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**Updated September 2014**

**Better Care Fund planning template – Part 1**

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

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

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

1. **PLAN DETAILS**
2. **Summary of Plan**

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| Local Authority | **London Borough of Sutton** |
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| Clinical Commissioning Groups | **Sutton Clinical Commissioning Group** |
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| Boundary Differences | **NA** |
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| Date agreed at Health and Well-Being Board: | **15/09/2014** |
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| Date submitted: | **19/09/2014** |
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| Minimum required value of BCF pooled budget: 2014/15 | **£614,000** |
| 2015/16 | **£12,168,000** |
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| Total agreed value of pooled budget: 2014/15 | **£6,563,000** |
| 2015/16 | **£14,657,000** |

1. **Authorisation and signoff**

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| **Signed on behalf of the Clinical Commissioning Group** | Sutton Clinical Commissioning Group |
| **By** | Dr Chris Elliott |
| **Position** | Chief Clinical Officer |
| **Date** | 18th September 2014 |

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| **Signed on behalf of the Council** | London Borough of Sutton |
| **By** | Dr Adi Cooper |
| **Position** | Strategic Director – Adult Social Services, Housing & Health |
| **Date** | 18th September 2014 |

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| **Signed on behalf of the Health and Wellbeing Board** | Sutton Health & Wellbeing Board |
| **By Chair of Health and Wellbeing Board** | Councillor Ruth Dombey  Leader of London Borough of Sutton |
| **Date** | 18th September 2014 |

1. **Related documentation**

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

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| **Document or information title** | **Synopsis and links** |
| Joint Strategy for Health & Social Care in Sutton | [**http://www.suttonccg.nhs.uk/News-Publications/publications/Key%20publications/Joint**](http://www.suttonccg.nhs.uk/News-Publications/publications/Key%20publications/Joint)**%20Health%20and%20Social%20Care%20Strategy.pdf** |
| Sutton Joint Strategic Needs Assessment | [**www.suttonjsna.org.uk**](http://www.suttonjsna.org.uk) |
| A framework for collaboration between Sutton Clinical Commissioning Group and London Borough of Sutton | **Appendix 1** |
| One Sutton Commissioning Collaborative Terms of Reference | **Appendix 2** |
| Sutton CCG Our Plan on a Page 2014-15 | [**http://www.suttonccg.nhs.uk/News-Publications/publications/Key%20**](http://www.suttonccg.nhs.uk/News-Publications/publications/Key%20)  **publications/Sutton%20CCG%202%20**  **Year%20Plan%20on%20a%20Page%20-%20April%2014.pdf** |
| Adult Social Services Housing and Health (ASSHH) and Children, Young Peoples and Learning Disabilities (CYPLD) Directorates Commissioning and Finance Plans 2014/15 | **(ASSHH)** [**https://www.sutton.gov.uk/CHttpHandler.ashx?id=23496&p=0**](https://www.sutton.gov.uk/CHttpHandler.ashx?id=23496&p=0)  **(CYPLD)** [**https://www.sutton.gov.uk/CHttpHandler.ashx?id=23445&p=0**](https://www.sutton.gov.uk/CHttpHandler.ashx?id=23445&p=0) |
| Better Care Fund Stakeholder Engagement Presentation | **Appendix 3** |
| Sutton CCG Stakeholder 130214 Event Feedback | **Appendix 4** |

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| **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** |

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| **1 What does our JSNA tell us about the population of Sutton?** |
| **1.1 How our population is projected to change over time**  The London Borough of Sutton (LB Sutton) uses population projections from both of the two main providers of such data: the Office for National Statistics (ONS), and the Greater London Authority (GLA). Both providers base their projections on the census but they have slightly different methods which result in a variation between estimates over time. Differences are largely due to the anticipated level of net migration, which is higher under the ONS projection. In contrast, the GLA includes a forecast that indicates future net out-migration due to constraints of the limits of anticipated housing supply. These have the advantage that they can be used to compare with the whole of England, and not just London.  Key points from the 2011 census and from Office for National Statistics (ONS) population projections are as follows:   * There were 191,123 people living in Sutton at the time of the census. This number is projected to rise to around 222,000 by 2021 * Children aged under 5 years accounted for around 7% of the population in Sutton in 2011, similar to London (7%), and higher than England (6%). The proportion of young children in Sutton is projected to remain similar through to 2021. At time of the 2011 census there were 12,870 children aged under 5. * Children aged 5 to 19 years accounted for around 18.1% of the population in Sutton in 2011, higher than London (17.2%), and England (17.7%). The proportion of older children in Sutton is projected to remain similar through to 2021. At time of the 2011 census there were 34,523 older children aged 5 to 19. * The Sutton working age population (20-64 years) numbered approximately 116,000, i.e. 61% of the whole population (lower compared to London (64%), but higher than England (60%).The proportion of working age people in Sutton is projected to remain fairly constant over the next ten years through to 2021. * People aged 85 and over accounted for 2% of the population in Sutton, a similar proportion compared to London and England. At the time of the 2011 census there were 4,031people in Sutton this age group.   According to ONS population projections, Sutton’s population will increase by 15.9% from 2011 to 2021, which is a higher rate of increase than for either London (14.2%) or England (8.6%).    The population of children and younger people (aged 0 to 19 years) is expected to increase by 18.3%, compared to 14.5% for London and 7.9% for England – again a higher rate of increase.    For older people aged 65 and over, the population is expected to increase by 18.7% by 2021, which is the same rate as for London, but less than for England (23.6%). Similarly the population aged over 75 is expected to increase by 17.1% by 2021, compared to 18.6% for London, and much less than the 27.2% projected increase for England. If these projections are accurate, then the profile of Sutton is changing and by 2021 the borough could have a younger profile than at present.    At April 2013 the number of people registered with GPs in Sutton was 185,831. The registered population (i.e. the number of people registered with a GP practice) is different from the resident population of Sutton as patients may register with a GP in a different borough, or conversely a resident of a neighbouring borough might be registered with a Sutton GP. The difference is important because Clinical Commissioning Groups (CCGs) are responsible for commissioning services for the registered, rather than resident, population. Conversely, Local Authority departments including social services are responsible for providing care for residents.    However, in Sutton the registered and resident population structure is similar, so assumptions about population growth based on the resident population are likely also to apply to the CCG, though this should continue to be monitored.    **1.2 Prevalence of Long Term Conditions**  The JSNA also gives us a good picture of the prevalence of long term conditions in the borough. Whilst it is notable that prevalence of respiratory and circulatory conditions and stroke this is still a large number of people who we will place a particular emphasis on in our work to integrate and improve services.  Information based on GP Registers (for QOF purposes) show that Sutton has a prevalence of 1.3% for COPD (1 in every 75 people) compared to 1.7% (1 in every 57 people) nationally. This represented 2,490 people in 2012/13.  For asthma the prevalence is 5.6% (1 in every 18 people) compared to 6% (1 in every 17 people) nationally.  Sutton’s prevalence of CHD based on GP Registers (QOF) is 2.6%, representing 4,876 patients; that is in Sutton about 1 in 38 people have CHD compared to 3.3% nationally (1 in every 30 people).  Turning to coronary heart disease (CHD) the gap between expected and modelled prevalence recorded by GPs suggests that a significant number of people in Sutton with CHD/circulatory disease have yet to be identified. The work being set in place to support the implementation of the Avoiding Unplanned Admissions Enhanced Service and support service integration as well as the introduction of the NHS Health Check (a national initiative of regular vascular risk assessments) is likely to help identify these people.  The prevalence of stroke in Sutton, based on GP registers (QOF) is 1.3% of Sutton’s registered population representing 2,363 people; that is about 1 in 79 people have had a stroke. This is lower compared to the prevalence for England which is 1.7%, that is 1 in 59 people. However, Sutton’s prevalence is higher than the London average (1%). Compared to other authorities, stroke prevalence for Sutton ranks 5th highest in London. The borough also ranks comparatively high (8th out of 32 boroughs) for hypertension which is the main risk factor for stroke. In Sutton 12.3% of the population are on a GP register for hypertension (22,904 people) which is higher compared to 11% in London. However, Sutton’s prevalence of hypertension is lower than for England (13.7%).  It is indicated that, based on data from the General Household Survey, that the number of people in Sutton predicted to have a longstanding health condition caused by stroke through to 2020 will increase by 13.5% from a 2012 baseline. |
| **2 Our vision in Sutton** |
| This information has helped inform our vision which is to create an integrated service model based on the following principles:  (a) **Keeping people healthy and independent in the community**  *Delivering universal and preventative services*  (b) **Local access to specialised health and social care model**  *Delivering targeted primary and community care services*  (c) **Supporting people when they require hospital and residential services**  *Delivering acute care and care home services*  This vision sits at the heart of the Joint Strategy for Health and Social Care in Sutton which has been developed over the last year and was approved and adopted by the Health and Wellbeing Board at its meeting in June 2014. This provides us with solid and robust foundations for implementation, much of which is being undertaken through the vehicle of the Better Care Fund.  The implementation of the Better Care Fund (BCF) will result in the creation of a joint pooled fund between Sutton Clinical Commissioning Group (Sutton CCG) and LB Sutton of £6.6m in 2014/15 and £14.7m in 2015/16, which exceeds the minimum levels.  The work to keep the population healthy will involve close partnership working with public health in the local authority who commission alcohol and drug services and also the health checks programme which detects early indicators of cardiovascular risk and risks for renal disease at an early stage, enabling onward referral to lifestyle services and treatments to prevent development of disease. Stop smoking services are also a key part of primary and secondary prevention, helping people either avoid cancer and cardiac disease, or reduce episodes of ill health and hospital admission, for example in patients with lung disease such as Chronic obstructive pulmonary disease (COPD). This also involves close and effective working with NHS England, who commission programmes such as flu vaccination - this also prevents disease which may lead to unplanned hospital admissions. Falls prevention, currently commissioned by public health is another key part of admission avoidance  Sitting alongside services commissioned through these pooled funds, will be a larger set of **aligned services**, including community mental health, dementia, and relevant components of acute commissioning, that do not need to be commissioned through pooled funds at this time in order to deliver the intended outcomes for the BCF. The budgets will be aligned to this “whole system” vision and objectives and funding of these services will be reviewed in the future to identify whether they are best transferred into an expanded pooled fund at a later date.    Our vision for coordinated and integrated services will ensure that both these pooled and aligned funds are used to maximum effect, which will both improve quality of care for residents of Sutton and avoid any cost pressures resulting from fragmented services.  We have created a vision and strategy for out of hospital health and social care services in Sutton which reflect the joint ambitions for both of our organisations, and assist in addressing care needs for Sutton residents more holistically. Through our integrated approach to commissioning services and working with our health, social care and third sector providers, we envisage that appropriate care will be provided 7 days a week seamlessly without organisational and professional barriers.  By 2016, we will provide services that deliver high quality, integrated care to our residents through implementation of out of hospital initiatives which:     * support more patients to remain independent and receive care in their home or community; * minimise preventable hospital admissions, increasing timely access to community-based out-of-hours and urgent care where appropriate; * minimise residential placements, by supporting individuals to remain living in their own home; * provide effective reablement and rehabilitation services to support people in the community; * maximise self-care by supporting communities and individuals to look after their own health and wellbeing, especially for those with multiple LTCs; * transform the way in which care is provided characterised by a wide variety of organisations (including those in the voluntary sector) working collaboratively; * encourage independent community-based living which prevents social isolation and improves access to voluntary services which improve quality of life; and * provide an experience of joined up services, where professionals from different teams and organisations work together well, with appropriate and timely communication, supported by shared records. |
| **3 The vision for the 5 year strategy** |
| ***“People in south west London can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable.”***    In June 2014, the six south west London CCGs submitted their 5 year strategy for health services across south west London. This strategy, which is the culmination of joint working since January 2014, seeks to address the rising demand for healthcare in south west London, and the quality and financial gaps that exist at present in its provision. The clinical input to the strategy was developed by seven clinical design groups (CDGs), with integrated care being both a CDG in its own right and a major component of the strategy as a whole. Patient feedback was sought as part of this process and used by the CDGs in developing the initiatives in the five-year strategy.  For integrated care services in particular, the vision across south west London is to develop services that:     * help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates; * help to keep people with one or multiple LTCs and complex needs stable; * allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate; * support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home * provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence * support and provides education to both family and carers to ensure their health and well-being needs are met, and includes support to maintain finances and staying in work, where relevant * help people requiring end of their life care to be supported to receive their care and to die in their preferred place.   ***Our vision is to re-shape health, social care and wellbeing services so that people are supported to remain well for longer in their own homes, rather than becoming unwell and requiring hospital, residential and nursing care support.***  Our long-term vision for integrated health and social care services for Sutton aligns with the following strategic plans:   * The 5-year strategic vision and strategy for south west London as a whole * The Joint Strategic Needs Assessment for Sutton, informed by the voice of patients, service uses and members of the public * The Joint Health and Wellbeing Strategy * The Joint Strategy for Health and Social Care in Sutton * Sutton CCG’s 2-year and 5-year operational plans submitted alongside this BCF plan * LB Sutton’s Commissioning and Finance Plans for Adult Social Services, Health & Housing Directorate and for Children, Young People and Learning Directorate for 2014/15.   Our vision involves a step change in the way that we plan care, from reactively providing services when people fall ill, to proactively supporting people to stay healthy. We, as co-commissioners, Sutton CCG and LB Sutton, and in partnership with our community and acute providers, will deliver services in an integrated way that enables patients to receive effective care closer to their homes. Services will be person-centred and many schemes will be targeted at those groups identified at most risk of hospital or care home admission, and those with multiple long term conditions.    Given the ageing population, the approach is especially relevant to older people. Nationally, unplanned admissions for people over the age of 65 account for 68% of hospital emergency bed days.[[1]](#footnote-1) In addition, there is a range of risks associated with emergency admission, such as increased dependence, reduced mobility and contracting a Hospital Acquired Infection.[[2]](#footnote-2) There are therefore clear advantages to avoiding hospital admission from both the perspective of patient outcome and experience as well as reducing demand on acute services.  Furthermore, we will promote a universal offer to the residents of Sutton. We will provide services which enable people to be proactive about their health and wellbeing, and remain independent for as long as possible. This will be a whole-system approach which will also strengthen the relationships between services and professionals, including primary care, third sector services and the other community organisations. |

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

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| **1 What will this mean in Sutton?** |
| While developing the original plan we set up a focus-group with a range of patients, users and carers. The work to develop the detail of our schemes includes representation from Sutton Healthwatch and we are working with them to set in place ongoing arrangements to incorporate patient and user comments and feedback into the design of our integrated services and the ways in which we will work with them through the integration process. We have also built on the stakeholder events (such as those organised by Healthwatch and Sutton Clinical Commissioning Group) to ensure that our whole integration approach is informed by the patient and service user perspective. The views expressed by patients, service users, and carers are best summarised in the following “I” statements:   * “I expect mental as well as physical health and wellbeing to be taken into account in assessments of my health and social care needs” * “I expect to tell my story about my needs without duplication and to have a lead health and social care professional to work with me and my carers” * “I want those providing long term or complex care and support to work together to maximise my choice and control in how it is delivered”.   From the personal accounts that have been shared, the following case summaries illustrate the differences that people said they wanted to see from the proposals in the Better Care Fund submission. Whilst cost benefits are estimated, the benefits are sustainable due to the higher level of satisfaction these people experience.  **Case Summary 1**  John, an older gentleman, who had contracted polio at a young age, was experiencing long-term health conditions and increasing disability later in adult life. The repeated assessments of need for the Council, Continuing Healthcare, as well as specialist clinical assessments for the treatment and medication necessary for his mental health and physical wellbeing, were obstacles to this gentleman who felt less able to manage his condition as well as he was accustomed to as a younger adult. Due to the specialist nature of the health conditions no proactive holistic assessment was made.  *The Better Care Fund proposals would ensure there was a proactive joint assessment of health and social care needs, with patient consent for shared data, coordinated by one lead professional through whom the range of treatment and support would be arranged (community healthcare, social services, the GP, and mental health). This would help reduce both community, and especially hospital admission or attendances by this person, and through improved choice and control of support afforded by personal health and social care budgets, better enable this person to remain in their own home rather than experience admission to a residential setting.*  It should be noted that the avoidance of hospital admission would reduce hospital costs by £1,490 (as per BCF guidance on the national average) per hospital admission. Continuing Health Care personal budgets combined with social services budgets in 2015/16 would enable this person to purchase tailored support such as personal assistants, and/or canine assistance which were more suited to his individual needs. The cost of this personalised support would be, at least, 50% less than the 4 personal care visits daily currently required.  **Case Summary 2**  Jane, an older lady of 75 years of age, who was experiencing long standing mental health issues and disabilities, was assessed and treated solely by specialist mental health professionals. This led to duplicated and unconnected assessments by the GP and social services when physical health problems arose – or worse, posed barriers to accessing such assessments leading to crises or A&E attendances/hospital admissions. Jane also experienced partial sightedness, adding complexity to her daily life.  *Under the Better Care Fund proposals, joint assessments and a holistic approach to meeting needs would take place, coordinated by a lead professional well-known to the patient. This would enable Jane to give consent to shared data within a multi-disciplinary team, alongside enabling access to diagnosis, treatment and support across primary care and social services.*  *An integrated approach to social services, voluntary organisations, and National Health Service assessments enable appropriate equipment, as well as treatment and support, to take place through one clinic, easily accessed. This support would be integrated through health and social care being coordinated across agencies, with fewer different people visiting Jane’s home.*  *Jane has stated that this joined up approach would empower her to feel more in control of her life enabling her to remain independent in her own home, rather than the potential loss of confidence which might increase her risk of hospital or care home admissions.*  Each hospital admission avoided would reduce hospital costs by £1,490 (as per BCF guidance on the national average). The reduced duplication in assessments and support would reduce the overall cost by at least 25% on current homecare, community mental health, and related input. This should also reduce the number of separate visits from different professionals and organisations. The many visits can be disconcerting and disruptive, particularly for those people who are not used to having strangers in their homes. |
| **2 The 5 year strategy – implications for patients and service users** |
| For patients and service users, our aim by 2018/19 is to provide with improved access to services that meet relevant quality standards, with a greater proportion of care provided by multi-disciplinary teams closer to individuals’ home. We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and high quality care out of hospital whenever appropriate. Patients will benefit from services that are more proactive rather than reactive, and that will co-ordinate the efforts of multiple providers in seeking to improve the health and wellbeing of people across south west London.  Across south west London, we want people to experience an uninterrupted journey through services, ensure that patients’ families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care to enhance overall wellbeing, independence and ‘social capital’.    The drive to achieve the London Quality Standards, and other relevant standards, will result in patients experiencing improved outcomes from healthcare services in south west London. The further separation of elective and non-elective surgery is expected to support a reduction in average lengths of stay and infection rates, and to lead to an improvement in outcomes.  A key driver for the 5 year strategy is to address the health inequalities that exist across south west London. Improvements to services will result in more consistent outcomes for patients, regardless of whom they are or where they live. |

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| **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 contributes to this?** |

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| **1 The impact in Sutton** |
| The clearest manifestation of the changes in Sutton will be the creation of **three multi-disciplinary locality teams** linking primary care, community healthcare, social services, housing adaptations and home improvement services, and will be aligned with mental health. These teams will carry out **joint, integrated assessments** of health and social care needs of people, targeting those most at risk of institutional care through active case management and risk stratification. These teams will **work closely with an integrated hospital in-reach service** to reduce delayed transfers of care and length of stay, and through an expanded reablement/rehabilitation service in Sutton. The teams will be accountable for implementing **timely and practical measures to help prevent admission**, with a **central coordinating professional** who will be responsible for ensuring people are actively involved in their care and plans are person-centred. Additionally, multi-disciplinary assessments carried out by the Transitions team for 14-25 year olds with long term conditions and disabilities will be aligned to this approach.  To achieve this vision, we will make the following key changes to our services over the next five years:   * build capacity in the community to work collaboratively through integrated services to reduce non-elective admissions to acute settings and care homes; * the re procurement of community services will enhance the impact of integrated working through revised service specifications that support the integrated/partnership approach; * alignment of the Mental Health, in particular the work around dementia and the procurement of the Primary Care Mental Health care model will enhance integration; * build capacity in the community to respond to escalating or urgent care needs of identified people at risk, such as older people or those with multiple or deteriorating long term conditions; * expand the capacity of the reablement and rehabilitation services to support residents in the community, helping to reduce length of stay in acute settings and preventing readmissions by improved discharge planning; * work with acute sector providers (primarily Epsom and St Helier University Hospitals NHS Trust) to reshape NHS services in response to changing demands and increased community capacity; * maximise people’s capacity to self-care – by supporting communities and individuals to look after their own health and wellbeing; * plan and develop a community workforce in collaboration with providers, which can deliver an expanded community service model, and transition professionals from acute settings into the community; and * provide stronger links with voluntary services, local CCG partners and other community groups, preventing social isolation and dependency where appropriate.   Our aim is to deliver stepped improvements over the five years, with possible expansion of the pooled budget as the shift in culture, process, and delivery of integrated services is achieved and builds confidence. As community capacity is increased in the next two years, we aim to reduce overall demand through emergency admissions, as well as reduce delayed transfers of care. This plan through working in partnership with our local providers will allow medium term realignment of the acute hospitals to achieve improved patient outcomes, greater efficiency, and sustainable acute provider capacity on a different basis. Similarly we aim to build upon the LB Sutton’s previous success in reducing people supported in care homes (in the top 25% nationally), by meeting increased demand and further reduce care home admissions.  We also need to deliver the enablers for delivering care in the way described above. These include data sharing capabilities, organisational development, and processes to promote multidisciplinary working and care planning. It also requires establishing closer links with primary care with the further development of community services. Two key procurements in Sutton will support this. Furthermore, we are committed to delivering a health and social care model which expands 7 days a week capacity beyond what is already in place and provides the appropriate level of service out-of-hours. We will therefore ensure that the appropriate resource and skill is available to assist the transition into the integrated model of care provision.  Through implementation of the Care Act within our BCF Plan and pooled budget, we aim to maximise the capacity of local people and their families/carers to self-care. We will enhance provision and integration of information, advice, advocacy, and notably carer support, to promote independence for those with long-term conditions. This should have a preventative impact on intensive health and social care support, as well as help reduce admissions to hospitals and care homes. It will help mitigate the risk on social services under the national condition of protecting that sector. |
| **2 The South West London dimension** |
| The strategy as a whole will require fundamental changes to how services are delivered across south west London. Over the next five years, there will be an increasing shift in services from the acute to community services, with the development of more proactive services. Below are the anticipated changes by clinical area, as defined in the strategy by the seven clinical design groups:   * Children’s services - Investment in community children’s services in advance of rolling-out integrated children’s services and the Paediatric Assessment Unit model. The impact on acute capacity would then be assessed with a view to a future consolidation of acute children’s services. * Integrated care - Focus on the implementation of BCF plans during 2014/15 and 2015/16, with work in parallel to consider contracting, workforce and IT enablers for improving integration across south west London. Implementation of seven-day working in the community from 2016/17. * Maternity services – it is anticipated that all units to achieve 98-hours of consultant obstetric presence by the end of 2014/15, with full compliance achieved by 2018/19. This may differ across providers given the starting point for delivery of these targets. Midwifery-related LQS to be achieved by the end of 2015/16. * Mental health - Series of initiatives to develop capacity in community services, including developing a single point of access, increased access to IAPT and greater provision of home treatment, to be implemented between 2014/15 and 2016/17, with a view to reducing acute in-patient activity from 2017/18. * Planned care - Creation of an implementation plan for a multi-speciality elective centre (MSEC), with Urology services deployed in an elective centre from 2016/17, one further specialty from 2017/18 and three more from 2018/19. Planning to include consideration of appropriate quality measures and approaches to contracting. * Primary care - Fully networked model of primary care, in line with NHS England plans, to be achieved by 2016/17, with implementation plans for estates improvements and workforce transformation to commence in the same year. Greater emphasis to be placed on MDT working, prevention and supporting self-management. This may be possible to further influence through the CCGs expression of interest to support the development of co commissioning arrangements in primary care. * Urgent and emergency care - Implementation of seven-day working across urgency and emergency care services in SWL by 2015/16, supported by an ambulatory emergency care model. LQS to be achieved in all emergency departments by 2016/17. Further improvements in efficiency and effectiveness, including greater connectivity with other settings, to be pursued through implementation of new IT systems. |

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| **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. |

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| The approach being taken in Sutton builds on the themes written through the Joint Strategy for Health and Social Care in Sutton and the CCG Operating Plan. |
| **1 How integration will support improvement in Sutton – The Sutton Approach** |
| We have recognised that the differences in operational arrangements between organisations and professional groups across health and social care makes effective coordination and structures to plan around the needs of patients and service users challenging and hinders integrated care planning.  Whilst we do not yet have access to aggregate risk stratification data from all GP practices across Sutton at this time, we will be using an enhanced version of Sollis tool following planned roll out in October 2014. This will enable us to undertake the comprehensive targeting and segmentation of the population which will help ensure we are embarking on the schemes most likely to change and reduce patterns of non-elective activity. In the absence of this we have used non elective activity trends to give us early indications about what we need to target and this will be built on once we have undertaken the analysis using the risk stratification data. This analysis will include triangulation with the non-elective activity data and data from the JSNA in order to provide as meaningful a picture as possible of what schemes and interventions will have the greatest likelihood of success.  Progress has already been made in addressing this. Sutton CCG is organised into three geographical locality areas that relate to town centres and natural population groupings in the borough. These are Wallington, Carshalton and Sutton & Cheam. This grouping of GP practices has been in place for over two years and includes elected GP locality chairs that help ensure a local focus to planning. This provides a stable foundation on which to build integrated locality teams.  It has also been agreed that community health services, managed by Sutton & Merton Community Services which is part of The Royal Marsden NHS Foundation Trust (RMH), and adult social services will move to this configuration. Community health services moved into this coterminous locality configuration from the end of June 2014 and is currently bedding in. London Borough of Sutton is implementing arrangements, alongside consultation and planning for changes to meet requirements of the Care Act 2014, to reorganise adult social work and therapy services on this same footprint by March 2015.  This forms the core of the Sutton Approach to integration in the recognition that it is unlikely that we would be able to get to the position of building services around patients and service users in a way that is readily understandable and navigable without moving to this locality model. It should also be noted that we will subsequently consider mental health and services provided by other agencies such as the voluntary sector in the same configuration. It is recognised that whilst it would be good to do this simultaneously that realistically it will need to be done in a staged way over the next few years. |
| **2 The issues we need to address through the BCF** |
| The Joint Strategy for Health and Social Care in Sutton sets out the agenda that the local authority and CCG seek to jointly address under the strategic direction of the Health & Wellbeing Board. This can be found via the link in the references section at the front of this submission however the headlines are as follows:   * Non elective admissions rose in 2011/12 and 2012/13 with a very slight decreased in 2013/14 as shown below; * Non elective admissions for people aged 75 years and over are much higher than across other age groups at 9% with an increase in spend of 20% between 2011 and 2013; * Older people currently make up 70% of adults with eligible social care needs; * In 2013/14 £16.8m was spent on care home placements, £8.4m on domiciliary care and direct payments, £7.7m on supported living and £1.4m on reablement services; * Delayed transfers of care have historically been good with one per month on average, but recently have increased to 3 per month; and * **£0.6m** was spent on placement of equipment in 2013/14 following professional assessments and this service and budget continues to be under pressure from increasing demand.   These issues correlate with the demographic position relayed in the JSNA and provide a clear focus for the areas that the BCF needs to address. Having said this it is also important to note that we do not consider the BCF to be a stand-alone initiative and this is expanded upon in the alignment section of this submission.  Below are shown graphs of non-elective admissions for 2013/14 which we have used as a basis for targeting our work to reduce non elective admissions. We will be revisiting our approach to targeting the population once we have the risk stratification segmentation work.      In 2013/14, 82% of all emergency admissions were to Epsom & St Helier University Hospitals NHS Trust (ESTH) and 10% to St George’s Healthcare NHS Trust (SGH); however for patients aged 75 and over, 88% were admitted to Epsom & St Helier and 8% to St George’s.  We should therefore be looking at 497 emergency admissions reduction at ESTH with approximately 60 at SGH, being 90% of the admissions to ESTH and SGH combined.      2013/14 Emergency admissions by HRG Chapter: Across all age groups, 48% of emergency admissions are classified as digestive system, cardiac, musculoskeletal or respiratory, whereas for those aged 75+ these account for 56% of emergency admissions, with a further 13% for urological conditions. |
| **3 Risk stratification and segmentation of the population** |
| Through local QIPP work the CCG has targeted those parts of the patient population most amenable to setting in place care plans that could realistically avoid a non-elective admission such as the cohort presenting with the six ambulatory care sensitive conditions for which there is a generally accepted evidence base.  Since its implementation in 2013/14, Sutton's risk stratification tool (the Sollis, Johns Hopkins ACG System) has been used by all 27 GP practices to identify a minimum of 2% of their patients at highest risk of emergency hospital admission.  An enhanced version, due for roll out in October 2014, will allow the CCG access to aggregate data across all 27 practices.  This will enable commissioners to analyse this rich data source to ensure that appropriate groups of patients are targeted for proactive interventions and also to evaluate the success of schemes. We would envisage using the data in much the same way as is the case with the work that is currently being undertaken in Newham.  In the meantime the CCG and local authority will make use of the data that is already available to target activities and the work to be undertaken as part of the Planned Care Work stream (described in more detail in Annex 1) to put in additional practice level support to draw up integrated care plans will provide that level of targeting at a practice level. |
| **4 The data underpinning our position** |
| Thus the data we are using to understand unmet need is currently largely driven by non-elective activity data on the basis that our whole approach is to work to a situation where non-elective admissions are driven by unavoidable crises rather than the failure of the integrated system (which is significantly, but not wholly, made up of health and social services) to most effectively meet the health and wellbeing needs of the population.  As described above, once we have access to the enhanced version of Sollis from October will be able to target and segment our population much more specifically and thus ensure that our schemes are properly focussed on those parts of the community where there is the greatest risk of unplanned hospital admission and where there is an evidence base that our interventions have the greatest likelihood of success. |

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| **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** |

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| **1 Context** |
| It is most important to note that health and social care partners in Sutton are not at the beginning of an integration journey but, rather, are at an important staging post in the process where the BCF can be used to provide additional energy to the vision and strategy as set out in the Joint Strategy for Health and Social Care in Sutton.  Thus the strategy and the associated Delivery Plan set the wider context for the integration agenda in Sutton. The work to develop the strategy was approved through the Health and Wellbeing Board (HWB) and the detailed work driven through the One Sutton Commissioning Collaborative (OSCC) (which was originally called the One Sutton Board). When initially established this was purely a strategic commissioning body whose membership was made up of senior officers from the Local Authority, including the Strategic Directors for Adult Social Services, Housing and Health and for Children, young People and Learning Services, and from the CCG, including the Chief Clinical Officer and the Chief Operating Officer.  As described in the next section, which sets out the governance arrangements, the process of working through how the BCF can most effectively be delivered has already led to a widening of the membership to encompass health providers, the voluntary sector, Healthwatch and the vice chairs of the HWB in recognition that they are all key partners who are essential in delivering the vision, national conditions and metrics that sit within the BCF infrastructure.  It is also important to recognise that the work to set in place the planning and implementation programme to deliver the BCF commenced alongside the production and agreement of the April submission. This means that over the summer we have begun the work of agreeing with partners and stakeholders how we are going to manage the various areas of development and change that make up our BCF plans.  Thus, through a process of workshops and discussions at the OSCC we agreed that, rather than trying to organise separate projects and work streams for each element of the plan, we would reduce this to a much smaller group of work streams culminating in the agreement of the three described below.  A key part of the rationale for taking this approach was that it would avoid the risk of the work being undertaken in a disjointed fashion where the work was being done in parallel and did not join up as an integrated system. It was also felt that this approach would provide a more meaningful narrative for what would be different and improved for patients and the local community in the future. |
| **2 The Sutton Delivery Plan and Key Milestones** |
| The Sutton Better Care Fund delivery plan is based around three work streams which are:   * Unplanned Care * Planned Care * Mental Health   It is recognised that these schemes do not operate in isolation and therefore have a direct read across to the CCG 2 and 5 Year plans, the Joint Strategy for Health and Social Care in Sutton, the implementation of the Care Act, the Sutton System Resilience Plan and local QIPP plans. This will help ensure a focussed, consistent and coherent approach that will reduce the risk of duplication and parallel working.  Within the 2014/15 QIPP programme there are four schemes that we believe particularly well align to what we are aiming to achieve through the BCF in 2015/16. These are:   * Long Term Conditions Scheme * Older Peoples Pathway * GP Engagement Scheme * Health Coaching Scheme   These schemes will clearly be amended for 2015/16 dependent on the level of success achieved this year and how the population at risk of admission will be targeted next year (using analysis of the risk stratification data). They will sit at the core of our non-elective admissions reduction work wrapped around a new scheme we are developing to augment and accelerate the impact of the Avoiding Unplanned Admissions Enhanced Service that all Sutton GP practices have signed up to through dedicated practice level support to set in place accelerated and targeted integrated care planning for the highest risk 15% of patient groupings with conditions amenable to avoiding hospital admission that sit within the 2% of the GP practice population identified through the risk stratification process.  These components are all discussed in more detail at Annex 1.  The following table shows how the National Conditions and key QIPP schemes relate to the three work streams:   |  |  |  |  | | --- | --- | --- | --- | |  | **Work stream 1: Unplanned Care** | **Work stream 2: Planned Care** | **Work stream 3: Mental Health** | | **Area of Delivery** |  |  |  | | Long Term Conditions Scheme | X | X |  | | Older Peoples Pathway | X | X | X | | GP Engagement Scheme | X | X | X | | Health Coaching Scheme | X | X |  | | Support to practices with targeted integrated care planning | X | X | X | | 7 day working to support discharge | X | X | X | | Data sharing | X | X |  | | Joint Assessment and Accountable Lead Professional | X | X |  |   **2.1 Unplanned Care**  The first point to note in describing the Unplanned and Planned Care work streams is to say that we recognise that there is considerable crossover between what the two streams of work need to deliver and that the relationship between the two is critical. In order to ensure this relationship is maintained the Unplanned and Planned care work stream leads have organised their monthly work stream project meetings back to back so that representatives can attend both and ensure the necessary linkages across are there.  The focus of this work stream is to ensure an integrated model of delivery along the unplanned care pathway with particular emphasis on what this means at the interface with St Helier hospital in terms of non-elective admission avoidance, effective care and discharge planning for those that need a non-elective admission and ensuring the most effective discharge arrangements to minimise delays and reduce as much as possible the risk of an emergency re-admission.  The integrated unplanned care pathway provides the framework for taking forward the areas of work identified in the table above and will ensure alignment with both the Planned Care work stream and other initiatives in the wider Sutton health and social care community as described in section 6 of this submission.  The work stream lead is the Assistant Director of Operations for the community health services managed by the RMH which ensures the work is kept well aligned with operational delivery and also means that there is a good understanding within the work stream of the operational challenges and opportunities in taking this work forward. The work stream membership is made up of a range of stakeholders representing all health and social care organisations and professional groups including Epsom & St Helier University Hospitals NHS Trust, primary care, the voluntary sector and Healthwatch. For information the membership is set out at Appendix 5.    In order to ensure the necessary level of resource to facilitate the work to get integrated working and arrangements in place at the hospital interface we have put in place an Integration Facilitator (described in more detail at item 3 below) for the next 12 months to work through how this comes into being on the ground and support the alignment and integration of working practices and cultures across partners. This individual is a senior social services manager whose substantive role is to manage the social services resources that already work at the interface between hospital and community and therefore has a good understanding of issues and current operational arrangements. This role will be supported by the Oxford Brookes team whose role is described in more detail under item 4 below.  This evidence base underlying this work is set out in Annex 1a.  **2.2 Planned Care**  As stated above, this work stream is closely connected with the Unplanned Care work stream and will focus on setting in place integrated working across health and social care based on the three GP localities, Wallington, Carshalton and Sutton & Cheam. This will drive the delivery of the National Conditions and by setting in place integrated arrangements that target those parts of the community at highest risk of an emergency hospital admission through effective multi-disciplinary working and support for patients in much more effectively navigating the system. We believe that this means that the resultant support and packages of care will be more timely and tailored to the individual’s needs so that non-elective admissions are prevented appropriately and enable the system to progressively be built around a planned approach to integrated care rather than a model that is disproportionately dominated by the unplanned, emergency part of the system.  The work stream lead is the Director of Nursing for the community health services managed by the RMH which ensures the work is kept well aligned with operational delivery and also means that there is a good understanding within the work stream of the operational challenges and opportunities in taking this work forward. The work stream membership is made up of a range of stakeholders representing all health and social care organisations and professional groups including Epsom & St Helier University Hospitals NHS Trust, primary care, the voluntary sector and Healthwatch. For information the membership is set out at Appendix 6.    In order to ensure the necessary level of resource to facilitate the work to get integrated working and arrangements in place in each of the three localities we have placed an Integration Facilitator in each locality (described in more detail at item 3 below) for the next 12 months to work through how this comes into being on the ground and support the alignment and integration of working practices and cultures across partners. These three individuals are a senior social services manager and two of the nurse locality managers in community health services meaning that there is a good understanding of issues and current operational arrangements. This role will be supported by the Oxford Brookes team whose role is described in more detail under item 4 below.  The work to bring together this integrated model of working will firstly be tested through piloting in one GP practice in each locality. The three practices have agreed to pilot the integrated approach from October to December 2014 in order to understand what are the likely resource and working pattern implications for all health and social care partners in making integrated and multi-disciplinary care planning and service delivery work and using this as a basis for roll out from January. The pilot will be supported by the respective Integration Facilitator in each locality.  This evidence base underlying this work is set out in Annex 1b.  **2.3 Mental Health**  During the initial work to develop our Better Care Fund approach in Sutton it was agreed that mental health budgets would not be included in the pool however we were clear that in order to achieve truly integrated services that are built around the needs of the population that we will need to look across the whole range of needs including mental health and wellbeing.  It was agreed that whilst the focus for 2015/16 would be on the integration of community health services and social services that we would ensure that planning for mental health services was aligned with the two main work streams so that this could simplify the process of integration at a later date. This is in line with the Parity of Esteem agenda and should reduce the risk of mental health feeling like an add on rather than as an integral part of the integrated system. For information the membership is set out at Appendix 7.  This is a pragmatic approach that recognises that we cannot undertake all areas of work simultaneously but, instead, we are looking to ensure that we are best placed to ensure a roll out across all service areas over the next few years. This will provide the option for potentially expanding the pool to encompass mental health services in future years.  This evidence base underlying this work is set out in Annex 1c.  **2.4 Key Milestones**  Due to the level of alignment across our work streams the key milestones are set out together below although, of course, there are separate delivery plans for each in order to maintain the necessary focus within each work stream.  These milestones are the key developmental steps, common to all three work streams, to get to the point of implementation in April 2015. Each work stream lead will report against these milestones individually and further milestones will need to be agreed by work stream in the next three months to embed and further build on this implementation.   |  |  |  | | --- | --- | --- | | **Work stream and Locality Development** |  |  | | **1** | Finalise membership of Work Stream | 13/08 | | **2** | Work stream delivery plan development (1st draft) | 10/09 | | **3** | Map the current system/think tank about what we can do and define what planned and unplanned care is and understanding links | 19/09 | | **4** | Work stream delivery plan (revised draft) - present to OSCC | 25/09 | | **5** | Oxford Brookes – Agree programme of support to work stream leads and Integration Facilitators | 25/09 | | **6** | GP Locality Meeting – Enhanced Service and approach to using Risk Stratification data discussion | 30/09 | | **7** | Work stream prioritisation of schemes and delivery focus and identify key players | 08/10 | | **8** | Commence pilot of multi-disciplinary working in three practices (one per locality) | 01/10 | | **9** | Agree efficiency and productivity expectations of integrated locality teams | 08/10 | | **10** | Assuring alignment of schemes with deliverables (e.g.CQUINs,Telehealth, Enablement,Hospice,OOH GP, CHC, Pharmacy, LAS) | 08/10 | | **11** | Verify alignment with hospital interface and locality provision | 08/10 | | **12** | Identify data sharing opportunities and existing data reporting | 08/10 | | **13** | Define new way of working and get it agreed - Present to Transformation Programme Board | 13/10 | | **14** | Developing the new system workshops/planning groups. To develop IF work plan | 17/10 | | **15** | Undertake analysis and segmentation work on population using risk stratification tool | 01/11 | | **16** | End of MDT pilot in 3 practices | 31/12 | | **17** | Complete population analysis using risk stratification tool | 31/12 | | **18** | Agreement of milestones for 2015/16 by work stream | 31/12 | | **19** | Evaluation of MDT practice pilots | Jan 15 | | **20** | Ensure schemes are targeting the right parts of the population and modify as required | Jan 15 | | **21** | Recommendations for roll out of MDT pilot learning and approach across localities | Feb 15 | | **22** | Completion of work to establish integrated locality teams across Sutton | 31/03/15 | | **23** | Implementation of MDT model and locality based working | 01/04/15 | | **Multi Professional Team** | |  | | **24** | Agree principles of MPT working and clarify lead prof. - Present to TPB | 13/10 | | **Metrics and Savings Delivery** |  |  | | **25** | Review baseline activity data and identify any "failure demands" | 26/09 | | **26** | Agree finance and activity model and efficiency and productivity expectations that will be monitored through 2015/16 | 20/11 | | **Systems** |  |  | | **27** | Data Sharing update, Tech Fund Bid, NHS Smart Card and Data Batch System - To TPB | 13/10 | | **Risks** |  |  | | **28** | Work Stream Risk register in place | 30/09 | | **Engagement and Communication Activities** |  |  | | **29** | Develop Engagement and Communication Plan | 31/10 | | **30** | Identify Education & Training Needs and delivery | 01/12 | | **31** | Public/Stakeholder Events | 01/12 | |
| **3 The Integration Facilitators and Work Stream Leads** |
| The Integration Facilitator roles are central to the delivery and successful implementation of the Better Care Fund in Sutton. These posts have been in place since September 2014.  The aim of the four roles is to facilitate the establishment and bedding in of integrated working across health and social care staff in the three localities and at the interface between community and hospital based provision. These posts will lead implementation of the work set out by the three work streams.  The roles will work with all stakeholders in their locality across:   * Adult Social Services and Occupational Therapy * Carer and patient/user representatives * CCG staff * Community Health Services (including the Learning Disability Clinical Health Team) * Hospital based services * Non-statutory sector services * Other parts of the Local Authority (as appropriate) * Primary care * Supporting alignment with Community Adult and Older Peoples Mental Health Services   It is recognised that these are new roles operating in an emerging and changing integrated environment so additional training and development will be made available to them as needed.  The key responsibilities of the post holders will be to work with all the above teams and stakeholders to integrate ways of working, particularly with regard to multi-disciplinary team working and joint assessment. As well as facilitating the introduction of integrated working, the role will also lead on engagement across the relevant stakeholder groups and act as project manager for the area of integration on which they are leading.  Due to the particular features of the three community localities and the hospital interface there will be some differences between the roles. Some of the key features of each are set out below:  **A. Community Localities**  Key features include the establishment and/or strengthening of:   * Joint assessment and delivery of treatment, prevention and integrated services through one of the three locality multi-disciplinary teams; * Active case management using the risk stratification tool; * Care planning with a lead professional; and * Focus on prevention of admission to either hospital or care homes.   **B. Hospital Interface**  Key features include the establishment and/or strengthening of:   * The Sutton Older Peoples Pathway; * The integration of the Rapid Response Team to facilitate discharge home from St Helier A&E department and Community Prevention of Admission Team to facilitate the patient remaining at home and so avoid preventable emergency admissions; * Working with the liaison psychiatry team; * The alignment of specialist community nursing, primary care and acute staff, therapies staff, hospital social work staff, discharge coordinators and the reablement service; * The use of intermediate care to reduce avoidable admissions to care homes following discharge from hospital; and * Links to the Transitions from Children to Adults project to reduce avoidable emergency admissions for children.   These four posts will work closely with the three Work Stream Leads to support the development and implementation of the three work stream delivery plans. |
| **4 Our approach to managing Culture Change – working with Oxford Brookes University (Institute of Public Care)** |
| We believe that at the core of delivering successful and sustainable integration is effective culture change at all levels in the system from front line practitioners to executive teams across all partners. It was agreed that we needed help to do this successfully and have commissioned the Institute of Public Care, part of Oxford Brookes University to advise and support us on this journey.  The reason for approaching them is that they have worked with health and social care partners in Greenwich, one of the pioneer sites, for the last five years with impressive results in terms of embedding integrated models of work and integrated teams that enable much more effective navigation of the system by patients and service users and, as a result led to impressive reductions in non-elective hospital admissions. This resonates very strongly with the Sutton Approach and how we aspire to improve the quality and experience of services and improve the health and wellbeing of the population.  It is also recognised that whilst the initial period of consideration of the Better Care Fund is 2015/16 that this is a long term piece of work that will take time to really embed sustainable change and improvement. For this reason they have been commissioned to work with Sutton for three years. Whilst we have not mapped out the detail of what will happen across the entirety of this time period we have agreed the following priority areas for the first year (which commenced in June 2014):   * Establishing and running an Action Learning Set for the four Integration Facilitators and three Work Stream Leads to support them in their leadership roles in taking forward our integration delivery planning; * Facilitating workshops and development work with all stakeholders to support the introduction of an integrated Older Peoples Pathway for Sutton – this pathway is so central to work on reducing non-elective admissions as well as its impact on the work streams that it was a clear starting point for our integration journey; * Undertaking a headline evaluation of the health and social care integration pilots commissioned in 2013/14 in order to extract learning about the process of developing and agreeing those pilots and the way that they are working in order to inform our thinking on integration going forward; * Acting as a Critical Friend to our work and our approach; and * Providing the opportunity to learn from their experience of working with Greenwich and other parts of the country on their respective integration journeys as well as access to their Network where there is the opportunity to share experience with our parts of the country and understand routes to adapting best practice to best work within the features and characteristics of need and service configuration in Sutton. |
| **5 Cross Cutting Themes – The Golden Threads** |
| Through discussions at the OSCC and the workshops to establish our work streams there was agreement that there were a group of cross cutting themes across all our work that were most effectively done justice to by considering them under all three work streams rather than only under one.  These are:   * Protecting Social Services – LB of Sutton already has a Care Act programme structure and establishing something doing very similar work felt like a duplication thus it was agreed to maintain good links with that work stream and also ensure that all three BCF work streams took full note of the requirements for protecting social services and built into how they will work; * Dementia – as well as improved dementia diagnosis being the local BCF metric in Sutton all stakeholders agreed that more effectively meeting the needs of people with dementia sat within all three work streams and so would be built into the delivery of each rather than residing solely in the mental health work stream; * Carers – the role of carers and ensuring that they are a key part in the integrated network of care for many patients and service users meant that this needs to be considered across all work streams; and * Complexity – effectively meeting the needs of people with complex needs is central to the work of changing the dynamics of the overall health and social care system and will have a significant impact on non-elective admissions thus it has been agreed to consider this within all three work streams. |
| **6 The Enabler Work streams** |
| We have established three enabler work streams that will support all three delivery work streams and any other work we are undertaking to deliver the Better Care Fund in Sutton. These are:  **A. Communications & Engagement**  This work will report into the Transformation Programme Board and, as necessary, into the One Sutton Commissioning Collaborative. The BCF Programme Manager is working with the Communications teams at both LB of Sutton and Sutton CCG to set in place joint initiatives and approaches to communicate with all stakeholders and are engaged with the implementation of the work. This includes:   * Contributing updates on progress in existing public communications and newsletters in the borough; * Working with Healthwatch to communicate progress and seek views through their network; * Attending events organised by stakeholders across NHS Trusts, patients, carers and public (including the Sutton Patient Reference Group), voluntary sector fora including the Sutton Health, Wellbeing and Social Care Forum and the Children, Young Peoples and Families Forum and other relevant meetings such as the Sutton Senior Forum working on the basis of going to where people are rather than asking them to come to us; * Ensuring that all stakeholders are well represented and involved at all levels of activity in rolling out the BCF; * Using websites and other social media to get as wide coverage as access to information as needed; and * Being open to other approaches and ideas if our initial approaches are less successful than anticipated or there are parts of the community or network of partners we are not successfully engaging.   As well as drawing up a joint engagement plan for the Transformation Programme Board and the OSCC we will be undertaking an Equalities Impact Assessment to ensure what we are planning to do and how we are planning to engage partners in doing it does not serve to make access and quality of delivery and outcomes more difficult for any parts of the community and this is something that will be repeated and updated through the implementation process.  **B. Workforce**  We recognise that the changes planned through the implementation of the BCF will mean changes in both the way that organisations, professionals and sectors work together but also in the skill mix, experience and working practices that will be needed to enable these changes to embed and change the ways that we work.  This work stream will also be used to plan for meeting the training and skills needs of an integrated workforce and planning for how we prepare for seven day working and be best placed to have the right size and breadth of work force to successfully make this transition.  Alongside the culture change and organisational development work that we have commissioned from Oxford Brookes University the workforce leads at LB Sutton and the community health services at the RMH will work with the BCF Programme Manager and the chairs of the Transformation Programme Board to agree how this process of planning and change is managed over the coming years to ensure that the volume and nature of particular staff resources is in line with what is needed to take the integrated locality teams forward successfully.  As the work of establishing these integrated teams moves forward and all stakeholders develop a closer understanding of the opportunities that could arise then we will need to adjust and expand this enabler stream accordingly when working through the role of the voluntary sector, carers and other agencies that will have a role to play in effective integration.    The detail of this work stream has not yet been agreed and it is important to note that this is being developed alongside the work in the local authority to prepare for the implementation of the Care Act from April 2015.  **C. Performance & Finance**  This enabler stream will track performance against the BCF metrics as well as planned savings and expenditure within the pool and in terms of reduced non-elective admissions. This will also pick up the reporting of any other local metrics we will use to assure progress.  Due to the need to ensure that work streams have a clear focus on delivery reductions in activity and generating the efficiencies to enable investment in new community services all reporting is being reviewed following this submission and an agreed data set and monthly reporting arrangements will be finalised in November as se out in the milestones above.  Work stream leads will be responsible for reporting on progress and delivery to the Transformation Programme Board which is accountable to the OSCC who will ensure that progress is on track. |
| **7 Interdependencies** |
| As described through this section of the submission there are a number of interdependencies across all strands of the work in our BCF approach. Given that there are these interdependencies across the work streams the BCF Programme Manager is a key component in ensuring that there is clarity about accountability for particular deliverables or components of the integration work. He will work with the work stream leads and the Integration Facilitators to ensure meaningful monthly reporting and robust programme management arrangements across all elements of BCF delivery.  The clearest is in terms of the work of the Unplanned and Planned Care work streams and we believe that by running these work streams alongside each other we are best placed to ensure this is a strength rather than risk duplication of effort. This will also be supported by the work of the Integration Facilitators in directly supporting the implementation of the integrated teams.  Indeed, by forming a Learning Set across the three work stream leads and the four Integration Facilitators it is hoped that they will learn from their experiences in taking the work forward and operate as a team that reaches across all areas of activity in our BCF so that learning is not restricted to particular service of population areas and there is a real sense of this being a unified programme of activity.  In section 6 of the submission we describe the many levels of alignment between the BCF work and the strategic priorities of the local authority and the CCG which have acknowledged and will use as strength in being able to articulate an integrated vision and strategy against which all our work can be mapped. This will be invaluable when working across partners and staff within each organisation as well as our work with patients and the public in giving a clear picture of how we want to move forward and what we want to achieve. |

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

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| Below are set out the governance arrangements in place in Sutton to drive the integrated care agenda in Sutton.    The **Sutton Health and Wellbeing Board (HWB)** has strategic oversight and governance of the Sutton BCF and related arrangements. This Board meets quarterly and will receive summary reports on progress, outcomes and exceptions on performance and risks.  The **One Sutton Commissioning Collaborative (OSCC)**, which meets monthly, is the senior officer joint board that supports the HWB by developing and implementing commissioning plans to deliver the strategic objectives of the HWB, and to ensure executive delivery and monitoring is carried out. It will ensure monitoring of BCF progress and regular updating of the risk register associated with such performance.  The format of the OSCC has recently changed to reflect the importance of involving senior provider representation in ensure the greatest likelihood of delivering the BCF and an integrated system and also includes the HWB vice chairs to ensure a strong working relationship across the HWB and OSCC. The meeting is held in two parts with Part 1 having a wider membership that incorporates senior representation from London Borough of Sutton from adult social services and children services and senior representation from Sutton CCG as well as director and clinical lead membership from each of Epsom & St Helier University Hospitals NHS Trust (ESTH), Royal Marsden NHS Foundation Trust (RMH) and SW London & St Georges Mental Health NHS Trust (SWLSG), from the voluntary sector, Sutton Healthwatch and the HWB vice chairs. This is followed by a commissioner only Part 2 session to pick up on particular commissioning issues. Both parts of the meeting are chaired by the Strategic Director of Adult Social Services, Housing & Health from LB Sutton and the Chief Operating Officer from Sutton CCG.  The purpose of working in this way is to ensure senior provider involvement in strategic decision making to strengthen Sutton partnership working and provide additional provider impetus in implementation because there is greater provider ownership of decisions. This approach also means that there is the opportunity to address provider delivery concerns at both the OSCC and the Transformation Programme Board (see below) if required.  The **Sutton CCG Board and the Council’s Committees** will continue to have statutory budget responsibilities. This includes those decisions on Council budgets for inclusion in the BCF in 2015/16 which will be made in March 2015.  **The Transformation Programme Board** carries out the detailed monitoring of BCF progress and the delivery of commissioning plans in the Joint Health and Social Care Strategy, and related Winter Pressures or other plans, and puts recommendations to the OSCC. Membership will include NHS providers (RMH, ESTH and SWLSG), as well as Sutton CCG and LB Sutton officers. This Board also has a close link to the Sutton Urgent Care Working Group and Systems Resilience arrangements.  **The Better Care Fund Programme Manager** will ensure that work streams produce monthly reports on progress and also have work stream risk logs in place that are regularly reviewed and updated. This encompasses ensuring monthly reporting at work stream meetings that work stream leads will report on to the Transformation Programme Board. The BCF Programme Manager will be responsible for providing a monthly report to the One Sutton Commissioning Collaborative and for update reports to the Health and Wellbeing Board.  The bodies listed above will interface with other relevant statutory and non-statutory governance forums, including:   * The **Sutton Transition Board,** which oversees the implementation of the Transition Plan for those with long term health and social care needs between 0-25 years. It is chaired by an elected Member, and has commissioning, parent, advocacy and multi-agency representation. The BCF progress for these people will be monitored as part of the Transition Plan for Sutton by this Board. * The **Sutton Safeguarding Adults Board,** which is accountable through the Independent Chair and Director of Adult Social Services (DASS) to the Council’s Adult Social Services and Health Committee. |

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| **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** |

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| The delivery of the Sutton Better Care Fund will be focussed around the three work stream groups named in section 4A. The chairs of these groups are members of the overarching delivery group for the Better Care Fund in Sutton which is called the Transformation Programme Board and is co-chaired by the Executive Head of Adults and Safeguarding at LB Sutton and the Director of Commissioning and Planning at Sutton CCG. The three work stream leads are responsible for producing monthly reports on progress in delivering their respective work streams.  It is important to note that the membership of the work streams and the Transformation Programme Board is made up of key representatives from the CCG and Local Authority as well as from local providers, the voluntary sector and Sutton Healthwatch. This helps ensure an open, inclusive and transparent approach to managing progress and delivery across all partners in taking forward the integration agenda in Sutton.  Progress is reported through the Better Care Fund Programme Manager, who will assure the timeliness, accuracy and relevance of what is reported on a monthly basis. The work stream leads line of accountability is to the Transformation Programme Board, the chairs of which are accountable to the OSCC. Updates will also be made to each meeting of the Health & Wellbeing Board which holds the overarching responsibility. There is also regular reporting within London Borough of Sutton and Sutton CCG.  Where implementation and delivery issues arise that cannot be resolved within the work streams or at the Transformation Programme Board there are arrangements in place to escalate to the OSCC. The membership of the OSCC is made up of senior management representatives from the CCG and local authority together with senior provider representatives, the voluntary sector and the vice chairs of the Health and Wellbeing Board who are the Cabinet Member for Adult Social Services, Housing & Health, the chair of Sutton Healthwatch and the chair of Sutton CCG. The OSCC is co-chaired by the Strategic Director for Adult Social Services, Housing & Health at LB Sutton and the Chief Operating Officer for Sutton CCG.  This means that the membership have the seniority, authority and strategic oversight of the agenda to be best placed to address issues that arise across organisations, stakeholders and professional groups and map out how areas of difference in developing an integrated system are best addressed. If issues of performance or delivery in implementing the model set out in the Sutton Better Care Fund submission arise this group is equally well placed to agree how these are best resolved whether within particular organisations or across organisations or sectors.  Although not anticipated, there is also the ultimate option of taking issues back to the Health & Wellbeing Board if any core differences arise.  It is also worth noting that the Better Care Fund Programme Manager has a joint and equal accountability to the local authority and Sutton CCG and whose time is equally split between the two organisations and is equally responsible to the Sutton CCG Director of Commissioning and Planning and the local authority Executive Head of Adults and Safeguarding. This has the benefit of embedding the planning and delivery of the implementation work in both organisations. It is hoped that this will help with ownership of the agenda which will help support effective delivery. |

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| **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. |

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| **Ref no.** | **Scheme** |
| 1 | Unplanned Care  To establish an integrated community health and social care system that reduces demand for care home, hospital and A&E admissions and attendances.  Working alongside the Planned Care work stream (or scheme), we will combine community health care, social services and commissioned voluntary sector provision to integrate planning and activities with the acute hospital. This will maximise resources along the length of the unplanned care patient pathway to support diversion back home from A&E and prevent admission where appropriate. This will lead to greater efficiencies in discharge over 7 days, reablement and rehabilitation planning and delivery for patients. |
| 2 | Planned Care  Working alongside the Unplanned Care work stream (or scheme), to establish an integrated community health and social care system that reduces demand for care home, hospital and A&E admissions and attendances through integrated care planning, multi-disciplinary working organised through integrated locality teams.  Core to this strategic objective is early identification of those at risk of hospital admission so that a planned approach to care becomes the default rather than there being a primary focus on the Unplanned Care pathway. |
| 3 | Mental Health  The key elements of this work stream are:   * This work is largely aligned with the core BCF work on Unplanned and Planned Care in order to provide a platform for wider integration in the future. This means that the thrust of this work stream is:   + Through a focus on ensuring that the needs of people with dementia are addressed in the other two work streams   + Identifying opportunities to provide a holistic approach to care in line with the Parity of Esteem agenda   + Collecting the learning from this work to apply more widely in integrating mental health with other health and social care provision * Improving support to carers in order to strengthen integrated team working and recognising the crucial role if carers in this |

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| **5) RISKS AND CONTINGENCY** | |
| **a) Risk log** |
| 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. |

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| **There is a risk that:** | **How likely is the risk to materialise?**  *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely* | **Potential impact**  *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*  *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)* | **Overall risk factor** *(likelihood \*potential impact)* | **Mitigating Actions** |
| The BCF fails to deliver forecast shifts in activity in 2015/16 | 4 | 4 | **16** | A realistic savings target has been applied to the BCF. There is system confidence that the scheme can be delivered.  Detailed planning with NHS and social care providers to follow BCF submission to ensure providers meet performance and cost targets.  Oxford Brookes University have been commissioned in 2014/15 to ensure delivery of cultural shift. QIPP savings generate investment pool – no further investment in BCF if not generated. CCG also holds reserve for acute over performance. |
| The BCF is a new policy change requiring new ways of working between stakeholders (i.e. LAs, CCGs and HWBs) | 4 | 4 | **16** | Heath & Wellbeing Board will demonstrate leadership for joint working to all partners.  Sutton has developed a governance structure that brings together leaders from both the Sutton CCG and LB Sutton as the One Sutton Commissioning Collaborative as well as leaders from the provider organisations – this group considers issues of integration, including organisational development and training requirements. This group will consider future OD requirements required to transition to new ways of working.  The Joint Strategy for Health and Social in Sutton sets out the agenda that the local authority and CCG seek to jointly address under the strategic direction of the Health & Wellbeing Board. This can be found via the link in the references section at the front of this submission however the headlines are as follows:  Workforce development plans will specifically cover the cultural change required for integrated working at the frontline. |
| The re-tendering of community health services does not provide a service that is able to meet BCF expectations for integration and setting in place a service configuration able to deliver the National Conditions | 4 | 4 | **16** | The delivery plans being set in place to deliver the BCF will have a strong focus on the requirements for integration and the National Conditions and will place a strong focus on maximising efficiency and effectively so that the services are sustainable.  This sustainability is also tied to delivering reductions in non-elective admissions which will be a key element in providing new investment in community services.  The third element of the mitigation is ensuring strong links and co-ordination between the work to deliver the BCF and the development of the tender and service specifications for the new community health service. |
| Failure to align Call to Action, Better Care Fund programmes and Joint Strategy for Health & Social Care as a result of conflicting perspectives | 5 | 3 | **15** | Joint work between Sutton CCG and LB Sutton to develop joint plans, agreed with the HWB, which create a clear link between the Call to Action, Better Care Fund, Joint Health and Wellbeing Strategy and Care Act  Reporting to meetings of senior teams, members and the Board in CCG and the Council led by and attended by CCG Chief Officer and LB Sutton Strategic Director of ASSHH.  All strategy, schemes and plans fully debated and understood.  Transparency over financial plans on both sides including savings |
| Failure to deliver new operating model of integration, joint assessments and better ways of working in the community | 5 | 3 | **15** | Pump priming in 2014/15 for workforce development, joint commissioning, and service redesign in preparation for 2015/16.    Shape markets through early phases of commissioning to ensure whole system capacity (i.e. home care).  Realign resources to mitigate demand for acute services.  Work with Merton on community services contract recommissioning for April 2016. |
| Introduction of Care Bill results in higher than budgeted levels of demand/cost; and higher than budgeted capacity for carers services, eligibility assessments, and other requirements | 4 | 3 | **12** | £600k set aside in 1516 BCF for Care Bill based on DH guidance.  Forecasts will be reviewed as statutory guidance is published and modelling updated.  Review forecasts when Care Bill Programme delivers reorganised services to meet changes in assessments etc. |
| There is a risk that the pooled funds overspend, particularly where cost is activity based | 3 | 4 | **12** | Sutton CCG and LB Sutton have had constructive discussions which are on-going. Spend will be rigorously monitored through the OSCC (as it currently is under s256 arrangements) and options around risk share are being developed. Risk share arrangements already exist, an example is the pooled community equipment service where risk is shared in proportion to contribution. Options for other areas include share risk in proportion to the contribution to the pooled fund or, depending on the circumstances, a carry forward of the deficit ( or surplus ) in the LA with a plan to recover ( given the pooled nature of the BCF funds ). |
| Failure to deliver 7 day working to meet BCF hospital discharge targets | 4 | 3 | **12** | 7 day access to therapy, in reach community services and emergency duty social work already in place.  Services will be redesigned in 2014/15 to ensure 7 day working across whole system supports DTOC targets, including primary care. |
| Increasing demand on services through demographic factors such as an ageing population as well as increased service expectation | 3 | 4 | **12** | Sutton CCG financial plans include accounting for demographic growth. BCF pooled budget reduced from draft submission to mitigate amount of risk sharing.  Other (e.g. mental health) budgets aligned to meet BCF targets and enable expansion of pooled budget over time after April 2015. Also much better information and advice service as Care Act requirements implemented which will have an impact on diverting demand for services.  Contingency plans are agreed to cater for acute sector risks that can be deployed into pool if available.  Additional contingency to be designed into joint funding plans following 2014/15 redesign on new model.  Impact on NHS trusts to be mitigated through process of development of new model in 2014/15 and joint commissioning (including that with Merton). |
| The impact of work in neighbouring CCGs and BCF areas could adversely impact on Sutton plans. | 3 | 4 | **12** | Sutton already works closely with Merton to ensure consistency in approach. This will be extended to work closely with Surrey Downs CCG and partners as the other main user of Epsom & St Helier University Hospitals NHS Trust |
| Patients do not understand the new system or that we fail to capture the impact | 3 | 3 | **9** | Communications and engagement enabler work stream will have a strong focus on ensuring all stakeholders have a good understanding of the changes we are looking to set in place. We will also consider issues of patient navigation around the system within the planned and unplanned work streams. |
| Shifting of resources towards community providers destabilises one (or more) acute provider due to the cumulative impact of multiple BCF plans across the area | 3 | 3 | **9** | Close joint working with acute provider and associated mental health trust in 2014/15 to prepare for new BCF approach in 2015/16  Monitor impact through SWL Collaborative Commissioning and overall 5 year strategic plan  In annex 2 – provider Commentary- the provider is set the question ‘Can you confirm that you have considered the resultant implications on services provided by your organisation? Plans are set out in 1516 commissioning intentions. Providers are members of the OSCC. In many ways the acute Trust welcomes initiatives to reduce NELs as the amount of activity for which the Trust is paid a marginal rate and makes a loss. The Trust will remove equivalent cost as a result. Thus schemes to reduce NEL can actually increase the sustainability of the acute provider rather than threaten it. The commissioner and Trust thus have a common incentive.  In addition discussions on risk share and reward will take place with the Trust. |

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| **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 |

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| **Summary**  The Sutton CCG five year financial plan includes QIPP savings for the years 2015/16 to 2018/19 (including savings from reductions in non-elective admissions) that generate fund for investment in community and mental health services in accordance with Sutton CCG and LB Sutton joint Health and Social Care Strategy. Such investment of savings will enhance the BCF over this time. Investment will be made to the extent that savings are made and considered to be recurrent. Sutton CCG will make investment in discussion with the OSCC reporting to the HWB.  Sutton CCG is working collaboratively with providers on risk sharing and incentive arrangements to support the achievement of QIPP savings, in particular from reductions in non-elective admissions.  **Risk sharing arrangements between commissioners across health and social care**  The BCF pooled fund is not at risk from non achievement of the non elective admission reduction as it is fully funded from known or notified allocations and not reliant on acute savings to fund schemes. Acute budgets are not part of the BCF pooled funds. The Local Authority was resolute that it was not in a financial position to enter into a risk share agreement and both parties agreed it was not prudent to make firm expenditure commitments based on anticipated acute savings. Rather it was agreed that acute savings realised would be retained by Sutton CCG who, working with the HWB, would determine where those savings would be invested in the future. Given Sutton CCG’s stated strategy to reduce hospital admissions where appropriate, savings will be invested in community services which are very likely to enhance the quantum of the BCF pool. Only when savings are considered recurrent will they be invested recurrently in community services. Thus the BCF will grow over time as acute savings are made and activity shifts to a community setting. The new P4P arrangements mean that some £900k of the calculated BCF fund is performance linked. Thus should savings not be made this funding is retained by Sutton CCG. However, as said the BCF is already fully funded, and the effect of the Performance element in the case of the Sutton arrangements is that to the extent acute savings are not made, they will not be available for future investment in the BCF.  The P4P element is calculated by taking a 3.5% reduction in NEL multiplied by the NHSE average cost of £1,490 per admission.  Sutton CCG will work with the HWB through the One Sutton Commissioning Collaborative (OSCC) to agree how recurrent savings will be invested in existing and new BCF schemes and developments.  Where savings have been determined in year and are available for investment the CCG will work with the OSCC to determine the use of these savings will may be recurrent and non recurrent (e.g. to pump prime new schemes).  Sutton CCG will continue to ensure strong financial management is in place so that decisions are made on robust data.  It might be argued that the incentive for the LA to support the savings target is diminished as there is no risk share. However, the LA strongly supports the BCF model and has worked very constructively with the CCG in setting up the Sutton arrangement. The LA has confirmed that NHS funds will not be used as a substitute for LA funding. It is fully aware that acute savings made will be reinvested in services that are part of the BCF and therefore enhance the work of the pooled funds to the benefit if both the CCG and LA.  It should be noted that the acute provider (and other providers) are members of the OSCC.  **Risk sharing between providers and commissioners**  The commissioner draft commissioning intentions ( due to be sent to providers formally on 30 September but already shared with them ) states under the following sections :  3.2.3 Common incentive framework  *Commissioners will continue to sign up to national CQUINs and will honour those medium term CQUINs already in existence.*  *We will develop local mechanisms for using CCG funding to creative a common incentive framework that will allow us to take a more strategic whole system approach to the use of incentives to achieve desirable system change.*  3.2.4 Common payment structures  *We will continue to support the use of national currencies such as PbR, Best Practice Tariffs and the extension of Maternity Pathway Payment.*  *In addition we will develop innovative local payment structures outside out traditional block contracts and PbR*  For example, at this time the acute contract is run under the normal arrangements for PbR – however discussions will be held with the acute Trust on risk share and performance reward with regard to the NEL admission reduction.  As far as the current contract for community services is concerned, CQUIN targets and payments are used to incentivise the community provider to support reduction in non-elective admissions. This contract is being re-procured and the new specifications will include further incentives around achievement of unplanned care outcomes. |

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| **6) ALIGNMENT** | |
| **a) Please describe how these plans align with other initiatives related to care and support underway in your area** |

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| As described earlier in this submission, our BCF plans are driven by the Joint Strategy for Health and Social Care in Sutton which has been approved by the Health and Wellbeing Board. With both BCF implementation and delivery of the Joint Strategy coming under the auspices of the governance structure set out in section 4 of this submission there is the opportunity for both the OSCC and Health and Wellbeing Board to oversee progress and delivery and to cross reference the two areas of work to ensure that alignment is retained through the period of implementation.  The approach taken to reducing non-elective admissions is aligned to the Sutton CCG Operating Plan and Five Year Strategy, including working with the other south west London CCGs and local authorities, and this is reflected in the fact that the elements of our schemes that are focussed on reducing non-elective admissions align with QIPP plans and the recent Systems Resilience submission.  To support our joined up narrative we will ensure that our work streams are also consistent with our proposals for primary care co-commissioning. We are also using the opportunities provided by the Avoiding Unplanned Admissions Enhanced Service to draw strong links with our work to implement a comprehensive and effective approach to risk stratification, integrated care planning and multi-disciplinary decision making across all GP practices in the borough.  Within the CCG plans is a re-tendering process for community health services that will see a new contract in place from April 2016. The re-tendering and delivery of the BCF are strongly linked and co-ordinated to ensure they are aligned and consistent.  Our BCF plans have also been aligned with the LB Sutton Care Act implementation programme and is considered corporately within the local authority as part of the LB Sutton wide Smarter Council programme which is putting in place arrangements and programmes of work to maximise the effectiveness and efficiency of all local authority processes and functions.  Following a period of public consultation, the implementation of the new joint Sutton Carers Strategy references strongly across both the Care Act implementation work and our BCF plans.  In this way we can describe an integrated and consistent narrative across all our major streams of work in both the local authority and CCG and how this comes together through our joint governance structure.  As part of our BCF implementation we are developing a communications and engagement strand to ensure that local people, as well as all our partners encompassed in our governance structure, can understand what we are doing and see how all the various strands come together as an integrated Sutton Approach. By having a clearly understandable narrative we also believe that this is the best way to enable partners and local people to contribute to, and influence, the detail of our implementation so that we are best placed to ensure the system is comprehensible, navigable and patient or user centred.  The LB Sutton and Sutton CCG have also made a joint bid to the Integrated Digital Care Fund for a bid to provide a data sharing platform that will initially support data sharing between social services and primary care and provides the opportunity to subsequently further develop this to support a fully integrated data sharing system supported by the necessary patient consent and information governance requirements. Sutton has successfully reached the final round of this process and should be notified of the final outcome by the end of September. This is a matching funding proposal that would inject £1million into this work over the next three years. The benefits that would be accrued from this bid, if successful, are set out in the HWB Benefits tab in Part 2 of this submission. |

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| **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** |

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| As described above, the Sutton BCF Plan has been fully aligned with the existing 2 year operating and 5 year strategic plans as well as local authority plans and the plan as a whole is encapsulated by the Joint Strategy for Health and Social Care in Sutton.  Sutton shares the same community health services provider, the Royal Marsden NHS Foundation Trust, at least one of our main acute providers, Epsom & St Helier University Hospitals NHS Trust, and our main mental health provider, South West London & St Georges Mental Health NHS Trust, with our neighbour Merton. In order to ensure consistency in our relationships with these providers we liaise regularly with the BCF Project Manager for Merton who also sits on our Transformation Programme Board. We believe that this is critical in supporting successful implementation by avoiding the imposition to two very different approaches to redesigning care and monitoring change. Of course, we have different populations with different needs so where there may be a need to work differently we have the strength of relationships and governance arrangements to work through those differences in approach so that they do not generate any unnecessary difficulties for our providers in operationalising the changes we will be making. |

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| **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. |

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| Much of our BCF work has primary care input often at its heart, either through lead professional arrangements or the risk stratification and identification of patients.  Sutton has 27 practices, 26 of which are PMS contractors and 1 GMS contractor. Within the PMS contract there are a range of KPI’s that incentivise practices to undertake actions on behalf of their patients that fully support the improved access to services and reduction in use of hospital services including reduction of non-elective admissions.  The CCG has expressed an interest in the delivery of co commissioned primary care services in Sutton, we are keen to progress this rapidly to support delivery in the area and align incentives across the system.  GPs locally and separately are forming a Federation of practices to support local delivery and provision of services across the population of Sutton. Although currently there is no further detail to add to this submission this is an area that could be productively used to support integration and a multi-disciplinary approach to care across Suttons localities.  The CCG is actively recruiting for a senior primary care commissioner to support this developing area of work and whilst recognising the potential for conflicts of interest we continue to pursue this agenda. |

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| **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** |

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| **i) Please outline your agreed local definition of protecting adult social care services (not spending)** |
| The Sutton definition of protecting adult social services is **to deliver the requirements under the Care Act, and to build upon the on-going transfer investment in social care with health gain, through focus upon prevention, early intervention and for health and social services delivery, aimed at avoiding admissions to institutional care (especially care homes and hospitals).**    It focuses upon the statutory requirements of meeting the eligible needs of Sutton residents (including the new criteria within the forthcoming Care Act). It is based upon the social asset based model of helping people with health and social care needs to meet them by retaining their dignity and independence in their own homes through access to family, neighbour and community support together with specialist or essential health and social care and support.  The social services’ lead on multi-agency safeguarding adults will be developed under the Care Act, with local priorities secured within the BCF for Mental Capacity Act assessments, Deprivation of Liberty assessments, and general multi-disciplinary safeguarding adults activity.    The BCF guidance stipulates that the costs of implementing the Care Act are to come from the BCF and therefore form a ring fenced pooled budget item separate from the Council’s aligned social care expenditure which will be enabled in access against eligibility criteria through joint assessments outlined in the BCF Plan. |

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| **ii) Please explain how local schemes and spending plans will support the commitment to protect social care** |
| The development of previous transfer of funds to social services with health gains will, under the BCF, include key commissioning targets and funds to support eligible people in their own homes and maximise choice and control through homecare and personal care provision.    The BCF will also consolidate both Sutton CCG and LB Sutton expenditure on carers’ support in new integrated commissioning and procurement from 2015/16 that will secure new Care Act requirements, but also the respite and related support in transfer funding will be used to better effect to support more carers through personal budgets, increasing their choice and control.    The inclusion of reablement (Council funded as well as transfer funded), and in reach hospital social work services in the BCF will help protect the social services outcomes for those at risk of admission or admitted to hospital. An example to build upon is the Sutton Learning Disability Clinical Health Nurse employed by the Council and funded by the Sutton CCG, which supports those admitted to hospital to ensure they receive appropriate treatment, discharge planning and are safeguarded. |

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| **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.)** |
| Within our BCF pooled budget the sum of £1,990,000 has been allocated for the provision of adult social care services within Sutton.  This is based on existing spend allocation for services.  The £1,990,000 is focused on services supporting people to live at home and preventing hospital admissions.  It primarily provides care at home and a number of short term respite support type services.  This investment contributes to the overall BCF agenda to reduce demand on acute services and in social are to the reduction in residential and nursing home placements.   £600,000 (our proportion of the national £135M) has been allocated for implementation of Care Act duties. |

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| **iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met** |
| £600,000 of our BCF pooled budget has been allocated for the implementation of Care Act duties.  This funding will be targeted at meeting the new duties and demands including information and advice, safeguarding, and the new duty in relation to carers’ right to assessment and access to services on an equal basis to care for individuals and in meeting additional costs of care and support services for carers arising from their assessments. |

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| **v) Please specify the level of resource that will be dedicated to carer-specific support** |
| Within the BCF pooled budget an allocation of £650,000 has been included which is based on existing spend and support for carers across the CCG and the Council (£350,000 CCG funding and £300,000 Council funding).  As stated in section (iv) above, and additional £600,000 of BCF pooled budget has been identified as supporting a range of new duties including information and advice, safeguarding, and spend related to carers’ assessments.   However on our analysis and projections related to the new duties for assessing carers needs and supporting them through eligibility for care and support we consider that the projected demand will be significant higher than the identified funding available.  The projected new demand comes from the implementation of the Care Act duties and will predominately be additional demand upon social care services.  In 2013/14 650 carers were assessed as eligible (through the current Fair Access to Care Services eligibility criteria) for care and support through community care assessment.  Our projections are that and additional 1,500 carers will come forward for assessment under the new National Eligibility Criteria in 2015/16 and a further 1,500 in 2016/17.  Our analysis is that the new National Eligibility Criteria, as currently drafted, is a lower threshold to gaining access to statutory care and support funding than the current FACS criteria.  On these projections our determination is that the funding available will be insufficient to meet the new burdens of implementing the Care Act including supporting carers. |

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| **vi) Please explain to what extent has the local authority’s budget been affected against what was originally forecast with the original BCF plan?** |
| No change has been made to the Councils contribution to the BCF pooled budget since the original BCF submission, nor to any other Council budget as a result of contributing into the BCF pooled budget.   The Council will not finalise its budget position for 2015/16 until March 2015, therefore the allocations within the pooled budget are provisional at this time. |

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| **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 |

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| The Health and Wellbeing Board endorses this BCF proposal’s strategic commitment to 7 day working that best meets the needs of those targeted in the BCF Plan at risk of hospital or care home admissions, and DTOC from hospital in line with the revised BCF guidance. This is in line with all London CCGs’ commitment to work towards all of the London quality standards from all providers from April 2014, including the move towards routine services being available seven days a week, with the first stage being a review focusing on improving diagnostics and urgent and emergency care.  The delivery of this commitment will be monitored by the Transformation Programme Board and reported to the OSCC.  Social Services reablement service currently operates on a seven day working pattern, between the hours of 7am to 11pm, supporting people discharged from hospital back to their own homes. Our commissioned home based care and support services also operate on a seven day working pattern. Social work support is currently provided out of normal office hours by our Emergency Duty Team arrangement between 6pm and 8am, Monday to Friday and over the 48 hour period covering weekends.    With the move towards locality focused working and closer integration within the hospital admission avoidance and discharge pathways, we would seek to structure our service to meet the potential demand for any additional assessment and transitional support required. This may include extending our social work services working within the hospital pathway to covering weekends, linked to new referral routes to home based care and support arrangements. Likewise we would consider how to work within locality multi-disciplinary teams to enable seven days access to our commissioned support services, thus enabling health colleagues to refer directly to support providers where there are emerging needs outside normal office hours.  Telecare and telehealth services, together with night sitting emergency services have been piloted in the integration and winter planning. Subject to the evaluation of these pilots in autumn 2014, these will be incorporated in the BCF Plan for 2015/16 to support 7 day working to support discharges from hospital.  Sutton CCG already commissions RMH to provide some seven day services. This includes the community nursing team which has a 7 day and night provision. This extended level of provision is only available for patients requiring significant nursing input. Newly commissioned services including the Community Prevention of Admission Team and the Rapid Response Team, including the new investment to support the older peoples pathway, are commissioned to provide a 7 day service operating 10am-6pm at weekends and bank holidays. The challenge of commissioning 7 day services includes the workforce within the teams not being large enough to support a 7 day working rota and additional staff from other teams being required to support 7 day working at enhanced bank rates. Sutton CCG is working with the provider to ensure services are correctly resourced at weekends to reflect the workload and that staff can be recruited to reflect 7 day working commitment. In addition we need to ensure other services which the teams may need to access to prevent an admission / facilitate a discharge are also available 7 days.  Sutton will also be working with local primary care providers to ensure the appropriate level and model of primary care provision as part of the range of seven day services to support discharge. We will work with NHS 111 to ensure that the Directory of Services reflects seven day provision in primary and integrated community provision including working with Merton CCG to ensure that the GP Led Health Centre in Mitcham, which currently opens seven days a week, continues to meet its contractual requirements  Sutton has also had a successful End of Life Care at home by choice service in 2013/14 upon which the BCF Plan builds an expectation that it will enable 7 day working to be available as necessary in 2015/16. This draws upon the START, community healthcare, and GP services and will be in corporate in the integrated community approach outlined in this submission. |

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| 1. **Data sharing** |

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| **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** |
| NHS commissioned services are using the NHS number as the primary identifier for correspondence. Primary care, through contract changes effective from 1st April 2014, will also use the NHS number to communicate with other services.  Local Authorities do not currently use the NHS Number as the primary identifier for correspondence across all health and care services but have plans in place to do so.  LB Sutton is in the process of adopting the use of the NHS Number as the primary identifier for correspondence. The reason that local authority workers cannot use the NHS number as the primary identifier at present is that 97.5% compliance has not been achieved in terms of NHS numbers in the care management system.    Sutton CCG is using the NHS Number as the primary identifier for correspondence.  LB Sutton is committed to ensuring the consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements, by April 2015.    LB Sutton has been granted N3 access and via the N3 link (PSN Gateway/Capita) to 5 NHS systems which were identified by Public Health Service as ongoing requirements. As part of the system access available LB Sutton has also been granted access to the Demographics Batch Service (DBS) which will allow LB Sutton to synchronise the Social Care Client Record system (Frameworki) with NHS numbers.  Local Authorities are in the process of procuring a system with the CSU that will allow LA workers to accept both the NHS number and Frameworki number. We hope to subject to funding being available to have completed full system implementation within 3 years.  The following work to date has been completed on implementing the NHS number as the primary identifier:   * The last upload of NHS numbers was provided by the NHS Personal Demographics Service (PDS) through their batch trace service in 2010. This produced a matching of around 50% of our customers and these NHS numbers loaded onto Paris the Sutton Legacy system. The original estimate of completeness of NHS number in Frameworki was 60%. However recent batch upload from the MACs services has increased the match to 93.3 percent. * LB Sutton had originally intended to submit an application enabling DBS access via the Health and Social Care Information Centre (HSCIC) through the Commissioned Safe Information Sharing pilot. LB Sutton remains open to investigating other options including a mini-spine solutions such as ‘quicksilver’ and inter-systems’ both of which offer NHS number matching as part of their inbuilt functionality. * The CSU/CCG have now approved and agreed a process for providing LA Registration Authority support and this has been commissioned. Technical changes to LB Sutton’s N3 link which are required to enable the connection to the DBS are still currently ongoing with Capita. * CSU support to access to the PDS will be required to find missing NHS numbers (as not all will be captured by the batch trace process). * The NHS number has also been added as a field on the Initial Contact forms designed to accommodate the new Adult Social Care Collections (Zero Based Review – ZBR); which went live in April 2014   The Action Plan going forward includes the following to be completed by December 2014:   * The next stage is to do a batch upload to match as many customers as possible through a detailed listing of first names and surnames. In excess of 93% has already been achieved. * By December we plan to have gained access to the PDS directly through SECSU to allow staff to look up NHS numbers for new clients where the NHS number is not known. Once access to the PDS has been agreed they will need to set up identified staff with the smart cards that will allow access. * As part of the ongoing process for keeping the NHS numbers up to date we will run regular reports that will identify missing NHS numbers. These reports will be circulated to the relevant managers for action as part of our regular data quality monthly reporting. They will also consider developing an NHS number for completeness performance indicator. |

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| **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))** |
| LB Sutton and Sutton CCG are committed to using Open APIs, Interoperability Standards, and Open Standards.  LB Sutton and Sutton CCG are committed to using Open APIs, Interoperability Standards, and Open Standards. The systems currently in use that have open API capabilities include:   * Staffplan (Homecare Roster) – LB Sutton * Teleconfirmation (Server) – LB Sutton * SPOCC – LB Sutton * EMIS Web – Sutton CCG * Vision – Sutton CCG * Framework-I - to be confirmed   NHS Mail is widely used across our partnered NHS organisations, for the secure transmission of patient confidential data, and the Local Authorities that we intend to share data with have implemented third party email gateway security solutions such as Egress Switch and Cisco Ironport.    Further work on this will take place during 2014/15. |

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| **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.** |
| The council has an action plan for developing our IG maturity over time. This plan is approved by the ASSHH DMT and subsequently reviewed by the Information Security and Governance Board. Quarterly updates on progress are presented to both Boards. The council currently complies with all level requirements of the IG toolkit 11.  Standard contract condition both service and general will be applied to all commissioned contracts for which they relate.  The council and partners are monitored for compliance with Data Protection Act through use of and internal audit of asset registers and information flow maps. The drive to share information appropriately to help improve the delivery of care has been embedded in the overall service transformation and delivery plans. |

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| 1. **Joint assessment and accountable lead professional for high risk populations** |

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| **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** |
| In line with the Avoiding Unplanned Admissions Enhanced Service, all GP practices in Sutton have identified a minimum of the top 2% of patients who are at the highest risk of hospital admission.  The approach that has been used is defined within the Unplanned Care Enhanced Service Specification. Patients identified via the risk stratification tool are reviewed at the multidisciplinary team meetings (MDTs) and a care plan developed, implemented and monitored to address identified needs.  Sutton is undertaking a small scale pilot of an integrated model of social and health care in one practice in each of the 3 localities. This will enable the learning from this integrated model to be spread rapidly and widely across all GP practices  In addition integration facilitators will work with all GP practices to accelerate implementation of an integrated model of care |

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| **ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population** |
| There are two joint processes for assessment outlined in the Joint Strategy for Health and Social Care in Sutton 2013-15 for those most at risk of admissions to hospital and care homes, and related loss of independence for users and carers. These are:  1. Building on the Older Peoples Pathway (OPP), **a joint assessment and discharge tool will be used by all the multi-disciplinary professionals**. The local plan is to extend this to include a new role of hospital “navigator” for patients and carers for those most at risk of hospital readmission and loss of independence. The BCF Plan will build upon this to integrate assessments across health and social care.  2. Under the **Active Case Management approach** outlined in the Joint Strategy for Health and Social Care in Sutton, from early in 2014 three Locality Multi-Disciplinary Teams (MDT) will be developed for combining the multi-disciplinary and multi-agency support needed by those most at risk of hospital or care home admissions with complex or long term conditions. Primary care, community healthcare, mental health specialists, and social services will form the core to these locality arrangements with voluntary sector input as appropriate. The OPP work has already identified a significant proportion of those with more than two conditions already experiencing multiple A&E or hospital admissions. The new GP led risk stratification tool introduced from January 2014 will support the development in a new operating model with localised targeting of people across primary, community healthcare, social services with long term conditions.  The local plan will be to ensure **a lead professional is assigned to cases identified through this process by September 2014**. This will build upon the social services user focused personal contingency plan (100% of those FACS eligible for social services), and the integrated reablement with community health services (covers all those supported by the ICOPP joint assessments from November 2013). It will also build upon the newly implemented primary care risk stratification tool (from January 2014).  Carers have asked for a systematic approach to joint assessments in 2015/16 to include consideration and the offer of a carer’s assessment. This would support the Joint Carers’ Strategy and the Council’s implementation of the Care Act.    The JSNA identifies, based on a wide range of public health data, those most at risk of hospital and care home admissions. The Joint Strategy for Health and Social Care in Sutton and the Joint Mental Health plans aim to complete the identification of those most at risk by September 2014 as outlined above and assign lead professionals to these people.  Of particular priority in Sutton, those with dementia form a key element to both local plans, and the development of a whole system approach to the dementia care pathway is integral to the BCF plans for the next two years. Older people already form a key part of the Joint Strategy for Health and Social Care in Sutton, and joint assessments linked to better identification of dementia has started in the hospital.    The Health Education South London (HESL) has awarded Sutton funding for 2014/15 that will support training and development of multi-disciplinary work across professionals in the community focused upon older people at risk of admission. This will support the cultural changes as well as the data sharing and patient feedback measures that are in the BCF plan to combine and improve outcomes.    In addition, new integrated joint assessments of need and support for children and young people between 14 and 25 years of age are being piloted from June 2013 between education, health, children and adult social services with a lead professional from a joint social services unit. The health needs assessments are led and coordinated by the Learning Disability Clinical Health Team, already under section 256 for 2013/14 and scheduled to be included in the BCF. The BCF Plan is to extend this approach to those 0-25 years with appropriate needs. This will support the incorporation of the Care Act and Children and Families Act implications in the BCF plans to improve outcomes through integration processes and services for all ages. |

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| **iii) Please state what proportion of individuals at high risk already have a joint care plan in place** |
| We are currently in the process of developing care plans for the 3,500 patients identified as being at the highest risk of hospital admission through the risk stratification process undertaken to meet the Avoiding Unplanned Admissions Enhanced Service requirements.  The three GP practices piloting the implementation of an integrated model of social and health care will facilitate the development of joint health and social care plans and share the learning across all GP practices  The integration facilitators will also work with all GP practices to develop a consistent approach to joint care plans |

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| **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 |

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| We are establishing Communication and Engagement as an Enabler Work Stream as part of our BCF planning as discussed in Section 4 of the submission.  Central to our approach is an appreciation that we cannot employ a one size fits all approach because different parts of the community will want differing levels of information and differing levels of engagement. The detail of this work stream will be worked up from October and will strongly cross reference with the various engagement approaches employed corporately within the local authority and the patient engagement work developed at the CCG such as the Patients in Control approach.  Central to this work is maintaining a strong feedback loop with Healthwatch Sutton to ensure that there is the appropriate level of information and engagement options. Links with Healthwatch are enhanced by the Chair and Chief Officer being fully involved in the various governance elements of our BCF infrastructure ranging from the Health and Wellbeing Board to the three main delivery work streams – Unplanned, Planned and Mental Health.  As part of this work we are keen to set in place a meaningful patient/service user experience metric which we can use to really test how our level of success in ensuring that alongside the establishment of integrated services that improve delivery and reduce emergency hospital admissions that we really do improve patient and service user experience. For this reason we have decided that rather than rushing the process, and putting something in place that would not be meaningful, we are not including a patient/service user metric at this time. We do not have anything already in place that would effectively measure experience against our BCF work so we will plan and commission this work properly and fully, working with Healthwatch Sutton, the GP practice based Patient Participation Groups and the borough wide Patient Reference Group. This will include consulting with patient and user panels on what they would see as priorities in improving experience and commissioning a piece of work which patients and the public would have confidence in recognising as a meaningful measure of improvements in experience. This will be completed within 2014/15 (including the establishment of a baseline) and will be incorporated into the BCF performance arrangements and reporting through 2015/16.  In terms of patient, service user and public engagement in the development of this plan, we can highlight the following:   * As part of the process of producing the original April submission two, multiagency, provider and user workshops as well as a series of open engagement sessions were held across the Borough to present and discuss the model being developed for delivering the BCF in Sutton. This included a public event with 80 attendees earlier in the year. This same approach has been maintained when considering how our existing plans matched up against the requirements of the September submission informed by the associated guidance and other communications. This has meant that whilst even greater emphasis is placed on reducing non-elective admissions that the main areas of work remain the same meaning that what is proposed has not been changed. An Equality Impact Assessment will be undertaken in the autumn to ensure that this emphasis has no negative impact on access or outcome for hard to reach or high risk communities; * At the end of April an implementation planning workshop was held that included representatives of patient groups which provided the opportunity to incorporate their views into how the work streams should come together and this configuration sits at the heart of our implementation plans in the form of our implementation plans; * We have maintained communication and discussion with Healthwatch Sutton throughout this process so that they are clear what we are proposing and have the opportunity to influence our thinking through the OSCC, Transformation Programme Board and workstreams as well as at the Health and Wellbeing Board; and * The proposals in the new submission were discussed at a Healthwatch information and engagement public event on 18th September 2014 attended by 50 local residents. Whilst it is recognised that this was only a day before the submission the meeting provided an opportunity to test how we are communicating with the local population and also to pick up any areas that may need refining in the implementation phase. This work is already ongoing and through patient feedback and other mechanisms such as complaints we were already aware of some of the key issues that patients and carers felt frustrated about. The Better Care Fund was additionally introduced at the Healthwatch Sutton 2014 AGM. |

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| **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 |

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| **i) NHS Foundation Trusts and NHS Trusts** |
| We have focussed our efforts on working with our local acute provider, Epsom & St Helier University Hospitals NHS Trust (ESTH), as the provider for approximately 85% of Sutton activity. However it should also be noted that admissions to all acute providers are recognised in our proposal.  Officers from the Trust and other local providers are now members of the reformed OSCC which will enable them to engage in senior level oversight of progress in implementing the BCF and help steer direction. They are also represented on the Transformation Programme Board, BCF work stream groups other workshops to establish the work streams and agree how we will all work together.  To support and strengthen CCG relationships with the Senior Management team at ESTH a series of meetings, held monthly offer an additional forum for Sutton CCG operationally and strategically about the issues we individually and collectively face. This is also incorporating an executive to executive meeting in early October where BCF will be discussed further.  The BCF Programme Manager also meets monthly with the Director of Service Development at ESTH at the trust to ensure a joined up approach to working with them and to get an early warning of any issues. This has been strengthened by the employment of a BCF project manager to work closely with all the work streams.  The BCF Programme Manager also met with the Trust’s Executive Team on 3rd September to talk through the approach being taken to deliver the reduction in non-elective admissions and to provide the opportunity to talk through any queries or issues where more detail was required.  This has enabled a high level of alignment in working with the Trust and continued to building on the positive working relationships with the Trust.  Whilst the large majority of our acute activity goes through ESTH we are also conscious that approximately 10% of activity is undertaken by SGH. Although we have not held specific discussions with St Georges we will work with Wandsworth CCG and other south west London CCGs to ensure that we maintain a consistent approach in how we work with them and not set in place separate arrangements that could create challenges for the provider. BCF conference calls across SW London take place weekly and additionally the CCG Directors of Commissioning meet monthly to discuss current issues and where we might align to provide more coherent services to patients.  We are also working closely with RMH in developing and taking forward our BCF plans. As well as being part of all the governance groups and workshops as our acute provider there are monthly meetings between their Community Health Services Director, who is responsible for all their community services in the borough, and the Executive Head of Adults and Safeguarding at the LB Sutton. As well as monthly meetings between the two officers, the Director of Commissioning and Planning at Sutton CCG and the four Integration Facilitators (described under section 4) meet to ensure a shared understanding of progress in implementation and a place to address any operational issues that may arise. Additionally the Unplanned and Planned Work stream Leads are senior officers at RMH and also two of the Integration Facilitators come from this organisation.  This means that the RMH sits at the heart of the work we are doing and has been closely involved in the planning process for a number of months.  South West London & St Georges Mental Health NHS Trust is also involved at all levels in the Sutton integration and BCF governance structures and are therefore involved in the development as well as the implementation of our plans. As described earlier, mental health services are currently aligned to our plan rather than being part of the BCF pooled budget at this time. Having said this, it is recognised that in order to derive the full benefits of integration we need to look at the whole person and we will aim to include mental health services in our BCF at the next stage. Alignment now ensures that we do not miss the opportunity for early progress by excluding them from this first stage of BCF implementation. This provides the opportunity for cross fertilisation of ideas as well as the potential to contribute to our work on reducing non-elective admissions as well as the important role of mental health services in ensuring the best possible dementia pathway and contributing to our work to improve our level of dementia diagnosis. |
| **ii) primary care providers** |
| All GP members of the CCG have been updated on the approach being taken with the BCF and the main components of our plans through a combination of mechanisms including:   * Regular information sent out to practices by the CCG * Presentations to each of the three GP localities on the main components and plans for the BCF * Membership of the Planned and Unplanned work streams by the three GP locality leads * This will be augmented by regular meetings between the GP locality leads and the four Integration Facilitators so that they are kept up to date with progress. This also provides the opportunity for the locality leads to work through any issues in implementing the integrated locality arrangements, ensuring that this work will be seamlessly linked to the work to support practices to successfully implement all elements of the Avoiding Unplanned Admissions Enhanced Service so that a culture of risk stratification and multi-disciplinary decision making and care planning is embedded across all staff groups. This in turn all contributes to the reduction in non-elective admissions.   This will ensure a high level of alignment and provides avenues for raising and addressing any issues in implementing our plans. |

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| **iii) Social care and providers from the voluntary and community sector** |
| The voluntary and community sector, including those who provide social care services, are represented at all levels in the integration and BCF governance structures including membership of the Health and Wellbeing Board and the OSCC. They are also represented on each of the work streams and therefore are closely involved in the plans to implement the BCF in Sutton and have a range of avenues through which to raise and discuss issues.   In terms of widening this communication and engagement across the sector there has been a presentation to each of the voluntary sector forums - the Health, Social Care and Wellbeing Forum and the Children, Young Peoples and Families Forum - to highlight the main themes, the approach to implementation and also in terms of how individual organisations and the sector as a whole can be involved in bringing the BCF to life.   Beyond this the BCF Programme Manager has met with the Director of the voluntary sector umbrella organisation, Sutton Centre for the Voluntary Sector, to ensure that these engagement and communication mechanisms are working effectively and provide the opportunity to review through the implementation process, as required.   For other providers such as residential and nursing homes, supported housing and home based care and support providers the Council has a well-established provider forum structure at which key issues for strategic development, including for example the direction of travel arising out of the BCF, is communicated and discussed.  The Council is undertaking a review of its approach to provider engagement and this will provide an opportunity to implement a formal link between provider fora and the One Sutton Commissioning Collaborative.  This will ensure that social care providers are engaged in the strategic development of the BCF and its drive to improve community care and support services. |

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| **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? |

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| The introduction of the BCF is likely to have far reaching implications in terms of the way that health and social care is provided in the future. Recognising the impact on providers, Sutton, through bodies such as the Sutton Transformation Programme Board, has engaged with local providers to ensure that there is a shared awareness of the likely changes.  When the changes to integrated care are fully implemented, the whole-system effects are expected to provide benefits to local acute providers. A reduction in the numbers of emergency attendances and admissions will relieve pressure on trusts’ A&E departments, better enabling them to meet the 4-hour A&E target and also reduce the amount of activity that is funded at the marginal rate (currently 30% of tariff).  The Sutton Health and Wellbeing Board projected reduction of non-elective FFCE activity on our acute providers is shown in the table below. This takes into account projected 3.2% growth and will enable Sutton Health and Wellbeing Board to deliver an overall 3.5% reduction on non-elective FFCEs.  Activity impact of Sutton BCF schemes on our main acute providers    These calculations have been shared with providers as part of the BCF submission process and will be used as part of the 2015/16 contracting process to reflect planned QIPP savings. Current forecasts to quantify the benefits of reduction of non-elective FFCEs for the BCF submission have applied the national average tariff for non-elective admissions of £1,490; however, further work is required to validate this forecast and we will continue to work with our providers to estimate the financial value of the reduced activity which will be incorporated into the 2015/16 contract.  Financial impact of Sutton BCF schemes on our main acute providers |

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.

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| **ANNEX 1a – Detailed Scheme Description** |

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

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| **Scheme ref no.** |
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| **Scheme name** |
| Unplanned Care |
| **What is the strategic objective of this scheme?** |
| To establish an integrated community health and social care system that reduces demand for care home, hospital and A&E admissions and attendances.  Working alongside the Planned Care work stream (or scheme), we will combine community health care, social services and commissioned voluntary sector provision to integrate planning and activities with the acute hospital. This will maximise resources along the length of the unplanned care patient pathway to support diversion back home from A&E and prevent admission where appropriate. This will lead to greater efficiencies in discharge over 7 days, reablement and rehabilitation planning and delivery for patients. |
| **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 key elements of this work stream are:   * Integrating the Older Peoples Pathway (with particular emphasis on the hospital end) to prevent admission where appropriate and ensure a multi-disciplinary approach to planning an in-patient stay, early discharge planning and post discharge care to minimise re-admissions in 2014/15. In subsequent years the focus will shift to the community elements of the pathway. * All teams and services working in this work stream to benefit from the support of the Integration Facilitators to pilot, test and implement integrated working arrangements and care planning * Support from Oxford Brookes University (Institute of Public Care) to work with staff to address issues of culture change alongside the pathway and team working developments * Further development of the 2014/15 Long Term Conditions QIPP initiatives to minimise A&E attendances and unplanned admissions. For 2015/16 this is likely to include extension to patient self-management, Patients in Control and cardio vascular disease and further development of existing work such as COPD and Diabetes. * Ensuring alignment of GP Engagement QIPP scheme to support primary care involvement in integrated delivery supported by Integration Facilitators and Oxford Brookes University. * Improving support to carers in order to strengthen integrated team working and recognising the crucial role of carers in this |
| **The delivery chain**  Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved |
| |  |  |  | | --- | --- | --- | | **Service:** | **Delivered by:** | **Commissioned by:** | | Community Prevention of Admission Team (CPAT): and other nursing teams across the whole of Sutton – supplemented by System Resilience funding over the winter. | Royal Marsden NHS FT | Lead commissioner currently Merton CCG – over next two years Sutton CCG will hold own contract for community services | | Primary care provision | Independent GP contractors and primary care teams | NHS England | | Urgent Care Centre, A&E, Admissions and Discharge, Older Peoples Advice and Liaison Team OPAL team) | Epsom & St Helier University Hospitals NHS Trust | Lead commissioner is Sutton CCG | | Rapid Response Team: facilitating discharge from hospital | Royal Marsden NHS FT | Lead commissioner currently Merton CCG – over next two years Sutton CCG will hold own contract for community services | | Short Term Assessment and Reablement Team (START) short-term reablement service delivered by in-house reablement team.  This team does not use FACS criteria | LB Sutton | LB Sutton | | Older Peoples Assessment and Rehabilitation Team (OPARS) | Royal Marsden NHS FT | Lead commissioner currently Merton CCG – over next two years Sutton CCG will hold own contract for community services | | Age UK Sutton service: supporting discharge and prevention of admission. Also prevention of social isolation and supporting re-integration into their communities | Age UK Sutton | Sutton CCG | | Community Intermediate Care Beds: step-up and step down facilities to be used for rapid response to emergency and crisis situations. | Various nursing home providers. | Sutton CCG | | Carers | Family and friends and other unpaid carers | Carers support is jointly commissioned by Sutton CCG & LB Sutton | |
| **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 basis for this work largely comes from the well referenced national documents that have set out research to manage emergency admissions. These are primarily:   * The National Audit Office, Emergency admissions to hospital; managing the demand (October 2013)   <http://www.nao.org.uk/wp-content/uploads/2013>   * The Kings Fund, Emergency hospital admissions for ambulatory care sensitive conditions; identifying the potential for reductions (April 2012)   <http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf>   * The Kings Fund, Avoiding hospital admissions, what does the research evidence say? (December 2010)   <http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf>   * National QIPP Group Right Care * NHS Benchmarking Group work – Sutton CCG is a member of the network   This work also builds on the work undertaken in areas such as Leeds where they have introduced the interface geriatrician model and other areas where they have sought to develop models that cross the interface between hospital and community based services and the integrated approach in Torbay. It should be noted that there is still a relatively small body of quantitative evidence underpinning a lot of this work as it is either fairly recent or small scale however it has helped in understanding the rationale and approaches undertaken and thus enable local adaptation and adjusting to local needs and circumstances.  Thus, it is recognised that in many of the areas where such models were first implemented had a very different activity profile than Sutton which sits in the bottom third of non-elective admissions nationally.  In terms of our approach to integration, we are modelling on the approach taken in the Greenwich pioneer site which is discussed in more detail in the evidence section of the Planned Care work stream or scheme.  Further information on the Older Peoples Pathway and Long Term Conditions scheme are found at Appendices 8, 9, 10, 11 and 12. |
| **Investment requirements**  Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan |
| **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 |
| Within this work stream we expect to realise the benefits of the Integrated Digital Care Record funding we have bid for. This is set out below. We have not included this benefit in Tab 4 due to the risk of double counting said benefit but we are keen not to lose sight of this work as an important component of our Unplanned Care work.  We should see reduced emergency admissions due to better medication compliance and monitoring, better care due to sharing of information across organisational and professional boundaries. 1% of emergency admissions avoided per year based on 2013/14 volumes (15,600) and average cost (£2,200) - (£2200 x 156 admissions) |
| **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? |
| Reporting through Transformation Programme Board and One Sutton Commissioning Collaborative with regular overarching updates to Health and Wellbeing Board. The key elements of the feedback loop are:   * BCF metrics reporting (monthly) – to be finalised in November 2014 * QIPP delivery reporting (monthly) – to be finalised in November 2014 * Patient/user experience metric and other patient/user engagement arrangements (to be commissioned and set in place during 2014/15) * Feedback from the following SW London Clinical Design Groups on progress:   + Integrated Care   + Primary Care   + Urgent Care * As part of a communications plan  the CCG is looking at incorporating Survey Monkey on it’s website  as one method of engagement with patients, which is likely to have a monthly or bi-monthly focus on current health topics and will allow for analysis of responses.  In addition to giving talks/presentations to patient/resident groups. * The Integration Facilitators are also an important part of the feedback loop in that they will report where there is progress or challenge in implementation. |
| **What are the key success factors for implementation of this scheme?** |
| The following key success factors will be used:   * Reduction in Non elective admissions * Reduction in A&E attendances * Improved Patient/User Quality of Life * Reduction in Delayed Transfers of Care * Increased number of people remaining at home 90 days after discharge * Increased level of joint assessment * 7 day discharge arrangements operational and effective * Effective data sharing in place across health and social care * Recruitment and retention arrangements in place so that the right work force is in place and sustainable * Working protocols across agencies in health and social care are in place to support integrated working |

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| **ANNEX 1b – Detailed Scheme Description** |

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

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| **Scheme ref no.** |
| 2 |
| **Scheme name** |
| Planned Care |
| **What is the strategic objective of this scheme?** |
| Working alongside the Unplanned Care work stream (or scheme), to establish an integrated community health and social care system that reduces demand for care home, hospital and A&E admissions and attendances through integrated care planning, multi-disciplinary working organised through integrated locality teams.  Core to this strategic objective is early identification of those at risk of hospital admission so that a planned approach to care becomes the default rather than there being a primary focus on the Unplanned Care pathway. |
| **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 key elements of this work stream are:   * Implementation of three locality based integrated teams including good integration with primary care. The work will be led by the three locality based Integration Facilitators. The three localities are:   + Wallington   + Carshalton   + Sutton & Cheam * Implementation of data sharing across health and social care building on the work undertaken thus far and also the anticipated work associated with the Integrated Digital Care Record bid * The Integration Facilitators to lead implementation, in each of the three localities, of a Sutton model that incorporates:   + 7 day working to support discharge and prevent admission   + Locally agreed model of lead professional and multi-disciplinary care planning and decision making   + Data sharing arrangements with necessary patient/user consent   + Efficiency benefits from removal of duplication and integrated working that can help ensure sustainability in the model for both LB Sutton and Sutton CCG * Incorporating the analysis made available through the risk stratification tool to ensure services and schemes are targeted on those parts of the community where there is a realistic opportunity to intervene early and avoid a non-elective admission * Incorporation of the work of the Learning Disability Clinical Health Team into the integrated locality arrangements to ensure that parity is fully extended to people with learning disabilities * Incorporation of the learning and resultant model planning transition from children’s to adult services for young people with complex needs. This work is being informed by the Transitions Project which is currently underway |
| **The delivery chain**  Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved |
| |  |  |  | | --- | --- | --- | | **Service:** | **Delivered by:** | **Commissioned by:** | | Primary care provision | Independent GP contractors and primary care teams | NHS England | | District nursing and therapy services | Royal Marsden NHS FT | Lead commissioner currently Merton CCG – over next two years Sutton CCG will hold own contract for community services | | Community social work and therapies services including resources associated with the Transitions Project | LB Sutton | LB Sutton | | Learning Disability Clinical Health Team | LB Sutton | Sutton CCG & LB Sutton | | Older Peoples Assessment and Rehabilitation Team (OPARS) | Royal Marsden NHS FT | Lead commissioner currently Merton CCG – over next two years Sutton CCG will hold own contract for community services | | Voluntary sector provision that enables people to remain in their own homes | Various voluntary sector providers | Sutton CCG and LB Sutton | | Carers | Family and friends and other unpaid carers | Carers support is jointly commissioned by Sutton CCG & LB Sutton | |
| **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 basis for this work largely comes from the well referenced national documents that have set out research to manage emergency admissions. These are primarily:   * The Kings Fund, Making our health and care systems fit for an ageing population (March 2014) * The Kings Fund, Spending to save? (January 2014) * Nuffield Trust, Evaluation of the first year of the Inner North West London Integrated Care Pilot (May 2013) * The Kings Fund, Avoiding hospital admissions, what does the research evidence say? (December 2010)   <http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf>   * National QIPP Group Right Care * NHS Benchmarking Group work – Sutton CCG is a member of the network   We are working with the Institute of Public Care (IPC) at Oxford Brookes University who have wide experience in the area of integrated care such as their work with the Greenwich pioneer site since 2010. We are looking to IPC to advise and facilitate how we bring staff and managers across all agencies to work through how they will work together, bring together practice and protocol and set in place effective multi-disciplinary working practice. This is part of the work will operate alongside the work to deliver the National Conditions and the need to pull out efficiencies to enable re-investment in sustainable integrated community services and ensure quality, effective seven day services. The learning from IPC’s previous work will inform how we address culture change and introduce new working practice which is an essential component in delivering the measures of success of this work. |
| **Investment requirements**  Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan |
| **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 |
|  |
| **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? |
| Reporting through TPB and OSCC with regular overarching updates to Health and Wellbeing Board. The key elements of the feedback loop are:   * BCF metrics reporting (monthly) – to be finalised in November 2014 * QIPP delivery reporting (monthly) – to be finalised in November 2014 * Patient/user experience metric and other patient/user engagement arrangements (to be commissioned and set in place during 2014/15) * Feedback from the following SW London Clinical Design Groups on progress:   + Integrated Care   + Planned Care * The Integration Facilitators are also an important part of the feedback loop in that they will report where there is progress or challenge in implementation. |
| **What are the key success factors for implementation of this scheme?** |
| * Reduction in Non elective admissions * Improved Patient/User Quality of Life * Reduction in Delayed Transfers of Care * Increased number of people remaining at home 90 days after discharge * Increased level of joint assessment * 7 day discharge arrangements operational and effective * Effective data sharing in place across health and social care * Recruitment and retention arrangements in place so that the right work force is in place and sustainable * Working protocols across agencies in health and social care are in place to support integrated working |

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| **ANNEX 1c – Detailed Scheme Description** |

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

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| **Scheme ref no.** |
| 3 |
| **Scheme name** |
| Mental Health |
| **What is the strategic objective of this scheme?** |
| The strategic objective of this work stream is to set in place arrangements to align community mental health services with the community health and social care services encompassed in the Planned and Unplanned work streams. This lays the ground work for fuller integration in future years.  Within this objective there will be work to ensure that the needs of people with dementia are accounted for within the Planned and Unplanned work streams. |
| **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 key elements of this work stream are:   * This work is largely aligned with the core BCF work on Unplanned and Planned Care in order to provide a platform for wider integration in the future. This means that the thrust of this work stream is:   + Through a focus on ensuring that the needs of people with dementia are addressed in the other two work streams   + Identifying opportunities to provide a holistic approach to care in line with the Parity of Esteem agenda   + Collecting the learning from this work to apply more widely in integrating mental health with other health and social care provision * Contributing to the work of the Unplanned work stream in reducing non-elective admissions by focussing on services when they work with people with dementia to provide alternatives to hospital admission as appropriate * Improving support to carers in order to strengthen integrated team working and recognising the crucial role if carers in this |
| **The delivery chain**  Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved |
| |  |  |  | | --- | --- | --- | | **Service:** | **Delivered by:** | **Commissioned by:** | | Primary care provision | Independent GP contractors and primary care team | NHS England | | Carers | Families, friends and other unpaid carers | Carers support is jointly commissioned by Sutton CCG & LB Sutton | | Community mental health teams and other specialist community mental health teams including the mental health older adults service and IAPT | South West London & St Georges Mental Health NHS Trust | Lead commissioner Kingston CCG –Sutton CCG is an associate commissioner | | Voluntary sector provision | Sutton Mental Health Foundation, Alzheimer’s Society, Age UK Sutton and others | Sutton CCG and LB Sutton | | Urgent Care Centre, A&E, Admissions and Discharge | Epsom & St Helier University Hospitals NHS Trust | Lead commissioner is Sutton CCG | | Psychiatric liaison team at St Helier Hospital | South West London & St Georges Mental Health NHS Trust | Lead commissioner Kingston CCG –Sutton CCG is an associate commissioner | |
| **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 key reference points for this work are:   * The Kings Fund, Making our health and care systems fit for an ageing population (March 2014) * The Kings Fund, Long Term Conditions and Mental Health – the cost of co-morbidities (February 2012) * Department of Health, No Health without Mental Health (2011) * Royal College of Psychiatrists, Whole Person Care: From Rhetoric to Reality (Achieving Parity between Mental and Physical Care) (March 2013) * Department of Health, Living Well with Dementia: A National Dementia Strategy (February 2009) * Healthcare for London/ Commissioning Support for London, Dementia Services Guide (October 2009) * Learning from the Birmingham Rapid, Assessment, Interface and Discharge (RAID) model in strengthening mental health response in an acute care environment. |
| **Investment requirements**  Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan |
| **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 |
|  |
| **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? |
| Reporting through Transformation Programme Board and One Sutton Commissioning Collaborative with regular overarching updates to Health and Wellbeing Board. The key elements of the feedback loop are:   * BCF metrics reporting (monthly) – to be agreed in November 2014 * QIPP delivery reporting (monthly) – to be agreed in November 2014 * Patient/user experience metric and other patient/user engagement arrangements (to be commissioned and set in place during 2014/15) * Feedback from the following SW London Clinical Design Groups on progress:   + Integrated Care   + Mental Health * The Integration Facilitators are also an important part of the feedback loop in that they will report where there is progress or challenge in implementation. |
| **What are the key success factors for implementation of this scheme?** |
| * Improved rates of dementia diagnosis (as per local metric) * Documented learning of how to successfully integrate mental health and dementia care services into wider health and social care services that can be incorporated into subsequent service and commissioning integration * Reduction in Non elective admissions * Improved Patient/User Quality of Life * Reduction in Delayed Transfers of Care * Increased level of joint assessment * Effective data sharing in place across health and social care * Recruitment and retention arrangements in place so that the right work force is in place and sustainable * Working protocols across agencies in health and social care are in place to support integrated working |

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| **ANNEX 2 – Provider commentary** |

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

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| **Name of Health & Wellbeing Board** | Sutton |
| **Name of Provider organisation** | Epsom and St Helier University Hospitals NHS Trust |
| **Name of Provider CEO** | Chrisha Alagaratnam |
| **Signature (electronic or typed)** |  |

**For HWB to populate:**

|  |  |  |
| --- | --- | --- |
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 14424 |
| **2014/15 Plan** | 14179 |
| **2015/16 Plan** | 13682 |
| **14/15 Change compared to 13/14 outturn** | -1.7% |
| **15/16 Change compared to planned 14/15 outturn** | -3.5% |
| **How many non-elective admissions is the BCF planned to prevent in 14-15?** | 245 |
| **How many non-elective admissions is the BCF planned to prevent in 15-16?** | 497 |

**Note: the full 3.5% reduction for 15/16 over 14/15 is 606 admissions for all CCG providers.**

**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?** | The Trust fully supports the principles of the Better Care Fund and the schemes being developed by partner agencies in Sutton, led by Sutton CCG and the London Borough of Sutton to implement integrated care for the local population. Sutton is working collaboratively with the Acute Trust and other partners to establish clear objectives and agreed metrics across the schemes. We would support a programme management approach to monitor the impact at point of delivery of each of the schemes and establish how best to correlate these to acute emergency activity data. We would encourage a focus on data quality and data capture across the schemes, enhanced by clinical audit and user experience feedback. We will continue to develop a monitoring framework that contributes to understanding the schemes that demonstrate the greatest impact. |
| **2.** | **If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?** | NA |
| **3.** | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | Sutton has set the target reduction in non-elective admissions at 3.5% in 2015/16 compared to the equivalent period in 2014/15, which is made up of a QIPP reduction of 6.3% offset by growth of 2.8% (giving a net reduction of 3.5%). We would like to note that we have seen a 5% growth in year of attendances from all CCGs at St Helier A&E, including the urgent care centre. We will continue to work with Sutton CCG and other partners in Sutton through 2014/15 and 2015/16 to achieve the target number of non-elective admissions.  Further consideration may need to be given to the changing landscape with the closure of some London A&E departments and the potential impact on other A&E departments.  Contractually, the acute contract will remain as it is under PbR and any discussions regarding risk share and / or performance rewards will be from the default PbR position. |

1. *Older people and emergency bed use: Exploring variation* (2012), Imison, C. et al., London: The King’s Fund [↑](#footnote-ref-1)
2. Ibid. [↑](#footnote-ref-2)