NOTE TO HEALTH AND WELLBEING BOARD: THIS IS A WORKING DRAFT CONTAINING A NUMBER OF OMISSIONS AND SOME TEXT THAT NEEDS TO BE UPDATED. SUCH INSTANCES ARE GENERALLY INDICATED IN THE TEXT.

Tower Hamlets Integration and Better Care Fund

Narrative Plan 2017-2019

Building on our history for a sustainable future

Local Authority	**LONDON BOROUGH OF TOWER HAMLETS**
Clinical Commissioning Groups	**NHS TOWER HAMLETS CCG**
Boundary Differences	**NA**
Date agreed at Health and Well-Being Board:	**05/09/2017**
Date submitted:	**11/09/2017**
BCF pooled budget: 2017/18	**c£45m**
BCF pooled budget: 2018/19	**£xxxxm**

Contents –

1. Introduction

Tower Hamlets CCG, the council and their partners share a vision of health and social care services as a single, interconnected system. This entails joint planning, joint commissioning, the alignment of front line health and social care services, more jointly managed services and more co-location of staff teams. It also involves working jointly to design services that address common priorities, such as relieving pressure on the hospital system, supporting people in the community wherever practicable, jointly designing services that address unmet need and ensuring that the health and social care system *as a whole* secures maximum value for money.

This Better Care Plan builds on our strong achievements to date, in which a number of key health and social care services have been more aligned and additional resources have been directed towards the achievement of joint goals - not least that of supporting people to leave hospital as soon as practicable and to remain in the community wherever possible, by providing a range of community-based services.

Under the oversight of Tower Hamlets' Health and Well-being Board, the period 2017-19 will see a step change in the degree of integration of health and social care services. This will cover both commissioning functions and operational delivery. Our ambition is reflected in the doubling of resources that we propose to pool within the section 75 agreement, relative to 2016-17. This funding will be performance managed via the Joint Commissioning Executive of the council and CCG, itself an innovation of the past year.

Over the coming period, we expect to continue to increase the proportion of resources that are pooled, and extend integrated working to new service areas. This will be underpinned by the development of a joint infrastructure, including a joint outcomes framework, the redesign of front-line services to encompass more co-location and the joint management of staff, and a shared focus on services for the whole course of life.

As elsewhere in the country, health and social care services in Tower Hamlets are working under considerable pressure. In Tower Hamlets, the population is rising rapidly, as is the number of people with complex needs, at a time when resources in the health system are broadly static and resources available to the council are declining significantly. These pressures mean that very different models of operation are required, along with changes in the manner in which care services are accessed. The development of a sustainable health and social care economy will also require substantial behavioural change among the residents of the borough, if future needs are to be met within foreseeable resource levels.

Section 2 of the plan summarises the local context. Section 3 sets out the borough's vision for health and social care integration and the approach being followed in more detail. Section 4 highlights the progress made to date. Section 5 summarises the evidence base and local priorities for integration. Section 6 summarises the schemes within the BCF plan. Section 7 summarises progress against the national conditions of the BCF, while Section 8 summarises the main funding contributions in more detail. Section 9 outlines the governance arrangements for the programme. Section 10 considers issues of risk. Section 11

addresses national metrics and Section 12 outlines the borough's approach to delayed transfers of care.

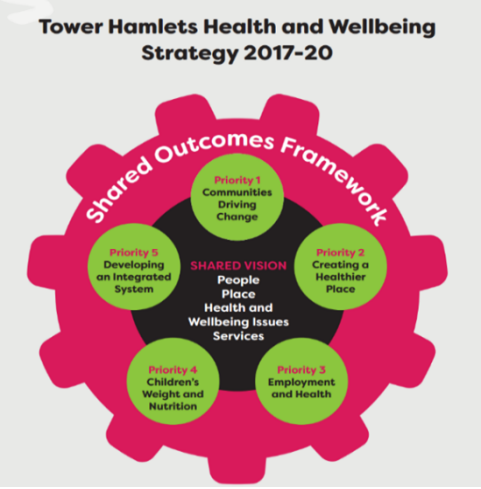
This plan was endorsed in draft by the Tower Hamlets Health and Well-Being Board on 5 September 2017 and the Tower Hamlets Together Board on 7 September 2017. These bodies include the senior representatives from the Council, the CCG, Barts Health, East London Foundation Trust, Tower Hamlets GP Care Group and the local voluntary sector.

2. Background and Context to the Plan

2.1 Our History is Important

We have a strong history of transforming health and social care in Tower Hamlets, and of primary care in particular. We are widely recognised as leaders in this area. We won CCG of the year in 2014 and have been awarded Pioneer and Vanguard status by central government. In 2017, Tower Hamlets CCG was rated 'outstanding' by NHS England. But most importantly, we have made a difference to people's health and care, and achieved better outcomes for patients who often are the most deprived, such as improved outcomes for people with diabetes, including reduced rates of unplanned hospital admissions.
We believe that a connected system of health and care organisations is good for the health of the population. Our overall vision for Tower Hamlets is to improve health and wellbeing through all stages of life (Health and Wellbeing Strategy: 2017-2020 Link Needs to be activated). We outlined our vision for integrated care across the borough more than a decade ago. The refreshed Health and Wellbeing Strategy: Towards a Healthier Tower Hamlets (2017-20) has five strategic priorities, one of which reaffirms the commitment to integration:

1. Communities Driving Change – changes led by and involving communities
2. Creating a Healthier Place – changes to our physical environment
3. Employment and Health - changes helping people with poor working conditions or who are unemployed
4. Children's Weight and Nutrition - changes helping children to have a healthy weight, encouraging healthy eating and promoting physical activity
5. Developing an Integrated System - changes which will join up services so they are easier to understand and access.



We have a history of working with other health, care and community partners to organise ourselves in a way that focusses on the needs of patients and the population and we continue to build on these foundations. This began with the formation of eight networks of GP practices in 2009 which later joined together to form the GP Care Group (GPCG). We then went on to form the Tower Hamlets Integrated Provider Partnership which, subsequent to receiving Vanguard funding, relaunched as Tower Hamlets Together, with a broader perspective. It is through this partnership we are really starting to see change happen, which will be picked up later in this plan.

2.2 Our population

Tower Hamlets has an estimated resident population of 304,900 people, with an unusually young age profile. This is the first time the area's population has exceeded 300,000 since before the Second World War. The borough's population has the fourth youngest median

age in the UK, at 30.6, and nearly half of our population is aged 20-39. Only 6% (18,000) of the population is over 65. (According to GLA projections, the population will rise from 297,800 in 2016 to 364,500 in 2026.) It is expected to be the fastest growing borough in London and one of the fastest growing local authorities in England over the next ten years.

Based on the census, 31% of the population is classified as White British and 32% Bangladeshi, though this distribution varies substantially across different age groups. The White British, White Irish and Black Caribbean populations in the borough have older age profiles compared to other groups, while residents from mixed ethnic groups, the Other Black group and the Bangladeshi group are all characterised by younger age profiles, with higher proportions of children. Over one third of the Bangladeshi population is children aged under 16, compared with only 9 per cent of White British residents. Conversely, only 5% of Bangladeshi residents are aged 60 or over, compared with 16 per cent of White British residents. Given the contrasting age profiles of the two largest populations, the ethnic makeup of the population varies significantly by age. The proportion of residents that are White British rises with age: 15% of the borough's children (aged under 16) are White British compared with almost two thirds (63%) of the population aged 75 and over. More than half of the borough's children are Bangladeshi.

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is shorter than the national averages (male life expectancy is 78.1 years and female life expectancy is 82.5).

Older adults are generally expected to have higher than average population growth. While residents aged 90+ are by far the smallest group in number, this group is expected to nearly double over the next decade, growing faster than any other. The population of residents in their forties, fifties, sixties, and seventies is also expected to grow faster than the average for all residents, increasing the pressure and demand on adult social care services.

Compared to London, when adjusted for age, Tower Hamlets has amongst the highest premature death rates for circulatory disease (103.3 per 100,000), cancer (150.9 per 100,000), and respiratory disease (40.4 per 100,000). These conditions typically constitute 75% of all premature deaths. Death rates vary across the borough and in general are higher in areas of higher deprivation.

Tower Hamlets has a higher rate of deaths that occur in a hospital, as opposed to other locations, (59%) than the national rate (47%). Around 1,000 Tower Hamlets residents die per year, of whom around 780 will need some form of last years of life care. Our aim is that care should focus on reversing/ stabilising or effectively managing deterioration in functional or health status, with palliative care as an integral component, in line with our shift of focus from palliative care to a wider Last Years of Life perspective.
Find out more from the Joint Strategic Needs Assessment here. Needs to be activated

2.3 Our Aims

Our principal aim for health and care services is of an integrated care system that coordinates care around the patient and delivers care in the most appropriate setting. Services will therefore:

- Empower patients, users and their carers
- Provide more responsive, coordinated and proactive care, including data sharing information between providers to enhance the quality of care
- Ensure consistency and efficiency of care.

Building upon the successes of the Waltham Forest and East London Pioneer initiative and the Tower Hamlets Vanguard UK New Care Model programme, we are also seeking to develop new models of care that that provide better outcomes for local people but in more economically sustainable ways.

The development of our integrated care strategy is within the overarching strategic framework of the borough's Health and Wellbeing Strategy, which aims to:

- Improve health and wellbeing throughout all stages of life
- Reduce health inequalities; and
- Promote independence, choice and control.

Our strategic partnerships to achieve these aims through the Better Care Fund in the period to 2020 are set out below and our local vision and approach is described in more detail in Section 3.

2.4 Our Partnerships for Health and Social Care Integration

The Care Act 2014 places a duty on Health and Social Care organisations to make evidence-based integrated care and support normal practice. Tower Hamlets' approach to health and social care integration is underpinned by strong partnership arrangements that have evolved over a number of years. The borough is currently taking a number of further steps to strengthen its partnership arrangements in line with the objective of securing integration by 2020. We recognise that as well as strengthening our partnership approach within the borough, it is also important to ensure we have strong relationships outside of Tower Hamlets, particularly as part of the Waltham Forest and East London footprint, known as WEL, and the East London Health and Care Partnership (ELHCP) as part of the STP.

(a) Health and Well-Being Board

The Health and Wellbeing Board (HWBB) sits at the apex of the borough's health and social care partnerships, and contains senior representatives from the local authority, the CCG, Barts Health, East London Foundation Trust (ELFT) and the local voluntary sector.
As noted above, one of the five strategic priorities of the refreshed Health and Wellbeing Strategy: Towards a Healthier Tower Hamlets (2017-20) is concerned with the development of an integrated health and care system.

(b) Tower Hamlets Together (THT)

The early establishment of the Tower Hamlets GP Care Group allowed for the creation of a provider partnership that encompassed partners across the health and care system, which as part of the vanguard status allowed this partnership to launch as Tower Hamlets Together (THT).

THT was established to take forward service design and secure operational arrangements for integrated health and Adult Social Care (ASC) services. This is a partnership arrangement made up of commissioners and providers of acute, community, mental health, social care and primary health services, from the following organisations:

- Barts Health NHS Trust
- East London Foundation Trust
- Tower Hamlets Council
- Tower Hamlets GP Care Group
- NHS Tower Hamlets Clinical Commissioning Group

THT attracted resources from central government through the 'Vanguard' programme, which has allowed it to establish a range of projects to improve health and care through partnerships across the borough. These initiatives complement our commissioning work streams and the BCF funding. THT members are developing close working links with wider partners including the local community, voluntary sector and hospice and have developed a Stakeholder Council for the borough, which is described later in this narrative.

THT's Vanguard status means that it has taken a lead on the development of new care models, which will act as blueprints for the health and care system nationally. The THT Board has provided a lead for strategic and operational decisions regarding health and social care integration, and has set up various sub-groups to deliver schemes or to identify operational or quality assurance issues. One of the sub groups is the Complex Adults Programme Board, which was previously known as the Integrated Care Board. This Programme Board is the working group for the delivery of the BCF.

At present, the THT Board and sub-group structure are able to make 'in principle' decisions which must then be ratified by referral to the relevant body within LBTH, the CCG, provider boards or the Joint Commissioning Executive (JCE). As outlined below, the governance and accountability structure of THT is currently under review and its role is set to be enhanced. This is to sustain and embed the partnership model following completion of the Vanguard programme in April 2018.

In June 2017, a decision was taken that the THT Board would report directly to the Health and Well Being Board. New substructures are currently being developed for particular aspects of the partnership's work, and consideration is also being given to how different organisations can best delegate responsibility and accountability to the THT Board and its sub groups, to improve the effectiveness of the partnership, whilst taking into account the autonomous nature of THT's member organisations. THT is now being regarded as the central driving force for the future of health and social care integration in Tower Hamlets, taking a whole population approach. The draft governance chart is described later in the programme governance section of this narrative.

(c) Joint Commissioning Executive (JCE)

In line with the desire of the CCG and the council to integrate health and social care commissioning functions more effectively, a Joint Commissioning Executive was established in 2016. This is responsible for the joint strategic commissioning of services in Tower Hamlets for children and young people, adults and public health.

The JCE is also responsible for coordinating the development of joint strategies for health and social care and ensuring necessary arrangements are in place to implement strategies and procure service changes. In addition, it is responsible for strategic market development and management and overseeing plans to re-commission and de-commission services, as well aligning this work with joint strategic procurement plans.

The JCE reports key decisions to the Health and Wellbeing Board and related Delivery Boards, as well as to relevant executive and governing bodies of the council and CCG. It has proven to be an effective forum for discussion and the development of shared strategic goals and operational programmes under the BCF and has decision making powers in respect of the BCF as agreed and set out in the BCF s75 agreement. It is made up of senior officers from the council and the CCG. It is not currently a formal sub-committee of the HWBB so is not able to make 'key decisions' on behalf of its component organisations. However, in line with the development of THT, its terms of reference, along with those of the Health and Well-Being Board, are currently under review.

The CCG and council are currently going through the process of jointly appointing to a Director of Integrated Commissioning. This appointment is a strong signal of how eager Tower Hamlets is to continue moving forward on our journey to integrate health and social care. Following this appointment the first task of the post holder will be to establish a Joint Commissioning Hub, which we hope to operationalise by April 2018.

(d) The Alliance Contract – TH Community Health Services (CHS)

Following the re-procurement of Community Health Services, an Alliance Contract was awarded in April 2017 to the GPCG, ELFT and Barts Health. They were also successful in bidding for the Health Visiting Service. This was an important milestone for the future of service delivery in Tower Hamlets, as organisations come together to deliver key outcomes under a central contract adopting a risk-share approach. Among the benefits of the Alliance model are that it allows for flexibility of scope and scale, and so can respond to different levels of organisational readiness and service scope.

It is important to include the Alliance contract in our context, because its scope is likely to increase over time as organisations and Alliance arrangements mature, and can weather other organisational and political change. For instance, the Alliance could take on more services, such as those commissioned/ provided by the local authority and voluntary/independent sector in the future. This future vision would complement the THT structure.

(e) Waltham Forest and East London – WEL Partnership

The case for change was developed across the three boroughs of Waltham Forest, Tower Hamlets and Newham, which in October 2013 became the WEL Integrated Care Pioneer,

and is now subsumed within the Transforming Services Together (TST) programme. Each borough within the programme has its own integrated board, reporting to the local HWBB. This ensures the inclusion of local factors within each borough's plans. However, there are many benefits to working at scale, in terms of development of enablers (for example, information sharing and governance and workforce development programmes).

The TST programme is monitored by the TST Board at the WEL level. The TST Board is made up of clinical and non-clinical executives from Tower Hamlets, Waltham Forest, Newham CCGs and Barts Health and Local authority representatives. The WEL governance structure, which mainly focuses on A&E delivery and Urgent Care delivery, including the TST Board, is undergoing a review so that its governance better reflects the emerging accountable care approach at a local borough and STP level.

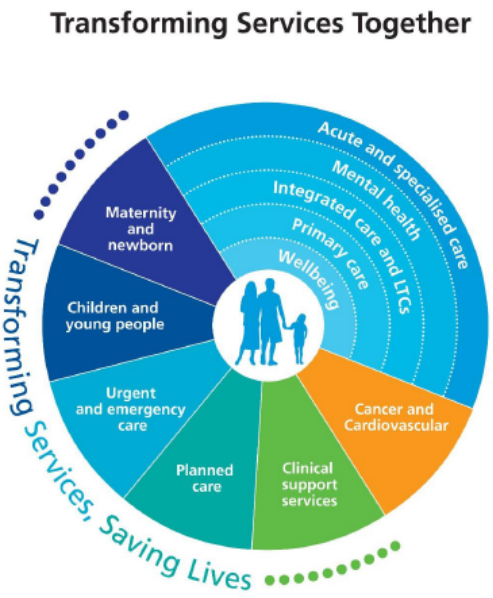
The WEL CCGs have developed and agreed strategic objectives and appropriate performance indicators. In drawing up metrics to monitor the delivery of the joint vision over the next five years WEL considered some of the key issues facing the local NHS:

- Newham and Tower Hamlets have lower than median life expectancy compared to national figures and have a higher level of potential years of life lost than the rest of the country
- There are high levels of childhood obesity
- Overall, WEL has lower than London average prevalence of health conditions, with the exception of obesity and diabetes. However, this masks a very high prevalence of common conditions in Tower Hamlets and Newham
- Vaccination rates are low in children (with the exception of Tower Hamlets)
- Use of acute services is high (bottom quartile A&E attendances), although there are lower levels of ambulatory sensitive admissions
- Providers in WEL have low Summary Hospital Mortality Indices (SHMI), low levels of falls and medication errors. There are few delays to transfers of care but trusts are in the bottom quartile for emergency readmissions
- Access to services is in need of improvement with poor access to GP services and poor patient satisfaction of both GP and acute care
- Mental health and learning disability care in WEL are delivering outcomes that are near or better than the national median.
- Community care also delivers above median outcomes in all areas except for immunisation of children (except for Tower Hamlets that performs higher than the median for immunisation).

The WEL CCGs agreed that the objectives of the five year plan should be:

- Excellent health and care services
- Integrated care
- Stable and thriving health economy
- Improvements in health and inequalities
- The same quality for mental health services as physical health.

The WEL partnership vision, upon which our STP plan is based, is a health and care service that is comprehensive and co-ordinated; where patients are put in control of their own health and well-being. We recognise the performance and quality challenges that we currently face as a system and we plan to deliver services that will be clinically safe, of the highest quality, efficient and easily accessible.



(f) Transforming Services Together (TST)

Transforming Services Together is a programme across WEL which aims to achieve the above objectives. The diagram on the left shows shared functions that focus on particular groups' needs, and cross cutting transformation programmes that reach across disease and population group boundaries.

Transforming Services Together addresses the longer-term changes that need to be made to the WEL health economy to meet the national, London-wide and local challenges and drivers. It will deliver improvements in productivity and ensure the quality of urgent and emergency care across the health economy.

The Better Care Fund is a key enabler for delivery, as it facilitates the integration of services, and the reduction in demand for acute emergency activity through better proactive care and a coordinated response to changes in individuals' needs. By pooling budgets across health and social care, it mitigates the risk of cost shifting, and allows commissioning partners to share in the benefits of greater coordination. Activity funded through the Better Care Fund will enable the delivery of this strategy.

(g) East London Health and Care Partnership – The Sustainability and Transformation Partnership

One of the new things that the Five Year Forward View (5YFV) mandated was the establishment of Sustainability and Transformation Plans (STPs) – a plan to achieve sustainability across a geographical 'footprint'. In East London this became the North East London (NEL) STP, now renamed the East London Health and Care Partnership (ELHCP). The ELHCP is still emerging, with the most recent set of plans being submitted at the end of March 2017. It has recently set up a Board with an independent chair. The STP has chosen to focus on certain areas, where it makes sense to do so over a larger footprint – such as workforce, and financial sustainability. In terms of delivery across the Waltham Forest and East London (WEL) area, Transforming Services Together (TST) has been coordinating joint activity across the Barts Health 'footprint', and in many ways a lot of what the STP seeks to achieve will be delivered through TST. Tower Hamlets' BCF-funded initiatives will dovetail with the ELHCP and TST wherever it is appropriate to do so. The transformation vision for the ELHCP is delivered through a shared framework developed for better care and wellbeing by:

- Promoting prevention and personal and psychological well being
- Promoting independence and enable access to care close to home
- Ensuring accessible quality acute services for those who need them.

2.5 Current state of the health and adult social care market

Needs Health perspective

Tower Hamlets has a wealth of organisations contributing to the health and wellbeing of our residents. Many of these are small and locally-based, such as pensioners groups, lunch clubs, with some nationally-led bodies with local bases. However, many organisations, including statutory services, whilst valuable, provide and commission more 'traditional' services. We want to work in a co-productive model with residents and partners to look at different models of meeting local needs, and building on people's support networks to maximise their independence.

The overall number of residential care and nursing home beds in the borough is low compared to other London and England authorities, with relatively low numbers of people paying for their own care from their own resources. We also have Extra Care Sheltered Housing schemes. But analysis of how we use these and whether we have the right configuration will be critical as our residents' needs change.

Tower Hamlets wishes to stimulate a diverse market for care and support offering people a real choice of services and skills. To achieve this aim, the council recognises that it needs to know how best it can influence, help and support the local market for support and related services such as employment support, community activities, advocacy, and information and advice to achieve better outcomes and value.

It is producing a Market Development Strategy underpinned by Market Position Statements (MPS) across five thematic areas (Ageing Well, Carers, Autism, Mental Health, Learning Disabilities) to initiate a new dialogue with care providers in our area where:

- Market information can be pooled and shared.
- The council is transparent about the way it intends to strategically commission and influence services in the future and how it wishes to extend choice to consumers of care and support.
- Services and workforce skills can be developed that people experiencing problems need and value.

- Developing social capital and strengthening social connectivity for people will become more significant in commissioning intentions.

The Market Development Strategy is aimed at existing and potential providers of adult social care support, including those who do not currently work in the borough and new start-up organisations. It reflects the council's intention to develop stronger and more effective partnerships between the council, people who use our services, carers and providers which will be needed to deliver the challenge of delivering the vision of ensuring our services are:

- Person led and ambitious – seeing people as individuals and focussing on the outcomes they wish to achieve
- Integrated – working in partnerships with individuals and with organisations
- Sustainable and cost effective – whilst maintaining high quality service provision which safeguards our service users and carers from harm
- More Enabling – offering greater choice for our service users and their carers, allowing them to be 'in control' of what and how services are provided and how those services contribute to meeting the outcomes that are important to them

The council is committed to stimulating a diverse, active market where innovation and energy is encouraged and rewarded, where poor practice actively discouraged and vulnerable adults remain safe. We want to have a dialogue with all providers with or desiring a presence in the borough, whether a micro provider or a national organisation.

The council and the NHS locally also commission a range of information and advice services for our local population. This can be face-to-face, telephone based advice or web based. We would want to ensure a more coordinated response.

In Tower Hamlets, people typically develop poorer health around ten years earlier than the rest of London and England, which impacts on their ability to maintain their employment. This can affect people psychologically and physically and the council, the NHS and voluntary organisations are working on programmes, such as social prescribing, apprenticeships, volunteering and pathways into employment to address this agenda. We want to do more in this area.

Overall, we are looking to adopting a strong co-productive approach with providers and people who use services, and this needs to be part of everything we do. Co-production is an opportunity to determine that local assets are available to meet local needs and enables us to focus on meeting our service user outcomes not what works best for us.

Our intention, in commissioning services and meeting needs, is to increasingly base our commissioning approaches on achieving planned outcomes. This needs to be co-produced by people who are using or may use adult social care in the future and will best be achieved by close collaboration with key services, such as public health, housing and NHS partners.

2.6 Key issues and challenges that the plan will aim to address

The Tower Hamlets Joint Strategic Needs Assessment highlights long standing issues of poorer health outcomes in the borough compared to most other parts of the country. The borough scores highly in terms of the wider determinants of poor health (income, poverty, housing, employment) and the main risk factors for health (smoking, poor diet, low levels of physical activity, problem drinking, and suchlike). Consequently, the borough's population experiences higher than average levels of illness, notably in relation to heart disease, stroke, diabetes, lung disease and lung cancer and poorer survival rates (e.g. in respect of cancer).

As set out in more detail in Section 2.2, the borough is continuing to undergo a period of rapid population growth. The services provided through the Better Care Fund closely reflect needs in the borough identified in the Joint Strategic Needs Assessment (JSNA) and other data sources.

To address these population health characteristics, health and social care organisations in the borough are taking a preventative approach, designed to reduce the prevalence of long term conditions, and promote better management of such conditions, where these exist.
As well as the burden of ill health, the high levels of need also place additional pressures on the health and social care system, where, too often, hospital care is the fallback position.
Although covering a wider range of functions than in 2016-17, this BCF Plan is built upon earlier years' plans, and shares the following themes:

- Strengthening our community, mental health and primary care teams to be more integrated and getting them to drive their own quality improvement through the primary care NIS scheme, RAID and the Extended Primary Care Teams.
- An emphasis on reducing pressures on hospitals through seven-day working by the local authority's hospital social worker team and the community equipment team service
- Strong and proactive Reablement and community equipment/assistive technology services that seek to intervene as early as practicable and thereby reduce pressures on the hospital system, and reduce the need to use of care homes.
- Wide-ranging support to carers, including Develop this

One of the key contextual differences for the period 2017-19, compared to previous BCF planning periods is the emerging sub-regional approach to health and social care services in East London, via with the East London Health and Care Partnership. Tower Hamlets will continue to engage with the STP process, while reserving its position on specific issues.

3. What is the Local Vision and Approach to Health and Social Care Integration?

3.1 Implementing our vision through partnership

This section sets out in more detail how we are implementing the local vision outlined in Section 1 and 2, above, including how we are continuing to deliver former national conditions 3-6 in the 2016-17 BCF policy framework, concerned with seven-day services; data sharing; a joint approach to assessment and care planning an agreement on any substantial impacts of changes on providers. It also the highlights the emergent interface between borough-level activity and that of the East London Health and Care Partnership, the Sustainability and Transformation Partnership for North East London.

In the introduction to this plan, it was indicated that Tower Hamlets CCG, the council and our partners share a vision of health and social care services as a single, interconnected system. This entails joint planning, joint commissioning, the alignment of front line health and social care services, more jointly managed services and more co-location of staff teams. It also involves working jointly to design services that address common priorities, such as relieving pressure on the hospital system, supporting people in the community wherever practicable, jointly designing services that address unmet need and ensuring that the health and social care system as a whole secures maximum value for money.

The Tower Hamlets Health and Well-Being Strategy for 2017-20, which has been adopted by all local partners, including the voluntary sector, includes a number of desired outcomes for a more integrated system, based on community engagement and ownership. We want more people to say that:

- They have easy access to information, advice and guidance which helps them to find what they need.
- They find it easy to get help from their GP practice and they can contact their Care Co-ordinator whenever they have any questions.
- There are different people involved in supporting them but everyone listens to what they want and helps them to achieve their goals.

To reconcile rapidly increasing needs and declining resources, health and social care providers in the borough are participating in a number of partnership arrangements. These are all seeking to develop more sustainable services through the adoption of new care models and new ways of working, sometimes involving the radical redesign of services.

This includes increasing the emphasis on preventative services; reviewing the way services are funded, in order to remove incentives that do not promote the economic sustainability of the health and social care system and looking for further ways to break down barriers between health and social care services. We are jointly designing new pathways, creating more holistic commissioning approaches and forging ahead with integrated commissioning, as the best means possible to meet the financial challenges ahead.

A further strand of our vision for the future of health and social care services is that people should be empowered to exercise more control over their health and wellbeing - and their care packages - and remain independent wherever possible. The borough's Health and Wellbeing Strategy makes a commitment to involve service users, carers, voluntary organisations and other service providers in shaping the services we provide. In the last year, the borough has developed a number of partnership strategies (e.g. Carers, Ageing Well, Adult Autism and an Adult Learning Disability Strategy) that will underpin our commissioning activity for the next 3-5 years. All were co-produced and this is now the agreed approach for all aspects of the commissioning cycle.

In a similar vein, the Health and Well-being Strategy also proposes a 'Health Creation' programme. In this, residents identify issues impacting on health and wellbeing and then participate in helping to develop and lead new ways of improving health and wellbeing locally. The strategy also proposes to deliver a programme across the partnership to promote a shared organisational culture that empowers people to be in control and informed about how to improve their health.

The aims of the Health and Wellbeing Strategy also accord with the principles underpinning the Care Act 2014, which place the individual at the centre of the process by which care services are determined and delivered. The local authority has introduced a practice framework, which aims to ensure that individuals are fully engaged in assessments; that issues are seen from their perspective, and that their opinions count when service needs are assessed.

In addition, the council and its health sector partners are taking active measures - not least via the Better Care Fund and Improved Better Care Fund - to address needs in community settings wherever practicable, thereby relieving pressures on local hospitals. Our model is based on the principles of care closer to home and is proactively focused on admission avoidance and speedy discharge from acute settings.

Our approach is aligned very closely with the local health and social care integration partnership, Tower Hamlets Together's, objective of delivering citizen-led care, and is reinforced by the responsibilities that the Care Act 2014 places on the council to promote wellbeing through prevention.

An additional benefit of integrated working is the opportunity to commission services jointly, reduce duplication and pool resources through multi-skilled, multi-disciplinary teams. All of these changes form part of a significant culture change that is taking place in the borough under the aegis of Tower Hamlets Together, the Tower Hamlets Health and Well-Being Board and the Joint Commissioning Executive. To support the process of change, healthcare organisations and the council are continuing to invest additional resources in learning and development, and provide tailored support to system leaders, service managers and staff teams.

As described in greater detail in Section 2, work is currently being undertaken to develop the role of Tower Hamlets Together. It is expected to become the lead partnership for integrated health and social care, under the strategic oversight of the Health and Well-Being

Board. It will also be closely linked to the Joint Commissioning Executive, which will propose the allocation of resources and the form of services provided. In its new role, Tower Hamlets Together will provide a forum in which commissioners and providers jointly address the financial challenges facing the borough and identify the most appropriate forms of service design to meet the needs of the community.

Over the last few years, a number of new developments have occurred nationally that will continue to change the way that health and care organisations work to deliver more joined-up care for patients and this translates locally for us by continuing the long standing work we have been doing with integrated care. While the STP looks at where we can do things across a wider footprint, we continue to develop integrated care with a local, Tower Hamlets focus.

We know a local focus is particularly important for primary and community care services, which aim to support those with the highest continuing needs, in a seamless way. We can deliver this by commissioning in a new way. The CCG and council have been working to develop their commissioning processes to allow greater alignment with other organisations'.

3.2 New approaches to commissioning and service redesign

Around three years ago the CCG decided that it could achieve more for patients by taking a new approach to commissioning, based on outcomes and not activity. In practical terms, this means it commissions services based on what is important to patients and service users, as opposed to traditional output-based commissioning (e.g. number of appointments). The CCG has also been exploring the potential of 'capitated budgets'. This is where organisations pool budgets and take on a shared agreement to achieve outcomes for the population, whilst sharing the risk. The East London Health and Care Partnership (STP) is currently consulting on payment reform proposals. These proposals were initiated in Tower Hamlets, through work on capitated budgets. We are aware that, in order to make the changes to health and social care, the contracting and payment models need to support us to do so.

The largest 'outcomes-based' contract developed by Tower Hamlets CCG is the CHS contract, which was put out to tender in 2014 and awarded in 2017. This is the contract known as an Alliance contract, mentioned above, through which the CCG has more ongoing involvement in co-ordination of the contract than in conventional CCG contracts. A significant part of the CCG BCF activity sits as part of this new model. The objectives set out in the new CHS Alliance Contract include:

- A Single Point of Access (SPA) for all health and social care services
- Extended "whole person care" primary care teams
- A new integrated community rehabilitation service
- A rapid access integrated frailty assessment service
- A new model for children's services, provided from one site, with the aim of developing a comprehensive integrated delivery model for children
- Specialist services for adults working across acute and community settings
- IT that works, with mobile working fully rolled out

- Piloting new ways of working (e.g. the Buurtzorg approach to community nursing and home care)
- Developing a "five partners, one way of working" culture
- Supporting staff to develop quality improvement tools and techniques, with the freedom to test creative solutions to problems
- Promoting prevention and self-care, including through social prescribing and a wellbeing hub.

In addition, the council is currently undertaking a wide-ranging review of its operational adult social care services, with a view to moving towards the alignment of social care and local health services by 31 March 2018, followed by their full integration. The initial phase of this work is being funded through the THT Vanguard. The envisaged changes will build on a number of initiatives that are funded through BCF, including the Community Health Social Work Team, as well as a number of other initiatives (e.g. the proactive use of Reablement to reduce pressure on the health system; the work of the seven-day hospital social work team and the community equipment service).

Tower Hamlets' approach towards health and social care integration encompasses much more than health and social care services, narrowly defined. Through the Health and Well-being Strategy and, in particular, the work of Tower Hamlets Together, it is concerned equally with the wider determinants of health, including housing, the environment and employment. For instance, a Population Health Strategy is being developed under the THT partnership to embed a prevention approach across the system that will focus on the wider determinants of health, with the long-term aim of reducing health inequalities.

The nationally recognised GP Care Group, with its eight GP networks across the borough, is also a key part of the borough's approach to integrated care. These networks have been evolving since 2009 and helped Tower Hamlets win the original bid to become a Multispecialty Care Provider (MCP) Vanguard site. The strong GP collegiate working arrangements provided the foundations for the new locality-based boards and Multi-Disciplinary Team ("MDT") arrangements now operating across the borough. The locality based boards are undergoing revision and are expected to become multi-agency local Health and Wellbeing Committees, with a wider remit than hitherto, that will involve not only the delivery of integrated care but also delivery of the broader population health strategy referred to above.

A further example of cross cutting work is the establishment in 2017 of a cross divisional DFG Working Group within the council, which is described in more detail in Section 6, below. During 2017-18, this Group will review the DFG programme, consider a pathway redesign for the grant and investigate the scope for greater integration of the DFG with assistive technology and other Home Care services.

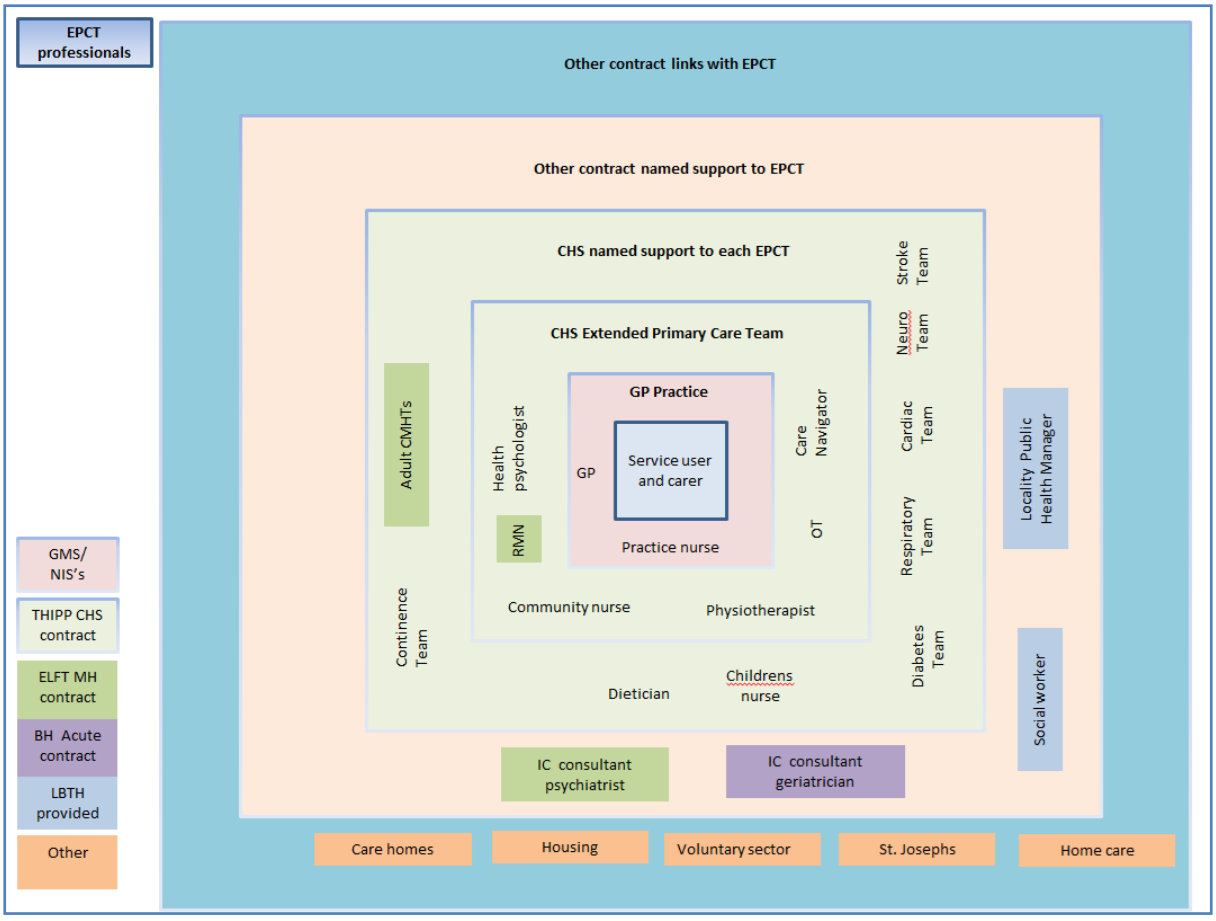
Linkages with the STP and its subsidiary structures were outlined in the previous section. The borough will engage constructively with these structures as their priorities and mechanisms for delivery become clearer. To be developed

3.2.1 ***Commissioning Innovation***

We recognise that we cannot deliver the changes and improvements we seek by doing things the way they have been done in the past. We see the providers of care for the borough's population as:

- being focused on outcomes, not inputs and outputs
- putting user involvement and experience at the heart of what they do
- working together to coordinate their services around individuals needs

Our community health services contract has been developed with these principles in mind, with a new model of care that wraps services around patient needs:



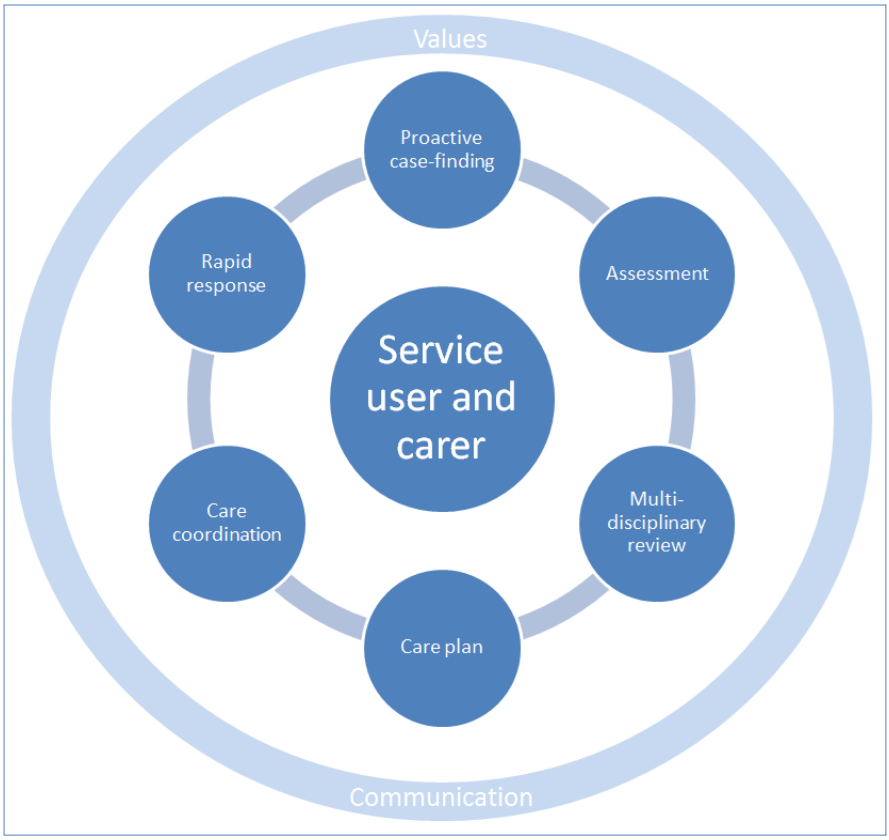
At the heart of the new model are Extended Primary Care Teams (EPCTs), locality-based services which include community nursing, occupational therapies, physiotherapy, clinical management and administration. Each EPCT has named support from specialist teams (e.g. diabetes, stroke, neuro, continence etc.), together with health psychology and mental health professionals in order to provide a whole person mental and physical health service. We are currently working together to align social care to these locality based teams going forward.

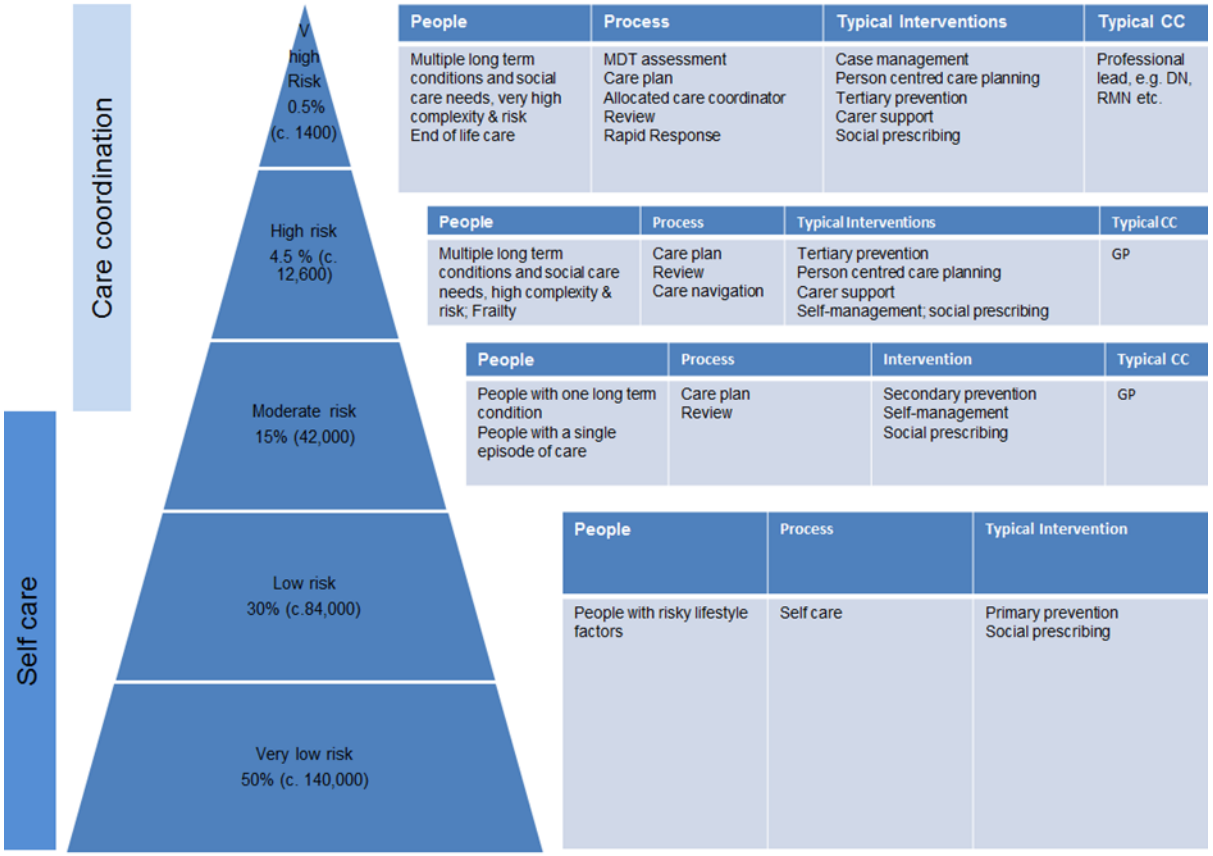
3.2.2. *Delivering health and social care integration through the Tower Hamlets Complex Adults Programme (formerly known as Integrated Care)*

The new model of care outlined above plays a key part in supporting adults with complex needs. These adults are identified in primary care and are classified under two categories:

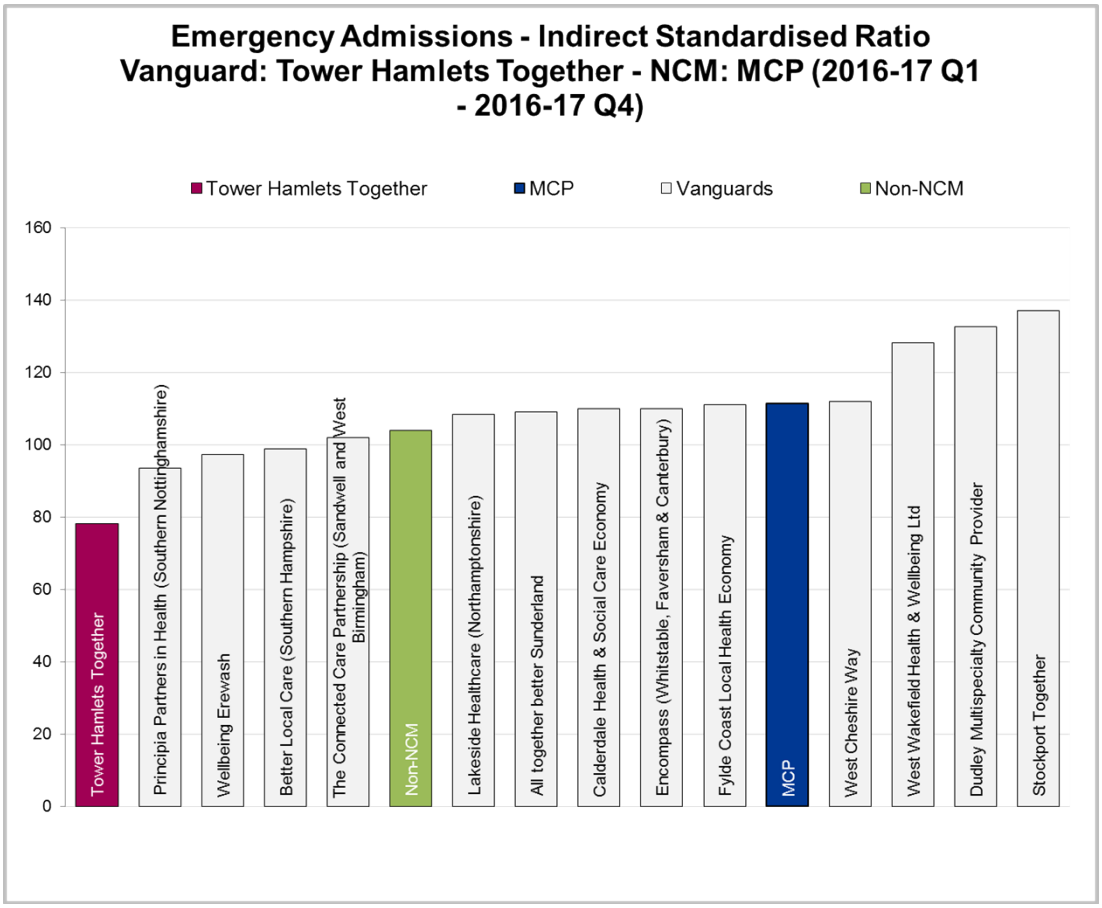
1. Complex care, which includes:
    - Patients with palliative care needs
    - Patients with dementia
    - Nursing home patients
    - A discretionary group equal to 12% of the practice's population aged ≥65 (minus the mandatory) in April 2017
2. Long term conditions, which includes patients with one or more long term conditions

The level of care provided across all partners is tailored according to individuals' needs and delivered in line with the principles shown in the diagram below:





Alongside this new model of care, we have been encouraging collaborative working through a Local Incentive Scheme (LIS). Focused on the delivery of shared outcomes, the incentive scheme rewards individual organisations for their contribution to support adults with complex needs. The shared outcomes of the scheme include key indicators, such as non-elective admissions, readmission rates and delayed transfers of care. Providers have themselves reported that this has encouraged joint working and this can be demonstrated by the dashboard below, which indicates that Tower Hamlets Together is the highest performing Multi-Specialty Community Provider (MCP) in the country against non-elective admissions.



We are seeking to build on the success of this and are in the process of agreeing the incentive scheme for 2017-18.

3.3 What difference will integrated care make to patient and service user outcomes?

Our vision for the new system is based on three aims:

1. *Empower patients, users and their carers*
   - Enable patients and service users to live independently and remain socially active
   - Establish education and self-care programmes for patients
   - Personalise care to patients' and service users' needs and preferences

2. *Provide more responsive, coordinated and proactive care*
   - Proactively manage patients' health and improve their outcomes
   - Enable high-quality care that responds to patient/service users' needs rapidly in crisis situations
   - Provide more care in the community or at home
   - Prevent avoidable admissions
   - Leverage tools and technology to deliver timely and better quality of care

3. *Ensure consistency and efficiency of care*
   - Deliver the best possible care at the minimum necessary cost

- Avoid duplication of effort in situations where patients are seen by multiple health and social care providers
- Ensure most effective possible use of clinical time and resources

We will measure benefits in a number of ways:

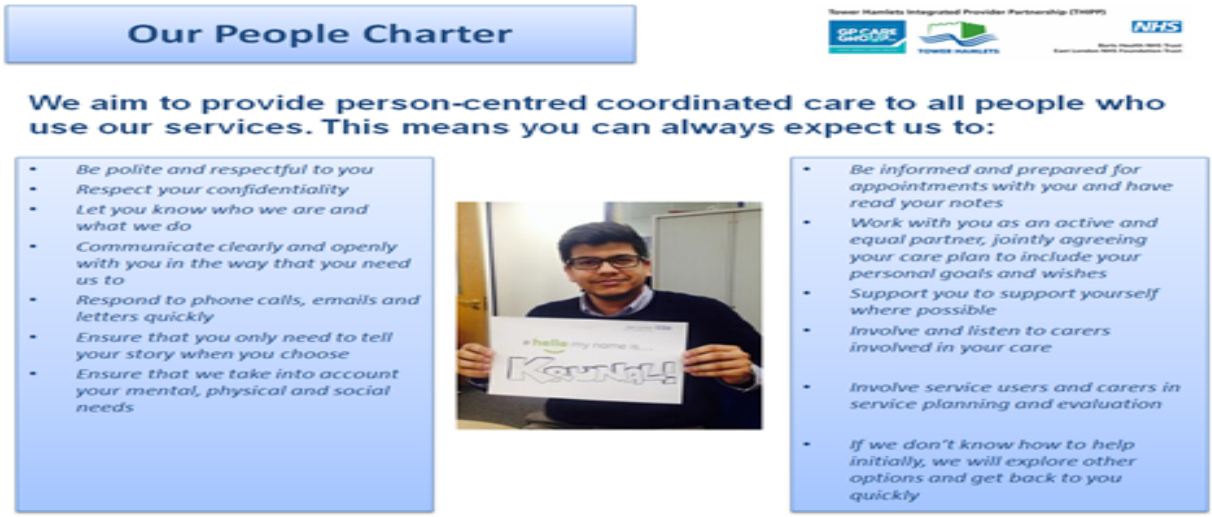
- Provider reporting: Our new community health services contract includes a number of patient and system related outcome measures and these are being monitored through our monthly alliance contract meetings
- Local Incentive Scheme (LIS) reporting: Our 2017-18 proposals are currently being finalised. This will include a series of metrics such as XXXX and reporting is expected quarterly. To be completed

3.4 Service user and public engagement

The compilation of the Tower Hamlets Health and Wellbeing Strategy itself has been underpinned by significant engagement with the local community.

Local people, local staff, local care

National Voices, a coalition of health and social care charities in England, work directly with some patients, service users, carers and their families, to improve care. It is committed to ensuring that there is a patient voice in the decisions made in health-care, and provides patient leadership training, amongst other programmes, as a way of achieving this. In 2013, National Voices published work commissioned by NHS England to provide a narrative for person-centred coordinated care. Tower Hamlets continues to be committed to the delivery of this definition of Integrated Care. The THT service model and vision for community involvement is shown here.



From its outset Tower Hamlets Together (THT) committed to creating person-centred services, by working with local communities and citizens to deliver the best health and social care possible. One of the ways of doing this is through a stakeholder council involving patients, carers, staff, the voluntary and community sector and other partners. In 2016 a series of pilot workshops were run to explore the challenges and opportunities and raised a number of issues including:

- Building confidence and the ability to think beyond the traditional attitudes adopted by different types of partner is vital if we want to move towards co-production.
- There is strength in bringing together a diverse range of voices willing to use their personal, organisational and political experience and expertise collaboratively.
- There was overall agreement that the stakeholder council could play a 'critical friend' role to the Board offering an open and problem-sharing forum.

The report from the pilot workshops was presented to the Board in February and there was overwhelming support to develop it further. Subsequent discussions about governance have delayed this somewhat but in July residents, staff from all levels, voluntary and community sector representatives and other partners came together to explore themes for the community discussion about the outcomes framework currently underway. This will reconvene in early October to reflect on the results of this and provide the launch pad for the next stage of the stakeholder council.

3.4.1 ***Engagement on our Strategy***

To be completed

3.4.2 ***Engagement in the delivery of services (co-production)***

Both the CCG and council have identified funding for the delivery of discovery interviewing techniques and it is intended to use this to gather feedback and involve users and their carers in the development of the integrated care services. The council has a rewards and recognition policy under which it can make payments to service users where appropriate.

The council and CCG jointly fund the Tower Hamlets LinkAge Plus network of services for older adults across the Borough. This provides a network of older people with whom the partnership can test out ideas and plans for integrated care.

Building on that work, the CCG has conducted a range of initiatives involving patients in developing Integrated Care in Tower Hamlets including Integrated Care "conversations" alongside voluntary sector patient groups. The first one to take place was run in conjunction with the *Tower Project*, which works with children, young people and adults with disabilities. Ten participants, predominantly carers, provided feedback and engagement on plans to integrate care.

Tower Hamlets CCG is also using its website and internet content to disseminate information about Integrated Care. The Tower Hamlets CCG website is easy to navigate, interactive, and is starting to embrace the use of videos and YouTube.

The council undertakes annual service user surveys that give insight over time into service users' experiences of social care services. Data from surveys such as the National Carers' Survey help to provide the HWBB with feedback on the changes being made. More widely, the annual Local Account captures all findings from the past year's adult social care engagement activity. This provides an analysis of performance in regards to service user satisfaction in comparison to previous years.

3.5. Outcomes Framework

In 2016, Tower Hamlets Together developed a draft outcomes framework. Drawing on extensive discussion with the community, both from historic and recent engagement, staff and other partners, the outcomes are designed to provide a clear and simple way of measuring the effectiveness of service delivery and an inspiration to improve further. Following endorsement from the THT Board in January, extensive work has been undertaken to underpin the draft outcomes with a series of performance indicators to move towards capitation locally. In the summer of 2017 the New Economics Foundation was commissioned to undertake further validation, especially with those parts of the community which have not already had their say. As part of this, in July 2017, the THT Stakeholder Council - which brings together a diversity of voices, including residents, staff, the voluntary and community sector and other partners, such as the police and housing - met to explore the key areas for the validation work. Proposals for how to align the aspirations of this latest community debate with more precise performance measures will be presented to the THT Board before the end of the year. The outcomes will also be a fundamental part of the Health and Wellbeing Strategy, particularly underpinning the 'communities driving change' strand and will link closely to the borough's community plan which is currently being consulted upon.

Our Outcomes Framework…	
After using Tower Hamlets Together services we want residents to be able to say…	
Around me	I feel safe from harm in my community
	I play an active part in my community
	I am able to breathe cleaner air in the place where I live
	I am able to support myself and my family financially
	I am supported to make healthy choices
	I am satisfied with my home and where I live
	My children get the best possible start in life
My doctors, nurses, social workers and other staff	I am confident that those providing my care are competent, happy and kind
	I am able to access the services I need, to a safe and high quality
	I want to see money is being spent in the best way to deliver local services
	I feel like services work together to provide me with good care
Me	It is likely I will live a long, healthy life
	I have a good level of happiness and wellbeing
	Regardless of who I am, I am able to access care services for my physical and mental health
	I have a positive experience of the services I use, overall
	I am supported to live the life I want

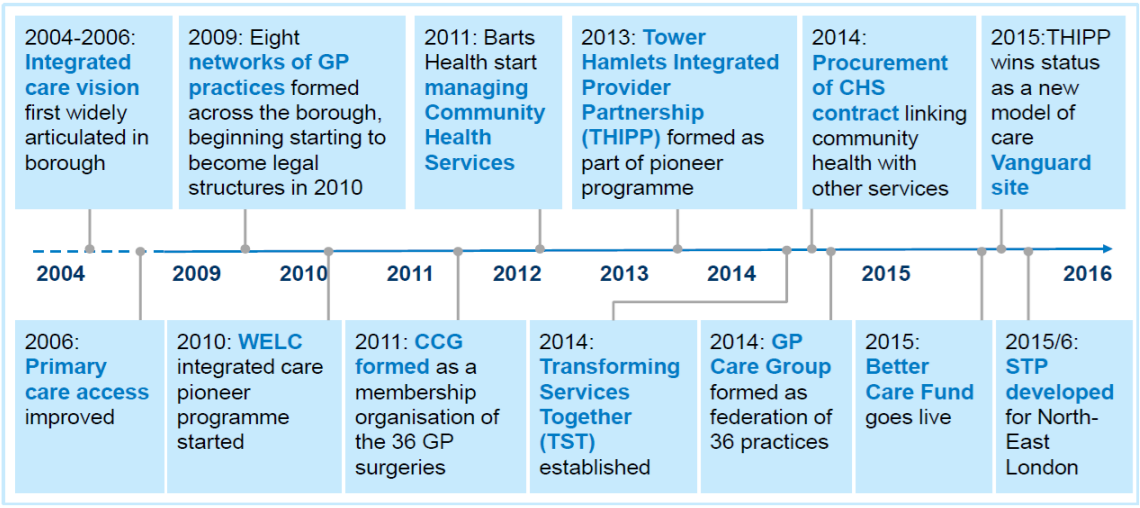
3.6 Joint Business Intelligence & Commissioning Dataset function

To be completed.

3.7 The Future: Accountable Care Systems

The timeline below illustrates some of the above mentioned developments, along with others. This section sets out the next steps for health and social care integration in Tower

Hamlets. Expand timeline.



Over the last year, with the freedom and scope for innovation that recent developments have given and our strong history of integrated care work, the CCG and the council have been thinking about how we should commission in the future. What has emerged is the concept of an Accountable Care System for Tower Hamlets, centred upon Tower Hamlets Together, which has the potential to address a number of the systemic challenges we face.

'Accountable Care System' (ACS) is an all-encompassing term that brings together a number of different elements of commissioning to facilitate a more integrated system. It offers a framework for providers to take responsibility for the cost and quality of care within an agreed budget. ACSs take many different forms, ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers. What they all have in common is a defined population, a uniform payment mechanism and a clear focus on health outcomes.

In Tower Hamlets we are already working on many of the building blocks that make up an ACS, such as paying providers in a different way (capitation), commissioning based on outcomes (CHS), and facilitating greater partnership working through commissioning (CHS). The development of an ACS in Tower Hamlets will be a step-wise process, something that evolves and builds, as opposed to something that starts at one point and finishes at a pre-defined end. This is an opportunity for Tower Hamlets and the wider NHS to do what works best and build on our strengths and history.

There is not a 'top-down' mandate for this but the message from government seems clear that we have an opportunity to shape our system as and lead that change, and we want to take that opportunity now. This is different to previous changes: we are not being told specifically what to do, and it involves a new set of challenges, but, we think, wider opportunities.

In practical terms, an ACS can be established at different levels or spatial 'footprints', based on where it makes sense for organisations to work together. The level at which they are established will also define the priorities and their collective work. The ELHCP is looking at

structures that could be put in place to develop ACSs across its geography, aligned to acute provider footprints. This may mean the term ACS will be associated with work aligned to TST (see Section 2) and so on for other areas, such as Barking, Havering and Redbridge. Although not yet fully established, an ACS at TST level may focus on payments and outcomes.

3.8 What Next?

3.8.1 April 2017

As part of this journey to creating an ACS for Tower Hamlets we have started to make some changes to the ways in which we commission and the governance structures that underpin our commissioning decisions. From April 2017, the CCG will have:

- Created a new CCG Finance and Investment Committee that defines our medium and long term financial strategy and will take recommendations from the newly formed THT Board to deliver the strategy (as below);
- Finalised the CHS negotiations and gone live with the CHS alliance contract;
- Introduced a shadow capitated budget with partners.

3.8.2 By October 2017

By October 2017, we expect to have achieved the following:

- Merged the THCCG Transformation Board with the THT Board to create a reformed THT Board that will oversee the delivery of 2017-18 QIPP plans and develop the 2018-19 commissioning plans;
- Merged the THCCG PMO structure with the THT PMO structure, so that the programmes which deliver transformation are better aligned;
- Through the new PMO structure, made plans and started to embed changes to the programme boards that sit under the THT Board, looking at membership, roles and responsibilities and governance arrangements;
- Developed and launched a development programme for the new THT Board;
- Reviewed and aligned communications and engagement activities across THT.

3.8.3 What we aim to achieve by 2020

By 2020 we want Tower Hamlets to:

- Be integrated around people, with staff not hindered by organisational boundaries or bureaucracy and able to put patients' needs first;
- Be person-centred, with residents and staff collaborating together and making the right decisions, based on individual needs;
- Have a culture of trust and continuous learning, with a 'can-do' attitude across health and care services;
- Make the most of scarce resources, by allocating them according to changing population needs, and with clear accountability between clinical decisions and resource allocation;
- Have good information and data for patients and staff to help them make effective and timely decisions; and
- Be joined-up to drive improved wellbeing through partnerships with local organisations outside of the health and care system.

Despite our successes, we know there are several challenges that we need to overcome if we are to ensure the sustainability of our health system and ensure continued progress in improving health outcomes. We know, for example, that our current system remains highly fragmented with different types of providers (primary, community, social care etc.) using different systems, budgets and incentives. This all contributes to a fragmented and often confusing patient journey.

We also know that providers suffer from a lack of skilled staff, resulting in high agency spend at a time when funding is limited and while the needs of our population are growing. Like many deprived areas, a significant proportion of our population is transient and its expectations are changing, resulting in greater uncertainty regarding what is needed in the future.

Regulatory constraints from the centre also lead to a focus on meeting top-down targets rather than focussing on population outcomes. Furthermore, the current commissioning contract mechanisms are inflexible – making it difficult for commissioners to drive the change we want within an annual commissioning cycle. Many of these challenges are shared across the country and have led to recent policy changes from the centre. However, by making radical changes to commissioning and governance arrangements and reorganising jointly the way health and social care services are provided, we are confident that we will move to a genuinely accountable care system over the next three years that builds on the significant progress already through the Better Care Fund and previous partnership working.

The historical success that we have in Tower Hamlets is achieved through the hard work, innovation and ambition of our staff and clinicians. We have a high reputation and plan to continue to build on this. There is lots to be done, some of which will require new ways of working. Changes are likely to be more bottom up and iterative than they have been in the past, when change has been imposed. The future will be led through our workforce and service users.

4. Progress to Date

4.1 Tower Hamlets' BCF programme

The priorities of Tower Hamlets' BCF programme have been largely consistent since the inception of the programme. Priority themes include:

- More joint working between health and social care staff (e.g. in the areas of the community health services and hospital discharge)
- The extension of seven day working, particularly in areas where this can reduce pressure on the hospital system.
- The redesign of services to facilitate more seamless interaction with patients of the service users.
- The sustainability of social care provision in the borough.
- The empowerment of service users (e.g. through co-production).

As has been summarised above, the BCF programme is part of a wider range of initiatives and much of the improvement in outcomes (e.g. through the redesign of services and pathways) is being delivered via partnership bodies such as Tower Hamlets Together.

The BCF programme, and health and social care integration more generally, monitored, on behalf of the Tower Hamlets Health and Well-Being Board, by the THT Complex Adults Programme Board, which now reports to the THT Board. This comprises representatives of the CCG, the council, the voluntary sector and health providers.

Progress with the BCF schemes in 2016-17 and our priorities for 2017-19 are outlined in Section 6.

4.2 Progress towards an Accountable Care System

Within the borough, a number of steps are currently being taken towards the establishment of an effective Accountable Care System. In 2015-16, a joint commissioning review was undertaken on behalf of the CCG and the local authority, which identified a number of ways in which greater integration of commissioning might be effected. Now, under the aegis of the Joint Commissioning Executive, the scale of the Better Care Fund pool is being increased progressively, with more functions expected to follow in future years. In 2016-17, the size of the pooled budget was £21.4m; in 2017-18 this is being increased to approximately £45m. Even allowing for the advent of the Improved Better Care Fund, which increases the total resources available, this represents a significant increase in the value of pooled resources.

To support the enhancement of integrated service design and delivery, the council and the CCG are developing a new integrated commissioning hub as a further stage towards greater joint working and joint commissioning.

Local governance structures are also being revised to take account of these developments. The Health and Well-Being Board is now formally recognised as having strategic oversight responsibility for all health and social care activity in the borough, and the THT Board will

take on the role of overseeing the development of health and social care integration on its behalf. In addition, the CCG's programme boards are now being integrated with THT structures to provide a more accountable and inclusive system of commissioning and service improvement.

We have gained system support to build THT into a strong position to support the implementation locally of the BCF and the North East London NHS Sustainability and Transformation Plan, which is now quite advanced. In March 2017, the CCG confirmed its intention to disband its Transformation Board and delegate its functions to the THT Board. THT is at present accountable to the CCG Board for any decisions taken and the CCG has proposed amending the THT terms of reference to reflect this change in purpose, and these are expected to be revised as the borough develops an Account Care System. In addition, there is widespread support for placing THT formally under the aegis of the Health and Well-being Board and the implications of this, not least in respect of organisational governance, are currently under discussion with THT partner organisations.

In the meantime, THT and CCG sub-structures - including the Complex Adults Programme Board, concerned with overseeing the delivery of Better Care Fund initiatives - are being integrated to allow the various aspects of the health and social care agenda in the borough to be taken forward.

4.3 Fundamental Review of Adult Social Care Services

Within the council's adult social care services, a major review is currently being undertaken, funded through the THT Vanguard, with the aim of, firstly, aligning the council's services with local health services and then moving towards their integration. A draft model has been designed which proposes the following:

Phase 1 – Align (level 2) ASC services with Health in 2017/18	Phase 2 – Integrate to level 2/3 from 2018/19
An **ASC Single Point of Access** ("SPA") to provide the ASC front door.	A **Shared SPA with health** combining the ASC and community health front doors into one function
Locality based social work and occupational therapy ("OT") teams that mirror the new Extended Primary Care Teams ("EPCTs") in health; This will include and build on the ICHT pilot that is already locality based.	**Joint Locality Teams** with shared community health and ASC teams.
A **seamless, coordinated service**, covering all stages of the customer journey.	Co-located Out of Hours ("OOH") Service with the emergency duty team working alongside OOH nursing support and GP access
A **Short Term Interventions Service** that brings together reablement, telecare, assistive technology and community equipment.	An Urgent Care Hub that integrates the ASC Hospital Team with the new Urgent Care Hub to support step up / down care and to facilitate admissions avoidance and discharge to assess more

	effectively
A **Mental Health ("MH") Liaison** team to support the locality teams and provide earlier MH support	

As referred to above, a review of the Local Integrated Care Boards (to be renamed Locality Health and Wellbeing Committees) is also being undertaken. These will be reconstituted as part of the new THT governance structure and will coordinate the delivery of integrated services at the local level.

4.4 Former BCF national conditions

The borough will also continue to address the former national conditions concerning (i) 7-day services, (ii) data sharing, (iii) a joint approach to assessments and care planning and (iv) Agreement on any substantial impacts of changes on providers.

4.4.1 *Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate*

Section 12 sets out the borough's approach to maintaining low levels of delays in transfers of care. Here it is worth highlighting two council services, which are enabled to operate on a seven-day week basis through BCF funding: the hospital social work team and the community equipment service.

- 7 Day Hospital Social Work Team: The scheme allows the council to extend the hospital discharge team at the Royal London Hospital from a Monday to Friday service to a 7-day operation. Social work staff assess and discharge patients on acute wards who are deemed medically fit for discharge at weekends and public holidays. This frees up acute beds within the hospital and uses resources more effectively. It also provides greater capacity for new admissions from A&E requiring an acute bed. The 7-day service also provides timely multidisciplinary assessments, which avoid unnecessary admissions to acute wards, and facilitates speedier discharges, by commissioning community services which permit patients to return home. In 2017-18, the scope and capacity of the Hospital Social Work Team is being enhanced by the allocation of Improved Better care Fund resources.
- Seven Day Working for Community Equipment Service Team: BCF funding is used to allow the provision of 7-day and extended hours equipment and minor adaptation delivery and installation services. The service seeks to enhance patient/service user experience and reduce pressure on the Acute Health Sector. The planned outcomes of this investment are a reduction in avoidable admissions and the facilitation of safe and early discharges, by making patients'/service users' home environments safer and making it practical for them to be cared for at home or to self-manage their support needs.

4.4.2 Better data sharing between health and social care, based on the NHS number

To follow

4.4.3 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

The Out of Hours and Day Service continues to operate 7 days per week within Barts Health NHS Trust, with particular attention to the Royal London Hospital, the Trust's trauma centre Patients discharged from hospital to the Admission Avoidance & Discharge Services (AADS) team, who require a rehabilitation and reablement pathway, are screened while still in hospital by one of the team (a nurse or therapist), or jointly with a social worker, if care support is required on discharge. Wherever possible, this support is arranged with the Reablement team, and a therapist and/or nurse from the AADS team is allocated the following morning, with a visit made in the community within 24 hours. On-going reviews take place based on patient/service-user need and this is tailored to what the person expresses as their goals or priorities. For some, this will be a return to full independence, while for others it may be to manage activities with the least intervention possible or for their carers to feel supported in this role.

All patients are jointly reviewed with the Reablement service on a weekly basis, and there is an opportunity for a more frequent (daily) integrated discussion, if this is felt to be required by the staff visiting the person, so concerns or changes that require an increase or reduction in care are addressed promptly. There is a key worker allocated to each person from health, as well as a social worker from the team when care support visits have been arranged. This support can continue for up to six weeks, when people are either discharged if they no longer need input, or referred on to other services/long term support.

Patients in the target population will have an accountable lead professional named within their care plan. This individual will be responsible for coordinating the review of their care and will lead discussions within the MDT. They will be the first port of call for queries, and will be accessible to other professionals and care coordinators. In the majority of cases, this person will be the patient's GP.

4.4.4 Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans

To follow

5. Evidence Base and Local Priorities to Support Plan for Integration

The demographic evidence base which underpins our BCF programme is summarised in Section 2and the Joint Strategic Needs Assessment (JSNA). Our approach to health social integration and priorities are set out in Section 3.

The original priorities for the Better Care Fund in Tower Hamlets were reviewed in the course of developing the present proposed programme. The great majority of 2016-17 BCF schemes will continue to form part of the Better Care Fund, and, with a small number of exceptions, will continue to be funded from the CCG 'minimum'.

However, as has been noted previously, the borough has agreed to work towards greater integration of functions within the section 75 agreement, and, taking into account the Improved Better Care Fund, the amount pooled in 2017-18 is more than double that in the previous year.

The process of pooling of functions will continue under the scrutiny of the Joint Commissioning Executive, and it is possible for further functions will be added to the section 75 agreement in 2018-19.

The table below shows council BCF schemes (column 1); priority areas where joint commissioning frameworks are to be developed in 2017-18 (column 2); and areas that would benefit from improved joint working (column 3). It is proposed that, as the integration of commissioning becomes further developed, the functions in column 2 will tend to be pooled into the BCF under the Section 75 agreement. The functions in column 3 are not envisaged for pooling in the short term, but this will be kept under review as services develop. Needs more of a narrative, showing reasoning behind the JCE's previous decisions on increasing pooled budgets and the approach being followed by the council to determine further pooling.

Included within the Better Care Fund Level 4	**Joint Commissioning Frameworks Level 3**	**Improved joint working Level 2**
Column 1	Column 2	Column 3
LinkAge Plus	Mental Health services	Children's Services
Reablement Team	Older People's Mental Health Team	Public Health
Community Health Team (Social Care)	Learning Disability services	Drug and Alcohol Action Team (DAAT)
7 Day Hospital Social Work Team	Hostels and homeless commissioning/ELFT homelessness project/Groundswell/HealthE1	Acute Emergency Care/Acute Planned Care
Community Equipment Services	Social Care services included within the Ageing Well strategy- e.g. Residential Care, Extra Care, Home Care, Day Care for Older	Continuing Healthcare

	People	
Care Act Implementation	Single Point of Access (Vanguard)/LBTH Information, Advice and Advocacy (IMHA &IMCA)	Personalisation (Direct Payments/Personal Health Budgets)
Carers Support		Safeguarding (Children and Adults)
Disabled Facilities Grant		Transitions
Local Authority Integration Support (Enablers)		Monitoring and measuring patient/service user experience
Community outreach service (Dementia)		
Dementia café		
Social worker input into the memory clinic		
Improved BCF		

Add text on local financial context for the BCF Plan

6. Better Care Fund Plan

In 2017-18, we are using the Better Care Fund programme as a platform for developing closer joint working between Tower Hamlets Council and the CCG. The development of integrated commissioning within the borough is reflected in the increased scope of the section 75 agreement, which is now considerably broader than in 2016-17.

The Table below sets out the schemes and associated budgets that have been incorporated into the 2017-19 BCF. The Tower Hamlets Joint Commissioning Executive (JCE) gave agreement to expand the 2016-17 Fund to enable associated areas of investment and activity to be brought together under a series of new Joint Commissioning Frameworks.

Table needs 2018-19 column

Pooled Fund	BCF Scheme	Lead Commissioner	Provider	BCF Allocation 2017-18 CCG 'minimum' needs to be uprated by 1.79% (1.9% for 18-19) (£)
Pooled Fund Hosted By London Borough of Tower Hamlets	LinkAge Plus	Council	VCS	650,000
	Reablement Team	Council	Council	2,413,871
	Community Health Team (Social Care)	Council	Council	895,500
	7 Day Hospital Social Work Team	Council	Council	1,230,800
	Community Equipment Services	Council	Council	TBC
	Care Act Implementation	Council	Council	733,000
	Carers Support	Council	Council	697,000
	Disabled Facilities Grant	Council	Council	1,733,988
	Local Authority Integration Support (Enablers)	Council	Council	208,000
	Community outreach service (Dementia)	Council	VCS	25,000
	Dementia café	Council	VCS	55,000
	Social worker input into the memory clinic	Council	Council	50,000
	Improved BCF	Council	Council	8,700,000
Total				TBC
Pooled	Extended Primary Care Team	CCG	ELFT	13,232,000

Fund hosted by	Integrated Clinical and Commissioning Quality Network Incentive Scheme	CCG	GP Care Group	4,461,313
	RAID	CCG	ELFT	2,106,420
	Adult autism diagnostic intervention service	CCG	ELFT	330,000
	Mental Health Recovery College	CCG	ELFT & VCS	210,000
	~~Falls prevention~~	~~CCG~~	~~ELFT~~	~~TBC~~
	Community Geriatrician Team	CCG	Barts Acute	110.000
	Personalisation (IPC programme)	CCG	VCS	212,000
	Psychological Support for People with Long Term Conditions (Previously Mental Health Personal Commissioning)	CCG	ELFT	150,000 (TBC)
	St Joseph's Hospice	CCG	St Joseph's	2,029,248
	Voices Survey	CCG	St Joseph's	£30,000
	Age UK Last Years of Life	CCG	VCS	£91,500
	Barts Acute Palliative Care Team	CCG	Barts Acute	959,086
	Discharge to Assess	CCG	THT	TBC
	Age UK Take Home and Settle	CCG	VCS	114,000
	CVS Commissioning Development Programme	CCG	THCVS	70,000
	Single Incentive Scheme	CCG	THT	500,000
			Total	TBC
			BCF total	**TBC**

6.1 Schemes Continuing from 2016-17

- **Community Health Team (Social Care)** - The team provides assessment, support and care navigation to a targeted group of people at medium or high risk of hospital admission, using co-ordinated, person-centred and Multi-Disciplinary Team (MDT) approaches. It promotes the wellbeing and independence of those living with long term conditions and assesses and supports Carers of people with long term conditions. The team has contributed to the reduction of unplanned admissions and readmissions to hospital, by maintaining patients in the community for longer and delaying admission to

long term care. A brief QA audit around Safeguarding Adults indicated that CHT (SC) is able to decrease risk for service users by timely and effective MDT working. The team is now working with over 400 service users who are on the ICP in the very high risk cohort, plus those who are undergoing active neuro-rehabilitation. It works closely with hospitals to plan and implement timely and safe hospital discharges (the hospital social work team carries this out for other Adult Social Care teams). There are also two named social workers linked to pilot Neighbourhood Care Team (Buurtzorg) and the CHT (Social Care) Development Team Manager is part of the Operational Design Group. The team's Operational Manager is actively involved in GP-led strategic planning regarding End of Life/Palliative Care. CHT (SC) has also been working closely with health partners around Continuing Health Care. This is essential in ensuring MDT good practice in completing Decision Support Assessments. It has led on planning and implementing CHC Legal training, along with the council's Learning and Development Team and Health Partners. In 2017-2018, the above work is expected to continue. In addition, the team is planning to increase its work at the local (via IBCF) and to increase social work and management capacity to support Continuing Health Care work, including at CHC Eligibility Panel (again, via IBCF). It will also participate in the development of the End of Life/Palliative Care offer to LBTH residents and champion this area of work. A Palliative Care social work post is also being created within the team.

- **Out of Hours 7 Day Hospital Team** - The scheme has enabled the council to extend the work of the Hospital Discharge Team at the Royal London Hospital from a Monday to Friday to a 7-day service. Social work staff are available at weekends and on public holidays to assess and discharge patients on acute wards who are deemed medically fit for discharge. This has freed up acute beds within the hospital, and allowed for resources to be used more effectively. It has also provided greater capacity for new admissions from A&E requiring an acute bed. The service has worked to prevent hospital admissions, support early diversion, reduce discharge delay, reduce re-attendance, and save ED staff time. The Service specifically prevents unnecessary hospital admission (social admission) for particularly the elderly frail patients into acute beds. The Out of Hours social workers within the Acute Assessment Unit (AAU) and ED respond to referrals within the hour, commission support and discharge patients whose do not have a clinical need to be in hospital. Achievements in 2016- 17:
    - The service continues to improve in the area of Delayed Transfers of Care, patient flow has been increased and trolley rates reduced. We have not needed to divert patients elsewhere or resort to escalation beds in the last 12 months.
    - The need for Non-Elective admissions has been reduced and the team has worked, proactively with staff in the Emergency Department to prevent unnecessary admissions.
    - Patient experience has been improved, by preventing unnecessary admissions and/ or facilitating prompt discharges.
    - Reablement support has been used as a preventative approach for patients presenting to the A&E and the pre-admission wards, in order to support them in regaining their independence and prevent the need for long term care and support.

  Proposed future changes for service in 2017-18 include becoming more proactive, reaching more wards and targeting more complex discharges and frequent hospital attenders. It is intended also to link in with the Community Health Teams, GPs and to be able to divert patients back to their GP practice and Multidisciplinary Teams in the

community. The aim is for the service to be scaled up and rolled out to all patients in acute and general wards, including supporting out-of-borough patients at weekends where possible.

- **Reablement Team**- the service has helped people with illness or disability cope better by learning or re-learning skills necessary for daily living. This service is now being reviewed to be jointly delivered with the Rehabilitation service to become the Reablement and Rehabilitation service. To be developed
- **Assistive Technology** (AT) – The project seeks to integrate the use of assistive technology into mainstream health and social care provision, to enable residents to live independently in their own homes. It uses a range of training and communication methods to raise staff awareness, giving them the knowledge, confidence and support to prescribe appropriate assistive technology equipment for their service users. The project also provides training and support on the use of AT equipment to health and social care staff in 19 operational teams across 9 locations. In 2016-2017, there were 26 formal training sessions, involving a total of 178 staff: 124 from health and 54 from social care. For the period April-June 2017, there have been 4 sessions, involving 30 staff (4 health and 26 social care). The project runs pilots to test specific pieces of equipment, or to evaluate equipment for specific client groups. These have included:
  - Working with our Independent Travel Training Team using smart phone apps and GPS technology.
  - Pill dispenser pilot working with District Nurses.
  - Part of a Pressure Ulcer pilot using a grant from THT.
  - A pilot to assess the use of monitoring equipment to understand how service users are coping with their support plans.

  The project was shortlisted for an Innovation Award by the Local Government Chronicle, and received a bronze award at the Innovation and Efficiency Awards 2017. In terms of future developments, the project will be investigating equipment that combines Telecare and telehealth capabilities.
- **Social Worker Input into Diagnostic Memory Clinic** - The social worker offers community assessments under the Care Act (2014); carers' assessments; organises provision of packages of care; signposting, and advice information and support to patients at a relatively early stage of Dementia. The post holder is based in the Diagnostic Memory Clinic Team (East London Foundation Trust) which supported the integration of these services. The inclusion of social care in the DMC provides a truly integrated model of care throughout the dementia pathway in Tower Hamlets. Access to social care in the Diagnostic Memory clinic helps improve service users' 'journey' at a vulnerable and anxiety-provoking time in their lives. The Scheme will continue to provide an earlier assessment of service users in need of some support through social care and earlier signposting to other non-statutory agencies for those not in need of social care input. Providing frontline social care input creates efficiencies, by reducing the number of referrals made directly to the Adult Social Care (Assessment and Intervention Team). In 2015-2016 user satisfaction was 97.5% positive of all the survey responses received.
- **Dementia Café & Community Outreach Service** – The Dementia Café provides an inclusive peer support service, 4 times a month including structured programme of activities, and promotes understanding of dementia for service users with mild to moderate dementia and their carers. This funding has supported a range of provision in

BME communities, such as awareness training, case finding and work to support people to understand dementia, break stigma and access services. The Community Outreach Service/ BME Inclusion service help to increase the proportion of people from Bangladeshi and other BME communities with dementia receiving a formal diagnosis, and in particular, when they are in the early stages of the condition. It identifies and supports hard to reach individuals with dementia and their carers to access services. (90 % of service users and carers indicate positive engagement.) The service provides a supportive community outreach service which is integrated with other dementia services and projects already up and running in Tower Hamlets. In 2017-18, we are exploring how to meet the existing outcomes using a different methodology, building on a recent innovative pilot that works through schools, using a multigenerational model.

- **Adult Autism and Diagnostic Intervention Service**- The Adult Autism Diagnostic and Intervention service (ASD service) supported the alignment of autism services in Tower Hamlets with the aims of the National Autism Strategy. East London Foundation Trust was commissioned to deliver a dedicated autism diagnostic team for adults, provision of a post diagnostic brief intervention programme and assist service users to access employment and training opportunities. Text to be updated
- **Community Equipment Service** - Community Equipment Services in Tower Hamlets include:
  - Community equipment service
  - Tele care service
  - Assistive Technology (see above)
  - Sight and Hearing

  The Community Equipment Service procures stores, delivers, installs, maintains, collects, cleans and recycles daily living, paediatric, moving & handling and sensory impairment equipment, and carries out minor adaptations and alterations to property. In 2016-17, BCF resources were used to allow for seven day working by the community equipment service team. This helped ensure a reduction in avoidable admissions, the facilitation of safe and early discharges and made patients'/service users' home environments safer, so that they could be cared for or self-manage their support needs. The investment in a 7-day service was expected to increase output of deliveries and installations by approximately 30% of current activity and achieve a minimum of 30 additional deliveries and installations of equipment over a seven day week. It has supported timely discharges and enabled complex care to be delivered at home to approximately 500 more patients and service users over a year. Out of these additional 500 patients, the majority received their standard non-urgent equipment items within or below the national benchmark of 7 days. A 95% target was set for people needing same day provision, 24 hours and 48 hours. BCF was also used to supplement resources to allow increased demand for community equipment to be met. For 2017-18, we are pooling all health and social community equipment budgets in the central BCF fund. This will allow the service to be looked at in its totality. The resources for seven day working and to meet additional demand will be rolled forward as part of this.
- **Carers** - A range of support is provided to carers. This includes preventative services, from whole-population measures aimed at promoting health, to more targeted interventions aimed at improving skills or functioning for one person or a particular group. Carers benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing. The primary support

service available to all carers is the Carers Centre. This was accessed by approximately 1,300 carers in 2016/17. It provides information, advice and advocacy service for carers and refers people with eligible needs to the local authority for statutory carers' assessments. Care packages, including respite services for carers are also available to carers following an assessment. The support provided to carers also includes peer support services, like dementia cafés and emotional support and stress management classes. The council is currently co-producing what the carers' services should include from 2018 onwards. This redesign includes an ambitious intention to review and improve carer support and services across health and social care to ensure carers have a better journey and are recognised as equal and expert partners of care. Text to be updated

- **Care Act Implementation** - A number of posts will continue to be funded to ensure the local authority is managing the demands and pressures experienced in Adult Social Care. These posts include operational support, strategic commissioning and workforce development. Text to be updated
- **Personalisation -** It is a fundamental part of our vision that care and support are personalised to patients' and service users' needs and preferences to support patients to feel more empowered and resilient, this will be a core part of the work under the BCF. Tower Hamlets is a demonstrator site for Integrated Personal Commissioning, and 2017-18 will see the expansion of personal health budgets and joint budgets with social care for people with learning disabilities, mental health needs and multiple long term conditions. The targets for 2017-18 are 1,500 personalised care and support plans, with the offer of a personal health budget, resulting in 300 personal health budgets or joint budgets. In 18/19 the expectation is that we will achieve 3,000 personalised care and support plans and 600 personal health budgets or joint budgets.
- To follow:
  Extended Primary Care Team
  Integrated Clinical and Commissioning Quality Network Incentive Scheme
  RAID
  Mental Health Recovery College
  Falls prevention
  Community Geriatrician Team
  Psychological Support for People with Long Term Conditions (Previously Mental Health Personal Commissioning)
  Discharge to Assess
  Age UK Take Home and Settle
  Single Incentive Scheme

6.2 Improved Better Care Fund

The size of the pooled budget has also been increased by the inclusion of the Improved Better Care Fund. The IBCF resources available to the borough are set out in the table below.

Tower Hamlets	2017-18 Additional funding for adult social care (£m)	2018-19 Additional funding for adult social care (£m)	2019-20 Additional funding for adult social care (£m)
2015 Spending Review	1.6	7.7	12.8
2017 Budget	7.0	4.2	2.1
Total	8.7	11.9	14.9

IBCF is being used by the council to address a number of high priority needs, including demographic pressures, safeguarding and ethical care and to meet inflationary pressures within the care system.

To strengthen the stability and sustainability of the provider market, it is also proposed to increase nursing home provision in the borough. This will complement already agreed uplifts in care funding to improve the quality of residential/nursing provision and wider support in the community, such as enhancing home care linked to hospital discharge and improving reablement approaches in day support. Work will continue with providers during the autumn of 2017 through a number of 'summits', in which further needs and different approaches may be identified. A contingency provision has been earmarked to finance these.

Building on the above theme, further investment of approximately £1.4m in a full year is being made that will benefit health services in the borough. This includes provision to enhance capacity and skills in the Community Health Social Work team to increase the number of people it is able to support on the integrated care pathway. It also includes the enlargement of the Hospital Social Work Team to get more people home quickly and safely and reduce the need for residential placements. In addition, the IBCF is being used to fund social work support to strengthen the continuing healthcare process, with a view to developing a new joint service model in the medium term.

A number of initiatives are being funded that are designed to address unmet need in mental health services. These include projects targeted young people transitioning from children's services to adults' and working with people at risk of anti-social behaviour. For instance, a Community Multi-Agency Risk Assessment Case Conference, MARAC, is being established, along with an Independent Anti-Social Behaviour Victim Advocate post. A scheme for people at risk of self-neglect and self-harming behaviours is also being funded.

A number of areas of unmet need and services experiencing demand pressures will also be supported via IBCF. Initiatives include a project to reduce isolation among vulnerable older people. Additional resources are also being directed to the reablement service to address rising demand, and a significant sum has been allocated to commission additional support to address assessment and review backlogs in adult social care. Finally, the IBCF is being used to support the implementation of a number of adult social services transformation reviews.

6.3 Disabled Facilities Grant

Disabled Facilities Grant (DFG) plays an important part in Tower Hamlets' approach to integrated care. Expenditure of the 2017-18 DFG has been agreed with the local Housing Authority and will centre on meeting our duties to provide adaptations and facilities in the homes of disabled people, as set out in the Housing Grants, Construction and Regeneration Act, 1996.

The local authority provides services to clients requiring adaptations through its Occupational Therapist service and Home Improvement Agency. It works closely with Registered Providers which own the majority of social housing in the borough. The tenants of the borough's Registered Providers account for around 75% of DFG expenditure. This spend reflects the relatively low level of owner occupied housing in the borough.
Since the integration of DFG into the Better Care Fund, a cross divisional DFG Working Group has been set up within the council to review the DFG programme, consider a pathway redesign for DFG and the DFG's integration with assistive technology and other Home Care services. The Working Group is also currently giving consideration to how it can make better use of the flexibility allowed in DFG spending by the Regulatory Reform (Housing Assistance)(England and Wales) Order 2002 . It is proposed to set aside £300,000 of the DFG allocation for this purpose in 2017-18.

Areas for potential development in 2017-18 are:

- a joint training and development programme to ensure the key people in the health and social care system understand best practice in prescribing equipment through the DFG
- the exploration of further uses of assistive technology
- to extend the excellent OT work concerning children with autism into the adults programme, in order to ensure safety and independence
- the exploration of new ways of working (e.g. the use of trusted assessors).

6.4 Other New Functions within the Pooled Budget

The following functions have been incorporated within the pooled budget for the first time:

- **LinkAge Plus -** This is a preventative service which provides Tower Hamlets residents aged 50 and over universal access to community outreach; a wide range of physical and social activities; information and advice, including signposting and onward referrals and a range of health-related services.
- **Specialist Palliative Care (St Joseph's Hospice) -** St Joseph's Hospice provides high quality, efficient and effective specialist palliative support for last years, months and days of Life care. It uses a multi-disciplinary approach to care, with access to the full multi-disciplinary team, as defined by NICE Supportive and Palliative Care Guidelines. It provides advice and support to nurses, doctors, GPs and other members of the wider health and social care team and care to the patient and their carer/family.
- **VOICES2 Survey -** This survey provides an annual measure of carers' experiences that can be monitored over time, and compared with the national average and other CCGs' results. It identifies factors in both positive and poor experience and enables this

information to be used to improve services. It also identifies gaps in the system and areas for improvement.

- **Age UK Last Years of Life -** This initiative works closely with hospitals and GPs in Tower Hamlets to engage socially isolated people, who may traditionally be reluctant to accept help and support - particularly from the statutory sector; It signposts and refers people into support services provided by the NHS, the council and the voluntary sector. The service undertake this needs assessments in order to understand people's requirements in their last years of life. It provides a befriending service and practical help in the home that is not covered by social services. It also provides support to carers, enabling them to have short term 'care-free' time and provides holistic support (e.g. therapeutic services). It also provides preventative services to protect the health and wellbeing of both cared for people and their carers through befriending, practical and emotional support.
- **Barts Acute Palliative Care Team -** The Palliative Care Team gives specialist advice about symptom control as well as psychological and social support to patients, families, carers and staff. In the early stages of illness, palliative care may be provided alongside other active treatments. For patients at the end of their life the service aims to provide appropriate end of life care to ensure comfort and dignity in death. Families, partners and carers may also need expert support in bereavement.
- **AADS Service - Discharge to Assess – To follow**
- **Age UK Take Home and Settle – To follow**
- **Tower Hamlets CVS Development Programme -** Objective is to build the capacity of the sector to respond to the changing commissioning landscape in health and social care to become partners in the delivery of improved health and well-being for the residents of Tower Hamlets. Capacity building aimed at 4 distinct areas:

  1. THCVS Priorities for Commissioning Intentions financial year 2017-18
  - Support the VCS consortium during its first year of delivery, seeking other opportunities &
  - private investment
  - Developing sustainable funding platform for strategic work
  - Supporting governance via the existing H&WB Forum
  - Building membership, quality insuring & improvement
  - Building relationships with commissioners/ & the private sector

  2. Continue to support the H&WB Forum & provide a strategic voluntary sector presence & leadership as currently, including to the health and wellbeing board and THT
  - Running 4 X Forum and 4 X Steering Group meetings
  - Re-run Leadership in Health workshop
  - Representation on Health & Wellbeing Board & Subcommittee
  - Representation on THT Board & Subcommittees
  - 20 HWB Bulletins / year

  3. Delivering training and support to increase VCS capacity
  - 4X Health development workshops annually
  - 1:1 support to 10 organisation's per quarter – re income diversification etc.

4. Continue to support best practice in commissioning

- Re-run NCVO commissioning Masterclass
- Prioritise Impact/Outcomes monitoring training
- Work with statutory partners to strengthen co-production
- Explore best practice around service co-design.

7. National Conditions

7.1 National Condition 1: Jointly Agreed Plan

This plan has been jointly agreed by the Tower Hamlets CCG and Tower Hamlets Council. It has been endorsed by Tower Hamlets Together Board and the Tower Hamlets Health and Well-Being Board. The local housing authority has been involved via the Disabled Facilities Grant Working Group. Approximately £300,000 of the borough's DFG allocation will be used to support new ways of working in conjunction with the Community Equipment Service. The use of the IBCF has been agreed between the council and the CCG and endorsed by the Health and Well-Being Board. Provider partners have endorsed the proposals through the Tower Hamlets Together Board.

7.2 National Condition 2: Social Care Maintenance

Planned spend on social care from the CCG minimum for 2017-18 and 2018-19 is equal to the amounts confirmed in the planning template (£7,524,476 in 2017-18 and £7,667,441 in 2018-19). In addition, the CCG is contributing from its own resources to one small social care project, the Social Worker Input to the Memory Clinic, as it did in 2016-17. The proposed funding is regarded as sustainable from the point of view of the local health and care system as a whole, and is not expected to have any adverse effect on the stability of the system. Indeed, much of the expenditure on social care is designed to support the financial and operational stability of local health services.

Most of the social care initiatives funded through BCF will have a direct or indirect impact on health services in the borough. These include the funding of the Reablement Team, the Community Health Team (Social Care), the Seven Day Hospital Social Work Team, the Seven Day Community Equipment Service, the Assistive Technology Team, the Dementia Café, Social Worker Input into the Memory Clinic, the BME Inclusion Service the planned investment in Carers and the Adult Autism Diagnostic Intervention Service. Much of the investment via the Disabled Facilities Grant also complements health provision in the borough.

All the investment in social care services via BCF has been agreed between the council and the CCG as being consistent with the priorities of this plan.

7.3 National Condition 3: NHS-Commissioned Out-of-Hospital Services

See attached planning template confirming funding committed to out of hospital services is above minimum allocation.

7.4 National Condition 4: Managing Transfers of Care

Narrative concerning eight High Impact Changes to be added after Task and Finish Group meeting to complete action plan. Meeting booked for w/c 28th Aug.

8. Overview of Funding Contributions

The planning template shows how the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose. Further details are provided in Sections 6 and 7. Among other things, specific funding has been allocated to the following areas:

- Implementation of Care Act duties
- Funding dedicated to carer-specific support
- Funding for Reablement
- Disabled Facilities Grant

This has been agreed with relevant stakeholders and is in line with the National Conditions.

In addition, the Improved Better Care Fund has not been offset against the contribution from the CCG minimum and will be spent entirely on additional activity. Plans for the use of IBCF money address all of the purposes set out in the grant determination, namely: meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

9. Programme Governance

9.1 Governance Arrangements

The overarching governance and accountability arrangements for integrated care in Tower Hamlets in 2017-18 are set out below.

Responsibility for the strategic development and resourcing of the BCF Plan and programme is undertaken by the Joint Commissioning Executive (JCE) of the CCG and the local authority. This is the 'Partnership Board' as defined in the BCF Section 75 agreement. The JCE also oversees the quarterly monitoring returns to NHS England and the Department for Communities and Local Government for the Better Care Fund and Improved Better Care Fund respectively.

The BCF programme is overseen and driven on behalf of the Health and Well-Being Board by a joint Complex Adults Programme Board (CAPB). The CAPB includes representatives from:

- CCG and local authority commissioners
- Provider colleagues from social care, acute, community, mental health and primary care
- Voluntary sector

As noted in Section 2, the role and membership of the CAPB is currently under review, as part of the wider development of health and social care partnership arrangements in the borough, in which it is proposed that Tower Hamlets Together will become the formally acknowledged health and social care integration partnership for the borough, under the Health and Well-Being Board. From 2017, it is anticipated that the CAPB will be chaired by a Tower Hamlets Together Board member.

Under the proposals currently being developed, the CAPB will become a formal sub-committee of the Tower Hamlets Together Board, which in turn will be a formal sub-structure of the Health and Wellbeing Board.

The THT Complex Adults Programme Board oversees:

- Delivery of commissioned Integrated Care services
- Implementation of Integrated Care, including the Better Care Fund

The governance arrangements are set out in the diagram below.

INSERT DIAGRAM

9.2 Management arrangements to support joint working

The management of the delivery of the Better Care Fund programme is as follows:

- Work streams within the Better Care Fund for service delivery are managed by the lead provider or providers for that function,

- The provision of Community Health Services is delivered by Tower Hamlets Together through the Alliance contract referred to in Section 2.

The Complex Adults Programme Board will receive the following management information:

- An integrated care dashboard, which will be refreshed in 2017-18
- Reports on individual schemes will be made on an exception basis, for example, as new developments are implemented. In addition, providers are required to produce recovery plans where delivery is off track.

Under the proposed new partnership arrangements, the CAPB's main route for the escalation of issues will be to the Tower Hamlets Together Board, and thence, as appropriate, to the Joint Commissioning Executive, the Health and Well-Being Board or the formal decision-making processes of relevant partner organisations.

The process of exception reporting to the CAPB, described above, together with regular financial monitoring and individual organisations' management and performance management arrangements are together intended to ensure that schemes perform effectively, and that effective remedial action can be taken quickly, if necessary.

In addition, during 2017, the council and the CCG are taking further steps to strengthen local integrated commissioning arrangements, through the recruitment of a new joint post Director of Integrated Commissioning. This is expected to be followed by the establishment of a Joint Commissioning Hub. To be developed

Benefits Realisation and Capturing and sharing learning
To be developed

We will measure benefits in three ways:

- Provider reporting: Our providers update the Complex Adults Programme Board bi-monthly. This picks up delivery progress and risks, and gives assurance on implementation
- Integrated Care Dashboard: Covers BCF metrics and a wide suite of further locally agreed metrics, designed to measure progress in meeting our integrated care objectives
- Patient Experience Metric: We are developing innovative metrics of patient experience with Picker and DoH as part of the Pioneer programmes.

Through Tower Hamlets Together, the borough has placed particular emphasis on sharing good practice and innovation with other areas, regionally and nationally. In addition, the council and the CCG have responded positively to requests for information and speakers from bodies, such as NHS England, and other health and social care networks. To be developed further, with examples

10. Assessment of Risk and Risk Management

As in 2016-17, Tower Hamlets' approach to risk sharing has been developed with the following principles:

- That risk for service budgets within the pooled fund sits with the providers of those services (see Section 75)
- The construction of a risk and reward pool between all THT partners and the CCG and council

The following table sets out the perceived most important risks and the actions that will be taken to address them.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Unexpected shifts in care costs not accounted for in BCF Planning to either LBTH or CCG.	2	4	8	KPIs allow early identification of shifts in pressure. The S75 agreement will have robust monitoring and evaluation procedures via the Complex Adults Programme Board and the Joint Commissioning Executive. The Better Care Fund Working Group and DFG Working Group monitors shifts in demand.
Failure to identify a high quality	2	3	6	Clear expectations set out in the process so that quality is achieved.

provider				Robust process underpinned with clear KPIs, deliverables and specification
One of the providers withdraws from the process	1	4	4	Ensure there is strong PMO support to ensure momentum Contracts do not allow for withdrawal before review period. Robust Commissioning Frameworks to manage risk.
Patient/client specific information is not able to be shared and this leads to fragmented care and lack of integrated working.	2	4	8	The following needs to be checked and updated INEL Information Sharing Agreement in place. SSISSA available for specific sharing. Patient/service user consent to share information forms used in ASC and health. Robust Information Governance in place (IG Toolkit compliant) Caldicott Guardian Seeking full signed consent as a matter of routine best practice from every patient/service user who is within the integrated care services. Currently applying for s251 approval and working with the Pioneer programme at the Department of health Review Client Information Sharing Agreement Form in ASC to ensure is legally compliant.
Achievement of DTOC metric	3	4	12	Monthly monitoring of KPIs for early identification of DTOC

put at risk due to people requiring specialist provision commissioned by NHS England remaining in hospital which will lead to delayed transfers of care (DTOC)				Joint Working Group oversees DTOC performance and regular updates are provided to Joint Commissioning Executive.
Risk BCF Plans will not be agreed between LBTH and CCG	1	5	5	Strong governance structures already exist between the two organisations through the Tower Hamlets Health and Wellbeing, the Joint Commissioning Executive Board and the Complex Adults Programme Board. These Boards will regularly review the planning and implementation of the BCF Plan.

Risk and reward pool – Local Incentive Scheme

Text to follow

11. National Metrics

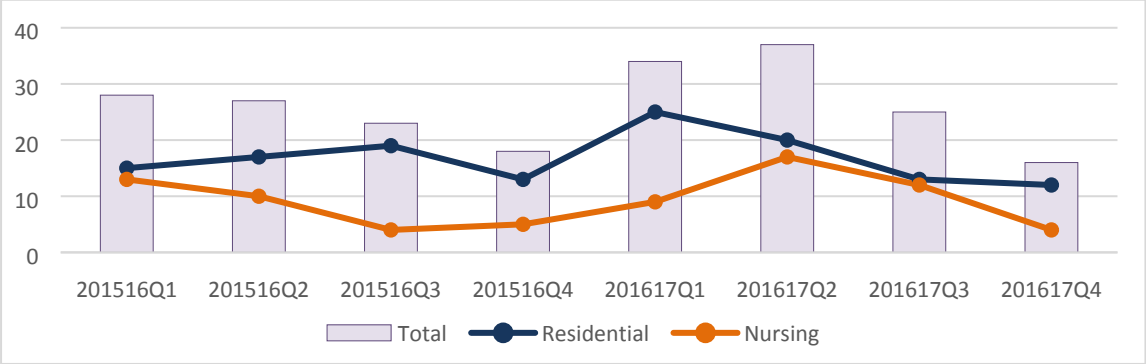
- **Non Elective Admissions** To be updated

A target has been set for general and acute NEA and included in the submission template. Section xx provides a list of BCF schemes which support the reduction of NEA. Needs to be developed

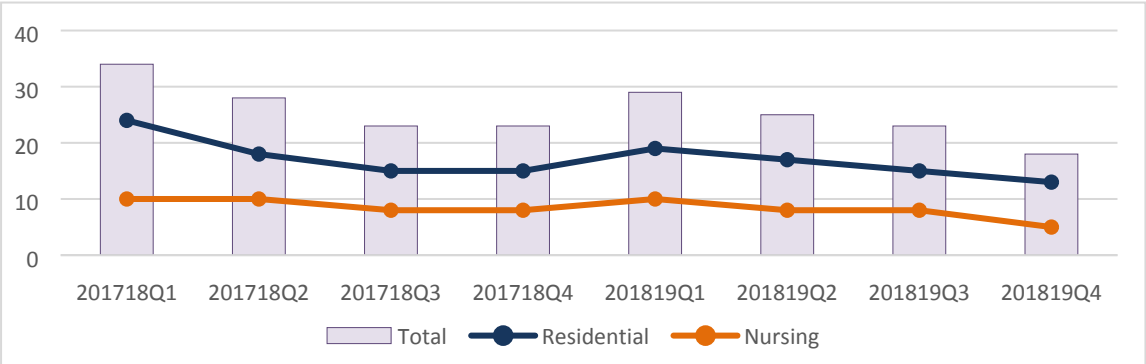
- **Admissions to Residential and Care Homes**

The tables below set out Tower Hamlets' admissions to residential and nursing care homes for people aged 65 and over. (Actuals are shown in the first table and forecasts for 2017-19 in the second.)

	201516Q1	201516Q2	201516Q3	201516Q4	201617Q1	201617Q2	201617Q3	201617Q4
Residential	15	17	19	13	25	20	13	12
Nursing	13	10	4	5	9	17	12	4
Total	**28**	**27**	**23**	**18**	**34**	**37**	**25**	**16**



	201718Q1	201718Q2	201718Q3	201718Q4	201819Q1	201819Q2	201819Q3	201819Q4
Residential	24	18	15	15	19	17	15	13
Nursing	10	10	8	8	10	8	8	5
Total	**34**	**28**	**23**	**23**	**29**	**25**	**23**	**18**

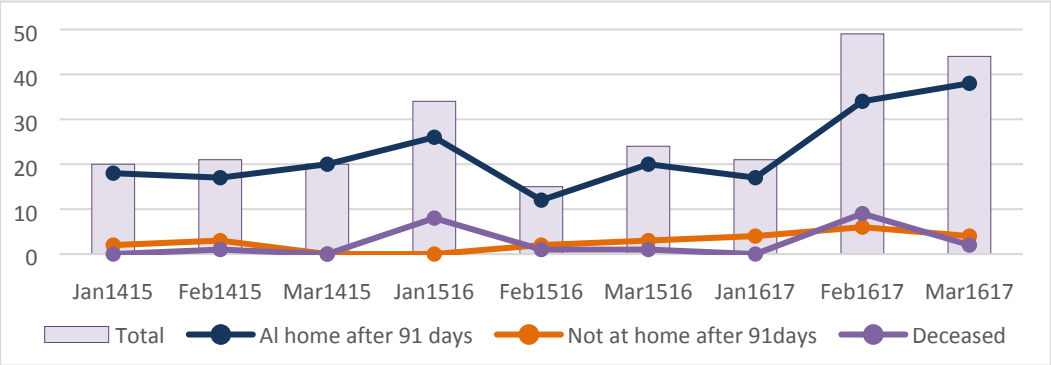


Under our prevention agenda, and with the support of BCF and IBCF resources, an Improvement Board has been set up to plan and manage the demand for residential and nursing care homes for people aged 65+. One of the key measures adopted as part of this plan has been a delegation of resources to the 'front door', with the intention of managing demand at the point of contact through more effective utilisation of equipment and adaptations, along with reablement services. This is reflected in the increased usage of reablement services in 2016-17 referred to above (cf ASCOF 2B 91 days indicator). The forecasts are ambitious but are considered achievable with the current improvement plans and additional support for coming years of 2017-18 and 2018-19 as per the tables above. Community Health Teams have begun engaging with high-risk integrated care patients with the aim of co-ordinated support to maintain independence. The reablement service continues to support the independence of service users.

- **Effectiveness of Reablement**

The tables below sets out performance to the end of March 2017 against the national metric.

	Jan1415	Feb1415	Mar1415	Jan1516	Feb1516	Mar1516	Jan1617	Feb1617	Mar1617
Al home after 91 days	18	17	20	26	12	20	17	34	38
Not at home after 91days	2	3	0	0	2	3	4	6	4
Deceased	0	1	0	8	1	1	0	9	2
Total	**20**	**21**	**20**	**34**	**15**	**24**	**21**	**49**	**44**



The overall number of people being supported with reablement services following a hospital discharge has increased significantly. This is in part a reflection of changes in policy and practice and an increase of staffing resources allocated towards supporting people leaving hospital. In the final quarter of 2015-16, 73 people received a reablement service following discharge from hospital. In quarter 4 of 2016-17 the corresponding figure was 114 people supported by reablement. The volume increased (by 56%). 78% of the cohort were still at home after the 91 day period, compared to a target of 82%. To a considerable extent this reduction in performance is a reflection of the substantial increase in the number of people supported.

Targets have been set for 2017-18 and 2018-19 of 80.0% and 83.1% respectively. These targets are considered achievable in the light of past years' performance. Improved Better Care Fund resources, are being invested in the reablement service to reduce waiting times,

and this is expected to have the effect of increasing the effectiveness of the support given to people leaving hospital.

- **Delayed transfers of care (DTOC) plan**

Section to be developed and updated

Tower Hamlets has a local action plan for managing delayed transfers of care, which includes stretching targets for their reduction. It should be noted that within Tower Hamlets, figures on the DTOC measure, as defined within the BCF guidance, are already relatively low compared to comparator boroughs. However, given we have a large tertiary trust which includes hyper acute stroke, and trauma services, hospital flow is impacted significantly by the challenges connected to managing patients whose homes are outside the borough, and even outside London. Therefore, our significant plans address both issues, but this is not reflected in the Borough metric.

Tower Hamlets' plan is within the context of the A&E Delivery Board plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community. The CCG has invested along with its partners in the STP area, via operational resilience monies, in a number of effective schemes to manage the system at points of highest pressure. This builds upon the recurrent investment the CCG has made over the last three years which is enshrined within the Better Care Fund and associated strategy. As such, reductions in emergency admissions, A&E attendances, all of which have a significant impact on DTOC, are reflected in CCG operational plans.

DTOC are a particular measure connected to the local incentive scheme, therefore acting as a local risk sharing agreements with respect to DTOC. Providers of services will be rewarded for the delivery of services in line with existing guidance and best practice. In the event of non-delivery, the commissioner is able to use this scheme to manage risk and make decisions on any additional investment, or changes in the existing portfolio to drive delivery. In agreeing our plans for System resilience and delayed transfers of care, Tower Hamlets CCG and council have engaged with our local acute and community trusts (Barts Health), and Mental Health Trust (East London Foundation Trust). All partners sit on the System Resilience Group, Urgent Care Working Group, A&E Delivery Board and are full members of the Tower Hamlets Together Board for the Better Care Fund. The GP Care Group, Barts Health and ELFT also hold an Alliance Contract for community services as mentioned above. The A&E Delivery Board has led on the implementation of national guidance and best practice, including the eight 'high impact interventions' that were agreed by ECIP. In addition there has been engagement with the independent and voluntary sector providers locally including the funding of such initiatives as "Take Home and Settle" with Age UK.

A DTOC target rate has been set of 330 per 100,000. We aim to reach this target following work undertaken in the last 12 months and work which is planned to happen as discussed in this narrative. 560/100,000 was the borough's original target. We are hopeful in achieving this ambition, based on performance in Q1 of 319. Performance is already low when compared to other areas. Our view is that a statistically significant reduction from this low baseline would not be achievable. The pressure on DTOC in Tower Hamlets is largely driven

by out of borough DTOCs, due to Barts Health's status as a major tertiary trust. DTOC driven by local flow issues (the focus of the BCF) are relatively low compared to other areas.

Please refer to the attached – DTOC Trajectory and Plan Assurance (add plan)

- **Delivery of 7 day services to support DTOC**

Rapid Assessment Interface Discharge

Rapid Assessment Interface and Discharge (RAID) is a service open to all patients with mental health and drug and alcohol problems over the age of 16 presenting at the Royal London Hospital and all associated Barts Health sites in Tower Hamlets. The service offers a comprehensive range of mental health specialties within one multi-disciplinary team. The role of this team is to provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff. The model emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on inpatient wards. This focus on prompt assessment and intervention is intended to improve patient experience and outcomes, support diversion and discharge from A&E and facilitate early discharge from inpatient wards. The RAID service is available 24 hours a day. There is evidence of an overall decrease in length of stay for patients with mental health and drug and alcohol problems since the introduction of RAID. This is largely driven by a reduction in bed usage for non-elective patients, especially for those with dementia, substance misuse and severe mental illness. It is estimated that this saved approximately 2833 bed days in the 2014/15 financial year. The occupied bed days data for 2016/2017 shows that when patients with mental health problems are referred to RAID they are being discharged at a faster rate evidenced by the trend line which is going down. RAID sees patients with more complex needs who would have otherwise stayed much longer in hospital. The data shows a saving of at least 1778 OBDs a year (an average saving of 1 OBD per patient when you exclude April 2016) and at most 4400 OBDs a year (an average saving of 2.5 OBD if you include April 2016).

Integrated Community Health Team

The integrated community health team provides health and social care input to housebound patients over the age of 18. The service offers a comprehensive range of specialities within one multi-disciplinary team, including nursing, therapies, social care, mental health and case management. There is also specialist input from a community geriatrician and palliative care nurse. The teams are divided into 4 localities across the borough. The focus of the service is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and providing personalised, co-ordinated care in the community. The emphasis is upon improving patient experience and outcomes, supporting self-care, preventing A&E attendances and hospital admissions and facilitating timely discharge from inpatient wards. The service is available 24 hours a day (between 8pm-8am, this is comprised of nursing provision only).

On average, across the four locality teams in March 2015, the service reported:

Responding to 98% of rapid response referrals within 2 hours

Providing input/putting in place packages of care for 97% of urgent referrals within 24 hours

Providing input/putting in place packages of care for 96% of routine referrals within 5 days

The model for community health services changed with the Tower Hamlets Community Health Services Alliance Contract. The community health teams will be remodelled into Extended Primary Care Teams with a focus of supporting self-care and improving health and well-being. The operation of a multidisciplinary Rapid Response Team, consisting of nursing, therapy and social work elements responds within two hours to put in place packages of care. Since April 2017, data shows that this service prevents ED attendance or admission in approximately 90% of patients referred to the team. The Rapid Response Team also works closely with the Physician Response Unit, which is operated by Barts Health.

There is a social care component integrated with the Community Health Team. Fundamental to the overall design of the wrap around approach within the GP networks, this scheme seeks to extend the involvement of social care functions on a spectrum of integration with Community Health Teams over time. The focus of this scheme is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and supporting them in the community, providing care and support closer to home. Targeting the 'frequent flyers' in the health economy, this provides the last resort to health management in the community. The extension of the scheme allows more people to be supported lower down the spectrum of risk to prevent more costly interventions arising. Learning points from this pilot team has been incorporated into the high level plan for Adult Social Care integration with Health. The plan for 2017-2018 it to align social care services with the existing community health teams in preparation for integration in 2018-2019.

Hospital Social Work Team

Through the BCF programme, the Hospital Social Work Team at the Royal London Hospital continue to operate seven day working and extended hours (9am – 8pm daily), with the aim of facilitating rapid discharge of patients who are fit to leave the hospital. As well as hospital based social work staff, the proposals include additional Brokerage staff and Reablement staff to complement weekend discharge and provide a whole system approach. The Hospital Social Work Team also seeks to help reduce further attendances and admissions to hospital by supporting people in the home and other settings.

The focus of this scheme is about preventing people from being admitted to hospital in the first instance, leading to reduced bed days. In addition, through good quality discharge arrangements, people are safely discharged at weekends where they will have previously waited until the following week, or discharged without input from social care, or the carer not being involved in the discharge planning. This will ensure that any carers are fully involved in the discharge, preventing breakdown of care; support is in place in the home (or in step down arrangements) to meet needs preventing relapse and beds are freed up in a planned way over the course of seven days rather than five.

Social workers are based in Acute Assessment Unit (AAU) and the plan for 2017-2018 is for social workers to be proactive in case-finding on all hospital wards. This will lead to efficiencies in assessment turnaround times and improved multi-disciplinary working. The Team also works closely with the Community Health Team to identify people who are frequent visitors to hospital, via the Integrated Care Pathway list. The plan for 2017-2018 is for people on the

Integrated Care Pathway to be more quickly identified redirecting them back home to their GP locality under the care and support of their MDT. Develop this

Rehabilitation and Reablement

Reablement, traditionally provided by the local authority, and Rehabilitation, provided by health services are so closely aligned that the pathway for people leaving hospital and requiring support to return to baseline or maintain their level of independence can be inconsistent and involve duplication across the system. Under the plan for Adult Social Care integration with health services, the two functions will be aligned during 2017-2018 and integrated in 2018-2019. The focus of this scheme is on preventing, reducing and delaying health and care needs from taking root, by offering a spectrum of bringing joint expertise to bear on individual cases, but also espousing the ethos of each other's expertise within specific cases to get the best outcomes for individuals. Getting people back in control of their situations will reduce the call on health services, enable self-management of conditions far more and enable Carers to support individuals appropriately.

Admission Avoidance and Discharge Service (AADS) including D2A

A pilot for a discharge to assess model was funded in 2015/16. Further operational resilience funding has been provided from September 2016 to March 2018 for the Admission Avoidance & Discharge Service (AADS) which incorporates the discharge to assess model for patients at the Royal London Hospital. The community service operates 7 days per week from 8am-6pm with up to 6 weeks input. The team takes a proactive and responsive approach to discharge; aiming to triage patients within 2 hours of referral. Most patients who received the service have been admitted to wards on the 11th and 14th floors at RLH. Since July 2017, patients who are expected to return to their usual place of residence and have had a positive checklist and are awaiting a continuing health care assessment (DST) and expected to return to their usual place of residence can have this assessment completed at home. Between September 2016 and May 2017, over 200 patients have benefited from the discharge to assess model and received a care package via AADS. On average, over 20% of patients require no or reduced social care input at the end of the 6 weeks with AADS.

Approval and sign off

An earlier draft of this plan was endorsed by the Tower Hamlets Health and Well-Being Board on 5 September 2017 and the Tower Hamlets Together Board on 7 September 2017. The final draft of the plan, as submitted to NHS England, was signed off on behalf of the HWBB by Simon Hall, Acting Chief Officer of Tower Hamlets Clinical Commissioning Group and Denise Radley, Corporate Director, Health, Adults & Community, Tower Hamlets Council.

In the event that a second submission of the plan is required, it is envisaged that it will be agreed for submission by the Joint Commissioning Executive on behalf of the Health and Well-being Board and formally ratified by the HWBB at its meeting on 7th November.