Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

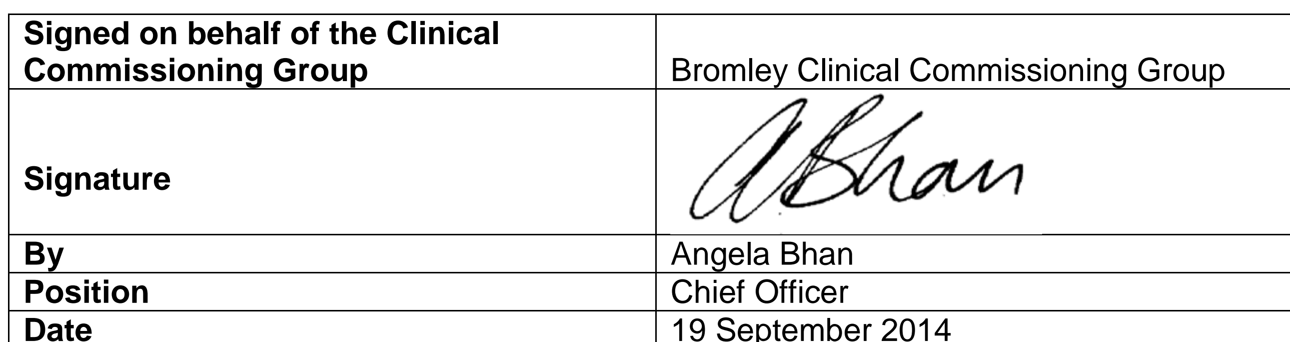
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

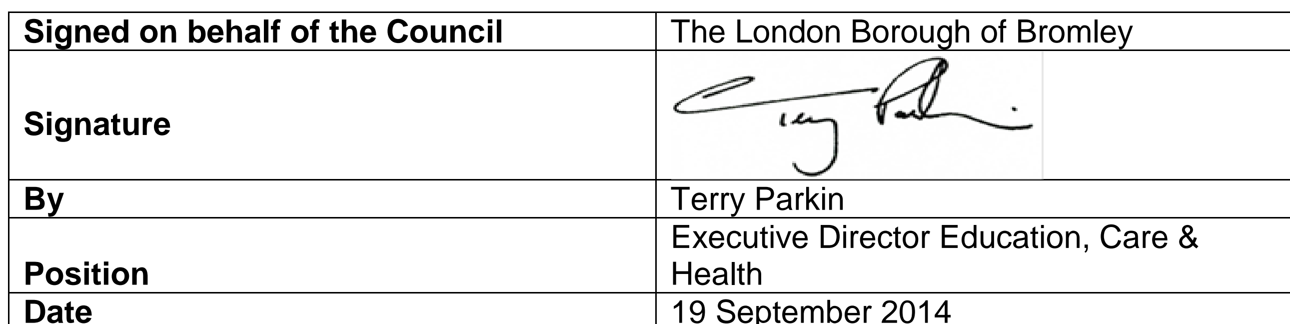
a) Summary of Plan

Local Authority	**The London Borough of Bromley**
Clinical Commissioning Groups	**Bromley Clinical Commissioning Group**
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**19 September 2014 (chair's action)**
Date submitted:	**19 September 2014**
Minimum required value of ITF pooled budget: 2014/15	**£5.456m**
2015/16	**£19,232m**
Total agreed value of pooled budget: 2014/15	**£8.760m**
2015/16	**£20.837m**

b) Authorisation and signoff



Signed on behalf of the Clinical Commissioning Group	Bromley Clinical Commissioning Group
Signature	
By	Angela Bhan
Position	Chief Officer
Date	19 September 2014

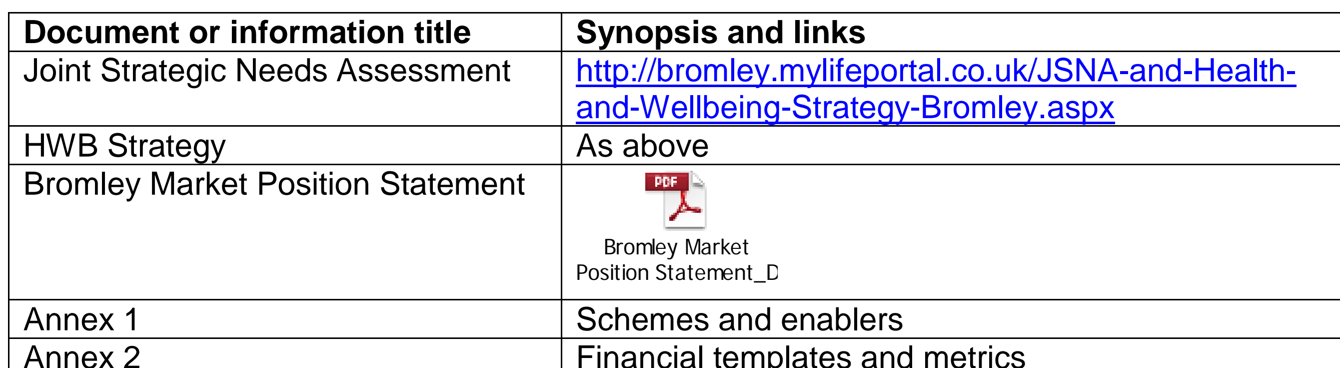


Signed on behalf of the Council	The London Borough of Bromley
Signature	
By	Terry Parkin
Position	Executive Director Education, Care & Health
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	Bromley Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Peter Fortune
Date	19 September 2014

c) Related documentation

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



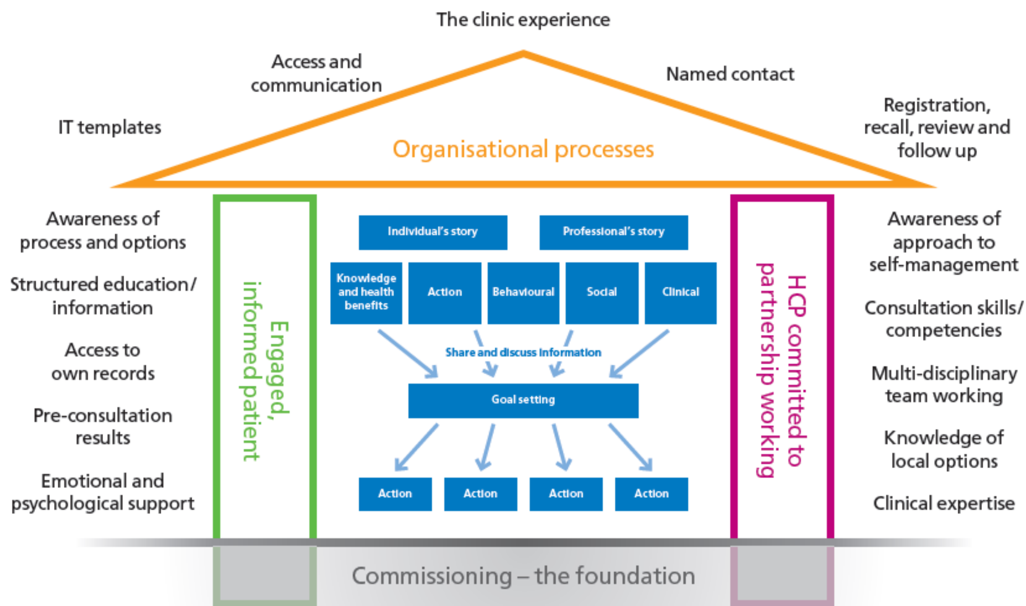
Document or information title	Synopsis and links
Joint Strategic Needs Assessment	http://bromley.mylifeportal.co.uk/JSNA-and-Health-and-Wellbeing-Strategy-Bromley.aspx
HWB Strategy	As above
Bromley Market Position Statement	Bromley Market Position Statement_D
Annex 1	Schemes and enablers
Annex 2	Financial templates and metrics

2) VISION FOR HEALTH AND CARE SERVICES

a) Our vision is to reduce health inequalities and improve the health and wellbeing of people living and working in Bromley. Our Health and Wellbeing Strategy, developed with key health, local authority and community stakeholders describes its strategic vision for every resident as, "*Live an independent, healthy and happy life for longer".*

To improve the quality of life and wellbeing for the whole population of Bromley and for those with specific health needs, leading to an increased life expectancy in key targeted areas will involve working in partnership and increasingly integrated ways with cross-sector partners, commissioners and providers, including local residents, voluntary organisations and community groups.

Originally initiated by the CCG, through what is known locally as the ProMISE (Proactive management and integrated services) and now embraced by the Health & Wellbeing Board, we are working increasingly closely together to effect this transformation in the way that services are commissioned and provided; developing the Bromley 'House of Care' model a metaphor best described by the image below:



Underpinning our approach and the design of services to address the priority areas are the views of Bromley service users and carers sought through surveys conducted by the CCG and LBB, which included to stakeholder conferences with a carers and adult service users theme respectively. Service users and their representatives want:

- more choice and improved access to advice, information and support to maximise independence and help them to better manage their own health and care needs;
- to be involved in decisions about their care and in planning to meet their needs;
- more coherent, joined up services and better support for carers to enable people with complex needs to be supported at home wherever possible and safe to do so.

Together the CCG and LBB had already agreed to refocus service design and delivery on the needs of residents, not the convenience of providers or commissioners, reflecting the principles of the Better Care Fund.

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

Refocusing the design and delivery of services through this plan will ensure that in future:

- People's care needs will be identified at an earlier stage and they will be actively involved in directing their care and support through collaborative care planning and personal goal setting.
- People's needs will be met in their homes or local community, wherever safe and appropriate to do so, in locations and at times that meet their needs and fit in with their lifestyles.
- People will spend more time in their family homes and less time in secondary care and care homes, including at end of life.
- Patient held integrated records, will be accessible to providers involved in their care, leaving service users more reassured because their needs and the needs of their carers have been shared with the professionals involved in supporting them
- Interventions will typically be at a lower level and less frequent through earlier diagnosis and support, leading to improved outcomes that help to prevent people from entering into high cost, long-term care packages.
- Carers needs will better met so that they are able to continue care giving in the community
- There will be a thriving local health and care market, meeting the care needs of local people, whilst empowering, promoting and enabling health and wellbeing.
- People will know that decisions about their care will be made with them and more quickly and they will feel like they have greater control over their health and wellbeing, helping them to live full, healthy and independent lives.

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

We have already made demonstrable progress through collaborative commissioning and the commissioning of enhanced primary and community services. The BCF will provide the focus and further impetus to build on these strong foundations as our schemes for investment from the Better Care Fund will focus on:

- Avoidance of emergency admissions
- Better care for people who require health and social care services
- Improving the efficiency of service provision by greater integration of services
- Enabling people to live healthier lives within community settings
- Improving the capability and capacity of our workforce and infrastructure.

In five years' time, we will have fully realised the Bromley House of Care and be able to demonstrate marked improvements in the highest priority areas identified. Specifically:

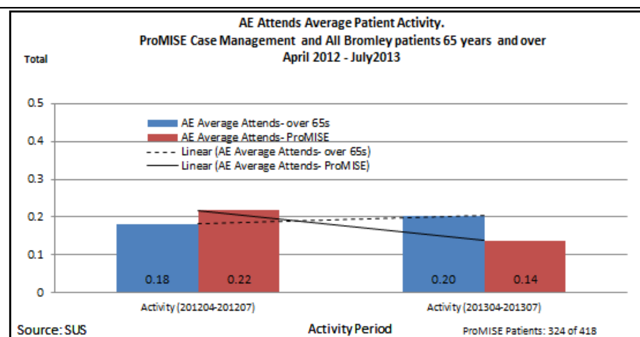
- There will have been a reduction in emergency admissions and a significant shift of resources from emergency bed based secondary health care into community based health and care services
- There will be co-located multi-disciplinary teams comprising health, social care and

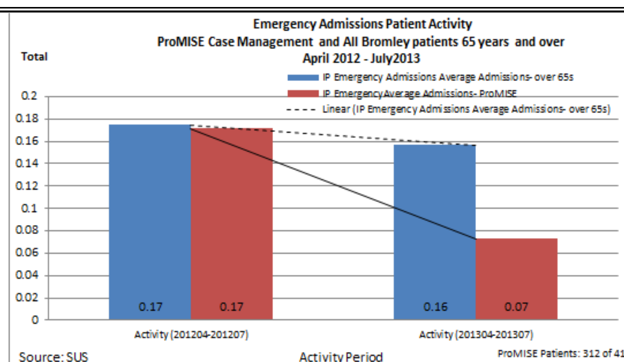
community resources working within local clinical networks with GPs as senior accountable professionals at the centre of organising and coordinating people's care and with direct access to diagnostics and specialist advice

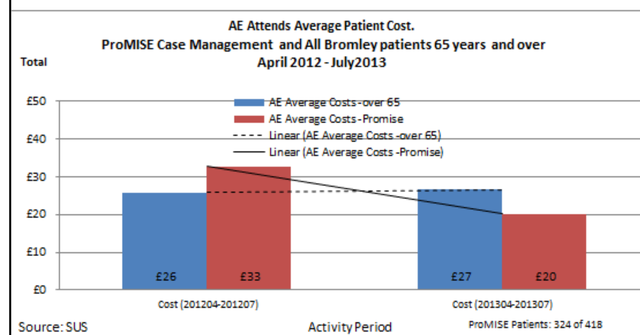
- There will be a single point of entry for service users providing effective access to early information, advice and guidance, robust joint assessment of those most in need identified through risk stratification, and more effective reablement targeted at those most likely to benefit and remain independent in their community.
- Service users and providers will have access to patient held integrated records and care plans to support coordinated, collaborative and person-centred care.
- Individuals and their carers will see a single care manager and co-produce a single care plan over which they feel a real sense of ownership and which is served by integrated teams focused on maintaining them in their homes safely and for as long as is possible.
- Our already effective third sector will be working in partnership at the heart of supporting and maintaining resilient individuals, carers and the community
- Whilst the need for long-term care will be delayed and independence maximised, there will continue to be a strong residential supply from extra care housing units through to high quality nursing homes, providing quality care towards end of life.
- Health and social care workers will be working across professional boundaries, allowing residents to work with fewer professionals but in a more targeted way.
- We will have increased dementia prevalence and have a comprehensive range of supporting services.
- People with be better managing their own health through education, access to improved advice, information and support, access to telecare and improved community and primary services
- Individuals, aided by the wider community, will rely less on services allowing resources to be focused more on those with complex and challenging care needs
- There will be marked improvements reported by service users through national and local surveys in access to services, increased confidence in managing their own care and better support when they need it
- A whole system commissioning approach with pooled budgets and joint assessments by trusted assessors, will deliver greater efficiency and release resources for further investment in services that benefit local people.

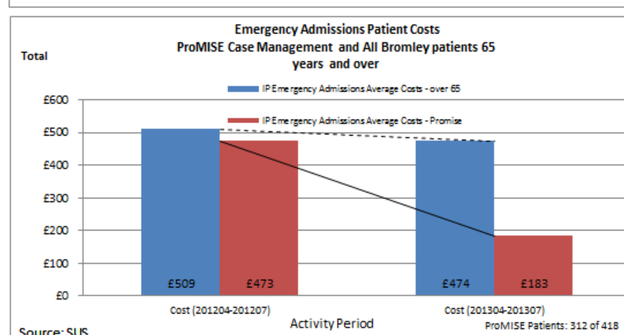
Through this plan we will:

- Increase the capacity for home-based assessments and case management for patients identified though risk stratification to build on the success of a ProMISE pilot which has already demonstrated significant reductions in unplanned activity for such patients as shown by the following charts:









- Build upon the high levels of satisfaction and increased confidence patients and carers supported in this way are reporting, "Having been hospitalised in the PRUH four times, I was feeling neglected at home when I was contacted by the visiting matron, Helen. She helped me enormously with her professional support. Congratulations to whoever initiated this marvellous scheme!"[1]
- Build upon the integration of GP practice and community records on the E-mis platform as the basis for an integrated care record.
- Extend our self-management programme through investment in education, workforce development, advice and information, telecare and the third sector.
- Build significantly upon existing dementia services to increase prevalence and improve support from diagnosis through to end of life.
- Consolidate and enhance newly commissioned end of life and falls services to fully realise the potential of these developments.
- Develop our established local care networks (LCN) building upon the integrated care pilot in one network to integrate mental health and social care across all.
- Work with providers to realise multi-disciplinary working and person centred and collaborative care planning within the networks, developing the joint assessment tool and trusted assessor role.
- Strengthen LCN links with end of life, the third sector, specialist/ other services.
- Establish joint posts to review and consolidate services, such as carers support, with a view to pooling budgets and establishing integrated commissioning
- Target resources towards early identification, prevention and intervention, such as working with service users identified as at high risk of diabetes
- Continue to support King's College Hospitals NHS Foundation Trust recovery plan through continued investment in resilience schemes beyond the winter months, helping to release bed days and speed emergency department throughput .

[1] *Thank you letter sent to ProMISE programme team.*

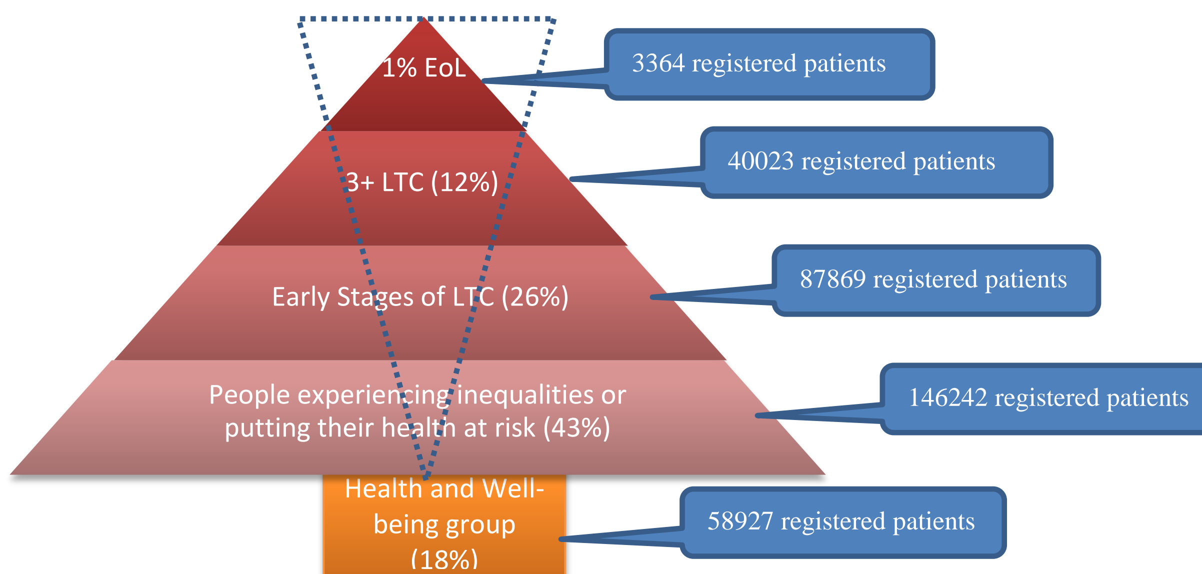
3) CASE FOR CHANGE

In this section, we explain the health and social care challenges facing us as identified by our JSNA and our approach to risk stratification. We also explain how integration will be developed further by the schemes selected to improve further the standard of care.

Bromley has one of the largest populations in London (Bromley registered population 336,425) and the largest ageing population in London, with more than 55,000 people aged 65 and over at 2013; the number is expected to increase to almost 71,000 by 2030. This demographic situation is increasing the demand for health and social care services – older people tend to have more complex health and social care needs and meeting the challenge of helping to keep them at home for longer is leading to increasingly expensive support packages and putting more demand and pressure on budgets and services.

Bromley, has adopted the Kernow 'Christmas Tree' population segmentation model being adopted across the SE London collaborative long-term conditions and primary care workstreams, in which Bromley is actively involved. This tool is supporting targeted service development and integration and admissions avoidance work locally and provides a useful high level benchmark to gauge the effectiveness of our programmes.

Christmas Tree model - Bromley CCG	No	%
People reaching end of life	3,364	1
People with multiple long-term conditions/complex needs/ people who are frail or vulnerable	40,023	12
People at early stages of long-term conditions or living with a long term condition that is stable if managed well	87,869	26
People experiencing inequalities or whose personal choices/lifestyles are putting their health and wellbeing at risk	146,242	43
Everyone successfully managing their health and well-being themselves	58,927	18
Total Population	**336,425**	**100**



The added inverted triangle (dotted line) offers a proportionate representation of emergency admissions associated with the local population. Higher rates of emergency admission and bed-based care are associated with end of life and multiple, complex needs where standard services are not effective; many services typically being accessed without coordination and frequently by people likely also to be experiencing mental health problems and lacking support from family networks.

Our challenge in Bromley is to:

- increase the proportion of people successfully managing their own health and well-being themselves, though effective health promotion and prevention, education and improved access to self-care;
- reduce the proportion of our population experiencing health inequalities or putting their health at risk, with targeted efforts for the main contributors to poor health and long-term conditions;
- identify people with long-term conditions in primary care, supported by risk stratification, to provide coordinated and person centred care and care planning to keep people well for longer; and
- provide specialist and enhanced multi-agency packages of care for people with multiple complex needs and/or at end of life to manage crisis out of hospital and in patients own homes and community settings wherever possible and reduce the proportion of deaths in hospital as a proportion of all deaths.

The JSNA has identified the key causes of death in Bromley as circulatory disease, cancer and respiratory disease, driven by a range of factors including obesity, unhealthy lifestyles and poor housing. Key disease challenges in Bromley are heart disease, diabetes, respiratory disease and dementia:

- The number of people with diabetes is increasing as demonstrated in the table below. This is particularly significant given it can be a precursor to heart disease, stroke, or chronic kidney disease. Despite this increase there are estimated to be a further 5,292 adults with undiagnosed diabetes living in Bromley. There is a need to improve control of diabetes, improve identification and focus more upon diabetes prevention.

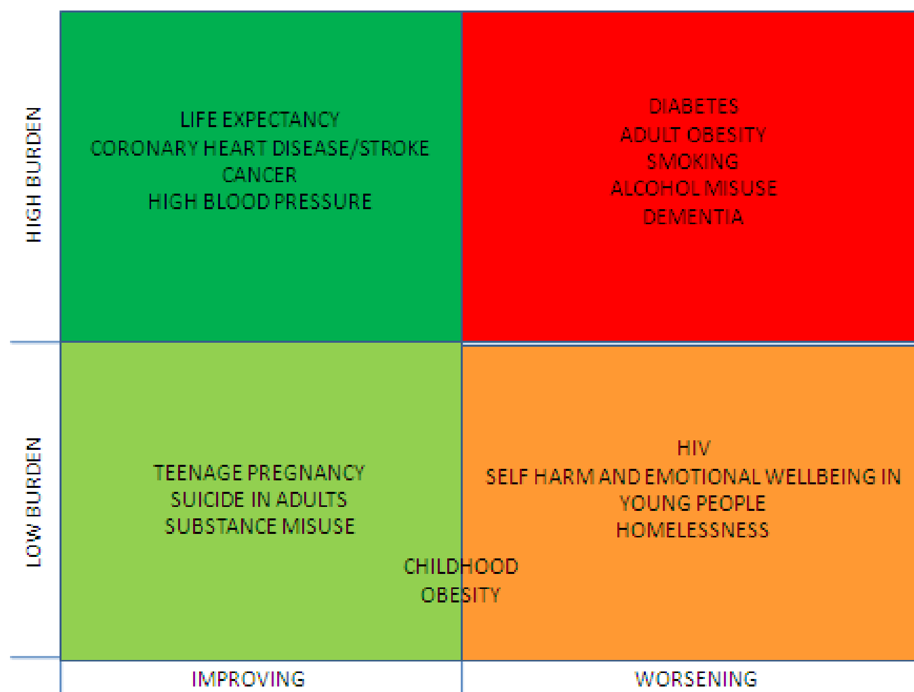
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Diabetes Register Size	8,861	9,244	10,084	10,504	11,261	11,979	12,509	13,307	13,335	13,681
Diabetes Prevalence	2.73%	2.56%	3.07%	4.06%	4.12%	4.56%	4.75%	5.00%	4.91%	5.20%
Source: HSCIC/ QOF, 2014										

- Respiratory conditions are prevalent in the area also and represent almost 13% of total deaths in Bromley.
- Bromley has the third highest levels of obesity in London, 65% are either overweight or obese and the prevalence is rising. Excess weight contributes greatly to the incidence and progression of diseases such as type 2 diabetes, circulatory disease and cancer.
- In 2012, it was estimated that there were 4,102 people with dementia in Bromley, with the number expected to increase as the population ages to 6,047 by 2030. GP registers identify 1,794 patients with dementia suggesting that there is under-diagnosis of dementia and emphasis is required to identify and treat the condition.
- 10% of Bromley’s population (approximately 31,000 people) are carers. The number of carers known to services in Bromley is much smaller, however. The 2013 Bromley Carers Survey found that only 45% of the respondents had undergone a Carers Assessment, which is significant given that many (particularly older) carers have a long term condition or disability themselves, and also many report that caring has a negative impact on their mental health.

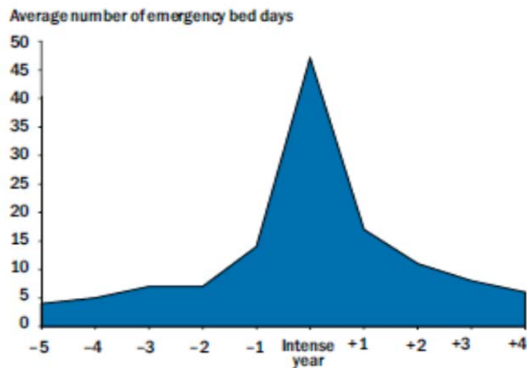
The continuous rise in numbers of residents with type-2 diabetes is an example of a disease area of predominant concern, that is driving our focus on developing and improving services aimed at proactively ensuring that care is well-planned and monitored to avoid placing residents at high risk of deterioration, whilst looking to also address the contributory factors such as obesity through targeted prevention work with high risk groups.

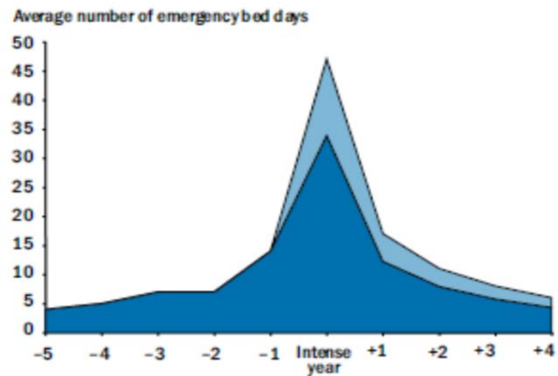
The evidence from the JSNA demonstrates the increasing burden and demands placed upon health and care services in Bromley, as a consequence of a large and growing ageing population and increasing prevalence of certain diseases and the underlying risk factors that contribute to these, i.e. the link between diabetes and obesity. This is leading to year on year growth in emergency admissions and bed-based care.

The priority areas that have been agreed in partnership across the entire health and social care economy in Bromley, informed by health outcomes and prevalence data locally and nationally and our long-term conditions model approach are described in the prioritisation framework below, identifying as the highest priority the issues creating the highest burden and which appear to be worsening over time.



The CCG has developed in partnership with Emis and commissioned on behalf of all GP practices the Q-admissions risk tool which utilises GP practice held patient information. The tool is being utilised by 43 of 45 GP practices in Bromley to identify patients at risk of admission within the next twelve months and support proactive care planning and case management. As evidenced by Gerraint Lewis', "Predictive Modelling in Action", a significant reduction to emergency bed days can be demonstrated with the use of case finding and proactive intervention before a patient reaches their "intensive year".

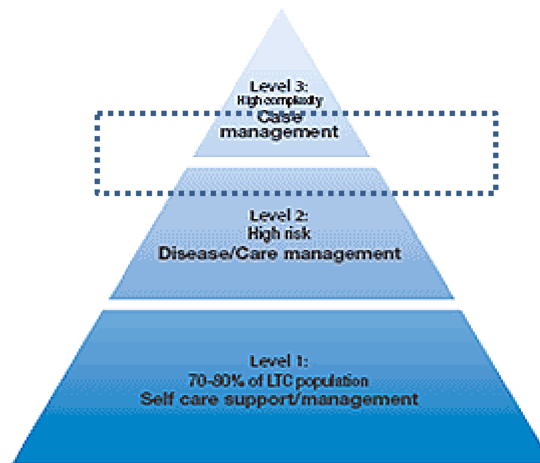




The local adaptation of the tool responds to changes in risk score and the score is driven less by acute activity, as is the case with many other risk tools, but other key risk factors identified locally through three years' experience of risk stratification and care planning, such as age, polypharmacy, carer stress, isolation/depression, falls, co-morbidities etc.

Risk stratification is used in individual practices, but information governance rules stop this being a 'system wide' tool. Individual GP practices are being asked to give access to data on a pseudonymised basis to enable eventual 'system-wide' analysis and tracking.

Referencing the Kaiser Permanente risk model, our approach to risk stratification, case management and proactive care planning is not to target those at the very apex, i.e. typically end of life patients who are well known to care services and whose care would be better enhanced by offering improved complex, multi-disciplinary and bespoke packages of care such as the 24 hour end of life care coordination centre. Instead, we on the 'high risk group' with increasing complexity, with a view to pre-empting deterioration in health which will require an admission.



With the BCF we are building on what has worked in our ProMISE programme, to advance integration and improve the quality of care. In order to select our schemes key leads in the CCG and LBB worked with partners across the health and social care community to consider how we could tackle the key challenges we face. As a result, we identified eight schemes to target admission avoidance, promote self-care and enable us to have a significant impact on enhancing integration and improving the quality of care in In Bromley. We are confident that these schemes will achieve the scale of change proposed by moving activity from acute to community settings. These assumptions have been built into the CCG's overall strategy and support local provider strategies.

4) PLAN OF ACTION

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

The BCF Plan in Bromley does not stand alone. It is a continuous part of our existing approach to integration as initiated within the ProMISE programme. The schemes which have been selected have been subject to rigorous scrutiny via a business plan process so that we can be sure that they deliver key outcomes within specific timelines while also ensuring good value for money. Detailed descriptions of the schemes developed are attached as Annex 1. We plan to implement these schemes in 2014/15 and ensure measurement of success against key outcomes which will include:

- An overall reduction of 2.8% in unplanned admissions
- A reduction in avoidable admissions to and from residential and nursing care homes
- A reduction in lengths of stay and delayed transfers of care.
- Professionals involved in both the CCG and LBB feel that integration has improved and that they can work effectively as part of an integrated team
- Service users and carers feel that care has been improved
- People feel supported to manage their own care

We have already started negotiation with partners to ensure speedy implementation and delivery of key outcomes and will work with providers across the health and social care community to ensure that our approach is fully understood and that our approach is integrated with their plans.

The schemes and enablers described in 4d below are expected to have the following impact on emergency admissions in 2015/16:

Christmas Tree Category	No. FFCEs	% Total Adms	Step Up/down Services	Medical Support to Care Homes	Community Matrons	Falls	End of life	2015/16 Projected Outturn
People Reaching End of Life	3,100	13%	12	7			185	2,896
3+ LTC	8,242	35%	145	77	41			7,979
Early Stages LTC	3,047	13%			90	105		2,852
Inequalities/Lifestyle	4,778	20%						4,778
H&W Group	4,181	18%						4,181
	23,347	**100%**	**157**	**84**	**131**	**105**	**185**	**22,685**

Our milestones for realisation of the emergency admissions reduction are summarised below:

Scheme Reference and description	Impact 2015/16				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total (rounded)
Scheme 1 - Step up/down services	0	31	63	63	**157**
Scheme 2 - Support to Care Homes		17	33	33	**84**
Scheme 3 - Community Matrons	33	33	33	32	**131**
Scheme 3 - Falls	26	26	26	27	**105**
Scheme 3 -End of life	46	46	46	46	**185**
2015/16 Total					**662**

The phasing associated with Step/down and Support to Care Homes reflects local plans for implementation and assumptions linked to demand associated with winter pressures. The three other schemes will be at full capacity and fully operational at 1 April 2015 and are expected to realise reductions consistently across the year.

The following extract from the two and five year operating plan describes the anticipated changes in non-elective admissions to be realised in Bromley over the next five years from the current baseline, as well as other outcomes that this plan and associated schemes will contribute towards

Metric	Baseline	Year 1 (14-15)	Year 2 (15-16)	Year 5 (18-19)	2 year (vs Baseline)	5 year (vs Baseline)
Non Elective Admissions	23345	N/A	22683	22178	-2.8%	-5.0%
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	458.1	414.9	380.3	375.6	-17.0%	-18.0%
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	70	72.1	74.2	76.3	6.0%	9.0%
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	240.5	233.8	226.6	219.8	-5.8%	-8.6%
Proportion of people feeling supported to manage their (long term) condition	0.82	0.84	0.85	0.86	3.7%	5.0%
Dementia Diagnosis	0.423	0.67	0.67	0.67	58.4%	58.4%

We are working closely with the local acute trust to support its own recovery plan and critical to the success of our BCF plan and transformation goals will be the continued open and supportive collaboration with Kings and other key providers (Bromley Healthcare and Oxleas); This is a critical interdependency to ensure that resource and capacity needs are understood and correctly aligned to support our strategic vision whilst maintaining necessary levels of service and achieving key performance targets.

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

The BCF Programme will be overseen by the Bromley Health and Wellbeing Board which has been developed in partnership between Bromley CCG, the London Borough of Bromley and partners across the Health and Social Care community.

The overarching governance structures which are summarised in the diagram below demonstrate the organisational links of the HWB board which link to the CCG governance arrangements and CCG Clinical Executive and the London Borough of Bromley through its Executive and the Portfolio Holder for Care Services.

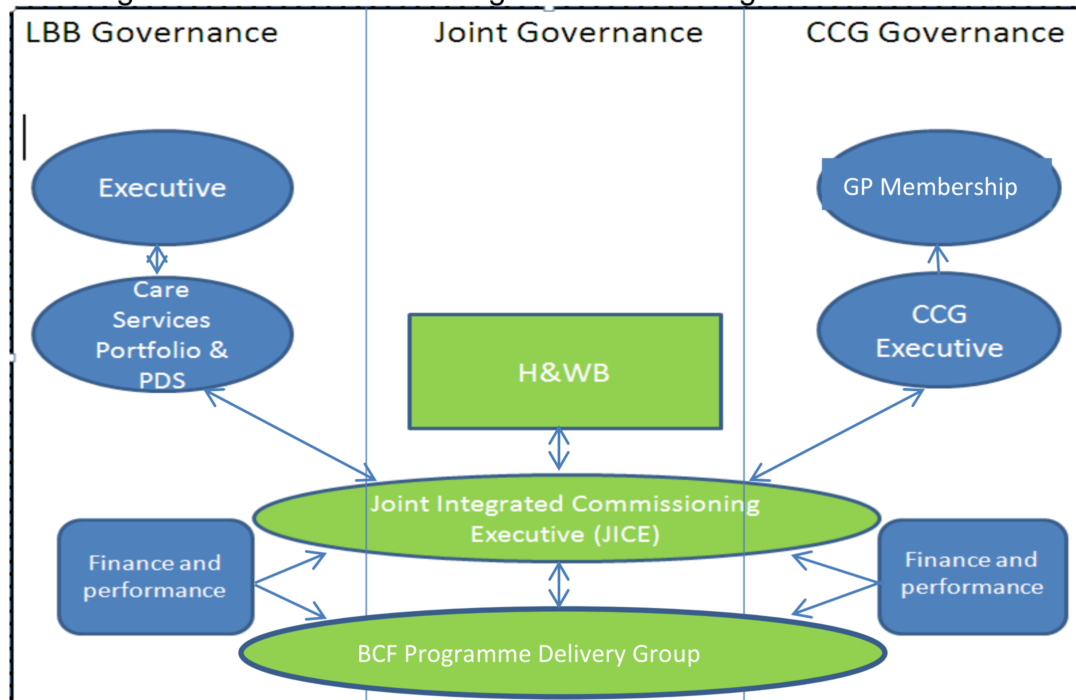
To ensure effective delivery of BCF and other initiatives we have developed a Joint Integrated Commissioning Executive (JICE) with agreed terms of reference and membership. The membership is: the Chief Officer, Chief Finance Officer and Director of Commissioning at the CCG; and the Executive Director, Education, Health and Care Services and the Assistant Director of Commissioning, Education, Care and Health from LBB; with programme leads (management and clinical) in attendance.

The JICE will:

- take responsibility for reporting back through the governance structures and delivering on the national conditions set out in the BCF;
- sign off all associated programmes; and
- ensure that detailed and fully costed project plans are developed and delivered for the proposed schemes set out in this high level BCF plan for 2015/16.

Supporting the JICE is a programme delivery group tasked with implementing the constituent schemes or ensuring their implementation where the work is already being taken forward within an existing programme of work.

The diagram below illustrates the governance arrangements:



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

As mentioned above the CCG and Borough have developed a clear governance arrangement to will ensure that the BCF schemes are implemented and that they deliver key outcomes.

On implementation BCF leads from the CCG and LBB will:

- drive the development and delivery of all projects
- ensure project performance through the management of exception reports
- produce reports for Health and Wellbeing Board Programme on implementation and delivery.

As with all project management processes each scheme will have a sponsor, clinical engagement plus programme and project support including support from finance and information specialists.

Project delivery will be managed via regular joint project groups which will ensure that agreed timetables and outcomes are delivered and that any exceptions are followed up an corrected as required. Regular reporting will be achieved against agreed activity, quality ar financial metrics. Similarly a risk log will be developed and report variations considered anc mitigated as necessary.

d) **List of planned BCF schemes (and enablers)**

These are a mixture of schemes that will reduce emergency hospital admissions and enablers that will contribute less directly but are vital developments to help deliver and sustain reductions in secondary care activity, address prioritised health and care needs and help realise the Bromley House of Care. Also, included in this section is a summary of other spend areas within the BCF Plan.

Ref	Scheme Name	Description	£000	Admissions to care homes	Effectiveness of reablement	Delayed transfers of care	Patient/ service user experience	Hospital admission avoidance
1.	Step up/step down	• Increase capacity: step down beds and home based care • Make available step up beds • Establish an integrated discharge team • Increased Medical Response in the community • Extend the duration of the home based rehabilitation programme	1,658			Yes	Yes	Yes
2.	Support into care homes	• Increase medical cover to care home and extra care housing residents • Increased skills of care home staff	694			Partial	Yes	Yes
3.	Extension of Integrated Care (Promise)	• Increase palliative care service caseload • Community based falls prevention and treatment • Increased Community Matron & therapist capacity • Developing the wider integrated care team • Enhanced primary care diabetes service	2000	Yes	Yes	Yes	Yes	Yes
Sub-total			**4,352**					

Ref	Enabler	Description	£000	Admissions to care homes	Effectiveness of reablement	Delayed transfers of care	Patient/ service user experience	Hospital admission avoidance
4.	Dementia (enabler)	• Training to improve awareness and identification • Increased capacity to assess, diagnose & manage • Develop 'Living Well with Dementia', community services • Increased liaison services within secondary care • Increased capacity for home treatment • Improved advanced dementia and end of life care	1,081	Yes (longer-term)	Yes (longer-term)		Yes (longer-term)	Partial

5.	Self-management (enabler)	• Expert patient and carer education programmes • Targeted education for patients at high risk of developing diabetes • Health coaching training • Improved and integrated health and care advice, information and support services • Extended telecare provision • Community champions	993				Yes (longer-term)	Partial (longer-term)
6.	Carers support (enabler)	• Increased level of support to avoid carer breakdown and need for high cost bed based interventions and long-term care packages	600	Yes (longer-term)		Partial	Yes	Partial
7.	Resilience (enabler)	• Retain 7 day working arrangements • Provide fast track access to equipment	1,586	Yes	Yes	Yes	Yes	Yes
8.	Integrated Care record (enabler)	• To establish an integrated care record across health and social care allowing real time data sharing and effective multi-disciplinary working	410	Yes (longer-term)	Yes (longer-term)	Yes (longer-term)	Yes (longer-term)	Yes (longer-term)
Sub-total			**4,670**					
Other areas of spend		**Description**						
Social Care		Protecting	3,500					
Social Care		Impact of new duties	750					
Existing Grants		ASC Capital Grants Disabled Facilities Grants Carers Funding Reablement DoH Social Care Grant	663 943 500 1200 4260					
Sub-total			**11,816**					
Total BCF			**20,838**					

5) RISKS AND CONTINGENCY

a) Risk log

There is a risk that:	Likelihood	Impact	Score	Owner[2]	Mitigating Actions	Status
1. The reduction in emergency admissions is not achieved and dependent BCF initiatives cannot be supported	2	4 (£1.41m)	8	CCG	Consider contractual levers, incentives or risk share, particularly King's given implemented plans to speed ED throughput leading directly to increased zero length of stay emergency admissions. Maintain good engagement/ communications with Trust through joint unscheduled care and recovery plan groups. Ensure CCG/LA representation on associated Trust workstream	Link to CSU through DoC Ongoing Ongoing
2. CCG/LA working relations are compromised in debates over which part of the system funds what part of the service – e.g. when is it a health cost, when is it a care cost etc.	2	3	6	JICE	Strengthening relations through regular meetings, workshops and 1:1 numbers to establish positive working relationships Move to a more mature funding position that evaluates whole system spend and moves funds flexibly according to need and where the money can achieve the best outcomes for residents Creation of a pooled budget under a Section 75 agreement Establishment of joint posts	Ongoing Carers and MH initially Progressing Through BCF
3. Lack of resources and capacity impede delivery	1	4	4	JICE	Identify specialist resource to deliver projects (funded through BCF pot) Make it the focus of key commissioners within both organisations (tie it into performance objectives)	Report to JICE on 27/10 Plans with milestones & owners to JICE on 27/10
4. Effective planning and evidence of success is undermined by poor data quality and limited access	3	3	9	Joint	Both organisations committed to improving data quality and data sharing but some national blockers. Set aside some of the BCF specifically to address systems and data which can be poor and hamper joint initiatives. Consider solutions tested by other local health and care partnerships.	CCG Head of Performance and Integ Care Info analyst to liaise with LBB counterparts. Shared Care record group established
5. Primary care development plans compromise/delay effective integration	2	4	8	CCG	The CCG has started discussions with GPs about primary care development.	Clin Exec workshop held. Membership meeting in October. SEL workstreams (Primary Care & LTCs aligning)
6. LA cannot maintain social care to the level needed to support the out of hospital agenda & effective integration	2	4	8	LBB	Significant funds set aside within plan. Close monitoring through the JICE given LBB wider funding pressures over the next few years that will make maintaining statutory duties a challenge.	Dataset for monitoring to be developed and presented to JICE

[2] There will be a director/senior manager owner from either or both organisation assigned to each risk locally, for example the CCG Director of Commissioning will own risk 1.

There is a risk that:	Likelihood	Impact	Score	Owner[2]	Mitigating Actions	Status
7. Recommissioning the community service contract may impede progress towards integrated care	3	3	9	CCG	To produce an options appraisal on the way forward considering the benefits and risks of extension/reprocurement	Clinical Executive support contract extension subject to legal advice and Governing Body approval
8. The current provider workforce lacks the capacity, skills and attitudes to deliver partnership and new ways of working	2	3	6	Joint	BCF Plans include Self-management and coaching for health training, Care planning training, care home and extra care housing training Established GP practice academic seminars; Practice Nurse, Manager and administrator forums. Non-clinical practice staff training programme ongoing Review of community roles specifications. Integrated care team development manager to engage with local care networks, defining new roles and encouraging collaborative working	See schemes Review commenced Six month appointment made and work commenced

b) Contingency plan and risk sharing

The CCG has a record of successfully shifting activity to the community from the acute sector. We anticipate further success as a consequence of our BCF schemes which will be factored into our operational planning approach with local providers and linked as appropriate with risk share arrangements. King's, our main acute trust, supports the planned reduction in non-elective admissions targeted through the BCF, integrated in a wider programme of pathway change aimed at keeping people out of hospital. Through ongoing engagement with King's around its resilience planning and transfer of care workstreams, there should continue to be a shared interest in achieving the reductions planned. This work also offers the potential for reaching an acceptable risk share agreement linking the CCG's ongoing support for Kings recovery plans with the planned reductions in admissions set out in this plan.

The CCG is currently triangulating commissioner and provider plans including the management of risk and associated mitigations.

The financial value of the non-elective admission saving/performance fund is calculated as £1.41m, representing a 2.8% reduction in Bromley CCG responsible activity. This ambition is slightly lower than the suggested target of 3.5 % as we recognise that our planned reduction in activity will be partly offset by anticipated population growth and the timing of implementation for some of the schemes.

The view taken is that the financial risk of underachievement of planned activity reductions falls mainly on the CCG as commissioner - if the reduction in emergency admissions is not achieved, it will bear the cost of these admissions. Consequently, it is considered impracticable to withhold or 'claw back' funds committed under the BCF if the anticipated result is not achieved in Yr 1. Therefore the financial risk will sit initially with the CCG and be managed via a QIPP programme that treats BCF as a cost pressure and puts in place a range of initiatives to achieve efficiencies to match. The CCG has established a range of internal mitigations to support this approach.

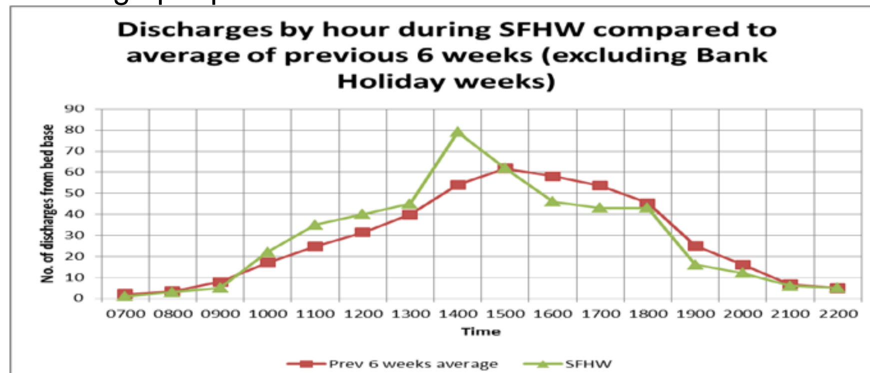
6) ALIGNMENT

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

The BCF is part of the Borough's overall approach to health and social care integration, which has been developing steadily over recent years. This plan aligns to a number of initiatives related to care and support: the integration of health and social care, including the ProMISE scheme; our approach to reablement, unplanned care and mental health services programmes; and the development of joint commissioning initiatives.

Our plans also link closely with the King's recovery plan to ensure the successful delivery of the 4 hour maximum wait in their Emergency Department. King's plan includes new pathways and processes that ensure patients flow more smoothly through the hospital and are discharged when they are medically stable and fit for discharge. There is an expectation that the equivalent of 20 acute beds will be released as a result of more timely transfers of care from hospital to the community. A "Transfer of Care" project has been initiated with all local health and social care provider partners.

The time of day that people are discharged from hospital can increase their chances of "reconnecting" with core community service and minimise the chance of readmission. During the Safer Faster Hospital week in June 2014, when all health and social care providers tested over 7 days new ways of working, the King's tested their desire to discharge people before lunch from the PRUH:

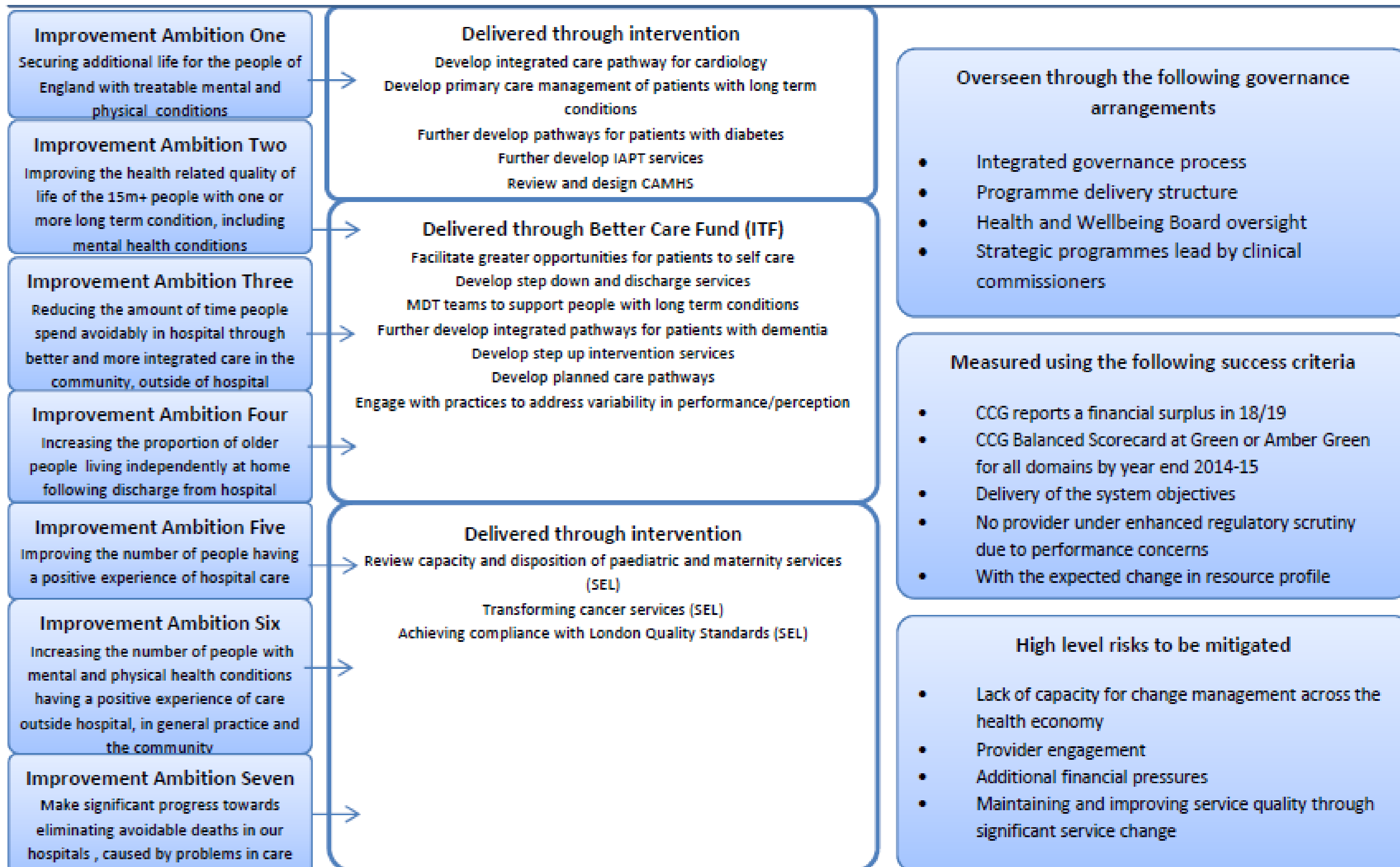


The achievement of "home before lunch" and the reconnection of vulnerable people to core services form a key part of the Better Care Fund plan; there are critical interdependencies between the acute trust's recovery plan, the resilience plan and the Better Care Fund Plan.

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

The Bromley CCG Plan on a Page (see below) taken from its five year integrated plan and building upon its two year operating plan summarises how the Better Care Fund is already an integral part of the vision to:

- improve health outcomes and reduce health inequalities across Bromley;
- transform the landscape of healthcare, by developing partnerships, leading to an integrated health and care system with improved access and quality; and
- create a sustainable local health and care economy reinforced through collaborative working


Improvement Ambition One
Securing additional life for the people of England with treatable mental and physical conditions
Improvement Ambition Two
Improving the health related quality of life of the 15m+ people with one or more long term condition, including mental health conditions
Improvement Ambition Three
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
Improvement Ambition Four
Increasing the proportion of older people living independently at home following discharge from hospital
Improvement Ambition Five
Improving the number of people having a positive experience of hospital care
Improvement Ambition Six
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and the community
Improvement Ambition Seven
Make significant progress towards eliminating avoidable deaths in our hospitals , caused by problems in care
Delivered through intervention
Develop integrated care pathway for cardiology
Develop primary care management of patients with long term conditions
Further develop pathways for patients with diabetes
Further develop IAPT services
Review and design CAMHS
Delivered through Better Care Fund (ITF)
Facilitate greater opportunities for patients to self care
Develop step down and discharge services
MDT teams to support people with long term conditions
Further develop integrated pathways for patients with dementia
Develop step up intervention services
Develop planned care pathways
Engage with practices to address variability in performance/perception
Delivered through intervention
Review capacity and disposition of paediatric and maternity services (SEL)
Transforming cancer services (SEL)
Achieving compliance with London Quality Standards (SEL)
Overseen through the following governance arrangements
Integrated governance process
Programme delivery structure
Health and Wellbeing Board oversight
Strategic programmes lead by clinical commissioners
Measured using the following success criteria
CCG reports a financial surplus in 18/19
CCG Balanced Scorecard at Green or Amber Green for all domains by year end 2014-15
Delivery of the system objectives
No provider under enhanced regulatory scrutiny due to performance concerns
With the expected change in resource profile
High level risks to be mitigated
Lack of capacity for change management across the health economy
Provider engagement
Additional financial pressures
Maintaining and improving service quality through significant service change

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

Bromley CCG working with colleagues across Greenwich, Bexley, Lewisham, Lambeth and Southwark has submitted an expression of interest in the co-commissioning of primary care and is current focussed on developing a collaborative agreement between the CCGs. Co-Commissioning provides a number of opportunities that very much align with our BCF plans:

- To achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care
- To raise standards of quality within general practice services including:
  - clinical effectiveness
  - patient experience
  - patient safety
- To reduce unwarranted variations in quality;
- To enhance patient and public involvement in developing services; and
- To tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities

Expressions of interest were invited to take on varying levels of responsibility as detailed below. The South East London EOI opted for Category B.

- Category B (joint commissioning) requires the appropriate governance arrangements and the creation of a “Committee in Common” across NHS England and the CCG(s). We are designing the appropriate framework for this new arrangement. Given that under this option funding will remain on the NHS England financial ledger, and that NHS England will remain party to all decision making, the establishment of the Committee in Common needs to be robust and all governance processes around it appropriate.

It is proposed that new arrangements will, subject to the necessary approvals process, be in place from April 2015.

7) NATIONAL CONDITIONS

a) Protecting social care services

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

Shared Ambition
The Health and Wellbeing board are committed to reducing avoidable hospital admissions. However it is recognised that to do so places a burden on community services further upstream and that this includes Adult Social Care. JICE are committed to reviewing this situation as schemes shift service delivery from acute out into community settings and projects are implemented and rolled out across the borough. The ongoing protection of social care will require a joined up approach across our new governance arrangements to make sure that funding flows to where services are being most effectively delivered.

Protecting core service
The eligibility criteria in the London Borough of Bromley match those described as meeting substantial and critical need in the national guidance on fair access to care services (FACS), with a small number of legacy clients receiving services broadly in-line with moderate needs following a Member decision not to change services to those at the point of change already in receipt of services from a lower threshold. LBB, using BCF, can commit that the thresholds will be retained at our current levels and in line with the new national criteria established in law under the Care Act for 2015/16. The Local Authority have a budget gap of £8m in 2015/16 reported to Executive in February 2014 and part of action to reduce the budget gap includes efficiencies required in all area including social care which represents a significant part of the Councils budget. In addition there will be ongoing budget pressures which is reflected in the existing overspend on adult social care with further pressures expected to continue next year. On that basis funding from the Better Care Fund will be critical towards protecting social care.

Service transformation through BCF
Whilst maintaining current eligibility criteria is one important aspect of protecting social care and BCF funding reflects this, there is also a focus on developing new forms of joined up care where social care is embedded into core health pathways, providing a joined up health and care service to the local community. The schemes set out in this plan have endeavoured to include social care as core to the development of integrated services. For example, there is funding set aside in the integrated care record scheme specifically to look to link in the social care system, Care First, with the core health system in Bromley.

Future risks recognised
However, central government should be under no illusions that the positive steps to protect social care under this joint fund do not provide a solution beyond 2015/16 for social care funding. The numbers dealt with under the BCF are welcomed and provide a good platform for further work but are only committed for 2015/16 and do not provide a solution to this future funding gap. Future pressures on the Local Authority to find savings in order to balance a budget while continuing to meet their statutory duties will require more radical proposals that go further than this current Better Care Plan.

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

Bromley's Better care Fund protects Adult Social Care in three ways:

i. Provides £3.5m for core social care services and offsets cost pressures created through demographic pressures and to sustain existing eligibility criteria. The funding can be used to underpin the core adult social care budget
ii. Provides £750k of crucial funding towards full implementation of the Care Act. There are considerable new financial burdens on local authorities as a result of the Care Act. This funding along with the DCLG grant will go some way to making sure that the Local Authority can meet those responsibilities.
iii. Redirects £9m spend from acute into new community based prevention and intervention services that look to maximise independence and prevent clients entering into long term care packages for longer. Specifically the schemes around Dementia, Carers support, self-management and integrated care record are particularly welcomed as they include social care as core to the schemes and set aside funding to support social care as part of a holistic health and care solution for residents managing long term conditions.

These schemes target prevention and short term intervention services that represent a shift in funding from acute and long term care packages allowing for important service transformation. This shift is very much in line with the Authorities Market Position Statement (attached in this submission) which looks to take every opportunity to maximise people's independence and prevent reliance on long term state funded care.

It should also be recognised that many of the preventative service suggested in these schemes impact on residents before they meet eligibility criteria and represent a low level intervention which for the Local Authority has become increasingly difficult to continue to fund since the 2010 comprehensive spending review set out by the coalition government. The BCF therefore has helped to protect and even increase our collective focus on prevention to the benefit of residents by shifting funding across the health and care system into the community and allowing the opportunity to focus on best practice intervention with relation to new NICE guidance which is coming out around supporting people with dementia and their carers.

Joint Integrated Commissioning Executive have been able to use the BCF to move funding around the system to where best practice advises it is most effective. The schemes and the pass through of funding to protect social care funding in Bromley as well as funding to support implementation of the care act for 2015/16 help a great deal with what is becoming a difficult funding situation for social care provision in the borough.

Should the schemes meet their desired outcomes then they should prove the case for prevention and short term targeted interventions by demonstrating a reduction in the needs for longer term high cost care packages, including residential and nursing care placements which put the greatest strain on budgets (subject to demographic pressures). If this is proved to be the case this will also help to protect social care allowing us to meet the needs of more residents through prevention and delaying or even preventing their needs increasing to such a level where 24/7 care is the only suitable solution.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services.

The local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.

The total amount committed to protect social care within this plan, including the Care Act contribution, is £4.25m. There are also social care components built into the CCGs new community based schemes around dementia, self- management, system integration and carers support.

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

Local government officers predict the costs of the Care Act for 2015/16 will be 2.8m. The main cost pressures of the Act in 2015/16 are:

- Cap and Cared-for Assessment (beginning Oct 2015)
- Carers Assessments
- Carer Services/ Support

Funding being made available includes:

- £750k set aside within the Better Care Fund
- £1.85m New Adult Social Care Burdens Grant (DCLG)

This leaves the Local Authority around £250k short which they will need to fund from other sources or as part of the protecting social care funding within the BCF.

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

A detailed scheme has been developed with up to £600k committed to increase the levels of support to carers, specifically to avoid carer breakdown and the consequent need for high cost acute interventions or long-term care packages where the outcomes for the service users are often poorer (see scheme 3)

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

The new schemes are still in development and their impact on social care budgets in terms of moving services out of health settings and into traditionally considered social care settings will be closely monitored by the Joint Integrated Commissioning Executive.

However the CCG has endeavoured to make the schemes a jointly commissioned piece of work; working with LBB leads to make sure that social care concerns are built into their new care pathways, e.g. when considering step up/down services they have targeted part of the resource specifically at support into care homes and extra care housing.

We are confident that any unforeseen impacts of these schemes could be picked up and negotiated through the JICE once clear evidence was presented to the board that social acre was inadvertently picking up a large service user burden that was impacting negatively on social care budgets.

b) 7 day services to support discharge
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The CCG already commissions NHS 111 and out of hours access to emergency primary care (EMDOC) and a range of other local 7 day services to both avoid Emergency Department attendances and unplanned admissions and to support effective discharge, as described in the table below.

Care management support at the hospital presently offers a 24/7 service that will be expanded to allow for 7 day discharge into intermediate care or reablement and rehabilitation services.

The CCG is considering how to provide enhanced 7 day services across primary and community services and will be utilising the BCF to help achieve this condition; for example, they have extended seven day provision to support admission and discharge planning and the resilience scheme annexed to this plan proposes to continue this arrangement in 15/16.

- Bromley has allocated a proportion of the winter resilience funding to both extend the opening hours from 5 to 7 days as well as increase the capacity of existing 7 day services, with the following initiatives funded through resilience monies:
  Hospital Pharmacy 7 day service, extended opening hours Monday to Friday to 20:00 and Saturday 10:00 to 17:00, Sunday 11:00 – 17:00 (an additional 8 hours at the weekend and 13 hour 45minutes between Monday to Friday).
- Hospital In-patient scanning service – a morning list on Saturday and Sunday to meet the current demand for scans at weekends and to deal with additional scans requested to support increased weekend working across the hospital.
- Hospital CT additional in-patient weekend service (Saturday and Sunday)
- Hospital Ambulatory unit to open 7 days (from the current 5 days) resulting in 25% reduction in the number of zero length of stays on AMU. (Scheme 7)
- Community Advanced Nurse Practitioner – new 7 day service to be located in the hospital to improve the patient flows from the Emergency Department, Acute Medical Assessment Unit, Clinical Decision Unit and the Ambulatory Unit to the community Medical Response Team and home and community bed based rehabilitation services.
- Increased access to Equipment- either shorter delivery time 5 days a week or weekend ordering and deliveries (subject to contract negotiations) (Scheme 7)
- Mental Health Liaison and Treatment service – increasing the capacity of the existing 7 day service. (Scheme 4)
- Social care – Increase in social workers to co-ordinate the increase in social care packages, with further work to scope the potential for working collaboratively with Bexley and Croydon boroughs.
- End of life care – Increase the capacity of the current 7 day service (Scheme 3)
- Primary Care – Extension to the current Visiting Medical Officer to extra sheltered housing units (Scheme 2)

Services available 7 days a week - Bromley

NHS
Bromley
Clinical Commissioning Group

SERVICE	BROMLEY HEALTHCARE
Urgent Care Centre (Beckenham Beacon) **Contact: 01689 866037**	**What is the service:** Bromley Healthcare Urgent Care Centre for minor injuries and illnesses **Service Operating Hours:** 08.00 – 20.30hrs 7days per week **Service Manager:** Sara Maines – Head of Unscheduled Care 07825 979077 Debby Battista – Operations Director 0208 315 8950 Fiona Christie – Operations Manager 0208 315 8908
Bromley Rehab Service **Contact: referrals 01689 863392**	**What is the service:** Bromley Healthcare Rehab Service - Home-based & bed-based rehab service, including short term supported discharge. The bed based service is at Lauriston House in Bickley. Referrals to Lauriston House must be signed off by the patient's named consultant or registrar. A referral checklist should be completed. Patients discharged to Lauriston House must also have: • Agreed discharge bundle as described by Bromley Healthcare (Moving and Handling Risk assessment, Nursing Care Plan including pressure area risk assessment, Falls Risk assessment, Therapy Discharge Summary) • Discharge summary with OPA • Blood trend report • Relevant investigation results • Completed signed transfer checklist **Service Operation Hours:** Bed base 24/7, Home pathway 08:00 – 20:00 7 days **Service Manager:** Jenny Gummery – Home Pathway Team Lead 0208 269 9838 / 07770704479 Nicola Pavey - Unit Leader beds 020 8295 3972 Debby Battista – Operations Director 0208 315 8950 Fiona Christie – Operations Manager 0208 315 8908
Community Teams **Contact: Referrals via Single Point of Entry referral form or 0208 315 8715** ***(out of hours contact the Medical Response Team)***	**What is the service:** Bromley Healthcare Community Teams Multi-disciplinary locality based Community Teams offering care to people living with on-going ill health who may need extra support from a range of different out-of-hospital services. The professionals in the team are District Nursing, Adult Community Physiotherapy, Adult Occupational Therapy and Community Matrons. **Service Operating Hours:** • District Nursing 08:15 to 16:45 7days a week • Twilight District Nursing 18:30 to 22:30 7days a week • Night Nursing 22:30 to 07:00 7days a week • Therapies and Community Matrons 09:00 to 17:00 5 days a week **Service Manager:** Debbie Bristow – Community Teams Service Lead (Therapies) 0208 295 3634 Jane Parker – Community Teams Service Lead (Nursing) 0208 269 9829 Janet Ettridge – Operations Director 0208 315 8946 Rachel Street – Assistant Operations Director 0208 315 8956
Medical Response Team **Contact: 0208 315 8723**	**What is the service:** Bromley Healthcare Medical Response Team **Service Operating Hours:** 08.00 – 20.00 7 days per week **Service Manager:** Sara Maines – Head of Unscheduled Care 07825 979077 Debby Battista – Operations Director 0208 315 8950 Fiona Christie – Operations Manager 0208 315 8908

SERVICE	London Borough of Bromley
Social Services **Contact: Care Manager/Social Worker – 01689 864596 / 591/592 or Bleep 123 or 759**	**What is the service:** Bromley Social Care support to assist patient with package of care, reablement, ECH, residential or nursing home placement **Service Operating Hours:** M-F 08.45 – 17.00 hrs. Sat & BH 09.00 16.00. (Sun 09.00 – 16.00 only if required) **Service Manager:** Merle Longe – Operational Manager 02084617471 / 07985529930 Barbara Apostolides – Team Leader 01689 864598 Sharon Edwards – Senior Care Manager 01689 864595 / 07949514129

SERVICE	GREENBROOK
Urgent Care Centre (PRUH) **Contact: 01689 863050**	**What is the service:** Greenbrook Urgent Care Centre for minor injuries 24/7 **Service Operating Hours:** 24/7 **Service Manager:** Simon Buttrum – Operations Manager 07795 822361 Sarah Noon – Service Manager 01689 863053

SERVICE	PRUH -KCH
Emergency Department **Contact: Deputy Divisional Manager – 01689 863483**	**What is the service:** PRUH Emergency Department **Service Operating Hours:** 24/7 **Service Manager:** Nicki Abbott – Deputy Divisional Manager for Medicine
Ambulatory Unit **Contact: Deputy Divisional Manager – 01689 865880**	**What is the service:** Ambulatory Unit – Service available for medical patients that require emergency assessment and treatment, but unlikely to require hospital admission. **Service Operating Hours:** 09:00 – 17:00 (7 days per week) **Service Manager:** Deputy Divisional Manager Nicki Abbott – Deputy Divisional Manager for Medicine
Take home and settle service **Contact: 0208 315 1850 / 07958 459 212 (Out of Hours)**	**What is the service:** AGE UK Take home and settle service Provides an Age UK Bromley volunteer who accompanies an older people (must be retired) back home from the PRUH ED and settles them in with fresh food so that they can start settling back to life at home. **Service Operating Hours:** 8am-9.30pm & weekends 9am-5pm **Service Managers:** Mark Ellison – Services Director 0208 315 1850 Christina McGill – Services Administrator 0208 315 1850

SERVICE	OXLEAS MENTAL HEALTH
Mental Health Liaison Team **Contact: 01689 863000 bleep 144**	**What is the service:** OXLEAS Mental Health Liaison Team Providing assessment, management plans and treatment for people with moderate to severe mental health problems, medically unexplained symptoms and dementia related conditions from the age of 18 upwards who are admitted to the PRUH. The team covers all the wards at the PRUH excluding peads. The team is comprised of nurses consultant and psychologist. **Service Operating Hours:** 24/7 **Service Manager:** Bridget Mhako – Lead Practitioner 01689 880000 (ext:1268) Helen Jones - Service Manager 020 8301 9400 / 07962 015598 Jon Cooley- Service Manager 0208 8368555

SERVICE	St Christopher's Bromley
St Christopher's Personal Care Service **Contact: Deborah Holman – Social Care Lead 0208 768 4648**	**What is the service:** St Christopher's Personal Care Service This provides home-based care for people thought to be in their last six months of life, who require a new package of care. The service is for patients registered with a Bromley GP. The service will only accept referrals from a discharge coordinator, a member of the palliative care team or a social worker. If you are one of the above, the referral form is available from St Christopher's, completing pages one to three for personal care referrals and page four if community nursing service care referral is needed. Referral can be done by fax, email or telephone, ideally 48 hours should be given. The St Christopher's clinical services manager will assess the patient on the ward and agree the package of care. **Service Operating Hours:** 7am-11pm 7 days per week
St Christopher's Bromley Care Coordination Centre **Contact: Jan Noble – Service Manager 01689 892997**	St Christopher's Bromley Care Coordination has been set up to enable patients with advanced illness or frailty, thought to be in the last year of life, to receive timely and coordinated care. The service is supported by 24-hour telephone advice for any urgent concerns that cannot wait until the next day. The key worker will identify and prioritise health or social care needs with the patient and as necessary signpost to other services. **Service Operating Hours:** 9am-5pm Mon-Fri (OoH St Christopher's' on call 0208 7684500) Please note that referrals to the Bromley Care Partnership can be made by PRUH staff (also by GPs, Bromley Healthcare and Oxleas NHS Foundation Trust). Specialist Nursing service only, 9am to 5pm Monday to Friday. There is 24-hour telephone advice for any urgent concerns that cannot wait until the next day.
Specialist Palliative Care **Contact: Anne Porritt - Community Service Manager 0208 768 4500**	Specialist Palliative Care Healthcare professionals may refer any patients with advanced cancer, or any other advanced, progressive and life limiting non-malignant disease, where the complexity of the illness needs the services of a specialist palliative care team to achieve control of symptoms and social, psychological and spiritual support to the patient and family. To refer to the service, request and complete the London Cancer Specialist Palliative Care Community /inpatient form. **Service Operating Hours:** 24/7

c) Data sharing

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

All health and care systems will be using the NHS Number as the primary identifier by April 2015. This follows a programme of investment and testing by the local authority during 2014/15, utilising the Migration Analysis Cleansing Service (MACS) developed nationally for this purpose, to populate and match test the NHS number in Care First; the local authority social care information system.

Regular matching programmes will be in place by April 2015 to ensure that as new clients receive services, the social care information system will hold the correct NHS number and continue to be a primary identifier.

In scheme 6, Integrated Care record, there is a fuller description of how records will be integrated across health and social care during 2015/16, using the NHS number as the primary identifier.

The most significant challenge will be the respecification or reprocurement of the social care information system during 2015/16, with the current system linked to the Oracle finance system for charging and invoicing clients. That critical process will ensure that the system will integrate effectively to realise a truly integrated record across health and social care, allowing real time data sharing between providers to ensure that service users receive coherent and coordinated care.

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

Bromley is committed to adopting systems that are based on Open API and Open Standards. The Councils Social Care Information System, CareFirst, is delivered by OLM Systems Ltd and they are also committed to full integration.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Both organisations have designated Caldicott Guardians, including the Director of Adults fulfilling that role for the local authority. The requirements of the Caldicott 2 review are also fully supported by both organisations.

The CCG has established an IG group, led by its Chief Finance Officer, and is undertaking a comprehensive review and where appropriate rewrite of all IG protocols, policies and procedures to ensure compliance with all NHS requirements, in particular Caldicott 2.

LBB does have a current approved IG Toolkit in place, and is currently reviewing progress made on the Improvement plan to ensure that the IG toolkit V 11 will be submitted for approval by the 31st March 2014. The Council has an Information Governance Board, which meets 4 times a year, to manage Information Governance,

ensuring that all policies, procedures and controls are followed by staff.
To strengthen the IG arrangements and to facilitate effective data sharing, LBB and the CCG will be looking to co-opt a representative to join each other's respective governance groups as the first step towards planning the establishment of a single integrated information governance group and associated shared plan for data sharing.

The respective information governance groups will maintain a critical oversight of the integrated care record scheme, ensuring compliance with Caldicott and other information governance legislation and standards.

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

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

In Bromley, GP practices have been risk stratifying using a predictive risk tool and producing associated care plans, using a bespoke template, for three years. 43 of 45 GP practices in Bromley are participating in the Unplanned Admissions Direct Enhanced Service Scheme (DES) in 2014/15 and all have implemented the Q-admissions risk algorithm which identifies patients at high risk of hospital admission. The risk stratified patients are those being prioritised for care planning and where appropriate home-based assessment and care coordination by community matrons. In every case the GP remains the accountable lead professional for the patients identified.

The community provider, an effective social enterprise originally established by the GPs, has reorganised its teams to operate as six, co-located locality teams comprising a dedicated team leader and team coordinator, community matron, district nurses, physiotherapists, occupational therapists, nurse rehabilitation assistants, healthcare assistants and physiotherapy assistants. Through this plan additional community matron capacity will be commissioned and sustained to support risk stratified patients requiring home based assessment, typically frail, elderly patients who are housebound, or near housebound.

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

In one of the six local clinical networks, the team has already been joined by a co-located social care manager and community psychiatric nurse to support joint assessment via a single point of entry, the allocation of a lead professional based upon prevailing/ overriding need and the improved coordination of care and care planning.

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

There are no individuals who explicitly have a joint care plan in place but within one of the six local clinical networks joint assessments and the allocation of a lead professional are taking place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Engagement on the BCF started in the autumn and winter of 2013 when the CCG undertook a series of engagement activities; seeking views from local people about Bromley's health services, to help inform future planning. These activities were linked to the 'Call to Action' agenda but were very much tailored to reflect local priorities: integration; long-term conditions; the frail, elderly and vulnerable; carers; self-care and prevention. The activities were wide-ranging to enable a diverse range of views. The approach included focus groups and workshops as well as an online survey.

One of the overriding messages was the desire for services to be commissioned in the community and closer to home, which accords with and validates our ambitions with the Better care Fund Plan.

Service users fed back that people require more readily accessible and comprehensive information about long-term conditions and the services/support available to them. This has been reflected as one of the priority areas for development in this plan, building on the work already progressing within the CCG ProMISE programme and the Mytime online resource developed by LBB.

Services users also fed back that better patient and carer education and support is needed on living with long-term conditions and also raised the need for greater awareness of local support networks. The CCG Patient Advisory Group has now invited the chair of a local patient carer forum to join, as well as other carers from across Bromley. This plan again reflects as a key priority area self-care and education, building upon much of the innovative work and significant investment already underway and planned across both of our organisations, such as the CCG Patient Liaison Officer scheme; Self-Management for Life patient, care professional and carer education programmes; the UTI dipstick training initiative for carers (professional and informal); the handbook for older people; and the community (health) champions scheme.

LBB recently undertook a survey of carers across Bromley, incorporating a number of health questions. This helped to shape the planning and focus of a recent joint adult social care conference, attended by over 150 service users and their representatives across the voluntary sector. At the event, both LBB and the CCG described at a high level our commissioning plans before breaking into workshops where delegates were able to both comment on existing services and inform and shape our plans going forward. The event focused very much upon carers and together with the survey has informed a joint health and care services 'Carers Action Plan' and underpinned the case for carers to be a significant focus of our collaborative efforts described within this plan.

LBB undertook a similar survey and event targeted at adult services service users, with contributions from the CCG in terms of the content of the survey and joint facilitation at the subsequent conference. This included two elements: an online survey and face-to-face engagement sessions. The purpose of the consultation was to understand people's low level care and support needs over the short and medium term. LBB was keen to consult with the following groups of people: those not currently in the 'care system'; those with 'low level' care needs; and those who pay for their own care and those with whom

the Council has not previously engaged. In total, 932 people responded to the consultation. This included 672 people who completed the online survey and 260 people through 13 face-to-face engagement sessions and focus groups.

The Call to Action also highlighted the difficulties that 'hard to reach' groups can experience in accessing services and support. We have engaged specifically with BME communities, in deprived areas and with the gypsy/traveller community, during 13/14 and our future engagement plans will specifically focus on working to ensure that services are designed that also take into consideration and meet their specific needs and that any campaigns to raise awareness, promote self-management and prevention are tailored to these particular groups. Through these activities hard to reach groups have been able to influence our plans as well as helping to shape our plans for future communications and engagement activities; for example we are now developing a UTI training scheme course for carers of learning disabled clients and a Self-Management patient education programme for deaf and hearing impaired service users.

Through pre-arranged forums such as the CCG Patient Advisory Group and LBB stakeholder groups and specific events targeting a particular group(s) relevant to a specific development, service users will be able comment, inform and influence through direct participation and through local service user representative organisations. Service users will be informed and able to influence via GP practice Patient Participation Groups, surveys, via the CCG and LA community information websites etc. The CCG has also established a local stakeholder bulletin aimed at the public and the local voluntary sector that highlights what they have told us about and what we have done as a result of that feedback; 'you said, we did'.

A Communication and Engagement Strategy has also been agreed by the Bromley HWB Board to encompass the further integration of health services through the strategic commissioning of shared pathways. This includes the ProMISE programme and communication and engagement relating to the BCF.

b) Service provider engagement

i) NHS Foundation Trusts and NHS Trusts

Engagement with NHS trusts also started in the winter of 2013 when a planned major engagement event with key stakeholder providers and representatives of service users helped to shape our approach and the resulting plan. The event which was held in December 2013 was focused upon integrated care and was billed as a 'Building the Bromley House of Care' co-design event. The event allowed us to set out the key national, London-wide and local drivers for integration; to describe the progress made to date under the auspices of the CCG ProMISE (Proactive management and integrated services for the elderly) programme; and afforded an opportunity for discussion of our commissioning intentions with providers, who were able to both comment upon and help to shape those plans as we move forward with building our 'House of Care'.
The CCG annual acute commissioning round for 2014-15, set the scene with King's for the scale of change required to free resources from the acute sector that will provide the investment necessary to progress and sustain our BCF plan from 2015-16 and beyond. This has been underpinned by a 'block' contractual agreement with Kings that subject to agreed tolerances will ensure delivery of a significant proportion of the CCG QIPP plan for 2014-15 and thereby free up resources for investment in integrated care locally.

We have developed our BCF schemes in partnership with colleagues from Kings to ensure that it delivers our joint aim of reducing non elective admissions and improving the range and quality of integrated community support. As a consequence our plans are understood within the Trust and complement its own recovery plan. We are also working with other key providers and most importantly Oxleas and Bromley Healthcare to ensure that their services can be transformed to deliver our joint aims.

In addition to developing our schemes in partnership, we anticipate that we will continue to engage with our providers across health and care services for the remainder of 2014/15, as we ensure that our plans are brought to fruition following negotiation and subsequent implementation in 2015/16.

ii) primary care providers

The CCG organises regular bi-monthly GP provider meetings across three local 'clusters'. Through these meetings GPs representing practices across Bromley are made aware of and able to shape plans and priorities for development; informed by their 'frontline' understanding of service users' needs and their experiences of services in terms of access, quality and outcomes.

The CCG is engaged in discussions with GPs about future primary care provision, to ensure that there is alignment between plans for developing the Bromley House of Care. This is informed by the evolving work from NHSE which emphasises networks of GPs working together to deliver the new service specification that is being developed for them. There are three proposed areas where patients can expect high levels of care through the new specification:

(i) Accessible Care – covering availability of Saturday appointments and primary care access from 8am-8pm every day, choice of access options such as Skype and email, pre-bookable appointments up to four weeks in advance, same day consultations for urgent conditions and appropriate care in appropriate time in the case of emergencies
(ii) Co-ordinated Care – covering proactively reviewing and co-ordinating care for patients identified as benefitting from such reviews, care plans, name GPs and multidisciplinary care reviews
(iii) Pro-active care – covering the co-design, with families and communities of approaches to improve health and wellbeing, the development and assets and resources to empower people to remain healthy and connected with their community, conversations with patients focusing on their health goals, providing access to health and wellbeing liaison and information and processes for supporting access for those who struggle with access and the those who are unregistered.

These proposals very much accord with the aspirations described within this plan and as such should ensure a degree of alignment that will support successful delivery.

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

A joint event with our strategic providers in the voluntary sector early in 2014, afforded us the opportunity to describe our plans for integration and engage on plans for joint funding of community services through the Better Care Fund; again with the intention of

encouraging collaboration and innovation to help deliver our intended outcomes.

This was a precursor to LBB developing a Market Position Statement (MPS) now published and launched at a recent adult service users stakeholder event and appended to this plan, which explains to providers how commissioning will be responding to the integration agenda as well as the Care Bill and focuses in on building capacity in the community sector.

c) Implications for acute providers

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

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

The impact of the schemes on King's at the Princess Royal Hospital in Bromley is a reduction of 662 emergency admissions in 2015/16 against outturn. The value of the impact in terms of income is estimated to be £1.41m.

There is real consistency and alignment between this plan and King's recovery plan and "Transfer of Care" project. The recovery plan aims to ensure the successful delivery of the 4 hour maximum wait in their Emergency Department. The plan includes implementation of new processes that ensure patients flow more smoothly through the hospital and are discharged when they are medically stable and fit for discharge. The reduction of … emergency admissions with the BCF will support the King's recovery plan.

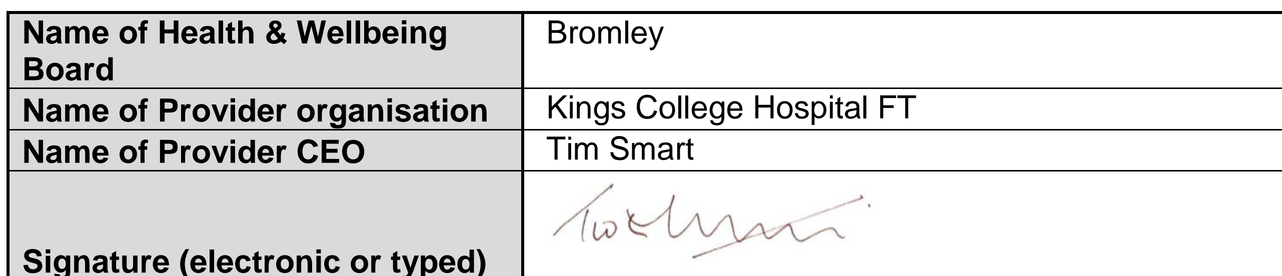
There is an expectation that the equivalent of 20 beds will be released as a result of more timely transfers of care from hospital to the community. The "Transfer of Care" project initiated with all local health and social care provider partners and the development of some of the enabler schemes within this plan such as integrated care records, mental health liaison and home treatment services, and support to carers are complementary.

In annex two, King's has given its support for the BCF planned reduction in non-elective admissions targeted on the basis that it is in accordance with its own objectives to reduce demand on A&E and inpatient admissions.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 2 – Provider commentary

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



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

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	23,959
	2014/15 Plan	23,345*
	2015/16 Plan	22,683
	14/15 Change compared to 13/14 outturn	-2.6% (relates to schemes outside of the BCF)
	15/16 Change compared to planned 14/15 outturn	-2.8%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	662

* **Adjusted to reflect BCF baseline periods (Q4 2013/14, Q1, Q2 Q3 from operating plan submission)**

For Provider to populate:

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