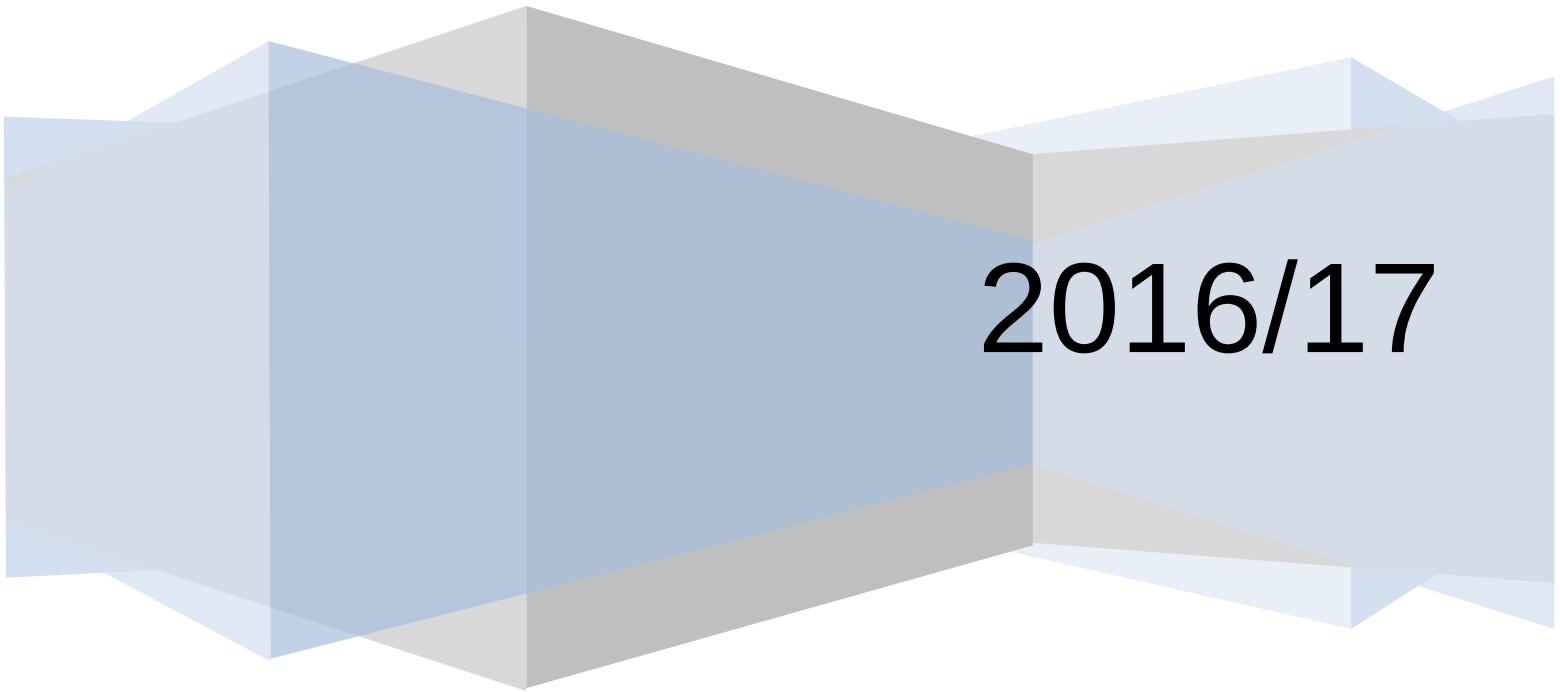
Bromley's Better Care Fund 2016/17

A Local Plan

BCCG & LBB



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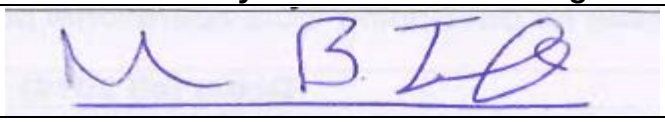
1. Authorisation

Signed on behalf of Bromley Clinical Commissioning Group	
Signature	
By	Angela Bhan
Position	Chief Officer
Date	20th March 2016

Signed on behalf of the London Borough of Bromley	
Signature	
By	Doug Patterson
Position	Chief Executive
Date	20th March 2016

Signed on behalf of the Bromley Health and Wellbeing Board	
Signature	
By	Councillor Jefferies
Position	Chair of Health and Wellbeing Board
Date	20th March

2. Introduction and Background

2.1. This will be the second full year of the Better Care Fund. The Department of Health (DoH) confirmed funding would continue for 2016/17.

2.2. The fund puts a requirement upon Clinical Commissioning Groups (CCG) and Local Authorities (LA) to pool budgets. Commissioners are then expected to use the pooled fund to integrate and join up services for the benefits of local residents using health and care services.

2.3. The Government considers the Better Care Fund to be a key tool in driving the integration of health and social care services. The Better Care Fund has been set up to enable local authorities, local health services and other stakeholders to come together to develop, and implement new approaches to service delivery, based on a much more integrated approach. The implementation of Better Care will support the delivery of safe and effective services in the here and now, and underpin a planning process to bring these services together over the longer term.

2.4. The total Better Care Fund will value £3.9 billion in 2016/17. This is in line with the NHS Confederation's requests that the mandatory minimum pool should stay steady, allowing local areas the freedom to increase local pools at the pace that is best for them. £3.519 billion will be taken from NHS England's allocation to CCGs to establish the fund, with a further £294 million contributed from the Disabled Facilities Grant to Local Authorities.

2.5. Whilst the policy framework remains broadly stable in 2016-17, commissioners need to make links to the NHS sustainability and transformation plans which NHS partners will be required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

2.6. In this Local Plan Bromley sets out a joint spending plan to be approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. This plan should be read with regard to other strategic documents produced locally such as the ***Health and Wellbeing Strategy***, the ***Out of hospital strategy*** and Bromley's ***Integrated commissioning plan*** all of which are attached that the end of this plan.

2.7. On 21st April 2016 the Health and Wellbeing Board met to formally discuss the plan. The board has cross representation from elected Members, commissioners and Healthwatch and fully endorsed the Local Plan. This has allowed Bromley's plan to be formally agreed and endorsed within the tight timeframes available from the guidance coming out in late February.

3. National Timeline

3.1. The process for developing plans has been simplified from the approach used for 2015-16 plans and will be aligned to the timetable for developing CCG operational plans.

3.2.	**Proposed timeline**	**Dates (all 2016)**
3.3.	Planning guidance and planning template issued	24 February
3.4. 3.5.	**Submission 1** BCF Planning Return submitted by HWB areas to NHS England regional team, and copied to the national team. This will detail the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.	**2nd March**
3.6.	**Submission 2** Full BCF plan submitted by HWBs to DCO teams, including BCF Planning Return version 2, which is to be copied to the national team for analysis	**21st March**
3.7.	Deadline for regional confirmation of draft assurance ratings for all BCF plans to the national team	6th April
3.8.	National calibration exercise carried out across regions to ensure consistency	7th–8th April
3.9.	Deadlines for feedback to local areas to confirm draft assurance status and actions required	11th April
3.10.	**Submission 3** Final plans submitted, having been formally signed off by HWBs	**3rd May**
3.11.	Deadline for regional confirmation of final assurance rating to BCST and local area	13th May
3.12.	Deadline for signed Section 75 agreements to be in place in every area	30th June

4. Minimum BCF Allocation for Bromley

4.1. Local areas are encouraged to place more than the minimum requirement into the fund, but initially Bromley will, like the previous year stay with the minimum allocation. They may however decide to vary and add to the fund in year if there is a good business case to do so and will do this under an amendment to our joint Section 75 agreement. The minimum requirement for Bromley as set out by NHS England stands at £21,611,000.

4.2. This plan provides a detailed breakdown of spent in section 10. In summary though the fund will continue to be used to create a shift in demand and supply from acute settings into

community based services, reducing emergency hospital admissions and moving to a more proactive rather than reactive model of care.

5. Local Vision and Evidence Base

5.1. 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".*

5.2. 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. Priority areas are defined through the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy (JSNA).

5.3. The headlines for Bromley's population of 320,000, as set out in the JSNA, are:

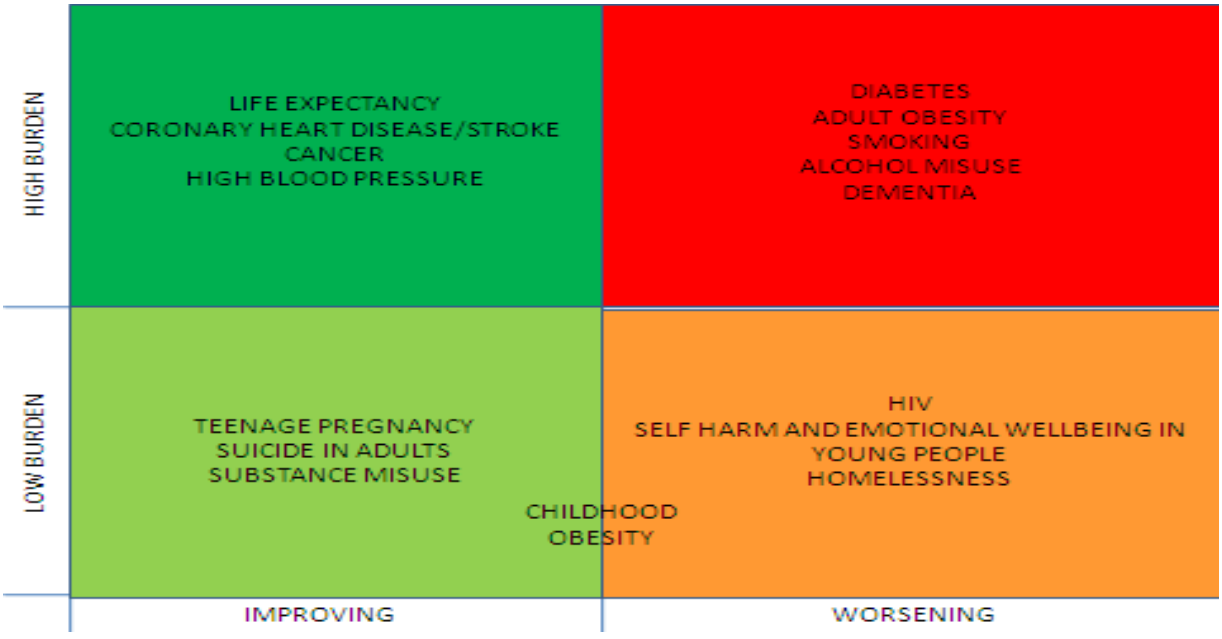
- Older people in Bromley will continue to increase from 17.7% of the population in 2014, to 18.3% by 2024
- Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 80.7 years for men and 84.5 years for women.
- There is an 8.7 year gap for men and 7.9 years for women between the highest and lowest life expectancy wards in Bromley
- Mortality in Bromley is chiefly caused by circulatory disease (32%) and cancer (30%)
- There is evidence to show that there are many people living in Bromley with undiagnosed hypertension, and a number of people with known hypertension which has not been adequately controlled
- Number of people with diabetes has continued to rise since 2002
- The number of people in Bromley with dementia continues to rise, especially in the over 85 year age group
- The number of live births is rising, reflecting the rising trends in the general fertility rates.
- There is a rising prevalence of smoking in Bromley
- Bromley has the third highest levels of overweight and obesity in London, 65% are either overweight or obese and the prevalence is rising.
- Approximately 71% of dwellings in Bromley are in owner occupation and approximately 13% are in the private rented sector, with 14% of social rented housing is supplied through Housing Associations.
- The volume of households faced with homelessness has risen dramatically during recent years
- The number of people with learning disabilities under the age of 64 years is predicted to rise by 9.2% over the next eight years.
- The number of people in Bromley with physical disability or sensory impairment continues to increase.
- In Bromley, one person in six has a mental health problem at any one time, and one in four will have a problem during their lifetime.

- Data from the 2011 census indicates that 10% of Bromley's population (approximately 31,000 people) are carers. Just over 6000 of these carers provide more than 50 hours of unpaid care per week.
- Alcohol misuse is a significant public health issue, with over 26% of the population regularly consuming quantities of alcohol sufficient to damage their health.
- In 2012-13 in Bromley, 5,362 A&E frequent attenders accounted for 22.4% of all A&E attendances. The frequency of attendances ranged from 3 to 135 times, with an average of 4 visits per year.
- there were a significant numbers of attendances relating to conditions which might be better dealt with in settings other than A&E e.g. attendance for intramuscular or intravenous injections, catheter problems, blood tests, feeding tube problems.

5.4. Analysing these findings across Bromley demographic the health and care priorities are set. A simple way of considering the relative priority of different health issues is to consider the burden in terms of the numbers of people affected, and then whether the problem is improving or worsening over time. The highest priority is allocated to the issues creating the highest burden which seem to be worsening over time.

Figure 1: JSNA Priorities.

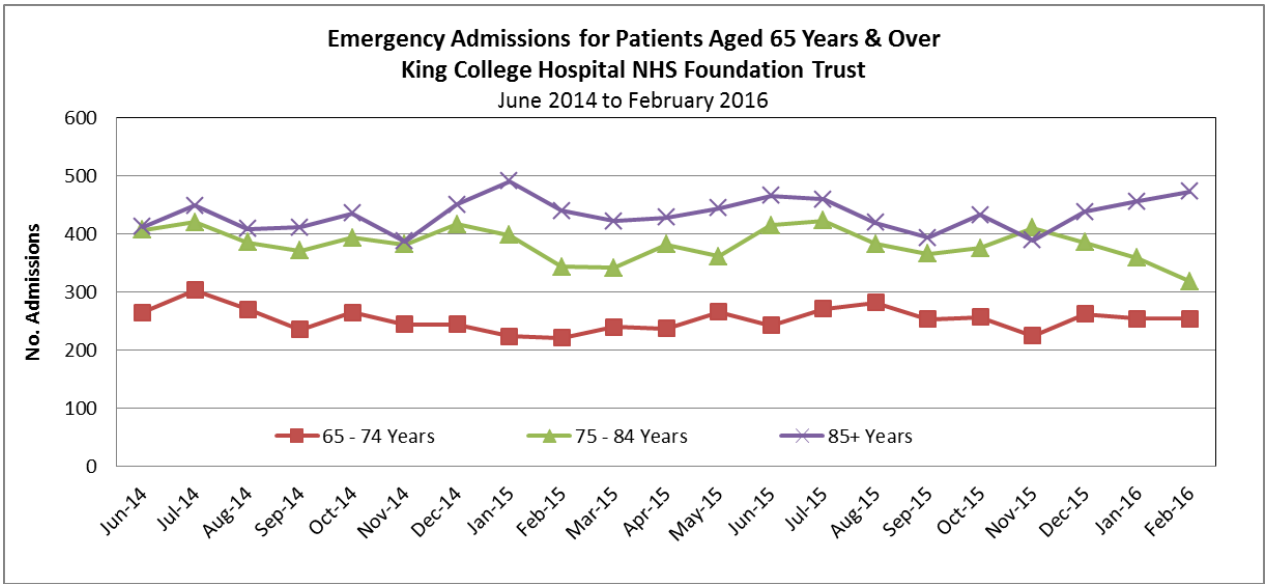
The table below has been populated to show the relative priorities of the key issues.



5.5. Evidence from analysis of emergency admissions

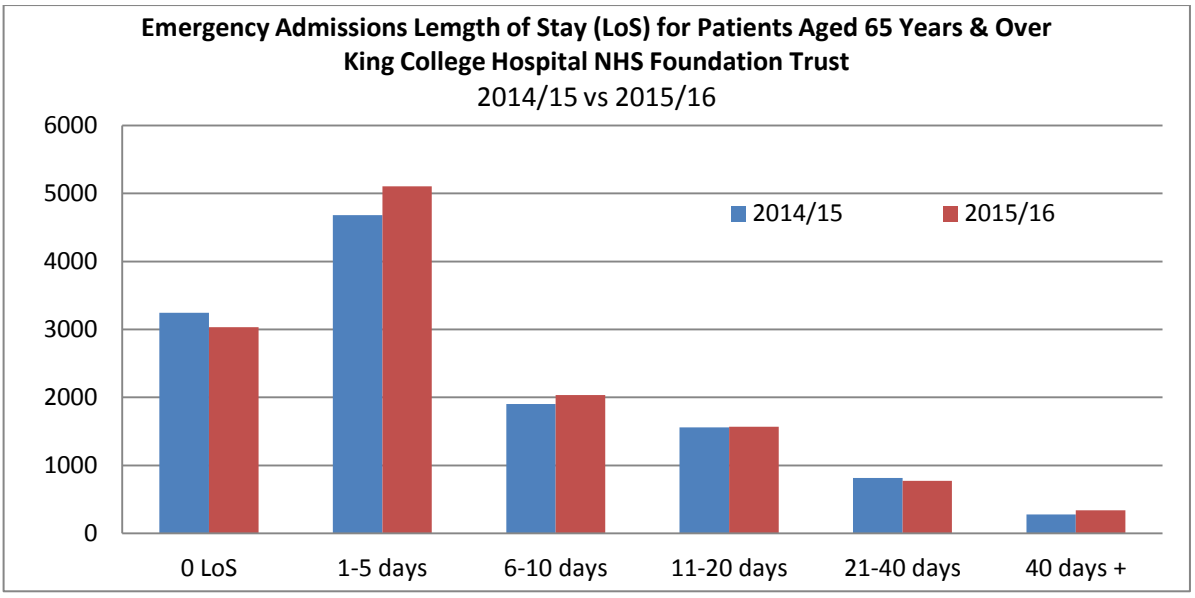
5.6. Around half of emergency admissions are for patients aged 65 years and over. The chart below shows the admissions by age band for this cohort of patients from April 2014 to February 2016 at Kings College Hospital (PRUH & Denmark Hill).

Figure 2: Emergency Admissions for Patients aged 65 years and over



5.7. Whilst admissions for this cohort of patients appears relatively static (3% increase year on year), there has been some significant changes to length of stay bands for these patients when 2015/16 is compared with 2014/15. The graph below sets out the length of stay bandings for the two years. It shows a 23% increase in admissions where patients stay in hospital for more than 40 days, this would suggest the number of complex admissions is rising. An increase of 9% is also evident for patients staying between 1 and 5 days. This increase is most likely due to CDU and ADU activity.

Figure 3: Emergency Admissions length of stay for Patients aged 65 years and over



6. Bromley's Transformation Programmes

6.1. Having interpreted the national conditions and the metrics within the BCF and the wider policy directives set out in the Health and Care Act 2012, Care Act 2014 and NHS Five Year Forward View Bromley has commissioned two significant change projects in 2015/16 and will continue to implementation stage in 2016/17:

'One Truth' from McKinsey's which involved applying an established methodology for reviewing work flow at the hospital to improve bed blocking and discharge from hospital into appropriate community services. This work has resulted in a single multi-professional discharge team in charge of referrals out into community services.

'Out of Hospital Strategy' working with iMPOWER to develop how services in the community can be better joined up and structured to deliver improved outcomes, especially for those patients with long term conditions. This work has resulted in the development of integrated care networks (ICNs). The CCG are planning to roll these new ICN governance structures out during 2016/17

6.2. A further major commissioning project to go out to market and to retender the existing community health services for October 2017 will be taking place throughout 2016/17. This significant procurement will complement the work of the *out of hospital strategy* requiring a provider or set of providers to deliver community services in partnership with general practice, social care and the voluntary sector. It will be split into three lots across *Children's, Adults* and *Intermediate care*, which includes step up and step down services working closely with the acute provider and the multi professional discharge team already established this year at the hospital.

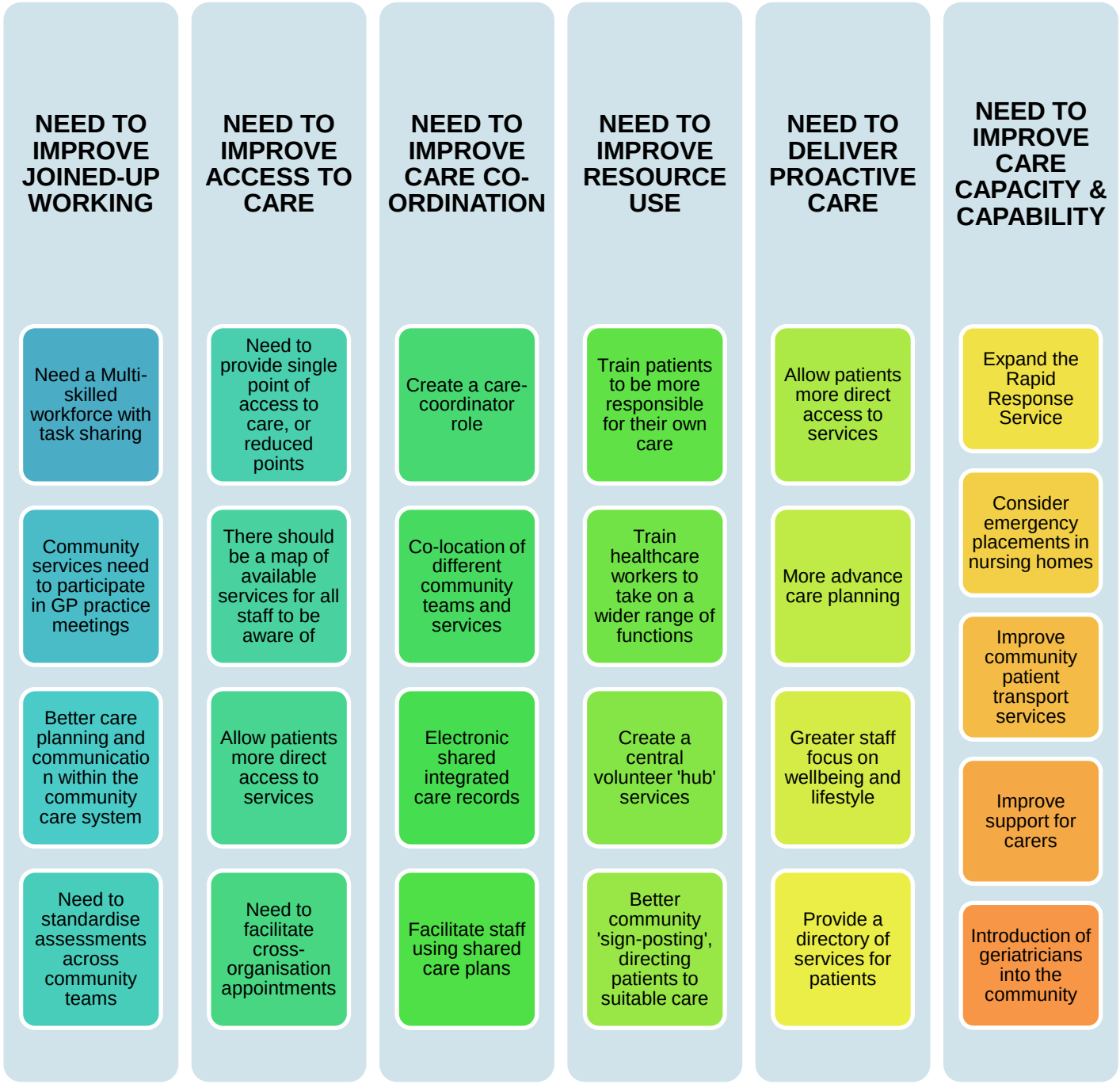
7. Integrated Care Networks and a Memorandum of Understanding

7.1. The BCF plan is being aligned with our change programmes and rather than a sequence of small impact projects, funding will be used to underpin the wider objectives to move care from an acute setting into the community. The BCF spend is all in community based services from preventative services through to supporting winter pressures through increased discharge capacity.

7.2. The way we propose to do this is through the development of Integrated Care Networks (ICNs). As set out in the strategy "*The aim is to provide coordinated care for patients via integrated services and responsiveness to patient's needs, while ensuring the best possible use of resources".* The report highlighted an estimated £72m funding gap across the Local Authority and Bromley CCG budgets by 2020. The report advised '*breaking the lock'* on historical issues and recommended a new model of care.

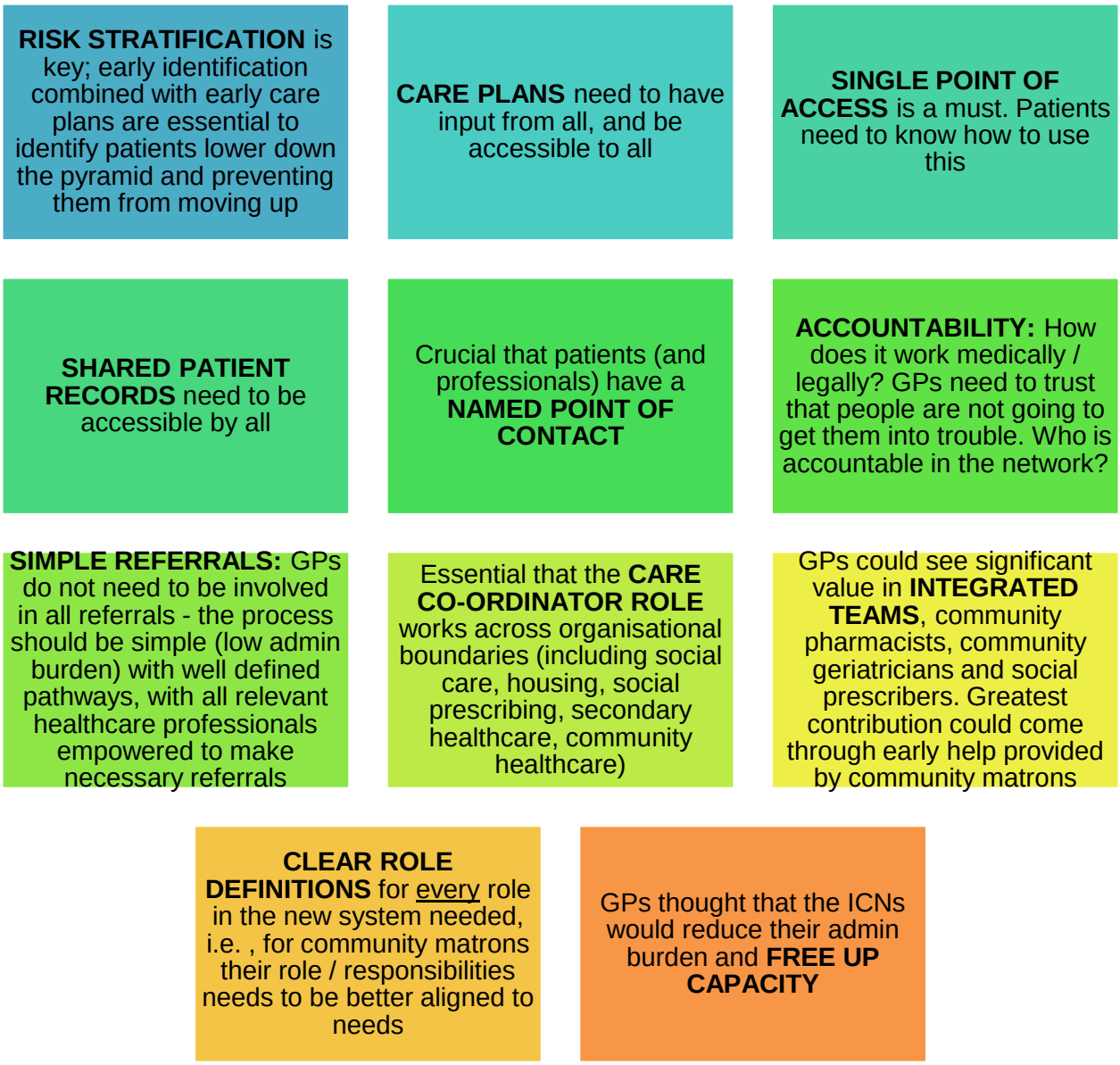
7.3. Through a sustained period on engagement and consultation with core providers we identified what needed to change and be improved within the existing system.

Figure 4: What needs to be changed



7.4. The next stage has been to focus on key areas that commissioners can help address in the new integrated care model.

Figure 5: Key areas of focus



7.5. This has led to a new operational model that is still being worked up and co-produced with the main providers responsible for delivering the model on the ground. Patient engagement sessions have also been held to ascertain local patient needs and to test the high level principles of the model.

7.6. This draft operation model (attached under additional relevant information) is being shared with providers as part of a much wider draft Memorandum of Understanding that providers will be signing up to in the spring.

7.7. Memorandum of Understanding (MOU)

7.8. The MOU (attached under additional relevant information) is the document that underpins the implementation of ICNs. It contains some shared metrics directly linked to performance payments shared across all the key providers that sign up to the MOU.

Figure 6: Metrics linked to payment in the MOU

MEASURE	DATA SOURCE	MONITORING FREQUENCY	TARGET (ANNUAL)
Reduction in emergency admissions (acute and mental health)	SUS	Monthly	825 fewer admissions per year
Reduction in DTOCs (relating to the participating Providers)	NHS England	Monthly	19.50% reduction in DTOCs
Reduction in A&E attendances	SUS	Monthly	825 fewer attendances per year
Delivery of planned reduction in emergency readmissions	SUS	Monthly	TBC

7.9. £1.5m has been made available to providers. £1m for up-front investment against provider bids to deliver the new operating model and £500k held back for performance payments against achieving the targets set out above. Providers are being encouraged to work together over the next couple of months to jointly bid to deliver parts of the new model of care for Bromley. This funding has been made available for transformation by the CCG and should be offset by the planned reduction in the acute contract for 2016/17 currently being negotiated.

7.10. There are operational details still to be firmed up and commissioners are working with providers to do this as part of the signing up process over the next couple of months. Workshops will be held on a weekly basis over the next couple of months to support providers to develop their bids against the £1m investment fund set out in the MOU. This will help to confirm how funding is released and how performance against the metrics is shared.

Figure 7: Investment in the MOU

INVESTMENT FUND ALLOCATION	TOTAL FYE IMPACT £'000	TOTAL PYE IMPACT £'000
INTEGRATED CARE NETWORKS	952	476
FRAILTY PATHWAY	428	214
CONTINGENCY	0	310
	1,380	**1,000**

7.11. Early financial models have been drawn up to estimate the additional staff requirements and resources required to fully implement ICNs but these are subject to change as Providers work up their detailed bids:

Figure 8: Staffing and salaries for new community capacity under ICNs

Band	New ICN capacity	Beckenham WTE	Bromley WTE	Orpington WTE	TOTAL WTE	Base Salary * £'000
	INTEGRATED CASE MANAGEMENT TEAM					
7	MDT Liaison (integrated case management)	4.0	2.0	2.0	8.0	41.3
4	Care Navigator (care planning support)	1.5	1.5	1.5	4.5	24.0
	COMMUNITY COORDINATION TEAM					
5	MDT Liaison (GP liaison and professional support)	0.5	0.5	0.5	1.5	28.8
4	Care Navigator (general navigation and support)	1.5	1.5	1.5	4.5	24.0
3	Care Navigator / Social Prescribing Advocate	2.5	2.5	2.5	7.5	21.2
	FRAILTY PATHWAY					
	Community Geriatrician	0.5	0.5	0.5	1.5	131.4
7	Specialist Nurse	1.0	1.0	1.0	3.0	41.3
2	Clerical Support					21.2
		11.5	**9.5**	**9.5**	**30.5**	

7.12. Providers will be submitting their bids in June/July 2016 to the ICN Board. Initial governance for decision making and rolling out ICNs has now been established for the next financial year. Along with a high level programme plan for the roll out of ICNs across the borough.

7.13. The modelling has been mapped out against existing capacity already in place under the current legacy contracts with community providers. Once ICNs are fully up and running to full capacity the expectation is that up to 50 patients a month will be going through the risk stratification process within each ICN. This equates to up to 150 a month across the borough each month and up to 1,800 a year. Those deemed suitable by clinicians will then be taken through the proposed proactive care pathway (model set out under operational model attached under additional information). Number will start to come through from October 2017 and ramp up over the remainder of 2016/17. Full Capacity is the aim from 2017/18.

7.14. The community coordination team with coordinate the follow up work for those patients at risk of unplanned admissions. Working with a lead clinician to establish an integrated care and support plan. The clinical lead for a patient will be determined by their primary need. The care plan is shared with the patient and their carer/s to establish the targets and outcomes which are personal to each patient in managing their long term condition and maintaining a level of independence in their local community. Multi-disciplinary team meetings will be arranged to review the case. Where appropriate and a patient is being well managed with good outcomes and is self-managing their condition they can step down from the MDT case load and will be passed to a community matron for general oversight and review on a less frequent basis.

7.15. The use of care navigators to support wider non-clinical solutions to help patients to maintain and self-manage their long term conditions is also a key part of the proactive system being set out under the ICN model of care.

Figure 6: Draft Governance Structure

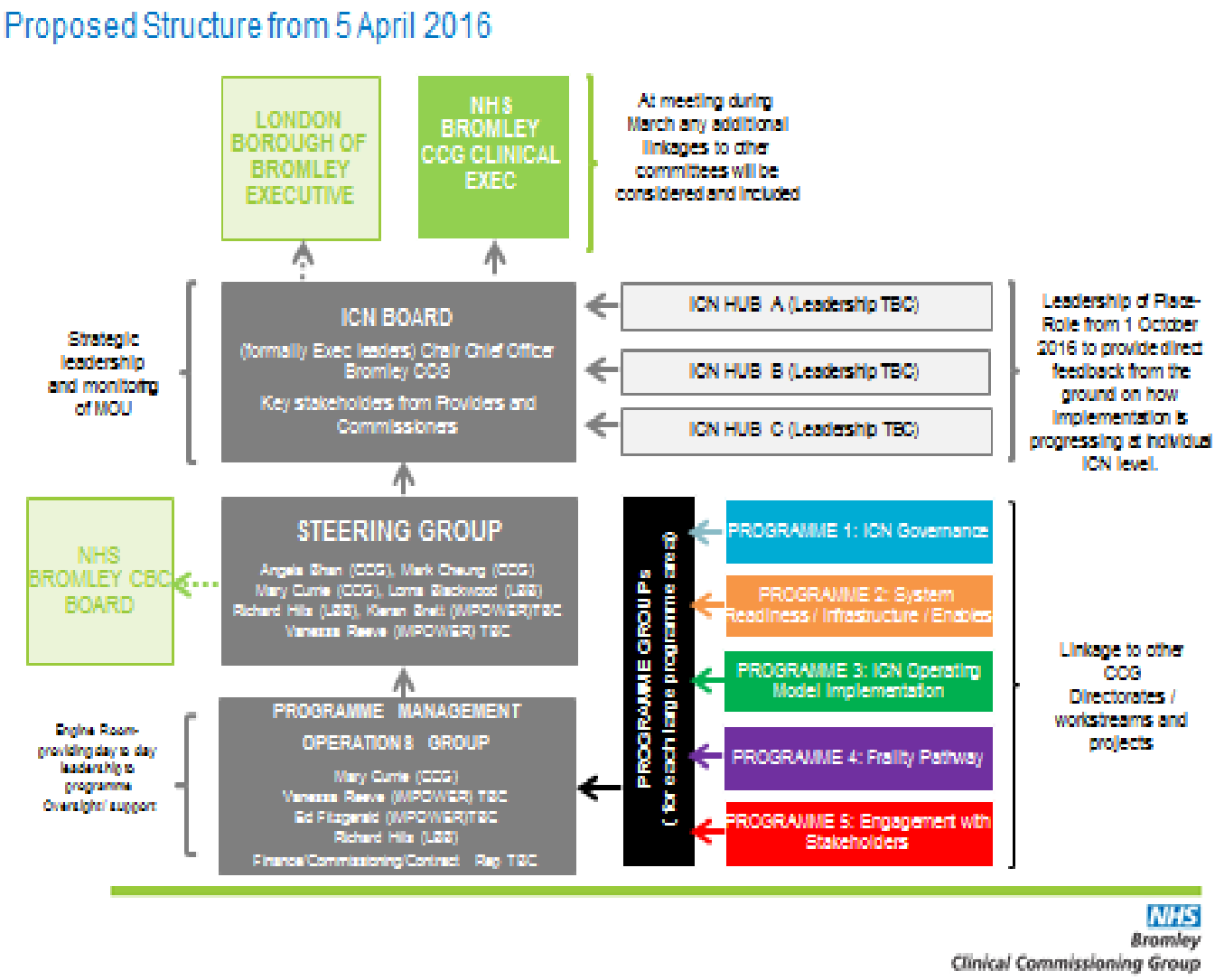


Figure 7: High Level Programme Plan for 2016/17

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-16	Feb-16	Mar-16
ICN - Memoradum of Understanding												
Shared data/information							★	◆	◆	◆	◆	◆
Workforce Development							★	◆	◆	◆	◆	◆
Risk Stratification							★	◆	◆	◆	◆	◆
Integrated Case Management							★	◆	◆	◆	◆	◆
Care Planning							★	◆	◆	◆	◆	◆
Social Prescribing					★	◆	◆	◆	◆	◆	◆	◆
Implementation of Carer's Strategy									◆	◆	◆	◆
Pharmacist role in GP Practices										★	◆	◆
Dementia Hub - Post Diagnosis Support					◆	◆	◆	◆	◆	◆	◆	◆
Out of Hours Crisis Support						★	◆	◆	◆	◆	◆	◆
Care in the Home								★	◆	◆	◆	◆
Frailty Pathway								★	◆	◆	◆	◆
ICN Communication Plans												

Enabling workstreams - workup/impementation/signoff — ★★ Go live

Activity influencing workstreams - workup/implementation — ◆◆ Phased BAU/Full BAU

7.16. Data sharing and integrated care records are major priorities for 2016/17 and 2017/18. The communications and engagement for this area will form part of the overall strategy in the development of ICNs. As part of our privacy impact assessment, we will be promoting information on data sharing via GP practices. During the implementation of integrated care records, individual patients will be given details on how their data will be used. Patients will be given the option to 'opt out' of data sharing but the risks of doing so will be highlighted to them.

7.17. Patient engagement has taken place during the programme:

- July 2015 – Patient Advisory Group engagement workshop to discuss the out of hospital strategy
- 25 Jan 2016 – Patient Focus Group with 7 patients to discuss their individual pathways and how the ICNs would benefit them

7.18. Currently planning a patient survey followed by a patient feedback event in May and another in September

8. Responding to the NHS Five Year Forward View

8.1. Responding to the direction set out under the *NHS five year forward view* this is seen as the first stage of moving towards a more provider led system where providers work together to meet outcomes and are incentivised to so. The plans to retender the community contract will also look to compliment this direction of travel requiring the market to, not only evidence quality clinical care and effective safeguarding procedures, but also to how they will work to deliver services with the ICN framework.

8.2. Also in line with the NHS five year forward view the new model of care for Bromley makes a concerted effort to bring in the third sector as a core provider, rather than an afterthought or bolt on to our traditional clinical care pathways. The newly formed 3rd Sector Enterprise has been a result of the sector coming together, with support from commissioners, to form a collegiate. The local voluntary sector now has a place on the Executive Leaders board along with all the main providers in the local system. It is hoped that with support from commissioners that the sector will be able to bid directly for delivery elements of the new model, especially at the front end where non-clinical solutions are required to assist people with managing their care and health requirements.

8.3. Utilising BCF funds as one-off investment to pump prime this work will be essential.

9. National Conditions

9.1. The national conditions and metrics drive two types of system change:

- ✓ An increase in planned community based activity
- ✓ A decrease in unplanned acute activity

Figure 8: Golden Thread from National conditions to local outputs

An increase in planned community based activity (especially prevention and targeted interventions)	A decrease in unplanned acute activity (and where an admission is unavoidable improved outflow back into an appropriate community services)
Local Change Programme: Integrated Care Networks	**Local Change Programme**: Discharge team and step up/ step down service recommissioned
Outputs that require investment: ➢ Shared MOU between 'Pillar' Providers ➢ Outcome based incentives ➢ Outcome based contracts ➢ Social prescribing and prevention ➢ Self-management ➢ Single point of access/ Demand management ➢ Comprehensive IAG services ➢ 3 clear ICNs co-ordinating resources ➢ Risk stratification of local population ➢ Personal health budgets	**Outputs that require investment:** ➢ Multi-professional discharge team ➢ One referral route ➢ New workflow for packages and budget management ➢ 7 day operation all year round ➢ Wider range of step up/ step down services ➢ Improved reablement capacity ➢ Flexible innovative interventions ➢ Increase in step up services

9.2. Therefore all our shared projects within the BCF aim to reflect back to these outcomes.

9.3. Current and planned performance against metrics is provided within the BCF plan excel spreadsheet submitted alongside this narrative and in section nine, but here is narrative description of activity against each of the national conditions.

CONDITION 1: Plans to be jointly agreed.

9.4. Officers from Bromley CCG and the Local Authority meet monthly to discuss and oversee integrated working and the Better Care Fund remains a standing item on the agenda. This meeting of the *Joint Integrated Commissioning Executive* (JICE) has allowed the time and space to build relationships and discuss options for how the fund can be best used to meet competing pressures of reduced resources across the local care and health system as a whole.

9.5. Plans, considered and drafted through JICE are then presented to the *Health and Social Care Integration Board* (HSCIB) which include decision makers from both commissioning organisations. Standing members include elected Councillors, CCG board members; clinical leads and the Chief Executive from both organisations (see governance section 12). This governance structure has allowed the organisations to have mature conversations about the funding available through the BCF and to set out this jointly agreed plan for how it will be jointly commissioned to meet the other national conditions.

CONDITION 2: Maintain provision of social care services.

9.6. A considerable percentage of the fund has been set aside again in 2016/17 for the direct provision of social care.

9.7. Existing grants included in the fund that were originally from social care have been protected and are still fully accessible to social care services e.g. DoH social care Grant £4.26m

9.8. New funding has been made available for the specific provision of social care and the requirements for the delivery of the Care Act - £4.4m

9.9. Further specific funding has been made available for projects that help deliver against the conditions set out in the BCF. These include winter pressures £974k for emergency intensive domiciliary care packages responsive within 4 hours to support discharge. Also additional reablement capacity, £800k to support an 'invest to save' business case that makes the case for higher levels of reablement to help avoid the need for long term care packages.

9.10. In addition a further percentage has been set aside to jointly fund the work of our voluntary sector providers in their universal provision of access to information, advice and guidance for residents as well as targeted projects such as a dementia hub and direct support to carers to avoid carer breakdown.

9.11. The dementia hub that has been jointly procured and evaluated should go live in July 2016. Provided through a 3rd sector collegiate this service will hold 160 dementia cases at any one time and is modelled to support over 1500 residents with dementia each year. The service based across locations in the borough can take self-referrals as well as direct referrals from GPs and our memory clinic post a diagnosis. The service can offer one to one post diagnosis support to those with dementia who would otherwise not be eligible for a service. This service therefore meets a gap in provision as identified through the JSNA and the Health and Wellbeing Strategy.

CONDITION 3: Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

9.12. The CCG already commissions NHS 111 and out of hours access to emergency primary care (EMDOC) as well as a 7 day urgent care centre and 24/7 end of life care coordination services and these services have been in place for some time. In addition to these and over the last year:

9.13. **Hospital** The remodelling of discharge services and the creation of the new single multi-professional discharge team, the Transfer of Care Bureau, now operates 7 days a week.

9.14. The Bureau brings together discharge co-ordinators from the PRUH, Bromley Healthcare health professionals, London Borough of Bromley care managers, St Christopher's end of life staff and some voluntary sector services. This integrated team is co-located and works together to manage effective, safe, appropriate and timely discharges and the transfer of care for patients between agencies. The team operates a 7 day service.

9.15. The service is aimed at patients who have ongoing needs and are often termed 'complex discharges'. Most discharges where there are no ongoing support needs are managed through the usual pre-existing processes. Every medical ward at the PRUH has a case manager linked to the bureau who works closely with medical and nursing staff on the ward to manage discharges and transfers of care for patients who need support or ongoing care.

9.16. The acute Speech and Language Therapy service has recently transitioned to Kings and been enhanced to support seven day working, giving patients access to the service at weekends, thereby facilitating a speedier discharge where appropriate.

9.17. St Christopher's provide seven day services to palliative care patients. St Christopher's staff work alongside hospital colleagues to identify patients requiring their services and supporting transition.

9.18. The current Neuro Rehabilitation service is under review and plans are in development to transition the service to seven day working arrangements. This will form part of the home rehabilitation.

9.19. Additional psychiatric liaison capacity in A&E was funded as a winter pressure scheme. Funding has been approved to extend this initiative for 2016/17 which will provide access for patients seven days a week.

9.20. **General practice** Bromley CCG have commissioned Bromley GP Alliance to provide primary care access hubs open initially for 3 months but will be extended for at least another 6 months before entering into a formal procurement exercise. Currently there are two sites which offer 100 appointments a day, available until 8pm on weekday evenings and 8am-12pm on Saturdays and Sundays.

9.21. The CCG commissioned this directly from the Alliance without a procurement process, to give the Alliance an opportunity to provide a significantly large scale and value service covering the whole borough. This is allowing the Alliance to gain experience of providing primary care services for the borough and embed itself as a provider organisation.

9.22. Data sharing agreements and Information Governance arrangements have been put in place to be able to access patient records and make onward referrals (thus differentiating this from a walk-in service). This pilot offers 100% population coverage. The hubs were opened on 1st December and ongoing evaluation and adjustment during this time means the hubs will also take urgent appointments via NHS 111 and out-of-hours GPs from Easter 2016, as well as routine and semi-urgent appointments via GP practices.

9.23. The CCG is also looking at options for a third hub in line with the out-of-hospital transformational plans for three Integrated Care Networks in Bromley. Average utilisation of hub appointments on Saturdays in the first five weeks of operating is 64% suggesting there is surplus capacity at the current time. As the hubs continue, we expect utilisation to increase as GP practices become more familiar with referring for Saturday appointments and NHS111 and out-of-hours GPs also start referring. The CCG will continue to monitor and adjust the scheme as patient need dictates and in line with the Strategic Commissioning Framework ambitions for Saturday morning opening

9.24. **Community** A number of community services across Bromley are now operating a seven day service. The Medical Response Team (MRT) delivers a 2 hour response to patients in

crisis 7 days a week, offering short term intervention to stabilise immediate needs and prevent unnecessary hospital admissions. Bromley's District Nursing and night sitting services operate 7 days. The home based rehabilitation service has been enhanced to accept referrals directly from primary care as well as the hospital, which gives support to patients in their own home and can avoid the need for a hospital admission.

CONDITION 4: Better data sharing between health and social care, based on NHS number.

9.25. Bromley's current version of the data sharing agreement covers all our main providers including, Bromley GPs, Mental health, social care, acute, end of life and community health services. The data sharing agreement was signed off by all providers Information Governance (IG) board, including our acute provider, Kings. The agreement covers all relevant IG legislation and provider requirements.

9.26. The Integrated Care Record (ICR) steering group agreed that the NHS number would be used as the unique identifier and the Bromley ICR steering group is linked to the South East London digital roadmap group and the London wide Interoperability group via the shared South East London lead.

9.27. Mapping has been carried out and commissioners are seeking a web based solution to share care plans across providers using open APIs. The first of these pilots opening up social care data to our community health provider is expected to go live early in the new financial year. CCG commissioners have attended pan-London meetings regarding the roll out of the *Health Information Exchange*, where the objective is to provide a pan London interoperability solution for all CCGs across the capital. Providing a web based platform where legacy systems can be plugged in or data easily extracted to create shared views of care plans for patients which can include primary, secondary and social care data.

CONDITION 5: Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.

9.28. In Bromley, GP practices have been risk stratifying using a predictive risk tool. They have referred patients onto community matrons who put together a care plan and include other professionals including social care. However, overall numbers under the pilot have been relatively modest and require a step change in scale to be able to have a marked impact reduction of unplanned admissions.

9.29. Therefore, the out of hospital strategy proposed a whole system move towards integrated care networks (as set out in section 7). With community based services wrapped around general practice. In Bromley this equates to three ICNs with an average population of a little over 100,000 and around 15 practices in each. The new operational model removes barriers to joint assessments with a pooled resource of professionals in each ICN acting as clinical and non-clinical care navigators. The role will perform risk stratification and signposting and referral through the community care system into:

- ✓ Step up intermediate care services
- ✓ Multi-disciplinary teams for detailed case management
- ✓ Single professional assessment by, for example and OT, District nurse or social worker
- ✓ Referral directly into the 3rd sector for training, advice, guidance and non-clinical support planning

9.30. Care navigators will administer the case and the patient will have contact details of their care navigator and lead professional. The whole model is there to support and alleviate pressures on primary care creating the wrap around community based services required to properly case manage the more complex patients.

9.31. Further details refer to the out of hospital strategy and the draft operational model attached to this plan.

CONDITION 6: Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans.

9.32. Through the Executive Leaders group all the main providers are represented and consulted with on any new plans and modelling impacting on their services. This includes our Mental Health provider and the Council as providers of social care assessments and the voluntary sector. The transformation programme is conscious that historically not all services have been put on a level footing and that Mental Health (under parity of care) and non-clinical providers are given an equal voice and have equal voting rights within the new provider structures being set up under integrated care networks so that these providers are able to be better heard and can bring their solutions to existing problems to improve care pathways.

9.33. There has been an extensive period of engagement and consultation on the out of hospital strategy and the BCCGs commissioning intentions, both of which are attached. The work of delivering and designing the ICNs has been done in partnership with core providers, who after all will be responsible for the successful delivery of the new model of care.

9.34. Each provider will have time to meet and feedback to senior CCG officers as part of the signing up to the memorandum of understanding during April 2016. By encouraging provider to bid together against the investment pot for ICNs commissioners are trying to create an environment where providers explore the consequential impact of the changes and work together to find ways to mitigate risk and increase opportunities to make improvements to the local system as a whole which will result in performance payments to providers.

9.35. As part of the planning process for 2016/17, Bromley has ensured that activity and performance targets have been agreed with providers to ensure a consistent view is reached across the health economy. The planned reduction in emergency admissions (825) has been signed up to by Kings College Hospital as part of the contract negotiations. This is further supported by the signing of the MOU in relation to the development of Integrated Care Networks. The MOU has been signed by key providers involved in the delivery of this transformation programme. The MOU covers the delivery of key performance indicators including; reducing emergency admissions and delayed transfers of care.

CONDITION 7: Agreement to invest in the NHS commissioned out of hospital services.

9.36. In Bromley this requirement equates to £5.66m of the total fund. As the BCF plan (excel spreadsheet) demonstrates Bromley have exceeded that target with the CCG directly responsible for commissioning £6.78m of the fund.

9.37. This BCF plan has direct investment in a number of specific NHS commissioned out of hospital services, including winter pressures funding, dementia diagnosis and support,

community equipment, intermediate care, health support into care homes and the additional costs of the newly formed discharge team.

CONDITION 8: Agreement on a local target for Delayed Transfer of Care (DTOC) and develop a joint action plan.

9.38. The aim of this plan (see attached DTOC plan) is to set out Bromley's agreement on a local action plan to reduce delayed transfers of care. In 2015 Bromley Clinical Commissioning Group and Kings College Hospital NHS Trust commissioned McKinseys to review the root causes of poor performance in emergency care across the entire health economy. The purpose of the review was to establish 'One Version of the Truth' that gave a shared understanding of flow and pressure points across the system so interventions could be prioritised.

9.39. One of the issues identified related to the flow of patients, in an inability to move a patient on to the next stage in their pathway because of 'blockages' downstream.

9.40. Around 300 patients a month require a supported discharge; if their length of stay post MSfD could be reduced by 3 days on average this would free up ~30 beds a month or a quarter of the total blocked beds

9.41. In response to the issue of supported discharge the Transfer of Care Bureau was established in November 2015. The Bureau brings together discharge co-ordinators from the PRUH, Bromley Healthcare, London Borough of Bromley social care, St Christopher's and some voluntary sector services. This integrated team works together to manage effective, safe, appropriate and timely discharges and the transfer of care for patients between agencies. The service is aimed at patients who have ongoing needs and are often termed 'complex discharges'

10. Performance against the National Metrics

10.1. Bromley is responding to the national metrics within the BCF. The below table sets out the current position for 2015/16 and the planned position and improvement targets for 2016/17:

Figure 9: Table illustrating metrics for Bromley

Metric	2015/16 FOT	2016/17 Plan	% Improvement	Comments
Non-elective admissions (General and Acute)	26,583	25,758	3.10%	The plan seeks to support the reduction of 825 admissions against the 2015/16 FOT position for Bromley. The planned reduction is phased over the year to reflect the development of the Integrated Care Networks (ICN) and their associated enabling initiatives as they commence
Admissions to residential and care homes	279	283	0%	Analysis of 2015/16 performance has been undertaken to ensure accuracy of local data due to move across to SALT return from ASCOF. Bromley plan to maintain robust performance

				against this measure in 2016/17 by maintaining people at home with domiciliary care where appropriate
Effectiveness of reablement	90.2%	93.6%	3.77%	Analysis of 2015/16 performance has been undertaken to ensure accuracy of local data. In 2014/15 Bromley reported the highest performance in South East London against this measure. Bromley plan to further improve performance against this metric in 2016/17
Delayed transfers of care*	329.7	2,65.6	19.5%	Historic performance analysis shows improvement against this metric over the last year. Bromley is planning a further reduction in the number of delayed days (rate per 100,000) in 2016/17 and plans are in place to support this across the health and social care system predominantly driven by the development of the Transfer of Care Bureau

10.2. Over the 18 months Bromley has seen a rise in emergency admissions at the local acute hospital. This is due to the Trust opening two new admitting units, the Ambulatory Care and Clinical Decision Units. Whilst this increase in activity has negatively impacted 2015/16 performance against a reduction in emergency admissions, Bromley is confident that a reduction will be achieved in 2016/17 as the Integrated Care Networks and associated work streams develop across the patch.

10.3. For admissions to residential/care homes and the effectiveness of reablement historic and 2015/16 performance has been assessed to ensure that ambitious but realistic targets are put in place for 2016/17. A significant level of investment is planned for 2016/17 to help keep people well in their own homes, which should positively influence performance against these targets but with an increasing aging population maintaining a steady state may be the achievable position. Bromley already outperforms its statistical comparator group by having the lowest number of permanent placements into a care homes.

10.4. Bromley has recently been named as one of the top 15 performing areas for Delayed Transfers of Care (HSJ). Bromley is keen to continue to reduce the level of delayed days and is further enhancing discharge services at the local acute hospital utilising the Transfer of Care Bureau (TOC). A detailed evaluation of the TOC Bureau is commencing in March 2016. It is anticipated that any recommendations to improve the service will be incorporated into the final version of Bromley's BCF and Improving DTOC plans.

10.5. Further detail of the plan to reduce DTOCs is detailed in 'additional relevant information' section at the bottom of this plan.

10.6. Local metrics – two local metrics have been agreed:

- Dementia Support Hub – post diagnosis universal community support
- Proportion of people feeling supported to manage their long-term condition

11. Bromley's BCF Funding Principles

11.1. Bromley have set out some funding principles for administration of the pooled fund between BCCG and LBB. These have been developed over the year and shared with the health and Social care Integration Board for their approval:

- ✓ The management of grants that pre-existed BCF and are now subsumed within it, as well as the on-going commitment to protect social care is protected and administered in exactly the same way as 2015/16
- ✓ Those new additional revenue commitments that have come out of the BCF in 2015/16 are also protected for 2016/17
- ✓ Agreement that not all funds for 2015/16 will be fully committed in year due to the fact that BCF was in its first year and that commissioners wanted to wait for the recommendations from the consultancy work before finalising implementation plans and targeting the remaining BCF funds at the transformation programme.
- ✓ That any remaining uncommitted funds from 2015/16 are rolled over into the BCF for 2016/17 and used as one-off funds to 'pump prime' the system change required to deliver the local change programmes.
- ✓ If any further 'one-off' spend is required to deliver the change programmes over and beyond this then BCCG will find the additional funding.
- ✓ That due to Local Authority funding the expectation is clear that although LBB support these local change programmes the LA cannot provide any additional funds to support the programmes. However they endorse the use of part of the BCF for this purpose as long as all existing commitments within the BCF and wider shared Section 75 are maintained.

12. Funding Decisions and Risk Share BCF 2016/17

12.1. Refer to BCF planning template – tab 4 – HWB Expenditure Plan detailing all schemes funded for 2016/17

12.2. £1.323m has been allocated against risk share as advised in the BCF guidance to ensure adequate contingency to cover over performance in emergency admissions and not meeting the 825 reduction to unplanned admissions. This is particularly important in Bromley as the planned reduction in emergency admissions was not delivered in 2015/16.

12.3. The contingency has been agreed and signed off by the CCG and the London Borough of Bromley and represents 57% of the risk. The outstanding 983k risk will be covered through the CCG's own contingencies and reserves. A key element of the MOU metrics is a performance fund dependant on the delivery of the emergency admissions reduction should the target not be met, this fund will be utilised to offset the risk set out above. The value of the contingency is a reduction from the performance fund value for 2015/16 of £2.0m, with investments agreed towards the Transfer of Care Bureau to support the delivery of the BCF targets. The 2016/17 contract has been agreed with Kings College Hospital which includes an agreed activity profile including the QIPP reductions and an element of risk share on the overall targets. On this basis, we are assured that the contingency level is appropriate and the outstanding risk is covered.

12.4. The workings showing the targeted reduction in volume and the financial modelling attached can be seen in figure 6.

Figure 10: Table showing modelling for savings in 2016/17

	Supporting Initiatives - Activity			
Month	**MRT Inreach**	**Care Homes**	**Integrated Case Management**	**Implementation of ICNs**
Apr-16	13	0	0	0
May-16	13	0	0	0
Jun-16	14	0	0	0
Jul-16	13	2	22	0
Aug-16	13	4	22	0
Sep-16	14	7	22	0
Oct-16	13	9	22	61
Nov-16	14	11	22	63
Dec-16	13	13	22	58
Jan-17	13	15	22	61
Feb-17	13	17	22	58
Mar-17	15	20	22	66
Total	**162**	**98**	**199**	**366**

	Supporting Initiatives - Finance			
Month	**MRT In reach**	**Care Homes**	**Integrated Case Management**	**Implementation of ICNs**
Apr-16	£37,441	£0	£0	£0
May-16	£35,658	£0	£0	£0
Jun-16	£39,224	£0	£0	£0
Jul-16	£37,441	£6,088	£61,810	£0
Aug-16	£37,441	£12,176	£61,810	£0
Sep-16	£39,224	£18,263	£61,810	£0
Oct-16	£37,441	£24,351	£61,810	£169,178
Nov-16	£39,224	£30,439	£61,810	£177,234
Dec-16	£35,658	£36,527	£61,810	£161,122
Jan-17	£37,441	£42,615	£61,810	£169,178
Feb-17	£35,658	£48,703	£61,810	£161,122
Mar-17	£41,007	£54,790	£61,810	£185,291
Total	**£452,859**	**£273,952**	**£556,290**	**£1,023,126**

Total Admission Prevention £2,306,227

12.5. The risks to providers in terms of a shift of acute spend being redirected into community services was explained to the HWB who fully support the direction of travel. It was explained that initial shifts in funding over the next year would be small but through building

capacity and investing in the community services that these shifts from reactive to proactive care would accelerate over the next few years.

13. Governance

13.1. The Local plan has now been agreed by both organisations executives and signed off collaboratively through the Health and Wellbeing Board.

13.2. The fund will be held by the Local Authority as in 2015/16 and the BCF will remain a standing item at the Joint Integrated Commissioning Executive (JICE) which meets monthly. Each organisation will give delegated powers to JICE to manage and oversee the day to day operations of the fund.

13.3. Increasingly the services paid for by the fund will be moved across into business as usual and subject to standard business processes and approvals, the only difference being that they continue to be funded through the BCF. The focus for JICE will be where BCF is funding new, redesigned or recommissioned services or projects under the local change programmes that are brought in to deliver against the national conditions. Where these services or projects require procurement, reports will be taken back through the usual business processes in order to meet EU regulations and each organisations authorisation requirements.

13.4. The governance structures put in place during the planning year of BCF will not be sufficient in the longer term to drive through the level of integration envisaged by the government as highlighted in the Comprehensive Spending Review 2015 and its requirement for full integration plans to be in place by 2017 and implemented by 2020. Governance will need to be more innovative and flexible if decisions are to be actioned effectively and efficiently within the timeframes envisaged by Department of Health and Department of Communities and Local Government.

13.5. Therefore the recent creation of a Health and Social Care Integration Board (HSCIB) which has representation from elected Members and the chairman of CCG along with both organisations' Chief Officers is timely. It can provide the level of seniority and leadership required to deliver the scale of change needed through clear accountability and transparency between the two organisations. As more services and funding are embedded into joint decision making processes the decision making powers of the shared board will be critical to success. Terms of Reference have now been agreed and the Board is meeting regularly. The Health and Wellbeing Board still operates as the public facing meeting for encouraging and promoting integration and better health outcomes for local residents.

14. Conclusion and Future Direction for Full Integration

14.1. This report sets out a strategic approach to administering the BCF in line with local and national drivers. It recognises the need to address the national conditions that come with Better Care Funding but also seeks to utilise the fund to make longer term systematic changes to the overall structure of the health and care economy in the borough.

14.2. The plan is put together in the context, and with an understanding, of the current limitations on the local authorities' funding position. There is also recognition that this pooled pot

comes largely from a top-slicing of CCG funds that have not yet been redirected or released from acute care commitments and contractual obligations. These factors place a strain on resourcing and limit the ability of commissioners to free up enough of the BCF from existing contractual commitments to be able to successfully fund transformation programmes.

14.3. Senior officers have been cautious on spending in the first year of the fund and there will be some 2015/16 money made available to cover acute over performance and for direct investment into the wider strategic objectives for integration as set out in this plan. The funds are being targeted at pump priming and double running our jointly commissioned change programmes, such as integrated care networks, which will require upfront, one-off investment to be able to get them established.

14.4. The plan recognises the opportunity to use part of the fund to support the local change programmes in a joined up way. The out of hospital strategy has made it clear that simply carving up the BCF to keep existing services running will not address the very considerable budget gap which is developing over the next few years. Utilising BCF to unpin the transformation work required in a joined up way provides a clear way forward.

14.5. This approach also allows Bromley to target programme implementation that supports national conditions and national and local metrics which is becoming increasingly important to be able to demonstrate progress to NHS England and to 'graduate' from BCF to the Sustainability and Transformation plan and the establishment of a shared integration plan both of which allow direct access to much needed transformation funds.

14.6. The Comprehensive spending review announced late last year makes it clear that BCF is just the first phase on the road to health and care integration.

> *The Better Care Fund has set the foundation, but the government wants to further, faster to deliver joined up care. The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution*.
>
> (5.3 Integrating and Devolving Health and Social Care, Spending Review and Autumn Statement 2015)

14.7. Local senior policy makers on both sides are aware that there is considerable work to be done locally to firstly achieve the outcomes set out for delivery of the BCF, to be able to move beyond this phase to the ambitions made clear for integration set out in the spending review.

15. Additional relevant information

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 CCG Integrated Commissioning Plan 2014-2019	Bromley Integrated Plan 2014-19.pdf
Bromley's Out of Hospital Strategy 2015 – summary (full report available upon request)	The Bromley Out of Hospital Transformati
Commissioning Intentions feedback 2015	2015.10.23 Commissioning Intent
Bromley's Memorandum of Understanding with Providers for ICNs	Bromley Memorandum of Unde
Risk Log ICNs	RIsk Log at 20 April.pptx
Bromley Market Position Statement	Bromley Market Position Statement_D
DTOC plan	
Draft operating model for ICNs	ICN Operating Model - 27April.pptx