Southwark Better Care Fund Plan

2016/17

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 Caldicott2.

Work has continued in developing an overarching Data Sharing Agreement (DSA). This has been via a Local Unified Care Record Data Sharing working group, comprising of Caldicott leads, LMC GP leads, and IG leads.

Key principles are:

- A framework to share between the organisations who are subject to the agreement (in accordance to the DPA and Caldicott principles)
- An agreement to share clinical information. The actual data set of information shared will be constrained by the system design and capability.
- A programme of communication to inform patients that in the course of their care data will be shared between clinicians with a legitimate reason to access their records
- Mechanisms to establish and record patient opt out preferences
- Appropriate system logic to exclude patient information on the basis of expressed opt out.

The patient choice not to share their record, expressed to any one or all of the partner organisations (King's, Guy's, SLAM or Primary Care), will be recorded in the partner organisation system and will exclude ALL record sharing for the patient between the partners.

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

Currently 3,340 adults have been identified through risk stratification as being at high risk of hospital admission, representing 1.4% of the adult population.

For risk stratification we use the HealthNumerics-RISC system which is a risk identification and stratification tool provided by United Health which identifies patients at risk of a future unplanned hospitalisation due to chronic conditions within the next 12 months. The source of data for the predictive modelling is GP data (register, activity and mediations) and Secondary Care (inpatient, outpatient and A&E). The system produces monthly reports with patient level risk scorings for clinicians.

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

Currently, our approach to care co-ordination and accountable lead professional has been implemented for older adults and led by Primary Care. We have an integrated approach to risk stratification and identification of high risk patients in primary care. In addition to the HealthNumerics risk data, older people will be offered proactive, holistic health assessments (HHAs) by their GP practice to help identify issues and risks early. People will be supported by Integrated Care Managers (ICMs) and GPs where it is deemed appropriate (adding to the support being implemented by NHSE in the national admission avoidance schemes). This care management and co-ordination will aim to ensure people are engaged in their own care and that a full range of support is made available to someone in a proactive way to improve overall wellbeing and outcomes and reduce the need for unplanned hospital admissions. ICMs and GPs will be supported by Community Multi-Disciplinary Teams (CMDTs) who will support complex care management, offer additional advice and support, help to unblock service issues and problems and ensure holistic care is being offered. These CMDT meetings are already established and supporting complex care in each locality. They consist of professionals from acute trusts, mental health, social care and community healthcare.

In 2015/16 GP practices and providers in Southwark are expecting 3324 to have had a HHA and 900 will be supported by Case Management with an Integrated Care Manager. A further 360 people will be discussed at CMDT meetings.

Our intention is to roll this model out to cover younger adults with Long Term Conditions or complex needs.

We recognise that we have further work to do to establish joint comprehensive assessment processes between health and social care and in developing the role of care coordinators or accountable lead professional across Southwark services. We will take this work forward building on what has already been done at a CMDT level to establish trust and relationships, and moving forward our work on neighbourhood level integrated care over the course of the next twelve months. One barrier to joint assessments being undertaken is joint data system and having a shared care record, which professionals can contribute to, being addressed through the data sharing workstream.

As part of the NHSE admission avoidance over 75s will now have a named GP and where appropriate a care co-ordinator. Additionally, as part of the local integrated care programme, all over 80s, those that are over 65 and housebound or haven't seen their GP for 15 months or more, will also be offered a Holistic Health Assessment and care plan. This assessment and care plan also shows the name of the professional undertaking the work and their contact details. On top of this anyone with more complex care, if they fall outside of the NHSE framework, will be supported by an Integrated Care Manager under the local Integrated Care Programme work.

GPs are at the centre of the local and national initiatives, supported to identify, assess and manage the needs of older and more complex people. In doing so they will be offered help, tools and guidance by the CCGs, local provider organisations and the local SLIC Integrated Care Programme. There are now contracts in place for the work, activity and outcomes expected, which have been jointly agreed by all parties. These targets and expectations are reported to a Governance Board each month which contains GPs, providers and commissioners.

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

27% of high risk people (900) are subject to case management with a community multi-disciplinary team.

e) Agreement to invest in NHS commissioned out of hospital services which may include a wide range of services including social care

As part of planning for 16/17 Southwark can confirm that £6.1m has been allocated for NHS commissioned services, comfortably above the £5.9m minimum ring fenced allocation proposed as part of BCF planning guidance. As with all other parts of our plan, this expenditure has been jointly agreed between the Council and CCG. NHS commissioned out of hospital services from 15/16 will continue for 16/17 ensuring consistency of approach, and it is hoped will yield further benefits given that schemes are now better established.

As detailed in the risk share section, a risk reserve of £1.3m is in place so that should activity levels at acute providers be higher than anticipated, the risk reserve can be drawn down to cover this additional expenditure through year-end agreements. Should activity be below expected levels, this funding will be able to be released to further bolster out of hospital schemes ahead of the winter period.

This approach is in line with our payment for performance arrangements in 15/16 whereby a risk reserve was established between the Council and CCG which could be drawn down upon should admissions targets fail to be met. This allowed for surety on expenditure against BCF plans, but also allowed for there to be a reserve in place which could be used to fund additional acute activity where needed. It was therefore felt that this approach ensured a balanced approach to managing risk, as it was agreed between all parties, that reducing expenditure on agreed schemes was likely to further exacerbate any increase in admissions or attendances in hospital.

A number of schemes are supported through the out of hospital allocation, but in particular:

@home – Supporting around 400 patients a month, the service supports those that are at risk of a hospital admission or who have had treatment but need more care when they return home from hospital. There are 85 virtual beds available, with numbers able to flex as demand increases. Usage is increasing month-on-month, and local hospitals are being supported by on-site in-reach @home nurses who help ‘pull’ patients from the acute setting in to the community. Further work is planned with both GSTT and KCH to ensure consistent use of the service, particularly over weekends.

Pal@home – Introduced in Q3 15/16, Pal@home, helps support those at the end of life to ensure that they are able to die in their own home. The service, run in conjunction with St Christopher’s Hospice and Marie Curie Cancer Care, also offers night time rapid response services, to ensure that those that need overnight care are able to receive this outside of a hospital setting. 16 virtual beds were in place during Q4, but now that this service is being mainstreamed, it is envisaged that capacity and utilisation will increase.

Children@home – Launched in January 2016, Children@home, expanded @home services to children and young people. The service has been running as a pilot, but will be fully mainstreamed during 16/17, and expanded to run 8am-10pm, 7 days a week from Q1. Successful recruitment has now taken place, with staff coming into posts progressively over the coming months. It is hoped that between 60-100 paediatric admissions a month will be avoided, the equivalent of 12-16 beds.

Analysis of these schemes has shown that:

- Over 500 LAS conveyances to hospital have been averted thanks to the use of the Alternative Care Pathway established between @home and LAS
- Over 3000 patients have been supported by @home during the course of 15/16, with an average length of stay of 6 days. This has led to a material reduction in admissions at local hospitals and a reduction in length of stay for patients who are admitted as they are able to access enhanced out of hospital support
- Less than 10% of patients referred to @home are admitted or re-admitted to hospital, demonstrating the effectiveness of the service and its ability to provide acute care at home

f) Delayed Transfers of Care

Key to system wide planning is the need to continue the significant progress made on reducing levels of DTOCS and patients that are medically fit for discharge (MFFD). Southwark have, in recent years, had some of the lowest levels of DTOCS anywhere in the country, with the latest figures indicating that the level of delays is a third of the national average. However, as part of 16/17 Better Care Fund plans, we have committed to trying to reduce these figures yet further. This is consistent with our CCG operating plans, and the plans of the Lambeth, Southwark and Bromley System Resilience Group.

15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures			
Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
501.7	408.2	280.7	390.9
1,228	999	687	971
244,755	244,755	244,755	248,374

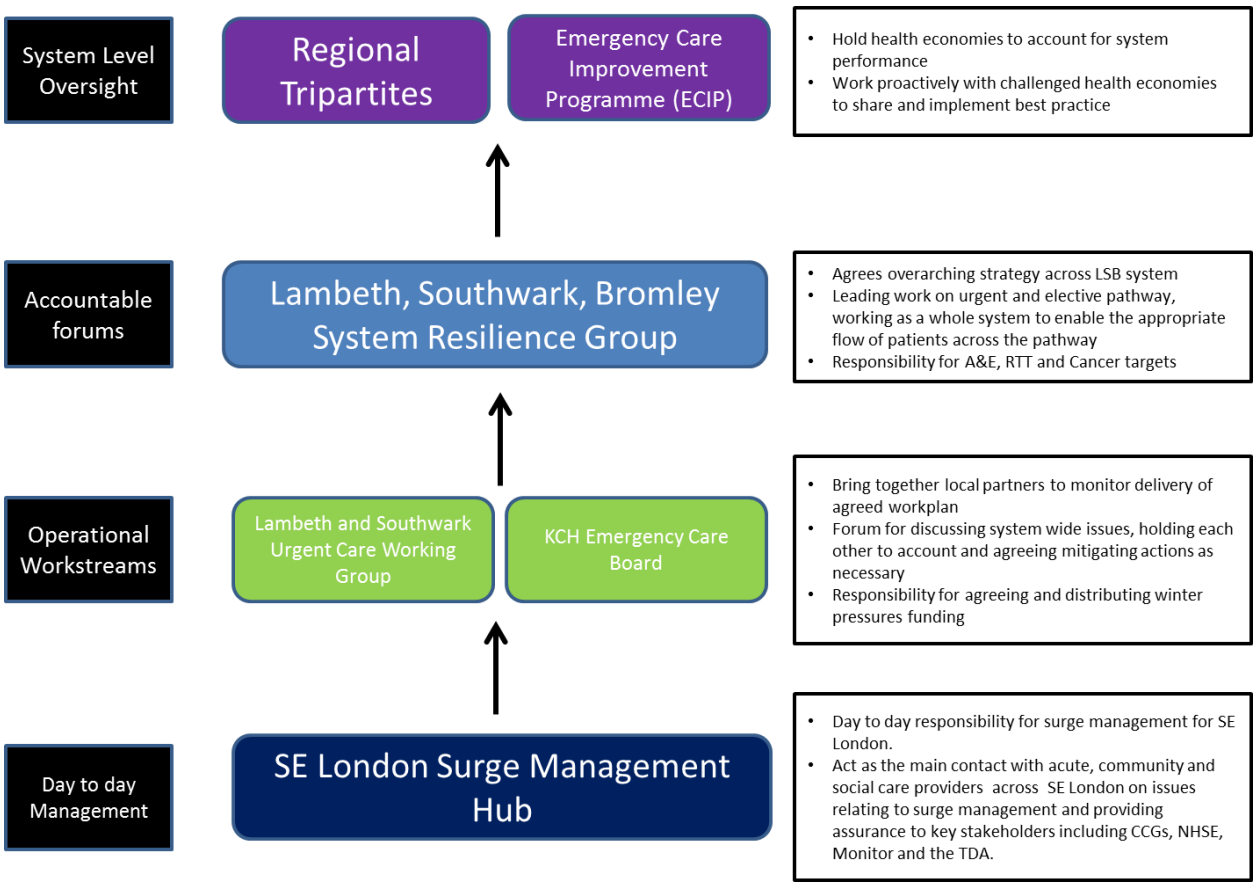
16-17 plans			
Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
352.3	352.3	352.3	347.5
875	875	875	875
248,374	248,374	248,374	251,777

It is also noted that many of the DTOCS and MFFD patients are from non-local boroughs. As part of our DTOC action plan, the CCG has undertaken extensive work with Lewisham to agree new processes to align pathways into continuing care and re-ablement services with those in place across Lambeth and Southwark. This should significantly reduce delays to Lewisham, with scope to expand this yet further to other SE London boroughs. In addition, the CCG has co-sponsored the Integrated Hospital

Discharge programme, which sees senior leads from Community Services, Social Care and the Continuing Health team, alongside clinicians from KCH actively support wards to expedite discharges to community and social care services. Key to this will be an education programme for ward staff to ensure that discharge planning is conducted at the point of admission, to help reduce length of stay and reduce the level of MFFD discharge patients at Denmark Hill.

From analysis of DTOCS in 15/16, it is noted that a significant proportion of DTOCs stem from patient and family choice, particularly where patients and their families have not made, or been supported in making, decisions about care arrangements post hospital. To help reduce these delays, in 16/17, a new Choice policy will also be formally rolled out across GSTT and KCH. This policy gives clearer advice to patients and their carers' and families about what support the patient is likely to need post-discharge to aid forward planning. Underpinning this, a Care Home Selection Service will be in place which will work proactively with families to help choose a care home for their relative. Evidence from elsewhere has demonstrated that that can help significantly reduce bed days for those needing to be transferred to care homes and nursing homes. We will also work closely with the ECIP team, who are supporting the local health economy, to ensure that these protocols are in line with national best practice.

There is a robust governance and accountability structure in place through which DTOCs are analysed and managed. The diagram below depicts this structure.



Through the System Resilience Group we will be monitoring progress on DTOCs and MFFD, and this is also picked up on daily surge management calls with all providers, where partners collaborate to rapidly troubleshoot issues related to discharge and ensure all necessary support is given.

The BCF also funds a number of voluntary sector initiatives which help manage DTOCs. An example of this is Southwark Wellbeing Support at Home (SWiSH) which helps patients to remain at home, living their own lives safely and as independently as possible by avoiding unnecessary or unplanned hospital admissions. SWiSH provides support for up to 12 weeks including home visits, drop-in sessions, advice and signposting to other services, practical support, advocacy and home audits.

g) Performance from 2015/16 and plans for 2016/17

Re-ablement

The re-ablement team work to support an individual to regain skills, confidence and independence, often following a specific period of illness or injury and hospital admission. It is a key service for supporting safe discharge from hospital and preventing admissions or re-admissions to hospital of people at risk, and reducing the need to use care homes.

The services is provided as a short-term, intensive alternative in the persons home, usually for up to 6 weeks (although can be less, dependent on goals achieved or appropriateness to the service). The team can provide short term care and support or assistive equipment to increase independence/safety with activities of daily living, transfers, and improving confidence.

The service is also the default assessment service for Southwark, and combined with the Supported Discharge Team facilitates 70% of all discharges from hospital.

In 2015/16 we set a target of 90% of all residents requiring re-ablement to still be at home 90 days after discharge from the service. This would represent an increase on the 87% achieved in 2014/15. Although we are awaiting the final results from 15/16, as of the end of Q3 2015/16, we had exceeded our target, with 92% of service users remaining at home 90 days after discharge. Given strong performance in this area, our target will be to maintain this achievement in 2016/17, whilst still seeking to improve wherever we can.

We believe that the BCF has been a key factor in meeting the re-ablement targets. By allocating £1.8m in 2015/16 (a figure which has been maintained in 16/17), we were able to ensure that the service could continue to meet demand, with sufficient resource to enable staff to give service users the care and support that they needed, and to liaise effectively with colleagues in acute and community settings to ensure that there was effective joint working and seamless handovers. In addition, the effectiveness of the service, has helped reduce the level of admissions to residential care.

Admissions to residential care

One key target has been to reduce the need for residents to be admitted to residential care, by being able to support them to live independently in their own homes. The re-ablement service, alongside health services such as @home have been instrumental to this, allowing patients to be supported at home and promoting discharge to assess models.

As of the end of Q3 we have met our targets for residential home admissions (see below table)

	Oct	Nov	Dec	Jan	Feb	Mar	2015/16	Apr	May	Jun	Jul	Aug	Sep
Target	13	13	13	13	13	13		13	13	13	13	13	13
Admissions	12	7	7	7	16	6		13	8	10	13	6	12

Although our population is ageing, our ambition for 16/17 is to continue to meet our target of no more than 13 admissions to residential care per month. Should there be any signs that the target is in danger of not being met in 16/17, the Integrated Working Group will request that a deep dive is undertaken to review each admission to establish whether there are any lessons that can be learnt regarding how the admission could potentially be avoided.

In addition, as part of winter resilience schemes, Southwark Local Authority piloted 2 step down flats for patients no longer requiring hospital care, but who were not yet ready to return home. In other circumstances, these residents may well have needed to be admitted to residential care either temporarily or permanently. Instead, these step flats allowed for a ‘discharge to assess’ model to be introduced, whereby residents were given intensive support to establish whether they would ultimately be able to live independently. This model has provided to be highly effective, with over 70% of service users able to return home after this respite support. This scheme has now been mainstreamed in 16/17, and further evaluation will be undertaken to establish whether there is sufficient demand for capacity to increase further.

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 plan is underpinned by a vision for improving services in the community through better integrated working that has been developed over several years and shaped by a range of engagement activity.

Our integration project (SLIC), which has developed much of the thinking behind our approach has actively consulted with the public through its Citizen's Forum over the past 30 months. For example, Southwark and Lambeth commissioners, working with the SLIC team, held engagement events with residents to identify what people wanted as outcomes from integration and to help us articulate those outcomes from a resident's perspective. This work supports our vision document, but will also help us as we work to further develop our local outcome measures for integrated care. This events included Healthwatch and the representatives of other engagement groups linked to the CCG and LA. The selection of our local metric (people feeling supported to manage their long term conditions) was informed by this engagement event.

Healthwatch have been closely involved through the various BCF and integration discussions at HWB, HWB workshops and CCG Boards and other events. The Director of Adult Care recently addressed a Citizens Forum event on social services and integration plans.

There will be further engagement activity as detailed implementation plans for 2016/17 are developed.

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

Our local acute trusts have been key members of the Southwark and Lambeth Integrated Care (SLIC) programme and are part of the Strategic Partnership and have been closely involved in producing and delivering the integrated care strategy to date, as well being involved in delivering some of the new integrated service models, for instance the admission avoidance programme. As part of planning for 16/17 a system wide CQUIN on supporting those with long term conditions and avoiding admissions will be in place which is actively supported by all local providers.

Regular reports on the BCF go to contract meetings with acute providers, and the findings are discussed to ensure that all parties are not only sighted, but actively involved in the design and delivery of BCF plans.

Our detailed proposals for integration in Southwark, including the schemes to be funded from the BCF, have been shared and discussed with acute providers in a number of fora including; the Health and Well Being Board, SLIC meetings and a Southwark and Lambeth joint planning meeting which includes CCG and Local Authority commissioners as well as representatives from our local providers (GST, KCH and SLAM).

Service providers have also been active participants in a number of change programmes and consultations that together help form our local integration programme. For instance, Social Care providers have been involved in My Home Life and other quality initiatives that form part of this wider plan, including the development of the re-ablement service model and home care redesign.

Our plans and trajectories for the BCF and, specifically our plans regarding Delayed Transfers of Care, have been presented at the Lambeth and Southwark Urgent Care Working Group – a subgroup of the System Resilience Group, featuring representation from all of our acute, mental health, community and social care partners and have been endorsed.

ii) primary care providers

As per acute providers as set out above, our primary care providers are CCG council members and key members of the SLIC and Strategic Partnership programme which has shaped our approach to integration which has shaped the BCF.

As part of the PMS review, Primary Care will also be incentivised under the system wide CQUIN.

See also 6(c) on alignment with primary care plans.

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

Social Care has been closely involved in the BCF preparations and the wider integration agenda from the offset. The SLIC Sponsor Board, and its successor in the Strategic Partnership includes the Strategic Director of Children's and Adults services. The SLIC Operations Board is jointly chaired by the Director of Adult Care and there is a provider group workstream which includes the Director of Adult Care representing social care from the provider perspective.

Community Action Southwark, representing the voluntary sector, are represented on the Health and Wellbeing Board and have been involved in the development of the BCF as a result. Partnership Boards all include voluntary sector representation and integration is frequently on the agenda.

We have engaged with providers and the community sector in a focussed way on specific

BCF themes, for example a detailed consultation on the carers strategy, home care quality etc, and will continue to do so as plans are implemented.

In Southwark there is an Early Action commission looking at the role of the voluntary sector in the prevention and care agenda. This will include the services funded from the £910k BCF budget for community support services delivered by the voluntary sector for info and advice/befriending services and how we need to ensure these fully contribute to the overall outcomes for the BCF.

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 2016/17 consistent with the BCF plan set out here?

The impact of our plan on NHS services will mean:

1. Expanded community based admission avoidance and discharge support services, preventing emergency admissions and reducing length of stay
2. Support for 7 day working from integrated social care and community services, which will enable more efficient discharge processes and shorter hospital stays
3. Extended access to primary care, 7 days a week, supporting improved health outcomes for local people and reduced reliance on urgent care services/A&E
4. More support to keep people living independently in their own homes, including self management support, telecare, increased community mental health services and better quality home care

Savings will be realised in acute hospital services, largely at Kings College Hospital and Guys and St Thomas NHS Foundation Trusts. Savings will come, primarily from reductions in emergency admissions and readmissions and shorter length of stays, as well as lower A&E attendances and reduced elective cancelations. The details of these savings are being agreed with providers both as part of our contractual negotiations and QIPP plans.

It should be noted that Southwark and Lambeth's main acute providers, Guys and St Thomas NHS Foundation Trust, and Kings College Hospital NHS Foundation Trust, are tertiary providers covering a large geographical catchment area, and the proportion of their work relating to the two boroughs is less than 50%. Although Southwark is an important local referrer and partner to the two hospitals in the integration programme, the impact on our providers of changes to local demand is not as significant as it would be for district general type hospitals.

Within our local acute providers, capacity will be rebalanced to reflect the reduced use of emergency services by Southwark people. This will be through a combination of increasing the amount of tertiary work undertaken, through specialised services growth and consolidation, as well as bed reductions in some acute medical and older people's

wards. This rebalancing of capacity will be agreed and tracked through the Strategic Partnership programme.

There are two key risks for acute providers:

1) That the bed savings do not materialise, in which case there would be a cost pressure within the local health economy. We are seeking to mitigate this in a number of ways:

- Proactively taking acute capacity out of service as the new integrated capacity is developed, or redeploying capacity in the community
- Performance managing the integration programme to deliver agreed benefits, and holding partners in the system to account through the Strategic Partnership
- Entering into risk management agreements between commissioners and providers
- Evaluating the impact of the overall integration and admission avoidance programme, and amending components of the programme where there is shown to be low impact or less value for money

2) That the programme does release acute capacity, but this is not taken up by more profitable specialised activity. In this case there would need to be rationalisation of total acute capacity and reductions in fixed costs to create efficiencies.

The impact on service delivery targets if savings and activity reductions do not materialise would include pressures on emergency capacity, leading to pressures on A&E performance and possibly also referral to treatment times for elective work. However, the comment re the proportion of our FTs' activity which relates to Southwark patients means that this impact is diluted by other demand and volume of activity from other commissioners, including other boroughs and NHS England specialist work

Appendices

Document or information title	Synopsis and links
1. Southwark Five Year Forward View	*Attached appendix 1, 3*
2. Health and wellbeing strategy	*http://moderngov.southwark.gov.uk/documents/s51406/Appendix%201%20Health%20and%20Wellbeing%20Strategy%202015%20-%202020.pdf*
3. JSNA	*http://www.southwark.gov.uk/jsna*
4. CCG Primary and Community Care Strategy	*http://www.southwarkccg.nhs.uk/our-plans/out-of-hospital-care/strategy-2013-18/Documents/Southwark%20Primary%20and%20Community%20Care%20Strategy.pdf*
5. Our Healthier South East London Strategic Plan	*http://www.ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/Our%20Healthier%20South%20East%20London%20Full%20Strategy%20v2.pdf*
6. Local Account – Adult Social Care	*http://www.southwark.gov.uk/localaccount*
7. SLIC website and project plans and reports	*http://slicare.org/*
8. Carers Strategy	*http://www.southwark.gov.uk/downloads/download/3605/our_draft_carers_strategy_2013*
9. Adult Social Care Vision	*Attached appendix 2*