Tri-borough Better Care Fund – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority
City of Westminster
London Borough of Hammersmith and Fulham
Royal Borough of Kensington and Chelsea

Clinical Commissioning Groups
Central London Clinical Commissioning Group
Hammersmith & Fulham Clinical Commissioning Group
West London Clinical Commissioning Group

Boundary Differences
Co-terminus (limited exceptions)
The Plan covers all three boroughs so the CCG boundary exception is not relevant to the narrative. The finance section sets out local authority funding by borough and CCG funding by CCG so the NHS figures for Westminster are split between CLCCG (78%) and WLCCG (22%).

Date to be agreed at Health and Well-Being Boards:
24/03/2014
(draft agreed in December 2013/January 2014)

Date submitted:
To be completed

Minimum required value of BCF pooled budget:	**2014/15**	£2,590,000
	2015/16	£47,836,000
Total proposed value of pooled budget:	**2014/15**	£157,110,353
	2015/16	£211,460,612

b) Authorisation and sign off

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Dr Fiona Butler
Chair,
NHS West London CCG

Date ___________________________

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Councillor Mary Weale
Cabinet Member for Adult Social Care &
Public Health, RB Kensington and Chelsea
And Chair, RBKC Health & Wellbeing Board

Date ___________________________

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Dr Ruth O'Hare
Chair,
NHS Central London CCG

Date ___________________________

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Councillor Rachael Robathan
Cabinet Member for Adults &
Public Health, Westminster City Council
And Chair, WCC Health & Wellbeing Board

Date ___________________________

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Dr Tim Spicer
Chair,
NHS Hammersmith & Fulham CCG

Date ___________________________

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Councillor Marcus Ginn
Cabinet Member for Community Care,
LB Hammersmith and Fulham
And Chair, LBHF Health & Wellbeing Board

Date ___________________________

c) Service provider engagement

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

This plan reflects a number of existing programmes which have included health providers as active participants. Together with a range of local social care providers, and our voluntary and community sector as a whole, providers are now also being engaged in developing future plans.

Details of existing consultation work can be found in *Shaping a Healthier Future*, our agreed *Out of Hospital Strategies* and *Living Longer and Living Well*, and our successful application to become an Integrated Care Pioneer.

A joint commissioner and provider forum across North West London forms a core part of the co-design work in our Whole Systems Integrated Care Programme. A number of the BCF workstreams are particularly relevant to our community health services providers and we are involving them closely in these developments.

As part of creating the Tri-borough Market Position statement the local authorities have been developing a more regular dialogue with local providers of social care, including community organisations. In developing the Better Care Fund plans for the future we are looking to link this wider range of social care and community providers to the Whole Systems forum as a reference group for the BCF and for the wider Health and Wellbeing programmes.

d) Patient, service user and public engagement

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

Our vision for whole system integrated care is based on what people have told us is most important to them: high quality, integrated care provided in people's homes and communities, tailored to their needs.

Through patient and service user workshops, interviews and surveys across North West London (NWL) we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.

A North West London Patient and Public Representative Group has now been established, including CCG Patient and Public Involvement lay members, representatives from HealthWatch and from service user and carer groups to ensure that the patient perspective is reflected in all our programmes as they develop.

At a borough and CCG level, service users and carers are involved in developing person centred services; and each Health and Wellbeing Board has adopted the National Voices approach, involving service users in identifying local measures of success.

Tri-borough Adult Social Care is currently undertaking a Customer Journey project to understand better the views of service users and carers on their experience of social care. This builds on the information already received through the national survey and will inform our integrated operational working.

We will be building on these existing approaches to develop a strong service user and community voice within the Better Care Fund to ensure that our integration plans deliver better outcomes and experiences for all our citizens. The draft engagement plan is included in the supplementary documents.

e) Related documentation

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

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref	Document	Synopsis
D1	**“Living Longer, Living Well” Pioneer Application June 2013**	The vision for whole system integrated care in NW London, including that people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people’s care; and systems will not hinder the provision of integrated care.
D2	**“Shaping a Healthier Future” NHS North West London**	The strategy for future healthcare services in North West London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.
D3	**Out of Hospital Strategies**	NHS West London CCG, NHS Hammersmith & Fulham CCG, and NHS Central London CCG’s strategies for commissioning and delivering better care for people, closer to home. These focus on local care provided out of hospital, integrating with the future development of acute services across the region as outlined in “Shaping a Healthier Future”.
D3	**Joint Strategic Needs Assessment (JSNA)**	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities for each of the 3 localities.

Ref	Document	Synopsis
D4	**Joint Health & Wellbeing Strategy(JHWS)**	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the 3 localities.
D5	**Joint Commissioning Intentions**	A single view of commissioning intentions across the Triborough health and social care landscape. The CCGs commissioning intentions for 2014/15 have been mapped against each other and also against the Triborough market statement (which brings together Local Authority Social Care commissioning intentions across Westminster, Kensington & Chelsea, and Hammersmith & Fulham).
D6	**CIS Business Case**	This outline business case argues for the development of a detailed single specification for a Triborough Community Independence Service (CIS) which will integrate and enhance existing local models and delivery frameworks to achieve common and improved outcomes for the populations of Hammersmith & Fulham, Kensington and Chelsea and Westminster.
D7	**Delivering Seven Day Services**	North West London's vision to be an early adopter for seven day services across health and care.
D8	**Individual CCG QIPP, operating and local authority corporate and service plans**	Detailed plans by the CCGs and Local Authorities for the funding and delivery of services and associated efficiency targets for 2014/15 and 2015/16.
D9	**Borough/CCG Health and Wellbeing Partnership Agreements**	S75 Partnership Agreements established between each local authority and CCG as a framework within which integrated commissioning can be implemented; along with annually agreed service schedules of those services jointly commissioned or in a pooled budget.

2) VISION AND SCHEMES

a) Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.
- What changes will have been delivered in the pattern and configuration of services over the next five years? - What difference will this make to patient and service user outcomes?

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **co-ordinate around individuals**, targeted to their specific needs;
- **improve outcomes**, reducing premature mortality and reducing morbidity;
- **improve the experience of care**, with the right services available in the right place at the right time;
- **maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing;
- **through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

To do this, our starting point is our patients and service users themselves.

The following 3 "personas" are examples of those which have been developed to capture the experience of typical service users. They bring together feedback from real people and from the frontline professionals who are working to help them today. They allow us to focus our interventions on meeting the needs of individuals, working with them on the things which are most important to them.

Example Personas

Asmita

- *Asmita is 66 and lives in Westminster. She has a low income and lives alone in a rented basement flat. She is recently widowed. Her husband, who was her carer and organised her medicines also used to translate for her as English is not her first language*
- *She often feels lonely as her family lives abroad and she cannot communicate easily with her neighbours.*
- *Asmita has multiple long term conditions including diabetes, arthritis, chronic heart failure and early onset dementia. However, she does have some capacity at the moment.*
- *She receives a number of different services which include meals on wheels, two homecare visits a day to help her dress. Since her husband died, she makes frequent 999 calls and associated A&E visits. Her medicines are delivered by the pharmacy but she often misses her regular doses.*

April

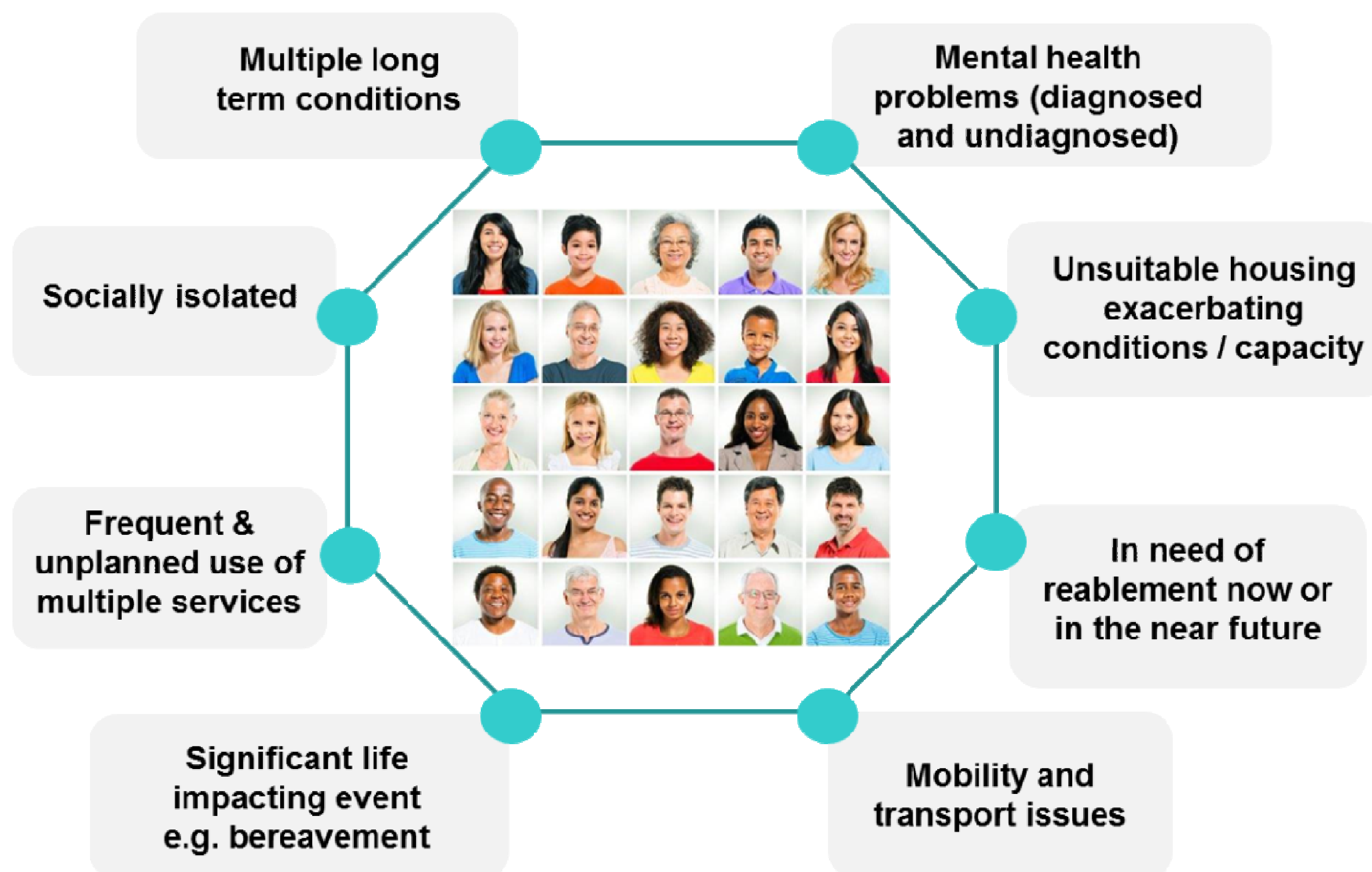
- *April is 82. She lives in a second floor, privately-rented flat near Holland Park. There is no lift and a stone staircase, so she is at high-risk of falling. She has had 2 hip replacements and is currently taking warfarin following general anaesthetic for her second operation.*
- *She regularly visits her GP for blood pressure checks and has high levels of anxiety, leading to panic attacks. She has an informal support network in her block of flats, but her daughters live abroad and will not be returning to the UK.*
- *She has physio services for her hips and accesses transport services for hospital appointments. April has capacity at the present time, but is at high risk of losing her independence. She would benefit from help in the home to keep her in her current accommodation for as long as possible. She would benefit from some computer literacy, for example, to help with shopping, general contact etc.*

Les

- *Les lives in Hammersmith. He has two children. He lives on his own in social housing and is currently unemployed.*
- *Les feels isolated. He receives services in a reactive way, although he is on the brink of receiving more proactive services. He does not have a care manager.*
- *Les has multiple long term conditions including diabetes (which may not have been diagnosed at this stage). He is a smoker who has alcohol issues and heart problems. He also has mental health problems (a combination of depression and dementia).*
- *He frequently uses Charing Cross Hospital A&E (visits are often alcohol-related). He has lots of disconnected referrals to care managers, social workers and district nurses. With the right advice and support Les could potentially care for himself.*

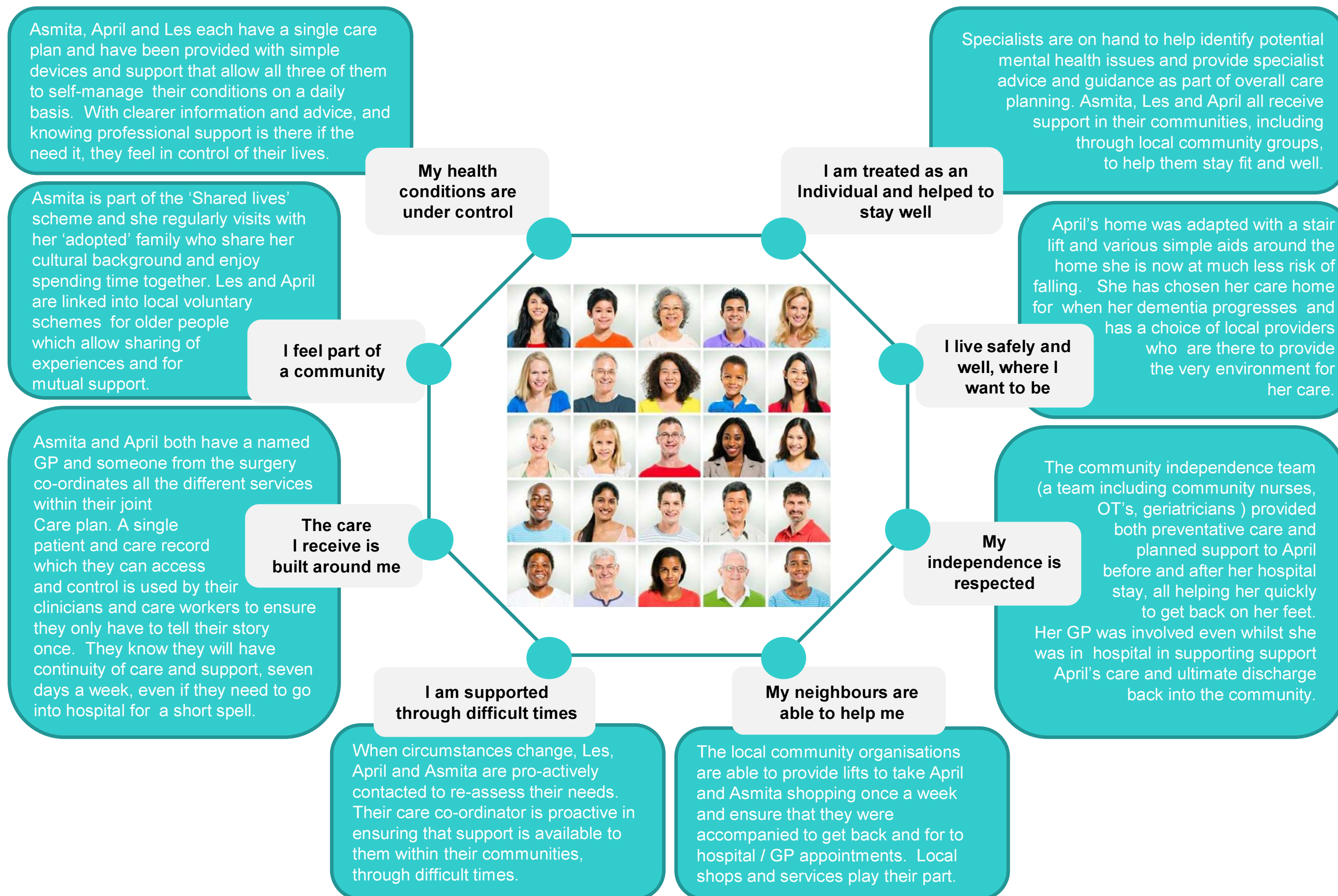
Transforming outcomes, transforming lives

As our work and engagement in this area has evolved, so increasing we have been able to identify a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing.



Our vision for those we serve

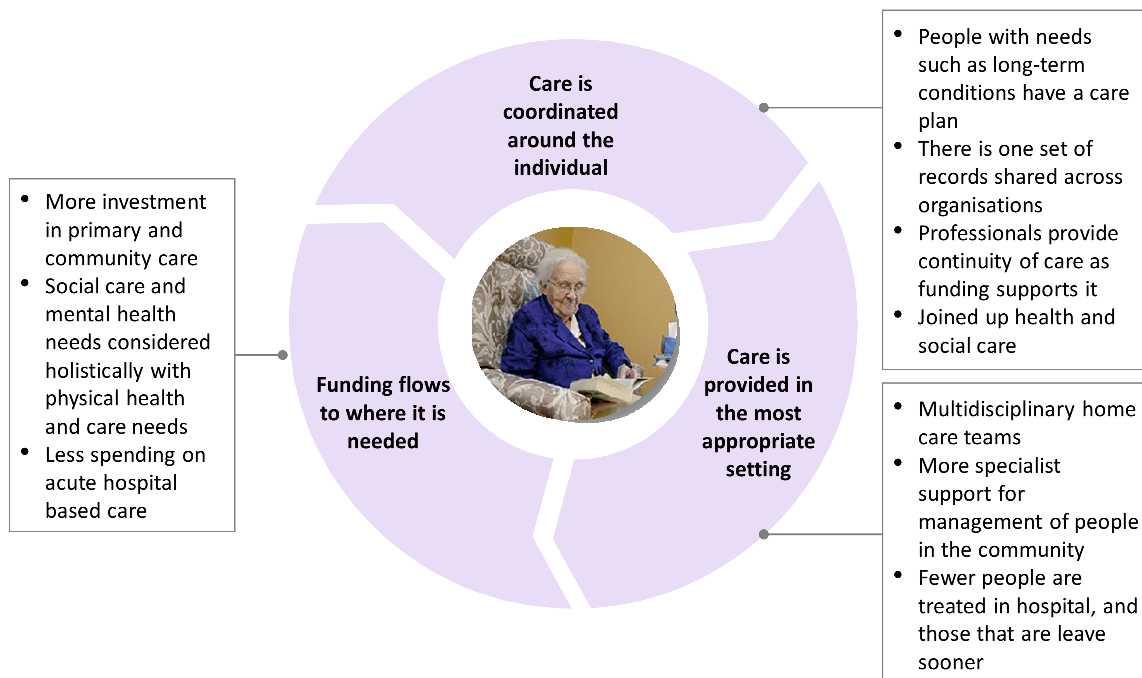
Our vision for 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.



Our Vision - What this will mean for our health and social care services

Our vision for whole system integrated care is based on what people have told us is most important to them. **Through patient and service user workshops**, interviews and surveys across North West London (NWL), we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.

We recognise that realising this vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, **all providers of health and care services will need to change** how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the Triborough are committed to working together to create a marketplace, and to effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.



In ***Living Longer and Living Well***, our application for Pioneer status, we set out our strategy for developing person-centred, co-ordinated care in North West London.

This strategy is based on 3 core principles:

1. **People will be empowered** to direct their care and support, and to receive the care they need in their homes or local community.

2. **GPs will be at the centre** of organising and coordinating people's care.

3. **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system

This work starts and ends with the individual experience of care. Through mapping the current experiences, capabilities and needs of our patients and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas. This is about not simply looking at people in terms of the cost of their care, or the types of interactions they currently have with local public services, but looking further to the root cause of the challenges many experience today, and how these can be converted into more positive experiences and outcomes in the future.

For Asmita, April and Les – typical individuals who are being supported by a range of local health and social services within the Tri-borough today, but have been identified as being at high risk of losing their independence – our focus is on helping them to manage their physical or mental health conditions, and enabling them to live safe, well and comfortably in their own homes and communities for as long as possible.

In practice, this means that from 2015/16 we will work towards the following vision:

- **The care I receive is built around me:** Asmita and April both have a named GP and someone from the surgery co-ordinates all the different services within their joint Care plan. A single patient and care record which they can access and control is used by the clinicians and care workers who are involved in their care, to ensure they only ever have to tell their story once. They know they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell.

- **My health conditions are under control:** Asmita, April and Les each have a single care plan and have been provided with simple devices and support that allow all three of them to self-manage their conditions on a daily basis.

With clearer information and advice, and knowing that professional support is there if they need it, they feel in control of their lives

- **I feel part of a community:** Asmita is part of the 'Shared lives' scheme and she regularly visits with her 'adopted' family who share her cultural background and enjoy spending time together. Les and April are linked into local voluntary schemes for older people, which allow sharing of experiences and for mutual support.

- **I am supported through difficult times:** When circumstances change, Les, April and Asmita are contacted to re-assess their needs. Their care co-ordinator is proactive in ensuring that support is available to them within their communities, through difficult times.

- **My neighbours are able to help me:** The local community organisations are able to provide lifts to take April and Asmita shopping once a week and ensure that they were accompanied to get back and forth for hospital and GP appointments. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

- **My independence is respected:** The community independence team (a team including community nurses, OT's, geriatricians) provided both preventative care and planned support to April before and after her hospital stay, all helping her quickly to get back on her feet. Her GP was involved even whilst she was in hospital, supporting April's ongoing care, and ultimate discharge back into the community

- **I live safely and well, where I want to be**: April's home was adapted with a stair lift and various simple aids around the home she is now at much less risk of falling. She has a choice of local providers who are there to provide the very best environment for her care.

- **I am treated as an individual and helped to stay well:** Specialists are on hand to help identify potential mental health issues and provide specialist advice and guidance as part of overall care planning. Asmita, Les and April all receive support in their communities, including through local community groups, to help them stay fit and well.

As a result of these changes, Asmita, Les and April and those around them feel confident in the care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including their local A&E departments, are significantly reduced. If they

do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission.
They routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

Overall pressures on our hospitals and health budgets have reduced, as we shift from high-cost reactive to lower cost preventative services, supporting greater self-management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved care at home reduces the need for high-cost nursing and care home placements.

To achieve this we are engaging with local health and care providers, and associated public, private and voluntary and community sector groups, to "co-design" models of care that will engage with and meet people's aspirations and needs.

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring, self-management and time-banking programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

At the heart of this will be integrated Community Independence teams that will provide a rapid response to support individuals in crisis and help them to remain at home. Community Independence will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our re-ablement services. By

establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;

- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals"

In doing so our plan is to go far beyond using BCF funding to back-fill existing social care budgets, instead working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

Shaping a Healthier Future describes what success in this area will require of, and mean for, our hospitals, with services adapting to ensure the highest quality of care is delivered in the most appropriate setting.

The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and Community Independence provision, will mean we will eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

We recognise that there is no such thing as integrated care without mental health. Our plans therefore are designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

GPs will be at the centre of organising and coordinating people's care.

Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined up support for those individuals with long-term conditions and complex health needs.

As a result of all of these changes, some GPs may have smaller list size with more complex patients and with elements of basic care delivered by nurse practitioners; and in the acute sector, our specialist clinicians will work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a "whole person" way.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our CCG and Social Care commissioners will be commissioning and procuring jointly, focussed on improving outcomes for individuals within our communities.

In partnership with NHS England we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.

In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible, and in doing so live healthy and well lives.

In order to track the results, we will leverage investments in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the Tri-borough are integrated around the NHS number, and individual information shared in an appropriate and timely way.
We are ensuring related activity will align by working in close collaboration with the other boroughs in northwest London (NWL) in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

Our plans are aggregated into the NWL Pioneer Whole Systems Plan in order to accelerate learning and joint planning. On a NWL basis the NWL Integration Board provides oversight to this process, as described in the governance section below; with each locality Health & Wellbeing Board taking the lead in approving local joint commissioning plans.

b) Aims & Objectives

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

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

Our aim is to provide care and support to people in their own homes and communities, with services that:

- **co-ordinate around individuals** and are targeted to their specific needs;
- **improve outcomes**, reducing premature mortality and reducing morbidity;
- **improve the experience of care**, with the right services available in the right place at the right time;
- **maximising independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing;
- **through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

We recognise that this journey will involve further significant changes to the way in which services are designed and delivered, but that journey is now underway. From 2014/15,

- **Our CCG and Social Care commissioners will be commissioning and procuring jointly**, focussed on improving outcomes for individuals within our communities starting with enhanced Community Independence and Nursing and Residential Care.

- **Our community providers** will be implementing new models of service delivery, driven by clinical staff on the ground, and integrated with our broader health and wellbeing strategies.

  This will involve a single approach to assessing and meeting the needs of individuals in their homes and communities, with seamless delivery of health and care functions.

- **Our GP practices will be collaborating in networks** focused on populations over at least 20,000 within given geographies.

  Community, social care services and specialist mental and physical health services will be organised to work effectively with these networks, enabling GPs to ensure their patients are getting the very best person-centred care.

  We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over; and practices will take responsibility for out of hours services and individuals will be able to register with a GP away from their home.

- **We will be investing in co-ordinated care** that promotes a holistic view of individual needs and works with people to empower them and enable them to stay as independent as possible.

  This means ensuring there is a good quality care plan in place for all those at risk, backed by co-ordinated provision commissioned to deliver on the required support and outcomes envisaged in each and every plan.

- **The volume of emergency and planned care activity in hospitals, together with the number of residential and nursing care placements, will be reduced** through enhanced preventative and community independence functions, and improved support in the community and in the home.

  By improving individual health and wellbeing, and access to home and community based services, we will relieve pressures on our acute services and

help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk of deterioration.

In parallel, results of investment in 7 day social care provision and critical capacity areas such as neuro-rehabilitation will help us to eliminate delayed transfers of care.

In order to manage and track outcomes, we will leverage investments in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems to provide both real time information and managerial analytics.

By autumn 2014, our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record; the BCF will help ensure this happens by joining up Health and Social Care data across the Tri-borough, linked via the NHS number.

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow effective identification and management of need and outcomes across our health and care economy as a whole.

In parallel, we will be investing in developing our infrastructure around understanding the experience of care, including introducing in 2014/15 regular customer satisfaction surveying for those with one or more long-term conditions, looking holistically at their experience of care.

Part 2 describes how we expect these changes to impact on key performance measures, including our proposed local measure.

c) Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including: 1. The key success factors including an outline of processes, end points and time frames for delivery 2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We recognise that achieving our vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the Tri-borough are committed to working together to create a marketplace, and effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Across North West London, our process for achieving our vision, as set out in our joint commissioning intentions means:

- **Local health and social care commissioners**, supported by public health and in partnership with NHS England where necessary, identifying what populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; the performance management and governance arrangements to ensure effective delivery of this care. Commissioning plans will reflect local priorities set out in the joint strategic needs assessments for each borough and captured in the Health and Wellbeing Strategies.

- **Local health and care providers**, and associated public, private and voluntary and community sector groups, co-designing the care models that will deliver these outcomes; transitioning resources into these models to deliver the outcomes required; ensuring governance and organisational arrangements are in place to manage these resources; agreeing the process for managing risks and savings achieved through improving outcomes; establishing information flows to support delivery; and ensuring effective alignment of responsibilities and accountability across all the organisations concerned.

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

We will use the BCF to:

- **Help people self-manage and provide peer support** working in partnership with voluntary, community and long-term conditions groups.

- **Invest in developing personal health and care budgets** working with patients and service users and frontline professionals to empower people to make informed decisions around their care.

- **Implement routine patient satisfaction surveying** from GP Practices to enable the capture and tracking of the experience of care.

- **Invest in re-ablement** through a new joint Tri-borough approach to Community Independence, reducing hospital admissions and nursing and residential care admissions.

- **Reduce delayed discharges** through investment in Neuro-Rehabilitation services and strengthen 7 day social care provision in hospitals.

- **Integrate NHS and social care systems** around the NHS Number to ensure that front-ine professionals, and ultimately all patients and service users, have access to all of the records and information they need.

- **Undertake a full review of the use of technology** to support primary and secondary prevention, enable self-management, improve customer experience and access, and free up professional resources to focus on individuals in greatest need.

GPs will be at the centre of organising and coordinating people's care.

We will use the BCF to:

- **Roll out the Whole Systems Integrated Care model** building on existing care planning, care co-ordination, risk stratification and multi-disciplinary teams.

- **Invest in 7 day GP access** in each locality and deliver on the new provision of the GMS.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

We will use the BCF to:

- **Establish a Joint Integration Team** working across the local authorities and CCGs to support the implementation of integrated commissioning of health and social care.

- **Review all existing services**, including services commissioned under existing section 75, 76 and section 256 agreements, to ensure they represent VFM and effectively deliver integrated working

- **Create a joint Nursing and Care Home Contracting Team** focussed on improving outcomes through transforming the quality, consistency and co-ordination of care across the nursing and care homes of the Tri-borough.

- **Extend Psychiatric Core 24 services** to cover all acute sites in Tri-borough, providing holistic support for physical and mental health needs.

The full list of schemes which we propose to take forward in 2014-15 and 2015-16 appears below:

Group A – Integrated Operational Services				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF01 & BCF15 7 Day Services – Social Care and GPs	As part of the NWL Early Adopter for 7 Day Services, extend social care to provide 7 day access particularly to facilitate early discharge; and extend primary care offer to prevent unnecessary attendances at A&E	7 day services; avoidable admissions; delayed transfers of care	Review of 13-14 arrangements Business case for extension Implementation	Apr-May 2014 June- July 2014 October 2014
BCF 08 - Community Independence Services	Investment in an integrated network of community support and multidisciplinary teams to provide step up and step down care, preventative care and reablement through a community independence approach.	reduce non-elective admissions and nursing and residential care costs and maximise service user independence	Complete business case Undertake procurement Implement new service	Apr-June 2014 July – Dec 2014 April 2015
BCF10 - Rehabilitation and Re-ablement Services	Increase investment in additional community and bed based capacity, particularly for neuro-rehabilitation; streamline process Extend community rehabilitation period up to 12 weeks in the community including home care	Reduce delayed discharges; better experience for patients; reduce admissions to care homes	Complete business case Undertake procurement Implement improved services	Apr- June 2014 July-Dec 2014 April 2015
BCF11 – Integrated Services for People with Long Term Conditions	Develop integrated approach to prevention and early intervention for people with, or likely to have, long term conditions including housing interventions and home care – Links to Whole Systems Early Adopters (BCF17)	Joint approach to assessment and care planning, service user experience; reduce admissions to care homes	Early adopters develop business cases Pilot models Roll out models	Feb-Apr 2014 Apr 2014 – March 2015 April 2015
BCF13 – Psychiatric Liaison [will be taken forward as part of BCF01 and BCF08]	Develop psychiatric liaison services in line with the NWL wide review, delivering a common specification and contracting of services to ensure equity of access, improve performance and consistent standards assurance	Joint approach to assessment and care planning; service user experience; 7 day services	Service specification developed Procurement Implementation	Apr-June 2014 October 2014

Group B – Service User Experience				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF02 – Developing Self Management and Peer Support	Working with individuals and community groups to co-design, co-develop and co-produce improved health and care outcomes, maximising service user capacity within the system	Joint approach to assessment and care planning Service user experience	Project plan to be developed	Feb-May 2014
BCF06 & BCF12– Patient Satisfaction/Service User Experience/Patient Surveys	Set up routine collection of patient satisfaction from GP practices to enable capture of experience of care for people with long term conditions	Service user experience; evaluation of the whole programme	Project plan to be developed	Feb-May 2014
BCF16 – Developing Personal Health and Care Budgets	Extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care; link to BCF02	Joint approach to assessment and care planning; service user experience	PHBs for continuing healthcare in place PHBs for long term conditions in preparation Implementation	April 2014 April-Dec 2014 April 2015

Group C – Integrated contracting and commissioning				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF03 – Transforming Nursing and Care Home Contracting	Create a single care home placement contracting team across health and social care; develop outcomes based specifications, maximise value and ensure appropriate and timely provision reduces pressure on hospitals	Admissions to care homes; delayed transfers of care	Business case developed Consultation on changes Implementation	Jan-March 2014 April – June 2014 October 2014
BCF07 – Review Portfolio of Jointly Commissioned Services	Review all existing jointly commissioned services with S75 and S256 partnership arrangements, to ensure services provide value for money and are aligned with the objective of integrated working	Plans to be jointly agreed; joint approach to assessment and care panning; reablement	Review programmes Include recommendations in Commissioning Intentions	April – August 2014 Sept 2014
BCF09 – Integrated Commissioning	Review range of health and social care services to be jointly commissioned and infrastructure required including establishment of an Integrated Commissioning Team - Links to BCF programme implementation and joint	Plans to be jointly agreed; data sharing; joint approach to assessment and care planning	Scoping future integrated commissioning programme Identifying infrastructure required	March-May 2014

	commissioning review			
BCF17 – Whole Systems Integrated Care Early Adopter Pilots	Incorporating current investment in the Whole Systems Integrated Care programme into the BCF, to build fully integrated and sustainable risk stratification, care planning, care coordination, and multi-disciplinary team working across health and social care	Plans to be joint agreed; integrated approach to assessment and care planning; service user experience	Early adopter pilots agreed Pilots under way Evaluation and roll out	March 2014 April 2014 April 2015

Group D – Programme Delivery				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF04 – Better Care Fund Programme - including Performance and Governance	Programme for development, implementation and monitoring of delivery of the BCF	Plans to be jointly agreed; all elements	Programme developed Governance structure in place Implementation and reporting	Nov 2013 – March 2014 March 2014 April 2015 onwards
BCF05 – Information Technology and Information Governance	Implementation of IT and IG solutions to link tri-borough social care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier	Data sharing; joint approach to assessment and care planning	Implementation plans developed Implementation to be completed	March 2014 March 2015
BCF18 – Care Bill Implementation	Programme of work to implement all aspects of the new Care Bill	Protection for social care spending; all elements	Preparatory work Detailed preparations	Oct 2013 – March 2014 April 2014 – March 2015

An overview of the overall timeline on both a North West London and Tri-borough perspective is provided below:

August - December 2013:

- On a North West London-wide basis, we created a framework and supporting toolkit that identifies target population segments, their desired outcomes, and the finances available.

- On a North West London-wide basis, we developed approaches to some of the most difficult practical aspects of making integration across providers effective, for example, information requirements and explored how we will put these in place, how GP and Provider Networks could contract to incentivise collaborative working and developing options for joint commissioning governance model.

- Across the Tri-borough, we have developed joint commissioning intentions, outline specifications, business cases and plans to support the greater co-ordination and integration of priority services, including in relation to community health and adult social care.

January – March 2014:

- On a North West London-wide basis, we are developing locality integration plans, which set out the scope of commissioners' plans for integrated care, including target population, desired outcomes and budgets available, as well as providers' responses.

- Across the Tri-borough, prepare the detailed specifications and plans for joint commissioning and provision in 2014/15 as per the priority areas outlined above.

- Planning in detail each of the constituent schemes, identifying interdependencies, gaining engagement and support from key stakeholders and mobilising ready for implementation in April.

- Understanding in greater detail the potential impact of the schemes on service delivery on a provider-by-provider basis – we will be working closely with our local NHS and social care providers to model this.

- Discussing and agreeing the local metrics at HWBs throughout March

- In-depth understanding of the impact should scheme outcomes not be delivered or in the case of savings not materialising, and creating clear contingency plans to mitigate against this

- Further work on our approach for joint governance arrangements to support delivery of the BCF plan, including a detailed focus on how risk will be shared

- Further provider engagement to ensure alignment and buy-in across the Tri-borough

- Further discussion and agreement with the governing bodies, cabinet members and Health and Wellbeing Boards on the most efficient and effective vehicle for the pooled budget(s), understanding the implications of the various options

- In addition, we are currently undertaking a comprehensive review of anticipated financial and non-financial benefits to ensure they are as robust as possible.

April 2014 – March 2015

- On a North West London-wide basis, we will complete detailed planning to implement concepts developed during the co-design phase to achieve our objectives.

- On a North West London-wide basis, we will use Wave One Whole System sites to test models and share learning.

- On a North West London-wide basis, we will monitor financial flows in shadow budgets to evaluate financial impact of possible models on different providers and on total cost to commissioners.

- Across the Tri-borough, we will manage the implementation and benefits tracking for the newly integrated services that are "live" and developing our next tranche of joint commissioning plans in line with local needs and the Whole Systems approach.

- Introduce regular customer satisfaction surveying to develop our baseline for user experience.

From April 2015

- Use preparation from planning using co-designed materials and learning from Wave One sites and local schemes to implement new models of care at scale with actual budgets attached.

We are ensuring related activity will align by working in close collaboration with the other boroughs in North West London (NWL) in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

Our plans are aggregated into the NWL Pioneer Whole Systems Plan in order to accelerate learning and joint planning. On a NWL basis the NWL Integration Board provides oversight to this process, as described in the governance section below; with each locality Health & Wellbeing Board taking the lead in approving local joint commissioning plans.

Each Health and Wellbeing Board has agreed a Health and Wellbeing Strategy based on local joint strategic needs assessment and identifying key priority areas for action. The Better Care Fund programme is consistent with these priorities and

will be reported regularly to the Health and Wellbeing Board as part of evidencing delivery against these actions.

Within Tri-borough, building on the Community Budget programme, we are developing an approach to strengthening self care and preventative action by drawing on community assets within our neighbourhoods to complement the out of hospital strategies developed by the CCGs.

d) Implications for the Acute Sector

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

Shaping a Healthier Future and our ***Out of Hospital Strategies*** set out how we plan to reconfigure hospital services in North West London to focus on the needs of our patients. These plans have been developed and consulted upon with local authority, hospitals, community and mental health services and other local stakeholders fully engaged.

Achieving our targets will require significant investment in primary and community care and reduced acute activity, as described in our *Out of Hospital Strategy*. In *Shaping a Healthier Future*, we set out major changes in how services will be configured in our health economy over the next 3-5 years, including:

- **Central Middlesex** becoming a local hospital and elective hospital
- **Charing Cross** becoming a local hospital
- **Ealing** becoming a local hospital
- **Hammersmith** becoming a specialist hospital with obstetric-led maternity unit and a local hospital
- **St Mary's** – a local hospital, a major hospital, a Hyper Acute Stroke Unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital onto the site)

Following Secretary of State agreement, implementation of *Shaping a Healthier Future* is now being taken forward. This depends on development of local hospital arrangements and local primary and community hubs in each borough. Business cases for local hospitals are currently in preparation and will be confirmed during 2014-15. Local hubs business cases are also in development, with the new north hub in Hammersmith (White City) about to open in Spring 2014.

The ***North West London Whole Systems Integrated Care (WSIC) Programme*** and related initiatives are focussed supporting these developments through improving patient pathways to reduce hospital stays, by number and length of stay. We have evaluated our proposed changes on the Value for Money criterion. These covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes.

The analysis indicates that commissioner forecasts over the five years (across NWL) involve a gross QIPP of £550m, with reinvestment in out of hospital services of £190m.

Our local community health services provider, **Central London Community Healthcare (CLCH)** and mental health trusts, **Central and North West London Mental Health NHS Foundation Trust (CNWL)** and **West London Mental Health Trust (WLMHT)** have been fully involved in the development of community services and in the co-production of different models of care to deliver the changes described above. The WSIC pilot schemes will see providers working together to offer integrated services to improve both patient experience and value for money.

We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce mortality through better access to senior doctors; improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them; reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community; and ensure less time is spent in hospital by providing services in a broader range of settings.

If we do not deliver activity reductions through improved out of hospital care, we expect most NWL sites to move into deficit, with no overall net surplus. In the downside scenario there would be an overall deficit of £89m, with all bar one acute site in deficit.

We anticipate that the changes proposed will have a significant impact on community services, and both statutory and independent providers of health and social care will

be partners with us in delivering this Better Care Fund Plan. We will be assessing this impact scheme by scheme in the next few months.

e) Governance

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

Across the Tri-borough, we have invested significantly in building strong governance that transcends traditional boundaries. The Health and Wellbeing Board in each of our boroughs has matured well, and this year we have been able to write joint commissioning intentions covering all of our CCGs and local authorities as well as signing off Health and Wellbeing Strategies, based on the joint strategic needs assessments. We have regular meetings between our 3 council cabinet members responsible for health-related services and our 3 CCG chairs, (The Integration Partnership Board) together with joint monthly meetings between the executive teams of our CCGs and local authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG.

We have formal Health and Wellbeing Partnership Agreements in place between each borough and CCG providing a legal framework for closer integration of commissioning and an established programme of jointly commissioned services which are already overseen by the joint executive team referred to above. This will enable us to put in place the new pooled budget required by April 2015. We anticipate that this will be hosted by the local authorities, in view of the practical advantages which this offers in relation to treatment of VAT and the carrying forward of funding, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, be that local authority or CCG.

However, we also recognise the opportunities to deepen these relationships in the context of the scale and ambition of our future joint fund.

A shared approach to leadership and management

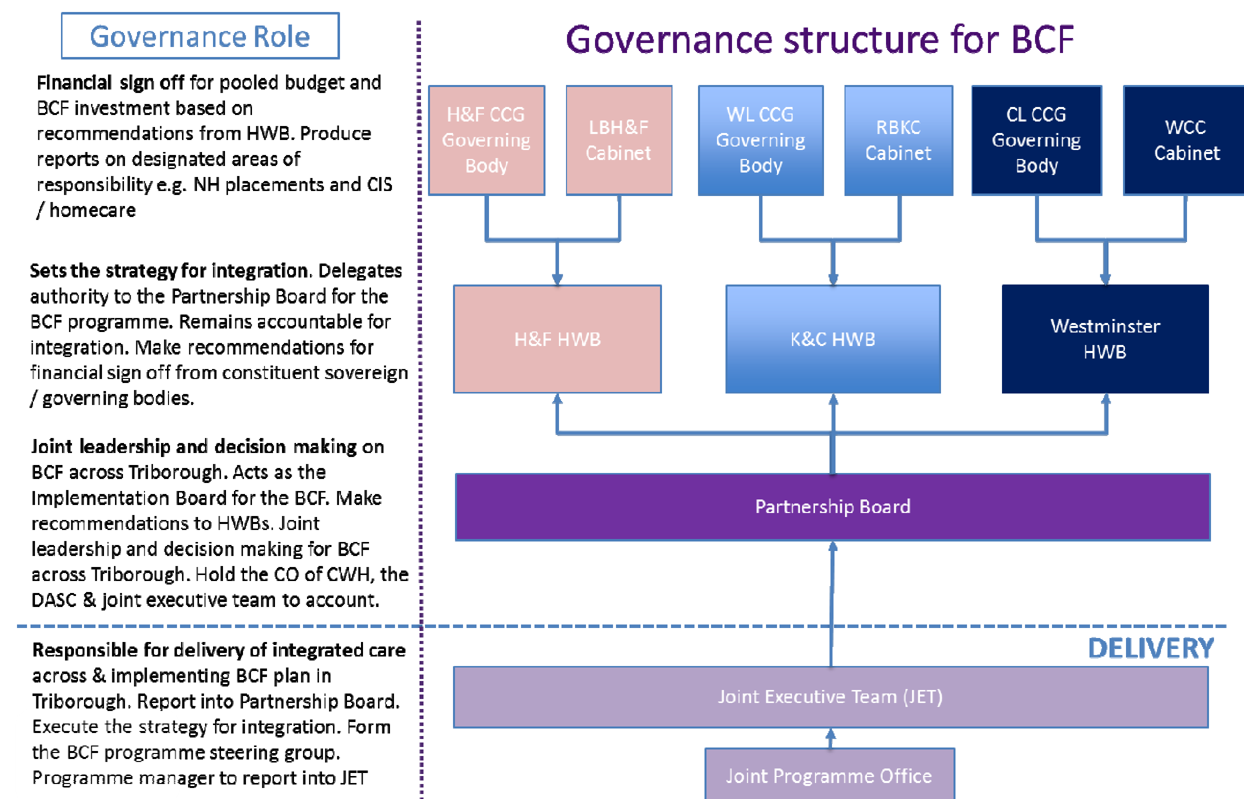
To deliver the ambition contained in our BCF, we recognise the need to develop further our strategic and operational governance arrangements. We therefore propose to look at, as part of this process, how we bring together management responsibilities and accountability across care and health services, for our residents and patients as whole. We would see our future management team accountable for the commissioning of integrated care, through the Health and Wellbeing Board, to both the Local Authorities and the CCGs. In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the BCF. The initial areas that we wish to

consider are the contracting of nursing and residential care placements, and the contracting of care delivered in people's homes.
Our business case for the contracting of nursing and residential care home placements demonstrates that, if this were done as one team across our agencies, we would save money and improve quality. Our local authorities have a strong track record in this area, and we are therefore looking at options for our CCGs to delegate this responsibility to the local authorities. We envisage that these joint arrangements would enable us to remove current gaps and duplication in procurement and improve oversight of quality and safety within this area of service provision.

In addition, joint commissioning of community independence and re-ablement services will enable us to procure integrated and effective services in the community and in people's homes, preventing unnecessary admissions to hospital and reducing length of stay for those who are admitted.

The first step in doing this will be to pool our funding for these services, and to establish one team who will be responsible for managing the health and social care budget for these functions (including assessment, brokerage and in-house provision). We envisage that both the local authority teams and the CCG teams would be held to account for the delivery of these services by a strengthened Health and Wellbeing Board. The diagram below outlines our proposed governance structure across Tri-borough.



Providing effective oversight and co-ordination

Regular briefings to Cabinet are designed to help to ensure effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities. Cabinets are the constitutional forum for key decision making and a core part of the due process for the changes envisaged in this document, which will also include scrutiny and challenge across each locality.

Throughout this process, we will ensure that the local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Better Care Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value, reflecting the needs of our local communities as identified through the joint strategic needs assessment and captured in the Health and Wellbeing Strategies.

Reviewing the Terms of Reference of our current Health and Wellbeing Boards, and ensuring they are in a position to provide effective governance for the new joint funding, will be a priority for the coming months.

Across North West London, the North West London Whole System Integration Board, combining health and local authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography. The Shaping a Healthier Future (SaHF) Programme Board will continue to oversee the delivery of the acute hospital and Out of Hospital reconfigurations, and we will continue to be accountable to the CCG collaboration board made up of the 8 CCGs in NW London. This will ensure we have a comprehensive view of the impact of changes across North West London on the Tri-borough, and vice-versa; and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

In terms of operational governance, the Integration Partnership Board (3 Cabinet members and 3 CCG chairs) will act as the BCF implementation Board. They will be accountable for the delivery of the BCF programme. The Joint Executive Team will be responsible for delivery and report into the Partnership Board. A joint programme office will be established to oversee, manage and co-ordinate this major transformation programme across the 6 partner organisations, to ensure the effective engagement of partners – service users, carers, citizens as well as service providers – and to evaluate the success of the programme, reporting to the Health and Wellbeing Boards on progress in achieving the outcomes agreed.

2) NATIONAL CONDITIONS

a) Protecting social care services

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

Protecting social care services in the Tri-borough means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility thresholds is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

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

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authorities to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible.

This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation / re-ablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)

North West London was awarded “Early Adopter” status by the NHS England/NHSIQ Seven Day Services Improvement Programme, meaning that we have a responsibility to progress the seven day services agenda at scale and pace.

The joint strategic needs assessments and Joint Health and Wellbeing Strategies (JHWS) have helped us to identify the main areas where integration and joint working will improve outcomes and informed our commitment to drive forward 7 day services.

The 7 Day Services programme is an overarching programme which includes a number of projects, many of which will be delivered through existing work streams. The work streams closely linked with the BCF programme relate to social care and primary care providers.

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

Additional funding has been identified within the Tri-borough area during the winter period of 2013/14 to facilitate 7 day services in health and social care. This will enable partners to assess what additional capacity is required to develop an ongoing 7 day service offer and to evaluate how successful the approach is to facilitating discharges and avoiding un-necessary admissions

Further work is also being undertaken to understand the Adult Social Care Customer Journey, including interfaces with health providers to enable timely assessment and transfer, and 7 day services in social care will be considered as part of this work.

A costed plan for 7 day services will be developed in 2014 for implementation in advance of the 2014/15 Winter period.

c) Data-sharing

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

All health services use the NHS number as the primary identifier in correspondence.

Social services are in the process of adopting this, and we are committed to ensuring this adoption is universal across the 3 local authorities of the Tri-borough.

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

Number to be the primary identifier across all 3 localities by April 2015.

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

We are committed to adopting systems based upon Open APIs and Open Standards. We already use:

- System One, a clinical computer system that allows service users and clinicians to view information and add data to their records;

- Emis Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record;

- Carefirst 6, a software solution to provide a range of services and content to social care, while allowing the involvement of health care partners.

To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.

By Autumn 2014 our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record; the BCF will help ensure this happens by joining up Health and Social Care data across the Tri-borough, linked as above via the NHS number.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

All of this will take place within our Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully

- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual

- Information that is shared for the benefit of the community should be anonymised

- An individual's right to object to the sharing of confidential information about them should be respected

- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

d) Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

North West London has been implementing an Integrated Care Programme across local CCG areas that involves risk stratification of practice populations and review by multi-disciplinary groups, followed by implementation of care planning and case management as appropriate.

In Hammersmith and Fulham and West London CCGs the ICP risk stratification tool, modified from the Combined Predictive Mechanism (CPM), has identified 4% of the population at high risk of hospital admission. Central London CCG uses WellWatch who are planning to transition from an approach which selects patients on the basis of pathways, to one based on selecting patients on the basis of their relative risk score. WellWatch may begin to use the ICP risk stratification tool.

Each CCG has set different targets around care planning:

- In Hammersmith and Fulham, they are working towards the 4% having a joint care plan and accountable professional
- In West London, all patients with a risk score of 20 or over will be care planned, and those with a risk score of 65 or over will be case-managed
- In Central London, WellWatch Case Management Services will care plan for those in the 61-91 centile risk stratified cohort.

Our integrated plan envisages GPs taking a lead in coordinating care as the agreed accountable lead professionals for people at high risk of hospital admission.

Under the Integrated Care Programme, around 2% of patients and service users have a care plan, and this will increase to 4% to account for the population that has been identified as high risk. The CPM algorithms are used to predict emergency hospital admission in the next year. The algorithm draws on information from primary and acute care, as well as patients' ages, to make its predictions.

Further, we stratify segments of our population based on risk. The segments identified as high risk are (a) diabetes; (b) chronic obstruction pulmonary disorder (COPD); (c) coronary heart disease (CHD); or (d) if they are over 75. The multi-disciplinary groups within each borough also use these segments as a bsis for focussing their discussions. Based on these four indicators, approximately 4% of our population is at high risk of hospital admission.

Based on the algorithm and our stratification, we then closely monitor those classified as at high risk of hospital admission within the next year.

The Early Adopter pilots being proposed by the CCGs as part of the Whole Systems Integrated Care programme reflect a commitment by GP networks to undertake systematic risk stratification and care planning for their high risk populations and to develop an integrated response to providing treatment and care.

4) RISKS

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.

The table below provides an overview of some of the key risks identified through the co-design process to-date. A full risks and mitigations log is being produced in support of our final BCF submission.

Ref	Risk	Risk Rating	Mitigating Actions
1	Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, both in the acute and community sector	High	• Our current plans are based on the agreed strategy for North West London, as outlined in "Shaping a Healthier Future". • The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of our Whole System Integrated Care programme, allowing for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process. • We will establish strong mechanisms for involving service providers, both statutory and independent, in our programme.
2	A lack of detailed baseline data and the need to rely on current assumptions means that our finance and performance targets for 2015/16 onwards are unachievable.	High	• The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. • We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
3	Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	High	• Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. • We will build on existing arrangements such as the Whole Systems Integrated Care Programme which have already established some of the infrastructure and mechanisms for engagement, data gathering and analysis, and work closely with public health and the academic community to add value to our own capacity.

Ref	Risk	Risk Rating	Mitigating Actions
4	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	High	• We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative. • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • We will rigorously evaluate the impact of our workstreams and, where these do not appear to be contributing to the required outcomes, we will bring them to an end and look to alternative approaches.
5	The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	• We have undertaken an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop our final BCF response, and begin to deliver upon the associated schemes. • We believe there will be potential benefits that come out of this process, as well as potential risks. • We will work with other local authorities across the country to monitor closely the anticipated impact of the Care Bill.
6	Risks associated with pooled budgets	Medium	• The three local authorities and CCGs have established Health and Wellbeing Partnership Agreements which contain the necessary legal and financial framework to protect local sovereignty while facilitating partnership and collaboration. • During 2014-15 the terms of the new pooled budgets will be developed, consulted up on and agreed to provide all authorities with the confidence and trust they need to go forward.

Ref	Risk	Risk Rating	Mitigating Actions
7	Risk of failing to achieve targets	Medium	• Performance against the national metrics is already strong locally, so the setting of additional stretches is challenging and there is a risk of double counting. • The programme office will ensure that we monitor carefully, understanding the attribution of outcomes between workstreams both within the BCF programme and externally, and take steps to address slow performance as soon as a problem is identified.
8	Cultural change and workforce development	Medium	• Changing organisational structure is not necessary or sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care as well as the efficiency and effectiveness of delivery.

Tri-borough Better Care Fund

Part 2 Outcomes and Finances

The development of our outcomes framework and financial plans is now underway.

This has commenced with a baseline of current joint spending and national performance measures across health and care in the 3 localities which make up the Tri-borough, followed by development of high-level estimates for the priority interventions, over the next 2 years, which will help to make our overall vision a reality.

In addition to the identified savings we will be constructing a financial model which enables NHS revenue to flow into out of hospital services delivered by social care, and reimburses the local authority against agreed targets. This will reflect an agreed portion of the savings which will accrue to the NHS by preventing admissions and facilitating timely discharge from hospital.

The current joint commissioning arrangements under s75 partnership agreements are now fully reflected in the 2014-15 figures. The established partnership agreements provide a framework for the development of a new pooled budget(s) for the Better Care Fund.

We are in parallel looking at a local "person-centred" outcomes framework which will help us define our and our communities' expectation of what good looks like, for future providers of integrated care within the Tri-borough; and allow us to evaluate at a more detailed level our progress over the next 5 years. In doing so we will work with partners including NHS England, the LGA and other localities to ensure that our measures are consistent, achievable and represent genuine improvement on the ground for the populations we serve.

At present the options we are considering for a Local Metric are contained in Appendix A.

Please see the attached BCF Part 2 Excel file for details of current baseline performance and metrics for our areas, and estimates of our BCF costs and benefits.

The assumptions upon which our costs and benefits are based are set out in Appendix B attached.

Appendix A – Options for a Local Metric

Indicator	Relevance to BCF Projects	RAG	Accuracy/ benchmarking	RAG	Feasibility of measurement	RAG
Rate (per 1000) of avoidable admissions for persons aged 75 and over supported in the community with social care	It is a joint health and social care indicator, therefore embodying the principles of the BCF. It targets the cohort most likely to be impacted by BCF projects. It is therefore a very strong indicator.		Locally defined indicator, so not possible to benchmark with other areas outside Tri-borough. Could be monitored quarterly, but admissions will probably need to be on a rolling 12 month basis to ensure sufficient numbers to detect change. May have to focus on those social care clients registered with a Tri-borough GP to ensure there is associated hospital activity		It is a NEW indicator which is reliant on data linkage being carried out by the CSU DMIC Team at regular (probably quarterly) intervals by linkage to NHS number. This poses a risk, as a process to facilitate this linkage does not appear to currently be in place between social care and the DMIC. Data linkage would need to take place before the end of Q1 2014/15 so that a baseline can be provided and a target set.	
Number of persons aged 65 and over supported with long term social care	This indicator would ensure that we have a 'whole system' view and that demand is not 'shunted' from different settings. If people can be better supported to manage long term conditions, avoid hospital admissions and when crisis occurs receive rehab/reablement, then fewer people should require long term social care.		May be possible to benchmark with other areas. But may be challenging to achieve targets given the 'other noise'.		This information is not currently reported but the data is available from the social care case management system to establish it as an indicator.	
Weighted percentage of people who feel supported to manage their long-term condition	This is a measure of the level of support patients in primary care feel they receive from their GP. It embodies some of the principles of BCF but does not give a full picture across both health and social care		Will be possible to benchmark against other areas, as this is calculated using a national definition. However, the response rate to the survey is relatively low (46%) and the numbers are therefore prone to fluctuate due to chance.		This is a routinely collected indicator, used for the NHS Outcomes Framework (2.1) and comes from the GP Patient Survey, which is collected routinely. It has been suggested as a potential local indicator in the Better Care Fund Technical Guidance. As of Dec 2013 the HSCIC states that the method of calculating the indicator is 'under review', but a consistent back series of data will be provided	

Appendix B – Tri-borough BCF Costs and Benefits Assumptions

BCF Investment	Costing Assumptions	Savings Assumptions
BCF01/11 - Strengthen 7 Day Social Care Provision in Hospitals	Costs based on 5 months of winter pressures funding with additional 7 months at 45% intensity of the winter months.	N/A
BCF02/06/12 - Developing Self-Management and Peer Support/Patient Satisfaction	Costs as per the scheme PID	N/A
BCF03/09 - Transforming Nursing and Care Home Contracting/Existing Joint Commissioning (CCG Joint Commissioning Team spend only - LA included within BCF07b)	Costs reflect the CCG contribution to the joint commissioning team plus project costs from the scheme PID.	Initial work done by PPL suggested an opportunity in spot placements alone of £1.2m from bringing 25% of the higher cost placements into line with the lower cost placements. Savings have been pro-rated by spend with £0.82m in LA spend and £0.38m in CCG spend.
BCF04 - Better Care Fund Programme Management	Costs from scheme PID	N/A
BCF05 - IT Integration	Costs from scheme PID	N/A
BCF07a - Review Existing Section 75 services	Costs reflect existing Section 75 agreements	Assumes that 50% of Section 75 agreements would be reviewed and 2% savings could be achieved. £867k in LA, £561k in CCG
BCF07b - Existing Section 256 pass through funds (including LA Joint Commissioning team spend)	Costs reflect the existing Section 256 Social Care to benefit health spend and includes the LA contribution to the joint commissioning team.	N/A
BCF07c - Existing Community Services (unless included in other schemes)	Costs reflect the community services commissioned from CLCH which align with an integrated service target operating model	Assume 2% savings on Community Services review
BCF07d - Carers	Costs reflect current Carers Section 75 agreements	N/A
BCF07e - Reablement Section 256	Costs reflect current reablement Section 256 agreements	N/A
BCF08 - Community Independence Service	Costs taken from the draft CIS business case which includes £11.1m of existing spend plus £6.1m of new investment	Savings based on high-level benchmarking done by PPL as part of the CIS business case with some triangulation against the LGA Value Cases toolkit. Savings are a combination of reduced demand for Nursing and Care homes and reductions in emergency admissions. Current split is £8.89m CCG and £3.2m LA. Savings are indicative and subject to further validation and assessment as the CIS business case is developed.

Appendix B – Tri-borough BCF Costs and Benefits Assumptions

BCF Investment	Costing Assumptions	Savings Assumptions
BCF09 - Integrated Commissioning		N/A
BCF10 - Rehabilitation and Reablement Services	Costs based on estimated requirement of 18 new neuro-rehabilitation beds	N/A
BCF13 - Psychiatric Liaison	Costs reflect existing investment in Psychiatric Liaison plus an additional 0.5m investment by H&F CCG in Hammersmith and Charing Cross Hospitals.	N/A
BCF15 - GP 7-Day Access	Costs based on 2 practices per locality open 8 hours a day Sat and Sun	Assumes that 10% of the additional capacity is used by people diverting from UCC where providers are reimbursed on a cost per case.
BCF16 - Developing Personal Health and Care Budgets	Costs as per PID	N/A
BCF17 - Whole System Integration		N/A
BCF18 - Implementation of Care Bill	Costs as per PID	N/A
BCF14/19 - Developing integrated services for people with Long Term Conditions		N/A
Disabled Facilities Grants	As per notified allocations	N/A
Community Capacity Grant	As per notified allocations	N/A