Triborough Better Care Fund – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	City of Westminster
	London Borough of Hammersmith and Fulham
	Royal Borough of Kensington and Chelsea
Clinical Commissioning Groups	Central London Clinical Commissioning Group
	Hammersmith & Fulham Clinical Commissioning Group
	West London Clinical Commissioning Group
Boundary Differences	Co-terminus (limited exceptions) The Plan covers all three boroughs so the CCG boundary exception is not relevant to the narrative. The finance section sets out Local Authority funding by borough and CCG funding by CCG so the NHS figures for Westminster are split between CLCCG (78%) and WLCCG (22%).
Date agreed at Health and Wellbeing Board:	Original plan agreed 24/03/2014, 2nd revised plan agreed 19/09/2014
Date submitted:	04/04/14 (1st Revised plan submitted 09/07/14, 2nd revised plan submitted 19/09/14)
Minimum required value of BCF pooled budget: 2014/15	£2,590,000
2015/16	£47,836,000
Total agreed value of pooled budget: 2014/15	£156,143,602
2015/16	£193,094,230

b) Authorisation and sign off

Dr Fiona Butler
Chair,
NHS West London CCG

Date: 19th September 2014

Councillor Mary Weale
Cabinet Member for Adult Social Care &
Public Health, RB Kensington and Chelsea
And Chair, RBKC Health & Wellbeing Board

Date: 19th September 2014

Dr Ruth O'Hare
Chair,
NHS Central London CCG

Date: 19th September 2014

Councillor Rachael Robathan
Cabinet Member for Adults &
Public Health, Westminster City Council
And Chair, WCC Health & Wellbeing Board

Date: 19th September 2014

Dr Tim Spicer
Chair,
NHS Hammersmith & Fulham CCG

Date: 19th September 2014

Councillor Vivienne Lukey
Cabinet Member for Health and Adult Social Care
LB Hammersmith and Fulham
And Chair, LBHF Health & Wellbeing Board

Date: 19th September 2014

c) Related documentation

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref	Document	Synopsis
D1	**"Living Longer, Living Well" Pioneer Application June 2013**	The vision for whole system integrated care in North West London, including that people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people's care; and systems will not hinder the provision of integrated care.
D2	**"Shaping a Healthier Future" NHS North West London**	The strategy for future healthcare services in North West London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.
D3	**Out of Hospital Strategies**	NHS West London CCG, NHS Hammersmith & Fulham CCG, and NHS Central London CCG's strategies for commissioning and delivering better care for people, closer to home. These focus on local care provided out of hospital, integrating with the future development of acute services across the region.
D3	**Joint Strategic Needs Assessment (JSNA)**	Joint Local Authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities for each of the 3 localities.
D4	**Joint Health & Wellbeing Strategy(JHWS)**	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the 3 localities.
D5	**Joint Commissioning Intentions**	A single view of commissioning intentions across the Triborough health and social care landscape. The CCGs commissioning intentions for 2014/15 have been mapped against each other and also against the Triborough market statement (which brings together Local Authority Adult Social Care commissioning intentions across Westminster, Kensington & Chelsea, and Hammersmith & Fulham).
D6	**CIS Business Case**	This business case argues for the development of a detailed single specification for a Triborough Community Independence Service (CIS) which will integrate and enhance existing local models and delivery frameworks to achieve common and improved outcomes for the populations of Hammersmith & Fulham, Kensington and Chelsea and Westminster.
D7	**Delivering Seven Day Services**	North West London's vision to be an early adopter for 7 day services across health and social care.

Ref	Document	Synopsis
D8	**Individual CCG QIPP, operating and Local Authority corporate and service plans**	Detailed plans by the CCGs and Local Authorities for the funding and delivery of services and associated efficiency targets for 2014/15 and 2015/16.
D9	**Borough/CCG Health and Wellbeing Partnership Agreements**	S75 Partnership Agreements established between each Local Authority and CCG as a framework within which integrated commissioning can be implemented; along with annually agreed service schedules of those services jointly commissioned or in a pooled budget.
D10	**Draft BCF Communications and Engagement Plan**	Draft plan for involving stakeholders in the development, implementation and evaluation of the BCF.

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

Integration across the health and social care system is a key theme in the Triborough's Joint Health and Wellbeing Strategy (JHWS). Each of the JSNAs for the boroughs identifies strategic priorities for which the portfolio of projects in the Better Care Fund Programme is a crucial enabler. These include:

- *For the Westminster locality*, ensuring access to appropriate care at the right time and supporting people to remain independent for longer
- *For the Hammersmith and Fulham locality*, integrated health and social care services which support prevention, early intervention and reduce hospital admissions
- *For the Kensington and Chelsea locality*, ensuring safe and timely discharge from hospital.

The vision across the Triborough is founded on population needs assessment and patient, service user and carer feedback, which has developed over the long-term through a broad spectrum of engagement and consultation. This includes the *Shaping a Healthier Future* service reconfiguration programme that builds on extensive analysis by a series of Clinical Working Groups to develop suitable models for clinical services, culminating in the 2011 Commissioning Strategy Plan. This set out the case for a shift in the balance of resources between acute and community provision, leading to a detailed strategy to localise care close to individuals' homes, to centralise specialist care, and to integrate care for people with long term conditions and the elderly.

Supporting the highest risk proportion of the population who consume the majority of resources is a particular focus, and the consequences of these changes in need and environment are already evident. Critical services have started to be centralised where necessary to deliver higher quality care (e.g. Major Trauma and Stroke services) and improvements are being made to the way services are delivered in the community so care is delivered as close as possible to where individuals live and is integrated with local hospitals.

We recognise that more must be done to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; to support individuals with long term conditions; and to enable older people to live more independently.

Our shared vision for whole systems integrated care is that we want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community. It is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys, we know that people want choice and control and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want care delivered by people and organisations that show dignity, compassion and respect at all times.

This strategy is centred around 3 core principles:

1. **People will be empowered to direct their care and support**, and to receive the care they

need in their homes or local community

2. **GPs will be at the centre** of organising and coordinating people's care

3. **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **co-ordinate around individuals**, targeted to their specific needs;
- **improve outcomes**, reducing premature mortality and reducing morbidity;
- **improve the experience of care**, with the right services available in the right place at the right time;
- **maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing;
- **through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

To do this, our starting point is our patients and service users themselves. The following 3 "personas" are examples of those which have been developed to capture the experience of typical service users. They bring together feedback from real people and from the frontline professionals who are working to help them today. They allow us to focus our interventions on meeting the needs of individuals and work with them on the things which are most important to them.

Asmita

- *Asmita is 66 and lives in Westminster. She has a low income and lives alone in a rented basement flat. She is recently widowed. Her husband, who was her carer and organised her medicines also used to translate for her as English is not her first language*
- *She often feels lonely as her family lives abroad and she cannot communicate easily with her neighbours.*
- *Asmita has multiple long term conditions including diabetes, arthritis, chronic heart failure and early onset dementia. However, she does have some capacity at the moment.*
- *She receives a number of different services which include meals on wheels, two homecare visits a day to help her dress. Since her husband died, she makes frequent 999 calls and associated A&E visits. Her medicines are delivered by the pharmacy but she often misses her regular doses.*

April

- *April is 82. She lives in a second floor, privately-rented flat near Holland Park. There is no lift and a stone staircase, so she is at high-risk of falling. She has had 2 hip replacements and is currently taking warfarin following general anaesthetic for her second operation.*
- *She regularly visits her GP for blood pressure checks and has high levels of anxiety, leading to panic attacks. She has an informal support network in her block of flats, but her daughters live*

abroad and will not be returning to the UK.

- *She has physio services for her hips and accesses transport services for hospital appointments. April has capacity at the present time, but is at high risk of losing her independence. She would benefit from help in the home to keep her in her current accommodation for as long as possible. She would benefit from some computer literacy, for example, to help with shopping, general contact etc.*

Les

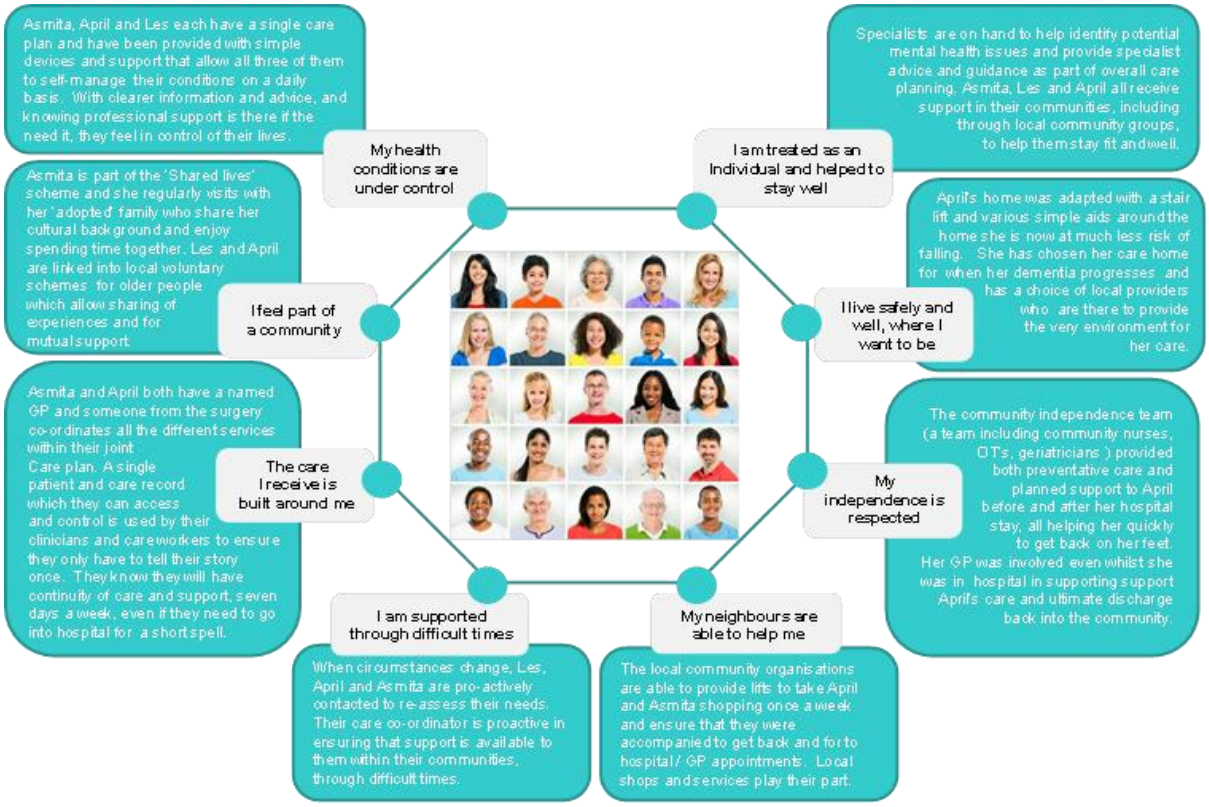
- *Les lives in Hammersmith. He has two children. He lives on his own in social housing and is currently unemployed.*
- *Les feels isolated. He receives services in a reactive way, although he is on the brink of receiving more proactive services. He does not have a care manager.*
- *Les has multiple long term conditions including diabetes (which may not have been diagnosed at this stage). He is a smoker who has alcohol issues and heart problems. He also has mental health problems (a combination of depression and dementia).*
- *He frequently uses Charing Cross Hospital A&E (visits are often alcohol-related). He has lots of disconnected referrals to care managers, social workers and district nurses. With the right advice and support Les could potentially care for himself.*

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

As our work and engagement in this area has evolved, increasingly we have been able to identify a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing. These include:

- Mental health problems (diagnosed and undiagnosed)
- Unsuitable housing exacerbating conditions/capacity
- In need of reablement now or in the near future
- Mobility and transport issues
- Significant life impacting event e.g. bereavement
- Frequent and unplanned use of multiple services
- Socially isolated
- Multiple long term conditions

Our vision for 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.



This work starts and ends with the individual experience of care. Through mapping the current experiences, capabilities and needs of our patients and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas. This is about not simply looking at people in terms of the cost of their care, or the types of interactions they currently have with local public services, but looking further to the root cause of the challenges many experience today, and how these can be converted into more positive experiences and outcomes in the future.

For Asmita, April and Les – typical individuals who are being supported by a range of local health and social services within the Triborough today, but have been identified as being at high risk of losing their independence – our focus is on helping them to manage their physical or mental health conditions, and enabling them to live safe, well and comfortably in their own homes and communities for as long as possible.

In practice, this means that from 2015/16 we will work towards the following vision:

- **The care I receive is built around me:** Asmita and April both have a named GP and someone from the surgery co-ordinates all the different services within their joint Care plan. A single patient and care record which they can access and control is used by the clinicians and care workers who are involved in their care, to ensure they only ever have to tell their story once. They know they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell.

- **My health conditions are under control:** Asmita, April and Les each have a single care plan and have been provided with simple devices and support that allow all three of them to self-manage their conditions on a daily basis. With clearer information and advice, and knowing that professional support is there if they need it, they feel in control of their lives

- **I feel part of a community:** Asmita is part of the 'Shared lives' scheme and she regularly visits with her 'adopted' family who share her cultural background and enjoy spending time together. Les and April are linked into local voluntary schemes for older people, which allow sharing of experiences and for mutual support.

- **I am supported through difficult times:** When circumstances change, Les, April and Asmita are contacted to re-assess their needs. Their care co-ordinator is proactive in ensuring that support is available to them within their communities, through difficult times.

- **My neighbours are able to help me:** The local community organisations are able to provide lifts to take April and Asmita shopping once a week and ensure that they were accompanied to get back and forth for hospital and GP appointments. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

- **My independence is respected:** The community independence team (a team including community nurses, OT's, geriatricians) provided both preventative care and planned support to April before and after her hospital stay, all helping her quickly to get back on her feet. Her GP was involved even whilst she was in hospital, supporting April's on-going care, and ultimate discharge back into the community

- **I live safely and well, where I want to be:** April's home was adapted with a stair lift and various simple aids around the home she is now at much less risk of falling. She has a choice of local providers who are there to provide the very best environment for her care.

- **I am treated as an individual and helped to stay well:** Specialists are on hand to help identify potential mental health issues and provide specialist advice and guidance as part of overall care planning. Asmita, Les and April all receive support in their communities, including through local community groups to help them stay fit and well.

As a result of these changes, Asmita, Les, April and those around them feel confident in the care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including their local A&E departments, are significantly reduced. If they do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission. They routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

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?

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

Over the next 5 years, community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well.

We will invest in empowering local people through effective care navigation, peer support, mentoring, self-management and time-banking programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

At the heart of this will be multi-disciplinary teams delivering an integrated Community Independence Service that will provide a rapid response to support individuals in crisis and help them to remain at home. The Community Independence Service will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our re-ablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention

- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals

In doing so our plan is to go far beyond using BCF funding to back-fill existing social care budgets, instead working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

The aim is to reduce the volume of emergency activity and planned care activity in hospitals through the use of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the provision of Community Independence Services, will mean we will eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

We recognise that there is no such thing as integrated care without mental health. Our plans are therefore designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and the individuals they care for in a similar way to physical health specialists.

By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

GPs will be at the centre of organising and coordinating people's care.

Through investing in primary care, we will ensure that individuals can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provision of General Medical Service contracts, including named GPs for individuals aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined up support for those individuals with long-term conditions and complex health needs.

As a result of all of these changes, some GPs may have smaller list sizes with more complex individuals and with elements of basic care delivered by nurse practitioners; and in the acute sector, our specialist clinicians will work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a "whole person" way.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our CCG and Local Authority commissioners will be commissioning and procuring jointly, focussed on improving outcomes for individuals within our communities. In partnership with NHS England we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.

In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible and in doing so live healthy and well lives.

In order to track the results, we will leverage investments in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the Triborough are integrated around the NHS number, and individual information is shared in an appropriate and timely way.

We are ensuring related activity will align by working in close collaboration with the other boroughs in Northwest London (NWL) in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

Our plans are aggregated into the Pioneer Whole Systems Plan in order to accelerate learning and joint planning. The NWL Integration Board provides oversight to this process, as described in the governance section; with each locality Health & Wellbeing Board taking the lead in approving local

joint commissioning plans.

3) CASE FOR CHANGE

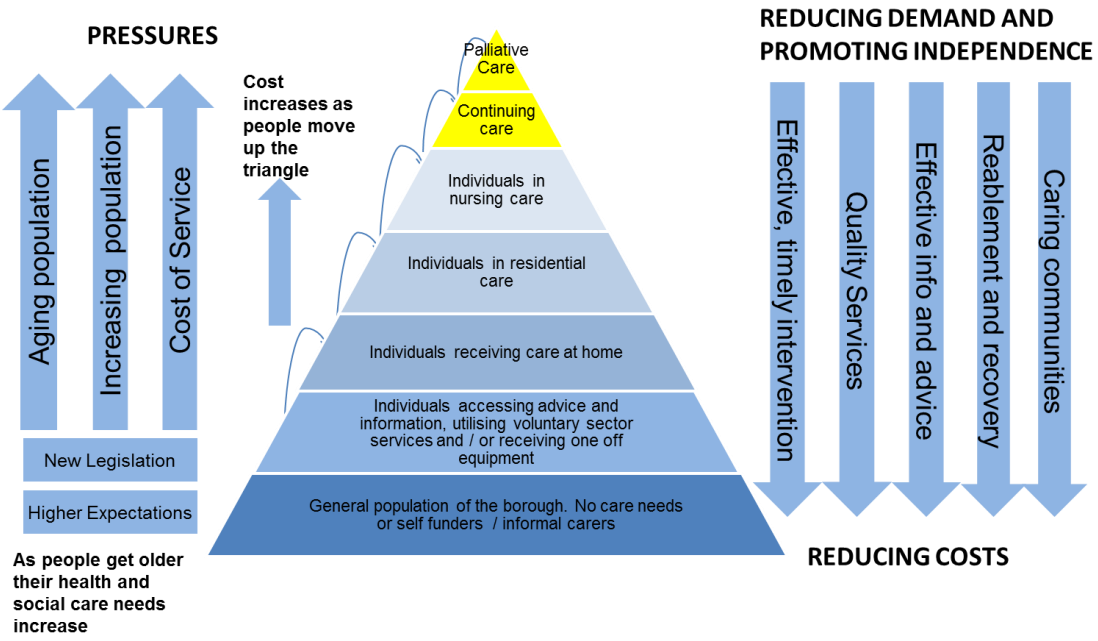
Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The demographic pressures of an ageing population with increasingly longer term, complex care needs and the downward pressure on public finances have compounded and require urgent and innovative responses from the health and social care sector.

There is a clear need for integration to support the shift in the centre of gravity away from treating people in expensive and often inappropriate acute settings and towards treatment and support for people in their own homes.

The diagram below sets out a summary of the pressures that are facing the health and social care system, and highlights the importance of integration and effective community care to help relieve some of these pressures.

Pressures and potential solutions for the local health and social care economy.



Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. Integrated care allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals. Creating networks of providers that deliver care across professions will make it possible to deliver innovative person-centred models of care, based around multi-disciplinary teams.

The Triborough Local Authorities and CCGs are already aware of the benefits of the integrated care model and have introduced various services that have improved the quality of care. The schemes that have been developed vary significantly in the populations they target, the design of the programme,

and the stage of implementation. In general, the efforts so far have been small in scale and tackled the problem piecemeal, which is insufficient in the face of the challenges ahead.

In addition, people's current experience of health and care services is often disjointed and fragmented. Each individual providing care may be doing a good job, but taken as a whole the individual and their family experience care that can be poorly coordinated and confusing. Our objective must be to deliver better organised care at home which therefore avoids preventable emergency stays in hospital, or long-term dependency on institutional care.

The Triborough Local Authorities and CCGs are uniquely placed to be in the vanguard of health and social care integration nationally, not only due to the partnership amongst the Local Authorities and combined approach to commissioning, but also due to the multiple change programmes already in progress across North West London which are transforming and reshaping the local health and social care economy.

Across the Triborough health and social care environment, there is already a shared commitment that:

- People are enabled and supported to stay as healthy and as independent as possible for as long as possible
- People are supported to live in the most appropriate place according to their choice and needs and are able to maintain maximum control over their lives.

The BCF creates a pooled fund to catalyse integrated working and is entirely compatible with whole systems integrated care programme, both of which deliver tangible multidisciplinary and integrated services and teams focused on delivering benefits to distinct cohorts of the population.

The current system does not always allow commissioners and providers to best meet the needs of service users. People who use services have identified three key reasons for frustration in their service experience that commissioners and providers can address through the enablers of whole systems integrated care that is at the heart of our vision (described in Section 2a).

Reason 1: Service users feel disempowered in a reactive care system
People who use services are disempowered by a reactive care system that focuses more on dealing with problems after they arise than prevention. This creates too many avoidable admissions, which can be unpleasant for services users and expensive for the system. The system is not set up to help people to not need acute services in the first place. We need to empower individuals to direct their own care, keeping them in their homes and local communities as much as possible.
Reason 2: Service user experience is confusing
Those with long term or complex conditions must interact with health and social care services frequently, but they receive fragmented and varied care. There can be a bewildering array of providers that may not appear to communicate with each other, and sometimes it is not clear to service users who is in charge. People may have to repeat their story multiple times to different providers, which makes accessing care a frustrating experience. National Voices has published several 'webs of care', designed by service users or their organisations to illustrate these challenges. We need GPs to be at the centre of organising and coordinating people's care.
Reason 3: Providers can find it hard to work together
There is sometimes little information flow between providers, which is frustrating for health and

social care professionals as well as patients and service users. This can be a barrier to collaborative working, and current funding and budget systems can make it hard to reallocate resources to where they are needed most. The system also needs to reward outcomes rather than activity. We need to help providers collaborate, and not get in their way.

Risk stratification

Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care. Grouping the population helps to ensure that the models of care address the needs of individuals, holistically, rather than being structured around different services and organisations.

Through our Whole Systems Integrated Care Programme, a framework for grouping the population has been agreed for NWL, based on four primary organising characteristics:

1. Type of condition and age
2. Social and demographic factors
3. Utilisation risk (risk stratification)
4. Behaviour.

A summary description of groups based on these characteristics is in the table below:

Description of the groups

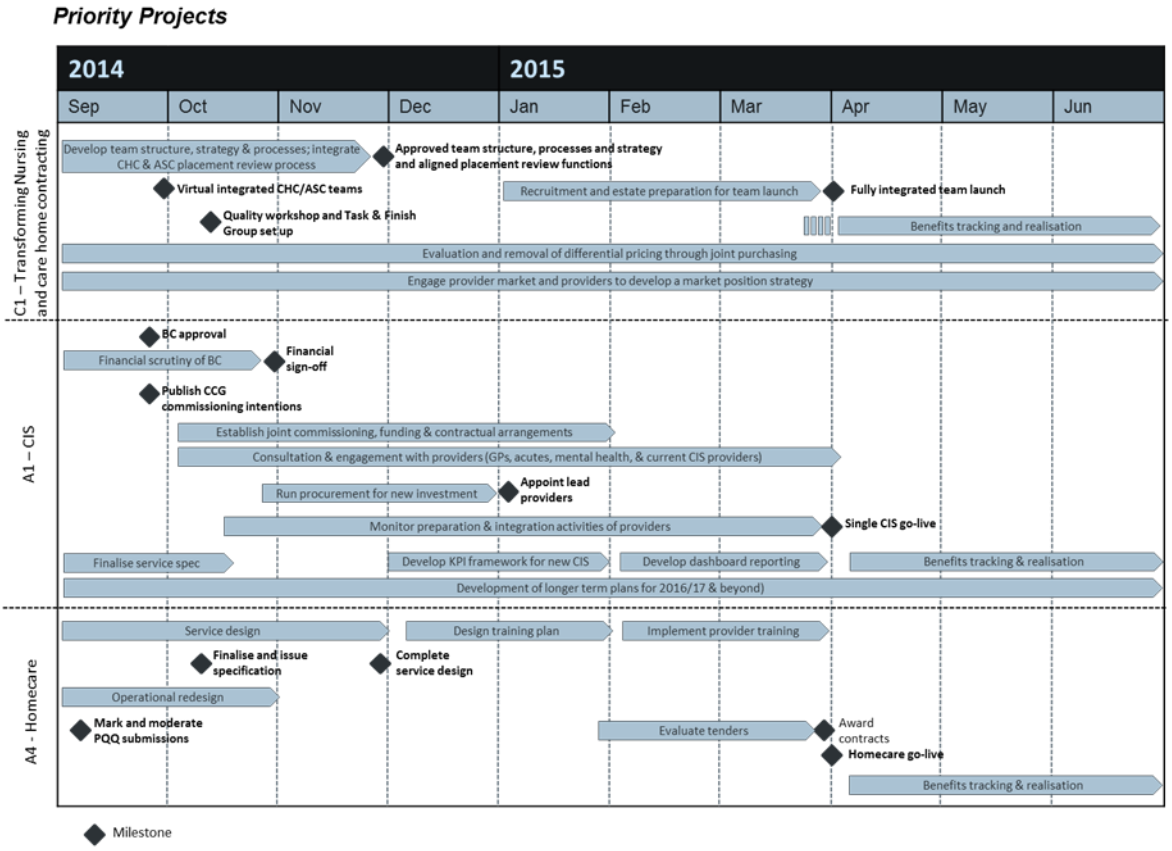
	Description of group
1 Mostly healthy adults <75	▪ People aged between 16-75 who are mostly healthy and do not have LTCs, cancer, serious and enduring mental illness, physical or learning disabilities and advanced organic brain disorders ▪ Includes those who have a defined episode of care, e.g., acute illness with full recovery, maternity
2 Mostly healthy elderly (>75) people	▪ Same as group 1 but for those who are above the age of 75
3 Adults (<75) with one or more LTCs	▪ People aged between 16-75 who have one or more long-term conditions, e.g., HIV, COPD, diabetes, heart disease ▪ Includes common mental illnesses, e.g., depression, anxiety
4 Elderly (>75) people with one or more LTCs	▪ Same as group 3 but for those who are above the age of 75
5 Adults and elderly people with cancer	▪ People aged above 16 who have any form and stage of cancer
6 Adults and elderly people with SEMI[1]	▪ People aged above 16 who have a mental-health problem (typically people with schizophrenia or severe affective disorder) who experience a substantial disability as a result of their mental-health problems, such as an inability to care for themselves independently, sustain relationships or work
7 Adults and elderly with advanced organic brain disorders	▪ People aged above 16 who have a decreased mental function resulting from a medical disease rather than a psychiatric illness; includes dementia as well as other conditions such as Huntington's and Parkinson's disease
8 Adults and elderly people with learning disabilities	▪ People aged above 16 who have a difficulty learning in a typical manner that affects academic, language and speech skills ▪ Excludes mild conditions that does not have an impact on social relationships or work
9 Adults and elderly people with severe and enduring mental illness	▪ People aged above 16 who have a FACS eligible physical disability ▪ Excludes physical disabilities, including sensory disabilities, that are not FACS eligible ▪ FACS eligibility includes an inability to perform 3 or more household tasks
10 Adults and elderly people who are socially excluded[2]	▪ People aged above 16 who have chaotic lifestyles who often have limited access to care ▪ Includes the homeless, alcohol and drug dependency

1 Severe and enduring mental illness
2 For example, the homeless, people with alcohol and drug dependencies
Source: Whole Systems Integrated Care module working group

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

The summary below shows high level activities and milestones for the main schemes that drive the majority of financial benefits in our plan.



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

Across the Triborough, we have invested significantly in building strong governance that transcends traditional boundaries. The governance arrangements described below are designed to ensure all 6 sovereign entities are central to decision making without creating grid lock.

An Integration Partnership Board (IPB) provides a forum for Cabinet members and CCG Chairs (described in Section 4c below). The IPB makes recommendations to HWB members, particularly in relation to the large scale integrated initiatives that require a joint approach. The HWBs meet on a quarterly basis.

The Health and Wellbeing Board in each of the boroughs has matured well. Joint commissioning intentions have been written this year covering all of our CCGs and Local Authorities, and Health and Wellbeing strategies have been developed based on the Joint Strategic Needs Assessments. We have a joint monthly meeting between the executive teams in CCGs and Local Authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each Local Authority and CCG.

We have formal Health and Wellbeing Partnership Agreements in place between each borough and CCG providing a legal framework for closer integration of commissioning and an established programme of jointly commissioned services, which are already overseen by the Joint Executive Team referred to above. This will enable us to put in place the new pooled budget required by April 2015. We anticipate that this will be hosted by the Local Authorities, in view of the practical advantages which this offers in relation to treatment of VAT and the carrying forward of funding, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, be that Local Authority or CCG.

Regular briefings to the Cabinet in each borough are designed to help to ensure that there is effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities. Cabinets are the constitutional forum for key decision making and a core part of the due process for the changes envisaged in this document, which also include scrutiny and challenge across each locality.

Across North West London, the North West London Whole System Integration Board, which combines health and Local Authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography.

Through appropriate governance processes, we will ensure there is a comprehensive view of the impact of changes across North West London on the Triborough, and vice-versa; and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

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

To deliver the ambition contained in our BCF, we recognise the need to develop our strategic and operational governance arrangements. Our Joint Executive Team (JET) acts as the single accountable team for the implementation of the BCF Programme and delivery of the BCF outcomes and indicators. The JET includes the Chief Officer and Chief Financial Officer and Managing Directors of the CCGs, and the Executive Director and Adults Leadership Team from the Triborough Local Authorities.

The JET reports to the 3 council members and 3 CCG chairs (see Governance Structure diagram below). In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Since the local government elections in May 2014, it is important to note that there is a new administration in the London Borough of Hammersmith & Fulham. The governance process will

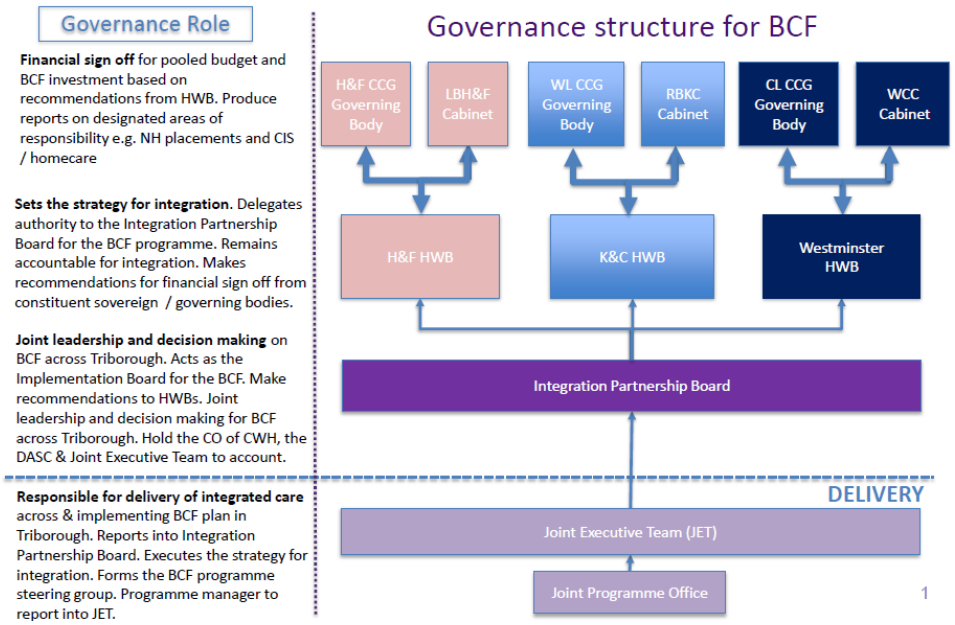
ensure engagement and approval at the appropriate level. We continue working together across the Triborough to build strong relationships and deliver the best possible outcomes for the population we serve.

Hammersmith and Fulham Labour Local Authority has given commitment to working on and delivering out of hospital care for their residents. However, this does not mean they support the plans to change the function of the A&E at Charing Cross. The BCF was agreed by the previous administration and the new Labour Council reserves their position currently on the alternative provision locally and offer to H&F residents until they have seen the detail and evidence on quality of GP access and performance.

Joint commissioning of community independence and re-ablement services will enable us to procure integrated and effective services in the community and in people's homes, preventing unnecessary admissions to hospital and reducing length of stay for those who are admitted.

Our business case for the contracting of nursing and residential care home placements demonstrates that, if this were done as one team across our agencies, we would save money and improve quality. Our Local Authorities have a strong track record in this area and we are therefore looking at options for our CCGs to delegate this responsibility to the Local Authorities. We envisage that these joint arrangements would enable us to remove current gaps and duplication in procurement and improve oversight of quality and safety within this area of service provision.

The first step in doing this will be to pool our funding for these services, and to establish one team who will be responsible for managing the health and social care budget for these functions (including assessment, brokerage and in-house provision). There will be an agreed joint programme budget and agreed tolerances within which the programme will be managed, in line with current financial delegated authorities. If the programme looks likely to fall outside these tolerances for cost, quality or time it will be raised as an issue. The programme will be managed in stages with financial sign off at each stage. The programme office will provide a central role in providing control, reporting and assurance mechanisms. There will be a strong performance framework in place to monitor and manage the programme in line with its agreed purpose. Due process will be followed for all financial sign off, in line with statutory responsibilities. The diagram below outlines our governance structure across Triborough.



We will ensure that the local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Better Care Fund. We maintain a principle of pooling as much health and care funding as is sensible to do so, and a focus on developing our joint commissioning and outcomes frameworks to drive quality and value, reflecting the needs of our local communities as identified through the joint strategic needs assessment and captured in the Health and Wellbeing Strategies.

The IPB will act as the BCF implementation Board. They will be accountable for the delivery of the BCF programme.

JET will be responsible for delivery and report into the IPB. A joint programme office will be established to oversee, manage and co-ordinate this major transformation programme across the 6 partner organisations, to ensure the effective engagement of partners – service users, carers, citizens as well as service providers – and to evaluate the success of the programme, reporting to the IPB and Health and Wellbeing Boards on progress in achieving the outcomes agreed.

A central joint programme office will also ensure effective management of interdependencies within and between programmes, outline the critical path, manage and mitigate risks, monitor and measure benefits and outcomes, help to drive forward integration and provide assurance of investment decisions.

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.

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health & Care Budgets
	B3	Community Capacity
C	C1	Transforming Nursing and Care Home Contracting
	C2	Review of Jointly Commissioned Services
	C3	Integrated Commissioning
D	D1	Information Technology
	D2	Information Governance
	D3	Care Act Implementation
	D4	BCF Programme Implementation and Monitoring

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.

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
1) The introduction of the Care Act will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently.	This will impact on the sustainability of current social care funding and plans.	5	5	25	LAs	We will work with other local authorities across the country to monitor closely the anticipated impact of the Care Act.	We have undertaken an initial impact assessment of the effects of the Care Act and will continue to refine our assumptions around this as we deliver upon the associated schemes. We believe there will be potential benefits that come out of this process, as well as potential risks.
2) Procurement and HR lead in times.	Delay in scheme implementation.	4	4	16	CCGs/ LAs	Flag where timelines not being met	Ensure procurement and HR requirements understood and planned for and that these departments understand importance of timely implementation.
3) Shifting of resources to fund new joint interventions and schemes.	Destabilises current service providers, both in the acute and community sector.	4	4	16	HWB	Drop in quality of service of some providers. Closure of certain services.	Our current plans are based on the agreed strategy for North West London, as outlined in “Shaping a Healthier Future”. The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of our Whole System Integrated Care programme, allowing for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process. We will establish strong mechanisms for involving service providers, both statutory and independent, in our programme.
4) Lack of detailed baseline data and reliance on current assumptions.	Finance and performance targets for 2015/16 onwards are unachievable.	4	4	16	CCGs/ LAs	Baseline data reviewed to test validity and whether refresh required	The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
5) Plans developed lack sufficient detail to enable effective implementation.	Implementation is slow and targets are not achieved.	3	4	12	Programme	Set clear timelines for delivery and ensure met.	Programme office will provide support to workstream leads to ensure completion of plans and practical achievable steps to implementation.

[1] Scale of 1-5, Low to High – Risk Rating = impact x likelihood

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
6) Operational pressures restrict the capacity of the workforce.	Unable to deliver the required investment and associated projects.to make the vision of care outlined in our BCF submission a reality.	4	4	16	CCGs/LAs	Monthly review of implementation progress to identify early any slippage in delivery	Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. We will build on existing arrangements such as the Whole Systems Integrated Care Programme which have already established some of the infrastructure and mechanisms for engagement, data gathering and analysis, and work closely with public health and the academic community to add value to our own capacity.
7) Improvements in the quality of care and in preventative services fail to translate into the required reductions in acute and nursing / care home activity by 2015/16.	Impacts on the overall funding available to support core services including social care and future schemes.	4	4	16	HWB	We will rigorously evaluate the impact of our workstreams and, where these do not appear to be contributing to the required outcomes, we will bring them to an end and look to alternative approaches.	We will rigorously evaluate the impact of our workstreams and, where these do not appear to be contributing to the required outcomes, we will bring them to an end and look to alternative approaches. We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. Financial modelling will include impact of changes on social care to ensure that social care is not disproportionately disadvantaged by the programme.
8) Risks associated with pooled budgets including longer term funding commitments and liabilities for withdrawal.	Unanticipated pressures on authority budgets. Reduced flexibility in year.	3	3	9	CCGs / LAs	Monthly/quarterly monitoring of activity and spend to provide early warning of variations from plan and disproportionate impacts.	The three local authorities and CCGs have established Health and Wellbeing Partnership Agreements which contain the necessary legal and financial framework to protect local sovereignty while facilitating partnership and collaboration. During 2014-15 the terms of the new pooled budgets will be developed, consulted up on and agreed to provide all authorities with the confidence and trust they need to go forward.

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
9) Failure to meet the national conditions and performance outcomes agreed with NHSE.	Results in a need for external support (reputational damage)	2	3	6	CCGs / LAs	The programme office will ensure that we monitor carefully, understanding the attribution of outcomes between workstreams both within the BCF programme and externally,	Performance against the national metrics is already strong locally, so the setting of additional stretches is challenging and there is a risk of double counting. Take steps to address slow performance as soon as a problem is identified.
10) Lack of engagement from front line staff because do not buy in to the integration agenda or lack the skills.	Integrated services not effective and do not deliver better customer experience	3	3	9	Service providers	Review changes in work culture over the agreed period and evaluate staff commitment and delivery of integrated offer	Changing organisational structure is not necessary or sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care as well as the efficiency and effectiveness of delivery.
11) There is a risk of further national policy changes (such as additional adjustments to BCF funding, or restrictions on the use of funding).	Increase the strategic risks to Local Authority partners and lead to their withdrawal from the plan	3	4	12	Programme management	Close monitoring of developments	The Joint Executive Team will continue to work effectively to progress BCF plans and jointly review and discuss any further changes that may affect plan viability or increase collective or organisation specific risks ensuring that social care is protected.

Risk Identification and Cause	Risk Consequence	Impact	Likelihood	Risk Rating[1]	Risk Owner	Risk Trigger	Mitigating Actions
12) There is a risk that current challenges to local governance arrangements leads to delays in decision making.	The decision making process will create a blockage in implementation plans of schemes	3	3	9	LA/Programme Management	Close monitoring of developments	It is hoped that independent review of the partnership currently in progress will help to clarify what is needed to maintain effective working relationships in the Triborough.
13) There is a risk that misalignment of planning cycles (specifically the LA need for input to the 2 year MTFP cycle to include 16/17, vs. CCG financial plans and BCF allocation that are not defined beyond 15/16) leads to delay in decision making.	Planning cycles are not aligned with delivery of schemes and therefore key decision-making checkpoints are not met	3	3	9	Programme Management	Work closely with LA and CCG governance leads to mitigate	Close working between the finance teams across health and social care to share early stage plans and assumptions, with regular review of progress and issues.

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

Some core principles of risk sharing have been agreed within the BCF programme:

- Organisations take responsibility for the services they sign-up to deliver (against agreed specification of service quality, type and volume)
- Organisations take responsibility for the benefits that are expected to be realised in their organisation
- Effective monitoring arrangements to identify where there are variances and to reconcile back to the original budget (similar to s.75 arrangement)
- Commitment to a shared approach to resolving variances and amending service model and share of costs if required

These principles suggest that the BCF can be made to work by keeping on top of the management information and refining the service model so that the required net benefits are achieved. There is of course the significant risk that, if the planned net benefits are not delivered, there will have to be a call on existing resources in the CCGs and Local Authorities.

The CCGs currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. In addition, the risk will be managed through financial planning, which will include the setting aside of reserves and contingencies to manage risks.

The implementation of Whole Systems Integrated Care models, including capitated budgets across health and social care, will also help to manage the risk beyond 2015/16. Early implementers are currently developing their detailed plans to move into operation from April 2015, with shadow financial arrangements in place.

6) ALIGNMENT

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

The BCF is one of the key transformational programmes that aim to improve experience of, and outcomes from, health and social care provision for the populations we serve. Other programmes include:

- Adult Social Care Transformation (ASC Transformation)
- Whole Systems Integrated Care (WSIC)
- Primary Care Transformation (PC Transformation)
- Shaping a Healthier Future (SaHF)

There is strong alignment in the visions of for these programmes:

- They encourage working as a single team across adult social care, public health, housing,

mental health, primary care, community care, hospital care and other allied services
- They are dedicated to improving the health and wellbeing of the 600,000 people who live in Hammersmith & Fulham, Kensington & Chelsea and the City of Westminster

We are working together because as our populations grow, we share a commitment that local services should support individuals, their families and communities in living longer, and living well. Our understanding of physical and mental health is growing all the time, and new treatments are becoming available which make conditions that would have been untreatable in the past, into manageable "long-term" conditions.

Yet, while expectations are rising about the quality of life and support possible into old age, at the same time our resources are coming under ever-greater pressure, and there are real variations in the quality and results of care achieved across our populations.

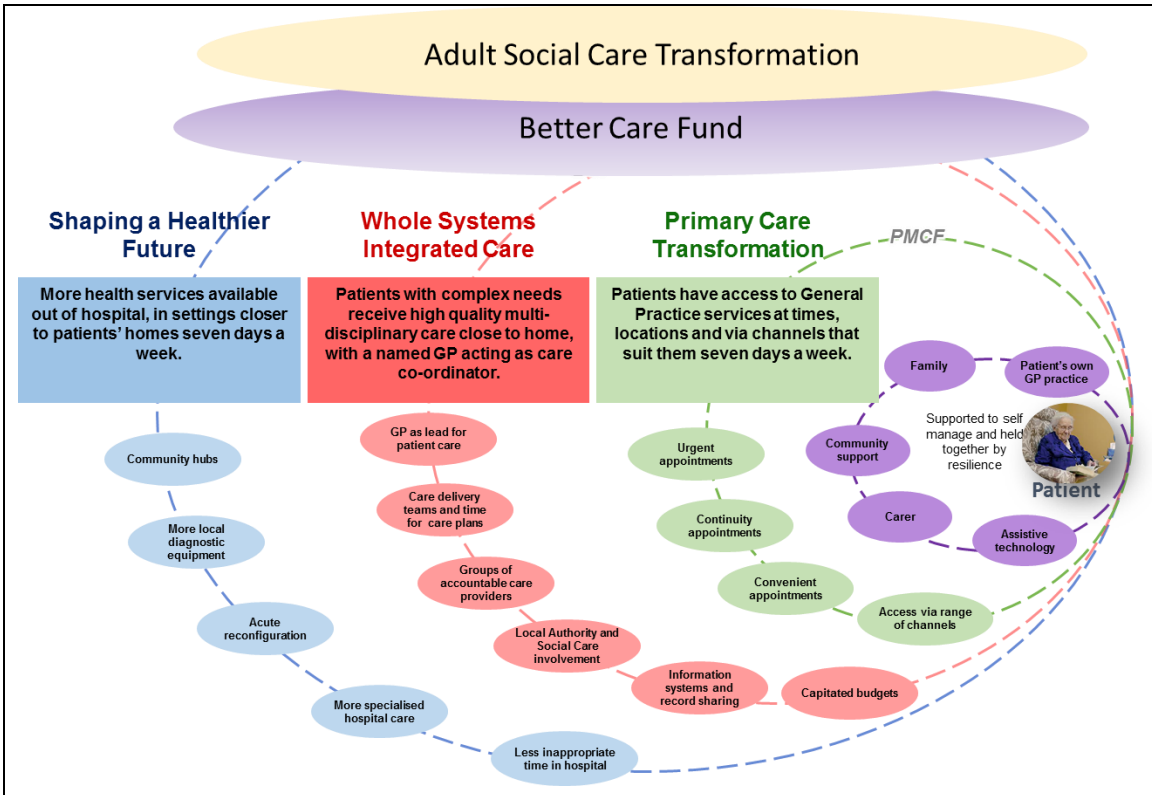
We believe that the future lies in services that are constructed around the people that they are intended to help; services which work jointly with individuals and their carers, to keep them independent and well. Each programme plays a distinct role in achieving these goals. In every area, there are "live" services today upon which our communities depend. By investing in the future, we can build upon the best of what exists today, and ensure that no-one falls between the gaps.

As demand increases and resources tightens, we need to "shift" towards better co-ordinated, person-centred care in our communities. This shift is not driven by cost efficiencies, but by the wishes of people to remain living safely and independently within their homes and communities rather than in hospitals or council-funded residential and nursing homes. With the right support, community and home-based care is often the best place for treatment. As a result, and if we are successful, we may have less need for hospital beds and institutional homes – but we will still need both, and overall we should be delivering more care, not less.

Each of these programmes are interlinked, designed to create integrated teams to deliver services that are constructed around the people that they are intended to help. These are services that will work jointly with individuals and their carers and will help them to remain independent and stay well.

Interlinking of transformational programmes across Triborough

The diagram below provides a visualisation of how the transformational programmes align:



Through programme structures and close working arrangements, we are ensuring that related activity aligns by working in collaboration with neighbouring CCGs and boroughs to co-design approaches to integrating care. This aims to ensure that shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

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

As described in Section 6a, the range of transformational programmes across NWL, including BCF, are aligned to deliver the overall vision of improving health and social care for the local population.
In the 3 CCGs' 2 year operating plans, CLCCG, WLCCG and H&FCCG have set targets for some key outcome ambitions that relate to initiatives within the BCF and align with the overall strategic vision and objectives. These key outcome ambitions include:

- Ambition for improving health-related quality of life for people with long term conditions
- Ambition for reducing emergency admissions
- Ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and in the community

The 5 year strategic plan for NWL sets out how the 8CCGs, including the 3 CCGs that cover the Triborough area, and their partners will work collaboratively to transform the health and care landscape across the region in order to achieve its shared vision, deliver improved outcomes and

patient experience, ensure a financially sustainable system and meet the expectations of individuals using health and social care services. It sets out the collective plans and priorities of the eight CCGs working in partnership with NHS England and has been developed in line with NHS England planning guidance.

In particular the section within the 5 year strategic plan that focuses on Whole Systems, highlights the BCF and the need for all local areas to develop BCF plans. It is noted that these local BCF plans are an important stepping stone in the journey to long term transformation, with their focus on bringing together health and social care resources to deliver personalised and integrated care.
It also notes that the vision, principles and co-design work undertaken within the Whole Systems programme has been fundamental to the development of the BCF plans in each borough.

BCF plan alignment with Local Authority plans
The 3 Local Authorities in Triborough are running a strategic Adult Social Services Transformation Programme. This is an overarching 3 to 5 year programme that will:

- Help achieve savings of £45m over three years
- Meet the increased demand for care services from an ageing population and the requirements of the new Care Act
- Improve the experience of people by making services clearer and easier to use and more joined up

The programme focuses on aligning assessment and care management services within ASC to create a consistent core service offer and operating model; building more personalised community delivered care services that help people to be more independent; integrating social services with health, focusing on intermediate short-term care and care for people with disabilities and long-term health conditions.

The portfolio of programmes within the Triborough BCF plan align with the overall objectives for the Triborough Adult Social Services Transformation Programme and will contribute to the savings that need to be achieved.

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.

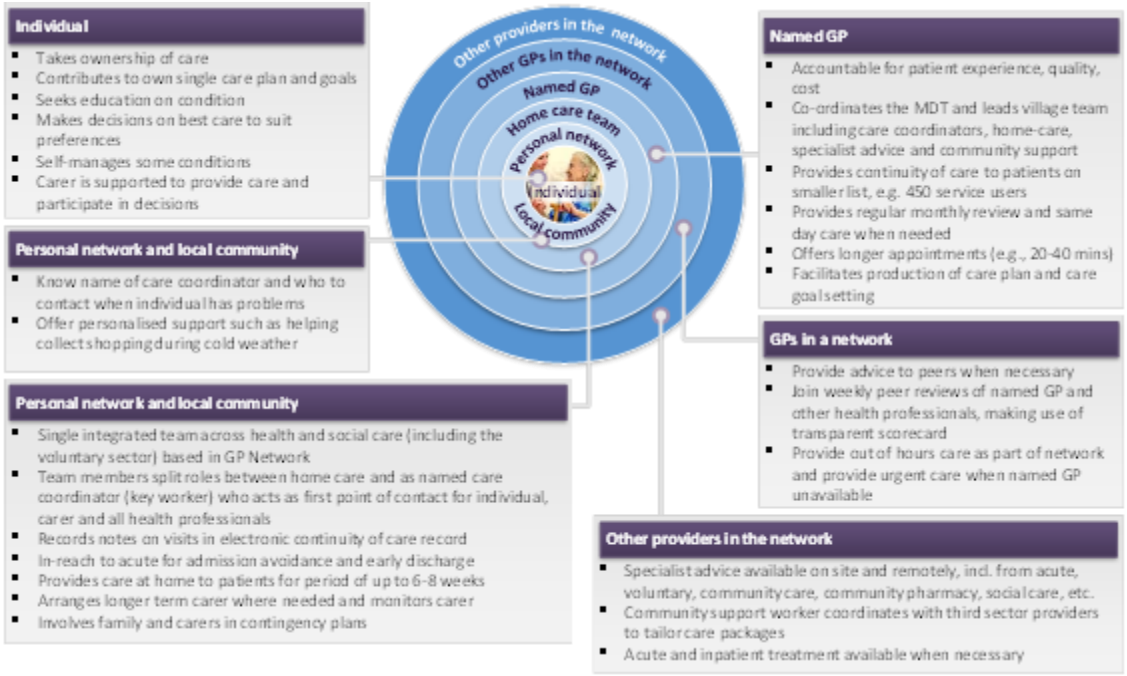
At the heart of the vision for whole systems integrated care – where care is proactive accessible, coordinated and personalised – General Practices (GPs) will be at the centre of organising and coordinating care for practice populations, both as individual practices and in networks delivering care seven days a week.

GPs are developing new ways of working and there is a programme of primary care transformation which sits alongside whole systems integration to support them. Some of the transformational initiatives include:

- Developing local GP networks to enable GPs to work together, share learning and resources (with the support of the PMCF)

- Introducing 7 day working in primary care
- Ensuring that a proportion of the significant additional investment in out of hospital care will be in general practice (£190m annual revenue investment).

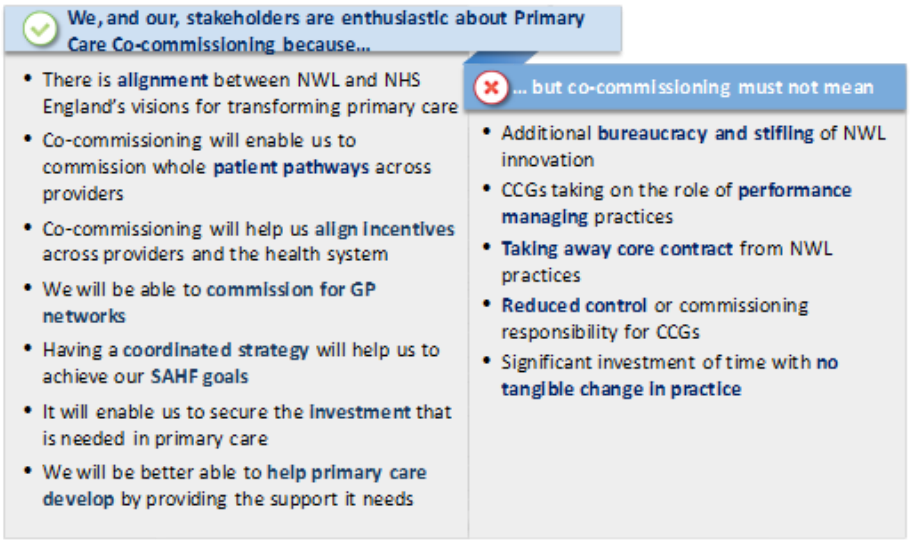
This will put the patient at the centre of their care, with a wide range of levels of care to support them.



Co-commissioning of primary care services is a way of enabling the changes being implemented. GPs want individuals to participate in a new model of care but need to develop and implement supporting contractual mechanisms that encourage both innovation and sustainability. It is felt that these mechanisms will be best established by the Triborough CCGs and NHS England working together as co-commissioners.
Current constraints faced by CCGs and NHS England to drive the transformation in primary care include:

- CCGs unable to shift funding from other parts of the health system to primary care, or make investments in enablers such as estates or IT
- Lack of local management resource in NHS England to drive change or proactively manage performance
- Paradox for the CCGs of being elected by GPs and being best placed to understand local needs versus requiring some 'distance' from general practice in their discharge of public funds

Commissioners across Triborough believe that co-commissioning needs to be about helping general practice to secure the right level of investment, provide greater flexibility to innovate and support GPs to improve quality of care and achieve better outcomes for individuals.



Proposals for Primary Care Co-commissioning

There are a number of models that can achieve Primary Care co-commissioning. CCGs have worked closely with NHS England, general practices across the region, lay members and other relevant stakeholders to explore the different options available, and have confirmed that the most appropriate model is for 'joint commissioning' arrangements, whereby CCGs and area teams make decisions together, potentially supported by 'pooled funding' arrangements.

Currently, an Expression of Interest has been submitted to NHS England (in June 2014) to pursue this model and there is consideration as to whether a shadow form of a joint committee may commence in November 2014, which could lead to a 'live' joint committee in operation from April 2015. Discussions about the responsibilities and functions of the joint committee are on-going, with a focus on commissioning rather than contract management or performance management.

Alignment of BCF plans with plans for Primary Care co-commissioning

As described in section 2, the BCF is an enabler to support the overall transformational portfolio of work being undertaken to deliver better outcomes and experiences for the population. Primary Care co-commissioning is a key enabler to supporting change that will impact both some of the schemes within the BCF as well as the wider whole systems integrated care programme.

Ultimately, having the Triborough CCGs and NHS England work together as co-commissioners will support the achievement of the vision for whole systems integrated care centred around Primary Care, with its priorities outlined below:

1. Enhanced patient and public involvement
2. Improved quality of services by improving standards and reducing clinically unexplained variations
3. Greater integration and therefore more efficient and effective use of resources and workforce
4. Reduced health and care inequalities with greater transparency and accountability.

Supporting the third priority the BCF is focused on developing improved ways of working for both the health and social care elements of the system. The BCF is redefining how different providers, with GPs at the heart of the system, will work together to deliver care.

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)

Protecting social care services in the Triborough means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility thresholds is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

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

A key component of the Triborough BCF plan is the additional investment in social care through the Community Independence Service to enhance rehabilitation and re-ablement services, reducing hospital re-admissions and residential / nursing home admissions.

Rehabilitation services will be delivered via an integrated CIS across health and social care, operating 8am to 8pm, 7 days a week, providing time-bound rehabilitation (therapies) for referrals via the Single Point of Referral service by treating people with non-complex conditions in a community setting. The team will respond to all referrals within 24 hours and commence care within 72 hours.

Reablement services will also be delivered via a multi-professional rapid response service (covering medical, nursing and social care), operating 8am to 8pm and 7 days a week. This will provide face to face assessment at home within 2 hours of referral, support up to 5 days following referral and providing referrals to ongoing support.

It is anticipated that the Community Independence Service will contribute to a reduction in admissions to residential and nursing care, and to lower level care packages to support people in the community in addition to enabling many clients to delay their need for long term care. However, it may also lead to additional pressure on social care by shifting the level of needs from continuing health care to local authority funded care and to short term pressures on social care for those people supported at home rather than in hospital. This additional pressure has been acknowledged in the financial arrangements developed for the Better Care Fund in Tri-borough and the proposed flow of funding into the local authorities to support this programme of work.

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.)

There is protection of Adult Social Care through existing funds for "Social Care to Benefit Health" (>£11m across the Triborough), which will be via CCGs from 15/16. There is also funding from the CCGs through the BCF of £1.8m to support implementation of Care Act duties. Non-recurrent funding of £2.8m for new investment into the CIS in 15/16 will be funded by the CCGs. The total projected savings for social care set out in the BCF (£5.3m) will accrue as projects develop.

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

The implementation of the Care Act presents both opportunities and challenges for the Triborough which will be met with a strong commitment. The Act presents an opportunity for greater consistency in the delivery of care focussed on the wellbeing and outcomes for people, integration, carer involvement, transparency and personalisation. Key challenges arising from implementation of the Care Act, include:

- The impact of the reforms in terms of affordability including the impact arising from increased support for carers and self-funders
- Developing a shared understanding of the funding allocations
- Clarity about IT system requirements
- Developing the market and local communities, and the supporting information and advice to enable wider choice of care and support
- Working collaboratively across the Triborough and with external partners to deliver greater integration and partnership
- Clear communications with all stakeholders either involved in implementing the reforms or affected by them
- Workforce implications within the Triborough and externally

We have focussed on attaining compliance with the Care Act by April 2015 when the first tranche of deliverables are due. We have reviewed existing policy to align it to the Act followed by a review and redesign of the operating model and supporting infrastructure.

This will result in holistic assessments that enable improvements to provision of primary, secondary and tertiary services that help prevent, reduce or delay needs for care and support. Low care need will be met through effective care navigation, providing sufficient guidance on available local support, as a central component of the BCF redesign.

Those with low level need must be supported to stay healthy and independent, delivering preventative services to ensure needs do not escalate. Timely and accurate signposting allows for independent decision making and individual ownership of need reducing the pressure on health and social care professionals. A key enabler in adopting service user independence is the role of the carer and therefore a structured support service will be implemented (including carers assessments) to recognise the contribution of carers.

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

The level of resource dedicated to Carers' Services in 2015/16 is £1,931,875 which reflects funding for: assessment, advice, information and support, primary care navigators, personal budgets and health and wellbeing projects as well as respite care and short breaks.

The breakdown of resourcing is as follows:

Borough	Local Authority	CCG	Total
Hammersmith & Fulham	£230,200	£203,100	£433,300
Kensington and Chelsea	£116,450	£324,125	£440,575
Westminster	£641,700	£416,300	£1,058,000
TOTAL	£988,350	£943,525	£1,931,875

Figures taken from the s75 Service Schedules 2014/15.

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

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the Local Authorities to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible.

This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Act requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation / reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

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

North West London was awarded "Early Adopter" status by the NHS England/NHSIQ Seven Day Services Improvement Programme, meaning that we have a responsibility to progress the 7 day services agenda at scale and pace. The Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (JHWS) have helped us to identify the main areas where integration and joint working will improve outcomes and informed our commitment to drive forward 7 day services.

The 7 Day Services programme is an overarching programme which includes a number of projects, many of which will be delivered through existing work streams. The work streams closely linked with

the BCF programme relate to social care and primary care providers.

Additional funding was identified within the Triborough area during the winter period of 2013/14 to facilitate 7 day services in health and social care. This enabled partners to assess what additional capacity is required to develop an on-going 7 day service offer and to evaluate how successful the approach is to facilitating discharges and avoiding un-necessary admissions.

Further work is also being undertaken to understand the Adult Social Care Customer Journey, including interfaces with health providers to enable timely assessment and transfer, and 7 day services in social care will be considered as part of this work.

A costed plan for 7 day services has been developed in 2014 for implementation in advance of the 2014/15 Winter period as part of the Triborough Resilience Plan and this will provide a basis for the establishment of 7 day services throughout the year from 2015/16.

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

All health services use the NHS number as the primary identifier in correspondence.

Social services are in the process of adopting this, and we are committed to ensuring that use is universal across the 3 Local Authorities of the Triborough. The business case for this project has been signed off by the relevant governance bodies and the project is currently entering Phase 1. The technical changes required to achieve this have been defined and budget approved. The NHS number will be the primary identifier across all 3 localities by April 2015.

The information governance requirements to support data sharing have been defined and work is in progress as part of the BCF to embed them (see further details below).

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)

We are committed to adopting systems based upon Open APIs and Open Standards. We already use:

- System One, a clinical computer system that allows service users and clinicians to view information and add data to their records
- Emis Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record
- Carefirst 6, a software solution to provide a range of services and content to social care, while allowing the involvement of health care partners

To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and

analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.

By Autumn 2014, our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record. The BCF will help ensure this happens by joining up Health and Social Care data across the Triborough, linked as above via the NHS number.

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.

All of this will take place within our Information Governance framework, and we are committed to maintaining 5 rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users and patients should be treated confidentially and respectfully
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them should be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

Triborough local authorities are working closely with the NHS to put in place strong IG arrangements as part of the wider programme of integrated working and these will be completed during the autumn of 2014.

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

An Integrated Care Programme has been implemented across local CCG areas that involves risk stratification of practice populations and review by multi-disciplinary groups, followed by implementation of care planning and case management as appropriate.

H&F CCG/ LBHF and WL CCG/ RBKC use the ICP risk stratification tool, modified from the Combined Predictive Mechanism (CPM), which has identified 4% of the population at high risk of hospital admission. CL CCG/ WCC uses WellWatch and are planning to transition from an approach which selects individuals on the basis of pathways, to one based on selecting individuals on the basis of their relative risk score. WellWatch may begin to use the ICP risk stratification tool in the future.

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

We stratify segments of our population based on risk. The segments identified as high risk are (a) diabetes; (b) chronic obstruction pulmonary disorder (COPD); (c) coronary heart disease (CHD); or (d) individuals over 75. The multi-disciplinary groups within each borough also use these segments as a basis for focussing their discussions.

Based on these four indicators, approximately 4% of our population is at high risk of hospital admission. Based on the algorithm and our stratification, we then closely monitor those classified as at high risk of hospital admission within the next year.

The Early Adopter pilots being proposed by the CCGs as part of the Whole Systems Integrated Care programme reflect a commitment by GP networks to undertake systematic risk stratification and care planning for their high risk populations and to develop an integrated response to providing treatment and care.

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

Each Triborough locality has set different targets around care planning:

- In H&F CCG/ LBHF, they are working towards the 4% having a joint care plan and accountable professional
- In WL CCG/ RBKC, all individuals with a risk score of 20 or over will be care planned, and those with a risk score of 65 or over will be case-managed
- In CL CCG/ WCC, WellWatch Case Management Services will care plan for those in the 61-91 centile risk stratified cohort

Our integrated plan envisages GPs taking a lead in coordinating care as the agreed accountable lead professionals for people at high risk of hospital admission.

Under the Integrated Care Programme, around 2% of individuals have a care plan, and this will increase to 4% to account for the population that has been identified as high risk. The CPM algorithms are used to predict emergency hospital admission in the next year. The algorithm draws on information from primary and acute care, as well as individuals' ages, to make its predictions.

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 BCF is a key enabler for whole systems integration. Through patient and service user workshops, interviews and surveys, we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

At a Local Authority and CCG level, service users and carers are involved in developing person centred services and each Health and Wellbeing Board has adopted the National Voices approach, involving service users in identifying local measures of success.

Triborough Adult Social Care (ASC) has completed a Customer Journey project as part of the ASC transformation programme to understand better the views of service users and carers on their experience of social care. This builds on the information already received through the national survey and will inform our integrated operational working.

Feedback on the draft BCF indicated that there was great interest and enthusiasm from the voluntary and community sector, service users and carers, and representatives such as Healthwatch to be involved in taking forward integrated health and care.

A North West London Patient and Public Representative Group has been established, including CCG Patient and Public Involvement lay members, representatives from Healthwatch and from service user and carer groups to ensure that the patient perspective is reflected in all our programmes as they develop.

We will be building on these existing approaches to develop a strong service user and community voice within the Better Care Fund to ensure that our integration plans deliver better outcomes and experiences for all our citizens. The draft engagement plan is included in the supplementary documents.

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

At programme level, the BCF plan reflects a number of existing programmes which have included health providers as active participants. Together with a range of local social care providers, and our voluntary and community sector as a whole, providers are now being engaged in developing future plans.

Details of existing consultation work can be found in supporting documentation including the Out of Hospital Strategies for each Triborough locality, and *Living Longer and Living Well*, our successful

application to become an Integrated Care Pioneer. A joint commissioner and provider forum across North West London forms a core part of the co-design work in our Whole Systems Integrated Care Programme. A number of the BCF workstreams are particularly relevant to our community health services providers and we are involving them closely in these developments.

We are developing our Communications and Engagement Plan to include a range of ways in which provider representatives, including front line staff, can be involved in the development, implementation and evaluation of all our programmes. Clinicians and other practitioners will play a key role alongside service users and carers in ensuring that the BCF makes a positive difference to people's lives

For some schemes there is already regular engagement with stakeholders from across the organisations involved, including relevant managerial leads, clinical leads and decision makers. For the Community Independence Service, where stakeholders have not yet been immediately involved in the project, concerted effort has been made to ensure that they have been consulted and informed of its progress through existing forums, such as Whole Systems Design Groups, Locality Meetings and Urgent Care Board. Whole Systems groups have been the primary vehicle for clinical and service user engagement, and will be the route used to consult on future models and their implications for providers. The Urgent Care Board, as the forum at which providers come together, has been used to ensure that acute and community providers are aware of progress with the initiative through a number of presentations at the board on CIS. In addition, specific engagement events have been held to communicate CIS programme intentions. These included a learning session, held at the University of Westminster in June, with attendance from acute, community and ASC providers and a presentation at subsequent ASC Leadership and operations team events.

ii) Primary care providers

There has been engagement with primary care providers through the Whole Systems Design and Locality Groups and through the Whole Systems Integrated Care engagement groups which have been used to inform decisions and monitor progress. We will increase the level of engagement with primary care providers in the next phase of the programme following from the detailed communications and engagement plan that is in production.

iii) Social care and providers from the voluntary and community sector

As part of creating the Triborough Market Position statement, dialogue on the BCF programme has been undertaken through existing forums with voluntary sector providers across Triborough. In developing the Better Care Fund plans for the future we are looking to link this wider range of social care and community providers to the Whole Systems forum as a reference group for the BCF and for the wider Health and Wellbeing programmes.

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?

Transformation plans have been developed and consulted upon with Local Authority, hospitals,

community and mental health services and other local stakeholders fully engaged.

Achieving our targets will require significant investment in primary and community care and reduced acute activity, as described in the Out of Hospital Strategies. In Shaping a Healthier Future, we set out major changes in how services will be configured in our health economy over the next 3-5 years.

The North West London Whole Systems Integrated Care (WSIC) Programme and related initiatives are focussed supporting these developments through improving patient pathways to reduce hospital stays, by number and length of stay. We have evaluated our proposed changes on the Value for Money criterion. These covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The analysis indicates that commissioner forecasts over the five years (across NWL) involve a gross QIPP of £550m, with reinvestment in out of hospital services of £190m.

Our local community health services provider, Central London Community Healthcare (CLCH) and mental health trusts, Central and North West London Mental Health NHS Foundation Trust (CNWL) and West London Mental Health Trust (WLMHT) have been fully involved in the development of community services and in the co-production of different models of care to deliver the changes described above. The WSIC pilot schemes will see providers working together to offer integrated services to improve both patient experience and value for money.

We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce mortality through better access to senior doctors; improve access to GPs and other services so individuals can be seen more quickly and at a time convenient to them; reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community; and ensure less time is spent in hospital by providing services in a broader range of settings.

If we do not deliver activity reductions through improved out of hospital care, we expect most sites to move into deficit, with no overall net surplus. In the downside scenario there would be an overall deficit of £89m, with all bar one acute site in deficit. We anticipate that the changes proposed will have a significant impact on community services, and both statutory and independent providers of health and social care will be partners with us in delivering this Better Care Fund Plan. We will be assessing this impact scheme by scheme in the next few months.

Over the course of 2015/16, through delivery of the BCF schemes and in particular a new single integrated Triborough Community Independence Service (and crisis response team) we expect to achieve a reduction in emergency admissions and delayed transfers of care equivalent to an average reduction in activity across the Triborough of approximately 5%.

The detailed table below provides the breakdown of numbers per Trust and splits the impact into 2 types: A&E admission avoidance and reduction in mon elective admissions.

Chelsea & Westminster

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	114	206,532	192	23,668
West London	301	571,094	506	64,068
Hammersmith and Fulham	197	357,030	230	30,053
Total	**612**	**1,134,657**	**928**	**117,789**

ICHT

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	496	898,597	834	102,978
West London	416	789,286	699	88,545
Hammersmith and Fulham	492	891,669	575	75,057
Total	**1404**	**2,579,553**	**2109**	**266,580**

GSTT

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	122	221,026	205	25,329
West London	0	0	0	0
Hammersmith and Fulham	0	0	0	0
Total	**122**	**221,026**	**205**	**25,329**

UCLH

	NEL Admissions		A&E Attendances	
CCG	**Activity reduction (n)**	**Contract reduction (£)**	**Activity reduction (n)**	**Contract reduction (£)**
Central London	55	99,643	92	11,419
West London	0	0		
Hammersmith and Fulham	0	0		
Total	**55**	**99,643**	**92**	**11,419**

The success of the Out of Hospital strategies across the 3 localities can already be seen by increased packages of homecare enabling better care closer to home and for individuals to be cared for within their own communities. The impact of this, as expected, has resulted in extra costs for ASC. This additional cost will be funded by CCGs and the teams are working together to demonstrate this linkage and enable the funding flows from CCG to ASC.

The Trusts are already aware of the BCF schemes at an operational level through the links to the Urgent Care Boards and how the schemes will strengthen and harmonise the approach to community care and confidence in out of hospital provision. The BCF Plan and in particular the Community Independence Service have been discussed at Chief Executive level with our local hospital and community providers to ensure a full understanding of the implications and how the BCF programme will contribute to the delivery of already agreed strategies for out of hospital care. This is reflected in the provider commentaries at Annex ii. We will also be working with all our providers over the coming months to further engage them in co-design of in depth solutions facing the health and social care economy in Triborough.

We have an agreed 5 year plan in NW London to implement SaHF which will create 5 major hospitals and also a significant shift of work to community / primary care setting. This will result in a significant reduction in emergency admissions. The plans contained in the BCF are consistent with this. For 14/15 contracts with both Imperial and Chelsea and Westminster hospitals a run rate reduction of 5% in emergency admissions. The proposals in the BCF are a continuation of this. We have not yet agreed the SLA for 15/16 and will be expecting them to contain the impact of the proposals in the BCF.

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

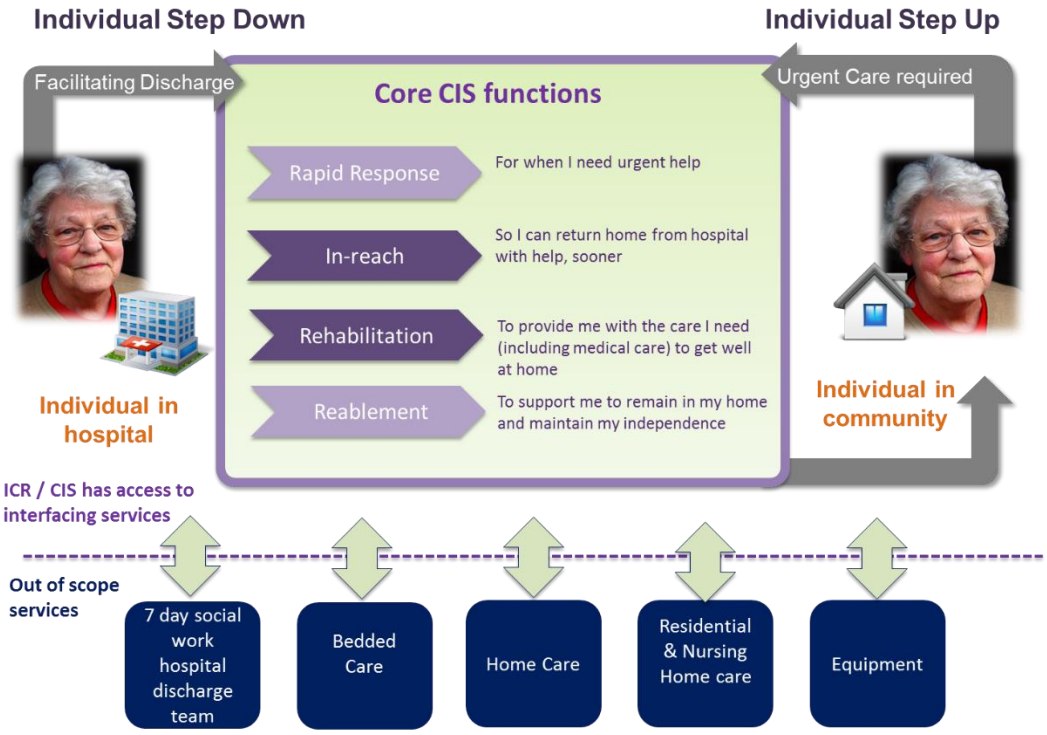
For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
A1
Scheme name
Community Independence Service
What is the strategic objective of this scheme?

As part of the BCF planning process, a detailed business case has been prepared to assist decision making by Triborough LAs, CCGs and Health & Wellbeing Boards in September 2014. It proposes the way forward to develop a Triborough Integrated Community Independence Service (CIS) which will integrate and enhance existing local models and delivery frameworks to achieve common and improved outcomes for the local population.

The Community Independence Service provides a range of functions including rapid response services to prevent people going into hospital, and rehabilitation and reablement which enable people to regain their independence and remain in their own homes.

Below is a simple visual of the proposed CIS model from the perspective of a person using the service:



Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

The aim is to develop a single model of care, working across the Triborough area to replace a range of variable specifications across the existing, often duplicated, services. The single service model

specified is both integrated across health and social care and multi-disciplinary (nursing, medical, therapies and social care) and operates 7 days a week. The proposal is to provide rapid and responsive care to support patients at risk of admission to hospital, enabling hospital inpatients to be transferred in a timely manner to community settings, and ensuring recovery. This service is to be jointly commissioned across health and social care and delivered across the three CCG and Triborough ASC service areas.

There are four overall features to this model of care:

1. Intensity of support to deliver care at home
2. Collaborative multi-disciplinary working
3. Effective information sharing
4. Best use of workforce skills

And four core elements:

1. Rapid Response
2. In-Reach
3. Non-Bedded Intermediate Care/Rehabilitation
4. Reablement

Target patient cohort

The target patient cohort includes:

- Individuals with long term care requirements who need support to prevent crises or deterioration
- Individuals who require support following discharge from hospital
- Individuals who need support to prevent (or delay) admission into hospital.
- Individuals who want to regain their independence at home or in another community setting.
- Individuals who require urgent care.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:

Central London Community Healthcare NHS Trust
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham
London Central and West Urgent Care Centre
Central and North West London NHS Foundation Trust
West London Mental Health NHS Trust
Allied Healthcare

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National drivers

The demographic pressures of an ageing population combined with budgetary pressures and increasing costs exacerbates an already challenging environment. At present, care is fragmented across the health and social care provision and the approach to managing long-term conditions is outdated.

Local population need for intermediate care

As well as the health and social care economy in Triborough, there are also national pressures. The intention for community care, of which the proposals for CIS form a part, is that resources will be

made available to support the delivery of high quality care, with people in control of their care, within a viable and sustainable health and social care economy.

In July 2014, an assessment of the population need for Intermediate Care in the Triborough was completed. It considered:

- What is the need for intermediate care services in the local population?
- Do existing services meet this need?
- How will need change over the next 20 years?

The report identified the following key findings:

- Intermediate care services are mainly (but not exclusively) used by older people. Based on data from Hammersmith & Fulham, three-quarters are 71+ and 92% are 56+.
- Demographic change is likely to mean that need for intermediate care will increase by around 40% over the next 20 years, as the number of older people and the number of people with long-term conditions increases.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £23,514,141
Investment:- £2,681,180
New delivery costs:- £1,931,318
Existing costs:- £18,901,643

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Total:- £8,019,589
Savings from payments to acute providers:- £4,543,982
Savings form care home providers:- £3,475,607

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

New governance and management arrangements will need to be established to effectively manage the new Triborough CIS from April 2015 onwards. It is proposed that an operational management committee is established with representation from across the 6 commissioning organisations and that it will also include provider representation. The Committee will meet monthly to review performance and take key decisions in the ongoing delivery and development of the CIS. A single framework of Key Performance Indicators (KPIs) will be developed with associated dashboard reports to enable transparency of service delivery performance and enable the tracking of both costs and benefits.

The Committee will also track the development of the provider programme of integration and interoperability initiatives across the multiple providers to ensure that the 'transition year' achieves the target of delivering a 'single' service.

What are the key success factors for implementation of this scheme?

Key principles have been identified that will underpin successful implementation:

- Maintain strong relationships with other transformational programmes across NWL and the Triborough
- Develop genuine joint working between commissioners and providers to overcome challenges that arise
- Ongoing communications with all stakeholders to establish confidence in the CIS and its ways of working
- Ensuring cultural and behavioural change sits alongside process and system change

Scheme ref no.

A2

Scheme name

Community Neuro Rehab Beds

What is the strategic objective of this scheme?

To increase investment in additional community and bed based capacity, particularly for neuro-rehabilitation, and to extend the community rehabilitation period up to 12 weeks in the community including Homecare.

There is further work to do to confirm the costs and benefits of this scheme after plan submission. Costs and benefits sit with health.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

The rehabilitation services are commissioned across Triborough with the objective of providing goal focused interventions to facilitate the restoration of a person to regain optimal functioning (physically, psychologically and socially) to the level he/she is able or motivated to achieve (DH 2008).

This project will focus on the additional provision of neuro beds across Triborough with the aim of reducing delayed transfers of care.

Work to be undertaken as part of this scheme includes:

a. Establish the current referral and delivery pathway for bedded and non-bedded community rehabilitation /neuro-rehabilitation services
b. Analyse current need/demand for and waiting times for community based and other specialist hospital rehab/neuro-rehabilitation
c. Analyse performance of community rehab provisions (bedded & non-bedded) – nos. of referrals, LOS, waiting times (referral to 1st intervention)
d. Quantify the 13/14 costs in delivering the current rehabilitation/neuro-rehab service pathway
e. Redesign service pathway (assessment to delivery) for community rehab/neuro-rehab to reduce DTOC, LOS in specialist neuro-rehabilitation services and admissions to care homes
f. Specify the service types required to deliver the new service pathway
g. Quantify the cost of delivering the new service pathway
h. Quantify the potential saving if new service pathway is delivered (including any assumption)

Target patient cohorts

Patients who require rehabilitation services to regain a loss of physical, mental or social functionality

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:

Central London Community Healthcare NHS Trust
Imperial College Healthcare NHS Trust
Chelsea and Westminster NHS Foundation Trust
Alexandra rehabilitation unit (RBKC)
Ellesmere rehabilitation unit (RBKC)
Thamesbrook rehabilitation unit (RBKC)
Athlone rehabilitation unit (WCC)
Farm Lane rehabilitation unit (LBHF)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Intermediate care and rehabilitation delays remain a consistent issue in the two acute hospitals - Chelsea & Westminster Hospitals (CWH), and St. Mary's Hospital (ICHT).

The table below shows the total numbers of delay days lost reported to NHS England relating to intermediate care and rehabilitation for the first three quarters of 2013/14.

Delays per borough area - intermediate, rehab	**1st April – 30th June**	**1st July – 30th September**	**1st October – 31st December**	**Total**
Kensington & Chelsea	124	144	313	581 days
Westminster City Council	391	197	147	735 days
Hammersmith & Fulham	164	107	104	375 days

The solution requires a multi- pronged approach for bedded provision, including:

- Better demand and capacity modelling to understand current and future need
- Redesigning a clinically efficient as well as a cost effective care pathway
- Streamlining (and in some cases changing) the referral pathway from acute to test community capacity/capability to provide rehab support in community based settings
- Re-designing existing community rehab provision (bedded and non-bedded) to provide step down neuro-rehab support for people to reduce DTOC in acute and LOS in specialist (short - medium term)
- Improving the process of access and communication into current bedded provision
- Bolstering home based capacity within Community Independence Service (CIS) - to reduce need for bedded provision - including readily access to medical support
- Commissioning additional rehabilitation capacity or changing the existing use of some of the current rehab beds
- Ensuring that community teams (neuro/Stroke ESD) to follow up patients in specialist neuro-rehab and work with ASC to support them back into community

Further micro analysis of the summary data on DTOC associated to intermediate care and rehabilitation indicate that approx. 50-60% of the acute bed days relate to neuro-rehabilitation.

In addition the mapping of current community based rehab/neuro-rehab services (bed and non-bedded) indicate a gap and need for:

I. Step down neuro-rehab bedded services to provide disability management to support those waiting for specialist neuro-rehab, as well as facilitate discharge from specialist rehab services.
II. Step-down neuro- rehab for people with functional and organic mental health needs/presentation who require both physical and cognitive rehabilitation to meet their needs.

Lack of step down neuro-rehab options within our bedded provision mean that the system is unable to provide informed and cost effective 'maintenance' neuro-rehab when a person is experiencing a wait for specialist neuro-rehab intervention. This is therefore likely to lead to longer length of stay in costly specialist centres for some people as they become more debilitated and dependent whilst waiting for specialist services.

Initial quantification work undertaken in CWH and modelled across ICHT indicates a requirement for community based step-down neuro-rehab of between 15 – 20 beds across Triborough areas. This could potentially increase to 29 beds if the needs of Ealing and Hounslow areas are included.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £2,808,000 (new delivery costs – draft subject to further work)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Total:- £1,417,758 (draft subject to further work) Cashable savings from payments to acute providers:- £849,918 (as above) Cashable savings from payments to community providers:- £567,840 (as above)
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This will be determined with further work on this scheme, following prioritisation to date on scheme A1 Community Independence Service.
What are the key success factors for implementation of this scheme?
As above

Scheme ref no.
A3
Scheme name
Homecare
What is the strategic objective of this scheme?
To successfully commission, procure and implement a new Homecare service in Tri-borough that will better enable our patients and service users to remain independent in their own homes.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model of care The programme aims to commission, procure and implement a new and improved homecare service across the 3 Tri-borough LAs. The service will be based on: • Achieving outcomes for people using services, moving away from "time and task" focused provision • Providers working directly with people using services to agree details of care and how outcomes will be achieved • Ensuring that dignity and compassion are core values in the service • A measured integration of health and social care tasks over the life of the contract • People being helped to feel a part of their local community In order to achieve the above, we will need to deliver on a number of objectives. The main objectives have been set out below: 1. Development and sign off of a comprehensive service specification 2. Development, issue and evaluation of a pre-qualifying questionnaire (PQQ) and invitation to tender 3. Training needs analysis and workforce development plan for new providers and other existing providers with which the new service will be dependent on 4. An agreed plan of integration of social care and health care tasks over the course of the contract 5. A new e-monitoring system to support the monitoring and evaluation of the new Homecare service 6. Financial and information sharing protocols between Tri-borough Adult Social Care and Health 7. An agreed means to monitor and evaluate quality of care provided by new providers **Target Patient Cohorts** People who wish the Councils to arrange a care at home service on their behalf following an assessment of their need.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:
Central London Community Healthcare NHS Trust
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is a national and local consensus that the current system of home care provision is not fit for purpose and cannot meet the increasing levels and complexity of need. The population of people that are being supported to live at home now have a range of complex needs and this population is increasing. Current activity and future projections show that home care services need to be able to support more people who have increasingly complex care needs. This requires greater integration with Adult Social Care services and Primary and Community Health Care provision.

In addition, in the current system, qualified nurses are spending time undertaking basic tasks that could be conducted more cost effectively by an unqualified resource, therefore releasing time for increased case management to registered nurses in the community. The LAs' & CCGs' commissioning intention to move towards an enablement model of care such as the Community Independence Service has also meant that the on-going long term care approach is required to adapt. The current system fails to capitalise on the health and well-being gains during the reablement period by providing a service that supports people by doing tasks for them. Key issues currently experienced include;

- Dissatisfaction from the LA regarding the high number of providers in the homecare market with varying quality outcomes and poor patient experience (as demonstrated in the skills for change report)
- Difficulty for CLCH to fully recruit to nursing posts and retain experienced staff leading to inconsistency in workload distribution
- Failure for CLCH to ensure that appropriate health tasks are delegated to unregistered nursing staff leading to highly paid nurses provided low level healthcare support.

As part of the homecare initiative a consultation report was produced by Frameworks 4 Change, an independent provider who facilitated the consultation events on behalf of the Tri-borough. In summary, people felt that the key features of any new service should be:

- Consistency of care worker
- A service which looks more widely at people's lives including outcomes for them
- A more streamlined assessment process
- Integrated care provision
- Support for people to lead good lives.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

New joint contractual arrangements following homecare procurement will provide better information to enable an understanding of drivers of cost. In the meantime, health and social care partners will jointly review long term trends within homecare to identify any systemic shifts in activity and if necessary undertake joint causal analysis to understand those movements.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

There are clear service improvement objectives associated with this scheme but BCF plan savings are not currently predicated on it.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are clear objectives in the scheme workplan to define monitoring and evaluation approach.

What are the key success factors for implementation of this scheme?

There are dependencies with the Customer Journey programme which is required to develop a solution to both the functional and business change requirements of the care at home programme.

The programme is dependent on the direct payments project delivering a suitable direct payments option for customers in time for contracts going live in April 2015.

Scheme ref no.

B1

Scheme name

Patient/Service User Experience and Care Planning

What is the strategic objective of this scheme?

This scheme focusses on developing two key aspects of care delivery:

- Patient and Service User Experience
- Self-management and Peer Support

To improve the way patient, service user and carer experience data is gathered, analysed and used to inform commissioning decisions and to work with support patients and communities to have greater control over their health and wellbeing by co-designing self-management programmes and interventions.

Better use of data in commissioning and a focus on evidence-based co-design of self-management and peer support programmes will positively impact patient experience and health and care outcomes.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

There are two interdependent tasks within the project;

- The first will develop in partnership with patients, service users and carers, an improved and integrated approach to data collection (quantitative and qualitative, experiential), consolidation and use. Outputs from this work will include a framework for engagement across all BCF schemes, underpinned by co-design principles. This will facilitate a more consistent and effective approach to the capture and use of patient experience data in commissioning.
- The second task will review and co-design self-management and peer support programmes and interventions; this will include the creation of specifications and subsequent development, implementation, monitoring and evaluation of these programmes. This task will help ensure patients and communities have greater control over their health and wellbeing.

This scheme will focus on:

- Service users, carers and adults with a long term condition, or at risk of a long term condition
- All GP practices within the three Triborough localities
- Hard to reach communities particularly those in deprived areas
- Vulnerable homeless adults

The development of self-management and peer support programmes/interventions will target in particular those with COPD, Cancer, Diabetes and/or Dementia. It will also seek to address the prevalence of long term conditions in black and minority ethnic communities, and in deprived communities. Importantly, this scheme will also deliver practitioner - based self-management training and development to professionals.

Our approach to each task will include the following stages:

1. Project mobilisation – PID, implementation plan, communications

2. Scoping and gap analysis - existing patient experience data and existing self-management programmes across the Triborough
3. Refining requirements in partnership with patients, service users, carers, 3rd sector providers and other key stakeholders and co-designing new approaches to capturing and using patient experience information. Collection and review of existing data and information and development of baseline positions against which to compare future performance
4. Development and implementation of best practice models and evidence based, co-designed programmes
5. Monitoring, evaluation, streamlining and feedback: describing how patient experience and insights are driving evidence-based decision-making and integrated care programmes across the Triborough. Describing how this is driving the development of a sustainable approach to self-management and peer support across the Triborough

Target patient cohorts

- People with a long term condition or at risk of developing a long-term condition
- Seldom-heard groups
- Vulnerable homeless people
- All GP Practices within the three CCG boroughs
- Hard to reach communities in particular within deprived areas

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- A significant amount of quantitative and qualitative data is collected on patient experience but this is not consistent across the Triborough, nor is it consolidated in a way that makes it easy to use in commissioning decisions
- There are gaps in our understanding of 'patient experience' and inefficiencies in the way we use this information to design and improve services
- We have responded to the NHS outcomes framework (domain 4), which states that the NHS should collect and use patient experience information in real time and use it for service improvement
- This will support delivery against the NHS Patient Experience Framework which draws attention to coordination and integration of care across health and social care systems
- Evidence supporting increased self-management can be found within:
  - The Health Foundation 'Co-creating Health'
  - NHS Outcomes Framework - domain 2
  - Transforming urgent and emergency care services in England
  - The Cochrane Collaboration - Self-management education programmes
  - Kings fund self-management and long-term conditions

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total: -£500,000 (new delivery costs)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and

is not working in terms of integrated care in your area?

In line with good practice, a feedback mechanism will be developed to ensure patients, service users, communities and the public are informed about changes to service commissioning or delivery as a result of their feedback. This scheme will also be governed through the following:

- Programme Board for the Better Care Fund
  - A Board comprising of key stakeholders for the Better care fund who meet monthly
  - The board will provide sign-off for key deliverables and resources
  - The quality review process should check to identify any: errors, omissions, misunderstandings, false assumptions, ambiguity and non-compliance with any local quality standards.

- WSIC Lay Project Group
  - A group comprising of lay representatives who meet bimonthly
  - The group will provide the mandate for the project and ensure that project delivery is transparent, accountable to local people, and aligned with the patient experience framework and co-design principles

What are the key success factors for implementation of this scheme?

- Ensure that the engagement and communication co-design approach is aligned with the full BCF programme
- Ensure the right stakeholders are included and engaged early and appropriately and ensure resources are approved
- Ensure the designed approach identifies and focuses on gaps
- Gather the specific demographic and patient cohort information required, drawing on other BCF schemes
- Co-design with service users, patients and carers, use local knowledge and ensure an effective feedback loop
- Ensure modelling within the WSIC includes long term conditions
- Identify appropriate infrastructure/ platform for interactive internet based forums
- Ensure any procurement commences as soon as possible after project approval
- Ensure there is rigour in setting targets and indicators for success are clearly defined and measurable

Scheme ref no.

B2

Scheme name

Personal Health and Care Budgets

What is the strategic objective of this scheme?

To extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

This is a compliance project which must be live by April 2015. This project will build on the existing Personal Health Budgets to:

- Ensure that the PHB programme for continuing healthcare is rolled out across all care groups in a consistent manner, with evaluation and quality assurance mechanisms developed and monitored.
- Ensure that the Triborough CCGs and local authorities are ready to implement Personal Health Budgets for Long Term Conditions from April 2015
- Building on current arrangements, develop an integrated approach to the provision of personal budgets and personal health budgets, including direct payments, so that customers who are eligible for both budgets can use these to commission an integrated package of services.

During 2014/15 the project will:

- Implement Personal Health Care Budgets for Continuing Healthcare across all Children's and Adult Care Groups as required by NHS Operating Plan
- Consolidate arrangements for care management and financial management of direct payments of customers with PHBs, through the local authorities
- Scope and Pilot Personal Health Care Budgets for Adult with Long Term Conditions for implementation in April 2015
- Integrate Social Care Personal Budgets and Personal Health Budgets for Long Term Conditions through Integrated Care Pathways and Provision
- Prepare an Organisation and Workforce Development Plan for Front Line Health and Social Care Staff in the Implementation and Case Management of Personal Budgets for Long Term Conditions
- Scope the Financial Impact of Implementation for LTC on Existing Contracted Community Services
- Develop and implement a Quality Assurance Programme for Personal Health Budgets
- Commission a JSNA – Long Term Conditions (refresh) to inform the 2015 programme
- Develop Learning Networks across Health and Social Care to embed person centred planning and effective use of personal budgets

Target patient cohorts

- Children
- Older People
- Physical Disabilities
- Learning Disabilities
- Mental Health

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget, and this becomes a right to have a budget in October 2014. Personal health budgets are an NHS Mandate commitment and one of the tangible ways the NHS can become becoming dramatically better at involving people, and empowering them to make decisions about their own care and treatment.

The provision of Personal Health Budgets for Long Term Conditions is expected to be an NHS England Requirement for April 2015.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £100,000 (new delivery costs)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

NHS England Personal Health Budgets Delivery Team have developed a Self-Assessment Tool – Quality Markers of Progress which enables CCGs to self-assess and then benchmark their progress across other CCGs in London and Nationally.

What are the key success factors for implementation of this scheme?

- Ensure that policy guidance is the result of sufficient and appropriate engagement with all relevant stakeholders and financial scrutiny
- Accurate evaluation of the pilot scheme before roll-out to a wider volume of service users

Scheme ref no.

B3

Scheme name

Community Capacity

What is the strategic objective of this scheme?

To design and implement a project that develops community capacity and assets across Triborough.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The overarching objectives of the programme are:

1. To identify and map community and citizen assets in Queens Park and White City in relation to independence, health and wellbeing
2. To identify gaps and strengths in community and citizen assets
3. To mobilise community assets effectively and sustainably
4. To identify citizen and community level insights about where social capital can be strengthened or optimised
5. To design and deliver substantial, innovative interventions and actions which are co-produced with public and community sector
6. To make a measurable difference to key demand and quality indicators within the health and care system (e.g. urgent care demand, social isolation, residential/nursing care referrals)

There will be a requirement eventually for three projects to be completed:

The Design is Project 1 of a larger programme. Project 2 would consist of **Mobilisation and Trial Delivery**. Project 3 would consist of **Evaluation, Authorisation and Mobilisation and Tri-borough wide implementation.**

At this stage, the proposal is for Project 1 only. Within Project 1, we are suggesting 8 main components as follows:

- Discovery/framing
- Community asset mapping
- Asset valuation
- Trial design
- Business case
- Authorisation
- Mobilisation (part)

The trial design would develop a basket of outcome, system usage, process and experimental measure which would feed into an evaluation design for the trial (possibly involving Oxford Brookes as an academic partner).

The sorts of interventions and approaches to be included within the trial are:

- Self-care
- Public health interventions
- System leadership
- Demand segmentation – identifying high demand groups where there is potential for change
- Behaviour identification and behaviour change

- Social mobilisation via community networks e.g. faith groups
- Asset based working with natural networks such as families, friends, neighbours

The design process and trail could attract external funding and support.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This will be decided in more detail during the design phase.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Success of the community budget pilot
- Assumption that investment in neighbourhood networks and/or local area coordination can unlock these assets to provide supportive communities and contribute to reduced. This is set out in a number of reports including The Generation Strain, Collective Solutions to Care in an Ageing Society, IPPR, April 2014
- Assumption that Neighbourhood networks or local area coordinators benefit from being run by community organisations who can involve volunteers and neighbours in everyday tasks, and from being provided with a medium term funding agreement (5 years in Leeds).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

N/A at this stage

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A at this stage

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Project steering group to be established. Project partner to be appointed to deliver project to time and budget. Steering group to oversee outputs and address any obstacles encountered

What are the key success factors for implementation of this scheme?

- Successful design and strategic alignment of the scheme
- Sufficient engagement and consultation with local community providers

Scheme ref no.

C1

Scheme name

Transforming Nursing and Care Home Contracting

What is the strategic objective of this scheme?

To create a single care home placement contracting team across health and social care and to develop outcomes based specifications, maximise value and ensure appropriate and timely provision reduces pressure on hospitals.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care

The purpose of this project is to align available resource and develop a consistent, joint approach to contracting, quality assurance and safeguarding across Continuing Healthcare (CHC) and Adult Social Care (ASC) nursing and residential placements and will realise quality improvements and process and cost efficiencies though integrated working practices and more proactive market management and engagement.

The **objectives** of the project are to:

- Improve the quality of the placement experience through implementation of a more streamlined and integrated ASC/CHC customer journey
- Improve process efficiencies
- Realise cost savings by improving value-for-money in parallel with service quality
- Establish an integrated ASC/CHC placements team that will implement a consistent approach to contracting and brokering placements and ensure a joint response to safeguarding issues across the Triborough
- Improve governance and reduce process barriers to achieve efficient contracting and purchasing Triborough ASC and CHC placements
- Achieve more rounded pricing and consistency of contracts across ASC/CHC placements within the Triborough
- Singular ASC/CHC invoicing for providers.
- Evaluate, align and optimise placement review resources cross ASC and CHC placements
- Improve contract management and quality monitoring
- Embed placement reviewing officers/nurses within the joint ASC/CHC team to improve information sharing around quality assurance and safeguarding.
- Foster relationships with providers to tailor services to meet the needs of the Triborough population to optimise capacity, improving quality and placement outcomes.
- Identify opportunities for proactive management of the provider market to optimise provider relationships, optimise placement outcomes and future proof placement activities.

Target patient cohorts

Patients whose care needs demand placement in a nursing or care home

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Providers:

Central London Community Healthcare
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

It has been identified that when people require institutional care, their needs are higher and more complex. This is due to the fact that the UK population is living for longer with more complex health and social care needs. At the same time funding levels for both the NHS and local authorities are decreasing and patients wish to remain as independent as possible for as long as possible. There is therefore a need to commission improved residential and nursing homes that is 'fit for purpose' - safe, cost effective and quality driven.

An analysis of 2012/13 benchmarking data across the Triborough local authority highlights a wide range in price (between 22 and 102% difference) for similar placements across the three boroughs. For spot placements alone, £1.2m could be saved just from bringing 25% of the higher cost placements into line with the lower cost placements. The benchmarking data and analysis shows that in terms of average weekly expenditure (gross, by service and client group), Triborough spend exceeds the inner London benchmark for:

- Older people in nursing care
- Older people in residential care
- Adults with a learning disability in residential care
- Adults with a mental illness in nursing care
- Adults with a physical disability in nursing care

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £711,000
Investment:- £111,000
Existing costs:- £600,000
N.B. these costs include costs from scheme C3: Integrated Commissioning

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Total:- £1,200,000 (cashable savings from payments to acute providers)
N.B these benefits include benefits from scheme C3: Integrated Commissioning

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

New governance and management arrangements will need to be agreed to enable the CCGs to retain sight of continuing healthcare placement activities hosted by the local authority. The means by which the CCGs will remain accountable for the continuing healthcare budget, and the local authority for the adult social care budget, will be determined once the host arrangement for the team is confirmed. Establishment of an operational management committee, with representation from the 6 commissioning organisations and larger providers, is anticipated. Regular provider-commissioner forums are also anticipated to foster and strengthen provider relationships communication channels. Regular contract monitoring and quality assurance meetings will also be needed, at regular, repeat intervals, involving commissioner and provider representatives. Providers will be monitored against pre-agreed quality assurance metrics and key performance indicators to enable transparency of service delivery performance and enable the tracking of both costs and benefits.

What are the key success factors for implementation of this scheme?

- Achieving a shared vision (between local authority and Health stakeholders) of what constitutes quality in terms of nursing and residential care
- Developing a single contracting and brokerage team with an embedded, co-located placement review function to inform brokerage activities and more strategic commissioning of placements
- Avoiding cost-shifting between continuing healthcare and adult social care placements
- Focusing on quality and value – rightsizing contracts and continued evaluation of care package against needs (stepping down care requirements where appropriate)
- Strengthening of provider relationships and proactive market management to achieve quality and sustainability within the sector

Scheme ref no.

C2

Scheme name

Review of Jointly Commissioned Services

What is the strategic objective of this scheme?

To review all existing jointly commissioned services with S75 and S256 partnership arrangements, to ensure services provide value for money and are aligned with the objective of integrated working.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

Each CCG and Local Authority in Tri-borough has an existing S75 Partnership Agreement in place with an agreed Service Schedule of jointly commissioned schemes. The majority of these are lead commissioning arrangements where the local authority contracts on behalf of the CCG. There are a small number of pooled budgets.

This project will review all of the schemes within these programmes to evaluate the outcomes being achieved and the effectiveness of the commissioning and contracting approach in order to inform commissioning intentions for 2015/16 and recommend how these services should be commissioned in future.

The project will deliver:

- A report for each CCG and Local Authority on the schemes currently being jointly commissioned, containing a description of the services, an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of CCG Out of Hospital and LA strategies and the rest of the BCF programme and indicating how they should be incorporated within commissioning plans going forwards
- Recommendations for those services suitable for a pooled budget and how this could be created

Target patient cohorts

- Older people
- Learning disabilities
- Mental health
- Carers
- Children with special needs

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The review will provide the evidence base to inform the assumptions on which services are redesigned or provided in the Commissioning Intentions.
Documents that will make up the evidence base include:

- A report for each CCG and Local Authority on the schemes currently being jointly commissioned, containing a description of the services, an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of CCG Out of Hospital and LA strategies and the rest of the BCF programme and indicating how they should be incorporated within commissioning plans going forwards
- Recommendations for those services suitable for a pooled budget and how this could be created

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £159,149,444 (existing costs)
Review existing s.75 services:- £110,803,620
WCC s.75 LD placements currently under review:- £10,502,949
Existing s.256 pass-through funds (including LA joint commissioning team spend):- £11,125,000
Existing community services:- £22,710,000
Carers:- 1,931,875
Reablement s.256:- £2,076,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Total: £1,839,245 Efficiency savings: £1,385,045 (S75 review) Cashable savings from payments to community providers: £454,200 (existing community services)
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The evaluation methodology will be considered by the BCF Executive Group and agreed before implementation. Progress reports will be received monthly to ensure that the project is on track and any problems are dealt with in a timely fashion since the project is time critical.
What are the key success factors for implementation of this scheme?
The services included in the Joint Commissioning Schedules link into a number of other BCF workstreams as well as other plans, for example the Learning Disabilities and Mental Health Commissioning Strategies. Success will rely on the services being evaluated within those wider contexts, not simply of themselves.

Scheme ref no.
C3
Scheme name
Integrated Commissioning
What is the strategic objective of this scheme?
To address the current fragmentation in commissioning across Triborough health and social care commissioners. In designing the new commissioning structures, the project will seek to understand, validate and address existing issues.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>Model of care and support</u> It will review how services are currently commissioned and contracted and identify better ways to commission integrated services. It will therefore link with Scheme C2 which reviews those services currently joint commissioned and those community health services which could be jointly commissioned in future. This scheme will ensure that these developments contribute to the overall objectives of the Better Care Fund and are linked to make most effective use of resources and systematically review those associated aspects (such as assistive technology and housing support) which will add value to the programme. Key project objectives include: • Review the as-is model for ASC joint commissioning • Develop shared understanding between LA and CCGs of current issues • Design and implementation of new commissioning structures **<u>Target patient cohorts</u>** All patients with long term conditions who require an integrated response.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioners: West London CCG Royal Borough of Kensington and Chelsea Central London CCG Westminster City Council Hammersmith and Fulham CCG London Borough of Hammersmith and Fulham

Providers:
Central London Community Healthcare
Westminster City Council
Royal Borough of Kensington and Chelsea
London Borough of Hammersmith and Fulham
Imperial College Healthcare NHS Trust
Chelsea and Westminster Hospital

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

More effective integrated commissioning will support the delivery of high quality integrated care

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £711,000
Investment:- £111,000
Existing costs:- £600,000
N.B. these costs include costs from scheme C1: Transforming Nursing and Care Home Contracting

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Total:- £1,200,000 (cashable savings from payments to acute providers)
N.B these benefits include benefits from scheme C1: Transforming Nursing and Care Home Contracting

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

TBD

What are the key success factors for implementation of this scheme?

- Agreement that more integrated commissioning will improve efficiency, value for money and have a resultant positive impact on service users
- Accurate understanding of current risks and issues as well as all opportunities for improvement

Scheme ref no.

D1

Scheme name

Information Technology

What is the strategic objective of this scheme?

To implement IT solutions to link Triborough Adult Social Care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support
This project will integrate ASC and GP IT systems. The project rational is based on the assumption that sharing of medical and social records across different settings of care reduces risk, reduces duplication and improves outcomes and speed in both assessment and care of the individual, as well as enhancing the client's experience. As part of this initiative we will:

- Implement a mechanism to ensure NHS numbers are up-to-date, validated and available in the ASC. This will be a key identifier which will facilitate creating a single view of a client's record
- Undertake an exercise within the ASC system to ensure there is only one unique record per client/service user
- Form a joint project group with appropriate representation from CCGs, key health care

providers, ASC and IT system providers

- Identify the data sets to be shared by ASC and Health Care with lead users from LA and Health Care providers (and potentially users and carers themselves)
- Agree through robust options analysis, the most appropriate manner of achieving IT integration. There are a number of options available, for example:
    - Building direct interfaces to ensure systems are fully integrated
    - Data warehouses which hold information centrally to create a 'single view of a client'
    - Middleware which views information centrally to create a 'single view of a client'
- Specify the agreed option and if necessary procure relevant providers
- Pilot for a specific service function
- Test and Implement

Target patient cohorts

N/A

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Currently, people often fall through the cracks between GP's and Care and Support provided in the community. Issues include:

- people having to re-tell their story every time they encounter a new service
- people not getting the appropriate support that they need because different parts of the system don't talk to each other or share information and notes
- vulnerable people often with complex needs not being readily identified and supported across multiple settings of care, increasing risk, costs and delivering poor outcomes
- older people discharged from hospital to homes not adapted to their needs, only to deteriorate or fall and end up back in A&E – cutting emergency readmissions will bring a much better experience for patients
- home visits from health or care workers at different times, with no effort to fit in with people's requirements
- patients facing long waits in hospital before being discharged in part because of inadequate coordination between hospital and social care staff

This scheme aims to solve these problems locally by attempting to integrate the Social Care and GP IT systems.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total:- £810,558
Investment:- £609,881
New delivery costs:- £200,677

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

D1 is an enabler to transforming health and social care. It does not directly contribute directly to the performance measures included as part of the Better Care Fund (BCF) submission. However, good quality data and systems integration will be critical for the success of many of the other projects

included in the BCF.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
One single Project Manager will be responsible for delivering this scheme- a joint appointment using a combination of existing resources and specialist contract resources. Ideally this will be completed as a partnership led project with both GP representation and Social Care.
What are the key success factors for implementation of this scheme?
• Sign off and release of funding • Engagement with BCF scheme D2

Scheme ref no.
D2
Scheme name
Information Governance
What is the strategic objective of this scheme?
To implement IG solutions to link tri-borough social care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>Model of care and support</u> Sharing of information between the NHS and Local Authorities is a critical enabler for the commissioning and provision of integrated services to our residents. In addition to providing the information technology to enable information to be shared between staff and with service users themselves, we need to ensure that we have robust information governance arrangements to protect people from the misuse of data, while ensuring that data is shared appropriately to keep people safe, provide integrated treatment and care and improve health and wellbeing. This scheme will ensure we have the necessary policies, procedures and practice in place and implemented. This is an enabler project for many of the BCF schemes. The project will deliver: • A review of information governance arrangements in Adult Social Care and Children's Services in the Tri-borough Local Authorities and recommendations for action to address areas of weakness • Delivery of action on the recommendations to put in place all the necessary arrangements to meet the requirements of Caldicott2 • Actions to develop practical but safe mechanisms for the sharing of data between the Local Authorities and the NHS for the purpose of integrated commissioning and contracting • Actions to develop practical but safe mechanisms for the sharing of data between the Local Authorities and the NHS for the purpose of providing integrated services • Actions to develop practical but safe mechanisms for the sharing of data between the statutory authorities and independent providers of services for the purposes of providing integrated services **<u>Target patient cohorts</u>** N/A
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioners: West London CCG Royal Borough of Kensington and Chelsea Central London CCG Westminster City Council

Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

Others:
Caldicott Guardians
IT leads within Local Authority and NHS
IG leads within Local Authority and NHS

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Work on the WSIC Early Adopters has emphasised the importance of IG working between the Local Authorities and the NHS to deliver data analysis for planning, and information sharing for customer care planning and delivery.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

N/A

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Triborough Adults, Children's and Public Health Information Governance Group has been established to oversee the project. This will include representation from the NHS for the consideration of data sharing issues between authorities.

An IG specialist consultant has been recruited to undertake the review of current arrangements and make recommendations for action necessary to establish and maintain strong IG within the local authorities and between them and the NHS and independent sector partners. This work has been completed.

An IG Lead will be identified going forward who will work closely with NHS IG leads and as part of the London Network of Caldicott Leads.

The IG project will report into the BCF Executive Group and through them to the BCF Programme Board.

What are the key success factors for implementation of this scheme?

- Engagement with customers, both service users and carers, involving them fully in their assessment and care planning and ensuring they understand the way in which information may be shared in order to improve their care pathway is also part of the Customer Journey work being undertaken by Triborough Adult Social Care
- Appropriate infrastructure to prompt and record both the customer identifier (NHS number) and consent is being implemented through the Frameworki system now being used by the local authorities
- Infrastructure for sharing information between the various NHS bodies is being established as both GPs and community health services adopt the use of SystemOne

Scheme ref no.

D3

Scheme name

Care Act Implementation

What is the strategic objective of this scheme?

To implement the key requirements of the Care Act (detailed in the Care Act Impact Analysis) within the required timescales.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Care Act sets out key proposals for reforming the way in which adult social care (ASC) is funded. This includes a proposed Care Cap, which limits the lifetime costs an individual has to pay for their care, and the accompanying infrastructure required to manage the cap. At the same time, the Care Act will also impact upon the duties and functions provided by ASC services. Processes and practices will need to be reviewed to ensure that they are not only compliant with the new legislation but that the way in which we deliver care will enable us to deliver the changes required.

A report completed by a task and finish group in ASC in January 2014 recommended that a programme of work be carried forward in order to meet the legislative requirements set out in the Care Act. The report contains an impact analysis of each clause and prioritises the work that should be addressed in order of priority. The work in the Care Act Implementation Project according to the prioritisation methodology set out in that report. In summary the key requirements that the project will focus on are:

a) Duties on prevention and wellbeing
b) Duties on information and advice (including advice on paying for care)
c) Duty on market shaping
d) National minimum threshold for eligibility
e) Assessments (including carers assessments)
f) Personal budgets and care and support plans (reviewing the RAS to make sure we meet legislative requirements)
g) New charging framework
h) Safeguarding
i) Universal deferred payment agreements
j) Extended means test
k) Capped charging system
l) Care accounts

<u>Project Timescales</u>

The scale and complexity of this work is such that it needs to be managed as part of a separate project. Large scale change is required, across many different areas of the department. The Care Act replaces more than a dozen pieces of legislation and changes will range from minor (such as duties simply modernise existing law) to major such as for duties that are both new in law and in practice (such as advocacy, information and advice, care account etc.).

The first wave of legislation is due to be implemented in **April 2015,** with the remaining funding reforms in **April 2016**. Sub-groups will be responsible for scoping, delivering and implementing this change within a tight timeframe, taking account of and informing on-going Tri-borough projects, such as the commissioning review, and especially the Customer Journey Review. Successful implementation of the Care Act will require robust project management of a series of complex work streams.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

Royal Borough of Kensington and Chelsea
Westminster City Council
London Borough of Hammersmith and Fulham

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme is a necessary enabler for implementing policy change/

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Total:- £1,888,288 Investment:- £138,850 New delivery costs:- £1,749,438
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
N/A
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
It is proposed that the project will be overseen by an Implementation Board co-chaired by the Triborough Executive Director of ASC and by the Triborough Director for Finance. Membership of the board will consist of a range of Triborough ASC officers, including participation of corporate colleagues in HR, Legal Services and Policy. The implementation board will meet on a monthly basis and oversee the delivery and implementation of the project. Portfolio Deliver Steering Group (ALTT) and Implementation Board to monitor. Stakeholder relationship with LGA, ADASS and London Councils will ensure that outputs are reviewed / informed with peers' methodologies and approaches to Care Act implementation.
What are the key success factors for implementation of this scheme?
• The Care Act updates the legislation which underpins social care practice and procedures. It is key that staff fully understand the Act. Staff will need to undergo training. Legal experts may be required to deliver some of this training. Initial legal training session for Members and senior management has been scoped and costed (to be provided by Belinda Schwer). More will be required • A clear communications programme will be required to underpin the implementation of the Act to ensure that staff and residents are appropriately engaged and prepared for the changes • In order to meet the requirements of the Care Act and support its implementation several projects will need to be undertaken. These projects are yet to be decided but the below states what some of the larger projects are likely to be: o Review of RAS o Development of local intelligence regarding self-funders o Development of local market intelligence o Review of assessment / review processes o Procure advocacy services • The Care Act will lead to a large increase in assessments and reviews, in the main from self-funders but also from carers. National guidance is that areas may wish to undertake 'early' assessments and reviews; 6 months prior 1st April 2016 • Training for operational staff will be needed to understand and implement new legal framework

D4
Scheme name
BCF Programme Implementation and Monitoring
What is the strategic objective of this scheme?
To successfully programme manage the BCF schemes, ensuring that each scheme delivers promised outcomes on time and to the right standard.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The programme management scheme is an enabler for the BCF. This scheme sits at the centre of the Triborough BCF and acts as the coordination point for all schemes.

The team will develop and manage a set of programme and project plans, tracking and mitigating risks and issues and managing the resource pool across the schemes. They manage progress against the plans and work with the LA and CCG to ensure that all decisions and documents pass through the appropriate governance mechanisms.
They will coordinate between the LA and CCG teams and provide regular updates to steering groups.

Target patient cohorts
N/A

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
West London CCG
Royal Borough of Kensington and Chelsea
Central London CCG
Westminster City Council
Hammersmith and Fulham CCG
London Borough of Hammersmith and Fulham

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme is a necessary enabler for the programme. The schemes are based on PRINCE2 and MSP management principles.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total: £307,800 – NR Investment

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Regular review of management approach
- Flexible resource for programme and project management

What are the key success factors for implementation of this scheme?

N/A

ANNEX 2i – 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	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	Chelsea and Westminster Hospital
Name of Provider CEO	Tony Bell OBE
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10,900
	2014/15 Plan	11,805
	2015/16 Plan	11,193
	14/15 Change compared to 13/14 outturn	905
	15/16 Change compared to planned 14/15 outturn	-612
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	- 612

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?**	We agree with the overall direction of travel of the Triborough BCF programme and its constituent projects and the principle of the service changes that commissioners are trying to make. We have seen and had the initial opportunity to discuss the detailed business case for a new single TB Community Independence Service (CIS). It is understood that this forms the core of the BCF programme.

		A process is being put in place for us, as provider leads, to review and interrogate the CIS financial model which has generated detailed planning assumptions relating to an assumed reduction in non-elective (general and acute) admissions in 2015/16 compared to planned 2014/15 outturn. Interrogation of this model should help to satisfy us with regard to any specific assumptions and any reduction in activity.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We can confirm that our local CCG Commissioners have confirmed that their BCF assumptions are within existing QIPP and SAHF plans. Therefore will be contained within current CWFT strategic plans. What we cannot confirm at this stage without completion of the process indicated in stage 1 is the final impact on planned activity and contract value for 2015/16 or subsequent years. Commissioners have outlined in the business case that the next planned phase of implementation will involve a period of engagement with providers and commissioners to work through the detailed implications during Qs 3-4 2014/15. It is important to emphasise that this exercise should also reflect: 1) Impact of revised model of care on care pathways; 2) Impact on clinical governance, quality and performance 3) Impact on workforce 4) Impact on contract activity and values Once we have satisfactorily completed the planning process described, and gained assurance as to how the key outstanding items will be addressed, we will be able to fully assure ourselves of the deliverability of planned outcomes.

ANNEX 2ii – 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	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	Imperial Healthcare NHS Trust
Name of Provider CEO	Tracey Batten
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	27,206
	2014/15 Plan	27,027
	2015/16 Plan	25,623
	14/15 Change compared to 13/14 outturn	- 179
	15/16 Change compared to planned 14/15 outturn	-1,404
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-1,404

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**	See attached letter

	outturn?	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2iii – 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	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	Guy's and St Thomas' NHS Foundation Trust
Name of Provider CEO	Sir Ron Kerr CBE
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	2,201
	2014/15 Plan	2,330
	2015/16 Plan	2,208
	14/15 Change compared to 13/14 outturn	129
	15/16 Change compared to planned 14/15 outturn	-122
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	- 122

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?	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2iv – 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	Hammersmith & Fulham Kensington & Chelsea Westminster
Name of Provider organisation	University College London Hospital
Name of Provider CEO	Sir Robert Naylor
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	1,684
	2014/15 Plan	1,061
	2015/16 Plan	1,006
	14/15 Change compared to 13/14 outturn	- 623
	15/16 Change compared to planned 14/15 outturn	- 55
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-
	How many non-elective admissions is the BCF planned to prevent in 15-16?	- 55

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?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	