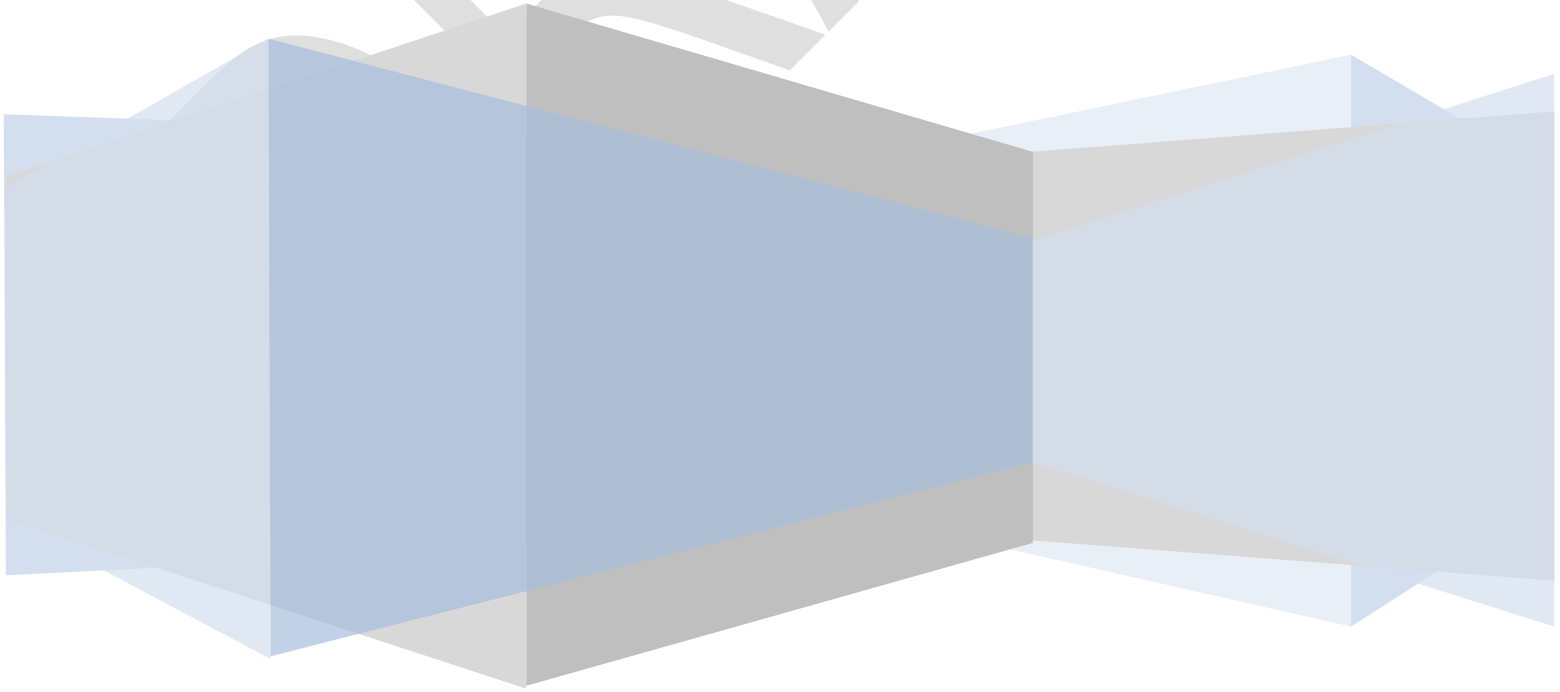
Bromley's Better Care Fund 2017-19

A Local Plan

BCCG & LBB



Contents

1. BCF Allocation for Bromley and Authorisation

Local Authority	London Borough of Bromley
Clinical Commissioning Group	Bromley
Date agreed at Health and Well-Being Board:	
Date submitted to NHS England:	
Minimum required value of pooled budget 2017/18	£22,125,000
Total agreed value of pooled budget 2017/18	£22,125,000
Minimum required value of pooled budget 2018/19	£22,670,000
Total agreed value of pooled budget 2018/19	£22,670,000

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

Signed on behalf of the London Borough of Bromley	
Signature	
By	Ade Adetosoye
Position	Deputy Chief Executive & Executive Director Education, Care & Health Services
Date	

Signed on behalf of the Bromley Health and Wellbeing Board	
Signature	
By	Councillor Jefferys
Position	Chair of Health and Wellbeing Board
Date	

2. Introduction and Background

2.1. The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Clinical Commissioning Groups (CCG) and Local Authorities (LA) for the benefits of local residents using health and care services.

2.2. For 2017/18 the total Better Care Fund will be increased from £3.9 billion to £5.128 billion and to £5.650 billion in 2018/19 with the inclusion of an additional £1.115 billion social care grant funding for 2017/18 increasing to £1.5 billion in 2018/19 as announced at Spring Budget 2017. £3.582 billion will be taken from NHS England's allocation to CCGs to establish the fund in 2017/18, with a further £431 million contributed from the Disabled Facilities Grant to Local Authorities.

2.3. There are two key changes to the policy framework since 2016/17. The first main change is that the framework covers the two financial years 2017-19 and the requirement for plans to cover the two year period rather than a single year as before. The second change sees a reduction in the number of national conditions that areas are required to meet, reducing from eight down to four. Areas will however be encouraged to maintain progress on the policy areas which are no longer national conditions through their BCF plans, as they remain important for the delivery of wider integration commitments.

2.4. With the Government's ambition that all areas graduate from the Better Care Fund to be more fully integrated by 2020 areas are asked to set out how they are going to achieve further integration by 2020. The plan should therefore align with the local NHS five year Sustainability and Transformation Plan (STP) produced jointly by NHS partners, local authorities and other partners and which set out plans for the future of health and care services.

2.5. 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. The plan 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.

2.6. This plan should be read in conjunction with other local strategic documents including the ***Health and Wellbeing Strategy***, the ***Out of Hospital Strategy*** and Bromley's ***Integrated Commissioning Plan*** attached at the end of this plan.

2.7. The minimum required value of pooled budget for Bromley for 2017/18 is £22,125,000 and £22,670,000 for 2018/19.

3. National Timeline

3.1 The submission and assistance process will follow the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	11 September 2017 Scrutiny
Scrutiny of BCF plans by regional assurers	12–25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care	November 2017

4. Local Vision and Evidence Base

4.1. Our vision is to reduce health inequalities and improve the health and wellbeing of people living and working in Bromley by delivering integrated health and care that focuses on maximising people's health, wellbeing and independence. Our current 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".

4.2. To improve the quality of life and wellbeing for the whole population of Bromley and particularly those with complex health needs and to ensure that more of our population stays well, avoiding the need for hospitalisation or institutional care, we must continue to work more collaboratively and in more integrated ways with cross sector partners, commissioners and providers, including local residents, voluntary organisations and community groups.

4.3. Locally we face similar challenges that are experienced nationally. The numbers of older people in Bromley are rising and health and social care provision needs to reflect the increased need.

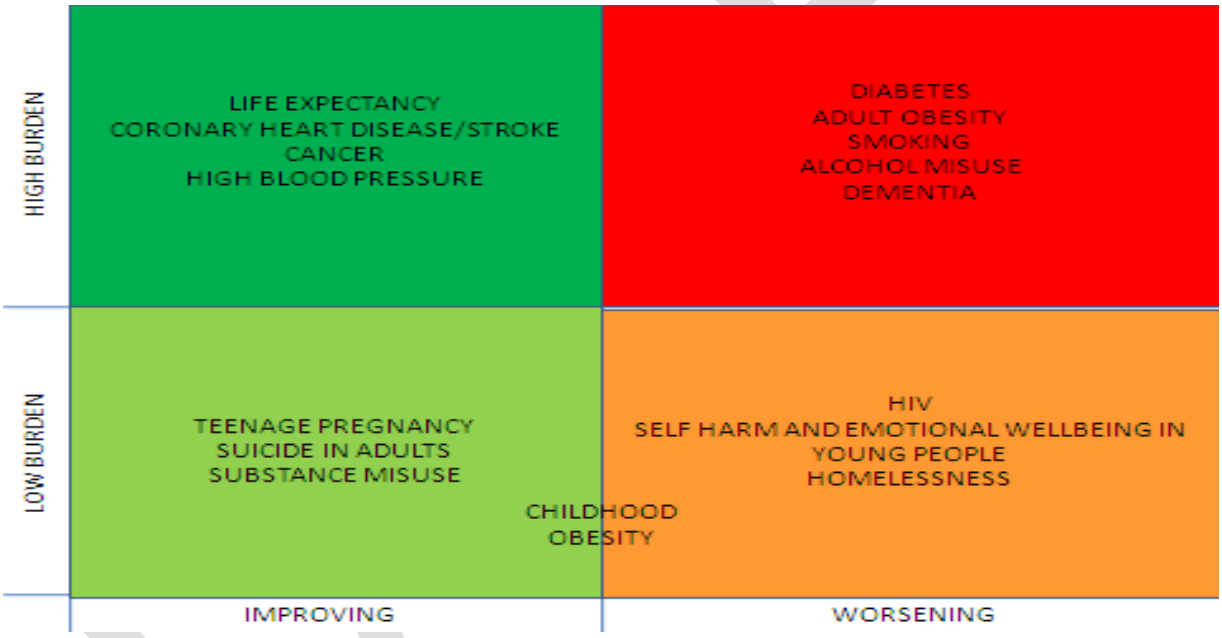
4.4. Our priority areas are defined through the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy The headlines for Bromley's population of over 326,000, as set out in the JSNA 2016 are:

- Bromley has a greater number of older residents than any other London Borough. The proportion of older people (65 years and over) is currently 17.7% and is predicted to rise to 19.1% by 2026.
- Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 81.4 years for men and 84.9 years for women.
- There is an 9.7 year gap for men and 6.7 years for women between the highest and lowest life expectancy wards in Bromley
- Mortality in Bromley is chiefly caused by circulatory disease (29.1%) and cancer (29%) with higher mortality rates for both conditions in more deprived areas of the borough.
- 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
- Diabetes represents a continuing challenge in Bromley. The number of people affected 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 has increased since 2002, but is projected to decrease by 2021.
- Bromley has the sixth highest proportion of adult overweight and obese in London, 63.8% and rising.
- Over 2,500 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness.
- Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories.
- Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.

- The volume of households faced with homelessness continues to rise
- 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.
- 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.
- 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.

4.5. *Figure 1* below shows our relative priorities of the key health issues. The highest priority is allocated to the issues creating the highest burden which appear to be worsening over time.

Figure 1: JSNA Priorities



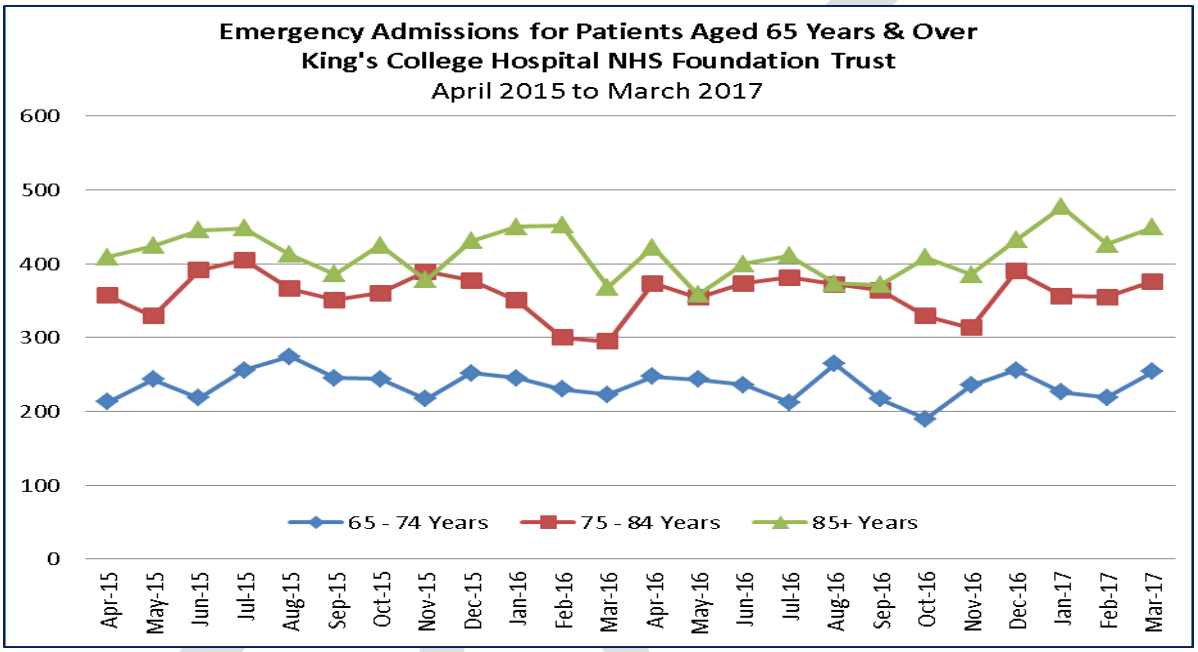
4.6 Following a recent review of our JSNA for 2016, our new HWB Strategy for 2017 will be produced towards the end of this year and will be based on pathway based priorities for vulnerable groups. This will include the elderly, the socially isolated and those with mental health issues. The health and wellbeing of children will also be integral to the revised strategy.

Evidence from analysis of emergency admissions

4.7. Analysis performed on hospital admissions data for Bromley patients shows that around 57% of emergency admissions are for patients aged 65 years and over.

4.8. *Figure 2* below sets out these admissions by age band for this cohort of patients from April 2015 to March 2017 at Kings College Hospital (PRUH & Denmark Hill).

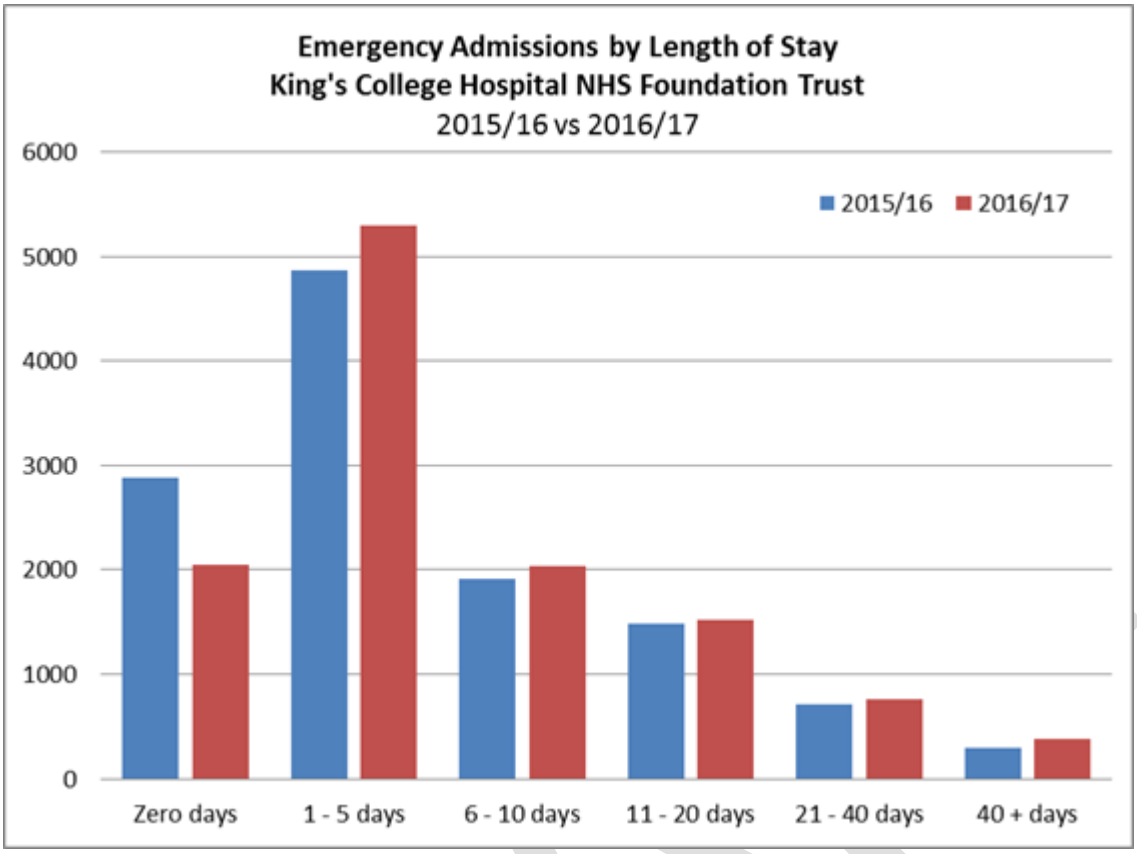
Figure 2: Emergency Admissions for Patients aged 65 years and over



4.9. Whilst admissions for this cohort of patients appears relatively static (a 1% decrease year on year), there has been some significant changes to length of stay bands for these patients when 2016/17 is compared with 2015/16.

4.10. *Figure 3* sets out the length of stay bandings for the two years. It shows a 28.3% increase in admissions where patients stay in hospital for more than 40 days, this equates to 83 more long stay patients in 2016/17.

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



4.11. This may suggest the number of complex admissions is rising. The number of zero length of stay admissions decreased by 835 (28.9%) in 2016/17.

4.12 The decrease is most likely due to changes in coding by the Trust; whereby Ambulatory Care Unit activity is now recorded as outpatient attendances rather than emergency admissions as it was in 2015/16.

5. Delivering Integrated Care - Our Progress to Date

5.1 To meet the increasing care needs of our rising population, in a way that enables people to live more independently with complex long-term conditions, Bromley commissioned two significant change projects in 2015/16, in line with 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

5.2 The BCF plan for 2016/17 was therefore aligned with our change programmes and rather than a sequence of small impact projects, funding was used to underpin the wider objectives to move care from an acute setting into the community. As such BCF spend was targeted in community based services from preventative services through to supporting winter pressures through increased discharge capacity.

5.3 *Figure 4* below details how all our shared projects within the BCF aimed to reflect back to the outcomes below.

Figure 4: 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 1: **Integrated Care Networks**	**Local Change Programme 2**: **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

Local Change Programme 1 – Integrated Care Networks

5.4 The national Five Year Forward View (5YFV) sets out a clear direction for the NHS to develop new models of care, aiming to have more integrated services with patients at the centre. To turn this vision into a reality, barriers between primary, community and hospital care will need to be removed so that we focus on systems of care and not organisations. This will help in providing more personalised and coordinated health services for patients. The 5YFV recommends that more care needs to be provided out of hospital, and services need to be integrated around the patient so that all their health needs are met.

5.5 Over the last year in Bromley we have started to make this vision a reality for our most vulnerable patients. Following the publication of our Bromley Out of Hospital strategy in the Autumn of 2015, 2016/17 saw the successful implementation and development of proactive and frailty pathways of care and the establishment of three Integrated Care Networks (ICNs) to provide a framework for delivering joined up care.

5.6 The three integrated care networks have been developed with local partners, clinicians and patients with staff from a range of services and organisations working together in multidisciplinary teams. Each ICN covers one-third of the population and brings together services delivering proactive care for patients with complex care needs. The aim is to keep these patients well and avoid a crisis, which may lead to them having to go into hospital. This new method of working is changing the way these patients receive care and how it is arranged for them.

5.7 The Proactive Pathway was mobilised at the end of October 2016 and good progress has been made with weekly integrated Multidisciplinary Team meetings (MDTs) now happening across all three networks. Patients are proactively identified by their GP and assessed by a community matron before a discussion with a multidisciplinary team of staff working within the ICN. This team works very closely together to support those patients and help keep them well. New ‘Care Navigator’ roles have also been created to support patients and signpost them to the services they need, including voluntary sector services where suitable.

5.8 The ICN’s have now seen around 700 patients through the pathway with a number of patients benefiting from onward referrals on to Age UK for additional support, we are currently working through the data to get a break down of those patients who required a referral to social care post MDT and those that had a change to their care package.

5.9 While it is too soon to assess the full impact of the pathway there have already been positive case studies.

5.10 The following two case studies illustrate examples of positive outcomes, including a reduction in the number of emergency contacts.

Case Study 1: "SG"

"SG" is a 59 year old male known to the community mental health team. He has had a series of emergency calls to 111 and visits to the PRUH Emergency Department. A visit to the patient showed that home hygiene is compromised, he is struggling to survive on benefits and his home was cold through lack of heating.

Advice was given on benefits and the need to maintain provisions e.g. buy non-perishable items. Contact was made with a food bank to provide assistance, EDF energy to place credit on his meter and credit was added to his Oyster card to enable him to travel to planned medical appointments.

In the six weeks before the MDT intervention, SG had called 111 on 16 occasions and visiting A&E 4 times. Six weeks after there have been no emergency contacts.

Case Study 2: "CS"

"CS" is a 74 year old female currently receiving reablement following an inpatient episode. She lives alone in an upper floor flat. Her carer is a friend but she doesn't live nearby.

She has a complex history of severe COPD (known to Community Respiratory team), Ischemic Heart Disease and confusion. Oxygen was prescribed but later removed on safety grounds. In the last two years she has had an acute myocardial infarction and breast cancer. She will not accept support with personal care, is non-compliant with medication and refuses to attend a memory clinic.

Actions include memory assessment, establishment of power of attorney with next of kin, a social care package following reablement, review from Medicine Optimisation Service, and oxygen re-established following disconnection of unused gas cooker. Bromley Care Coordination are now providing support.

Medicine compliance is now greatly improved resulting in a reduction in calls to primary care. Measures are now in place to prevent secondary care admission.

5.11 Some patients, particularly those who are older and frail, may need to have some hospital inpatient care, so the CCG has also invested in two new community wards at Orpington Hospital. The aim of the inpatient element of care is to provide short-term hospital care for frail patients who either need an assessment and a little bit more help so they can get back to independent living, or who have been in the Princess Royal University Hospital (PRUH) and need additional support to help prepare them to leave hospital.

5.12 A dashboard is being finalised to monitor patient activity before and after the patient enters the Proactive Pathway and it will be monitored via the ICN steering group. An independent quantitative and qualitative evaluation of the ICN Proactive Pathway has also been commissioned and should be finalised during September.

5.13 The next workstreams that have been agreed by the ICN Board are :

- Care Homes
- Urgent Care Admissions for People at End of Life
- Integrated Discharge (Therapies)
- Integrated Heart Failure service

5.14 The focus for 2017-18 will be the complete mobilisation of Proactive and Frailty pathways and to continue to monitor progress in order to improve with the overall aim of embedding into business as usual.

5.15 A key enabler to the ICNs progress to date has been the current Memorandum of Understanding (MOU) put in place with system providers. The MOU runs until September 2017, as such, an Alliance contract is currently being drafted with the aim of moving even further with strengthening integrated working across the system. This is being discussed through the summer with the aim of having it in place for the Autumn/Winter.

5.16 The Alliance Agreement (AA) helps to build on the current MOU and aims to help the system move forward to a potential Accountable Care System in the future. If the AA is delayed, an extension to the MOU will be put in place to mitigate any potential gap.

Figure 5: Current ICN Governance Structure

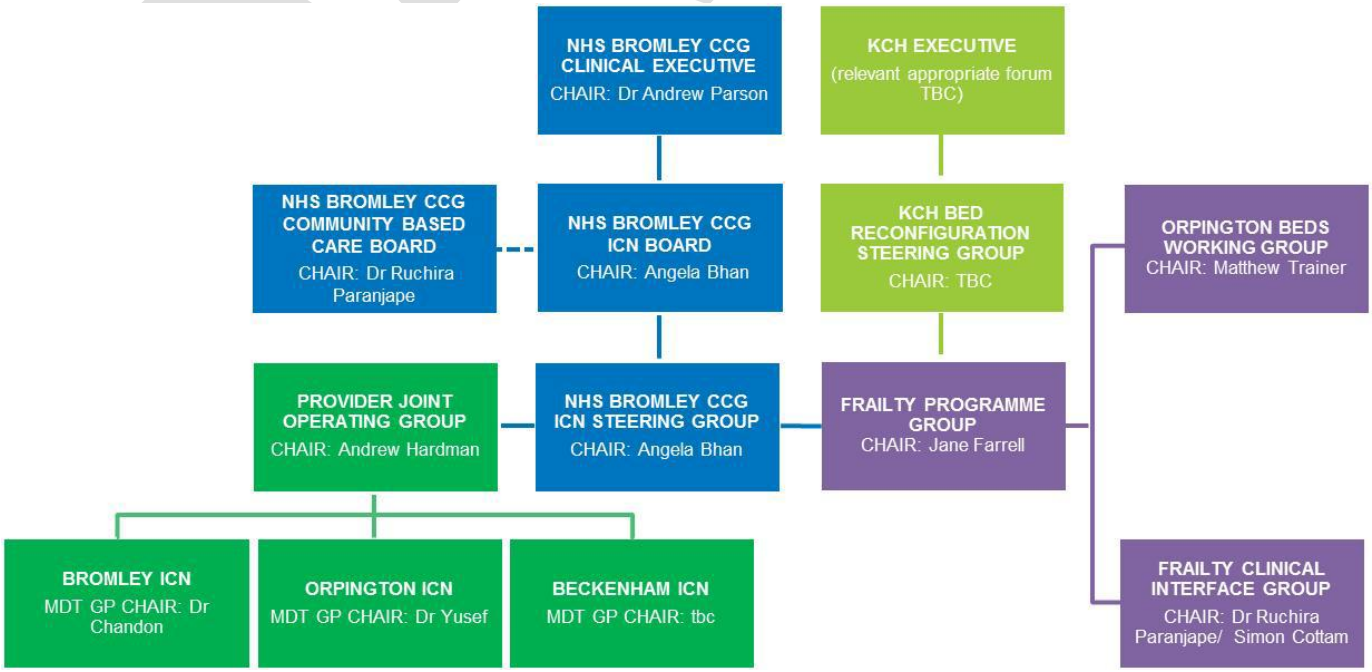
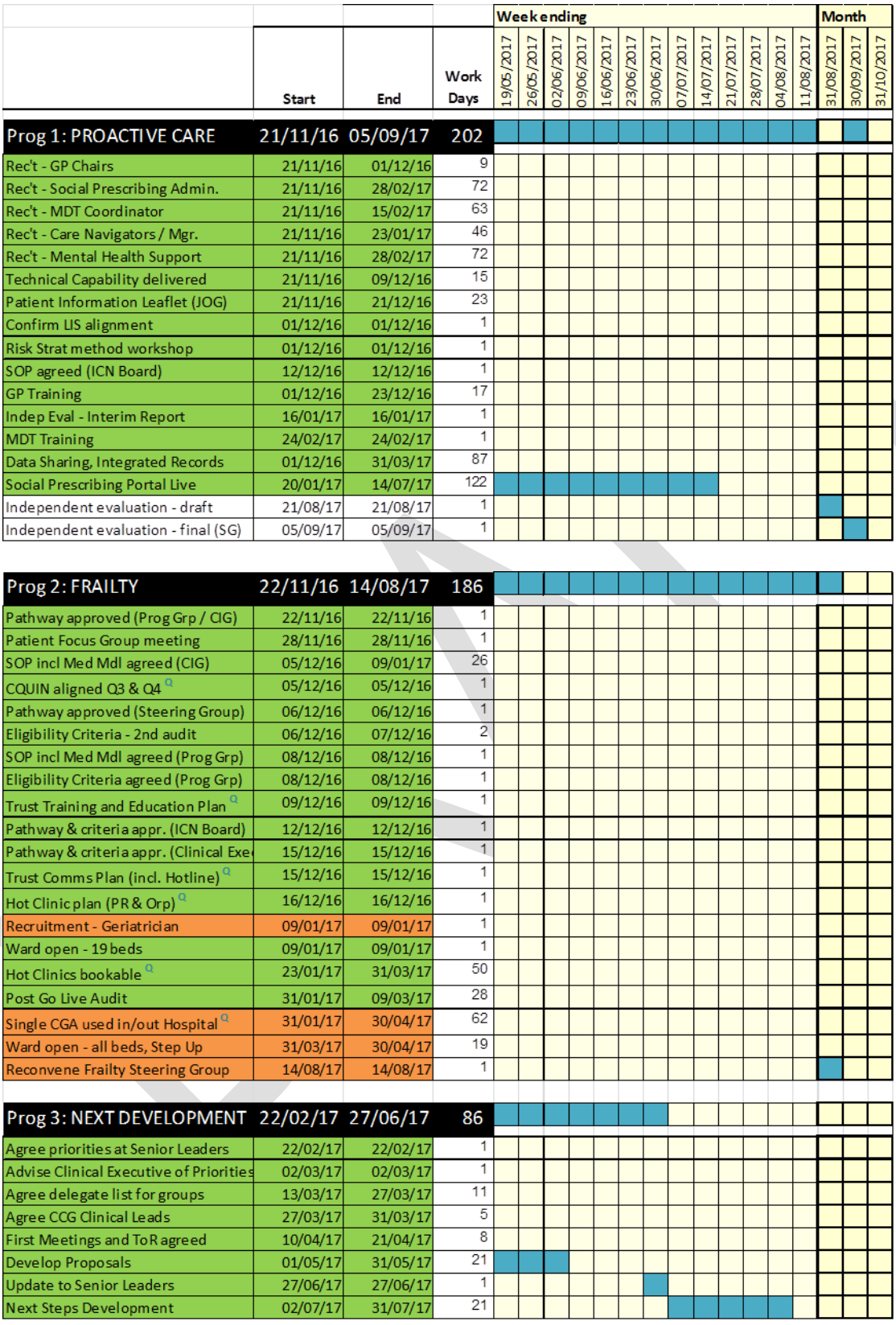


Figure 6: High Level Programme Plan for 2017



	Start	End	Work Days
Prog 1: PROACTIVE CARE	**21/11/16**	**05/09/17**	**202**
Rec't - GP Chairs	21/11/16	01/12/16	9
Rec't - Social Prescribing Admin.	21/11/16	28/02/17	72
Rec't - MDT Coordinator	21/11/16	15/02/17	63
Rec't - Care Navigators / Mgr.	21/11/16	23/01/17	46
Rec't - Mental Health Support	21/11/16	28/02/17	72
Technical Capability delivered	21/11/16	09/12/16	15
Patient Information Leaflet (JOG)	21/11/16	21/12/16	23
Confirm LIS alignment	01/12/16	01/12/16	1
Risk Strat method workshop	01/12/16	01/12/16	1
SOP agreed (ICN Board)	12/12/16	12/12/16	1
GP Training	01/12/16	23/12/16	17
Indep Eval - Interim Report	16/01/17	16/01/17	1
MDT Training	24/02/17	24/02/17	1
Data Sharing, Integrated Records	01/12/16	31/03/17	87
Social Prescribing Portal Live	20/01/17	14/07/17	122
Independent evaluation - draft	21/08/17	21/08/17	1
Independent evaluation - final (SG)	05/09/17	05/09/17	1
Prog 2: FRAILTY	**22/11/16**	**14/08/17**	**186**
Pathway approved (Prog Grp / CIG)	22/11/16	22/11/16	1
Patient Focus Group meeting	28/11/16	28/11/16	1
SOP incl Med Mdl agreed (CIG)	05/12/16	09/01/17	26
CQUIN aligned Q3 & Q4 [Q]	05/12/16	05/12/16	1
Pathway approved (Steering Group)	06/12/16	06/12/16	1
Eligibility Criteria - 2nd audit	06/12/16	07/12/16	2
SOP incl Med Mdl agreed (Prog Grp)	08/12/16	08/12/16	1
Eligibility Criteria agreed (Prog Grp)	08/12/16	08/12/16	1
Trust Training and Education Plan [Q]	09/12/16	09/12/16	1
Pathway & criteria appr. (ICN Board)	12/12/16	12/12/16	1
Pathway & criteria appr. (Clinical Exe	15/12/16	15/12/16	1
Trust Comms Plan (incl. Hotline) [Q]	15/12/16	15/12/16	1
Hot Clinic plan (PR & Orp) [Q]	16/12/16	16/12/16	1
Recruitment - Geriatrician	09/01/17	09/01/17	1
Ward open - 19 beds	09/01/17	09/01/17	1
Hot Clinics bookable [Q]	23/01/17	31/03/17	50
Post Go Live Audit	31/01/17	09/03/17	28
Single CGA used in/out Hospital [Q]	31/01/17	30/04/17	62
Ward open - all beds, Step Up	31/03/17	30/04/17	19
Reconvene Frailty Steering Group	14/08/17	14/08/17	1
Prog 3: NEXT DEVELOPMENT	**22/02/17**	**27/06/17**	**86**
Agree priorities at Senior Leaders	22/02/17	22/02/17	1
Advise Clinical Executive of Priorities	02/03/17	02/03/17	1
Agree delegate list for groups	13/03/17	27/03/17	11
Agree CCG Clinical Leads	27/03/17	31/03/17	5
First Meetings and ToR agreed	10/04/17	21/04/17	8
Develop Proposals	01/05/17	31/05/17	21
Update to Senior Leaders	27/06/17	27/06/17	1
Next Steps Development	02/07/17	31/07/17	21

Community Health Services

5.16 The ambitious and extensive process to re-procure BCGG's community health services contract which ends in November 2017 has involved developing innovative models of integrated community-based care that meet the needs of a growing population, many of whom have complex health needs; testing these models with local people, and agreeing who will provide these services.

5.17 The tender has included Children's Community Services, Adult Community Based Services and Integrated Rapid Response and Transfer of Care Services and also the joint commissioning of a number of Social Care services including Reablement and Intermediate Care.

5.18 By aligning social care services as part of the wider community health contract it has been possible to procure a holistic service that offers residents a seamless approach to care in the community and an integrated approach to working across the various hospital discharge pathways.

Primary and Secondary Intervention Services

5.19 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. The newly formed Bromley Third 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.

5.20 The proposal to create a Primary and Secondary Intervention fund within the Better Care Fund for the provision of primary and secondary intervention services was jointly approved in September 2016. The joint strategy set out a framework through which to design a set of Third Sector services that support people in the community to maintain their independence and delay and prevent the need for high cost care packages and early admissions to care homes and/or hospital.

5.21 The procurement process commenced in November 2016 and the contract award recommended for the Primary and Secondary Intervention Services in July 2017. The new services are due to mobilise from 1st October 2017.

5.22 The Primary and Secondary Intervention services will provide the following eight services:

- ✓ Carers Support Services
- ✓ Services to Elderly Frail
- ✓ Services for Adults with Long Term Health Conditions
- ✓ Services for Adults with Physical Disabilities
- ✓ Services for Adults with Learning Disabilities
- ✓ Mental Health Support Services
- ✓ Single Point of Access
- ✓ Support to the Sector

5.23 The services will deliver a cohesive set of targeted preventative services where the impact can be evidence and measured by tracking service users through the NHS number. The outcomes of the new services will be:

- ✓ To reduce the requirement for unplanned care and resulting emergency admissions
- ✓ To prevent and delay the requirement for long term care packages
- ✓ To support residents to remain independent in their local communities
- ✓ To build capacity in local communities by demonstrating economic impact and leveraging in further funding from other sources
- ✓ To leverage in further external funding to the sector
- ✓ To shape local services to facilitate social benefit to service users creating added value

5.24 The services are universal but are targeted at vulnerable groups. The services sit in front of eligible services and manage demand to reduce increasing demographic pressure on social care and health services.

5.25 The services will work within a larger system in order to provide effective Primary and Secondary Intervention for Bromley residents. The BCCG Out of Hospital Transformation Strategy outlines the creation of an integrated and sustainable programme to keep people within their community, primarily through the work of the ICNs. The Primary and Secondary Intervention Services link with the Care Navigator role which is a fundamental part of the ICN development. The navigators will signpost residents to the appropriate channels for support, including these services, thereby avoiding more formal interventions from social care and health.

5.26 A percentage of the total funding envelope will be kept as an innovation fund. This is to encourage innovation within the service and respond to any changing or developing needs for service users. This will promote sustainability and allow flexibility within the service provision.

5.27 Whilst the funding at this stage is primarily focused on adult's preventative services in line with the ICNs, there is nothing to preclude utilising this model if it proves successful to support wider preventative agendas. It could also be used to support public health preventative activities where these providers may be suitable to deliver their programmes.

Dementia Hub

5.28 The Dementia Hub was commissioned to establish a clear pathway for people with dementia and their carers following diagnosis. The service supports people in the early stages to ensure that support planning is in place, which will allow people to remain independent for as long as possible and delay or prevent the need for social care or health crisis as far as possible.

5.29 The service was tendered in February 2016 and went live in October 2016. It is provided by a partnership of organisations: Bromley and Lewisham Mind, Age UK Bromley and Greenwich, Oxleas NHS Foundation Trust and Carers Bromley. This collegiate approach provides a wraparound service for people who are diagnosed with dementia, their families and their friends.

5.30 This is particularly important as Bromley's ageing population means that the level of people suffering from dementia in the borough is higher than any other London borough.

5.31 Whilst there were existing services established, there was no clear pathway and finding out about these services was challenging for many people. This service provides 'a one stop shop' in terms of information, advice, support and planning for both the service user and the carer.

5.32 This is primarily encouraged through a direct route from the Memory Clinic. Anyone who is diagnosed with dementia at the Memory Clinic is signposted to the Dementia Hub for support. This means that people diagnosed with dementia have support in the community that is quickly and clearly communicated by clinicians.

5.33 People are also encouraged to self-refer to the Hub. This is predominantly used by people who were diagnosed before the Hub was in place, or for people who have had a worsening in their condition since diagnosis and may need more ongoing support than their initial engagement with the Hub.

5.34 Anyone diagnosed with dementia can be visited in their own home to plan support around their needs and receive information about dementia, their rights and local services. Everyone is treated individually and provided with information and support that is right for them.

5.35 Families and friends caring for a person with dementia can benefit from information, training and workshops to learn about dementia. Local activity and support groups are available for people with dementia and their carers to meet other local people with similar experiences of dementia. Personalised coaching in the home is also available for individual carers and family groups. This ensures that carers are better equipped to offer support and help manage changing dementia care needs, as they plan for the future.

5.36 The Bromley Dementia Support Hub volunteer befrienders are available to provide companionship, support to carry out everyday activities in the home and local community, help for people to stay active and give family carers a break from caring. It is crucial that whilst living with dementia, people are not isolated.

5.37 Since going live in October 2016 the number of cases allocated to a dementia advisor has increased with 43% of referrals being allocated in the first quarter 2017/18 compared to an average of 31% across 2016/17 and positive outcomes are being achieved.

5.38 The case studies provide examples of positive outcomes for both a carer of a person with dementia and a person diagnosed with dementia.

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Case Study 1:

Number of contacts
6 telephone calls
1 letter
2 office visits
Length of engagement: From 16th March 2017 – case still open

Outcomes:
• Carer attended Family Carers Information workshops for carers of a person with a dementia. This helped to enhance her knowledge and understanding of Dementia and to find out about the help and support available in the community.
• Carer is now attending the Carers Coffee Morning at Carers Bromley which provides a space for her to meet other carers, have discussions with other carers in similar situations and alleviate some of the isolation she was experiencing.
• Carer received emotional support and was given the opportunity to be listened to and discuss her caring role and the effect on her.
• Carer is now aware of the support available to her and receives the Carer Bromley newsletters.
• Carer was assisted in contacting Bromley Council Tax services regarding her husband's council tax discount.

Case Study 2:

Number of contacts
7 phone calls
1 home visit
2 personal contacts at a dementia café
Length of engagement: From 6.02.2017 – case still open

Outcomes:
• M. now able to bathe safely and potential injury accident, from faulty bath lift prevented.
• Social Services now engaged with client, exploring options to make stair lift safer.
• M. now has access to chiropody which both improves her mobility and her wellbeing.
• M. now has access to financial support around taxis
• M. and her family are currently considering information sent around meals and reading and health and welfare power of attorney.

5.38 The Better Care Fund supported the development of the Dementia Hub through aligning the CCG and Council's priorities around dementia diagnosis and support. This is evident through the unique clinical and third sector partnership that provides the services.

5.39 The success of the hub has led to more early intervention and prevention services being jointly commissioned using the Better Care Fund, which are due to go live in October 2017

Care Homes

5.40 The Bromley Joint Strategic Needs Assessment 2015 gave an in depth analysis of people in care homes identifying that people in care homes are more likely than the general population over the age of 65 years to have two or more comorbidities. Extra care housing residents tend to have a higher number of comorbidities than the care home residents, but care home residents are more likely to suffer from dementia, and to have mobility problems than the extra care housing residents.

5.41 The care home population present a more complex healthcare challenge. Compared with the over 65 population as a whole, care home residents are far more likely to have a diagnosis of dementia or stroke, and overall more likely to be suffering from heart disease, kidney disease, cancer or diabetes.

5.40 Our primary goal is to support people in their own home for as long as possible. If this is no longer viable, it is important to ensure that the best possible care within the allocated resources is provided to those in residential settings.

5.41 Bromley has 67 Care Homes, 18 nursing, 45 residential and 4 mixed and 6 Extra Care Housing schemes. There are approximately 829 nursing home residents, 971 residential home residents and 285 extra care home residents.

5.42 Bromley is keen to develop stronger oversight of Care Homes and the development of shared priorities is important to ensure that this happens.

5.45 The outcomes for improving the joint oversight and work with care homes are:

- Ensuring higher quality of care for care home residents
- Reducing hospital admissions and delayed transfers of care
- Supporting independence for vulnerable residents
- Creating a sustainable and diverse care home economy in Bromley

5.46 *Table 1* summarises Bromley's care home projects currently in progress.

Table 1

Workstream	Owner	Status	By
Care home strategy	LBB and CCG	A joint care home strategy is being developed to provide the strategic focus and vision statement for LBB and the CCG's work with care homes going forward.	Oct-17
Discharge to assess pilot	LBB and CCG	A range of discharge to assess beds are being procured over the winter period to reduce delayed transfers of care. The beds will be supported by increased community care support.	Oct-17
Shared monitoring information	LBB and CCG	The Continuing Healthcare and LBB contract monitoring team are developing a shared quality assessment framework to provide stronger oversight of the quality of care in care homes.	Sept-17
Block nursing beds procurement	LBB	LBB is procuring a new block nursing beds contract. This aims to increase the number of providers who have block contracts with LBB and ensure continued provision for social care funded residents.	Jan-18
Red bag implementation	CCG	The CCG is rolling out the hospital discharge bag to all care homes. This will improve communication with the hospital and reduce the length of hospital stays.	Apr-18
VMO support to care homes	CCG	The CCG is procuring a new model of GP support to care homes to ensure a parity of care from primary care providers.	Apr-18
MDT support to care homes	CCG	The CCG is expanding the new ICN model of care in Bromley to provide additional and targeted support to care homes. This will improve the health of residents in care homes and prevent unnecessary hospital admissions.	Jul-18

Children's Services

5.47 The joint partnership is now in year three of the Five Year Forward View for Mental Health and Future in Mind and the local emotional wellbeing and mental health plans have resulted in additional resources being allocated across the referral and care pathways. The additional resource has been focused, to date, on adding capacity in the system. There has been a significant uplift in the number of referrals entering the system as a result of the new Single Point of Access model.

5.48 CCG investments, via the Better Care Fund, have been allocated to support the capacity issues in the single point of access, early intervention service. In addition, the CAMHs Transformation Plan investments have resulted in the early intervention being able to offer longer and more intense interventions for those young people with a need greater than can be met through early intervention, but whose needs are not such as to require specialist mental health provision.

5.49 Investment in a co-production programme to lead on the emotional wellbeing and mental health system and service transformation aims to involve communities, voluntary sector, providers and health and local authority commissioners in developing a transformed model of care to support the aims of keeping well and improving accessibility to the right service in the right place at the right time.

5.50 A joint programme to improve access to physical and mental health services for young offenders has recently been set up by the CCG and Bromley's Youth Offending service. Investments have been made to co-locate early intervention services at the front door and this will be supported by access to physical health services and specialist forensic CAMHs available through the YOS.

5.51 LB Bromley and CCG are also leading a programme to develop the joint funding protocols, policies and procedures for complex cases and out of area placements. The development of joint funding and commissioning approaches will allow for improved oversight on outcomes for children and young people placed out of Borough as well as identifying opportunities to repatriate children and young people closer to home where clinically appropriate.

5.52 Supported by partners and providers, and as a result of the community health contract re-procurement, the CCG will commission a single access point/no wrong door policy so that any young person needing physical, mental or emotional health care can go to one place for the care they need. It is anticipated that as a result of this approach along with the community health contract re-procurement that there will be a reduction in the number of presentations to A&E by children and young people with fewer admissions and when admitted, the length of stay will be reduced.

5.53 Work is also in progress with providers and the voluntary sector to implement best practice care and treatment for asthma, epilepsy, ADHD and diabetes using modelling from across the London area and aligning the referral and care pathways with Health London Partnership guidance on standards and transformation of out of hospital care.

5.54 The CCG has initiated the development of a personal health budget offer for young people with long term conditions to provide greater flexibility and control over their care. The vision is that this initiative will align with local authority personal budget policies and procedures to facilitate seamless provision and improved service experience by children, young people and their families.

Local Change Programme 2 – Discharge Team

5.55 In 2015 partners from across the system came together to co-produce a response to the increasing number of patients with complex health and social care needs that required support to be discharged from the PRUH in a safe and timely way.

5.56 There have been many successes since the implementation of the Transfer of Care Bureau (ToCB) in October 2015 including;

- ✓ Key organisations and professionals have been brought together to work from a single place within the PRUH with additional GP, Continuing Health Care and out of borough capacity creating a specialist discharge function and single point of access to community services.

- ✓ Delayed Transfer of Care (DTOC) reduced significantly and patients are being transferred in a more timely way.

5.57 The ToCB, with single oversight of all complex discharges, provided a fresh insight into systemic challenges and issues in the transfer of patient care and identified growing areas of unmet demand across the system. As a result several out of hospital pathways have been streamlined and a major procurement of community health services has been undertaken to ensure a robust community infrastructure that is responsive to the changing needs in secondary care.

5.58 The new contract will be fully mobilised from December 2017 and brings together rehab (home, bed and neuro) and reablement alongside hospital in-reach and rapid response services accessed through a single point of access in the community. Rapid access to packages of care within 12 hours by care managers (and earlier when necessary), equipment delivered within 4 hours with major adaptations within 24 hours is now available with ring fenced step down accommodation available via the ToCB to support more timely discharge from hospital.

5.59 End of life pathways have been strengthened through proactive in-reach to identify and pull patients out of hospital and provide responsive, home based care and support for those in the last 12 months of life. Early outcomes from this work are showing a reducing in length of stay post medical optimisation from eight days to 1 day, reduction of readmissions and less people dying in hospital unnecessarily.

5.60 In addition further improvements across the acute hospital including the introduction of the SAFER bundle, fully functioning Multi Disciplinary Team (MDT) Board rounds and dedicated discharge transformation programme is continuing to improve patient flow and have a positive impact on reducing delayed transfer of care. The ToCB are fully integrated within MDT Board rounds at the front and back end of the hospital ensuring discharge planning commences from the point of admission.

5.61 Further work to strengthen hospital diversion is planned from September 2017 building on the success of discharge co-ordinators, a GP and care managers in front end departments. The co-ordinated team which will also benefit from a Community Matron and frailty nurse will work much earlier in the patient journey to ensure more people who do not require an acute intervention are diverted away from urgent and unplanned care and back to the community. MRT continues to provide a rapid response to those in crisis at home preventing the need for hospital attendance and possible admission.

5.62 The recruitment of a joint appointed Discharge Commissioner with responsibility for CCG and LA commissioning activity is showing positive results in developing co-ordinated, integrated out of hospital pathways that support both health and social care outcomes. The post has oversight of the whole hospital to home pathway to address potential blockages and ensuring on-going patient flow.

5.63 The post, alongside the solid foundations provided by transformation work to date will be key enablers to implementing the Eight High Impact Changes to further improve performance around delayed transfer of care.

6. Delivering Integrated Care – Future Direction

6.1 Bromley recognises the need to address the national conditions that come with Better Care Funding and is committed to utilise the fund to make longer term systematic changes to the overall structure of the health and care economy in the borough.

6.2 Our focus over the next 2 years is to further develop and embed our local integrated care networks as outlined in Section 5 above and to continue to implement our joint programmes with the aim of keeping people independent in their own homes where appropriate, thereby reducing the need for residential care and hospital admissions. Ensuring that we are maximising opportunities with the Third sector will be crucial.

6.3 Whilst Bromley has not put our local area forward for consideration for the first wave of BCF graduation, we are committed to working together towards a greater level of integration and we will continue to prepare for submission in a later wave.

6.4 To support this commitment we have already a number of joint funded posts in place and have recently agreed to appoint a joint Director of Integration to provide a key role for transformational change and to drive the delivery of key operational integration projects. We aim to have an interim post holder in place by mid-September.

6.5 Discussions are also progressing with regards to furthering joint working opportunities for example joint working with the Integrated Commissioning Unit.

6.6 Whilst many of the programmes will be long term for example the ICNs and the Transfer of Care, additional shorter term commissioning projects will evolve resulting in opportunities to explore the more efficient use of resources and the improved effectiveness of services.

7. Better Care Fund Plan 2017/19

7.1 Our BCF plan for 2017-19 continues to be aligned with the new model of providing services, with funding to underpin the wider objectives to move care from an acute setting into the community.

7.2 *Table 2* below provides a summary of the BCF schemes for 2017-19.

Table 2. BCF Schemes and Funding for 2017-19

Commissioner	Scheme Name	2017/18 budget £'000	2018/19 budget £'000
LBB	Reablement Capacity	853	870
CCG	Winter Pressures Discharge (CCG)	646	659
LBB	Winter Pressures Discharge (LBB)	1,027	1,048
CCG	Integrated Care Record	433	441
CCG	Intermediate Care Cost Pressure	625	638
LBB	Community Equipment Cost Pressure	422	431
LBB	Dementia Universal Support Service	520	531
CCG	Dementia Diagnosis	620	632
LBB	Extra Care Housing Cost Pressure	418	427
CCG	Health Support into Care Homes/ECH	314	320
CCG	Self Management and Early Intervention (inc. Vol sector)	1,047	1,068
CCG	Carers Support - New Strategy	633	646
CCG	Risk against acute performance	1,347	1,374
CCG	Transfer of Care Bureau	611	623
LBB	Protection Social Care	8,977	9,156
LBB	Disabled Facilities Grants - CAPITAL	1,838	1,976
CCG	Carers Funding	527	538
CCG	Reablement Funds	952	971
LBB	Reablement Funds	315	321
	Total Recurrent Budget	**22,125**	**22,670**

7.3 Current and planned performance against metrics is provided within the BCF plan excel spreadsheet submitted alongside this narrative.

8. National Conditions

CONDITION 1: Plans to be jointly agreed

8.1 Members of the Joint Integrated Commissioning Executive (JICE) continue to meet monthly to discuss and oversee integrated working and the Better Care Fund remains a standing item on the agenda. Officers from Bromley CCG and the Local Authority continue 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.

8.2 Plans, considered and drafted through JICE are then presented to the Health and Social Care Integration Governance Board (HSCIGB) 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 10). 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.

8.3 **Disabled Facilities Grant** meetings between Housing and Social Services and the PRU hospital Discharge Bureau were held in February 2016 to identify how DFG funding could be used to improve health and wellbeing, reduce hospital admissions and keep residents safely in their own home. The principles were shared and discussed with the CCG through the JICE and then taken through each organisation's governance structures.

8.4 The following items have been implemented

- A Rapid Hospital Discharge bed moving service is in place and allows hospital staff to request works in the home to facilitate a timely discharge. Consideration is also being given to follow up works to reduce re-admissions e.g. minor works or repairs that put clients at risk and move beds back upstairs following reablement. Extending the scheme to allow access to prescription system for minor works to improve health and safety in the home accessible to Care Managers, OTs, GPs and District Nurses, Wheelchair Service and Carers is due to be trialled in phases.

- The Specialist Housing OT post in the Housing and Homelessness teams to link properties to the right disabled client has been trialled and is now confirmed as a full time post. This role includes matching clients to suitable properties, increasing and maintaining the stock of adapted properties in the social rented sector and advising on adaptations to provide sustainable and effective housing for long term use.

- An assessment of the current mandatory DFG process to identify blockages for major adaptations. This included an assessment of our DFG process by Foundations, the Government funded national body who oversee Home Improvement Agencies. As a result a fast track route is being trialled, the inclusion of an OT in the Home Improvement Agency and using a schedule of rates instead of a tender process are also being considered.

- Provision of fire misting systems and of fire retardant bedding for high risk clients unable to escape unaided in the event of a fire.

8.5 The following items are under active consideration.

- Assistance with removal and relocation costs to help move clients to more suitable accommodation where a property cannot be appropriately adapted

- The use of discretionary grants for both adaptations and repairs (to deal with issues that put the client at risk) with minimal bureaucracy with consideration to remove the means test for works under £5000. The proposals are aimed at supporting works to prevent admissions or readmissions, to assist with accident prevention and to assist with the care of terminally ill patients. Proposals to accept direct referrals from a number of health care professionals are to be considered. Potentially charges will be recorded as a local land charge to assist with the recycling of funding.

- The introduction of grant funded rapid adaptations linked to and necessary for emergency housing provision to allow properties to be adapted in a timely fashion and keep clients close to their support network.

- Payment of client's contribution for mandatory grant, where hardship can be shown.

- Grants to remove adaptations and make good in private rented sector properties where the landlord would otherwise refuse permission for works to be carried out.

- To record NHS numbers on all grant applications in a searchable format, subject to clarification as to how this will be used to make the change appropriate.

- Housing Improvement team staff to be trained as trusted assessors and employment of an Occupational Therapist to work solely an adaptation work within the team.

- The annual payment of service agreements for lifting and hoisting equipment for safety and longevity reasons.

CONDITION 2: NHS contribution to social care is maintained in line with inflation

8.7 A considerable percentage of the fund has been set aside again in 2017/18 and for 2018/19 for the direct provision of social care.

8.8 Existing grants included in the fund that were originally from social care continue to be protected and are still fully accessible to social care services e.g. DoH Social Care Grant £4.49m.

8.9 Since the commencement of the BCF, the NHS contribution to social care has been increased in line with inflation as set out by NHS England. For 2017/18, this uplift was 1.8% as per the CCG allocation notifications.

CONDITION 3: Agreement to invest in the NHS commissioned out of hospital services

8.10 In Bromley this requirement equates to £5.76m of the total fund. As the BCF plan (excel spreadsheet) demonstrates Bromley have exceeded that target with the CCG directly responsible for commissioning £6.41m of the fund.

8.11 The BCF plan for 2017-19 will continue direct investment in the following specific NHS commissioned out of hospital services.

- ✓ Winter pressures funding
- ✓ Dementia diagnosis and support
- ✓ Community equipment
- ✓ Intermediate care
- ✓ Health support into care homes
- ✓ Discharge team

CONDITION 4: Implementation of the High Impact Change Model

8.12 There has been significant work across the local system to align, develop and co-produce local plans to fully implement the eight High Impact Changes (HICs). Overseen by the A&E Delivery Board, plans look to build upon solid foundations already in place locally and to provide significant investment in order to establish and fully mobilise all eight changes.

8.13 Early Discharge Planning (HIC 1) is in place for planned procedures and all unplanned admissions are allocated an expected date of discharge from point of admission. Further work to ensure Expected Discharge Dates (EDDs) are challenging and appropriate and led by clinical optimisation is underway at the PRUH.

8.14 Implementation of the SAFER Bundle initiative has started with a programme of activity to identify, review and improve red/green days across the hospital by the senior management team (SMT) including twice weekly scrutiny of all patients with a current or imminent EDD and those Medical Stable For Transfer (line by line) as well as regular SMT and site management team input into Board Rounds to drive SAFER Bundle implementation. The multimillion pound IT investment programme due to be rolled out across the PRUH will provide robust systems to monitor patient flow (HIC 2) and allow demand and flow issues to be proactively managed.

8.15 The Transfer of Care Bureau (ToCB) is a well-established multidisciplinary discharge team (HIC 3) with further worked planned to enhance the role of the voluntary and community sector through the BCF funded Primary and Secondary Intervention Support Services (PSIS) including the Age UK ‘Meet and Greet Service’ which enables patients, without carers or family, to be transferred home safely.

8.16 Bromley’s philosophy is that ‘home is best’ and should be the first consideration for all hospital discharge with a range of commissioning activity to support this. For example the joint commissioning of community health services including rapid response, rehabilitation and reablement into a single point of access will provide more responsive community infrastructure to meet the needs of patients leaving the acute hospital and support more people to return home sooner for their long term care and support needs to be assessed.

8.17 The Trusted assessor model which is used for health professionals at the front end of the hospital to restart packages of care is being rolled out to the back end of the hospital for patients whose care and support needs have not changed. In addition trusted assessor is being used to maximise the impact of ward based multi-disciplinary teams including rehab pathways to improve patient flow and continuity of care into the community.

8.18 Seven day working (HIC 5) is in place across the hospital with community health providers providing full services seven days per week. A reduced ToCB offer is available at the weekend and further work is required to ensure agencies are able to start and re-start packages of care, as well as access placements during evenings and weekends.

8.19 Recent implementation of trusted assessor (HIC 6) for acute therapists to access community rehab services and the roll out of restart of packages of care by any allied health professional is recuing unnecessary waste it in the system and improving timely patient transfer ensuring patients are in the right place, at the right time to meet their needs.

8.20 A localised discharge leaflet has been developed and is provided to all patients admitted to the hospital. A robust Choice protocol (HIC 7), shared across the local Acute Trusts, is in place with a fair and transparent escalation process. Patient and family engagement is done early to ensure individuals have the opportunity to fully consider their option while also ensuring a timely discharge form hospital. Care Home Select are commissioned via Kings Collage Hospital Trust to provide support, advice and guidance to self funders and are successful in brokering packages of care and placements in a timely way for this cohort of patients.

8.21 The red bag scheme has been rolled out across the whole of the borough to improve patient journey from care home to hospital and back again. Additional services are commissioned to support care homes including end of life care, Mobile Response Team (MRT) crisis response service and a Visiting Medical Officer (VMO) model. Further work to align existing activity to Enhanced Health in Care Homes (HIC 8) Guidance is underway with a Joint Care Home Strategy in development to provide a single vision and co-ordination of health and local authority resources to ensure a thriving and quality placement economy locally.

8.22 Going forward there are robust plans to further ensure all High Impact changes are realised fully locally. (See Section 13 – High Impact Change Areas).

9. Performance against the National Metrics

9.1 Bromley is responding to the national metrics within the BCF. *Figure 9* below sets out the planned position for 2017/18 and improvement targets for 2018/19.

Figure 9: Metrics for Bromley

Metric	2016/17	2017/18 Plan	2018/19 Plan	Comments
Non-elective admissions (General and Acute)	26,856	26,353	26,518	The plan seeks to support the reduction of emergency admissions and stem growth against the 2016/17 outturn position for Bromley.
Admissions to residential and care homes	432.2 (per 100,000 population)	425.0 (per 100,000 population)	425.0 (per 100,000 population)	Analysis of 2016/17 performance has been undertaken and Bromley plan to maintain robust performance against this measure in 2017-19 by maintaining people at home with domiciliary care where appropriate
Effectiveness of Reablement	89.3%	90.1%	90.1%	Analysis of 2016/17 performance has been undertaken and Bromley plan to further improve performance against this metric in 2017-19 by commissioning enhanced reablement services
Delayed transfers of care*	6,435	5,299	4,722	Historic performance analysis shows deterioration in performance against this metric over the last year. Bromley is planning to improve performance in the number of delayed days in 2017-19 and plans are in place to support this across the health and social care system predominantly driven by the further development of the Transfer of Care Bureau

9.2 Over the last year Bromley has seen a decrease in emergency admissions at the local acute hospital, with 661 fewer admissions in 2016/17 than in 2015/16. This is, in part, due

to a change in the coding of Ambulatory Care Unit activity. In 2015/16 this activity was recorded as emergency admissions and it is now coded as outpatient activity. A number of initiatives are in place across the health economy to support a reduction in avoidable emergency admissions.

9.3 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 2017-19. A significant level of investment is planned for 2017-19 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.

10. Bromley's BCF Funding Principles

10.1. Local areas are encouraged to place more than the minimum requirement into the fund, but initially Bromley will stay with the minimum allocation. Bromley 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 £22.125m

10.2 In summary 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.

10.3 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 2016/17.
- ✓ Those new additional revenue commitments that have come out of the BCF in 2016/17 are also protected for 2017/18.
- ✓ That any remaining uncommitted funds from 2016/17 are rolled over into the BCF for 2017/18 and used as one-off funds to 'pump prime' the system change required to deliver the local change programmes.
- ✓ 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.

10.4 The spending plan for the improved Better Care Fund (iBCF) funding for adult social care has been developed on the principle of investing the funding to create a sustainable adult social care system beyond 2020. The funding announced in November 2016 will be

invested in core social care services (£0m in 2017/18 and £2.014m in 2018/19). The additional IBCF announced in March 2017 (£4.184m in 2017/18 and £3.363m in 2018/19) will be invested in transformational projects that stabilise the social care market and support the High Impact Changes Model to reduce delayed discharges and reduce pressure on NHS services. It will also be invested in supporting and developing the provider market in the locality.

11. Funding Decisions and Risk Share

11.1 Refer to BCF planning template (tab 3) HWB Expenditure Plan detailing all schemes funded for 2017-19.

Care Act 2014

11.2 Total 2017/18 and 2018/19 funding is £0.6m relating to Support for Carers – New Strategy.

Reablement

11.3 Total 2017/18 funding is £2.118m and £2.161m for 2018/19

Carers breaks

11.4 Total 2017/18 and 2018/19 funding is £0.5m

Social Care

11.5 Total 2017/18 and 2018/19 funding is £9.0m. This consists of social care grant £4.5m and protecting social care £4.5m.

Improved Better Care Fund (iBCF)

11.6. It is confirmed that the IBCF will not be used to offset Minimum CCG contributions to the BCF. The IBCF will be invested in a number of schemes that are transformational and will ensure the sustainability of social care going forward.

11.6.1 In 2017/18 these investments will either be in pump priming revised services, dual running costs during pilots or other one off costs for schemes that support social care or reduce pressures on the NHS. Care has been taken in developing investment schemes for the IBCF that support the High Impact Changes Model. The relationship between the investment schemes and the High Impact Changes Model is summarised in *Table 3* below.

11.6.2 In addition a sum of money will be set aside to invest in an increase in residential nursing care in the Bromley locality.

Table 3. Investment schemes and the High Impact Change Model

IBCF Grant Condition	% of IBCF Invested in Grant Condition in 2017/18	Scheme Name	Supports High Impact Change Model
Meeting Adult Social Care Needs	62% (£2.599m)	Transformation of Social Care and Workforce Development	• 7 Day Services • Trusted Assessors • Focus on Choice
		Resources to Implement BCF and IBCF schemes	• Early Discharge Planning • Multi-disciplinary discharge Teams • Focus on Choice • Home First Discharge to Assess • Seven Day Services • Trusted assessors
		Transitioning from Children's Services to Adult Services	• Focus on Choice
		Public Health and Meeting Requirements of the JSNA	• Focus on Choice
		Investment in Additional Nursing Care facilities	• Enhancing health in Care Homes
Reducing Pressures on the NHS, including supporting more people to be discharged from hospital when ready	28% (£1.189m)	Placing Council Social Workers and Occupational Therapists into the Integrated Care Networks	• Early Discharge Planning • Multi-disciplinary discharge Teams
		Implementing Discharge to Assess in Extra Care Housing	• Home First / Discharge to Assess
Ensuring the Local Social Care Market is Supported	10% (£0.396m)	Investment in Mental Health Safeguarding	• Multi-disciplinary discharge Teams
		Investment in Increasing Uptake of Direct Payments	• Focus on Choice
		Developing and Supporting the wider provider marketplace	• Focus on Choice
		Investment into the 3rd Sector	• Focus on Choice
		Investment to Support Self Funders	• Focus on Choice

Risk Share

11.7 £1.347m has been allocated against risk share as advised in the BCF guidance to ensure some contingency to cover over performance in emergency admissions and not meeting the 1000 reduction to unplanned admissions. This is particularly important in Bromley as the planned reduction in emergency admissions was not delivered in 2016/17.

11.7.1 The contingency has been agreed and signed off by the CCG and the London Borough of Bromley and represents 27% of the risk. The outstanding £3.65m 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 2017/18 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.

11.7.2 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.

12. Programme Governance

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

12.2 The fund will be held by the Local Authority as in 2016/17 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.

12.3 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 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. Additional relevant information

Document or information title	Synopsis and links
Joint Strategic Needs Assessment 2016	https://bromley.mylifeportal.co.uk/media/20397/final-report-jsna-2016.pdf
HWB Strategy	HWB Strategy 2012-2015
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	Feedback on our 2016.17 Commissioni
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.pd
ICN operating model	ICN Operating Model - 15 December v1.ppt
High Impact Change Areas	201707 Hospitals to Home Response Deve