Southwark Council

NHS Southwark Clinical Commissioning Group

Southwark Better Care Fund Plan

2016/17

Introduction

The Better Care Fund (BCF) was announced by the government in June 2013 with a purpose of driving the transformation of local services to ensure that people receive better and more integrated care and support. The fund is designed to be deployed on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. In Southwark we put in place a pooled budget of £22m for 15/16 which is jointly governed with the council under a Section 75 agreement. These arrangements will continue in 16/17. Our plan was approved without conditions in 15/16, and our plan for 16/17 looks to build upon this strong platform.

The BCF allows the CCG and Council to jointly commission a range of services which help improve the health and wellbeing of the population, avoid admissions to hospital, and ensure timely and effective services are available in the community when patients are ready for discharge. These schemes are overseen by the Integrated Working Group, comprising Director level leads from both organisations.

Significant progress has already been made on a number of the key objectives:

- Delayed Transfers of Care (DTOCs) have been kept low, with Southwark one of the top 12 performers nationally, with delays less than a third of the national average
- Improvements have been made to re-ablement services, with a reduction in the number of patients re-admitted to hospital. Over 90% of patients remain at home 90 days after discharge.
- Care home admissions have been kept at low levels. Thanks to services such as Re-ablement, Night Owls, and @home, more people are being able to be cared for at home, helping rebuild confidence and mobility and reducing need for long-term placements.

However, we know there is more that we can do. Emergency Admissions, whilst reducing in Q3, are higher for the year as a whole. Although reductions in emergency admissions are no longer a core metric for BCF plans, locally we will maintain our focus on reducing admissions in order to ensure that we continue to develop out of hospital services, and reduce pressure on acute hospitals.

To meet this aim, we have conducted a full review of governance arrangements for the BCF which will see a number of subgroups established around key priorities. These subgroups will look to support BCF scheme-holders in maximising the effectiveness of their schemes, and allow greater opportunities for different schemes to collaborate and ensure that pathways are better integrated. The advent of Local Care Networks also offers an excellent opportunity to ensure that system partners are better sighted and actively inputting in to BCF schemes to ensure their success. The BCF is also a strong starting platform from which to build the Joint Commissioning Unit. This unit will bring together staff from both the Council and CCG, and allow for joint strategies and commissioning to be enacted.

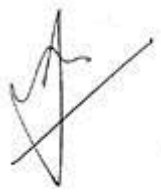
Throughout 16/17 we will continually monitor each BCF scheme and seek to build and develop capacity and capability, with regular reports to key CCG committees and to the Southwark Health and Wellbeing Board.

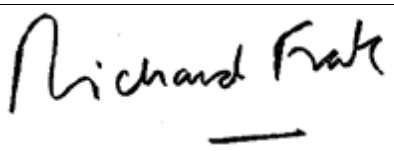
Plan Details

Summary of Plan

Local Authority	**London Borough of Southwark**
Clinical Commissioning Groups	**NHS Southwark CCG**
Boundary Differences	**No boundary difference**
Minimum required value of BCF pooled budget: 2016/17	**£21,828,441**
Total agreed value of pooled budget: 2016/17	**£21,828,441** This figure is comprised of £1,149,000 from the London Borough of Southwark and £20,679,441 from NHS Southwark Clinical Commissioning Group. Within this allocation, the CCG and Local Authority can also confirm that the BCF plan is fully compliant with respect to allocations towards Disabled Facilities Grants, Care Act implementation, Carer's funding, reablement funding, protecting Adult Social Care and NHS Out of Hospital services funding. A full narrative on scheme plans is included within this document.

a) Authorisation and signoff on behalf of the Southwark Health and Wellbeing Board

Signed on behalf of the Clinical Commissioning Group	
By	Dr Jonty Heaversedge
Position	Chair, NHS Southwark Clinical Commissioning Group and Deputy Chair of the Southwark Health and Wellbeing Board
Date	29/04/16

Signed on behalf of the Council	
By	Dick Frak
Position	Director of Commissioning, Southwark Council
Date	29/04/16

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 within Southwark

We want to enable the best possible health and social care outcomes for Southwark people and families. We set this out in this *Southwark Forward View* (**attached as Appendix A)**. It describes Southwark Council and NHS Southwark CCG's shared vision for local services, the changes needed in our health and care system, and the actions we will take to make this happen. 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 (JSNA/JHWS), the vision for Adult Social Care, NHS Southwark CCG's Primary and Community Care Strategy, CCG Operating Plan and Southwark's Housing Strategy and the Council's Fairer Future priorities.

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 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
- Parity of esteem between physical and mental health and wellbeing
- 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 continue to play a key enabling role in driving forward this vision by maintaining 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 has, and will continue to, provide a strong platform for developing more integrated approaches to services delivery and integrated governance, and we are looking to build on the achievements that the BCF has helped us achieve over the last 2 years.

The vision is also aligned with our neighbouring borough Lambeth with whom we, and all local provider organisations, collaborated on the Southwark and Lambeth Integrated Care (SLIC) programme. SLIC was 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.

We continue to have a particularly close relationship with our nearest neighbours in Lambeth. 2016/17 will see us embark on a new chapter in this partnership as the SLIC programme transitions into a new Strategic Partnership across both boroughs to embed the transformation that has already taken place; align the strategic direction of commissioners and providers in the local system; deepen patient and public involvement in our plans; and work together to implement changes at a bi-borough scale to support the population based approach to service delivery that we have described in our *Southwark Forward View*.

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 at least one of these goals.

A key principle of our BCF plan is to ensure that all schemes seek to improve clinical, functional and experiential outcomes for service users. Progressively, both the CCG and Local Authority are including outcome metrics within contracts, with the intention that we ultimately move towards outcome based contracts covering whole population groups.

One of the central tenets of our approach to outcomes is that they should be based on what local people say is important to them. To that end, we have co-developed with the SLIC Citizens Forum a series of 'I statements', based on work compiled by National Voices. By including these metrics in contracts, commissioners, providers and citizens are best able to meaningfully track progress and identify areas where we need to work together to make further progress.

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?

All commissioners and providers within Southwark recognise that the only way to make meaningful and sustainable improvements is to work constructively and collaboratively together. Alongside our Strategic Partnership, all providers and commissioners have been active participants in *Our Healthier South East London (see appendices)* programme which is helping design the future model of care across our wider system, and which will help shape our Strategic Transformation Plan.

Instrumental to this will be the continued development of Local Care Networks (LCNs). LCNs bring together local health and social care providers (including the voluntary sector and citizen forums) to work collaboratively to try and address common challenges. By coming together, providers can look at the range of services that they provide for our populations and see how they can work better together to improve and integrate them.

Whilst this sounds simple, it is a very different way of working for many providers. Previously they have been individually paid to deliver services by commissioners and have been rewarded for the amount of activity (e.g appointments, operations, home visits) they have undertaken. Whilst this approach has advantages, it does not reward providers for working together and can unintentionally lead to a situation where providers concentrate on the individual's immediate needs, without seeking to understand the underlying health and social issues that may be impacting on their wellbeing. Instead of paying for activity, we would like to move to a model where providers are paid on the basis of the outcomes acheived. This means that they will be rewarded for helping people to live happier, healthier and more independent lives – and this can only be achieved by working more closely together with each other and our local populations.

Specifically, some of the key aspects of change we are, collectively, working towards include:

- more care for older people and people with long term conditions delivered through LCN 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.

- less care needed in acute settings. A&E attendance and avoidable emergency admissions will reduced 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.

In all that we do, we are also committed to ensuring that there is parity of esteem between physical and mental health and wellbeing. Whilst we are proud that the BCF funds a significant number of schemes to help support those with mental health issues, the CCG and Council have jointly collaborated to develop strategies to make parity of esteem a reality. Through our Mental Health and Parity of Esteem Programme Board we have established the following principles the following as key features of a parity approach:

- It should apply to people of all ages, including preconception care, and to all groups in the population, including those at increased risk of mental health problems, such as people with intellectual disabilities, asylum-seekers, people in the secure estate, lesbian, gay, bisexual and transgender people, some Black and minority ethnic populations at greater risk, children in care, care leavers and others.
- Equal access to health and social care, including: comparable waiting times; equitable treatment for all, according to their need; the provision of equivalent levels of choice and quality regardless of condition.
- Holistic care – the mind and the body should not be regarded separately but

integrated: professional and public education, public health programmes, social care and treatment Achieving parity between mental and physical health approaches need to reflect this; an open-minded approach to whole- person care is essential

- Planning for integration – this requires movement away from mental health, physical health and social care ‘silos’; the consideration of mental health should be integral to all health and social care, at any point where someone with a mental or physical health problem comes into contact with a service.
- Investment in the prevention of mental health problems, and the promotion of mental wellbeing, in proportion to need.
- Investment in mental health research, in proportion to need.
- Investment of both funding and clinical/managerial time and attention should be proportionate to the prevalence of mental health problems and scale of mental health need.
- Aspirational outcomes and an expectation that mental healthcare should continuously improve (as is the case for other areas of healthcare).
- Respect and dignity for those with mental health problems across all areas of health and social care.

We will challenge ourselves to ensure we uphold these values, and all schemes will be assessed to ensure that they are consistent with this approach.

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.

Case for Change

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area

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 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 **the appendices** 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.

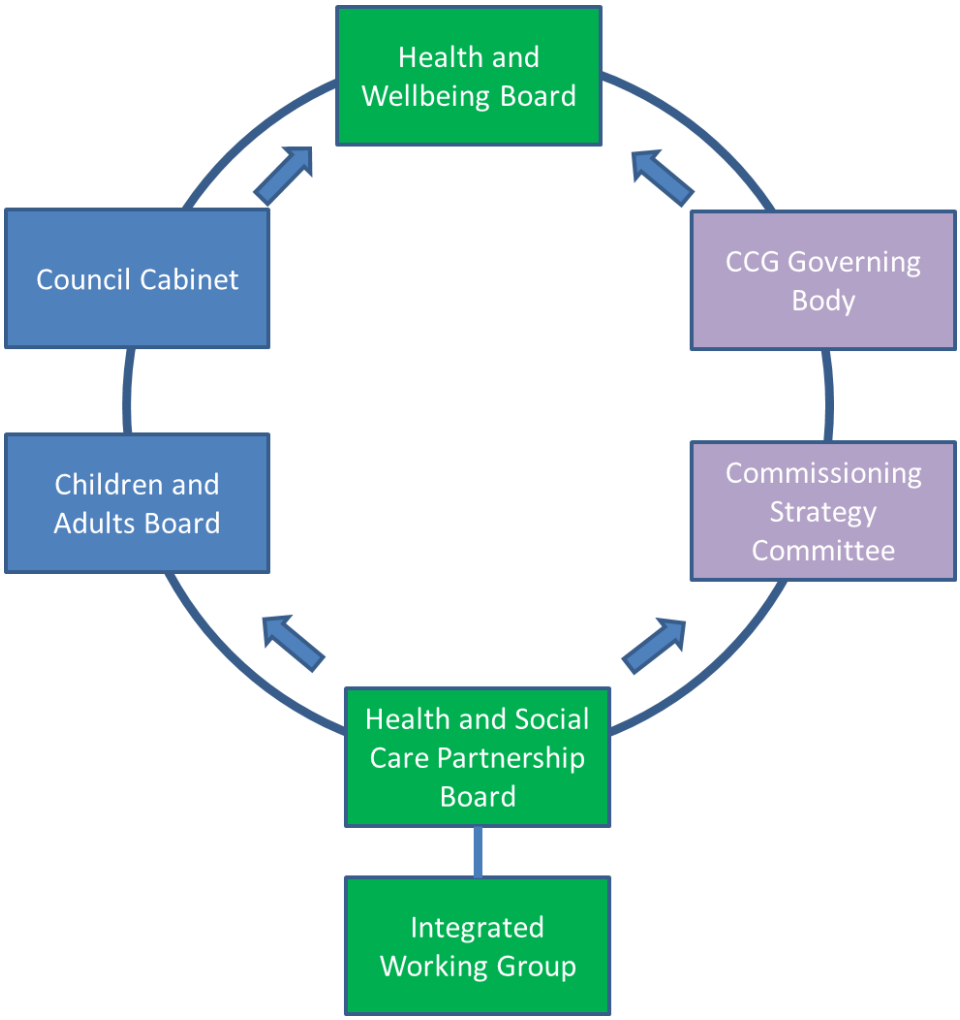
The challenges are also clearly set out in the Health and Wellbeing Strategy. Southwark has an aging population, with an extra 900 people aged 85 or over expected by 2020, which is an increase of nearly 30% on current levels. The number of people with disabilities and learning difficulties is also rising 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.

A key conclusion of the case for change work is that the current system is financially unsustainable without transformative change. 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.

Plan of Action

Governance arrangements for BCF and integrated working in Southwark



The Health and Wellbeing Board will be ultimately responsible for agreeing the Better Care Fund plan and overseeing its successful delivery.

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 is in place covering all key schemes expenditures, milestones, activity and performance. A Health and Social Care Partnership Board, a sub-group of the Board, is in place to ensure there is capacity to do this effectively, and an Integrated Working Group is in place to develop the programme of work and oversee its effective implementation.

During the course of 16/17, we also intend to set up a Joint Commissioning Unit between the Council and CCG. As part of the planning for this unit, we have ensured that in designating the schemes to be part of the BCF, these align with the proposed structure. Governance arrangements may therefore be amended in year, but will not materially affect the Section 75 agreement, and will only strengthen oversight of the BCF.

As part of the annual external audit, KPMG have reviewed both current and future governance arrangements, which have been fully assured.

It is also recognised that the BCF is only one element in the delivery of integrated care across Southwark. Attached as Appendix 3 is our *Five Year Forward View: into action* document which describes the overarching governance and accountability structures in place locally to support integrated care and how the BCF is fundamental to this.

Alongside this, we are working with all local partners to plan how we can ensure that we support and increase our workforce to ensure that we are able to meet current and future challenges. This includes functional mapping of the existing workforce, both paid and unpaid, and an assessment of what roles and capacity will be needed going forward. This is led through our Community Education Provider Network (CEPN).

The priorities for our CEPN this year are:

- development of a workforce data set which identifies the current skills and competencies of the workforce and helps us to scope the news skills and competencies that are needed to support our vision. This work will start in primary care and then expand to include the Local Care Network workforce
- effective use of indirect and direct funding streams to support the development of the non-medical workforce
- develop a culture of support and clinical leadership within the workforce. creating pre-registration nursing placements in primary care to support recruitment and retention of the primary are nursing workforce; increasing the number mentors to support the learning and development of the existing workforce and the pre-qualified workforce that extends beyond the boundaries of a single GP practice;.
- supporting the management of complex care identified by the presence of 3 or more long term conditions. This work will involve supporting multi-disciplinary learning and development around long term conditions managements, support care coordination and self-management with an aim to achieve the following:

    - Reduce the number of outpatient appointments for patients with LTCs
    - Reduce the number of A&E attendances and unplanned admissions
    - Improve clinical and patient reported outcomes
    - Support and empower the workforce (both paid and unpaid) within our system to deliver care which supports the overall health and wellbeing of patients rather than focus solely on single disease pathways

- Take the learning from this pilot in order to commission regular training on managing LTCs

b) 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 the Integrated Working Group and and its delivery sub-group structures. 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. This will feed into a quarterly report for the Health and Wellbeing Board to assess progress and discuss any areas that need unblocking.

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.

Programme management of the Better Care Fund is overseen by the Head of Integration and System Resilience for the CCG who reports to the Director of Integrated Commissioning of the CCG.

c) Key Milestones

The below table gives details of the key milestones to ensure that our BCF plan is successfully implemented and achieves its core objectives. It should be noted that each scheme will have their own individual milestones dependant on their level of development.

Conduct review of all existing BCF schemes	Q4 2015/16
Discuss results of review and agree spending plan for 16/17	March/April 2016
Commence implementation/continuation of all BCF schemes	April 2016
Conduct 'Star Chambers' for all schemes to formally agree KPIs (where not in place) and identify opportunities for further integration with other BCF/Commissioned initiatives	April/ May 2016
Commence BCF subgroups and monthly monitoring	May 2016
Assess slippage on schemes and reallocate funds where	June 2016

appropriate to maximize impact of BCF	
Mid-year review of BCF to identify what works well, what needs to improve, and to identify areas for development in 2017/18	September 2016
Move to new Joint Commissioning Unit arrangements	September/ October 2016
Second review of slippage and reallocation. Ensure that any funding of schemes is aligned with Winter Resilience Funding Allocations	October 2016
Commence Review of all BCF Schemes	December 2016/ January 2017
Develop initial plan for 17/18 including engagement with key internal and external stakeholders	February 2017
Final plan for 17/18 agreed	March 2017

d) **List of planned BCF schemes**

Following a year of bedding in BCF schemes, we are planning to continue with all key BCF schemes. The only exception to this is a scheme related to a capital development for a Dementia Centre. As this was a capital allocation, it was a non-recurrent expenditure, and so our plan for 16/17 is not materially different to that from 15/16. However, we feel that now that schemes are fully established, they are likely to have an even greater effect in the coming year.

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	2016/17 £000
1	**Existing NHS transfers**: range of social care services that support health care. To be reviewed along with other existing schemes to ensure best integrated approach.	**5,521**
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.	**1,221**
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.	**125**
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	**300**

Ref no.	Scheme	2016/17 £000
	people with mental health problems in the acute hospital sector including A &E at King's College Hospital and Guys' and St Thomas' Hospital.	
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**
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	**Disabled Facilities Grant:** existing grant for residents not in council housing, enabling disabled people to live at home.	**864**
15	**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**
16	**Seven day working:** programme to support seven day hospital discharge across primary, community and social care.	**1,493**
17	**Voluntary sector preventative services**: existing grants, to be reviewed as part of an integrated approach to prevention.	**910**
18	**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**
19	**Dementia:** Enhanced neighbourhood support, navigators and carers support for those with dementia	**184.177**
20	**Consultancy and Contingency:** to fund project support to develop plans around areas such as intermediate care, OD and formation of JCU	**203.654**
		21,828.441

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.

e) **Comparison to 2015/16**

The BCF pot in 2016/17 is marginally smaller than in 2015/16 (£21,828,441 vs £21,967,610). This is as a result of changes to central allocations to Local Authorities which need to be channelled through the BCF. Previously there has been an allocation for Social Services capital grants which has now been removed, with an increase to the allocation for Disabed Facilities Grant. As the Capital Funding supported the development of a Dementia Centre, this was always going to be a one off cost, so there is no direct impact on the running of any other BCF schemes. There are also a number of other schemes which were granted monies for one off costs in 2015/16, such as £100k for equipment for Telecare. As these schemes were always going to be non-recurrent, they have now ceased, with that allocation now going to support existing schemes, such as Nightowls.

As a result, all BCF schemes that required ongoing finance in 15/16 are being continued in 16/17 with either the same, or increased, levels of investment. Our approach to the BCF is to allow schemes to bed in so that they can fully realise their potential. As such, we feel that it would inappropriate to make radical changes at this juncture, as many schemes are likely to yield greater results in 16/17.

Regular reviews of all schemes will take place throughout the year, with ‘Star Chambers’ held with scheme-holders. As such, we can quickly establish whether there is any likely slippage on any plans and reallocate funds accordingly, under the jurisdiction of the Integrated Working Group. The learning from these sessions will enable schemes to identify opportunities where they can work more closely together, and will also inform funding allocations for 17/18.

f) **Contingency plans and non-elective admissions**

Whilst the BCF plan for 16/17 is not predicated against reductions in non-elective admissions, we are mindful of the national guidance that ‘the same pound cannot be spent twice’ and the advice that funds are set aside to cover the cost of non-elective admissions should these be above the plan set out in the CCG Operating Plan.

We feel that a formal risk share which would see community services decommissioned in year to fund additional non-elective activity would not be advantageous due to the complexity of decommissioning services mid-year (and the issues that that would bring), and acceptance that scaling back community services would likely lead to a further exacerbation of non-elective activity at acute sites. As such, we feel that the creation of a £1.3m contingency fund which is not committed against any BCF schemes would allow there to be greater flexibility, with the opportunity to either invest more in BCF schemes in year, or fund additional non-elective growth depending on circumstances.

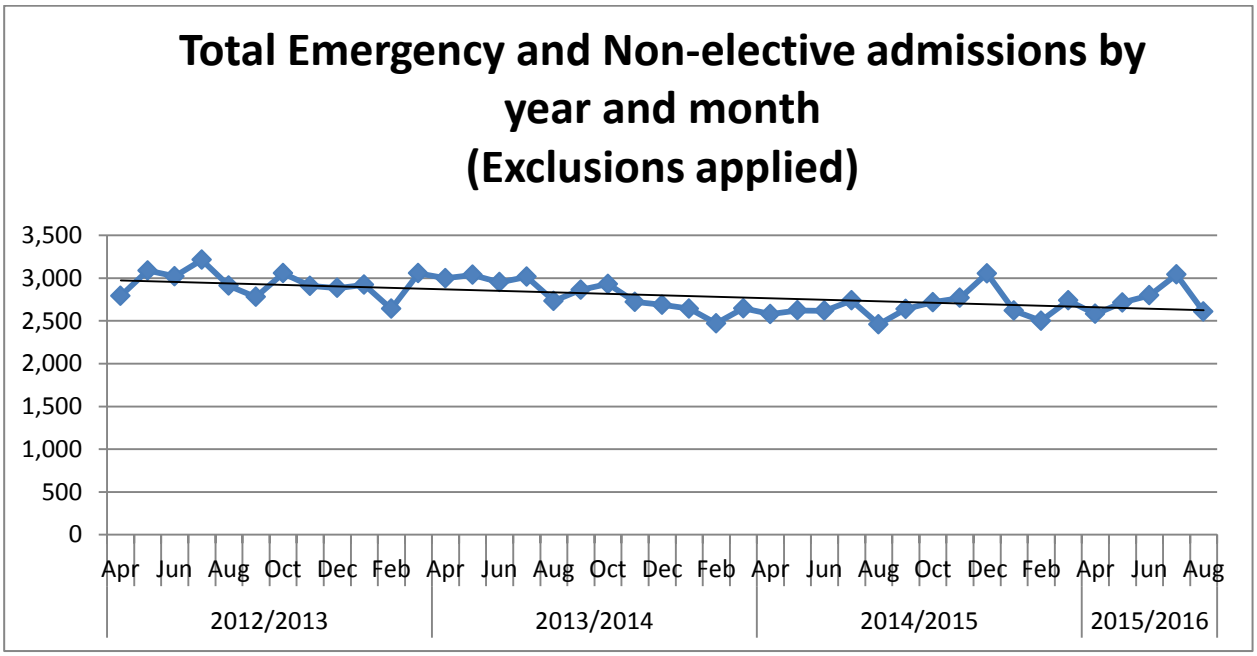
We are confident that we planned responsibly for non-elective activity in 16/17. We have agreed contracts with our main acute providers, which include growth of 7% in elective activity, 4% in non-elective activity and 6% in outpatient activity against 15/16 outturn. As such we feel that we have put in place significant risk mitigation on over performance. However, the £1.3m contingency fund will provide further risk mitigation, whilst also allowing for further investment in community and social care in year, should activity be in line with contracted values.

As such, in 16/17 there is no separate BCF target or trajectory for the reduction of emergency admissions, with this being superseded by overall trajectories within the

Operating Plan. However, we will ensure that at the BCF scheme level, schemes will have KPIs which include targeted reductions in admissions where relevant.

The performance against the non-elective admissions targets in 15/16 are set out below. It should be noted that Southwark opted for a highly ambitious trajectory in 15/16 of reducing admissions by 3.5% - higher than many of our peers across the country. Although missed as whole, an improvement has been noted during Q3, with both November and December seeing the target achieved. Overall admissions grew by 1.8% in the year. As a further mitigating factor, many of the types of schemes that have helped other areas reduce admissions (such as hospital at home schemes and 7 day working) were already in place within Southwark, and it should be noted that despite an increase in admissions, these levels are still significantly lower than 12/13 and 13/14.

	Feb	Mar	2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Target	2,384	2,553		2,501	2,543	2,538	2,656	2,385	2,560	2,635	2,684	2,961	2,538	2,425
Admissions	2,500	2,739		2,590	2,720	2,782	3,000	2,592	2,602	2,748	2,592	2,633	2,592	2,464



Risks and Contingency

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 a risk reserve of £1.3m has been established which can then be used to fund additional hospital admissions, through year-end agreements with acute providers. 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

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
				promptly where necessary. 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.
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, SRG 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.
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

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**
				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 16/17 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 community based support and undermining Care Act implementation.	3	3	9	Ensuring effective integrated use of resources in the community.
Insufficient input from key partners in the development of	3	3	9	Use HWB and LCNs to help unblock problems. NHSE dialogue.

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
integrated approaches, e.g. from GPs in CMDT roll out, as a result of complex commissioning structures.				

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

Although the BCF met the vast majority of its targets in 15/16, we are unlikely to have achieved our target of reducing emergency admissions by 3.5%. It should be noted that the longer term trend is positive, with admissions lower than in 12/13 and 13/14.

Whilst emergency admission reductions are no longer a core part of the BCF national metrics, locally we will maintain a strong focus on reducing admissions by investing in preventative services and a comprehensive suite of primary and community services to increase support to our local population. It should also be noted that the focus on reductions in admissions is a shared target across our system, and will be the focus of a system wide CQUIN in 16/17.

In the CCG operating plan we have forecast a small increase in admissions for 16/17. Whilst we are confident that this plan will be met, the CCG have put aside a risk reserve of £1.3m (matching the risk reserve created in 15/16) to fund additional admissions should they be above plan. By creating this risk reserve, we will be in a position where this money can be released to acute providers as part of year end agreements should admissions be higher than plan. Alternatively, should admissions be lower than or on plan, the risk reserve can be used to bolster or fund new schemes in year, particularly for Q3 and Q4 to support system resilience for winter.

It is felt that this approach fairly balances the need to provide surety on BCF schemes, and recognition that disinvestment in community schemes is likely to exacerbate any increase in admissions. As such, a full years funding will be available for all projects, with increases in allocations possible dependent upon whether operating plan admissions targets are met. This will enable services to be planned with a stable footing and will be reflected in the Section 75 agreement underpinning the pooled budget.

Key to system wide planning is the need to continue the significant progress made on reducing levels of DTOCS and patients that are MFFD. Both Lambeth and Southwark

have, in recent years, had some of the lowest levels of DTOCS anywhere in the country, with the latest figures indicating that the level of delays is a third of the national average. However, as part of 16/17 Better Care Fund plans, both boroughs have committed to trying to reduce these figures yet further.

It is also noted that many of the DTOCS and MFFD patients are from non-local boroughs. The CCG has undertaken extensive work has been undertaken with Lewisham to agree new processes to align pathways into continuing care and re-ablement services with those in place across Lambeth and Southwark. This should significantly reduce delays to Lewisham, with scope to expand this yet further to other SE London boroughs. In addition, the CCG has co-sponsored the Integrated Hospital Discharge programme, which sees senior leads from Community Services, Social Care and the Continuing Health team, alongside clinicians from KCH actively support wards to expedite discharges to community and social care services. Key to this will be an education programme for ward staff to ensure that discharge planning is conducted at the point of admission, to help reduce length of stay and reduce the level of MFFD discharge patients at Denmark Hill.

In 16/17, a new Choice policy will also be formally rolled out across Denmark Hill. This policy gives clearer advice to patients and their carers' and families about what support the patient is likely to need post-discharge to aid forward planning. Underpinning this, a Care Home Selection Service will be in place which will work proactively with families to help choose a care home for their relative. Evidence from elsewhere has demonstrated that that can help significantly reduce bed days for those needing to be transferred to care homes and nursing homes. We will also work closely with the ECIP team to ensure that these protocols are in line with national best practice. a review of data on DTOCs it has been noted that a significant proportion

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 2016/17 currently underway is based upon a consideration of the impact BCF resources on the overall delivery strategy. On specific areas, Adult Social Care will work closely with other Council departments such as housing, education and community engagement. Strong joint working on BCF programmes already exists through schemes such as Disabled Facilities Grants and Telecare with housing colleagues.

In addition to social care, the Council Plan is well aligned with BCF priorities through the "Healthy Aging" 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/Strategic Partnership programme is closely linked to the BCF, with certain key schemes funded directly by the BCF in 2016/17 (@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 agreed multi-agency carers strategy.

The Head of Integration and System Resilience is responsible for identifying 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 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 Operating Plan for 2016/17. 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.

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.

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

As part of our 16/17 BCF plan, we will continue to support social care services in a manner consistent with that agreed in 15/16.

The Better Care Fund directly funds a range of adult care services, with around 75% (£15m) 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 2016/17.

The 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 funding has been allocated for the implementation of Care Act duties.)

The total sum invested in social care services comes to £15m as set out in the allocations template, directed towards a range of services, all of which can be considered as protecting social care. Of this £0.5m has been allocated in 2016/17 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 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.

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 2016/17 for rolling out the Carers Strategy (see scheme details in annex 1.10) which is consistent with the level of support in 15/16. In addition to this,there is also a potentially significant element of funding within the Care Act implementation budget. The schemes proved to be highly successful in 16/17, and we continue to roll-out personal budgets and carer support packages. This will be further supported by the work of the LCNs and by close working with the voluntary

sector to ensure that the needs of carers are met.

We recognise that the likelihood of hospital admissions and exacerbation of health or wellbeing issues is increased should carers not receive the support that they need. As such, we will maintain a key focus on this area, with dedicated time at IWG subgroups to further explore the issue and to ensure that all possible steps are taken. We will continue to work closely with Southwark Carers to maintain a joint approach and ensure learning is disseminated and acted upon.

As part of our move to outcome based contracts, there will be a series of clinical, functional and experiential outcome measures inserted into contracts so that both the CCG and Council can track progress and take remedial action where necessary.

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 and social care economy, we are now moving beyond simply establishing 7 day services, to a greater cultural shift where 7 day services are seen as the norm rather than the exception. Examples include weekend discharge support within the Supported Discharge Team, along with a the mainstreaming of a simplified discharge pathway, which operates 7 days a week interfacing with the @Home service and Enhanced Rapid Response.

Social Care and Guy's and St Thomas' Community Services are also working to establish a single point of access for a range of community and social care services to simplify access, improve responsiveness and joint working, and reduce duplication. As part of this work, both organisations are looking at a joint programme of workforce development to upskill staff and ensure there are shared competencies across the home care and nursing workforce.

Our local acute Trusts have also moved to 7 day working, and we will continue 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.

Southwark CCG has commissioned extended primary care working on a 7 day basis since November 2014, which has increased the capacity of primary care to offer both planned and urgent care. Increasing accessibility of GP services should 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. Since April 2015, primary health care has been accessible to all Southwark residents 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. During 15/16 we significantly increased the level of on-site support at hospitals from social care at weekends to ensure that discharges and packages of care could commence 7 days a week, and we continue to work with our acute providers to ensure that referrals to these services are maintained throughout the week to minimise the levels of medically fit for discharge patients on wards, and smooth out admission and discharge profiles.

Reflecting this strategic commitment to 7 day working, a budget of £1.5m has been set aside in 2016/17 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.

Strong progress has been made in ensuring that all local partners across SE London meet the milestones associated with the Clinical Standards for 7 Day Services. This has been a core principle of the *Our Healthier South East London* work, with providers collaborating to see where individual providers need to make progress, and what the interdependences are for services. The requirement to meet these standards has also been included in provider contracts and as such any risk associated with providers being non-compliant will be addressed through strong contractual management.

In May 2016, we will, in conjunction with the Emergency Care Improvement Programme (ECIP) run a workshop on discharge planning and 7 day working. This workshop, and the resulting programme, will focus on how we maximise utilisation of 7 day services that are already in place. The learning from this workstream will inform future BCF plans.

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 continues to be 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 and again in 2015/16 with very good results. Plans are being developed for South London CSU to support the PDS batch processing for the councils.

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. In 15/16 we moved to the next stage of our development by moving to the LCR (Local Care Record). This has enabled the real time sharing of clinical information between Kings Health Partners (Guy's and St Thomas', King's College Hospital, and South London and the Maudsley) 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 have instead a clinical portal (across acute, community and mental health). With all GP practices using EMIS Web this is an ideal opportunity to make the 'link'.

LCR allows 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 is 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 during 16/17. With common goals of patient centric care and patient empowerment, the final stage would look to integrate into local patient / public portal. Data Sharing agreements with all partners is approved. LCR aligns to the work underway with the MIG (Medical Interoperability Gateway) for the viewing of primary care records across the patch.

The below table demonstrates the progress made to date and the milestones expected to be achieved over the next year.

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	Live	In development	In development	Live	In development
Projected 'go-live' date (dd/mm/yy)			01/04/17	01/07/16		01/04/17

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 mediations) 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 2015/16 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.

e) Agreement to invest in NHS commissioned out of hospital services which may include a wide range of services including social care

As part of planning for 16/17 Southwark can confirm that £6.1m has been allocated for NHS commissioned services, comfortably above the £5.9m minimum ring fenced allocation proposed as part of BCF planning guidance. As with all other parts of our plan, this expenditure has been jointly agreed between the Council and CCG. NHS commissioned out of hospital services from 15/16 will continue for 16/17 ensuring consistency of approach, and it is hoped will yield further benefits given that schemes are now better established.

As detailed in the risk share section, a risk reserve of £1.3m is in place so that should activity levels at acute providers be higher than anticipated, the risk reserve can be drawn down to cover this additional expenditure through year-end agreements. Should activity be below expected levels, this funding will be able to be released to further bolster out of hospital schemes ahead of the winter period.

This approach is in line with our payment for performance arrangements in 15/16 whereby a risk reserve was established between the Council and CCG which could be drawn down upon should admissions targets fail to be met. This allowed for surety on expenditure against BCF plans, but also allowed for there to be a reserve in place which could be used to fund additional acute activity where needed. It was therefore felt that this approach ensured a balanced approach to managing risk, as it was agreed between all parties, that reducing expenditure on agreed schemes was likely to further exacerbate any increase in admissions or attendances in hospital.

A number of schemes are supported through the out of hospital allocation, but in particular:

@home – Supporting around 400 patients a month, the service supports those that are at risk of a hospital admission or who have had treatment but need more care when they return home from hospital. There are 85 virtual beds available, with numbers able to flex as demand increases. Usage is increasing month-on-month, and local hospitals are being supported by on-site in-reach @home nurses who help ‘pull’ patients from the acute setting in to the community. Further work is planned with both GSTT and KCH to ensure consistent use of the service, particularly over weekends.

Pal@home – Introduced in Q3 15/16, Pal@home, helps support those at the end of life to ensure that they are able to die in their own home. The service, run in conjunction with St Christopher’s Hospice and Marie Curie Cancer Care, also offers night time rapid response services, to ensure that those that need overnight care are able to receive this outside of a hospital setting. 16 virtual beds were in place during Q4, but now that this service is being mainstreamed, it is envisaged that capacity and utilisation will increase.

Children@home – Launched in January 2016, Children@home, expanded @home services to children and young people. The service has been running as a pilot, but will be fully mainstreamed during 16/17, and expanded to run 8am-10pm, 7 days a week from Q1. Successful recruitment has now taken place, with staff coming into posts progressively over the coming months. It is hoped that between 60-100 paediatric admissions a month will be avoided, the equivalent of 12-16 beds.

Analysis of these schemes has shown that:

- Over 500 LAS conveyances to hospital have been averted thanks to the use of the Alternative Care Pathway established between @home and LAS
- Over 3000 patients have been supported by @home during the course of 15/16, with an average length of stay of 6 days. This has led to a material reduction in admissions at local hospitals and a reduction in length of stay for patients who are admitted as they are able to access enhanced out of hospital support
- Less than 10% of patients referred to @home are admitted or re-admitted to hospital, demonstrating the effectiveness of the service and its ability to provide acute care at home

f) Delayed Transfers of Care

Key to system wide planning is the need to continue the significant progress made on reducing levels of DTOCS and patients that are medically fit for discharge (MFFD). Southwark have, in recent years, had some of the lowest levels of DTOCS anywhere in the country, with the latest figures indicating that the level of delays is a third of the national average. However, as part of 16/17 Better Care Fund plans, we have committed to trying to reduce these figures yet further. This is consistent with our CCG operating plans, and the plans of the Lambeth, Southwark and Bromley System Resilience Group.

15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures			
Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
501.7	408.2	280.7	390.9
1,228	999	687	971
244,755	244,755	244,755	248,374

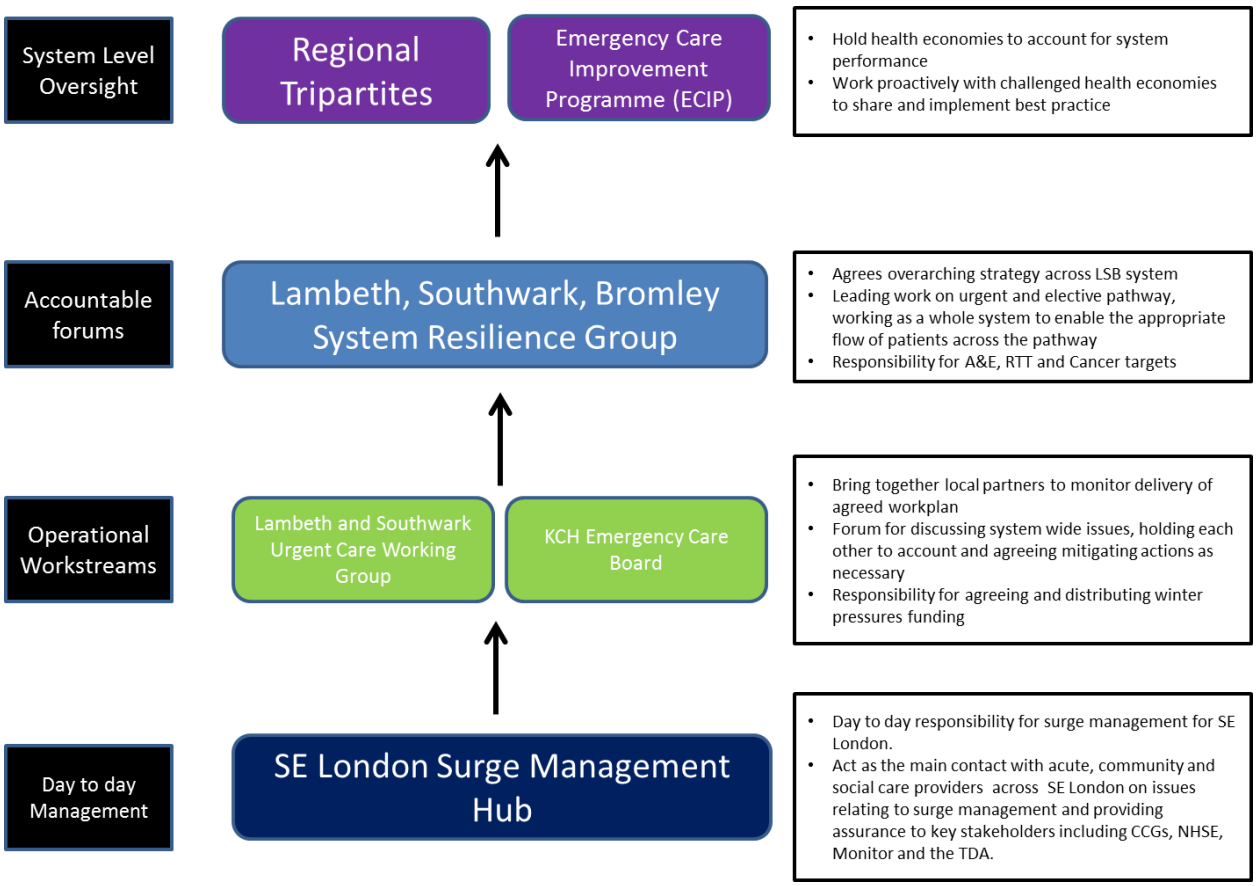
16-17 plans			
Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
352.3	352.3	352.3	347.5
875	875	875	875
248,374	248,374	248,374	251,777

It is also noted that many of the DTOCS and MFFD patients are from non-local boroughs. As part of our DTOC action plan, the CCG has undertaken extensive work with Lewisham to agree new processes to align pathways into continuing care and re-ablement services with those in place across Lambeth and Southwark. This should significantly reduce delays to Lewisham, with scope to expand this yet further to other SE London boroughs. In addition, the CCG has co-sponsored the Integrated Hospital

Discharge programme, which sees senior leads from Community Services, Social Care and the Continuing Health team, alongside clinicians from KCH actively support wards to expedite discharges to community and social care services. Key to this will be an education programme for ward staff to ensure that discharge planning is conducted at the point of admission, to help reduce length of stay and reduce the level of MFFD discharge patients at Denmark Hill.

From analysis of DTOCS in 15/16, it is noted that a significant proportion of DTOCs stem from patient and family choice, particularly where patients and their families have not made, or been supported in making, decisions about care arrangements post hospital. To help reduce these delays, in 16/17, a new Choice policy will also be formally rolled out across GSTT and KCH. This policy gives clearer advice to patients and their carers' and families about what support the patient is likely to need post-discharge to aid forward planning. Underpinning this, a Care Home Selection Service will be in place which will work proactively with families to help choose a care home for their relative. Evidence from elsewhere has demonstrated that that can help significantly reduce bed days for those needing to be transferred to care homes and nursing homes. We will also work closely with the ECIP team, who are supporting the local health economy, to ensure that these protocols are in line with national best practice.

There is a robust governance and accountability structure in place through which DTOCs are analysed and managed. The diagram below depicts this structure.



Through the System Resilience Group we will be monitoring progress on DTOCs and MFFD, and this is also picked up on daily surge management calls with all providers, where partners collaborate to rapidly troubleshoot issues related to discharge and ensure all necessary support is given.

The BCF also funds a number of voluntary sector initiatives which help manage DTOCs. An example of this is Southwark Wellbeing Support at Home (SWiSH) which helps patients to remain at home, living their own lives safely and as independently as possible by avoiding unnecessary or unplanned hospital admissions. SWiSH provides support for up to 12 weeks including home visits, drop-in sessions, advice and signposting to other services, practical support, advocacy and home audits.

g) Performance from 2015/16 and plans for 2016/17

Re-ablement

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

In 2015/16 we set a target of 90% of all residents requiring re-ablement to still be at home 90 days after discharge from the service. This would represent an increase on the 87% achieved in 2014/15. Although we are awaiting the final results from 15/16, as of the end of Q3 2015/16, we had exceeded our target, with 92% of service users remaining at home 90 days after discharge. Given strong performance in this area, our target will be to maintain this achievement in 2016/17, whilst still seeking to improve wherever we can.

We believe that the BCF has been a key factor in meeting the re-ablement targets. By allocating £1.8m in 2015/16 (a figure which has been maintained in 16/17), we were able to ensure that the service could continue to meet demand, with sufficient resource to enable staff to give service users the care and support that they needed, and to liaise effectively with colleagues in acute and community settings to ensure that there was effective joint working and seamless handovers. In addition, the effectiveness of the service, has helped reduce the level of admissions to residential care.

Admissions to residential care

One key target has been to reduce the need for residents to be admitted to residential care, by being able to support them to live independently in their own homes. The re-ablement service, alongside health services such as @home have been instrumental to this, allowing patients to be supported at home and promoting discharge to assess models.

As of the end of Q3 we have met our targets for residential home admissions (see below table)

	Oct	Nov	Dec	Jan	Feb	Mar	2015/16	Apr	May	Jun	Jul	Aug	Sep
Target	13	13	13	13	13	13		13	13	13	13	13	13
Admissions	12	7	7	7	16	6		13	8	10	13	6	12

Although our population is ageing, our ambition for 16/17 is to continue to meet our target of no more than 13 admissions to residential care per month. Should there be any signs that the target is in danger of not being met in 16/17, the Integrated Working Group will request that a deep dive is undertaken to review each admission to establish whether there are any lessons that can be learnt regarding how the admission could potentially be avoided.

In addition, as part of winter resilience schemes, Southwark Local Authority piloted 2 step down flats for patients no longer requiring hospital care, but who were not yet ready to return home. In other circumstances, these residents may well have needed to be admitted to residential care either temporarily or permanently. Instead, these step flats allowed for a ‘discharge to assess’ model to be introduced, whereby residents were given intensive support to establish whether they would ultimately be able to live independently. This model has provided to be highly effective, with over 70% of service users able to return home after this respite support. This scheme has now been mainstreamed in 16/17, and further evaluation will be undertaken to establish whether there is sufficient demand for capacity to increase further.

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 30 months. For example, Southwark and Lambeth commissioners, working with the SLIC team, held engagement events with residents 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 events included 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 Citizens Forum event on social services and integration plans.

There will be further engagement activity as detailed implementation plans for 2016/17 are developed.

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 have been key members of the Southwark and Lambeth Integrated Care (SLIC) programme and are part of the Strategic Partnership 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. As part of planning for 16/17 a system wide CQUIN on supporting those with long term conditions and avoiding admissions will be in place which is actively supported by all local providers.

Regular reports on the BCF go to contract meetings with acute providers, and the findings are discussed to ensure that all parties are not only sighted, but actively involved in the design and delivery of BCF plans.

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, 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).

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.

Our plans and trajectories for the BCF and, specifically our plans regarding Delayed Transfers of Care, have been presented at the Lambeth and Southwark Urgent Care Working Group – a subgroup of the System Resilience Group, featuring representation from all of our acute, mental health, community and social care partners and have been endorsed.

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 and Strategic Partnership programme which has shaped our approach to integration which has shaped the BCF.

As part of the PMS review, Primary Care will also be incentivised under the system wide CQUIN.

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 offset. The SLIC Sponsor Board, and its successor in the Strategic Partnership 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.

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 2016/17 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.

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 Strategic Partnership 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 Strategic Partnership
- 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

Appendices

Document or information title	Synopsis and links
1. Southwark Five Year Forward View	*Attached appendix 1, 3*
2. Health and wellbeing strategy	*http://moderngov.southwark.gov.uk/documents/s51406/Appendix%201%20Health%20and%20Wellbeing%20Strategy%202015%20-%202020.pdf*
3. JSNA	*http://www.southwark.gov.uk/jsna*
4. CCG Primary and Community Care Strategy	*http://www.southwarkccg.nhs.uk/our-plans/out-of-hospital-care/strategy-2013-18/Documents/Southwark%20Primary%20and%20Community%20Care%20Strategy.pdf*
5. Our Healthier South East London Strategic Plan	*http://www.ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/Our%20Healthier%20South%20East%20London%20Full%20Strategy%20v2.pdf*
6. Local Account – Adult Social Care	*http://www.southwark.gov.uk/localaccount*
7. SLIC website and project plans and reports	*http://slicare.org/*
8. Carers Strategy	*http://www.southwark.gov.uk/downloads/download/3605/our_draft_carers_strategy_2013*
9. Adult Social Care Vision	*Attached appendix 2*