DRAFT Better Care Fund planningtemplate – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Tower Hamlets**
Clinical Commissioning Groups	**Tower Hamlets CCG**
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15 (	**£1.2m**
2015/16	**£20.367m**
Total agreed value of pooled budget: 2014/15	**£18.681m**
2015/16	**£20.367m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

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

The CCG and local authority are committed to engaging with all our providers, across the statutory and independent sectors. Both of our local Trusts and the Tower Hamlets Voluntary Community Sector (THCVS) are members of the Health and Wellbeing Board (HWB B) and are fully engaged in the business of the Board including the development of this plan.

All members of the Board are signed up to the Tower Hamlets Health and Wellbeing Strategy. This has four priority areas, which are to be delivered by a set of "enablers" – these are the ways of working and things we need to do to implement the Strategy. There are six enablers, three of which are relevant to this section of the BCF plan:

- **Community engagement and co-production** – a local "out in the community" approach to identifying priorities to improve health and wellbeing and to designing interventions;
- **Integrated care** – bringing different providers together to deliver joined up holistic packages of care; and
- **Commissioning with commitment** – developing a plurality of provision of health, social care, and wellbeing services through the development of local providers and services

The Health & Wellbeing Board has an Engagement & Co-production sub group (see section (d) below).

In addition to this subgroup, the CCG and Local Authority, the commissioners on the HWB Board, each have their own engagement mechanisms to work with both the statutory and the independent/ voluntary sectors. Both the CCG and Local Authority have contracts for a range of services with many third sector organisations and they contribute to the THCVS' Health & Wellbeing Forum where the plans for integrated care have been taken. There are also two representatives from THCVS who sit on the Integrated Care Board in Tower Hamlets.

The Local Authority "Local Account" of performance for adult social care is an annual publication that has tracked developments in how social care works with the Health

Service locally. This is circulated to all local providers. The Council holds regular forums for Adult Social Care providers where providers are informed about key issues and proposed changes. They are a forum for consultations and communication about integrated care plans. Key Council publications for current and potential providers are the Market Position Statement and the Commissioning Plan (current plan covers the period 2012 – 2015). These documents are part of a continuing dialogue with providers. Both of these documents are in the process of being updated and the next editions will reflect changes related to the Better Care Fund.

The Tower Hamlets 2013/16 Prospectus, published in May 2013, sets out the CCG's commitment to work with all providers of health and care based services locally – with specific reference to commissioning services that are arranged around individual people, with the flexibility to be personalised as much as possible. The prospectus highlights the aim of commissioning services that act together seamlessly through adopting an approach that involves a collaborative approach with different commissioners and providers through partnership working. We will build on past successes of integrated services for older people, which has required much closer working between commissioners and providers (CCG, Local Authority, GPs, community health services and social care) and has seen a significant improvement in management of long term conditions, most notably in diabetic care.

A key channel of communication and engagement for the CCG with primary care providers is through the 8 local primary care networks. In each locality, members of practices local to that area meet regularly and the agendas of these groups have started to include integrated care, considering the role of GPs, and the interface of primary care with the new community health teams. Primary care provider involvement in developing the integrated care system in Tower Hamlets includes:

- Briefings and workshops at Clinical Leads, Network, and Locality meetings about the design of integrated care interventions, ensuring primary care is a"co-producer" of service redesign. Organisational development activities, including an event with a speaker from the Nuffield Trust to talk about different primary care provider models.
- Facilitation of a borough wide Task & Finish Group of clinical and managerial primary care representatives from across the 8 local networks to determine the role of primary care in the strategic management of integrated care service provision.
- The development of a single body at borough level for clinical and managerial primary care representatives to represent and support primary care to play its part in the delivery model of integrated care.
- Facilitation of and support for primary care involvement in the senior provider group.

The Council has commissioned a local organisation, using s256 funding, to undertake a range of engagement and peer research activity (SUPeR Group) over the next 2 years. Areas they have been commissioned to work on include: the experience of the ***discharge process from hospital to home,*** identifying issues related to delays in the discharge process, an in depth piece of work on the experience of stroke patients, and ways of engaging people with dementia in residential and nursing care homes.

d) Patient, service user and public engagement

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

As stated above patient, service user and public engagement are built into the Health and Wellbeing Strategy. The compilation of the Strategy itself has been underpinned by significant engagement with the local community.

National Voices "work directly with some patients, service users, carers and their families", in order to improve care. They are committed to ensuring that there is a patient voice in the decisions made in health-care, and provide patient leadership training, amongst other programmes, as a way of achieving this. In 2013, they published work commissioned by NHS England to provide a narrative for person-centred coordinated care.

Engagement on our Strategy

The Tower Hamlets Health and Wellbeing Strategy has an Engagement & Co-production sub groupwhose remit is stakeholder communications and engagement. This group is led jointly by the local authority, CCG and Healthwatch. It aims to explore ways to deliver services in an "equal and reciprocal relationship between professionals, people using services, their families and their neighbours" (NEF & NESTA). In doing this, its ultimate aim is to engage patients fully at every stage of their care. This sub-group will be used to inform the development of the Better Care Fund. Part of this work will be to steer the engagement plan and to build on an initial public event held by the CCG in October on integrated care.

In addition, the Tower Hamlets 2013/16 Prospectus, referred to in the section above, sets out the plans for integrated 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, is interactive, and is starting to embrace the use of videos and YouTube. One such video, on Integrated Care is available at: http://www.youtube.com/watch?v=rqAz8x3m0lM. This kind of communication makes it easy for patients to engage with the CCG's plans.

The Local Authority undertakes annual Service User surveys that give insight over time into service users' experiences of social care services (see also Outcomes and Metrics). There are plans nationally to revise some of the questions to include health interface questions, but as an interim measure locally a question has been added into the 2014 survey to test how people experience joined up care and support. Furthermore, the next national Carers survey, which is completed every 2 years, is due in autumn 2014. Data from these surveys will help to provide the HWB Board with feedback on the changes being made in 2013-14 for building into service redesign plans. More widely, the 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.

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 Local Authority 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 conjunction with the *Tower Project*, which works with children, young people and adults with disabilities. 10 participants, predominantly carers, provided feedback and engagement on plans to Integrate Care. Further similar conversations are due to take place with patients, service users, carers or other stakeholders involved with organisations including Toynbee Hall, which works with deprived communities to reduce poverty and disadvantage, and Age UK, which helps and supports the elderly.

We have recently recruited a local voluntary sector organisation Urban Inclusion, working in conjunction with HealthWatch to carry out "a patient and carer-based evaluation of our "Integrated Care" programme." The aim of this evaluation is to understand "the experiences of and feedback from users of the new service, evaluating their first six months of using it" including:

- Experiences of services before the changes
- Feedback about how easy the new services are to use, navigate and how the service feel to use e.g. did people feel they were treated as partners in their care, did they feel cared for.
- How peoples' health has changed since using the new services, and how their perceptions of their health and ability to manage their health has changed.
- Ideas for improvements and new designs to the Integrated Care programme.
- This user-based evaluation will be used to tailor and improve the Integrated Care programme to the needs of the people who use it.

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

Document or information title	Synopsis and links
Tower Hamlets Health and Wellbeing Board Strategy 2013 - 16:	
Tower Hamlets Joint Strategic Needs Assessment	
Tower Hamlets CCG Patient and Public Involvement Strategy 2013/14:	
Action points from the December Integrated Care Board meeting – including discussion and actions for care coordination & rapid response:	
Care Co-ordination Workstream -on-going developments. From the December Integrated Care Board meeting:	
National Voices narrative slide-pack on 'coordinated care'	National Voices narrative slide-pack on 'coordinated care'
Feedback from the Tower Project patient user group engagement event:	
Websites for: The Tower Project, Toynbee Hall and Age UK.	The Tower Project - website Toynbee Hall - website Age UK - website
Write up of the 2013 Health Conversation – Patient and public engagement event, Whitechapel Idea Store, 19 October 2013:	
Tower Hamlets CCG 2013/16 Prospectus:	Tower Hamlets CCG 2013/16 Prospectus *See pp11 – 12 for Patient and public involvement, and pp30 – 33 for Integrated Care*
Integrated Care programme - patient and carer evaluation: Project specification:	
Understanding co-production	
See 3) National Conditions; a) Protecting social services	
See 3) National Conditions; c) Data sharing	

2) VISION AND SCHEMES

1. Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The development of our integrated care strategy is within the overarching strategic framework in the Health and Wellbeing Strategy with the aims to

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

Our Vision

Our vision for health and care services[1] is of an integrated care system that coordinates care around the patient and delivers care in the most appropriate setting. That services:

- 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

Case for Change

The Tower Hamlets Joint Strategic Needs Assessment highlights long standing issues of poorer health outcomes in the Borough compared to elsewhere relating to wider determinants of health (income, poverty, housing, employment), higher prevalence of risk factors for health (smoking, poor diet, low physical activity, problem drinking etc), higher levels of illness (eg heart disease, stroke, diabetes, lung disease, lung cancer) and poorer survival (eg cancer). As a result of these population health characteristics a preventative approach is taken locally to reduce the prevalence of long term conditions in the population, and promote better management of long term conditions where they exist. As well as the burden of ill health, this also places additional pressure on the health and social care system, where too often, hospital care is the fall back position.

Our strategic objectives to achieve this vision over the next 5 years are set out below:

(a) Delivery of the Tower Hamlets Integrated Care Programme

The new model of Integrated Care will be targeted at the top 20% of patients in Tower Hamlets, who account for around 85% of total acute activity and 75% of acute spend

Interventions will be delivered via integrated multidisciplinary teams coordinated around GP practice networks and localities. This will build on the well established locality and

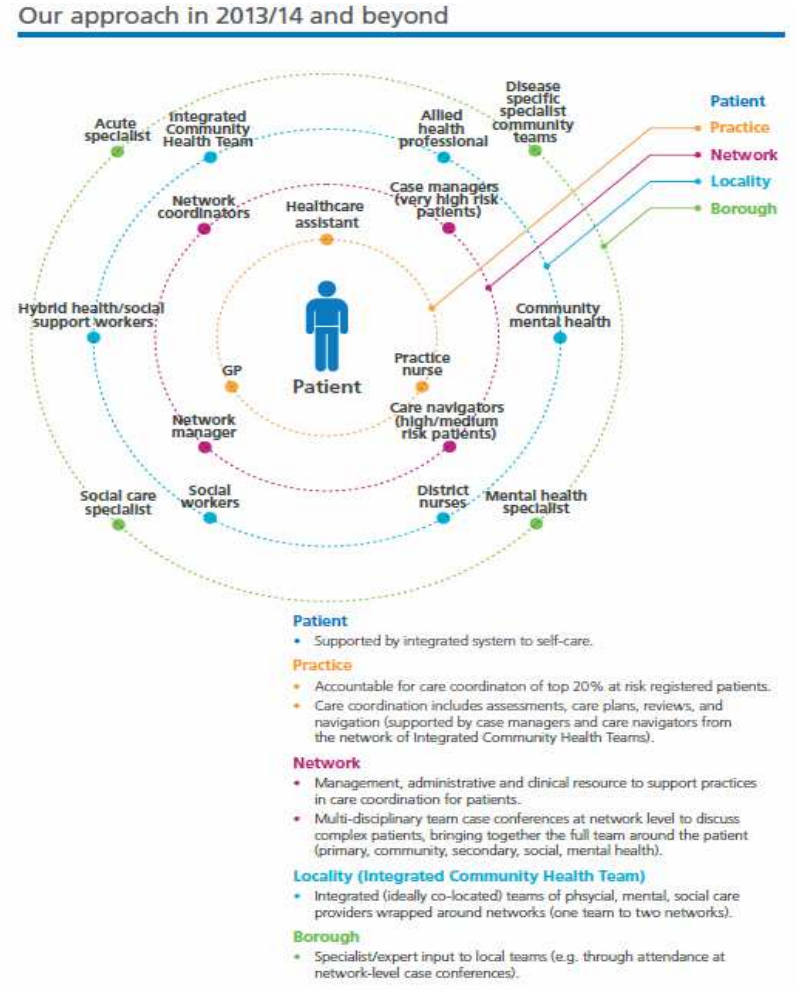
[1]Implementing Integrated Care across Tower Hamlets, East London and City April 2013

GP network that exists in Tower Hamlets.

The programme will have two dimensions:

- The redesign of the model of services and care pathways including the development of an "integrator function" that will hold the whole system of services together to operate in a joined up way; and
- The joint commissioning of services ensuring where appropriate the contestability of services. Services will be commissioned in such a way as to ensure that there is the flexibility for services to be personalised as much as possible. The "whole system" will be commissioned so that services can work together seamlessly.

For more information see 'description of planned changes'



(b) WELC Pioneer

The case for change has been developed across the three boroughs of Waltham Forest, Tower Hamlets and Newham who in October became the "WELC Integrated Care Pioneer". Each borough within the programme has its own integrated board reporting to the local HWB Board ensuring the inclusion of local factors within each borough's plans. However there are many benefits for working at scale in terms of development of enablers (for example information sharing and governance, workforce development programmes etc).

(c) Personalisation

It is a fundamental part of our vision that care and support are personalisedto patients' and service users' needs and preferences, and this wil be a core part of the work under the BCF. More specifically, 2014-15 will see the introduction of Personal Health Budgets for Continuing Care, and then for all Long Term Conditions from 2015. These will be built into the new models of care with detailed financial modelling being developed within phase 2 of the programme.

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 our population to be:

- Focused on outcomes, not inputs and outputs
- Put user involvement and experience at the heart of what they do
- Work together to coordinate their services around individuals needs
- Work together to share risk and reward, and break down traditional barriers between health, social care, and the voluntary sector.

In order to deliver this, we will be commissioning an 'Integration Function' in which all providers will be compelled to participate in order to be commissioned for Integrated Care. See 'description of planned changes' for more information.

b) Aims and objectives

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

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

Aims and objectives of the integrated system

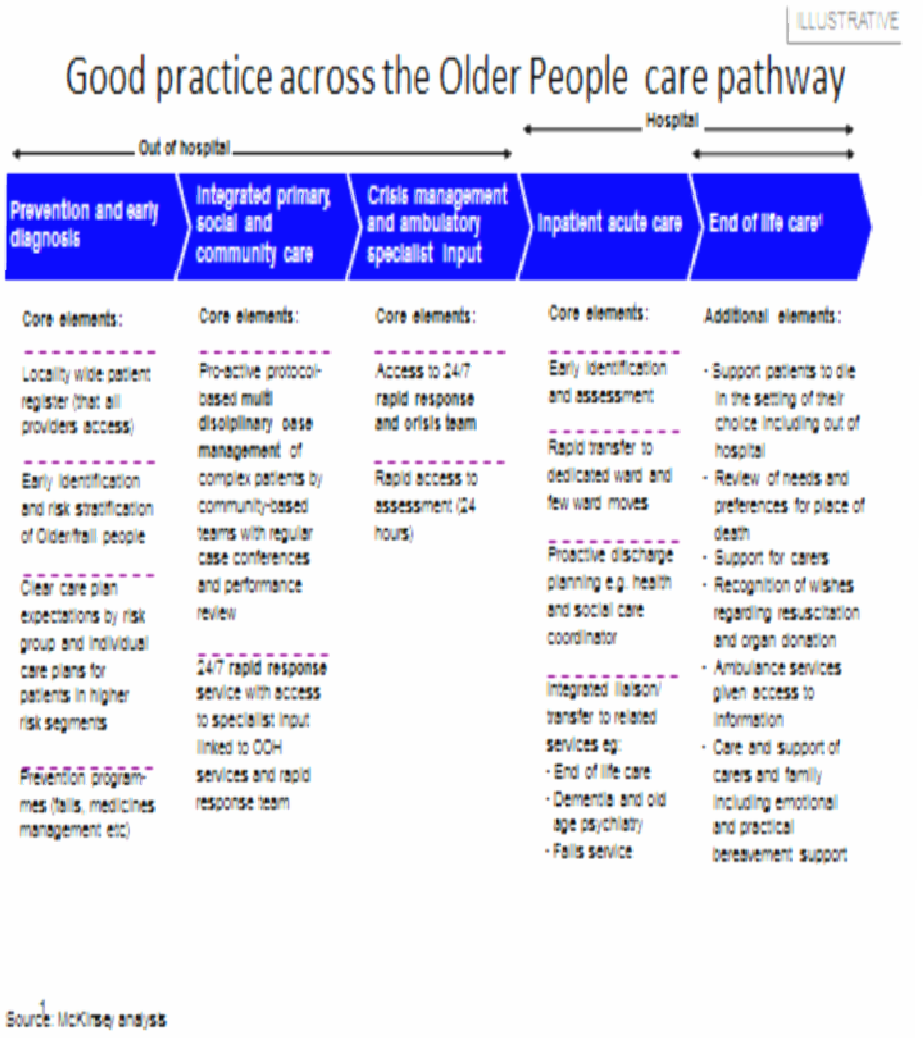
Our vision for the new system is based on three aims with a set of objectives/desired outcomes for the new system as follows:

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 patient's health and improve their outcomes
   - Enable high-quality care that responds to patient/service user 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 minimum necessary costs
   - Avoid duplication of effort in situations where patient is seen by multiple health and social care providers
   - Ensure most effective possible use of clinical time and resources

The diagram below sets out pictorially the vision of how the pathway for Older People will work.



Measurement of aims and objectives

The new integrated service model will be composed of three tiers which will provide a structure to measure the system's aims and objectives:

Tier 1 – Commissioner Level: The Better Care Fund and Key Performance Indicators. The Metrics used by the BCF will be reported to the Health and Wellbeing Board (as commissioner of the BCF) on a regular basis.

Tier 2 – System Management: 'The Integration Function'. The Integration Function will have five key aspects/functions: Governance, Outcomes, Care Plans, Single point of access and communication and information sharing. The outcomes function will be comprised of a dashboard that describes the desired outcomes of individual integrated care services lines and will be used by both providers and commissioners. This will be used to measure the aims and objectives across the whole system.

Tier 3 – Service Delivery: . All Teams that come under the 'Integration Function' (such as Community Health Teams) will have built into their operational policies and team plans the objectives, activities and milestones. These will be fed up to Tier 2.

Measuring health gain of population

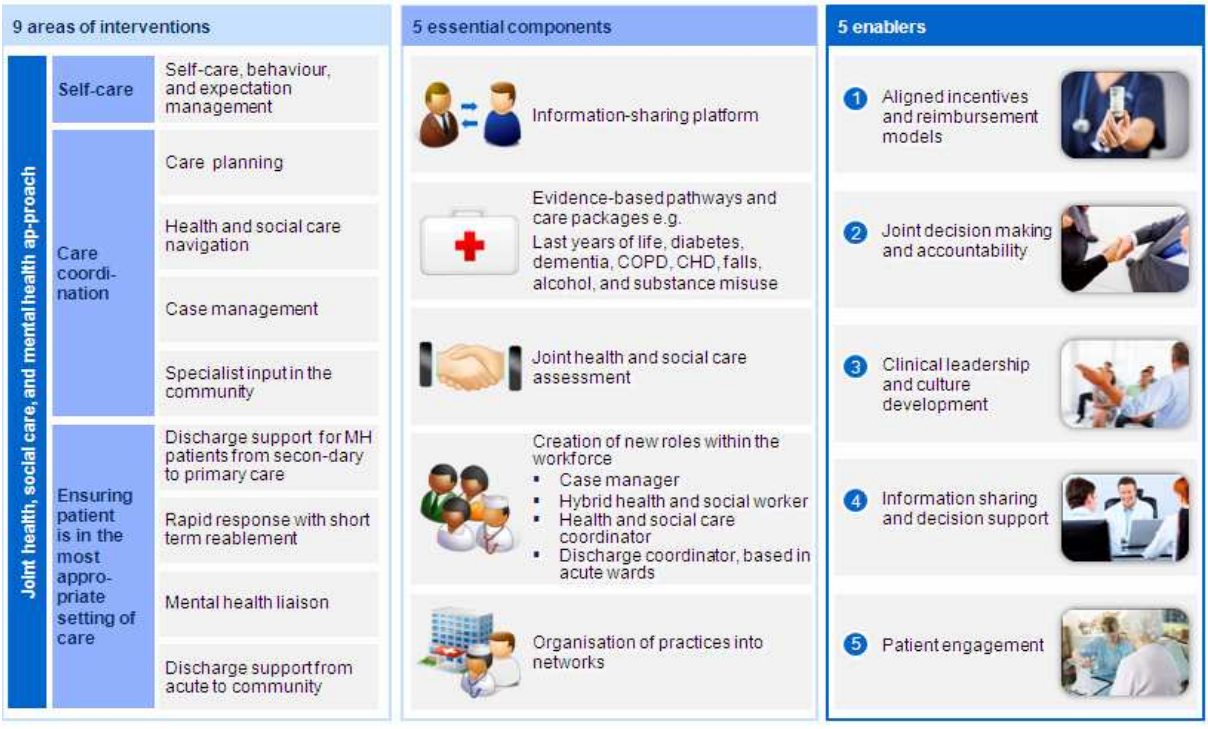
The Tower Hamlets Health and Wellbeing Strategy is composed of four priority areas, which in turn have four Action Plans. These Action Plans cover Maternity Early Years, Healthy Lives, Mental Health and Long Term Conditions and Cancer. Collectively with the outcomes in the three national outcomes frameworks, they provide the Health and Wellbeing Board with a comprehensive measurement of the health of the population over a four year period 2013 – 2016. See Tower Hamlets Health and Wellbeing Strategy in related documentation for further detail.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The Integrated Care Programme in Tower Hamlets is based on 9 key interventions, 5 essential components and 5 enablers as shown in the diagram below.



This model of care has been adapted from international best practice and evidence. The

result is a suite of standard interventions that broadly cover supported discharge, care planning and coordination, and mental health liaison and Rapid, Assessment, Interface and Discharge (RAID).

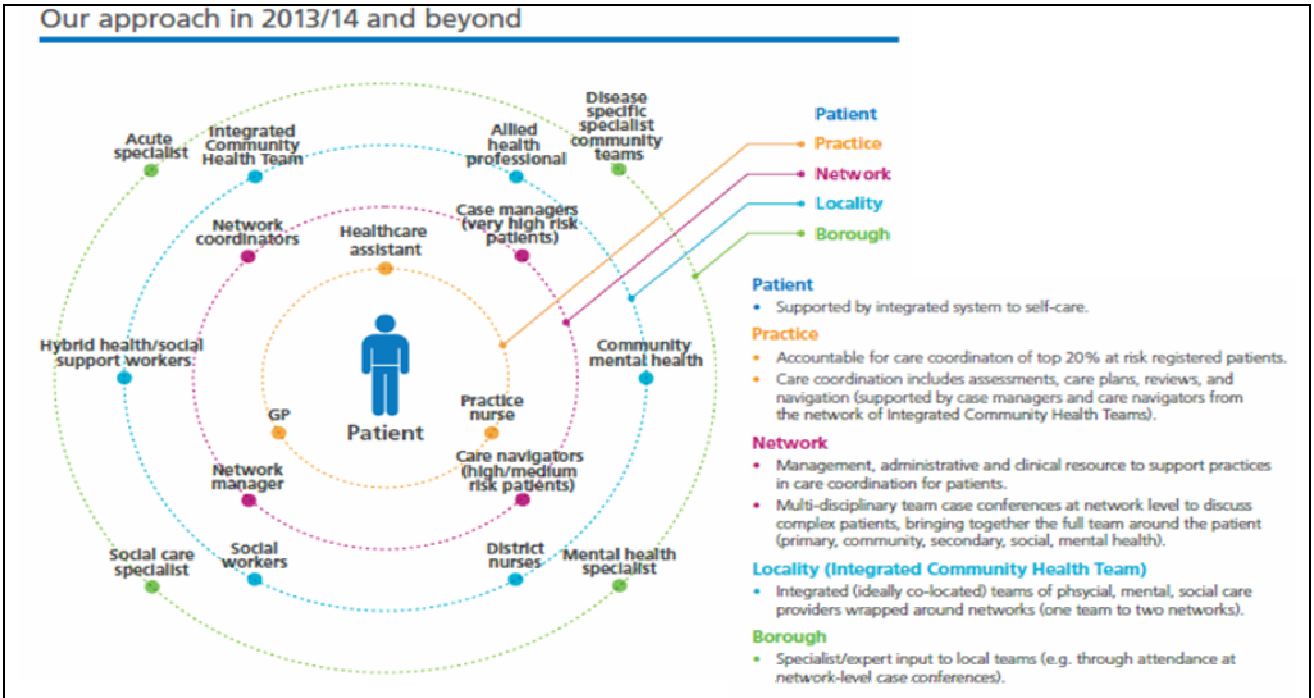
In the first two years, planned changes will revolve around the topics of risk stratification, care coordination, rapid response, discharge support, mental health liaison. In years 2 – 5 the focus will move to increasing input from the voluntary sector, self-management/ care, and assistive technology. Alongside these changes, will be the introduction of personal health budgets. The work to bring together different components of the health systems across primary, community and secondary services is already underway with the work to incorporate social care following during 14-15. It is expected that by the end of 15-16 there will be alignment of health and social care services for the target population for integrated care.

Risk Stratification

Some patients have a higher risk of requiring an emergency admission following a crisis than others, and certain characteristics can be indicative of that risk. Therefore we can stratify patients into categories of risk. Information used to identify this risk includes age, their previous acute admissions, and the existing long-term conditions. Because of the high and growing number of people in the borough with one or more long-term conditions, stratifying the risk of patients in order to focus on those with the highest risk of admission is increasingly important. Our risk stratification has identified the following split of our registered population into the following categories:

Risk factor	**National average - percentage**	**Total**
Very high risk	0.5%	1,662
High risk	4.5%	11,871
Moderate risk	15%	23,600
(Total TH population)	-	261,536
(Total TH population that are very high – moderate risk)	-	37,133

For 2014/15 and 2015/16 the model of care we will be introducing will focus on the Very High and High risk patients groups. The model of care is summarised in the diagram below



Self-care:

Using extensive evidence on the effectiveness of interventions for the self-management of long-term conditions, compiled predominantly at Queen Mary's University, both the CCG and the local authority will be looking to commission interventions that teach patients/ local residents how to manage their conditions. This could involve managing the symptoms to reduce their impact, or adjusting psychologically to life-style changes that living with the condition require. Some of the interventions also involve other people as well as the sufferer, including friends, family, and colleagues.

Where effective, these can have a range of different effects, from reducing the number of admissions and check-ups, to a greater degree of mental wellbeing for the patient. It should free-up both patients and services, and certainly links with the vision of integrated care making patients' care more smooth and reliable by putting control into their hands.

The evidence also presents cases where interventions have not proved successful, have shown some signs of success, or related issues that require more research. All of these could become helpful to implementing integrated care by influencing commissioning choices; either commissioning or decommissioning services or interventions, and by influencing further research.

The planned changes in self-care are also relevant to voluntary sector input, as in some cases; it is voluntary sector organisations that provide the interventions enabling patients to self-manage their conditions.

Care coordination: provided by general practice and an Integrated Community Health Teamthis comprises:

- **Care planning** - joint health and social care assessment.
- **Health and social care navigation** - Administrative support to ensure patients are receiving the correct services. Also provides a 'one stop shop' for questions about

their care plan..

- **Case management** - Deliver care and perform detailed review of a patient's case and condition by GPs, case manager, or MDTs.
- **Specialist input in the community**

Rapid response

The rapid response team will be responsible for providing community based urgent assistance predominantly in patient's own homes in response to acute episodes. The rapid response service will be available for patients, clinicians and care navigators to call on during extended working hours to provide advice and attend the patient as necessary to wherever possible remove the need to call on other emergency care provision, and work with primary and social care.

Discharge support: provided by the acute trust, community health services and social care, this includes

The development of clear discharge procedures, and to build on the opportunities brought by sharing of information between providers. Specifically will include:

- **Discharge support for mental health patients from secondary to primary care;**

ensuring that patients who no longer require specialist mental health care are transitioned to primary care and that GPs are empowered to care for them.

- **Discharge support from acute to community:**

Ensure discharge planning starts from day 1, that patients are assessed regularly during their stay, and that all required care packages are in place for when the patient returns home. This will also aim to ensure that post-acute care can happen at home as much as possible, e.g. rehabilitation, or within alternative housing options and that it can be put in place in time for a patient's discharge.

- **Discharge Coordinator** (Band 4+ hybrid health and social care worker (Allied Health Professionals)

- ***Discharge management***

The function aims to reduce the number of beds days used for each patient, ensure a smooth transition for the patient from hospital to home and improve the communication. They act as the interface between acute and community care.

- ***Mental Health Liaison***

The mental health liaison function operates in the acute setting in A&E and on the wards. It aims to ensure that patients are adequately diagnosed for mental health comorbidities and referred to the right setting of care so that patients with mental health issues who attend A & E can avoid admission, where possible, or if they are admitted, the length of their stay is reduced.

Planned Changes to the Commissioning of ServicesThe Integration Function

The aim of the integration function is to ensure that from a patient perspective the hand offs from one provider to another, one service line to another, one clinician to another are seamless and that patients feel health and social care needs are coordinated around them and with them. For the integrated care approach to be completely successful requires that providers work together to provide an integrated system with the patient at its centre. The integration function will be delivered by all core service providers working in concert to ensure that the benefits of integrated services are realised.

The integration function will need to operate across provider and physical boundaries with key staff being available as required for urgent escalations, but not necessarily face to face. It is envisaged that the provider will need to commit dedicated staff to the delivery of the integration function and will also draft in front line and management staff in a matrix form.

The integration function will operate in a way that supports the patient seamlessly across provider boundaries. Care must be taken to explain to the patient at each stage of their journey what will happen next and at the point of hand over a dialogue will be established with the receiving provider to ensure the patient's needs are understood by the receiver. The integrationfunction will monitor and work to keep to a minimum the number of different health and social care professionals a patient interacts with. Information sharing between providers will be critical to successful integration and providers should be working towards safe, secure and efficient mechanisms to share relevant data across organisational boundaries.

The core integrated care services must include the local authority to ensure that from a patient perspective a seamless health and social care service that centres on the patient is delivered. The core services must also be integrated with primary care providers to the same end.

The integration role will need to cover the providers that are directly involved in the provision of integrated services but will also need to cover the links with other provider groups including social services, LAS and the wider primary care network.

From 2015/16 onwards, part of the payment to the providers will be based on the successful delivery of the Integration Function.

Voluntary Sector Input:

Several voluntary organisations already provide health and social care to Tower Hamlets residents; however this is often not within the framework of any other care they receive. In other words, it is sometimes not linked up with their NHS care or social care from the Local Authority. This means that the services are not necessarily quality assured or accountable, and that there is no interaction between their official care providers and the providers of the care they receive through voluntary organisations.

We want to ensure that the huge value of the voluntary and community sector is realised through better integrated care. We have been working with the network of local voluntary organisations, CVS, to map the services that they offer, and are engaging in conversations with them over the coming months in order to involve them heavily in plans for integrated care, with a view to commissioning services from them.

Assistive technology:

The Local Authority has an established Assistive Technology (AT) project that was set up to implement a new approach to supporting people with Telecare/AT. Instead of AT being aimed mostly at people with low to medium level needs, it is now also offered to people with higher level needs, especially those with long term health conditions. People with dementia and patients on community virtual wards (CVWs) are of particular interest to the new provision. The variety of devices has been increased to cater for a wider range of people's circumstances and health conditions. Training has been provided to potential prescribers of AT, to make them familiar with the application of AT devices and solutions and to ensure they are aware of risks and ethical issues. The process for providing AT includes appropriate approvals for prescriptions as well as points at which reviews are done to check the suitability of prescribed devices. The current AT project is supported through existing S256 monies and the success of the existing AT projects will be developed on through the BCF. This will be achieved through linking the work with ongoing work streams of the health and Wellbeing Strategy.

d) Implications for the acute sector

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

Impact on Secondary Care

Operational and Cultural Impact

Moving health services to a personalised approach from one based on disease categories will require significant transformational change. The Integrated Care Board, and WELC pioneer group have been actively working with all providers on potential implications for OD and workforce. It is likely that providers will respond to these intentions by making changes to their team structures. This work has already started in Tower Hamlets, with a full redesign of an Integrated Community Health Team, and the development of a competency framework for care coordination and navigation.

Financial Impact

Investment

Our plans include some investment in enhanced services in secondary care namely:Investment in mental health liaison – the provision of a single multi-disciplinary mental health and drug and alcohol assessment service to provide expert advice, support and training to Royal London Hospital clinicians. The Service will be fully integrated into the acute trust sites in Tower Hamlets, and will maintain a very high profile.

Disinvestment

The Integrated Care Programme in Tower Hamlets aims to improve the health and wellbeing of those at highest risk of a hospital admission. As outlined previously, we will do this through a combination of patient centred care planning, information sharing, and redesigned services to better respond to patients' needs. Therefore we expect that as a result, there will be a reduction in income to secondary care as a result of:

- Reduced emergency admissions to hospital from patients within very high and high risk groups by around 25%-40%
- Reduction in emergency activity in A&E from patients within very high and high risk groups
- Potential reduction in "elective" procedures due to better managed conditions
- Reduction in drugs costs associated with very high and high risk groups

Risk of non-delivery

Through our provider appointment process providers have been instructed that the remuneration framework for their services will move from a purely activity based or block contract, to a mixed contract which includes incentive payments for the production of high quality outcomes for patients.

Improved provider efficiency

Through transformational change, adjustments to investments and disinvestments, and through innovations such as data sharing and hybrid roles, that providers will be able to release operational efficiencies. For example, our case for change assumes that we can avoid a significant number of emergency admissions and reduce length of stay. This will support provider organisations to be able to secure income and minimise costs

Integration Function

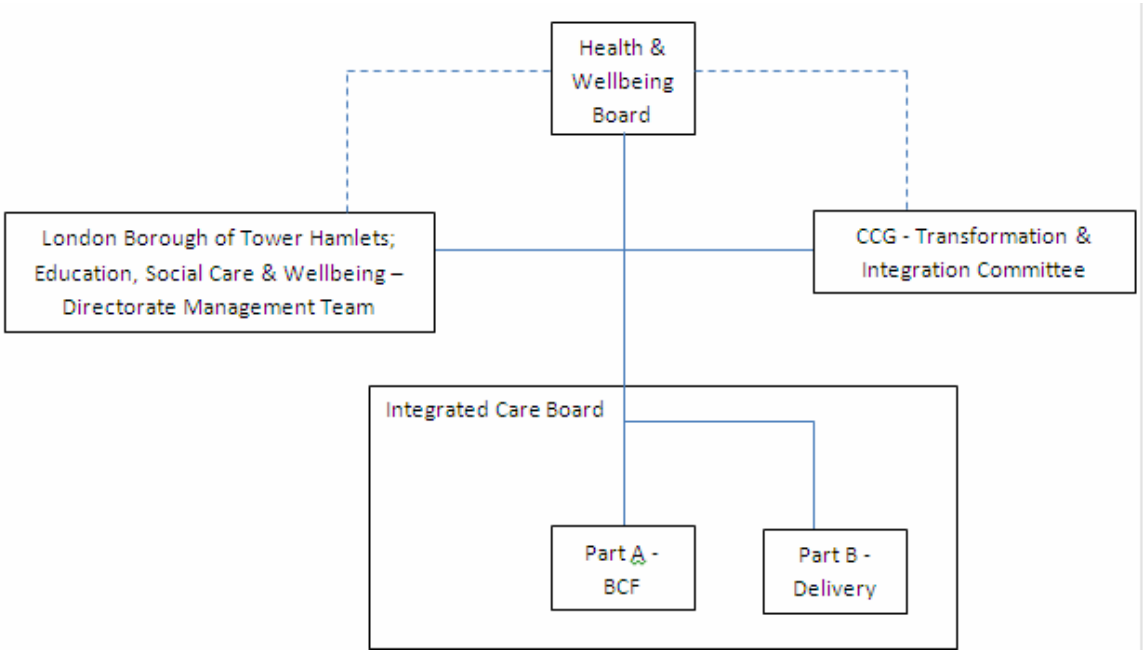
The integration function will require organisations delivering part of the patients' care, including hospital acute care, to work together much more closely than they ever have before and hold each other to accountfor delivery of seamless care across the system. Working together will need to be underpinned by robust shared management and governance arrangements, and it is proposed to put in place a pooled fund into which a proportion of the savings will be placed and used to mitigate the risks of additional costs resulting from service change and shifts in activity between providers.

In particular providers will be required to articulate:

- Collaborative vision for joined up care
- An agreed plan that describes how partners will share risk and deal with clinical governance issues for the collaborative.
- How any share of the savings pool created by integrating services will be used to further develop integrated services

e) Governance

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



ICB governance

The Better Care Fund will be governed by the Integrated Care Board (ICB); which comprises members of the CCG and the Health & Wellbeing Board (HWB). Within each constituent organisation the, London Borough of Tower Hamlets' Education, Social Care & Wellbeing Directorate Management Team, and the CCG's Transformation & Integration Committee respectively hold important governance functions. Ultimately in this model it will be the role of the Health and Wellbeing Board to hold the whole system to account at a strategic level.

It is proposed that monthly ICB meetings will be split into two sections; Part A for commissioning only and Part B is for commissioners and providers. The use of the Better Care Fund will be dealt with under the commissioning section of the ICB.

In 2014-15, the first year of the BCF, there will be a Memorandum of Understanding between the Council and CCG. From the second year (2015/16) onwards, the allocation of funds will be governed by a Section 75 Partnership Agreement,

A programme management approach will be taken to overseeing the Better Care Fund in Tower Hamlets. A joint project plan with agreed milestones will be agreed between the CCG and the Borough, managing the transfer of funds, and the commissioning of services using those funds. This will involve regular meetings between both parties, regular monitoring of performance against outcomes and objectives, including ones expressed here, but also more detailed and time-specific ones that can be reviewed as we progress with implementing integrated care.

Outcomes and objectives monitoring will be underpinned by the development of a Better

Care Fund dashboard, in order to keep a clear and continuous record of outcomes against objectives. Using the programme management approach, escalation routes will be agreed so that problems can be identified early on, and there are agreed strategies for prioritising and dealing with them swiftly.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Yes the eligibility criteria will remain the same.

We will ensure that eligibility criteria for Tower Hamlets will remain the same that is providing care for those who met Critical and Substantial within the Fair Access to Care Services criteria. As stated above in section 2(d) the pooled budget will be used to mitigate any risks arising from significant shifts in activity.

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

The redesign of how care is delivered locally, described in section 2c) above will change the way health works with social care and will move care out of hospital into the community. This is likely to change the distribution of costs and savings between the different parts of the health service and between acute and community care, and health and social care. The BCF will be utilised to enable progress to be made with integration and to ensure that shifts in costs and savings are not impediments to the integration of services by using a pooled budget (from 2015-16) to match resources to where they are needed.

The pooling of the health and social care budgets from 15-16 will reduce some of the risk associated with shifts in activity between providers. This will not only protect local social care services, it will strengthen them.

Recognising the potential changes to the distribution of costs and savings, the local authorities involved in the WELC programme have agreed to track the changes and model the costs and savings: a financial modelling exercise to identify and capture the financial implications of integrated care for social care services.To do this will require sharing of patient/service user level information. This is discussed further below.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

This is already being done by NHS services, and there is a strategic agreement to enhance 7 day working across all services including social care services. Current winter plans provide 7 day working, covering evenings and weekends. This will provide a benchmark for the level of service to be provided long term, in line with Sir Bruce Keogh's initiative to drive seven day services across the NHS over the next three years, in response to concerns about the safety and accessibility of services, amongst other

things, at weekends.

A series workshops organised by NHS Improving Quality are being organised aimed to build “CCGs’ capability to lead transformational change in the care delivery system”. This will involve seven workshops, each approximately one month apart. Each cohort will bring three or four Alliance teams together, each of which will be tackling a specific “change challenge”. The cohort that Tower Hamlets CCG is enrolled on will tackle the topic of building the capability to do 7 day working across the system. The CCG will also invite other relevant partners – possibly from the local authority, third sector, the CSU, and/or the Area Team.

c) Data sharing

Background

Data sharing was identified early on as a key component and enabler of integrated care. As such, finding a way to introduce and implement a system that could deliver this became a priority. The Virtual Community Ward Pilot system (precursor to the integrated care programme) was designed to allow identified users to view patient data shared between clinical systems across designated organisations using a “clinical portal” into a data warehouse containing data for all organsiations within the integrationusing a system called the Orion Health Rhapsody Integration Engine.

Both the CCG and the Council are committed to introducing Orion as quickly as possible, and enabling it to be fully functioning soon (although they are working to different timetables). The system is already partially functioning, and enables access tosecure patient/ service user records across different systems and providers to communicate with their other records, remain up to date and will facilitate mobile working. This will enable cooperation and coordination between providers and transparency into the care that patients are receiving.

We would also like to be able to start implementing the Orion system in the voluntary organisations that we work with. As voluntary organisations become more involved with providing commissioned care/ services, they will have and require data that could influence patients’ care elsewhere in the integrated system. It is therefore extremely important to work towards being able to achieve this next step. Challenges involved include making the Orion system compatible with different types of organisations’ own IT systems, as well as data security.

As well as the sharing of patient data between providers, tracking integrated care changes and modelling the costs and savings (see *protecting social services*) requires sharing of patient level information. To overcome the barriers that these present on Information Governance, it is proposed over the next 6 months:

1. That a data sharing agreement be put in place to enable appropriate health and social care data to be linked for activity and costs to be tracked over the full care pathway and to support developing a full view of the full cost per patient. This will come back to DMT and the Council’s IG Group as required for sign off by the end of March 2014. The approach will be underpinned by the governing principle that wherever possible service user/patient consent to sharing information about them will be obtained.

2. That a time limited project be set up (under the Social Care Transformation Programme umbrella?) to address confidentiality and IG issues. WELC will be applying for s251 approval[2] from the Confidentiality Advisory Group (of the DH) but failing obtaining approval an alternative approach will be needed which will be overseen by this group.

3. That a three borough working group to set up the modelling and tracking process and to report from time to time on cost and savings shifts. To identify an SRO from this group to coordinate the work across the three boroughs.

To underpin the above there is a WELC Informatics Strategy in near final draft form that seeks to ensure we have a strategic approach to using patient data and technology to deliver integrated care.

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

CCG/ CSU: YES
LA: *No we do not currently use the NHS number but have plans to do so in the future*

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

CCG/ CSU: N/A
LA: *In place circa June 2015. Have begun to store the NHS Numbers of service clients in anticipation of using them as the primary identifier. At present, it has the NHS Numbers of:*

60% of clients of Learning Disabilities services
60% of clients of Mental Health services
43% of clients of physical disabilities/ frailty services
34% of clients from other vulnerable groups (usually drugs and/or alcohol related)

Given the number of people in the top 20% (at risk) being older people London Borough of Tower Hamlets has committed to getting increasing the levels for clients of physical disabilities/ frailty services and from other vulnerable groups, to at least the same level at learning disabilities services and mental health services (60%).

[2]Section 251 of the NHS Act 2006 (originally Section 60 of the Health and Social Care Act 2001) provides the statutory power to ensure that NHS patient identifiable information needed to support essential NHS activity can be used without the consent of patients. The power can be used only to support medical purposes that are in the interests of patients or the wider public, where consent is not a practicable alternative and where anonymised information will not suffice.

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

CCG/ CSU: YES – message source between systems using open source HC7 standards
LA:: *Yes we are committed to ensuring we support open APIs and Open Standards*

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

CCG/ CSU: Systems hosted by NEL CSU; IG Toolkit Level 2;
ASHU (?) Accredited; Hosts DSCRO
LA: *We are committed to ensuring that all appropriate IG controls will be in place.*

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The agreed accountable lead professional will be:
- The GP: for those aged over 75, and those identified as Very High Risk
- For other patients, the lead professional will be based on their primary health need. Therefore it could be a doctor, therapist, or secondary care clinician

The joint process for assessing risk, planning care and allocating a lead professional involves GP practices running a monthly risk stratification testto assess risk amongst their patients.

The proportion of the adult population identified as at very high risk, high risk and moderate risk of hospital admission in Tower Hamlets is:

Risk factor	**National average - percentage**	**Total**
Very high risk	0.5%	1,662
High risk	4.5%	11,871
Moderate risk	15%	23,600

(Total TH population that are very high – moderate risk)	-	37,133

We are currently recruiting stratified patients to care coordination and care planning. For some of these patients, this will build on and ultimately replace existing care plans for specific conditions, to create a comprehensive plan and assessment.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk 1: Risk of transfer of activity and therefore care costs from NHS to Council (social care)		Use the Evaluation and Outcomes Group to monitor significant shifts in activity in social care To and develop a savings pool to ensure that resources move in line with activity.
Risk 2: There is a failure in one part of the integrated care system that places pressure on another part of the system.		The implementation of the integration function
Risk 3: Providers fail to commit to delivery of the integration function		To seek to procure a provider for the integration function
Risk 4: Baseline outcomes and metrics data is based on 2012/13 data, as 13/14 YTD data is not available, so we are basing our level of ambition on old data.		Keep monitoring 13/14 performance in order to start working towards targets and take action if necessary before 14/15/
Risk 5: that providers and commissioners are not able to share data and information		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 DH.
Risk 6: The local health and social care system currently performs well on the DTOC measure – most DTOCs are due to specialist services commissioned by		To focus on DTOCs caused by delays in social care To develop alternative measures to track reductions in lengths of stay

NHS England.		

Possible (risk mitigation) options include (as provided by THCCG):

- Pool risk based on the contributions of each partner
- Pool risk based on the lead or integrated commissioner model (this is the model being developed by the WELC Integrated Care Pioneer project) [3]
- Increase the pooled budget to include budgets that will be exposed to risk as a result of the programme, for example, the CCG's non elective budget, and LBTH's Adult Social Care Budget

[3] See DMT/CMT paper on Integration Sept/Oct 2013

FINANCE - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actu contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority	N	£8.314m		
CCG	N	£10.367m		
CCG and Local Authority	TBD		£20.367m	£20.367m
Local Authority #2				
etc				
BCF Total		**£18.681m**	**£20.367m**	**£20.367m**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

TBD

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD
Outcome 2	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Integration	Barts/Local Authority	£14.331m				£16.645m			
Reablement/Rehabilitation	Local Authority	£0.473m				£0.303m			
Carers	Local Authority	£0.150m				£0.150m			
Mental Health	ELFT	£0.447m				£0.290m			
Enablers	CCG	£1.11m				£1.11m			
Learning Disability	Local Authority	£0.04m				£0.040m			
Helping People live at Home	Local Authority	£2.130m				£1.829m			
Total		**£18.681m**				**£20.367m**			

OUTCOMES & METRICS

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

REDUCED *Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population*–**figures derived from ASCOF.**
Reducing the number of admissions of older people to residential and nursing care homes means that more are receiving appropriate and effective care of their conditions. As a result, their health will deteriorate less, they have appropriate support, and they can maintain their independence, therefore do not need to be admitted permanently to residential and nursing care homes.

INCREASED *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services* – **figures derived from ASCOF.**
Reablement/ rehabilitation services aim to provide patients with the tools and support to carry out their daily lives as independently as possible. These services can re-teach patients skills and daily tasks that in turn allow them to stay active, healthy and independent. Remaining at home, as opposed to being admitted to hospital or care, signifies independence and capability, so a higher proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehab services represents success.

REDUCED*Delayed transfers of care from hospital per 100,000 population (average per month)* – **figures derived from ASCOF.**
A delayed transfer of care means that a patient stays in hospital for longer than is needed, which increases the risk of infection, and indicates either that the hospital staff are too busy to discharge the patient, or, if the patient requires transferring to other hospital or social care services, that those services do not have the capacity to receive the patient, causing a delay in them receiving the care that is most appropriate for them. Reducing this number means that patients have reduced risk of infection and receive the right care faster.

REDUCED - *Avoidable emergency admissions (composite measure)* – **composite measure being developed by NHS England.**
Many emergency attendances are avoidable, as are many admissions to emergency services. This can cause over-crowding in emergency services and stretches staff, amongst other negative effects. Over-crowding and stretched staff can lead to long waiting times and can also lead to lower quality, sometimes unsafe care. It is also very costly for those services and for the wider economy. Reducing emergency admissions can increase safety in emergency department. It requires patients' Integrated Care to step in with rapid response services, and more appropriate ways of a) increasing their awareness of emergency and other services, helping them to choose the right care option, and b) reduce the need for emergency services through improved health outcomes as a result of improved care.

REDUCED - *Local measure – emergency admissions per 1000 eligible population* – **Source data is from North East London Commissioning Support Unit (NELCSU) Sandpit SUS extract.**
As opposed to avoidable admissions, reducing all emergency admissions suggests explicitly that, patients' health can be maintained or even improved, with the right care. Indeed this can reduce the need for all interventions, including emergency admissions (including all the avoidable admissions who could have gone elsewhere). Reducing all emergency admissions will have similar benefits to reducing avoidable emergency admissions; reducing waiting times, higher quality, more appropriate care, reduced costs, and much more. This measure is also an indication of the success of the integrated care that eligible patients receive. One of the main aims of integrated care is to reduce the number of admissions amongst those most at risk in the population.

REDUCED - Local measure - Readmissions of eligible population receiving integrated care – **Metric not developed yet. Will be measured once formal integrated care is underway.**
As explained above, one of the main aims of integrated care is to reduce the number of admissions amongst those most at risk in the population. Reducing the number of times that those most at risk are readmitted is a clear indication of the success of integrated care at maintaining and improving their health.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We are currently in the process of developing our own local patient experience metrics, and intend to use for this purpose

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

For discussion at BCF board meeting

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Submission guidance recommended using http://ccgtools.england.nhs.uk/opa/flash/atlas.html for figures but it didn't have any of the relevant information. Instead, most data came from http://ascof.hscic.gov.uk/Outcome/711/.

http://www.hsj.co.uk/Journals/2013/12/17/u/q/z/Planning-guidance.pdf

http://www.local.gov.uk/documents/10180/12193/Better+Care+Fund+-+Technical+Guidance.pdf/cf2b02a5-4b3e-47c2-9246-435103b884df

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*			
	Numerator			
	Denominator			
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*			
	Numerator			
	Denominator			
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]				
*Local measure – **emergency admissions per 1000 eligible population TBD***	*Metric Value*			
	Numerator			
	Denominator			
*Local measure - **Readmissions of eligible populationreceiving integrated care TBD***	*Metric Value*			
	Numerator			
	Denominator