APPENDIX 1

Draft 5 September

Integration and Better Care Fund

Southwark 2017/19

Narrative Plan Template

Area	Southwark
Constituent Health and Wellbeing Boards	Southwark
Constituent CCGs	Southwark

Approval and sign off

Organisation	Signatory	Signature	Date
Health and Wellbeing Board Chair	Peter John, Leader of Southwark Council		11/9/17
Clinical Commissioning Group Accountable Officer (Lead)	Andrew Bland, Chief Officer NHS Southwark CCG		11/9/17
Local Authority Director of Adult Social Services (or equivalent)	David Quirke-Thornton, Strategic Director of Children's and Adults Services		11/9/17

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Introduction

The BCF was first set up by the government in 2013 with the purpose of driving the transformation of local health and social care services to ensure that people receive better and more integrated care and support in the community. The fund brought together a range of existing resources for community based health and social care into pooled budget arrangements.

In Southwark we put in place a pooled budget of £21.8m for 2016/17 which was jointly governed by the council and CCG under a Section 75 agreement. This budget will roll forward into 2017/18, alongside additional resources of £9.1m from the Improved Better Care Fund (IBCF) grant – increasing the total value of the fund to £31.4m. Plans for the use of the grant are included in this template and have been agreed between the Council and the CCG for two years. The grant will form part of the pooled budget and will be included in a revised Section 75 agreement covering both BCF and IBCF, but will be paid directly to the Council to ensure it can be utilised where it is most urgently needed.

The BCF allows the CCG and Council to jointly commission a range of health and care services which help improve the health and wellbeing of the population, avoid admissions to care homes and hospital and ensure timely and effective services are available in the community when patients are ready for discharge.

This is a two year BCF plan to 2019. For 2017/18 we are initially rolling forward our funding to the schemes as set out in the 2016/17 plan which have been positively evaluated. During 2017/18 we will undertake a further review of BCF services in the context of the High Impact Changes model with a view to reconfiguring our approach to a more collaborative and integrated plan for 2018/19. We want to ensure our approach is aligned with our developing joint strategic priorities set out in the Southwark Five Year Forward View and helps drive progress towards our goal of commissioning using a population segmentation approach based on our joint understanding of Southwark. This strategy is focussed on achieving sustainability in the context of increased demand and reduced resources through transformation. We will seek to pool budgets across services to support the same cohort of people where we are most seeking improvements through integration.

The development and delivery of the BCF plan is overseen by the Health and Social Care Partnership Board with regular progress reported to the Health and Wellbeing Board. In the last year Southwark has made some significant developments towards an integrated approach, through the establishment of a Partnership Commissioning Team (PCT), who oversee joint commissioning for Children and Young People, Mental Health and Well Being and Older people with complex needs as well as having oversight of the Better Care Planning process. A Joint Commissioning Strategy Committee has been established to oversee the work of the team and the approaches to population based commissioning. Work on integration is underpinned

by joint commissioning development groups for each of the broad population cohorts.

The local vision and approach for health and social care integration

Southwark Council and NHS Southwark CCG want to enable the best possible health and care outcomes for the people of Southwark. Our clear commitment to this is set out in our joint Southwark Five Year Forward View .

This describes our 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, and is based on evidence of need and the views of our residents. In particular it links to national and local strategies; including the national Five Year Forward View, Southwark's Health and Wellbeing Strategy, the vision for Adult Social Care, NHS Southwark CCG's Operating Plan, 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:

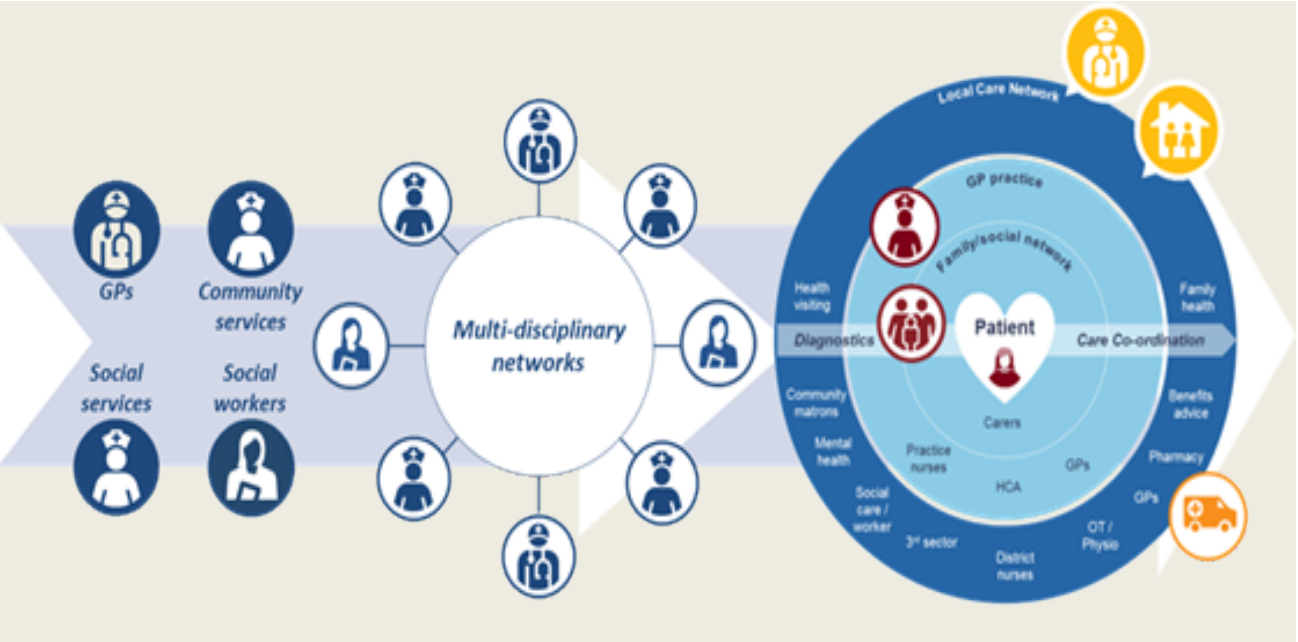
- Supporting people to manage their own health and well-being;
- Doing more to prevent ill health through early action and prevention;
- Providing more services in people's homes and in the community, with less reliance on care homes and hospital based care;
- Supporting people to feel in control of their lives and their care, with the services they receive co-ordinated and planned with them around their individual needs;
- Enabling stronger, more resilient and resourceful communities.

We recognise that achievement of this vision will require a significant change in our approach to commissioning so that we:

1) Contract on the basis of populations rather than providers;
2) Focus on whole system value rather than individual contract prices; and
3) Emphasise that 'how' care is delivered is as important as the 'what' (e.g. services considering people's mental and physical health and care needs equally, joining up care, and being proactive in our approach to care).

As part of the implementation of the Southwark Five Year Forward View, we have embarked on a programme of provider development and transformation, recognising that no one provider can meet system challenges in isolation. Southwark health and care providers have come together in two Local Care Networks (LCNs) (covering the north and south of the borough) to work collaboratively to try and address common challenges. A diagram illustrating the development of LCNs is shown below.

Fgure 1: The development of Local Care Networks in Southwark



Our aim is for these LCNs to hold population-based contracts and enable professionals to work together across traditional organisational boundaries through multi-specialty community teams that:

- Include all individual general practice staff within the locality, operating as part of an effective and collaborative federation, which can – individually or jointly – deliver core and enhanced primary care services
- Include social workers, operating on a geographical basis, whose clients live within the locality
- Include district nursing services, community mental health teams and the home care services that operate within the LCN
- Include named specialists (for example consultant or specialist nurses in paediatrics, general and elderly medicine, chronic disease and mental health) who can provide accessible outreach and support and act as a point of contact when residents require inpatient care
- Formally link to the urgent response and post-acute services, such as Enhanced Rapid Response and @home, so that preventable admissions are reduced and transitions into and out of hospital are timely, well-planned and coordinated
- Formally link into the wider network of support to people in their daily lives, for example local schools, community pharmacists, care and nursing homes, and other local voluntary sector and community assets.

The Better Care Fund (BCF) plan is consistent with local plans for implementing the Southwark Five Year Forward View, and the BCF will play a key enabling role in driving forward our shared vision by maintaining a substantial pooled budget between the Council and CCG for the delivery of community based care.

The BCF has, and will continue to, provide a strong platform for developing more integrated approaches to commissioning, service delivery and integrated governance. Building on our learning and achievements over the last 2 years, the BCF in 2017/18 will contribute towards greater health and social care integration across the Southwark system in the following thematic areas:

- Supporting people to be discharged from hospital in a safe and timely way
- Preventing non-elective admissions and re-admissions to hospital
- Supporting people to live in the community in their own homes
- Preventing people from developing more intensive health and social care needs
- Promoting the independence of people with mental health and learning disabilities

Population based approach to Commissioning

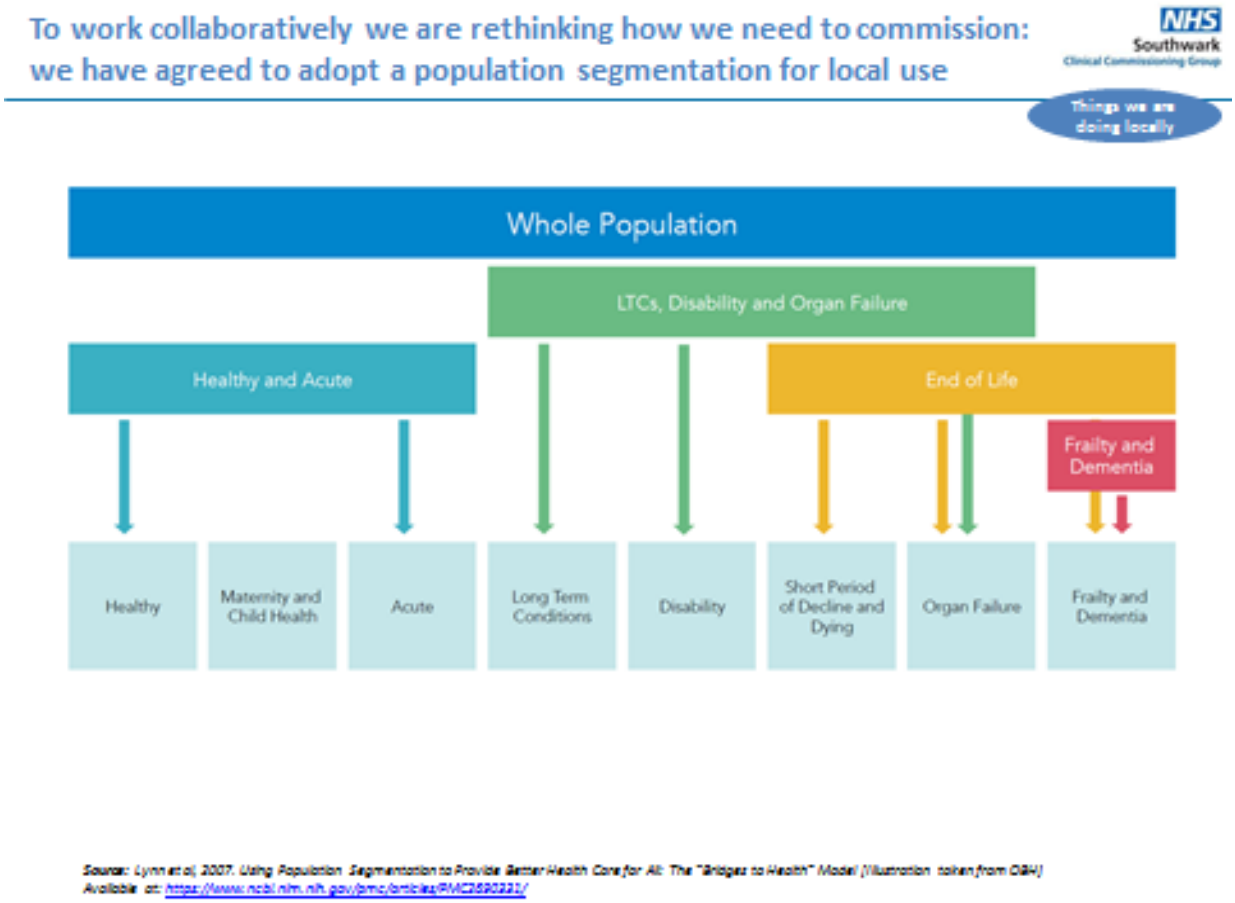
At the start of 2016/17 the CCG and Council established joint Commissioning Development Groups for Children, Severe and Enduring Mental illness and Adults to develop the approach to commissioning set out in the Forward View. These groups have made substantial progress over the year on segmenting specific groups within the key population groups including Looked After Children, the cohort of people with serious mental illness (SMI) who are in supported accommodation and adults with complex needs including 3 or more Long Term Conditions (LTCs). An approach to segmenting the population has been agreed, the “Bridges to Health” model, and we are twin tracking how we apply this segmentation to inform 2018/19 Commissioning Intentions. This will allow us to work differently with our providers in the future and will look to Accountable Care Systems and alliance contracting where they can improve support to residents e.g. those in care homes. We have already started to look at alliance arrangements for an SMI cohort who are based in residential care to improve outcomes for that group. This work will influence the reshaping of the BCF over 2017/18 ready for April 2018. The Commissioning Development Groups which have been working on population based commissioning for the past year are taking forward a number of projects which seek to address that aim including:

- A joint strategic framework for Children and Young People
- School readiness for all children to address inequalities of some key population groups
- Looked after children and the development of a sufficiency strategy to improve outcomes and address inequalities for this group
- For the SMI cohort living in supported accommodation where outcomes are poor – we are looking at the development of an alliance model for contracting

with providers across mental health, the residential care and voluntary sector market.

- For older people with complex needs we are looking to ensure we have sufficient intermediate care to ensure adequate community based provision to address delayed transfers of care and non-elective admissions to acute care.

The segmentation approach will be based on the Bridges for Health model, illustrated below:



Source: Lynn et al, 2007. Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model (Illustration taken from CSH) Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2692221/

Background and context to the BCF plan

Our work on integration and transformation originally initiated through the Southwark and Lambeth Integrated Care programme (SLIC) included a detailed programme that has examined the case for change. This work has been supported by the key local commissioners. The providers of acute, primary and community based care services who were engaged in the development of the business case. 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 appendix 2 there is a summary of some of the case for change work including graphical representations of the findings. The analysis shows that despite the existing configuration of world class health services available in the borough, outcomes remain poor for many local people. As previously outlined a population based approach to integrated commissioning and provision is being developed, including a greater focus on prevention, self care and building community assets and resilience, of which BCF funded services will be one part. This has helped us understand our priority groups, to map outcomes against population needs, thereby identifying inequalities and enabling a more targeted approach to specific challenges.

The challenges for Southwark are also clearly set out in the Health and Wellbeing Strategy. Southwark has an ageing 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 condition 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.

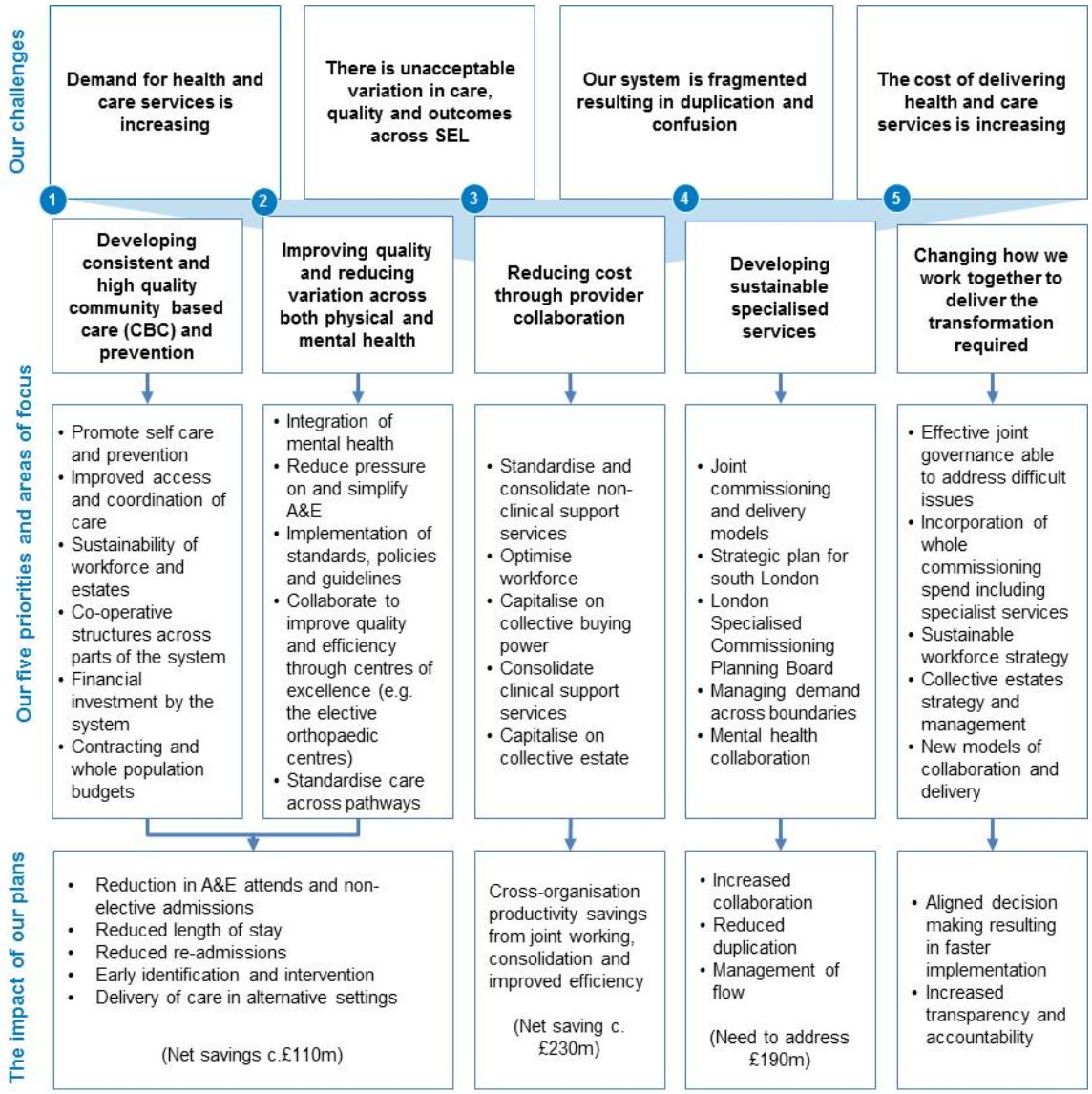
A key conclusion of the case for change work is that the current system is financially unsustainable without transformative change. The evidence shows that integration can help bridge that gap by shifting the balance of care towards more preventative community based care, and in so doing improve outcomes and shift the balance away from acute based care. All partners agree that there is scope to improve services and reduce costs by better integrating services. Our commitment to the 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 to date, with the development of an integrated reablement service and a new approach to care coordination.

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

Link to the Sustainability and Transformation Plan (STP)

The BCF and the Southwark Five Year Forward View are closely aligned with delivery of South East London STP priorities, particularly around the key priority of developing high quality integrated community based care and prevention. This is essential to reduce the demand for further acute capacity and achieve financial sustainability for the whole system. The collaborative approach taken to the BCF particularly aligns with developing joined up care so that people receive the support they need when they need it.

The community based care aspects of the STP supported by the BCF are predominantly decided at the borough level facilitated through the establishment of Local Care Networks. See appendix 6 for further detail on the STP.



Progress to date on the BCF 2016/17

Progress on the BCF is monitored quarterly with each scheme lead providing information on spend, activity, KPIs and outcomes including customer feedback and case studies. This process has provided assurance that schemes are being delivered in line with the agreed plan and having an impact, although we plan to review our services during 17/18 to ensure they are aligned with our developing approach to joint working and to closely align with the BCF key conditions and the key themes.

Examples taken from the large range of schemes within the BCF are shown below:

Supporting people to be discharged from hospital in a safe and timely way

- Hospital Discharge: At least 825 hospital bed days were saved by the hospital discharge activities in Q4

Preventing non elective admissions and readmissions to hospital

- Approx. 2,200 accepted referrals by admissions avoidance services (Enhanced Rapid Response and @home) as an alternative to hospital admission over 2016/17

Promoting the independence of people with mental health and learning disabilities

- Over 200 service users are living in the community as a result of interventions through mental health and learning disability schemes
- The Move-on support team has a caseload of 88 cases and has successfully moved on 15 people to independence during 2016-17
- 74 active users under the mental health reablement team who have a 61% success rate in reducing service user needs

Preventing people from developing more intensive health and social care needs

- Nearly 15,000 contacts made during 2016-17 as part of the prevention work, covering services such as voluntary sector befriending services
- 1,984 carers accessing information and advice during 2016-17
- 1,040 attendees at Walking Away From Diabetes self-management training
- Approximately 1,000 pharmacist interventions in care homes to improve medicines management

Supporting people to live in the community in their own homes

- 30 fewer people moved into residential or nursing care than the target which is equivalent to gross annualised savings of £750,000pa.
- The Telecare service has 870 users at the end of Q4. Over 250 falls were reported via Telecare during Q4. An estimated 34 care placements have been

avoided and an estimated 80 hospital admissions and/or delayed discharges avoided during 2016-17

Progress on operational integration - redesign of the urgent response reablement service

During 2016/17 a substantial project was undertaken to rationalise the urgent response system which has resulted in a plan to rationalise and integrate an array of related services, including community health emergency rapid response and social care re-ablement services so that there is a streamlined service available through a single front door funded through the BCF.

Progress on wider integration and the Southwark Five Year Forward View

In terms of progress towards integration in general, 16/17 progress on the Forward View started to develop some of the key priorities, including:

Addressing the fragmented arrangements of commissioning and contracting by:

- Establishing a Partnership Commissioning Team
- Establishing the Commissioning Development Groups which have met monthly over 2016/17 and driven forward the population based approach
- Creating fully assured BCF plans and agreeing a two year BCF and IBCF proposal to 2019 (IBCF subject to further discussions once allocation for 2018/19 are finalised)

Addressing fragmented arrangements of partnerships and professions by

- Establishing two Local Care Networks
- Putting into place two extended access hubs

Progress on establishing joint commissioning arrangements

To underpin our developing approach to population based commissioning, during 2016/17 we have fully established and recruited to a joint Partnership Commissioning Team led by an Assistant Director who has a dual reporting line into the Directors of Commissioning of the council and the CCG. The team consists of 14 specialised commissioners working on areas of joint commissioning based on populations across older people, complex needs, mental health and children's services. The partnership team also supports and manages the operation of the Better Care Fund. The team report progress on the population based commissioning and the integration of health and social care through the Joint Commissioning Strategy Committee.

Progress on Key BCF metrics

- **Non-elective admissions** were less than 1% over the agreed target for CCG patients - which is an achievement in the context of overall pressures on the acute care system.

- **Care Home Admissions** have been kept within target for the second year running.

However we have faced challenges in other key areas as follows:

- **Delayed Transfers of Care, a**fter a sustained period of relatively strong performance delays have increased over the second half of the year, and overall exceeded target by 47%. However, Southwark remains a top quartile performer. Southwark patient delays at Kings College Hospital (KCH), for which Southwark is the lead commissioner, amounted to 160 bed days – approx. 0.4% of all occupied bed days by all Southwark patients in the quarter, as compared to the national target of 3.5%. Also, the target required improvement on an unusually low 2015/16 baseline when Southwark enjoyed the 12th lowest rate nationally, which proved difficult to maintain. A prime reason for the increase in delays was a shortage of suitable nursing care capacity, which is an issue being addressed actively with the input of IBCF funding. In addition the IBCF will contribute to quality improvements in the home care market ensuring a stable community offer. This is an area of sustained focus and continued work on the High Impact changes plan will be monitored through the Southwark and Lambeth A&E Delivery Board.

- **Reablement** performance on the proportion of patients supported at home for 91 days after discharge shows an unexpected drop to 83.3% in Q4 against a target of 90.5%. The average across the full year was 88.8%. Analysis of the reasons for the drop in Q4 has been undertaken and a key factor has been a high numbers of patients who died within 91 days, linked with people with higher intensity needs coming into the service, at a later point in their life. The further integration of reablement services will provide a more integrated offer in the future.

Metrics discontinued in 2017/18: The following were discontinued in the national BCF framework but will continue to be monitored locally.

- **Local measure: GP Survey data – people feeling supported to manage long term conditions:** Last published data (July 2017) shows a decrease to 56.2% (from last year's figure of 59.7%) and is below the London average of 58.1%. This remains below the stretch target of 60% which was based on an ambition to achieve top quartile in London. This is being addressed through an enhanced focus on the quality of GP services by the CCG as it takes over delegated commissioning of primary care, with significant action being taken against GP practices that do not meet CQC inspection criteria.

- **Local measure on patient experience of integrated care** Local areas were required under the BCF to develop a local measure on service user

experience of integrated care. In Southwark it was agreed to add a local question to the annual adult social care user survey targeted at people receiving health and social care services. “Do all the people treating and caring for you work well together to give you the best possible care and support?”. Two years data are now available on this. In the 2016, survey 81% said yes (419 responses, excluding don’t knows). In 2015 the figure was 78%, hence a measurable improvement has been achieved**.**

Progress on discontinued national BCF objectives: The following issues no longer need to be addressed in BCF plans, but will remain key priorities as enablers of integration.

(a) Data sharing

(i) NHS Number as the primary identifier for correspondence across all health and care services:

Efforts continue to record the NHS number for each social care client. Processes are in place to try to capture NHS numbers for new records as early as possible in the life cycle. The council and the CCG are jointly funding software that will systemise capturing these numbers. Later releases of the social care system have an optional interface to the NHS systems to enable a more comprehensive search to identify the NHS number. BCF funding from the change management budget is in place to support this in 17/18.

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

The project to bring Southwark and Lambeth social care into the Local Care Record (LCR) is in progress. This will involve an interface from Mosaic, the social care system to the LCR system so that key social care data can be retrieved by health professionals and also certain health information can be retrieved from any of the systems run by health partners.

GSTT is leading on the project and is currently producing a full business case for the funding required for social care integration. Social care will go live on the LCR April 2018 after the business case is approved and a schedule is agreed with the system provider.

The LCR is already live for Guy’s and St Thomas’, King’s College Hospital, and South London and the Maudsley and primary care across the boroughs of Lambeth and Southwark.

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

(iii) Approach for ensuring that the appropriate Information Governance Controls will be in place.

Southwark's status for the IG Toolkit is rated as "satisfactory" for 2017.

There is an existing data sharing agreement between the Local Care Record organisations which Southwark will join which will be updated to take account of the General Data Protection Regulation in May 2018.

b) Seven day services

The BCF continues to fund seven days services including the weekend hospital discharge teams, funding for enhanced rapid response and 7 day primary care services. This complements the many services that already operate 7 days per week, including home care and residential and nursing care.

In addition local trusts have been developing plans to deliver against the 7 Day Services Clinical Standards including:

Guys and St Thomas':

- Review of the General Medicine medical model to enhance weekend consultant cover across all General Medical wards.
- Continued work to standardise and optimise daily Board Rounds on all acute wards, along with promotion of Clinical Criteria for Discharge to improve timeliness of discharge in the morning and at weekends.
- Review of the information provided to patients/family during a non-elective admission, to increase understanding of what to expect whilst in hospital and to enhance their involvement in care and discharge planning
- Continued provision of key 7 days services established and running in 16/17, including GSTT @Home and PAL @Home, Enhanced Rapid Response, Supported discharge teams, Transport, Pharmacy, Therapies, Hospital Social Service teams, GSTT Acute Older Persons Unit (ambulatory frailty care), which became a 7 day service in December 2016.

King College Hospital:

Completed the national 7 day Service Self-Assessment Audits in March 2016, September 2016 and March 2017. Using these results to ensure that they are meeting the requirements of the following standards:

- Standard 2 – Time to consultant review (to achieve by Q4 in 17/18)
- Standard 5 – Access to Diagnostics (to achieve by Q1 in 17/18)
- Standard 6 – Access to Consultant-directed interventions - Achieved
- Standard 8 – On-going review (to achieve 80% by Q2 in 17/18)

Currently working towards achieving these standards in the following areas by November 2017 – Vascular, Stroke, HASU, Major Trauma, STEMI Heart Attack and Children's Critical Care services. This remains in the Service Development Improvement Plan in 17/18.

The continued development of 7 day services is part of the High Impact Changes Plan.

c) Multi-Disciplinary Team working: is in place across a range of services and being further developed, for example through the Care Co-ordination approach being developed by Local Care Networks.

Evidence base and local priorities to support plan for integration

The Southwark Five Year Forward View sets out in detail the background to our approach and priorities, underpinned by the case for change in appendix 2.

For each of the schemes funded through the BCF there is a consideration of the evidence base taking into account evaluation against the High Impact Changes Model, and information on national models for services such as reablement. We will use our previously highlighted approach to segmenting the population to refresh this information to facilitate the review of the BCF through 2017/18.

Better Care Fund Plan – themes and schemes

For 2017/18 a more thematic approach has been taken to grouping the large number of schemes funded within the BCF against key outcomes. This is designed to ensure we can focus on the way different schemes work together towards key objectives for population cohorts as we evaluate the impact of the BCF and revise the plan during 2017/18 ready for 2018/19. The key themes and underlying schemes of the core BCF plan are shown below:

Theme	Target cohort	BCF outcome	Services included	Value 17/18
Theme 1: Hospital Discharge – I get the support I need to leave hospital and settle back at home	People medically fit for discharge who need support to be able to go home safely.	Delayed transfers, Reablement	Hospital discharge teams, including weekend discharge team, reablement, intermediate care	**£5,501,963**
Theme 2: Admissions avoidance - I get support that reduces the need to be in hospital	People with acute health needs who can be supported at home rather than hospital	Non-elective admissions	Community Health Enhanced Rapid Response and @home services , enhanced out of hours primary care services, self-management	**£5,062,500**
Theme 3: Community support and maintenance - I am helped to live in my community	People with high ongoing health and care needs requiring long term support to stay living at home	Care home admissions Non-elective admissions	Home care services, dementia support, end of life care, disabled facilities grant	**£3,500,350**
Theme 4: Prevention: I can access resources in the community that help me and my carers	Carers, socially isolated people and those who may currently be below social care eligibility levels	Non-elective admissions	Voluntary sector services, carers services, telecare, equipment	**£2,736,000**
Theme 5: Mental Health and Learning Disability – I get the support I need to leave hospital and settle back at home	People with mental health issues and learning disabilities requiring support to live in the community	Care home admissions Non-elective admissions	Range of community mental health services including reablement, and the funding of personal budgets	**£2,156,632**
Protecting social care services – system sustainability	all	all	Direct funding to protect social care for budget target, Care Act costs	£**3,010,610**
Service Development and change Management			Funding for Partnership Commissioning Team	£344,816
Grand total core BCF				**£22,312,871**

Detailed scheme budgets

Theme 1: Hospital Discharge – I get the support I need to leave hospital and settle back at home			
ref	**Scheme**	**2017/18**	**2018/19**
1.1a	Hospital discharge (CASC)	£600,000	£600,000
1.1b	Hospital discharge (Community Support team)	£600,000	£600,000
2.2	Hospital Discharge team 2	£187,336	£187,336
2.3	Broker to support hospital discharge	£53,117	£53,117
2.5	Supported Discharge team 4	£186,450	£186,450
2.6	Supported Discharge at weekends	£51,113	£51,113
2.7	Night Owls - overnight intensive homecare	£448,000	£448,000
17.3	Social Worker weekend working	£350,000	£350,000
1.2	Re-ablement – in addition to re-ablement grant (3)	£312,947	£312,947
1.4	Intermediate Care - Home Care Package costs	£900,000	£900,000
3	Re-ablement – previous grant	£1,813,000	£1,813,000
	Sub-total	**£5,501,963**	**£5,501,963**
Theme 2: Admissions avoidance: I get support that reduces the need to be in hospital			
Ref	**Scheme**	**2017/18**	**2018/19**
11,12	Community Health Enhanced Rapid Response /@home	£3,400,000	£3,400,000
2.4	Enhanced Rapid Response - social work team	£165,405	£165,405
17.1	7 day working Enhanced Rapid Response	£400,000	£400,000
19b	End of life - care home pharmacicst	£47,095	£47,095
17.2	Enhanced Primary Care Access - 7 day services	£743,000	£743,000
5	Self -management for long terms conditions	£307,000	£307,000
	Sub-total	**£5,062,500**	**£5,062,500**
Theme 3: Community support and maintenance: I am helped to live in my community			
ref	**Scheme**	**2017/18**	**2018/19**
6	Home care quality improvement	£1,900,000	£1,900,000
20	Dementia - Enhanced neighbourhood support	£184,177	£184,177
19a	End of life care	£152,905	£152,905
15	Disabled Facilities Grant	£1,263,268	£1,377,165
	Sub-total	**£3,500,350**	**£3,614,247**
Theme 4: Prevention: I can access resources in the community that help me and my carers			
ref	**Scheme**	**2017/18**	**2018/19**
18, 2.8	Voluntary sector preventative services	£920,000	£920,000
1.3	Voluntary sector carers work	£400,000	£400,000
10	Carers strategy	£450,000	£450,000
9	Telecare	£566,000	£566,000
10	Community equipment: contribution to council cost	£400,000	£400,000
	Sub-total	**£2,736,000**	**£2,736,000**
Theme 5: Mental Health and Learning Disability – I get the support I need to leave hospital and settle back at home			
ref	**Scheme**	**2017/18**	**2018/19**
2.1	Mental Health Re-ablement	£151,632	£151,632
8.1	Community mental health services	£655,000	£655,000
7	Psychiatric Liaison (AMHPs and reablement)	£300,000	£300,000
1.5	Mental Health – personal budgets	£600,000	£600,000
1.6	Learning Disabilities – personal budgets	£211,000	£211,000

8.2	Enhanced Psychological Support for those with LD	£239,000	£239,000
	Sub-total	**£2,156,632**	**£2,156,632**
Protecting social care – system sustainability			
Ref	**Scheme**	**2017/18**	**2018/19**
1.9, 16	Protect Adult Social Care – contribution to previous budget reduction targets	£2,010,610	£2,010,610
13	Care Act Funding	£1,000,000	£1,000,000
	Sub-total	£3,010,610	£3,010,610
Support for Integration			
4,21	Service development and change management	£344,816	£344,816
	Sub-total	**£3,355,426**	**£3,355,426**
	Inflation uplift 18/19 to be allocated across themes		£399,942
	Grand Total (Core BCF)	**£22,312,871**	**£22,826,710**

The above tables relate to the core BCF funding. The next section sets out the Improved BCF plan agreed by the Council and the CCG for 2017/18 and 2018/19.

The Improved Better Care Fund (iBCF) Grant Plan

This section sets out in full the Council's plans for the iBCF, including the background, context and rationale for the approach taken.

1.0 EXECUTIVE SUMMARY

Theme	Outcome	2017-18 Allocation (£)	2018/19 Allocation (provisional) (£)	Deployment of allocation
Theme 3: Community Support / Maintenance	Sustaining quality in block home care	£1,658,212 (original IBCF grant allocation, agreed through Council Assembly)	£1,658,212	Costs incurred in Older People homecare from reducing Delayed Transfers of Care on current performance as agreed through Council Assembly budget setting meeting. There are demographic increases in demand with more people being supported in the community as a result of improved DTOC management. The Council Assembly budget setting meeting in February 2017 also fully allocated the 2017-18 ASC precept for social care. 2017-18 inflationary cost pressures include the increase in London Living Wage, related National Insurance contributions, and the introduction of statutory pension obligations. This increased funding demonstrates support to sustain the fragile market and build resilience to maintain quality of services.
Theme 3: Community Support / Maintenance	Enhancing and investing in all spot purchased home care	£5,316,927 (new spring budget grant allocation for social care)	£5,316,927	The quality of all spot purchased home care (Older People, Learning Disability, Physical Disability, Mental Health and culturally specific home care e.g. Chinese community provision) is being enhanced and improved through the introduction of the Southwark Ethical Care Charter (London Living Wage, travel time and offer of guaranteed hours for all home care workers) and aligning home care with the two Local Care Networks in Southwark. These will support initiatives such as Trusted Assessor, timely seven day discharge, Discharge to Assess, enhanced medication compliance and partnership working within the wider health and social care economy, including overnight provision.
Theme 3: Community Support / Maintenance	Improving and investing in local nursing care homes	£1,904,334 (new spring budget grant allocation for social care)	£1,904,334	There are particular challenges to the market for nursing care homes in Southwark due to its inner London location and demographic profile. This investment will help support the sector, lead to stronger provision and increase

				the supply of quality nursing care beds locally, through market shaping and direct support. There are 2017-18 inflationary cost pressures in nursing care from increases in National Living Wage, National Insurance and introduction of statutory pension obligations. There are significant challenges to sustaining quality which impacts the council and CCG with direct impact on DTOCs. This investment will help to address quality concerns and increase capacity and choice locally.
Theme 3: Community Support / Maintenance	Transformation Fund to improve the health, wellbeing and resilience of vulnerable service users	£250,000	£250,000	A Transformation Fund to enable the testing of innovative improvements / enhancements to community care – home care, nursing home care, Extra Care Housing and residential care – to improve the health and wellbeing and resilience of vulnerable service users in the community, and in support of our work to reduce DTOCs, reduce hospital admissions and to support people to remain in the community post-discharge.
Additional allocation 18/19			£3,454,711 (tbc by DCLG)	The additional iBCF grant allocation for 2018/19 will be applied to home care and nursing care. Further details on this plan will be presented by the council following internal discussions on the 2018/19 adult social care budget. The plan will be discussed with the CCG on the 20th September and signed off through the Integrated Governance and Performance Committee on 28th September. If there are any national revisions to iBCF amounts and conditions following the government's November review the plans will need to be revisited.
Total		**£9,129,473**	**£12,584,184**	

2.0 BACKGROUND AND CONTEXT

2.1 According to the grant determination, the Improved Better Care Fund (iBCF) is intended for any of the following three purposes:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

2.2 There is no requirement to spend across all three purposes, or to spend a set proportion on each. Southwark Council has identified that by investing in the social care provider markets of home care and nursing homes, the council will deliver performance in relation to timely hospital discharge, address the pressures on the NHS in relation to emergency admissions and ensure that those with eligible adult social care needs continue to receive services from a sustainable community care system. Without the investment of IBCF funds in these markets, the ability to maintain the independence and quality of life of vulnerable people in the community are put at risk and would cause increased activity and cost for the acute sector.

2.3 In 2016/17, the Council's Revenue Outturn Report confirmed a balanced position, in line with the legal requirement for councils to do so, however this required the use of planned (and unplanned) reserves. The need for use of reserves was due to an overspend in social care and public health. The council established a Budget Recovery Board to bring down the overspend in 2017-18 and to restore sustainability going forward.

2.4 The budget set for 2017/18 assumes that savings being managed by the Budget Recovery Board are fully delivered. It also takes account of pay awards (1%) and inflation, no planned use of reserves, that the 3% ASC Precept is fully deployed to social care and assumes an increased yield from business rate retained growth and Council Tax Base.

2.5 The deployment of the iBCF monies, as proposed, will support the stabilisation of the workforce in the homecare market, including paying all of them in accordance with Southwark's Ethical Care Charter, and meet inflationary cost pressures experienced by providers to increase resilience and sustainability in this fragile market.

2.6 The iBCF monies will also serve to stabilise and build resilience in the local nursing home market. By investing in market development and increasing the number of nursing homes and the overall number of nursing care beds in Southwark, this will benefit local people, the CCG and acute providers.

2.7 To support innovation in these two community care markets the council will allocate £250k of the monies into a Transformation Fund. Use of the fund will be determined by the Strategic Director for Children and Adults (the statutory Director) and deployment will take account of the financial position of Adult Social Care. The principles which will govern the use of the fund will be that it will be to:

- Support reduction of costs in the system
- The fund will support collaboration with NHS partners for the benefit of the whole system, e.g. care workers undertaking pressure ulcer screening for early response and treatment in situ and avoiding the need for unnecessary hospital admissions.
- Support transformation which supports with whole health and care system.

3.0 IMPROVING AND INVESTING IN NURSING HOME PROVISION

2.1 Southwark Council has a commissioning intention to increase access to local nursing home beds rated as Good or Outstanding by CQC. An increase from 143 to 230 beds by 2019. This intention will benefit people funded by both the Council and NHS Southwark CCG, so that they can receive the care they need locally, where they choose to do so.

Background information

2.2 Southwark has three care homes registered to provide nursing care. Two are rated as Good by CQC and the other is rated as Inadequate. Across the three homes there are 271 rooms registered with CQC. However, one of the care homes, Queens Oak, is block-booked by Lambeth Council and has 88 rooms. This home is rated as Good. The other two homes are available to Southwark Council to purchase placements for local residents. These homes are Tower Bridge (rated as Good) and Burgess Park (rated as Inadequate). There is a fourth nursing home in the borough which is mothballed. This home is on D'Eynsford Road.

Policy implications

2.3 The Care Act 2014 introduced new duties to facilitate a vibrant, diverse and sustainable market for high quality care and support in each area, for the benefit of the whole local population, regardless of how the services are funded.

2.4 Local priorities include diversification of nursing homes. By bringing new providers into the market and by opening new care homes, commissioners are creating investment, resilience and competition in the local market. This increased capacity and choice benefits local residents, their families and the whole care system.

Needs analysis

2.5 Southwark Council owns Burgess Park and D'Eynsford Road (and other similar properties e.g. four care homes). Property colleagues commissioned 'Strategy and General Advice' to assist the council in its due diligence relating to reassignment of leases. As part of providing that advice, Lambert Smith Hampton commissioned CACI demographic analysis. The report concluded that 'Based upon the industry standard age based demand model, there is demand for some 843 care home places for which there are only 461 places currently available i.e. there is a material undersupply in the borough.' Given that the advice is for all care homes rather than specifically nursing homes; Partnership Commissioning has determined the undersupply for nursing homes to be c.100 beds. This determination is set out in the paragraph below.

2.6 Southwark currently has 291 people placed in nursing care homes. Of these placements 115 are local. To enable residents of the borough to stay local, when needing residential nursing care, there needs to be at least 100 additional beds in the borough. This determination is based on the number of nursing home placements funded (291) and the number of placements that are out of borough (176). Of these placements 25 are due to not being able to place up to the 80% (44) of beds in Burgess Park; and the fact that some of the out of borough placements are due to service user and family choice rather than lack of supply. The reason for not accessing the 44 beds in Burgess Park is due to the 'Inadequate' rating by CQC of the home.

2.7 In order to increase supply, commissioners need to open new nursing care homes and re-model existing care homes. Southwark has the opportunity to do both of these things due to being a significant landowner with assets that can support developing the market. With IBCF investment the council is minded to proceed with this commissioning, which will benefit the council, CCG and local acute providers. This increase in capacity and choice of quality local nursing home provision will directly

support the DTOC targets agreed by the council and CCG.

4.0 ENHANCING AND INVESTING IN HOME CARE PROVISION

3.1 Southwark Council has a commissioning intention to enhance all homecare provision by investing directly in the workforce that provides these vital and valued services.

Background information

3.2 The Southwark Five Year Forward View underlines the importance of ensuring there is good quality coordinated care and support in the community. This critically includes care and support available to people in their own homes, including Extra Care Housing which the council is increasing in 2017-19. Introducing the Southwark Ethical Care Charter (SECC) for social care block contracts has put Southwark at the forefront of work to deliver a step change in the way home care is commissioned, and how the home care workforce is valued. This means these home care workers are paid London Living Wage, paid for their travel time, training time and offered guaranteed hours as opposed to zero hours contracts. The expansion would introduce the SECC to spot purchased home care (43% of spend), which would build resilience into the whole workforce and stabilise the market.

3.3 The strategy set out in our procurement will allow the council to secure a series of geographically focused contracts to support closer working between home care services, primary care and community health services (Local Care Networks), as well as continuing to provide the flexibility that delivers the shared commitment to quality, choice and control for Southwark residents.

Quality considerations

3.4 High quality services are central to delivering good person-centred outcomes for residents. National research including the regular national home care surveys carried out by local authorities have consistently identified key quality themes from a service user's perspective around continuity of care, quality of interaction with their care worker and for care workers to have sufficient time to support individuals with dignity and respect.

3.5 Our tender approach will require all providers to sign up to delivering the SECC and will make clear that the council will expect providers to deliver quality improvements linked to reducing workforce turnover, improving the continuity of care for service users and working in partnership with the council and NHS on a care workforce development and training strategy to ensure home care workers are equipped and supported to deliver the enhanced care that supports our priority outcomes, including DTOC performance.

3.6 Local analysis of home care activity indicates that adopting a locality focus to the configuration of future contracts is necessary. Through establishing smaller geographic patches that support joint working between home care staff, primary and community health services, and wider preventative community support that tackles social isolation, there is real scope to delivering care around the person in a more person-centred way and with better outcomes. This is consistent and complementary to the development of

Local Care Networks in Southwark and has informed the recommended tender and contracting approach.

Cost considerations

3.7 The Procurement Strategy, approved by Cabinet, for Care at Home sets out that nationally there has been extensive research and review of home care services including the cost of home care services. This national work (e.g. PSSRU) and previous work undertaken locally has identified that the cost of home care services will increase in order to deliver the enhanced requirements of the SECC. The council however faces continued cuts to its budget.

3.8 It has therefore been important for the council to undertake affordability analysis to inform the procurement options. Local price modelling for the SECC, and drawing on information sharing with other London boroughs, particularly those who have recently completed tenders for home care services, has given the council a good understanding of the likely cost of commissioning all local home care to the SECC standard.

3.9 Although the enhanced specification associated with the SECC will prove significantly more expensive in terms of direct costs, the approach will allow the council to secure high quality provision that is of significant value to the whole system.

3.10 An innovative approach to cost pricing has managed the risk of affordability and a race to the bottom by introducing a cost envelope which sets out the prices at which the council may refuse to consider a tender where the price submitted was above the ceiling and therefore unaffordable or below the floor and therefore considered to be unrealistic in terms of maintaining quality, fulfilling the SECC commitments and delivering on our performance expectations.

5.0 SUMMARY OF COMMISSIONING INTENTIONS FOR IBCF MONIES

5.1 These commissioning intentions are ambitious, high value and will deliver a significant impact for vulnerable people in Southwark, the workforce, and the whole system that supports them. The Council is proposing to invest the iBCF in the transformation of these markets and the support that people receive in the community so that local home care and nursing home care markets are sustainable and resilient. This then puts these markets into a position to be able to safely test out transformative ideas that will further improve outcomes and performance. Consequently the sums set out in the Executive Summary will benefit the whole health and social care system in Southwark, and in support of the ambitious DTOC targets which have been agreed by the CCG and Council and submitted to the Department of Health in July 2017.

National Conditions

National condition 1: jointly agreed plan

The plan has been fully agreed through the individual governance arrangements of both the CCG and the Council, and through the joint governance of the Health and Wellbeing Board meeting of 11th September (see governance section page 30).

The development of the plan has been discussed at meetings and a workshop of the Adults Commissioning Development Group including representatives from Public Health and Southwark Healthwatch. The Joint Commissioning Strategy Committee has also discussed the BCF.

Prior to presentation to the Health and Wellbeing Board the plan was developed and agreed by the Health and Social Care Partnership Board which has established a BCF planning subgroup to ensure key planning decisions were given a full discussion. This includes agreement to the plans for investing the Improved Better Care Fund. Regular progress reports have been submitted to the Health and Well Being Board to keep them appraised of progress and advise them of progress on the BCF and IBCF policy guidance.

The £9.1m IBCF has been agreed for 2017/18 and 2018/19 focussing on home care and nursing care. In 2018/19 there is further growth of £3.5m in the iBCF for home care and nursing care, the detailed plans for which will be finalised as set out in the previous section. Discussions with local acute trusts have been undertaken on the plan at a draft stage.

The Southwark and Lambeth A&E Delivery Board has discussed and agreed the high impact change model to delayed transfers of care and the broader context of the BCF plan.

The use of the full Disabled Facilities Grant (DFG) has been agreed with housing services and will be fully deployed to enable individuals to adapt their housing to meet their needs. ASC and Housing have worked in collaboration to strengthen pathways for DFG's, and further develop the prevention agenda by ensuring that where possible and practical services are linked through pathways and referral routes to achieve better outcomes such as increased opportunity for independence.

Individual schemes within the BCF are subject to consultation processes, for example, the voluntary sector schemes are being redeveloped as a hub model as part of the Voluntary Sector Strategy and there has been extensive consultation on this.

National condition 2: social care maintenance

As a result of the government's austerity programme the central grant to Southwark Council has decreased from £295.6m in 2011/12 to £166.0m in 2017/18. This

unprecedented level of reduction in spending power has caused serious problems for the social care system, requiring savings in a range of areas of support for vulnerable people. All partners have been concerned to ensure that the Better Care Fund has been deployed in a way that supports social care as far as possible.

The planned spend on social care from the minimum CCG contribution to the core BCF remains in line with last year plus inflation, at £15.4m in 2017/18 and £15.7m in 2018/19. This is 73% of the total core BCF, which is in line with the maximum amount available after the CCG ringfenced minimum spend for commissioning community health services.

The additional iBCF grant is all being applied to the protection of social care services, in particular care in the home and the nursing home care market. Full details are set out in the previous section.

The range of social care services invested in are all judged to have a benefit to the health system, and the level of investment in these areas is seen as a positive overall decision in terms of whole system sustainability.

In addition to the £9.1m iBCF the BCF includes £5.5m in services relating to hospital discharge, reablement and intermediate care, and £5.8m in community support and prevention and £2m for community mental health social work and learning disability services. The BCF has provides budgets for Care Act implementation (£1m) and contribution to budget targets to protect services (£2m).

National condition 3: NHS commissioned out-of-hospital services

The BCF plan commits £6m to the provision of CCG commissioned out of hospital care, in line with the minimum sum of £5.981m. This includes some targeted investment in social care services that have a very specific health benefit (neuro-rehab support workers and intensive overnight home care for people with tissue viability issues).

This bulk of the investment is committed to community health admissions avoidance services Enhanced Rapid Response, @home and funding to support enhanced primary care access at weekends.

National Condition 4: Managing Transfers of Care

Maintaining good levels of delayed transfers involving Southwark patients is a key focus of the BCF. Performance has been strong at Kings College Hospital, for which Southwark is the lead commissioner (with just 160 days lost in Q4). However performance has deteriorated at GSTT and SLAM on this measure which is an area of high focus. Working in conjunction with the Southwark and Lambeth A&E Delivery Board we are using the high impact change model to drive change.

A summary of the local assessment of progress and plans to develop the high impact changes in Appendix 1, alongside a summary of the link to BCF investments. The assessment and plan has been agreed across the system and will continue to be developed over 2017/18.

It should be noted that a key funding source for the development of the High Impact Changes during 2017/18 will be from non-BCF sources, in particular winter pressures system sustainability funding.

Overview of Funding Contributions

The funding contributions for the BCF are as follows:

	2017/18 Gross Contribution	**2018/19 Gross Contribution**
Total CCG Contribution (1)	£21,049,603	£21,449,545
Council iBCF contribution (2)	£9,129,473	£12,584,184 provisional
Council non-iBCF contribution (3)	£1,263,268	£1,377,165
Total BCF pooled budget	**£31,442,343**	**£35,410,895**

Notes:

(1) The CCG contribution is set at the minimum level required under BCF rules
(2) The Improved Better Care Fund is set at the level in the grant determination provided to the council by the DCLG.
(3) The Council non-IBCF contribution is set at the minimum level which is the Disabled Facilities Grant as determined by DCLG. This is ringfenced for the provision of disabled facilities grants for householders.

The funding contributions are set at the minimum level. As part of the review for 2018/19 changes to the plan we will consider pooling together further budgets where joint commissioning activities are most advanced. The Better Care Fund is compliant with the requirement to preserve ring fenced sums for particular areas including;

- Care Act 2014 – the Better Care Fund provides £1m specifically for adults social care to implement and meet the costs of the Care Act. This is in line with the national estimated allocation within the BCF minimum amount.
- Reablement – the Better Care Fund incorporated and preserved all the services funded previously through reablement grant (£1.8m) and has invested further amounts in reablement since then, totalling £2.1m .
- Carers breaks – the BCF provides a total of £850k specifically for the costs of the carer's strategy including £450k in addition to Care Act funding.
- Social Care – the BCF continues to provide above mandated levels for Social Care funding, with £24.8m in 2017/18 rising to £28.6m in 2018/19 including iBCF. This provides a high level of protection and support for key social services vital to the overall running of the health and social care system. CCG commissioned services – at £6m is in line with the ringfenced minimum

- Improved Better Care Fund – is fully committed for Social Care services in line with grant conditions for 17/18 and 18/19.

The funding arrangements and applications of funds are agreed with stakeholders and set out in a binding Section 75 agreement on the pooled budget.

Programme Governance

The Partnership Commissioning Team lead on the Better Care Fund on behalf of the Council and the CCG, thereby linking it closely to other joint commissioning developments. The governance cycle is represented in the chart overleaf, consists of:

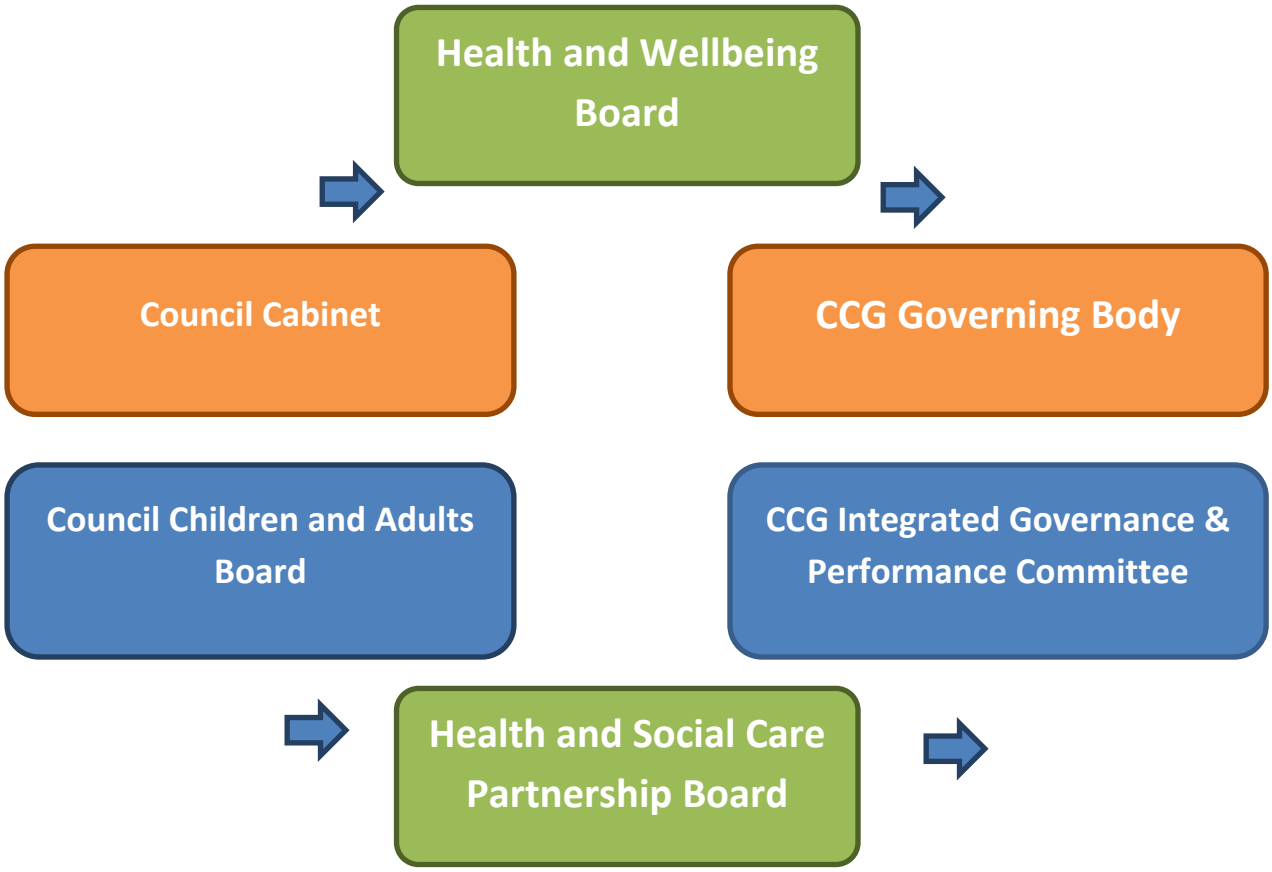
Developing the BCF

a) The BCF proposals are drawn up for agreement by the Partnership Commissioning Team supported by a BCF Working Group.
b) The Health and Social Care Partnership Board, which oversees the governance and monitoring of all joint funding arrangements, steers the development of the BCF proposals in an iterative process.
c) The Health and Social Care Partnership Board agrees a plan that is subject to agreement through the separate internal governance arrangements of the council and CCG.
d) When agreed by the Council and CCG, the plan is discussed at the Health and Wellbeing Board and agreed at this forum before submission to the national BCF assurance team.

Monitoring the BCF

a) The full BCF agreement is set out in a section 75 agreement signed by both parties which sets out agreed monitoring arrangements.
b) This includes the provision of quarterly monitoring and evaluation reports to the Health and Social Care Partnership Board, summarising more detailed scheme level monitoring outcomes.
c) A quarterly report on BCF progress is provided to the Health and Wellbeing Board following agreement at the partnership board.
d) The Partnership Commissioning Team prepare monitoring reports.
e) Council and CCG internal governance around budget and performance monitoring apply to schemes for which each organisation is the lead commissioner.
f) Evaluation of outcomes is incorporated into year end monitoring and this will be used to inform further developments in the BCF in 2018/19.

Figure 2 BCF Programme Governance



Key enablers supporting these governance arrangements include:

- The Partnership Commissioning Team
- The Adults Commissioning Development Group
- The Joint Commissioning Strategy Committee
- The BCF Planning Group
- The BCF working Group

A Member level group (the Integrated Delivery and Planning Group) has also been established to ensure progress is made on joint working.

Assessment of Risk and Risk Management

The BCF risk register below will be kept under review by the Health and Social Care Partnership Board, and incorporated into each organisations risk management 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**
Resource constraints in adult social care result in the withdrawal of key services outside the BCF that impact on health and social care objectives	4	4	16	The council and CCG will be working in close partnership on planning reductions in resources in order to minimise impact. Application of the improved Better care Fund and wider BCF in a way that best targets social care protection.
Resource constraints in the NHS, particularly in provider trusts with large deficits, impact on health and care objectives.	4	4	16	The council and CCG will be working in close partnership on planning reductions in resources in order to minimise impact. Ongoing work across the STP to achieve system sustainability.
Leadership across system not working in sufficient partnership in the face of extreme resource pressures	3	3	9	Strengthened joint working arrangements at all levels, including Partnership Commissioning Team and joint governance, and a new Integrated Planning and Delivery Group.
Non-delivery of delayed transfers of care targets adds further pressure to the healthcare system	3	3	9	System wide focus on delayed transfers through the BCF and A&E delivery board.

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 targets to reduce care home admissions and admissions to hospital impact on savings targets of health and social care.	2	2	4	Progress on providing effective community support to prevent admissions to care homes and hospitals is a key focus of the BCF.
Nursing Care market failure	3	4	12	The council and the CCG are proactively managing the market for nursing care, supported by iBCF funding.
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.
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.
The late production of BCF national guidance and assurance process means that the plan will only be agreed well into the financial year, risking disruption.	4	2	8	Agreement to roll forward all schemes into 2017/18 in advance of BCF agreement.

National Metrics – BCF targets 2017 - 2019

a) Non-elective admissions (NEA)

2017/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Total 17/18
Total NEA	**6,190**	**6,413**	**6,692**	**6,549**	**25,844**
2018/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 18/19
Total NEA	**6,277**	**6,345**	**6,629**	**6,484**	**25,735**

The above targets are prepopulated by the national BCF team based on the CCG Operating Plans submitted by CCGs and agreed by NHS England. An estimate is made for the borough population which is not co-terminus with the CCG populations, for example an adjustment is made for the proportion of Southwark residents that are registered with Lambeth GP's and vice versa. Hence these targets have been through a process of assurance to ensure these are set at a suitably challenging level.

In the BCF process consideration was given to setting a stretch target for non-elective admissions above the Operating Plan targets. This option was rejected locally as the impact of BCF funded services had already been fully taken into account in the setting of Operating Plan targets, and having different targets would be potentially confusing. This also removes the need to create a risk reserve for non-achievement of stretch targets, enabling full investment of CCG monies.

Performance (CCG level) for 2016/17, based on a similar methodology, was close to target, with 24,335 non-elective admissions as against a target of 24,117 (variance of under 1%). The 2017/18 target was set at a similar level of challenge to 2016/17, in the context of increased demographic pressures and A&E activity.

A number of BCF schemes have been designed to have a direct impact on preventing non-elective admissions and all schemes have a potential indirect preventative impact. It is difficult to estimate the exact number of admissions prevented by BCF funded services, however the @home service and enhanced rapid response service which provide intensive community based health care aimed at admission avoidance took 627 and 1572 referrals respectively. The further integration of these services with council re-ablement services during 2017/18 is anticipated to bring further benefits. In addition over 1000 people attended diabetes self- management training.

Admissions avoidance initiatives in the BCF are focussed on over 65s which benchmarking indicates is an area for improvement in Southwark.

b) Admissions to Care Homes

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	566.9	625.9	496.2	486.3
	Numerator	139	155	124	124
	Denominator	24,520	24,764	25,189	25,706

In 2016/17 there were 124 new care home admissions, significantly below the target. This is considered to be optimal performance taking into account demographic pressures and the 2017/18 and 2018/19 target has been set at a similar level.

Most BCF services have a key role to play in helping people live safely in their home and avoiding or delaying the need for a care home admission. The bulk of the new iBCF grant is being diverted to homecare budgets to help address existing levels of demand and activity.

c) Effectiveness of re-ablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	91.9%	90.5%	88.8%	88.8%
	Numerator	170	249	533	533
	Denominator	185	275	600	600

2016/17 final performance was 83.3%, with a drop in Q4 performance bringing the total below target. Analysis showed this was due to higher acuity of referrals accepted, and an increase in mortality within 91 days. However this brings Southwark into line with the national average 83.6% and is slightly below the London 2016/17 average (86%). The target equates to a 5.5 percentage point improvement. Re-ablement within the BCF will continue to be funded at existing levels

d) Delayed transfers of care

		17-18 plans				18-19 plans			
		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	568.1	534.8	524.2	508.5	521.2	527.0	516.6	502.1
	Numerator (total)	1,450	1,365	1,338	1,317	1,350	1,365	1,338	1,317
	Denominator	255,241	255,241	255,241	258,995	258,995	258,995	258,995	262,282

Within the above targets there are now agreed sub targets for NHS and Social Care caused delays in line with national expectations. These stand at around 49% of the total for NHS delays, 45% of the total for social care delays and 6% for delays caused by both.

In Southwark Delayed Transfer rates are in the top performance quartile and already meet the national target of delayed bed days representing no more than 3.5% of occupied bed days. Despite this Southwark has agreed to further improve performance in line with the national expectation for high performing areas to make a contribution to the national target. The above targets reflect the expected level and were first submitted as part of the BCF assurance process on 21st July.

Southwark did experience a deterioration over the winter months in 2016/17 and did not achieve the 2016/17 target which required improvement on an unusually low 2015/16 baseline when Southwark enjoyed the 12 lowest rate nationally, which proved difficult to maintain.

It is recognised that there is scope for improvement. As set out in Appendix 1 part of the plan includes the high impact changes plan agreed with local partners to improve transfers of care. In addition, an increase in the supply of quality nursing care is a key strategic commissioning aim, and this has been a frequent cause of delays. Work is also taking place on discharge to assess for the most complex CHC cohort to enable assessments to take place at home.

There will be a specific focus on delayed transfers in mental health setting which generate around one third of delays.

See also National Condition 4: Transfers of Care (page 27)

Appendices

Document or information title	links
1. High Impact Change Model – transfers of care	**attached**
2. Case for Change	**attached**
3. Southwark Five Year Forward View	*link:* Southwark Five Year Forward View
4. JSNA	*http://www.southwark.gov.uk/jsna*
5. South East London STP	http://www.ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/South%20East%20London%20STP%20October%202016.pdf

Annex 1: High Impact Changes Plan

Impact Change	Where are you now?	What do you need to do?	When will it be done by?	How will you know if it has been successful?	**Input of BCF investments**
Early discharge planning	Considerable work has gone into discharge planning between partners, with efforts made to ensure that all patients have an expected discharge date (EDD) set within 48 hours, or that patients are transferred to community provision early on in stay or straight from ED.	Setting of EDDs which help map out discharge plan has high compliance with 48 hour standard, but more work is planned at KCH to increase yet further. GSTT have 99% compliance, but both Trusts have work to do to ensure that Clinical Utilisation Review systems are fully in place so that EDD compliance can be monitored Further work also needs to be done across the system to ensure robust processes are in place for early discharge of elective patients.	Rollout of CUR is underway at KCH but full benefits will not be realised until end of March 2018. GSTT are currently reviewing options for similar system.	All patients have an EDD within 48 hours Monitoring of EDDs is systematically undertaken using the 'Red and Green Day' approach Elective patients who are likely to need social/community care support have provisional discharge plans in place prior to admission.	Although the focus of this work is on clinical systems in hospitals, the BCF indirectly supports the objectives of early discharge planning through extensive investments in hospital discharge related services (£5.456m) and enhanced community health care services (£3.9m). The iBCF is focussed on supporting provision of home and nursing care sufficiency which enables earlier discharge.
System to monitor patient flow	Organisations work flexibly to ensure that staff and capacity is flexed as far as possible during peaks in activity. Whilst individual services	Consideration needs to be given to having improved data flows between organisations to strengthen demand and capacity planning.	The SE London Surge Hub is currently reviewing options for improved data feeds and predictive tools – such as those	Data sharing arrangements in place which support development of whole system demand and capacity planning tool	This is not directly relevant to the BCF investment plan. However data sharing plans are a key enabler of integration and the council systems are being linked to the local care record.

Impact Change	Where are you now?	What do you need to do?	When will it be done by?	How will you know if it has been successful?	**Input of BCF investments**
	undertake demand and capacity modelling, this is not yet done as a whole system.		used in East Kent – with a funding application likely to follow. Unlikely to be in place prior to 18/19 given complexity of the system.		
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Excellent joint working is in place, with hospital based social workers from each borough attending MDTs. Voluntary sector services are not systematically included within MDTs but attend where appropriate and are embedded within discharge planning pathways	Single Universal Assessment and Referral Form is shortly to be piloted with the aim of there being one form for hospital based staff to complete when referring to the majority of community/social care teams.	Form due to be piloted in Q1 with roll-out thereafter if successful.	Form is now used as default referral form, enabling all hospital, community and social care teams to be using same criteria and documentation.	The BCF provides extensive investments in hospital discharge related services (£5.5) and enhanced community health care services (£3.9m) and voluntary sector services (£0.9m). The overall Integration and BCF plan is predicated on enhanced MDT working around local care networks.
Home First Discharge to Assess	Whilst people are still often assessed for ongoing care whilst on acute wards, a number of Discharge to	A CHC Discharge to Assess Board for Lambeth and Southwark has been established with the ambition to move CHC and complex	Outputs of CHC group intended to impact by March 2018. Reablement teams moving to	Achievement of 90% of patients who are suitable to receive CHC assessments outside of hospital.	The BCF provides investment for the intermediate care, reablement and community health teams that will support the discharge to assess model.

Impact Change	Where are you now?	What do you need to do?	When will it be done by?	How will you know if it has been successful?	**Input of BCF investments**
	Assess arrangements are operational across Lambeth and Southwark, including for example Enhanced Rapid Response teams (will support patients home from hospital with bridging care, and has social workers embedded within the team to complete SW assessments outside of the hospital) and local authority commissioned Discharge to Assess 'step down' flats	assessments out of the hospital and into a more appropriate setting closer to home. Work is ongoing to establish joint Reablement teams across health and social care in Lambeth and Southwark with the GSTT Community service team	new arrangements in Q1 2017/18	Implementation of new model of reablement services is in place.	Reconfiguration of these services within the BCF, including the development of more accommodation based step down provision.
Seven-day services	Core 7 day services in place, with social care presence on site at acute Trusts across the weekend, and community able to accept new	Adult Social Care have a 7 day presence in both acute hospitals, however not all hospital teams/community services operate 7 days which can limit discharge profiles at weekends.	Work to look at providers ability to start new packages of care and undertake weekend assessments will be reviewed as part of	Levels of weekend discharges increases.	The costs of the weekend discharge service are funded from the BCF (£400k) and specific funding for enhanced rapid response at weekends (£400k) is provided. The service funds care

Impact Change	Where are you now?	What do you need to do?	When will it be done by?	How will you know if it has been successful?	**Input of BCF investments**
	patients 7 days	Also, there is variation between some care agencies and care homes as to whether they will undertake assessments or commence new packages of care at weekends.	contracts over the next 24 months.		packages that cover weekends aimed at supporting discharge. e.g. Nightowls service
Trusted Assessors	In place for @home team and reablement teams which are key discharge routes for local health and social care economy	Need to embed Trusted Assessors across the SE London system, noting that the most significant delays are from non-local boroughs.	Single Assessment and Referral Form being piloted in Q1 17/18. Trusted Assessor protocols for SE London aim to be piloted by October 2017.	Local professionals are able to assessments on behalf of other organisations.	The BCF funds services in which trusted assessor models are in place; @home community health services.
Focus on choice	Choice Protocol jointly developed by all local health and social care organisations and is in in place. Voluntary sector provision also integrated into discharge teams to support people home from hospital	Work is ongoing to review and refresh information packs provided to non-elective patients, including expectations regarding discharge planning	Review of discharge materials in Q1 and Q2 17/18. Choice protocol review in Summer 2017	Reduction in DTOCs and MFFDs attributable to patient or family choice.	This workstream is focussed on improving hospital procedures around operation of choice policy. However the BCF funds the hospital discharge teams. The availability of an adequate supply of nursing care has an impact on choice delays and the iBCF provides £2.15m additional funding for this provision.

Impact Change	Where are you now?	What do you need to do?	When will it be done by?	How will you know if it has been successful?	**Input of BCF investments**
Enhancing health in care homes	Community service and primary care support is in place for all care homes in Lambeth and Southwark. As part of a winter initiative, Care Homes have also been visited and reminded of the value of 111 to support decision making	Working with the London team who are looking at 111 support to Care Homes to ensure that additionality augments existing GP support to care homes rather than causes confusion or destablisation	Q1 and Q2 17/18	Fewer ambulance call-outs to Care Homes and thus fewer admissions to hospitals for care home residents.	The BCF funds a community pharmacist to work in care homes to ensure safe management of mediations. Medicine reconciliation and medication review are core functions. The pharmacist also attends the monthly MDTs for each home. The BCF also funds end of life care co-ordinators working across care homes. The iBCF provides additional £2.15m funding to support the provision of Nursing Care.