Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**LONDON BOROUGH OF TOWER HAMLETS**
Clinical Commissioning Groups	**NHS TOWER HAMLETS CCG**
Boundary Differences	**NA**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**05/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**NA – SEE APRIL SUBMISSION**
2015/16	**£20.367m**
Total agreed value of pooled budget: 2014/15	**NA – SEE APRIL SUBMISSION**
2015/16	**£20.550**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	JANE MILLIGAN
Position	CHIEF OFFICER NHS TOWER HAMLETS CCG
Date	5th September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	London Borough of Tower Hamlets
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	Tower Hamlets Health and Wellbeing Board
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

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

Document or information title	Synopsis and links
Appendix A: Integration Function	Specification of the Integration Function underpinning the Tower Hamlets Integrated Provider Partnership
Appendix B: WEL Strategic Plan	"Transforming Services Together". THCCG's joint 5 year plan submission with Waltham Forest and Newham CCGs
Appendix C: IC Data Analysis Tower Hamlets	The method and data used to determine the impact of Integrated Care
Appendix D: NHS-Monitor PILS	First draft of joint work with Monitor on modelling cost of Integrated Care target group in social care
Appendix E: Co-Commissioning WELC CCGs	Expression of interest for Co-commissioning
Appendix F: Integrated Care Incentive Scheme	Specification
Appendix G: Development of national indicator for patient experience	Background and method for chosen patient experience metric
Appendix H: WELC IC Summary	Slidepack showing progress to date of WELC pioneer programme
Appendix I: THIPP overview	One sider summary of the Tower Hamlets Integrated Provider Partnership
Appendix J: TH Liaison Metrics	RAID metrics and KPIS

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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 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 under the Better Care Fund 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 GP network that exists in Tower Hamlets. Services will be provided by a local provider collaborative, the Tower Hamlets Integrated Provider Partnership, specifically:

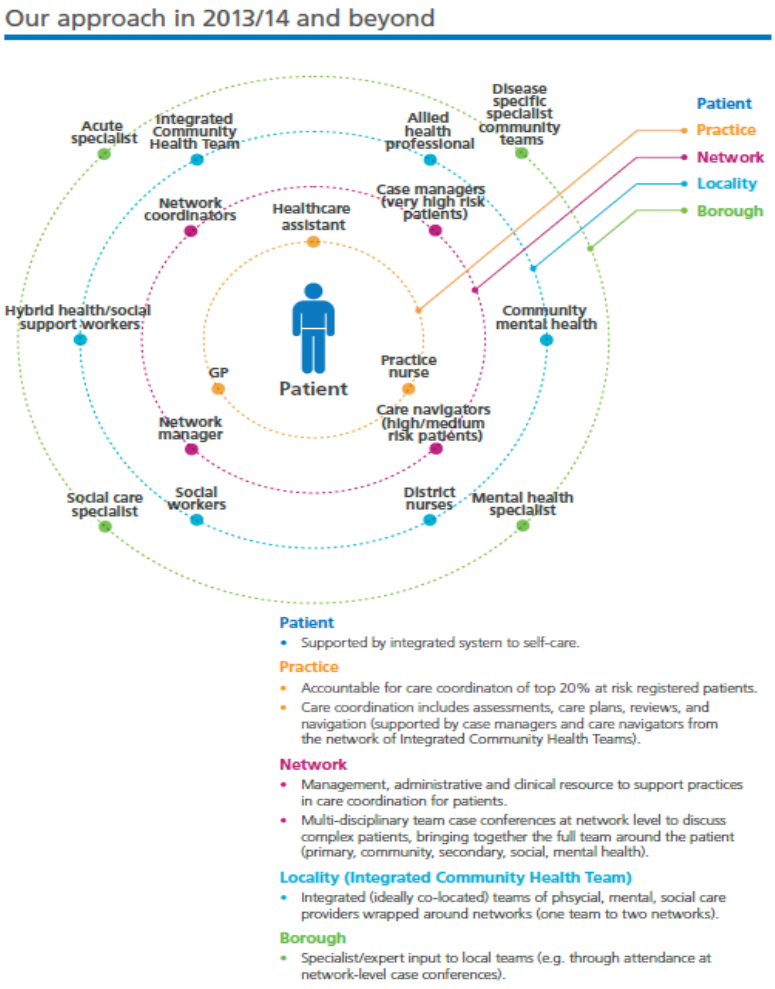
- Holistic care planning taking place in general practice for the top 5% of those at risk of hospital admission
- Care coordination and navigation provided by Tower Hamlets Community Health Services. This includes additional input from social workers from London Borough of Tower Hamlets and mental health professionals from East London Foundation

Trust

- Rapid response and discharge support functions carried out by Tower Hamlets Community Health service, working in close collaboration with Barts Health.
- Rapid Assessment Interface and Discharge (RAID) is a model of Liaison Psychiatry Service which is multidisciplinary service with a single point of access available 24 hours a day and open to all patients with mental health and drug and alcohol problems presenting to acute care.

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.



(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 personalised to patients' and service users' needs and preferences, and this will 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.

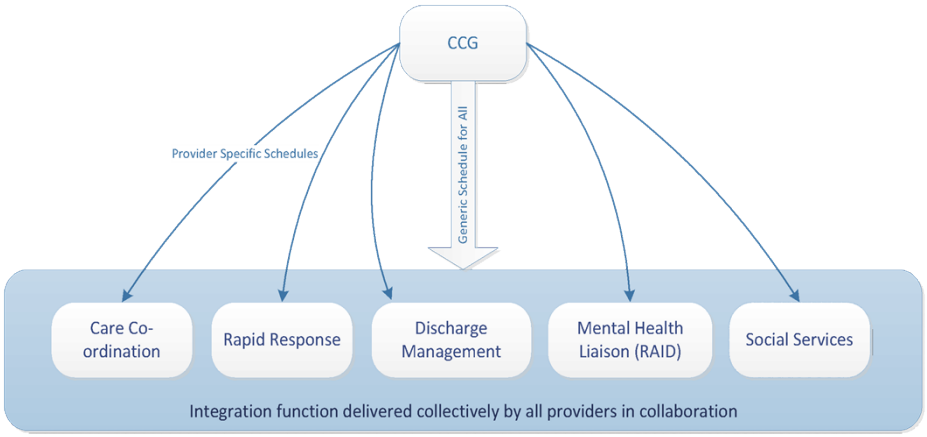
Commissioning Innovation – Integrator Function

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 participate in order to be commissioned for Integrated Care.

In 2014/15 providers will join together to provide a holistic approach in the management and care of each patient in the target population.



The integration function will focus on the target population and will :

- oversee the hand offs between each integrated care component service to ensure that they function smoothly;
- oversee hand offs with other services outside of integrated care;
- minimise duplication across providers, and from the patient perspective minimise the number of health and social workers with whom the patient has contact;

- ensure that all joint responsibilities are discharged and resolve any disputes between providers; and
- create a seamless service that wraps around the patient.

Providers will be rewarded for their individual service contribution according to cost and performance. In addition providers will have access to a share of the savings pool, which will be defined by providers. The performance of the integration function will be measured by the system wide outcomes indicators, against which a proportion of provider revenue will be determined.

For more information see the Integration Function specification in Appendix A

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

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

We will measure benefits in three ways:
- Provider reporting: our providers update the Integrated Care Board on a monthly basis. This picks up delivery progress and risks, and gives assurance on implementation
- Integrated Care Dashboard: Covers BCF metrics and a wide suite of further metrics (see Scheme descriptors in Annexe 1)
- Patient Experience Metric. Development of innovative metric with Picker and DoH as part of the Pioneer programmes (see Appendix G)

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

The strategy for Integration in Tower Hamlets is part of a shared 5 year plan, Transforming Services Together, across Tower Hamlets, Newham and Waltham Forest (WEL) (see Appendix B). This is based on a shared vision of comprehensive and co-ordinated are; where patients are 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. Our five year plan will deliver our ambition and we will work closely with our strategic planning group partners including NHS England specialised commissioning and primary care teams.

By putting patients in control we aim to unlock greater health benefits for our residents so they live longer and healthier lives. Services across our boroughs should be based on local need and focus on the priority issues for local communities.

Resources

CCGs receive an allocation based on historic levels of funding against which their budget is decided. Each CCG also has a 'target allocation'; a weighted calculation based on a fair-share distribution of the NHS budget taking account of local factors such as the size of the population, the age profile, local health factors etc. Every CCG is therefore deemed to have an allocation that is above or below the target. In the annual funding round CCGs that are below target will receive a greater share of new money than CCG that are above target. In this way the gap between actual and target allocation will gradually reduce.

Locally this means that there will continue to be no funding for pay and non-pay inflation; with providers continuing to finance this from annual Cost Improvement Programmes (CIPs). With the forecast allocations adjusted for likely inflation all three CCGs will receive a real-terms reduction in funding.

Newham, Tower Hamlets & Waltham Forest CCGs are planning to deliver £128m net savings to achieve a net surplus of 2% in 2018-19

Trust	2013-14 Underlying Surplus/ Deficit	Allocation Growth	Demographic Demand Growth	Non Demographic Demand Growth	Price Change	Investments & Other Cost Pressures	Other Full Year Effects	QIPP Target To Achieve Surplus Position In 2018-19	Planned Surplus
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	%
Newham	12	47	(48)	(27)	(1)	(29)	0	54	2%
Tower Hamlets	12	32	(32)	(31)	15	(29)	18	27	3%
Waltham Forest	0	55	(18)	(29)	6	(61)	5	47	1%
Total	**24**	**134**	**(98)**	**(87)**	**20**	**(119)**	**23**	**128**	

Source: McKinsey analyses of CCG financial template submissions

Improving Quality and Outcomes

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

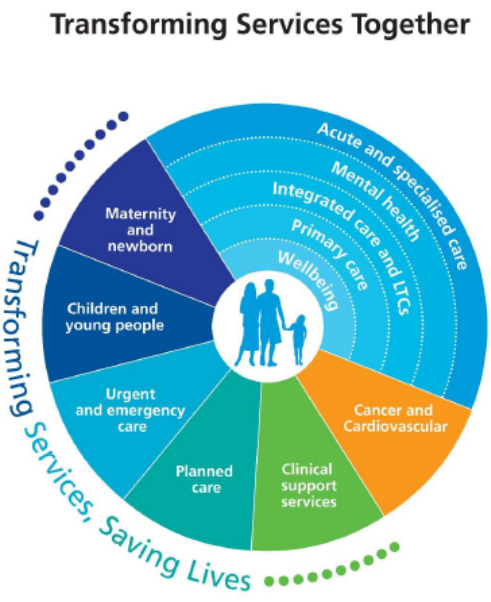
- Newham and Tower Hamlets have lower than median life expectancy compared to national figures and have a higher level of potential years of life lost than the rest of the country

- 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 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 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.

Our system vision is that health and care services will put patients in control of their health and wellbeing, be comprehensive and coordinated, be of the highest quality and easy to access. By putting patients in control, we aim to unlock greater health benefits for a our residents to that they live longer and healthier lives.



"Transforming Services Together" aims to achieve this. The diagram on the left articulates shared programmes that focus on particular groups' needs, and cross cutting transformation programmes that reach across disease and population group boundaries.

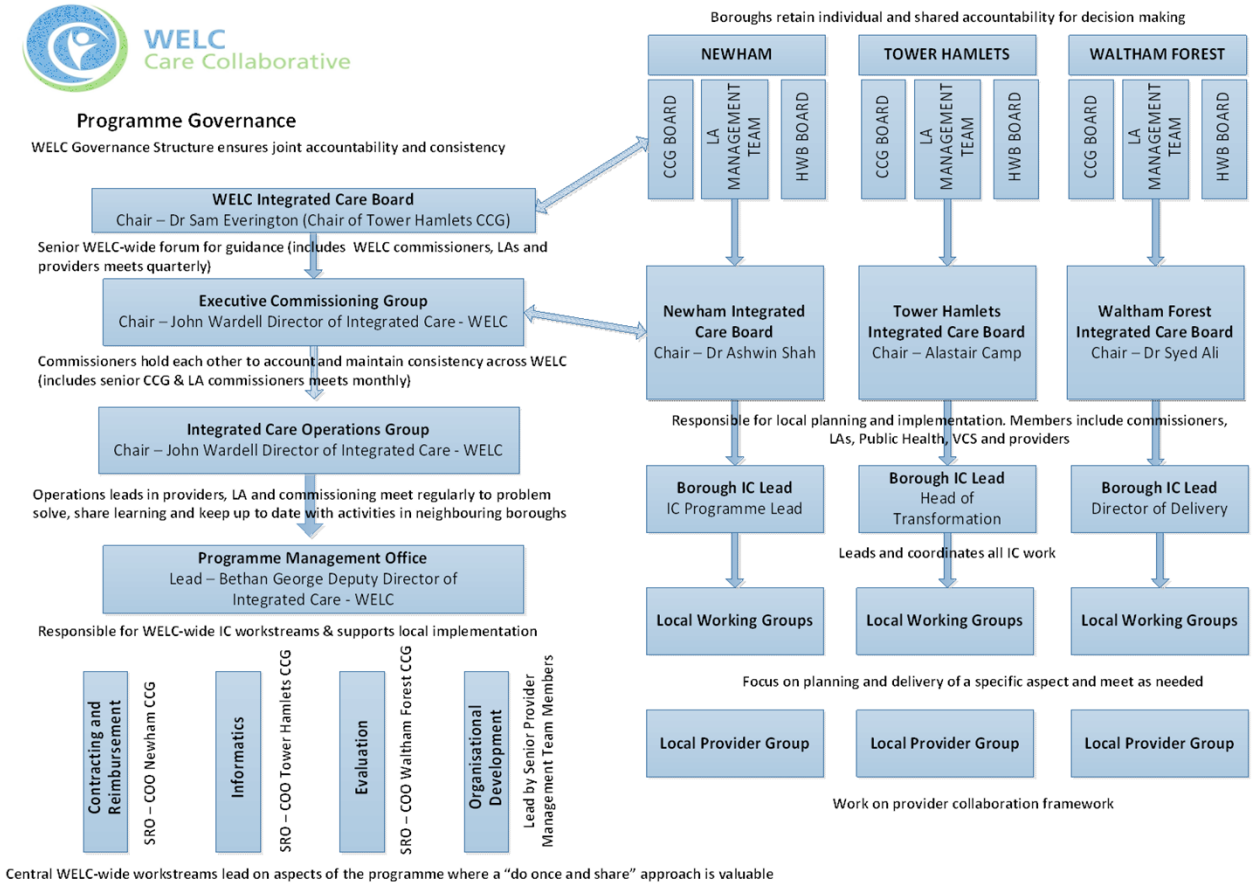
Our lead programme that is currently being scoped and the case for change developed, Transforming Services Changing Lives, will have an effect on the other four characteristics with some limited impact also with the other two characteristics. We anticipate that the programme, which will include the longer-term changes that may need to be made to the WEL health economy to meet the national, London-wide and local challenges and drivers for change, will importantly delivery improvements in productivity and ensure the quality of urgent and emergency care across the health economy.

The Better Care Fund is outlined as a key enabler for the delivery of this 5 year plan as

it facilitates the integration of services, and the associated reduction in demand for acute emergency activity through better proactive care, and a coordinated response to changes in individual's 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 and any savings. In summary, activity under the Better Care Fund will enable the delivery of this strategy

WELC Pioneer Programme

The WELC Pioneer Programme drives the delivery of the Integrated Care Programme within the 5 year plan. Governance arrangements can be found below and a summary of progress can be found in Appendix H



3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

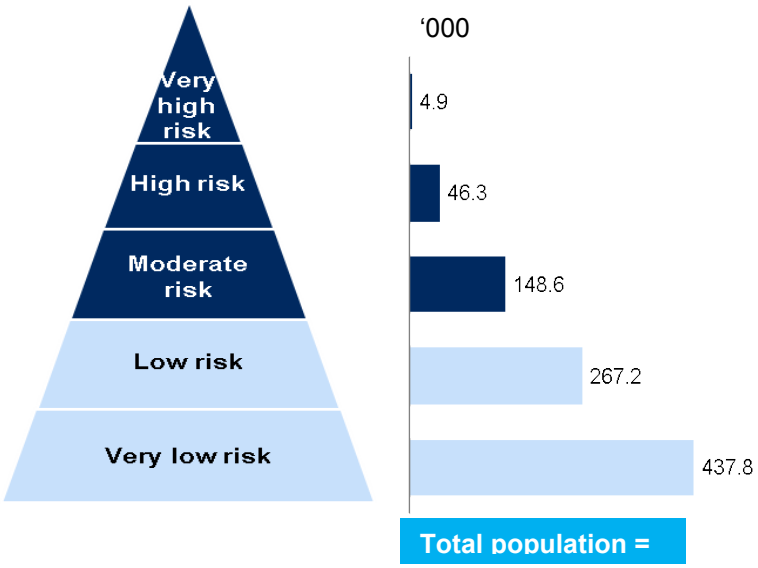
Tower Hamlets had resident population of c242,000 people with an unusually young age profile. Only 7.1% (15,000-18,000) of the population is over 65 with LAPS 1 and 5 having the oldest residents in the area and LAP 8 having the young working population due the presence of Canary Wharf. The population is expected to increase by over 23,000 people up to 2015, an increase of about 10%. The largest growth is expected in LAPs 6 and 8 (over 7,000 people in each, a 28% and 17% increase respectively). The age profile of residents is not anticipated to change dramatically over this time. 50% of the population is classified as white and 33% Bangladeshi although this distribution varies substantially across different age groups. 59% of the 0-20 age range is Bangladeshi, this proportion decreases to 25% of the 20-64 age range (adult) population and just 22% of the 65 years and over population. In contrast, just 21% of the 0-20 age range population is white, rising to 60% of the 20-64 age range population and 65% of 65 years and over population.

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 national averages (male life expectancy is 75.3 years and female life expectancy is 80.4). Tower Hamlets has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). There are an increasing number of complex patients with co-morbidities, particularly in the 65 years and over age group, and the distribution of these patients varies across the borough. The highest percentages of patients with multiple co morbidities are based in LAPs 1, 6 and 7. Within this there are variances in prevalence of long term conditions across different ethnicities, age groups and genders in Tower Hamlets. Hypertension, depression and asthma are the most common conditions affecting the white population, whereas asthma, diabetes and hypertension are most common seen in the Bangladeshi population.

Around 1,140 Tower Hamlets residents will die per year of which around 870 will need some form of last years of life care. The majority of these people will be aged over 65. Tower Hamlets has a higher hospital death rate compared to national (68%) and a significantly lower home death rate (17%) despite people's preference to die at home.

Integrated Care Programme

The integrated care programme requires that a holistic approach is taken to the management and care of each patient covered by the programme. However the component services within the programme are delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes.



The target population for Integrated Care is the same for all providers and is identified as patients who have very high risk, high risk or moderate risk of a hospital admission in the next 12 months, are either over 65 or have 1 or more long term condition and have consented to participate in the programme. This is target population for the full WELC programme.

Impact Modelling Methodology

To establish potential savings for the proposed integrated care developments, it is necessary to stratify existing activity into a condition specific baselines. The model we have used uses activity for 2012-13 as a baseline. The activity was run through the 2013-14 PbR Grouper to establish most recent HRGs and Prices.

This baseline has been risk stratified using the tool adopted by North East London CSU Health Intelligence. The methodology is outlined below, and the detailed calculation can be found in Appendix C

- The Qadmissions and the combined tool draws data from EMIS and calculates a risk score for each patient on a range of indicators including sex, co-morbidities, medication, blood and emergency admissions in 1213.

- Following risk stratification patient activity is attributed to conditions via diagnosis codes. Diagnosis codes have been linked to conditions

- The condition specific data provides potential volume and cost analysis of patient cohorts. Not all patients identified within the cohorts will be appropriate for IC case management. A further process was undertaken to filter out the following groups of patients within the Moderate, High Risk and Very High Risk stratifications:

  a) Patients aged under 18.
  b) Patients receiving non-elective non emergency procedures e.g. catheters, stents and births.
  c) Patients admitted as regular attenders e.g. chemotherapy, plasma cell disorders and malignant lymphoma.
  d) Patients receiving elective treatment.
  e) Patients admitted under treatment specialties unlikely to be included within Integrated Care e.g. General Surgery, Nephrology and Gynaecology
  NB (the excluded specialties are under constant review as the programme develops to ensure that Integrated Care activity is not excluded).

- A clinical review assessed the outcome of the IC model and targeted a cohort of patients that are legible for the integrated care programme. The clinical review consisted of clinicians from Barts Health Acute, Community and General Practice. The clinical review was to give an estimate of clinical impact of the schemes based on evidence base in the case for change, and the local design of schemes.
- Based on this review, A list of savings was developed and these have been used to form the assumptions.

Analysis of impact of Integrated Care Interventions on Social Care Activity and Cost

Appendix D contains initial analysis carried out in conjunction with Monitor on the impact of Integrated Care on Social Care and how this differs based on complexity, risk and certain condition groups. We have used an annonymised analysis of 2012/13 patient level data set for Tower Hamlets that links spend and activity for individual patients across primary care, acute, community, mental health, prescription and social care and develops a methodology for segmenting patients in Tower Hamlets, and begins to analyse the individual segments in terms of their resource usage and spend by different settings of care.

4) PLAN OF ACTION

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

Milestone	Owner	Date	Interdependencies
Agreement of submission with HWB	CCG & LA	Sept 2014	Review of Health and Wellbeing Strategy
Submission to NHS England scrutiny and support process	HWB	19th Sept 2014	
Commissioning Intentions Submitted to Providers	CCG	Sept/Oct 2014	CCG Board decision on CHS reprocurement options
Commencement of Self Management Pilots	CCG	Oct 2014	
Decision made on ongoing commissioning of social prescribing	CCG	Oct 2014	
Feedback from NHSE BCF assurance process	CCG and LA	Oct 2014	
Develop plan and section 75 in light of assurance feedback	CCG and LA	Oct-Nov 2014	
Sign off of Section 75 agreement by CCG and LBTH DMT	CCG/LBTH	Nov 2014	

Sign off of Section 75 agreement by HWB	HWB	Dec/Jan 2014	Publishing of NHSE Operating Framework
Mobilisation of Section 75	CCG and LA	Jan-March 2015	
Contract Negotiations with key providers	CCG	Dec – March 2015	CHS reprocurement timeframe
Go live of BCF	CCG and LA	April 1st 2015	
Mobilisation of service developments		April 1st 2015	
Q1 Review	CCG and LA	July 2015	
Q2 Review	CCG and LA	Sept 2015	
Commissioning Intentions Submitted to Providers	CCG and LA	Sept/Oct 2015	Earliest date of go live of new CHS contract
Contract Negotiations with key providers	CCG	Dec – March 2015	
Q3 Review	CCG and LA	Jan 2016	
Developments to BCF and S75 following Q3 review	HWB	Feb 2016	

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

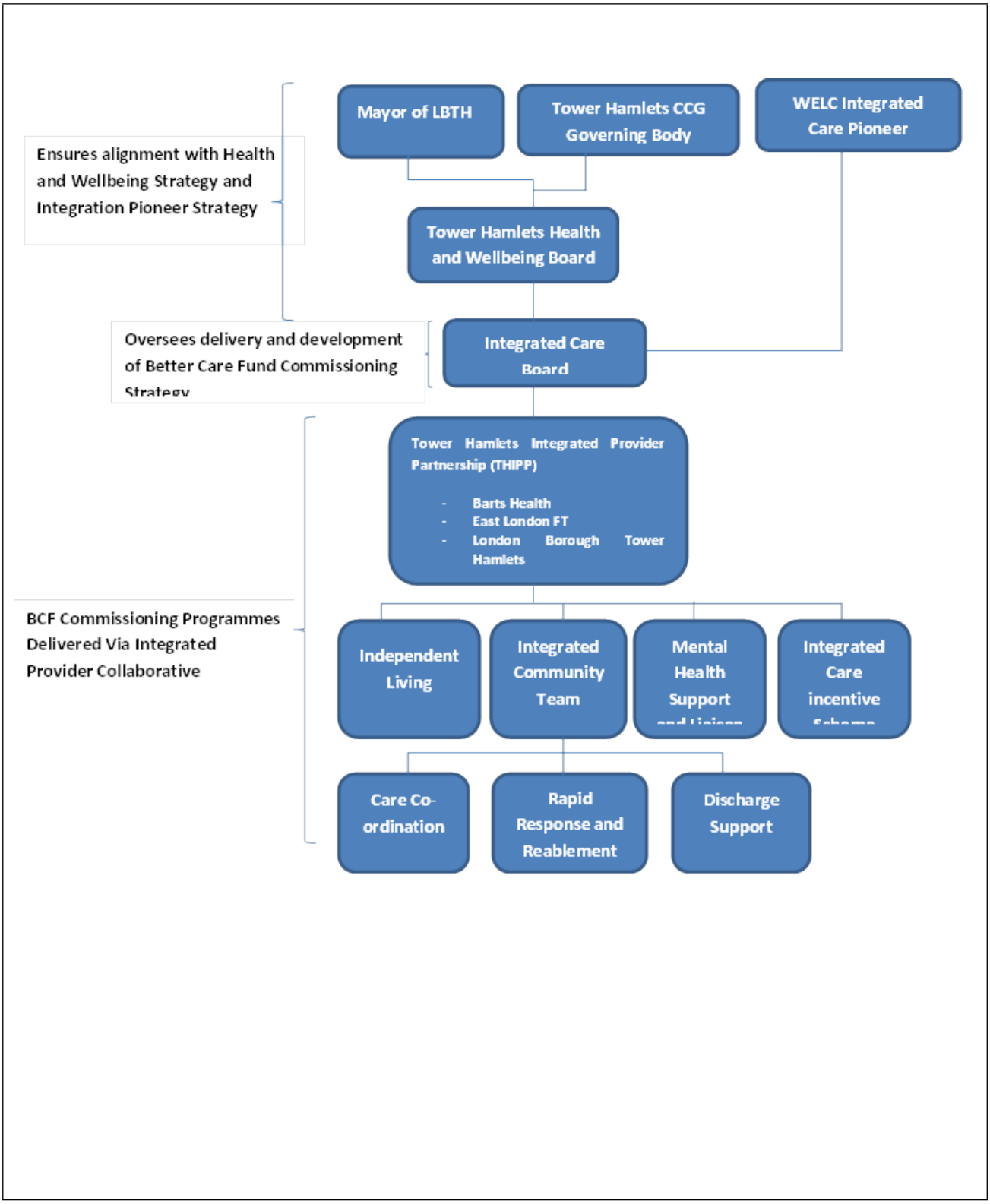
Integrated Care in Tower Hamlets is overseen and driven by a joint Integrated Care Board (ICB). The ICB includes representatives from:

- CCG and LA commissioners
- Provider colleagues from social care acute, community, mental health and primary care
- Voluntary sector
- Chaired by a provider non Executive director

The ICB is a formal sub-committee of the Health and Wellbeing Board, as well as being a Tower Hamlets CCG programme board. The Chair of the Integrated Care Board sits on the Health and Wellbeing Board, and Integration is a key strategic priority under the Tower Hamlets Health and Wellbeing Strategy.

The Integrated Care Board oversees:

- Delivery of commissioned Integrated Care services, provided by the Tower Hamlets Integrated Provider Partnership (see Appendix I)
- Development of Integrated Care strategy, including the Better Care Fund


Mayor of LBTH
Tower Hamlets CCG Governing Body
WELC Integrated Care Pioneer
Ensures alignment with Health and Wellbeing Strategy and Integration Pioneer Strategy
Tower Hamlets Health and Wellbeing Board
Oversees delivery and development of Better Care Fund Commissioning Strategy
Integrated Care Board
Tower Hamlets Integrated Provider Partnership (THIPP)
- Barts Health
- East London FT
- London Borough Tower Hamlets
BCF Commissioning Programmes Delivered Via Integrated Provider Collaborative
Independent Living
Integrated Community Team
Mental Health Support
Integrated Care incentive
Care Co-ordination
Rapid Response and Reablement
Discharge Support

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

Management of the delivery of the Better care Fund plan,

- Work streams within the Better Care Fund for service delivery are managed by the lead provider or providers for that function,
- Provision of Integrated Care services is delivered by Tower Hamlets Integrated Provider Partnership (THIPP). Details of these arrangements can be found in Annexe 2
- THIPP's role is to provide the Integration Function in the local health and care economy. Lack of delivery against this function will result in a reduction in the THIPP's remuneration
- THIPP have developed detailed management information to enable this joint working and delivery.

Oversight of the delivery of the Better care Fund plan

The Integrated Care Board receives the following management information:

- An Integrated Care dashboard
- An integrated report from Tower Hamlets Integrated Provider Partnership

Reports are made on an exception basis, and providers are required to produce recovery plans where delivery is off track.

The Integrated Care Board has two routes for escalation of issues. One is to the Tower Hamlets CCG Governing Body, and the other is to the Health and Wellbeing Board (see previous section).

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Scheme	**Sub Scheme**
Integrated Community Health Team	Integrated Community Health Team
	Reablement and Rehabilitation Joint Working Pilot
	7 day working at the social work team at Royal London Hospital
	Integrated Health and Social Care Continuing Health Care Assessment
Mental Health Support and Liaison	RAID
	Recovery College
Independent Living	Independent Living
Integrated Care Incentive Scheme	Integrated Care Incentive Scheme

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

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	2	4	8	No risk is shared for shadow year in 14/15. A robust set of KPIs will be developed during 14/15 to

Planning to either LBTH or CCG.				prepare for the BCF in 15/16. These KPIs will allow early identification of shifts in pressure. Ensure the development of the S75 during 14/15 has robust monitoring and evaluation procedures. The Better Care Fund Working Group to have a standing item on their agenda of monitoring shifts in demand. LBTH/THCCG will use the Evaluation and Outcomes Group to monitor significant shifts in activity in Health/Social care. Undertake review of scope of BCF in 14/15
Failure to identify a high quality provider	2	5	10	Clear expectations set out in the process so that quality is achieved. 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 withdrawl 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	5	10	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)

				Caldecott 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 put at risk due to people requiring specialist provision commissioned by NHS England remain delayed in hospital which will lead to delayed transfers of care (DTOC)	4	4	16	Monthly monitoring of KPIs for early identification of DTOC Regular updates given to BCF Working group through the Performance Challenge process within LBTH via the Performance Management and Accountability Framework. Analysis of ME, Commissioning and Brokerage statistics and Panel Procedures. Additional granularity of SITREP/HES data. Engagement with Strategic Commissioner within NHS England. Any issues fed back to Pioneer Programme if any issues identified to help get necessary action from NHS England.
Government funding of the reforms set out in the	3	4	12	The Care and Health Reform Programme in Tower Hamlets is linked into the Care Bill Finance Modelling (London

Care Bill is insufficient to meet the increased duties placed on the council from April 2015 which may lead to the need to scale back on non-statutory work in order to focus on these increased demand pressures				Councils, ADASS) work that is lobbying Government on funding Use of the Evaluation Steering group to monitor activity and impact on parts of the system. Reimbursement working group ensuring funding follows activity Ensure the BCF and Care Bill work programmes are closely aligned.
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 board and the Integrated Care Board. These Boards will regularly review the planning and implementation of the BCF Plans.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The risk within the Better Care Fund pooled budget lies within the expected reduction in emergency admissions. Using the methodology outlined in Part 2 this equates to c£1.1m. The methodology for calculating the impact of schemes is outlined in Section 3 and Appendix C

How the performance pool will be spent:
In line with national guidance this proportion of funding will be held back pending successful delivery of BCF schemes in delivering. The Integrated Care Board will use both the national metric requirement of unplanned admissions, and the local metric to judge whether delivery is due to interventions focused on the target groups. In the event of underperformance of planned schemes, this funding will be used to account for the financial risk to the CCG as a result of above plan emergency admissions activity

If performance is on track, the pool will act as a development fund. Between Quarter 1 and 3 in 2015/16 the Integrated Care Board will oversee the development of proposals to

non recurrently pilot additional Integrated Care interventions to be funded from the performance pot in 2015/16. These proposals will build on the experience to date and encourage innovation. By using the performance pool in this way, the partnership under the BCF will not encounter recurrent additional risk in future years as the performance pot will be held back each year to either hedge risk, or develop innovation on a non recurrent basis. Where pilot show delivery, they will be funded recurrently through the additional benefits they accrue, and potentially through additional contributions to the BCF from 16/17 onwards. The decisions on the targeting of the performance pool will be made jointly between the partners (not by a lead commissioner), and will be approved via the Health and Wellbeing Board.

Associated Risks
There is a risk for the CCG associated with not meeting the target for reduction in unplanned emergency activity. Namely there is likely to be some pressure on associated A&E and outpatient spend. This is already built into the CCG's QIPP projections within the operating plan and as such this risk has already been taken into account.

Risk Share
Currently, pending developed conversations on lead commissioner arrangements, risk will be held by the original commissioner. Therefore, currently the risk on emergency admissions and associated NHS activity will be held 100% by the CCG, and so the risk pool will be available to the CCG to offset any underperformance of schemes.

Risk Share Between Providers
See Annexe 2 and Appendix I

6) ALIGNMENT

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

Other associated work streams	**How will it support the delivery of the better care fund and what are the interdependencies?**
Re-procurement of Community Health Services	The proposed service model for a new community health service in Tower Hamlets builds on the Integrated Care principle of coordinated care by introducing a community service wide 'coordination function'. A successful procurement process for community health services will act as a key enabler to delivering coordinated care for Tower Hamlets residents, and formalise the current arrangements. The CHS service model is driven by the developing work and evidence base within integrated care. The delivery of integrated and coordinated services for the IC target population will rely on a high quality provider of community care, which is the ultimate aim of the CHS re-procurement process
Implementation of Personal Health Budgets	The CCG is currently in a position to offer personal health budgets for those with continuing healthcare needs, most of whom will be within the Integrated Care Target Population. This enables integrated care by providing a platform to have personalised care planning conversations, and analyse the impact these budgets can have on providers of care, and on commissioners. The CCG will meet its commitments to expand this to Long Term Conditions as outlined in the NHSE operating framework. We feel that the work on holistic care planning in Integrated Care, and Tower Hamlets strong background in LTC care provision, will enable the delivery of PHBs, and provide additional support to the delivery of coordinated care for the target population
Long Term Conditions Programme (CCG)	Tower Hamlets CCG has a well-developed LTC programme. One area of focus within this programme is emergency admissions for Long Term Conditions. This overlap is managed in the following ways: - A reconciliation exercise was undertaken to ensure that patients receiving the holistic Integrated Care NIS do not also receive condition specific care package input (rather these requirements are built in) - The Integrated Care Dashboard focuses on the Integrated Care Target population only, therefore we can analyse impacts based on those receiving the interventions, and those who are not - The LTC and Integrated Care programmes work together on lower risk groups, with a view to the programmes merging in 2015/16. For example on self-management and self-care

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

The impact of schemes described in this BCF plan are all included as part of the 2 year operating plans for 2014-2016 and aligned with 5 year strategic plans (see appendix B)

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

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Tower Hamlets made a joint expression of interest along with the four WELC CCGs (City & Hackney, Newham, Tower Hamlets, and Waltham Forest) to adopt responsibility from NHS England for a range of additional primary care commissioning activities aimed at delivering our Five Year Strategic Plan and supporting primary care transformation. Together, we see the co-commissioning of primary care as one of the key ways of enabling us to deliver all of our main strategic plans that include integrated care.

Our approach to co-commissioning would be based on using the strengths of our local knowledge and understanding of our communities needs together with our partnerships with local authorities and other key stakeholders in the Boroughs. We will also aim to plan some functions together at the Strategic Planning Group level to deliver strategic change working in partnership with other NHS organisations including NHS England, the LETB and our local authorities.

The aims of our co-commissioning are to:

- Improve the quality and outcomes of primary medical services
- Provide strategic leadership to the development of primary care
- Work in partnership with other NHS organisations to improve and modernise the primary care infrastructure.

Engagement with Providers

In the 6 weeks prior to submission of the expression of interest for co-commissioning we undertook the following engagement:

GP Constituent Engagement	LMC, Local authority, CCG meeting 2nd June CCG Board 3rd June Members Commissioning Meeting 3rd June
Other Stakeholder Engagement	See above – LA 2nd June Joint commissioning meeting 12th June NHS England 28th May

As key partners within the Tower Hamlets Integrated Provider Partnership, we recognise that there is a great opportunity in aligning commissioning plans for primary care with commissioning plans for Tower Hamlets as a Borough. Co-commissioning builds on a long history of successful working with primary care, and most recently on the direct involvement of general practice with the THIPP, and through delivery of the Integrated Care Incentive Scheme. In particular the following areas have been identified for further development and discussion:

- Identification of total spend on the Integrated Care target group within Primary Care. This will be vital when moving towards capitation outcomes based contracts
- Alignment of national incentive schemes with local strategy

Our co-commissioning expression of Interest can be found in Appendix E

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

With the implementation of the Care Act in April 2015, the new National Minimum Guarantee (NMG) of eligibility for people who need support and their carers will come into force. Viewed by DH as consistent with the previous Fair Access to Care Services guidance, this has been set nationally at what is currently 'critical and substantial' (FACS). However the entitlement is a new duty to meet Carers needs from next year and this poses some significant opportunities and challenges. This national NMG aims to provide consistency to help people receive a consistency of support if they were to move to another borough. Inherent in this is the overarching wellbeing principle that broadens out the range of needs that could be judged as eligible for LA support (resource). Whilst the CCG and borough broadly welcomes the reforms, there are increased risks to LA budgets that will arise if the current DH draft guidance is to be delivered as described. The NMG appears more generous, which will increase the levels of need in the borough that must be met as a duty. Our strategic outcome for local people that we will consult on is: ***For people to have a level of well-being comparable to that enjoyed by the majority of the community***. This will allow us and our partners to work together with local people in meaningful dialogue to ensure that the NMG will become a floor below which no-one will fall.

The use of the BCF in 2015/16 will help underpin protection of social care as described in the attached schemes, allowing a focus on those 'risk stratified' individuals, whilst focusing on the agenda to prevent, reduce and delay people from moving up the risk pyramid which often become less of a priority as budgets become tighter.

The opportunities presented by the BCF to further align services that are relevant for the benefit of individuals are good. The schemes, with some development work, are mainstream functions that should drive improvements and benefits over time.

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

7-day hospital discharge/avoidance and step down "pressure surge" arrangements
Extension of the current pilot of 7-day model of working within the First Response Hospital Team Out of Hours (OOH) service, which is provided to the A&E department and to two observation wards. It is planned to extend this model of working across all wards at the Royal London Hospital (RLH) from 9am to 5pm Monday to Sunday including Bank Holidays. 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.

Alongside this we are evaluating the possibility of commissioning additional capacity in both Residential and Extra Care Sheltered Accommodation for use as 'step down' temporary accommodation for clients that are medically fit for discharge but unable to either return home or have not yet chosen a residential home to move to. The rationale is that this will provide both improved health and social care outcomes for patients/service users and also a reduction in bed occupancy at the RLH.

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 will be 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 7 days rather than 5.

Rehabilitation and Reablement

Development work is planned to evaluate the care pathways of around 150 patients/service users that are in receipt of services from both Rehab and Reablement with a view to establishing a more integrated way of working to improve health and social care outcomes. Options include a single point of access, co-location of teams and improved care coordination of professionals and external providers.

The focus of this scheme is all about preventing, reducing and delaying health and care needs from taking root. An integral aspect of the scheme above, the focus will be on working bringing the 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 with 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.

Integrated Health and Care teams

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 will allow far more people to be supported lower down the spectrum of risk to prevent the more costly interventions arising.

Independent living service

Specifically about the provision of equipment that supports independent living and the services that support that provision (by OTs, the supply of equipment through the

Community Equipment Store, the provision of AT equipment and the Telecare (response) Service) and aligning with related provision available within the health economy (e-health solutions and e-health monitoring) to work towards offering this and other support involved in these pathways as an Independent Living Services, ideally under one roof. This could potentially include provision of minor and major housing adaptations (DFG), Handyman services and advice and information services.

This scheme aims to enable greater self-management of conditions in order to prevent hospital admission, residential admission, and minimisation of needs. The impact on Carers who receive this kind of support can often make the difference between being able to continue to provide care to their loved one, or developing needs for health and care support themselves. Carers provide a key service in preventing their loved ones escalating up the risk pyramid and we have good evidence that Carers are able to continue in their caring roles through provision of AT.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total amount allocated to the 'protection of social services' element of the BCF is £733k.

In addition, the allocation of BCF funding for the implementation of new Care Act duties has been identified and agreed for these purposes. The planning monies of £1.2m are specifically earmarked to support implementation of the new duties, which includes programme management support for integration.

Planning on the draft assumptions provided via the ADASS Budget Survey:

Care Bill implementation funding in the Better Care Fund (£135m nationally)		**Your allocation, £000s**
Personalisation	*Create greater incentives for employment for disabled adults in residential care*	*16*
Carers	*Put carers on a par with users for assessment.*	*90*
	Introduce a new duty to provide support for carers	*179*
Information advice and support	*Link LA information portals to national portal*	*0*
	Advice and support to access and plan care, including rights to advocacy	*135*
Quality	*Provider quality profiles*	*27*
Safe-guarding	*Implement statutory Safeguarding Adults Boards*	*44*

Assessment & eligibility	*Set a national minimum eligibility threshold at substantial*	*218*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*24*
	Clarify responsibility for assessment and provision of social care in prisons	*36*
Veterans	*Disregard of armed forces GIPs from financial assessment*	*14*
Law reform	*Training social care staff in the new legal framework*	*25*
	Savings from staff time and reduced complaints and litigation	*-74*
Total		***733***

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

Integration, co-operation and the use of the BCF are enhancing the focus of the design of the new care and support system in Tower Hamlets.

The programme of change is governed by a Care and Health Reform Programme Board, chaired by the ESW Director. This is a high level Board that is supported by a programme office, programme manager and project managers.

The programme alignments with integration are:

Using the Skills for Care Workforce Capacity Planning Tool on key themes such as Prevention, Advice and Information, Carers, Commissioning, Transitions, this will help us understand the contributions of the wider systems that contribute to wellbeing on a borough-wide basis.

Under the remit of the Health and Wellbeing Board, the Director of Public Health is leading the work required on prevention, advice and information. This will seek to identify primary, secondary and tertiary preventive services, identify gaps and promote the 'Every Contact Counts' agenda through a refreshed prevention and information strategy. The Workforce Capacity Planning Tool devised by Skills For Care will help identify the workforce, skills and competencies needed to deliver the changes within relevant access points across the borough. In addition, the focus on prevention within services will be reinforced through training and any contracting arrangements.

We are beginning to explore the opportunities for joint commissioning (health, public health and social care), and development of thematic Market Position Statements that set out the ambition for the health and care economy.

An Assessment, Eligibility and Support Planning Framework for those who need support and their carers is currently being developed that will enable assessments to be combined, joint or specialist. Underpinned by the strategic outcome outlined above, the key to this work is that whatever the integrated working arrangements, the discharging of

the council's duties and powers are met according to quality guidelines. This will require training of all staff in integrated teams to ensure awareness of the requirements and standards.

The programme of work includes workstreams specifically concerned with devising the integration schemes above, linked to a BCF working group tasked with producing the BCF plan and S75 agreement. These are aligned to the work of the HWBB and Integrated Care Board and overseen by the Care and Health Reform Programme, which the CCG Chief Officer and the Chief Exec of HealthWatch are members. In addition, links are formed with the SEND Board overseeing the implementation of the Children and Families Act reforms.

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

Carers make a huge contribution to our community and Tower Hamlets JSNA on Carers showed the significant numbers of carers in the Borough. The joint CCG and Councils three year plan for carers (2012/15), set out a the ways in which we were planning to develop services and to widen the range of support available for Carers. This included the introduction of personal budgets for carers, carers health checks, a wider range of respite and carers breaks options, and more specific support for carers of people with mental illness and dementia. Currently the Authority spends approximately £2.1m per year on carer services This plan will be rewritten over the next 6 months reflecting the new duties on Local Authorities and rights of Carers as introduced by the Care Act 2014.

From 1st April 2015, Carers will, through the Care Act 2014, for the first time have enforceable rights to care and support. This is likely to signify a sea change in the way Carers access and experience support and means that it is anticipated that demand for assessments and support from Carers will increase, posing significant financial risk to the local authority:

- **Carers' right to an assessment** – In 2013/14 1,385 carers assessments were carried out by Adult Social Care (provisional RAP Return). As a result of the proposed changes, we expect to see a significant increase in the number of carers coming forward for an assessment. According to the recent census there are 19,277 carers living in Tower Hamlets with 4.3% providing 1-19 hours per week, 1.4% providing 20-49 hours per week and 1.9% providing 50 hours or more per week. For all 3 ranges this is below that for England and Wales (6.5%, 1.4% and 2.4%) as well as London (5.3%, 1.3% and 1.8%). In London there has been little change in the last 10 years, with 8.4% of all Londoners providing unpaid care compared to 10.3% nationally. We estimate that approximately 3% of those carers currently unknown to us will come forward for assessment, resulting in an additional 578 assessments per year

- **Carers' rights to services** that meet their eligible needs is likely to lead to an increase in the number of carers requesting services such as respite. Currently the authority spends approximately £2.1m per year on carer services. At this point in time it is difficult to forecast how much more funding will be required.

The Carers element within the BCF amounts to £697,000 and this is additional to the current spend of £2.1m. This limited additional resource will be used to meet as much as

possible of the anticipated additional demand.

The first call on this funding will be to support those Carers supporting patients/service users in the very high risk and high risk levels under the care of the Integrated Community Health Teams and carers supporting discharge from hospital to home and those undergoing reablement/rehab. These have been identified by carers as key pressure points when they are more likely to require more bespoke support to help them in their caring role.

In order to implement the measures described above, from September 2014 workforce capacity mapping and planning using the Skills For Care tool will be started. This will enable the modelling of Carers needs, access points, skills and competencies of those who support them to inform a refreshed Carers Plan.

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

The local authority's budget in total has not been affected by the updated plans The April submission of the BCF was a high level strategic appraisal of our joint integrated care strategy. Since April the partnership has been able to:

- Develop our interventions and investment plans in more detail
- Align Local Authority spend more closely to care act requirements, particularly those focusing on carers.
- Make provision for a performance pool as per the updated guidance

Please see part 2 for our appraisal of the impact of Integrated Care interventions under the BCF.

b) 7 day services to support discharge

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

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,

In addition as outlined in annexe 1, input into the first response hospital out of hours service is to be extended to 7 days a week, including bank holidays. Step down facilities will also be introduced to facilitate more timely discharge and fewer DTOC.

c) Data sharing

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

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 integration using 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 to secure 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 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.

Use of NHS Number as Unique Identifier.

The NHS number is used in all NHS services and within the CCG and Commissioning Support as the unique identifier.

In LBTH use of the NHS number will be in place across the whole cohort in *June 2015. Have begun to store the NHS Numbers of service clients in anticipation of using them as the primary identifier. As of April 2014 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%).

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

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

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 for high risk populations

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

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 test to 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 (using Qadmissions):

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

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.

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

Patients in the target group for Integrated Care will have a shared care plan developed and reviewed in regular MDT meetings in the Integrated Community Health Teams, including input from social care, mental health, community care and general practice. Patients in the target group will have a care plan under the terms of the Integrated Care Incentive scheme, and this will be the master care plan for that individuals care.

In order to facilitate this the CCG has invested in an information sharing platform, Orion. This allows for a web based shared care record that can be accessed by professionals between health and social care. It can also be accessed by mobile device, unlocked efficiency benefits for the teams.

Patient 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. This person 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 patients GP.

GPs have received significant investment in a holistic care package methodology called the Integrated Care Incentive Scheme (see Appendix F). This includes care planning methodology and tools, and support with stratification and identification. GPs are supported to attend MDT meetings with partner professionals, and also to hold regular reviews with the patients concerned.

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

100% have a care plan in place as part of a LTC care package, or within the Integrated Care Incentive Scheme. 44% of the High risk groups have an Integrated Care Incentive Scheme package, with this projected to increase to 100% by September 2015

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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 group whose 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.

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.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The Integrated Care Board in Tower Hamlets has been in place since April 2013 with the following membership:

- Main providers (THIPP): The Tower Hamlets Integrated Provider Partnership came together to deliver the Integration Function of the Integrated Care Programe.

Provider	Type of Provider	Element of BCF Supported Services Provided
Barts Health	Acute NHS	Discharge Support
	Community Health	Care Coordination

	Services	Rapid Response and Reablement Discharge Support (inreach)
East London Foundation Trust	Mental Health NHS	Mental Health Liaison (RAID)
London Borough of Tower Hamlets	Local Authority	Reablement Support for Independent Living
Tower Hamlets Primary Care Provider Network	General Practice	Integrated Care Incentive Scheme

- Voluntary Sector Representatives x2
- CCG and LBTH Commissioning leads

The Better Care Fund has been a standing agenda item on the Integrated Care Board, and a working group has been established which reports on progress. All providers have been involved in both the development of the Integrated Care Strategy, and the development of the Better Care Fund.

The Integrated Care Board continues to meet, and will continue to meet following the go live of the BCF in April 2015 and will be the main oversight body for the delivery of programmes. Local providers will continue to be involved in that forum as our strategy is refined and developed going forward.

Tower Hamlets Integrated Provider Partnership (THIPP)

Developed in Summer 2014, THIPP exists to facilitate and deliver holistic seamless approach to care, ensuring appropriate services are provided based on individual need, aligning resources, skills, expertise and experiences and to shape best practice. This is in order to deliver the Integration Function underpinning Tower Hamlets Integrated Care strategy.

To date THIPP has formed terms of reference, obtained buy-in from relevant partners and has formed a monthly THIPP Board. Engagement with commissioners is developing and there are agreed assurance processes with the Integrated Care Board

THIPP works on eight workstreams, and has Identified workstream leads across partnership to a joint project plan. THIPP has also developed a proposed capitated financial framework and work together on risk management and mitigation

For an overview, see appendix I

c) Implications for acute providers

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

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

***For financial impact of BCF schemes on providers please refer to Part 2 of the**

submission template

***See annexe 2 for providers response to the BCF plans**

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 account for 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

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

ANNEX 1 – Detailed Scheme Description

See Separate Document

ANNEX 2 – Provider commentary

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

Name of Health & Wellbeing Board	TOWER HAMLETS
Name of Provider organisation	TOWER HAMLETS INTEGRATED PROVIDER PARTNERSHIP: - BARTS HEALTH (ACUTE AND COMMUNITY HEALTH SERVICES) - EAST LONDON FOUNDATION TRUST - LONDON BOROUGH OF TOWER HAMLETS - TOWER HAMLETS GP PROVIDER GROUP
Name of Provider CEO	Phillip Bennett Richards
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	21378
	2014/15 Plan	20749
	2015/16 Plan	20194
	14/15 Change compared to 13/14 outturn	629
	15/16 Change compared to planned 14/15 outturn	555
	How many non-elective admissions is the BCF planned to prevent in 14-15?	629
	How many non-elective admissions is the BCF planned to prevent in 15-16?	555

For Provider to populate:

	Question	Response

1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Barts Health is working with the CCG to reach agreement on the 13/14 out-turn and 14/15 plan for non-elective admissions. Subject to finalising this issue, the THIPP partners can confirm agreement with the overall targets to reduce non-elective admissions. The THIPP partners (Barts Health, East London Foundation Trust, Primary Care, LB Tower Hamlets) have been working with the CCG to develop and implement the integrated care programme in Tower Hamlets. The partners have successfully implemented the key elements of the programme: • Care co-ordination NIS • Avoiding unplanned admissions DES • Care navigation and care management • Rapid response • Discharge support • RAID THIPP has agreed a work programme to develop integrated management of these services, including quality improvement, patient experience, performance management, governance arrangements, and financial management. The aim of the integrated care programme, and of the THIPP development plan is to reduce the number of non-elective admissions as set out in the BCF proposal. The THIPP partners and the CCG are committed to working together to align the outcomes of this work programme with the activity targets.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*NA*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As described above, the THIPP partners have implemented key services, and are committed to working together to develop and improve the integration of these services. Barts Health and East London Foundation Trust have included the proposed changes within a range of contingencies as part of the five year planning process.

		The THIPP structure will enable the individual provider and system risks to be mitigated through the development of joint governance and performance management arrangements.