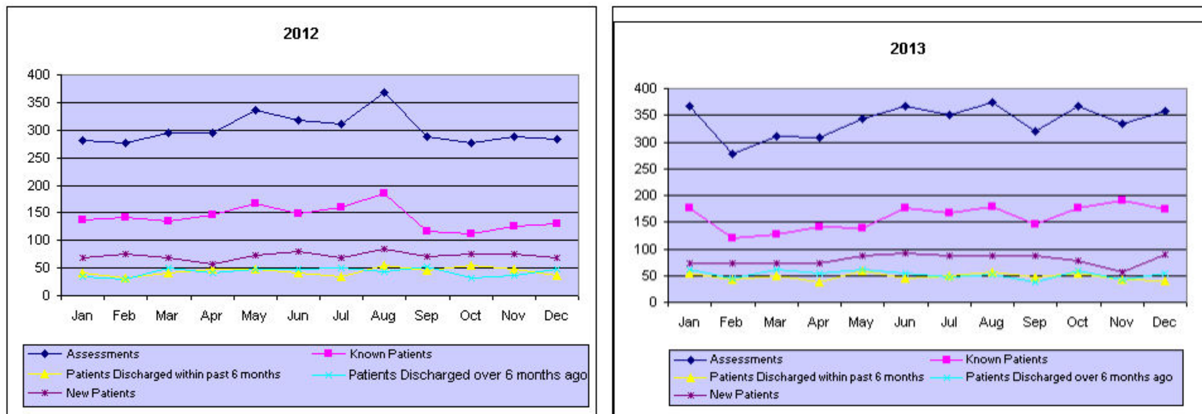
Recommendation

16. We recommend that the final draft of the Joint Mental Health Strategy is presented to the sub-committee ahead of publication for further scrutiny.

Numbers of people presenting at A&Es

61. The sub-committee heard from the Hospital Trusts specifically about the increasing numbers of people presenting at A&E departments with mental health conditions, alongside increased acuity and increased co-morbidity.

62. Hospital Trusts reported the worrying statement that the number of mental health patients presenting at A&E departments requiring assessment and appropriate interventions has increased significantly. In terms of numbers of presentations, Kings College Hospital reported that there was a 10.2% increase in assessments between 2011-2012 and 2012-13 (3370 to 3717). At the same time, there was a 32% increase in MHA admissions in the same time period from 88 to 117.



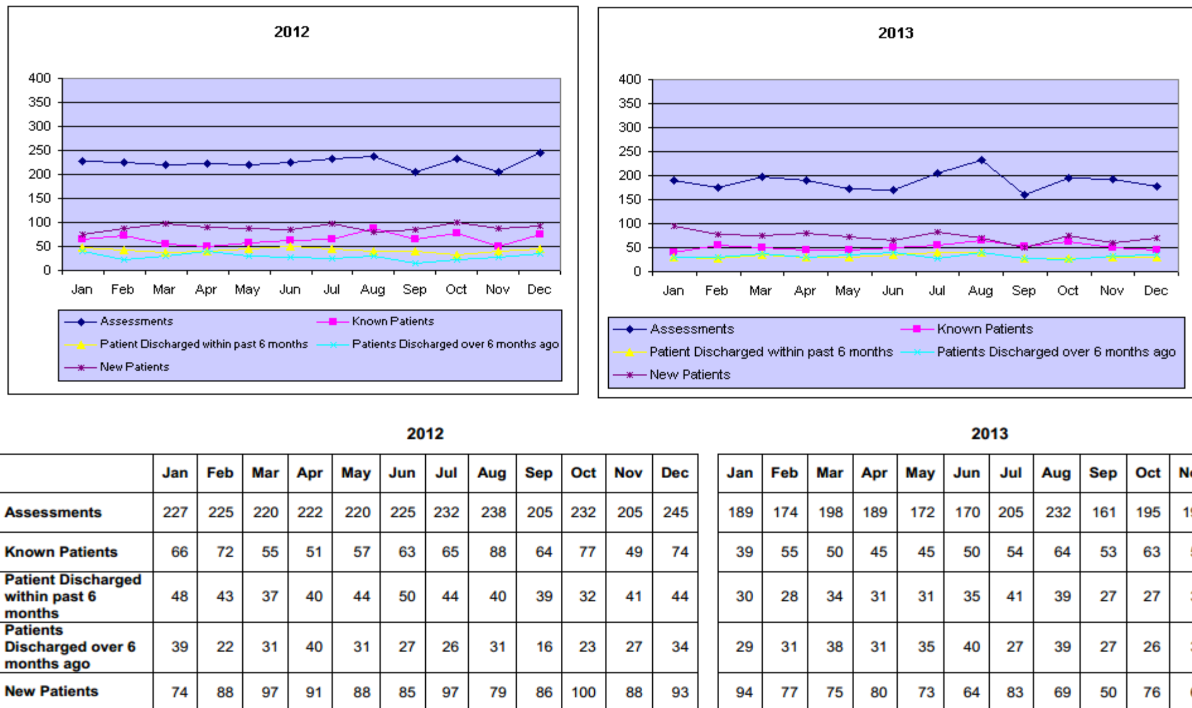
2012

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Assessments	282	277	295	294	336	318	312	369	287	276	287	284
Known Patients	138	141	136	147	168	149	159	185	117	113	126	131
Patients Discharged within past 6 months	42	31	41	47	47	41	34	55	46	55	49	37
Patients Discharged over 6 months ago	34	30	50	42	47	48	50	44	52	33	37	48
New Patients	68	75	68	58	74	80	69	85	72	75	75	68

2013

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
366	277	311	308	344	367	351	374	319	368	333	357
176	119	127	142	138	176	168	180	147	177	190	175
55	42	50	37	58	44	49	56	48	55	43	39
62	44	62	55	62	55	46	52	38	59	43	54
73	72	72	74	86	92	88	86	86	77	57	89

Figure 7: Kings College Hospital Mental Health Liaison Team 2012-2013, South London and Maudsley Mental Health Paper, January 2014



2012

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Assessments	227	225	220	222	220	225	232	238	205	232	205	245
Known Patients	66	72	55	51	57	63	65	88	64	77	49	74
Patient Discharged within past 6 months	48	43	37	40	44	50	44	40	39	32	41	44
Patients Discharged over 6 months ago	39	22	31	40	31	27	26	31	16	23	27	34
New Patients	74	88	97	91	88	85	97	79	86	100	88	93

2013

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Assessments	189	174	198	189	172	170	205	232	161	195	192	178
Known Patients	39	55	50	45	45	50	54	64	53	63	50	44
Patient Discharged within past 6 months	30	28	34	31	31	35	41	39	27	27	30	31
Patients Discharged over 6 months ago	29	31	38	31	35	40	27	39	27	26	32	34
New Patients	94	77	75	80	73	64	83	69	50	76	60	69

Figure 8: Guys and St Thomas' Hospital Mental Health Liaison Team 2012-2013, South London and Maudsley Mental Health Paper, January 2014

63. The Trusts also noted that there was an increase especially amongst local people who are unknown to the service and this is further complicated by the complexity of the social problems that these individuals are facing.

64. South London and Maudsley also told the sub-committee that they do not have detailed records of the numbers of different classifications of presentations to Emergency Departments, but are now in the process of collating this information.

Recommendation

17. The sub-committee finds these statistics concerning, especially in light of the comments that this increase seems to be amongst local people who are unknown to the service. We welcome the decision by SLAM to collate information on classifications of presentations to Emergency Departments and would recommend that this information is shared as part of the Joint Mental Health Strategy that is being developed.

Providing support for those with mental health conditions in hospitals

65. Individual Trusts also told us about the work that they are doing to support patients presenting with mental health concerns. Kings College Hospital has a KPI that all patients are to be seen by the specialist psychiatric team within 30 minutes from referral. It is also encouraging to see that they are up-skilling their staff through

specialist psychiatric training and increase provision of Psychiatric Liaison Nurses (PLN).

66. Guy's and St Thomas' also have PLNs available 24/7, in conjunction with SLAM to ensure that patients are receiving the highest levels of care at all times. They currently also have two cubicles which can be separated from some of the noise and the lights can be dimmed, but this is not an ideal situation.

67. The main issue raised by both Trusts was the provision of beds to admit patients to, and physical spaces within A&E departments to treat those presenting with mental health conditions.

68. As Guy's and St Thomas' set out in their evidence, this is a key issue, with patients from across the country utilising mental health bed provision in South London. In their experience, patients can wait for up to 24 hours to gain access to an appropriate bed in their local area, and during this time they are in a sub-optimal environment for their condition. The table below shows the wide range of areas that patients come from.

	April	**May**	**June**	**July**	**August**	
Abertawe					1	**1**
Barking & Dagenham	1					**1**
Barnet	3	2	2		1	**8**
Bedford		1			1	**2**
Berkshire East			3	2	1	**6**
Bexley	1		1	2	2	**6**
Blank / Unknown	12	12	11	12	4	**51**
Bournemouth	1					**1**
Bradford		1	1			**2**
Brent	1	2	2	2	3	**10**
Brighton		2				**2**
Bristol		1		1	1	**3**
Bromley	1		1	1	2	**5**
Bucks		1				**1**

Cambridge					1	**1**
Camden	1	3	1	2	4	**11**
City & Hackney	1	3		1	1	**6**
Cornwall & Scilly	1			1		**2**
Cumbria				1		**1**
Cwm Taf		1			1	**2**
Ealing	1	2	1	2	2	**8**
East & North Herts		1				**1**
Eastern & Coastal Kent				2	1	**3**
East Sussex Downs					1	**1**
Enfield		1				**1**
Gateshead					1	**1**
Glasgow		1				**1**
Gloucs		1				**1**
Great Yarmouth	1	2	1			**4**
Greenwich	1		3	4	2	**10**
Hammersmith & Fulham			1	1		**2**
Haringay	1		2	1	2	**6**
Harrow		1	1		1	**3**
Hastings			1			**1**
Havering			2	1		**3**
Herts	1				2	**3**
Hillingdon					1	**1**

Hounslow				1		**1**
Islington	1	2	1	1	1	**6**
Kensington & Chelsea	4	1	2	2	2	**11**
Kingston	1		1		1	**3**
Leeds			1		1	**2**
Lincolnshire West					1	**1**
Liverpool		1				**1**
Luton	1				1	**2**
Medway	1		1			**2**
Newcastle			2	2	1	**5**
Newham		1	1	2		**4**
North East Essex	1					**1**
North Lancs			1			**1**
Nottingham				2		**2**
Portsmouth					1	**1**
Redbridge	1	1		1	2	**5**
Richmond & Twickenham	1	1		2		**4**
Sheffield		1		1		**2**
Somerset				1		**1**
South Birmingham			1		1	**2**
South East Essex	2					**2**
South West Essex		1		1		**2**
Surrey	5	1	1	2	1	**10**

Sutton & Merton		6	4			**10**
Tower Hamlets	1	4	1	3	2	**11**
Waltham Forest			1	2	2	**5**
Wandsworth	8	6	4	5	3	**26**
West Essex				1		**1**
West Kent	2	1	1	1	2	**7**
West Sussex		3	2			**5**
Western Cheshire				1		**1**
Westminster	16	11	14	20	12	**73**
Wiltshire		1			1	**2**
Worcester			1			**1**
Total	**73**	**80**	**74**	**87**	**71**	**385**

Figure 9: Guys and St Thomas' Hospital, Mental Health Paper, January 2014

69. Both Hospital Trusts however are taking steps to change the way in which they provide support for mental health patients.

70. Kings College Hospital is in the process of an organisational reconfiguration in their outpatients department. This will support the final phase of the mental health assessment suite which will then provide a separate space for the treatment of these patients.

71. Guy's and St Thomas' are also in the process of a rebuild for the emergency floor which is due to begin in early 2014. This will lead to the creation of two specifically designed and located cubicles for the treatment of mental health patients in the Major Treatment Area.

Recommendation

18. The sub-committee notes with concern the current facilities for patients presenting with mental health conditions at A&E wards. We recommend that Kings College Hospital and Guy's and St Thomas' place the provision of safe, secure spaces for the treatment

of patients presenting with mental health conditions as a key priority in their workplans for 2014.

Providing support for those with mental health conditions in the community

72. The Council's Adult Social Care team currently has a number of initiatives to support people with mental health conditions in the community, which aim to help keep them safe in the community and away from A&E wards.

73. The mental health services in Southwark are provided by integrated health and social care teams, under the auspices of SLaM. They use a holistic approach which enables teams to support all health and social care needs under one service. These teams also provide 'in-reach' onto wards to enable earlier discharges.

74. The Adult Social Care team in their evidence, told the sub-committee about the services that are provided, including:

- Home Treatment Teams (HTT) who provide 24/7 care to service users in a crisis in their own homes, accept out of hours referrals from GPs, provide peer support for people in leaving HTT.
- Psychiatric Liaison Nurses (PLN) who are based in A&E and provide 24/7 mental health triage, as well as assessing for HTT.
- 13 weeks support through reablement with a Recovery and Support Plan aimed at avoiding future mental ill-health episodes leading to a crisis situation.
- Maudsley's 'place of safety' which is open 24/7 and where those with mental illness who are picked up by the police can be taken to instead of A&E
- AMHP team who can undertake assessments under the Mental Health Act without a need for referral to A&E
- Emergency Duty Workers (EDT) who provide rapid assessment under the Mental Health Act as well as care planning.

Recommendation

19. The sub-committee welcomes the services that are currently provided by SLaM to support those with mental health conditions in Southwark. We recommend that priority is placed by SLaM on supporting people with mental health in the community, and intervening ahead of any admissions to A&E wards.

General Practitioner Services

Pressure on GP Services

i. Bureaucracy

75. GP services are experiencing ever-increasing pressures, particularly in terms of bureaucracy. The Local Medical Committee (LMC) in their evidence to the sub-committee said that the Department of Health recognises that there is a 35% administrative 'tail' for every consultation. For every hour a GP sees patients, there is a further 20 minutes administration. Alongside this, clinical information following outpatient consultations is not sent to GPs in a timely manner, leading to further time spent chasing for information.

Recommendation

20. This extra time spent on largely bureaucratic tasks is concerning to this sub-committee. We recommend that the CCG and Hospital Trusts work together to reduce the time taken for GP surgeries to receive outpatient reports. We also recommend the CCG look into the ways in which they can provide template forms and support to GPs to help them reduce the time taken on administrative tasks related to patient consultations.

ii. Local Authority Support

76. The LMC reported to the sub-committee that as part of their GP Workload Survey, which was conducted Londonwide in August 2013, there were reported that whilst not contractually obliged to undertake the work, GPs are spending time dealing with local authority related issues such as assessments for blue badges and housing assessments.

77. The sub-committee requested further information on this from council officers directly. Southwark Council told the sub-committee that if a resident does not qualify for automatic entitlement for a blue badge, they will need to see an occupational therapist. The council employs two OT contractors to provide this service, to prevent redirection to GP services.

78. Southwark also carried out housing assessments for residents requesting re-housing. NMC registered nurses are employed to undertake these assessments, using the criteria as set out in Southwark's housing allocation policy.

Recommendation

21. The sub-committee is pleased to see the Local Authority supporting its residents directly, rather than directing them to healthcare services. However, we remain concerned that some residents may not know that these services exist within the

Council. We recommend that the Housing Options & Assessment and the Disabled Travel Team should carry out a review looking at the ways in which to influence customer signposting to ensure that residents are aware of the services that the Council provides in terms of assessing residents for blue badges and receipt of benefits.

iii. Walk-in centres and Urgent Care

Dulwich Hospital, Dulwich

79. A consultation was carried out by the Clinical Commissioning Group on future health service provision in Dulwich and the surrounding areas. Between 28 February and 31 May 2013, NHS Southwark CCG undertook a formal consultation, where people were asked to comment on a proposed service model for health services in community settings and two options for how these might be delivered.

80. Key findings from the consultation included:

- 80% of respondents were in agreement with the overall model of delivering healthcare in the community
- Respondents were supportive of more accessible settings for healthcare in the community rather than hospital
- Having healthcare delivered locally was an important issue for many respondents
- That health care should be joined up
- That provision of out of hours care was a concern for many respondents with 92% of respondents rating access to evening and weekend primary care as an important issue

Recommendation

22. This sub-committee has actively followed and partaken in the consultation around the future provision of health services at the Dulwich Hospital site. We have welcomed the work done by the CCG, and the sub-committee recommends that the CCG provides an update as necessary.

Lister Urgent Care Centre, Peckham

81. The LMC further highlighted the reports in the media about reductions in the number of walk-in centres nationally. They believe that this will impact in terms of capacity and workload.

82. In January 2014, the CCG presented to the sub-committee proposals for the Lister Urgent Care Centre in Peckham. The Lister Walk-in Centre has been operating since May 2009, and the contract is due to come to an end in September 2014. The CCG

agreed to review the current service, but wanted to use the opportunity to review the commissioning of urgent care across Southwark on the whole.

83. As part of the review into the Lister Walk-in Centre, a meeting was held on 26 November 2013, which aimed to engage the public about access and urgent care and provide information about the proposed plans for changes at Lister.

84. Four options for the provision of urgent primary care services were presented to the Southwark Commissioning Strategy Committee (CSC) for consideration in December 2013:

- Re-commission the Walk-in Centre service in line with the existing specification
- Commission limited Walk-in Centre service – unregistered patients and Kings re-directed patients only
- De-commission Lister Walk-in Centre and focus upon improvements in primary care access
- Commission alternative model of urgent primary care access based on extended access to GP practices on a locality basis

Recommendation

23. The sub-committee is pleased that this was brought to their attention by the CCG, and is grateful for the time taken to attend the scrutiny meeting. We recommend that the CCG report back to the sub-committee once more work has been done on the preferred option for the provision of urgent care services in the south of the borough.

Access to GP services

85. There is an ongoing perception within Southwark that there are difficulties in accessing GP services. This is not a view confined just to Southwark, but is being seen throughout England.

86. Reasons for this include the increase in patients presenting with complex conditions, which require more time to be spent by GPs in appointments, rather than the 10 minute slot allocated. At the same time, patients whose first language is not English often require extra time in consultation, which further extends the time spent with patients outside of the 10 minute slot.

87. Both local and national NHS policy is to promote more care out of hospital, which will mean that sicker patients are being cared for in primary care settings, placing further pressures on GP surgeries.

88. There are 45 GP practices in Southwark, with a combined registered patient list of 305,841 (as at 1 April 2013). All Southwark practices are required to be open from 08.00 – 18.30 and the majority of Southwark practices have not opted out of

responsibility for Out of Hours Care and are members of South East London Doctors' Co-Operative (SELDOC), a co-operative organisation of member practices which provides Out of Hours Services across Lambeth, Southwark and Lewisham CCGs, including telephone advice, GP consultations and home visits.

89. In addition to SELDOC, there is an 8am-8pm GP Led Health Centre at the Lister Health Centre in Peckham, which provides walk-in based care for registered and un-registered patients, 7 days a week.

90. NHS England carried out a survey into access to GP services for the whole of England. They found that people's overall experience of GP surgeries across England showed 87% of people thought they were overall good, whilst only 82% of residents in Southwark agreed with this view.

i. ***Opening hours of GP surgeries***

91. The CCG in their Community Care Strategy notes that whilst they found there to be sufficient capacity in terms of number of appointments across the borough and across days of the week, this masks the differences between practices and across days of the week.

92. The NHS England Access Survey looks at when patients would like to have more access to GP services, finding that this was primarily after 6.30pm, and on Saturdays and Sundays.

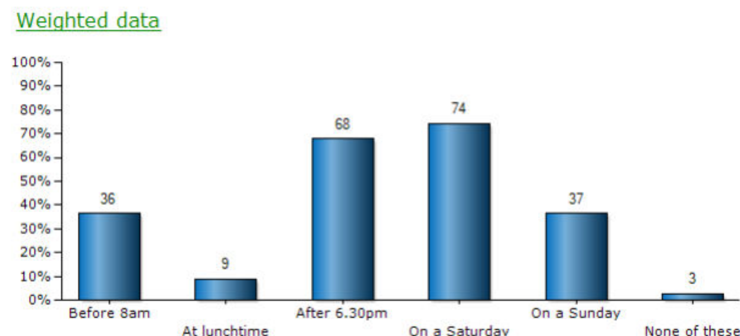


Figure 10: GP Patient Survey, Additional times that would make it easier for you to see or speak to someone, July 2012 – March 2013, NHS England Access to GP Services, October 2013

93. The LMC reported that most GP practices in Southwark are now offering extended hours for patients, alongside providing out of hours care through SELDOC (South East London Doctors' Co-operative).

Recommendation

24. The sub-committee welcomes the provision of the SELDOC service, especially in light of the delay in the rollout of the 111 Service in Southwark. We recommend that GP services promote the SELDOC service within their local practices, to signpost patients to out of hours services.

94. NHS England's GP Survey found that the percentage of people who were satisfied with the opening hours of GP surgeries was 80% for the whole of England, and 79% of Southwark residents.

95. As part of the Community Care Strategy, the CCG set out that it would be working to action clear arrangements for extended hours care in primary care. Jill Webb of NHS England also said as part of her evidence that 8am to 8pm opening will be considered in 2014.

Recommendation

25. The sub-committee welcomes this move. We recommend that NHS England report back to the sub-committee with an update on proposed opening hours of surgeries when appropriate.

ii. Appointment booking services

96. The sub-committee's own survey showed that a large percentage of respondents found it fairly difficult/very difficult to get a timely appointment with a GP.

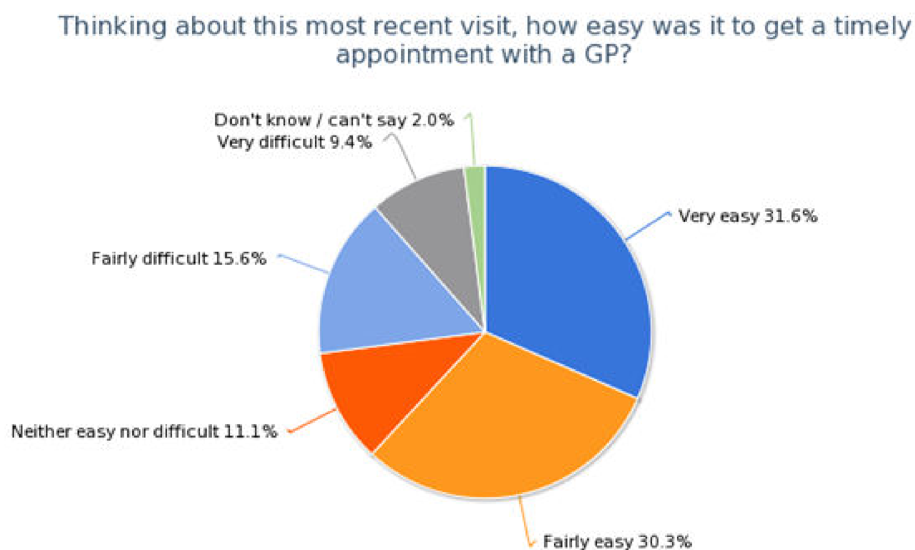


Figure 11: Access to GP appointments, Health Committee Survey, January 2014

97. GP practices throughout the borough do not have a consistent way of providing appointments for patients. These range from the ability to book appointments in advance, to having to call on the morning of the day you would like an appointment, through to calling for cancellations if you want an appointment on a specific day.

98. NHS England's Access Survey compared the responses for Southwark and the rest of England.

	Yes	Yes but had to call back	No	Can't remember
Southwark	70%	12%	13%	5%
England	74%	13%	10%	3%

Figure 12: Able to get an appointment or speak to someone, NHS England GP Patient Survey July 2012 – March 2013, NHS England Access to GP Services, October 2013

99. The sub-committee collated a number of comments from individuals who expressed their frustration with the appointment services.

"No appointments available in the next month, unless you call for an emergency one, plus they only take bookings for the next four rolling weeks

"No appointments available unless you can call at the crack of dawn - impossible for working people who can't take time off without clearing it in advance"

"You have to call right at 8am - if you're lucky you'll get something that day. Making appointments for any date in the future is absolutely impossible"

- Comments from Southwark residents

100. The sub-committee went on to look at where those who could not access a GP appointment went to for medical assistance.

101. From the survey conducted by the Health Scrutiny Sub-Committee, we found that a large proportion of people either went to walk-in centres, or to A&Es, thereby putting unnecessary pressure on other parts of the healthcare system.

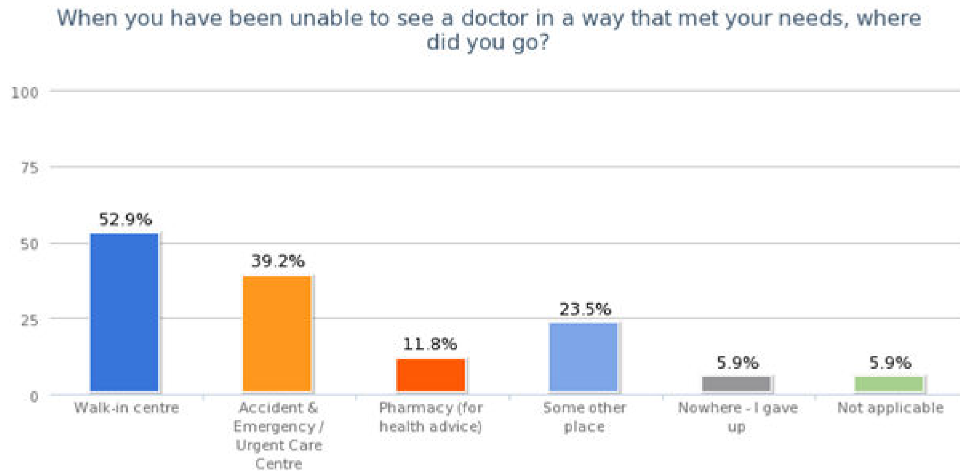
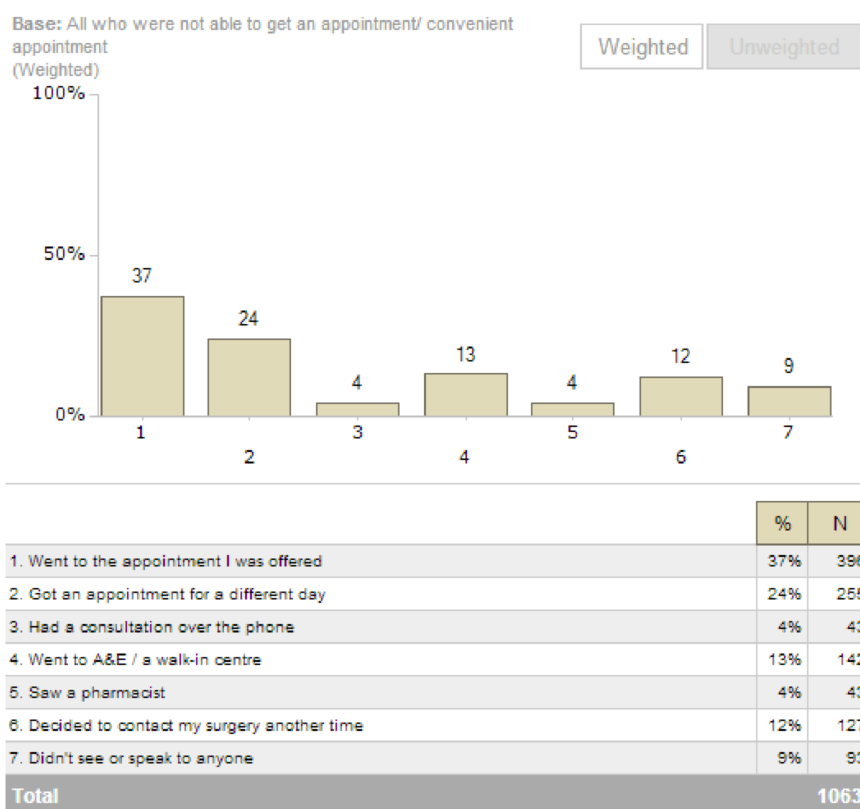


Figure 13: Health services accessed when unable to attend GP surgeries, Health Committee survey, January 2014

102. The Southwark CCG Health Survey, which will be more reliable, as it spoke to a larger sample of people, asked a similar question, about what a resident would do if they were not offered a convenient appointment. In that case, 13% of people went to A&E or an urgent care centre. Whilst this figure is less than the one from the Health Scrutiny Survey, it is still concerning to see 13% of people turning to urgent care services when they cannot access a GP appointment at a convenient time, thereby placing pressure on emergency services.



	%	N
1. Went to the appointment I was offered	37%	396
2. Got an appointment for a different day	24%	256
3. Had a consultation over the phone	4%	43
4. Went to A&E / a walk-in centre	13%	142
5. Saw a pharmacist	4%	43
6. Decided to contact my surgery another time	12%	127
7. Didn't see or speak to anyone	9%	93
Total		**1063**

Figure 14: GP Patient Survey: Southwark CCG. What you would do if you were not able to get an appointment/convenient appointment (December 2013)

103. We are also aware from the Health Sub-Committee's own survey, that there is a significant proportion of people who use GP services for managing their long-term conditions. In these cases, many patients would like appointments with their named GP, who understandably has more of an understanding of their ongoing medical needs.

104. The appointments system seems to be creating difficulties for many of these individuals.

"Appointments with your preferred GP have to be booked about 4 weeks in advance."

"When I try and book an appointment for more than four weeks ahead I'm told they only take bookings for the next few weeks and to call back in a week. When I do all the appointments are filled so I'm told to call again in a week. I do and again there are no appointments."

"Difficult to get an appointment with the same GP because you seem to have to always ring back as they release more appointments. This is despite them asking me to try to see the same person. It works for urgent problems but is not set up well for people like me with chronic health problems who would like to book well ahead for review."

- Comments from Southwark residents

105. The issue of not being able to access GP services as required is a worrying one. The sub-committee is concerned that whilst we are assured that there are enough appointments available within the system, patients are struggling to get them at times they would like. This is leading to extra pressure on other healthcare services.

Recommendation

26. We recommend that NHS England, with the support of the Clinical Commissioning Group, undertake a study into the best method for providing appointments consistently across the borough and consider a Southwark offer that ensures minimum standards of access for patients in Southwark in regards to contact with a GP if appropriate following NHS England's Call for Action response.

The King's Health Partners Merger

106. The previous sub-committee last received an update on the King's Health Partner merger in May 2013. At that point in time, King's Health Partners were continuing with the idea of a partnership. They noted that their partnership currently is complicated, with three different NHS organisations, with different structures, cultures and ways of doing things.

107. The Strategic Outline Case was published in July 2012, with a more detailed Full Business Case due to be developed, which would test a range of organisational models, including creating a single academic health organisation by merging the trusts, alongside looking at alternatives short of a three way merger.

108. They hoped to publish the Full Business Case in autumn 2013 and this sub-committee was committed to scrutinising that process. However, in November 2013, it was announced in a statement that the proposed merger would be progressing less quickly than anticipated.

109. In their statement, King's Health Partners stated that

"The further work we have been doing points us to the conclusion that only a merger between the NHS foundation trusts as well as closer integration with the university would enable us to maximise the benefits of our AHSC to patients.

Organisational change on this scale and complexity would need to take place at a measured pace, informed by clear evidence of the benefits for the patients and communities we serve.

If we are to proceed towards a merger then the next step would be to develop a full business case, for consideration by our boards, and in the case of the NHS partners, our councils of governors.

This is not the right time to take that step, not least because we will only do this if we are confident that a case for merger is likely to be approved by the regulators and we have made further progress in coordinating our services." (Kings Health Partners Statement, November 2013)

Recommendation

27. Since the merger was proposed, the sub-committee has taken an active interest in the decision-making process. The sub-committee noted with interest that this process has now been delayed and recommends that when a Full Business Case is developed, King's Health Partners should return to the sub-committee for further scrutiny.

APPENDIX B

Item No. 9.	Classification: Open	Date: 16 September 2014	Meeting Name: Cabinet
Report title:		Response to recommendations in Access to Health Services in Southwark (Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee)	
Ward(s) or groups affected:		All	
Cabinet Member:		Councillor Dora Dixon-Fyle, Adult Care, Arts and Culture and Councillor Barrie Hargrove, Public Health, Parks and Leisure	

FOREWORD – COUNCILLOR DORA DIXON-FYLE, CABINET MEMBER FOR ADULT CARE, ARTS AND CULTURE AND COUNCILLOR BARRIE HARGROVE, CABINET MEMBER FOR PUBLIC HEALTH, PARKS AND LEISURE

Health and wellbeing is at the heart of the council's ambition for a fairer future for everyone in Southwark. With the transfer of responsibility for public health and ever closer working with our health partners, we are in a strong position to improve services, deliver better health outcomes for our residents and importantly, reduce health inequalities.

As the vision articulated in our Joint Health and Wellbeing Strategy sets out, it is by working together that we can create a borough where everyone can realise their potential and have the best possible life chances. This means ensuring everyone can access the support they need, as well as supporting people to take responsibility for their own wellbeing.

We recognise the high levels of need across our diverse communities and we therefore welcome the report of the health, adult social care, communities and citizenship scrutiny sub-committee (now the healthy communities scrutiny sub-committee), Access to Health Services in Southwark.

The council, working closely with our health partners, is progressing several areas of work that are helping people stay well at home for longer, preventing emergency admissions and signposting residents to the right services at the right time. We are therefore pleased to present the following responses to the recommendations of the scrutiny sub-committee and look forward to continuing our work together to improve health and wellbeing for all our residents.

RECOMMENDATION

1. That cabinet agree the proposed response to the health, adult social care, communities and citizenship scrutiny sub-committee's report into Access to Health Services in Southwark.

BACKGROUND INFORMATION

2. The health, adult social care, communities and citizenship scrutiny sub-committee undertook an investigation into Access to Health Services in Southwark and the recommendations relating to council responsibilities were presented to cabinet on 22 July 2014 with a request for the relevant lead members to bring back a report responding to those recommendations.

3. This report therefore provides proposed responses to the recommendations specific to the council to be approved by cabinet.

KEY ISSUES FOR CONSIDERATION

Recommendations from the scrutiny sub-committee presented in the cabinet report of 22 July 2014 and proposed cabinet responses

Recommendation 7

4. It is a statutory requirement to list background documents and for them to be available for public inspection for a period of 4 years. It is also a statutory requirement for background documents listed in reports for a cabinet meeting or community council meetings making an executive decision, to be made available on the council's website.

5. We further recommend that Public Health supports the CCG in their "Not Always A&E" campaign, ensuring that public awareness of the alternative healthcare services increases.

Response

6. Public Health will add value and support the Not Always A&E campaign through its planned events, outreach activity and relevant campaigns.

Recommendation 9

7. We recommend that the Clinical Commissioning Group continues its programmes working specifically with older people and that Public Health identifies the further support that we, as an authority, can be giving them.

Response

8. Public health has been supporting the CCG and local authority in their work to co-produce an outcomes framework for older people and those with long term conditions as the basis for future commissioning.

9. Public health has also contributed needs assessment support for:

   - defined secondary prevention interventions including self-management
   - mental health of older adults

10. The Health Checks Programme also includes a dementia awareness element for over 65s and helps to sign post individuals to GPs for a full cognitive assessment.

Recommendation 10

11. This sub-committee commends the work of the CCG, jointly with the local authority and community services to help people stay well at home for longer. We would like to see further evidence of the work being done on the frail elderly pathway to ensure that we are offering our residents the best care services.

APPENDIX B

Response

12. The director of adult social care would be happy to arrange a further report for the sub-committee providing more evidence on the work being undertaken across health and social care on the frail elderly pathway. A meeting to discuss the required scope of this report can be arranged with the chair of the sub-committee.

Recommendation 11

13. This sub-committee welcomes the work being taken forward by the Adult Social Care department. We recommend an update report on the services provided for older people with high needs to be made to the next sub-committee.

Response

14. The director of adult care would be happy present a further report to the sub-committee during 2014/15 on the work undertaken by adult social care services for older people with high needs to prevent avoidable admissions to hospital. This report can be combined with the report requested in recommendation 10.

Recommendation 12

15. We recommend that further work is done by the adult social care team within the council, looking specifically at the ways in which we can identify and support older people to prevent admissions to A&E.

Response

16. This recommendation is being implemented through current work programmes. The adult social care division is working closely on this issue with health partners through the Older People's Programme with SLIC (Southwark and Lambeth Integrated Care). Initiatives include expanded Enhanced Rapid Response social work support to the Admissions Avoidance workstream and social work support for hospital support at home. The Better Care Fund plan agreed by the Health and Wellbeing Board sets out how services will be further integrated with a specific target to reduce avoidable emergency admissions.

17. For example; extra funding has been provided for night time intensive homecare aimed at those most vulnerable to admission to hospital; Reablement and Intermediate Care services are focussed on preventing people needing to be admitted or re-admitted to hospital after discharge; the investment in telecare is being stepped up, the Carers strategy agreed by cabinet helps ensure carers can combine their caring role with other aspects of their life; seven day working is being expanded. The latest position on these services can be summarised in the update report requested in recommendation 10 and 11.

Recommendation 13

18. We remain concerned however that there seems to be a lack of co-ordinated action by the health community to tackle the issue of increased acuity of patients. The sub-committee recommends that the Health & Wellbeing Board places this as a priority for 2014/15 and that Public Health carries out a piece of research into the reasons behind the increased acuity in Southwark.

APPENDIX B

Response

19. Existing health and social care strategies, including the Older People's Programme, are aiming to ensure an effective integrated response to this group to prevent their needs escalating and in particular to avoid them needing to attend A&E in crisis.

20. Due to demographic trends there are increased numbers of older people, including highly frail elderly people with multiple long term conditions and dementia. This is reflected in the Southwark JSNA which directly informs the Health and Wellbeing Strategy, for which the Health and Wellbeing Board is responsible.

21. The Health and Wellbeing Strategy priorities will contribute towards addressing the issues of increased acuity, in particular earlier detection and management of long term chronic health conditions, integration for better health and wellbeing outcomes and tackling neglect and vulnerabilities for children and adults. Public Health is informing and supporting the programme development, outcomes and evaluation of integrated care which will help to better understand and address the increased acuity in Southwark.

Recommendation 21

22. We recommend that the Housing Options & Assessment and the Disabled Travel Team should carry out a review looking at the ways in which to influence customer signposting to ensure that residents are aware of the services that the council provides in terms of assessing residents for blue badges and receipt of benefits.

Response

23. Homelessness and Housing Options Service employ nurses to undertake medical assessments for housing and the Disabled Travel Service uses external occupational therapists. However, we recognise that there is still a belief amongst some applicants that a doctor's letter will assist them. The Homelessness and Housing Options Service are seeking a meeting with GPs to discuss improved partnership working and the Disabled Travel Team will be included in the meeting when it is arranged.

24. Both the Homelessness and Housing Options Service and the Disabled Travel Service are offering more services online and we will review the online forms to assess whether we could reinforce the message that customers should not approach their GP. We have previously produced posters to raise awareness and we believe it would be useful to revamp these.

25. There are some smaller services who still seek agreement from GPs for applications. We have so far identified Taxi Card applications and disabled parking bays, but it is possible there are others. Taxi Cards are managed by London Councils on behalf of Southwark and we will work with London Councils to review what changes we can make to this process.

26. The Disabled Travel Team recently agreed to take on management of applications for disabled travel parking bays and will use Occupational Therapists in future to assess these requests, which will slightly decrease some of the pressure on GPs.

APPENDIX B

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Report to Cabinet from Overview and Scrutiny Committee, 22 July 2014 *Access to Health Services in Southwark* (Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee)	www.southwark.gov.uk	Peter Roberts Email: peter.roberts@southwark.gov.uk
http://moderngov.southwark.gov.uk/documents/s47482/Report%20Access%20health%20services.pdf		
Report of the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee, *Access to Health Services in Southwark*	www.southwark.gov.uk	Julie Timbrell Email: julie.timbrell@southwark.gov.uk
http://moderngov.southwark.gov.uk/documents/s47483/Appendix%20Access%20to%20Healthcare%20Services.pdf		

AUDIT TRAIL

Cabinet Member	Councillor Dora Dixon-Fyle, Adult Care, Arts and Culture and Councillor Barrie Hargrove, Public Health, Parks and Leisure	
Lead Officer	Alex Laidler, Director of Adult Social Care, Children's and Adults' Services	
Report Author	Rachel Flagg, Senior Strategy Officer, Children's and Adults' Services	
Version	Final	
Dated	5 September 2014	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		5 September 2014

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Dated: September 2014