Bexley Wellbeing Partnership Committee meeting held in public

14:00 – 16:00, Thursday 25th May 2023
Venue: Council Chamber, London Borough of Bexley, Civic Offices,
2 Watling Street, Bexleyheath, Kent, DA6 7AT

Agenda

No.	Item	Paper	Presenter	Time
Opening Business and Introductions				
1.	Introductions and apologies		Chair	14:00
2.	Declarations of Interest	A	Chair	14:03
3.	Notes from 23rd March 2023	B	Chair	14:04
Public Forum				
4.	*Let's talk about* Unpaid Carers			14:05
Decision/s				
5.	General Practice Premium Service	C	Graham Tanner	14:35
6.	Primary Care Business Report – Q4 2022/23	D	Graham Tanner	14:50
7.	Better Care Fund – Draft Plan 2023/24	E(i) – (iii)	Steven Burgess	15:05
Assurance				
8.	Supplementary Integrated Performance Report	F	Alison Rogers/Graham Tanner	15:20
9.	Month 12 Finance Report: • Place • Integrated Care Board • Integrated Care System	G(i) – (iii)	Julie Witherall	15:30
10.	Place Risk Register	H	Simon Beard	15:40
Public Forum				
11.	Public Questions			15:50
Closing Business				
12.	Any other business			15:55
13.	Glossary	I		
14.	**Date of the next meeting**: Thursday 27th July 2023, Council Chamber, London Borough of Bexley, Civic Offices, 2 Watling Street, Bexleyheath, Kent, DA6 7AT			

Presenters

- Committee Chair, Dr Sid Deshmukh
- Alison Rogers, Director of Integrated Commissioning, NHS South East London Integrated Care Board/London Borough of Bexley
- Graham Tanner, Associate Director – Primary Care (Bexley), NHS South East London Integrated Care Board
- Sarah Birch, Head of Primary Care Development (Bexley), NHS South East London Integrated Care Board
- Julie Witherall, Associate Director of Finance (Bexley), NHS South East London Integrated Care Board
- Simon Beard, Associate Director of Corporate Operations, NHS South East London Integrated Care Board
- Steven Burgess, Policy and Strategy Officer, Strategy, Performance and Complaints, London Borough of Bexley

Let's talk about Unpaid Carers

- Vikki Wilkinson, Chief Executive Officer, Carers Support Bexley
- Deborah Travers, Associate Director of Adult Social Care, London Borough of Bexley (Bexley Care)

ITEM: 2

ENCLOSURE: A

Declaration of Interests: Update and signature list

Name of the meeting: Bexley Wellbeing Partnership Committee **Date:18.05.2023**

Name	Position Held	Declaration of Interest	State the change or 'No Change'	Sign
Dr Sid Deshmukh*	Chair- Bexley Local Care Partnership Committee	1. Senior Partner Sidcup Medical Centre PMS Contract - Financial Interest Materiality 50% 2. Shareholder of GP Federation – Financial interest 3. Shareholder Frogmed Limited - Financial Interest (Dormant company) 4. Chair - Frognal Primary Care Network GP Lead – Financial interest 5. Wife (Dr Sonia Khanna-Deshmukh) is Frognal PCN Clinical Director – Indirect interest 6. Non-financial personal interest in Inspire Community Trust; a) Wheelchair service; b) Joint Equipment Store; c) Personal Health Budgets; d) Information and service support for people with physical and sensory impairment. 7. Clinical Lead for Diagnostics (Bexley) – financial interest 8. Clinical Lead for Urgent Care (Bexley) – financial interest 9. Director, Bexley Health Neighbourhood Care CIC – financial interest		
Stuart Rowbotham*	Bexley Executive Place Director, SEL ICS Director of Adult Social Care, London Borough of Bexley Council	Nothing to declare.		
Dr Nicole Klynman*	Director of Public Health London Borough of Bexley Council	Nothing to declare.		

Yolanda Dennehy*	Deputy Director of Adult Social Care, London Borough of Bexley Council	Nothing to declare.		
Raj Matharu*	LPC Representative	1. Chief Officer of Bexley, Bromley & Greenwich Local Pharmaceutical Committee 2. Chief Officer of Lambeth, Southwark & Lewisham Local Pharmaceutical Committee 3. Chair of Pharmacy London 4. Board Member of Pharma BBG LLP 5. Superintendent Pharmacist of MAPEX Pharmacy Consultancy Limited. 6. Wife is lead pharmacy technician for the Oxleas Bromley medicines optimisation service (indirect interest)		
Keith Wood	Lay Member, Primary Care (Bexley)	Nothing to declare.		
Jennifer Bostock*	Independent Member (Bexley)	1. Independent Advisor and Tutor, Kings Health Partners (financial interest) 2. Patient Public involvement Co-Lead, DHSC/NIHR 3. Independent advisor and Lay Reviewer, UNIS 4. Lay co-applicant/collaborator on an NIHR funded project 5. Independent Reviewer, RCS Invited Review Mechanism 6. Lay co-applicant, HS2		
Dr Pandu Balaji*	Clinical Lead – Frognal Primary Care Network	GP partner, Woodlands Surgery (financial interest)		
Dr Miran Patel*	Clinical Lead – APL Primary Care Network	1. GP Partner, The Albion Surgery (financial interest) 2. Clinical director, APL PCN (financial interest)		
Dr Nisha Nair*	Clinical Lead – Clocktower Primary Care Network	GP Partner, Bexley Group Practice (financial interest)		
Dr Surjit Kailey*	Clinical Lead – North Bexley Primary Care Network	###		
Abi Mogridge (n)	Chief Operating Officer, Bexley Health Neighbourhood Care CIC	Nothing to declare.		
Jattinder Rai (n)	CEO, Bexley Voluntary Service Council (BVSC)	Nothing to declare.		
Rikki Garcia (n)	Chair, Healthwatch Bexley	Nothing to declare.		

Kate Heaps (n)	CEO Greenwich and Bexley Community Hospice	1. CEO of Greenwich & Bexley Community Hospice – financial interest 2. Chair of Share Community - a voluntary sector provider operating in SE/SW London with spot purchasing arrangements with LB Lambeth – non-financial professional interest 3. Clinical Lead for End-of-life work for ICS		
Diana Braithwaite (n)	Chief Operating Officer, NHS SEL ICB (Bexley)	A relative is employed by SLaM (NHS SEL ICS Partners) and is currently on a secondment to NHS SEL ICB		
Sandra Iskander	Acting Chief Strategy, Partnerships & Transformation Officer Lewisham and Greenwich NHS Trust	Nothing to declare.		
Andrew Hardman	Chief Commercial Officer, Bromley Healthcare	Nothing to declare.		
Stephen Kitchman	Director of Services for Children and Young People, London Borough of Bexley Council	Nothing to declare.		
Sarah Burchell	Director Adult Health Services, Bexley Care	###		
Iain Dimond*	Chief Operating Officer, Oxleas NHS Foundation Trust	Nothing to declare.		
Dr Sushantra Bhadra	Clinical Director, North Bexley Primary Care Network (deputising for Dr Kailey)	1. GP Partner, Riverside Surgery – financial interest 2. Member of the Londonwide LMC – financial interest 3. Clinical Director, North Bexley PCN – financial interest	1 February 2010 1 June 2011 1 April 2021	Current Current Current
Deborah Travers	Associate Director of Adult Social Care (deputising for Deputy Director of Adult Social Care)	###		
Dr Sonia Khanna	Clinical Director, Frognal PCN (deputising for Dr Pandu Balaji)	1. GP Partner, Sidcup Medical Centre – financial interest 2. Practice is member of Bexley Health Neighbourhood Care – financial interest 3. Joint Clinical Director, Frognal PCN – financial interest	1 April 2018 1 January 2018 1 July 2019	Current Current Current

		4. Husband, Dr Sid Deshmukh, is Frognal PCN chair, BHNC Director, Clinical lead – Urgent Care, Senior Partner at Sidcup Medical Centre, shareholder of Frogmed Ltd (dormant company) and Chair of Bexley Wellbeing Partnership – indirect interest 5. CYP and Families Clinical Lead – Bexley – non- financial professional interest 6. Father, Mr Vinod Khanna, is Chief Executive Officer of Inspire Community Trust – non-financial personal interest. 7. Member of Bexley LMC – non-financial professional interest. 8. GP Appraiser for south east London – non-financial personal interest.	1 January 2018 1 April 2019 10 August 2010 9 November 2012 1 November 2015	Current Current Current Current Current
Ellie Thomas	Associate Director, Planning and Partnerships, Dartford & Gravesham NHS Trust	###		

***voting member.**

members who have not made the annual declaration for 2023/24 will be requested to make a verbal declaration within the meeting.

ITEM: 3
ENCLOSURE: B

Bexley Wellbeing Partnership, Meeting in public

Thursday, 23rd March 2023, 2:00pm to 4:00pm
Council Chamber, Civic Offices, 2 Watling Street, Bexleyheath, DA6 7AT
(and via Microsoft Teams)

Voting Members

Name	Title and organisation
Dr Sid Deshmukh (SD)	Chair, Bexley Wellbeing Partnership Committee, NHS South East London Integrated Care Board (NHS SEL ICB)
Jennifer Bostock (JB)	Independent Member, NHS SEL ICB (Bexley)
Dr Mike Robinson (MR) – *deputising for Dr Nicole Klynman*	Interim Consultant in Public Health, LBB
Dr Miran Patel (MiP) (*via MS Teams)*	Clinical Lead, APL Primary Care Network
Raj Matharu (RaM)	Chief Officer, Local Pharmaceutical Committee
Dr Sonia *Khanna-Deshmukh (SK-D) (via* MS Teams)	Clinical Lead, Frognal Primary Care Network
Deborah Travers (DT) – *deputising for Yolanda Dennehy*	Associate Director (Bexley Care), London Borough of Bexley
Diana Braithwaite (DB) – *Deputising for Stuart Rowbotham*	Chief Operating Officer (Bexley) NHS SEL ICB
Sarah Burchell (SB) – *Deputising for Iain Dimond*	Director of Adult Health Services – Bexley Care, Oxleas NHS Foundation Trust
Dr Sushanta Bhadra (SuB)	Representative, North Bexley Primary Care Network

In Attendance

Dr Clive Anggiansah (CA)	Clinical and Care Professional Lead - Primary & Community Care (Bexley)
Keith Wood (KW)	Lay Member, Primary Care (Bexley), NHS SEL ICB
Simon Beard (SiB) (*presente*r)	Associate Director of Corporate Operations Governance, NHS SEL ICB
Graham Tanner (GT)	Associate Director of Primary Care & Delivery (Bexley), NHS SEL ICB
Andrew Hardman (AH)	Commercial & Partnership Director, Bromley Healthcare
Aysha Awan (AA)	Head of Comms & Engagement (Bexley), NHS SEL ICB
Patrick Gray (PG)	Communications & Engagement Manager (Bexley), NHS SEL ICB
Ben Tunstall (BT)	Primary Care Communications & Engagement Manager (Bexley), NHS SEL ICB
Alison Rogers (AR)	Director of Integrated Commissioning (Bexley), NHS SEL ICB/LBB
Euan Stock (ES) – *Item 4*	Management Trainee, Policy Team, London Borough of Bexley
Kim Teasdale (KT) – *Item 4*	Chair, Lakeside Patient Participation Group
Rianna Palanisamy (RP) – *Item 4*	Corporate Governance Lead (Bexley), NHS SEL ICB
Rikki Garcia (RG) – *via MS Teams*	Chair, Healthwatch Bexley
Daniel Rattigan (DR)	Associate Director of Strategy, Lewisham & Greenwich NHS Trust

David Maloney (DM) – *deputising for Julie Witherall*	Director of Corporate Finance, NHS SEL ICB
Ellie Thomas (ET) – *via MS Teams*	Associate Director, Planning & Partnerships, Dartford & Gravesham NHS Trust
Sarah Birch (SaB)	Head of Primary Care (Bexley), NHS SEL ICB
Jenni Gilbert (JG)	Primary Care Delivery Manager (Bexley), NHS SEL ICB
Nicola Taylor (NT) – *via MS Teams*	Councillor, London Borough of Bexley
Christine Harper (CH) – *via MS Teams*	Member of the Public
Sue Wright (notes)	Business Support Lead (Bexley), NHS SEL ICB

Apologies

Stuart Rowbotham (SR)	Place Executive Lead (Bexley), NHS SEL ICB/Director of Adult Social Care, London Borough of Bexley (LBB)
Dr Nicole Klynman (NK)	Director of Public Health, London Borough of Bexley
Yolanda Dennehy (YD	Assistant Director of Adult Social Care, LBB
Abi Mogridge (AM)	Chief Operating Officer, Bexley Neighbourhood Health Care CIC
Dr Mehal Patel (MeP)	Clinical Lead, APL Primary Care Network
Iain Dimond (ID)	Chief Operating Officer, Oxleas NHS Foundation Trust
Dr Surjit Kailey (SK)	Clinical Lead, North Bexley Primary Care Network
Dr Lakhbir Kailey (LK)	Clinical Lead, Clocktower Primary Care Network
Jattinder Rai (JR)	Chief Executive, Bexley Voluntary Services Council
Jayne Garfield-Field (JG-F)	Joint Healthwatch Bexley Manager
Dr Pandu Balaji (PB)	Clinical Lead, Frognal Primary Care Network
Dr Nisha Nair (NN)	Clinical Lead, Clocktower Primary Care Network
Sandra Iskander (SI)	Acting Chief of Strategy, Partnerships & Transformation Officer, Lewisham & Greenwich NHS Trust
Julie Witherall (JW)	Associate Director – Finance (Bexley), NHS SEL ICB
Stephen Kitchman (SK)	Director of Children's Services, LBB
Basirat Sadiq (BS)	Director of Improvement, Dartford & Gravesham NHS Trust
Kate Heaps (KH)	Chief Executive Officer, Greenwich & Bexley Community Hospice

Notes

		Actioned by
1.	**Introductions and apologies** Introductions were made and apologies noted.	**SD**
2.	**Declarations of Interest** **Dr Sid Deshmukh, Governing Body, GP Lead (Bexley), NHS SEL ICB**, was conflicted on Item 5 (Personal Medical Services Premium – Amendments & Extension) and Item 6 (Care Homes Supplementary Network Service – Extension) and therefore **Jennifer Bostock, Independent Member acted as Co-Chair.** It was noted that there were 6 members remaining in the room who could vote on these 2 items. The minutes of the last meeting on 26th January 2023 were **NOTED**.	**SD/JB**
3.	**Public Questions** No public questions were received in advance. There will be an opportunity for members of the public to ask questions throughout the meeting.	**SD**
4.	**Let's Talk about Women's Health** There were 3 individual aspects to this item and all 3 speakers described how women should be supported in the borough: <u>Women's General Health in Bexley</u> **Euan Stock, Management Trainee, Policy & Strategy Team, London Borough of Bexley** ES helps to manage the Bexley Data Hub which provides data, insight and research about the London Borough of Bexley and can be accessed via Bexley Council's website. He gave an overview of the national and local picture around women's health: • Bexley has a high percentage of women – particularly from 30 years old and above. • Bexley's gender pay gap is larger than that of London and the UK, with male full-time workers earning £854.50 p/w and female full-time workers earning just £690 p/w – a difference of £164.50 p/w. Women and lone parents are more likely to receive support through the Council Tax Reduction Scheme. • MARAC cases (high-risk domestic abuse cases) have increased by 13.4% between 2021 and 2022. • Fairness and equality are both central to the priorities of the Bexley Plan – especially 'Happy, Healthy and Resilient Lives', 'Your life, your choice'. • Female life expectancy in England is 83.1% as compared to 79.4% in males. • In Bexley, women are unhealthier for longer. The heathy life expectancy 63.9 years compared to 66.4 years for men. This is a reverse of the disparities faced both in London and in England, where women have a longer healthy life expectancy than men.	**ES**

- In Bexley, women are impacted by disability earlier in their life than men are. The disability-free life expectancy for women is only 62.5 years, compared to 63.4 years for men.
- Bexley has a significantly higher rate of obesity in early pregnancy compared to London as a whole – 22.5% vs 17.8%.
- 12.6% of households in Bexley are households with one person aged 66 or over, which is around average for England and Wales but above average for London. This is particularly pronounced in Sidcup East.
- The north of the borough has a high concentration of single parent households with children under 18. The borough at large is barely above average for England and Wales, but the riverside areas of Crossway Park, Erith East, and Slade Green and Crayford Marshes are all in the top quintile. Women make up 89% of lone parents with dependent children in Bexley.

It was recognised that access to services in Bexley must be improved and consideration given to the various sub-groups of women and the different language barriers involved. ES's team is working to address these issues. SaB referred to the bullet point in Slide 12, namely "In the last 9 years, women's healthy life expectancy at birth went from being 1.5 years greater than men's to 2.5 years fewer. How do we explain this reversal?" and asked what was being done to address this. MR explained that Public Health were carrying out a data analysis as a first step, but accepted that it was not about merely producing a report, but about how the partnership were going to address the issues, whilst recognising that Bexley has a higher rate of repeat terminations than the national average. The choice of contraception/access to the most effective forms of contraception needs to be considered very carefully.

GT appreciated the dataset, but was unsure as to whether ample attention had been given to gender and age statistics and funding thereof.

<u>Endometriosis</u>

Rianna Palanisamy, Corporate Governance Lead (Bexley, NHS SEL ICB gave a personal update on her Endometriosis journey. Main facts:

RP

- Endometriosis affects more than 10% of women, resulting in a healthcare cost of £8.2bn per year.
- Diagnosis takes an average of 7.5 years.

RP then gave some background on her own experience.

She experienced painful periods at the age of 11 and saw a GP on multiple occasions who seemed in indicate that it was "all in her head". As the stomach cramps continued and did not necessarily relate to her menstrual cycle, RP was eventually referred to a local paediatric team via whom she undertook scans and an endoscopy which resulted in an eventual diagnosis of stomach migraines. All of this resulted in a substantial loss of school education. The symptoms slightly abated for a few years but, at the age of 20, she started to experience the painful periods resulting in a lot of time spent in bed

	which was difficult when trying to cope with full-time employment. As she was local to the area, RP then made an emergency visit to the out-of-hours service at the Erith Hospital site where the GP suspected it was Endometriosis which was finally diagnosed by a specialist at QEH in 2018. She was subsequently referred to a specialist at Guy's and undertook an operation, but still had to deal with pain and fatigue which had a huge impact on her lifestyle. RP noted that there was very little information available about the condition and wanted to raise awareness in order for sufferers to know about and get access to specialist services, such as Endometriosis UK. RP is under a specialist clinic and gave the advice that women should trust their bodies and reach out for necessary support. JB was inspired by RP's honesty and for raising this in such a public environment and asked whether she felt she would have had a faster diagnosis had she been male. RP responded that it may have been dealt with differently having been a male patient resulting in a more fast-track approach to a correct diagnosis. Ms Calera-Marco, a member of the public, spoke about her Endometriosis and said that she had recognised the symptoms experienced by her mother in Spain from an early age and therefore she knew that every time she attended a GP or gynaecologist appointment in the UK, it helped to prompt an earlier diagnosis because she knew the signs. She recognised that there is a gap in awareness, diagnosis and subsequent treatment in the UK. <u>Menopause</u> **Kim Teasdale, Chair, Lakeside Patient Participation Group**, described her personal experience with the menopause. Key facts: • The menopause is a natural time of ageing and in the UK the average age is 51 years, but around 1 in 100 people usually experience the menopause before the age of 40 years. • The perimenopause is the phase leading up to the menopause when a woman's hormone balance starts to change. For some people, this can start as early as their twenties or as late as their late forties. • It is estimated that there are around 13 million people who are currently peri or menopausal in the UK (Wellbeing of Women) which is equivalent to a third of the entire UK female population. • The menopause can cause a wide range of physical and psychological symptoms that can last for several years. Most menopausal people experience symptoms to varying degrees and can last for several years. KT first started the menopause at age 55 and has been on HRT treatment since 2016. She had training and got the opportunity to raise awareness in Bexley by holding an event at The Marriott Hotel in Bexleyheath which was very well attended and, unfortunately, just before the country went into the pandemic. Whilst KT was fortunate to have a good GP, she felt that there was still not enough awareness or university training of GPs and nurses. KT feels healthy now, and has a continuous HRT patch which she changes every 2 to 3 days and still has her womb.	**KT**

	KT was pleased that, from 1 April 2023, women prescribed for HRT will have access to a new scheme enabling access to a year's worth of menopause prescription items for the cost of 2 single prescription charges (currently £18.70). Researchers believe that oestrogen may cause the body to make more antioxidants, protecting brain cells from damage which could explain why the sudden drop in women's oestrogen levels following menopause seems to make them more vulnerable to Alzheimer's. CA thanked KT and said that one of his colleagues has a great interest in sexual health and had previously highlighted this issue. It is hoped to hold an event in June involving experts, and CA was pleased about the move towards an annual prescription for HRT thereby decreasing costs for women suffering with menopausal symptoms. JB was pleased to learn about CA's colleague's interest in sexual health, but pointed out that Endometriosis and the Menopause did not necessarily fall into the category of sexual health, but more around general women's health. CA responded that part of the work his colleague is doing is to try and socialise some of the healthcare pressures and had previously organised an event which attracted over 100 people. SD agreed that there was a lot more to be done by GPs and Oxleas and having a more robust partnership approach, not just addressing the issues at a planned workshop. DB felt it was important to ensure there is a medical policy in place, particularly for women aged 40+ around perimenopause.	
5.	**Personal Medical Services Premium – Amendments** & **Extension** *SD and CA left the meeting as they were conflicted on this item and other GPs and PCN representatives were asked to leave MS Teams and re-join at 3.25 pm.* SD handed over the chairing to JB**.** **Graham Tanner, Associate Director of Primary Care & Delivery (Bexley), NHS SEL ICB** presented the paper. On 24th March 2022, the Bexley Strategic Board approved a 12-month extension on the Personal Medical Services (PMS) Premium from 1st April 2022 to 31st March 2023. Consequently, work has commenced on developing a new three-year GP Premium, which is planned to commence on 1st July 2023 (subject to approval by the Bexley Wellbeing Partnership Committee) and the following interim extension and changes are recommended from 1st April to 30th June 2023: • Equally distribute the PMS premium funding across all contract types which will amount to a new GP premium of £9.15 per weighted patient. • Extend the existing PMS Premium KPIs at the same funding level of £4.99 per weighted patient. • Introduce additional KPIs commensurate with the additional amount of investment (£4.16 per weighted patient after equal distribution) that is currently not specified, to ensure value for money is secured from this funding stream. The total funding envelope remains unchanged. All figures are presented as annual amounts, but these arrangements will only apply	**GT**

on a pro rata basis for the first three months of the year. No changes to the funding levels are anticipated from 1st July 2023 onwards but the service specifications are anticipated to change.

GT's colleague, Marina Moores (Primary Care Service Delivery Manager), has already been fully involved in the necessary engagement work and an update can be brought back here in May.

JB commented on the number of acronyms in the recommendations of which she was not aware and asked if these could be simplified in future papers.

DT queried if the 3-month extension was a sufficient period of time to achieve this level of work, and GT pointed out that, whilst this is an ambitious timeline, this work has already been underway for some time with partners, stakeholders and GPs following the agreement by the Bexley Strategic Board a year ago today. However, a slightly longer extension could be considered if need be. DT commented that her concern was not on any of the recommendations, but the development of the Key Performance Indicators (KPIs) and how these can be achieved within the partnership in the local system. GT's team is looking to build in more flexibility as part of the new premium as priorities change. The PMS, GMS and APMS contracts are all linked to the national contract and were negotiated with the Local Medical Committee (LMC), whereas REMOS is a local incentive scheme which became very embedded and therefore difficult to change, amend or respond to future challenges.

RaM queried who was measuring the KPIs and who would pick up the cost in the event they were not met. GT responded that the function sits with his team and the approach is slightly different in that the PMS premium is directly linked to GP contracts so they are encouraged to deliver the outcomes. GT confirmed that any underspend is dealt with at the end of the year, along with any bottom-line financial issues, such as Prescribing, and if not spent, this becomes part of the year-end prioritisation.

Overall, GT believes the work is on track but, if need be, this could go back through a similar governance process with the LMC, get awarded an extension and then bring back to this Committee.

JB led the voting process and all 6 voting members in the room approved the 4 recommendations below.

On the recommendation of the Primary Care Delivery Group, the Bexley Wellbeing Partnership Committee **APPROVED**:

(i) The interim extension of the PMS Premium from 1st April to 30th June 2023.
(ii) Equal distribution of the PMS premium funding across all contract types which will amount to a new GP premium of £9.15 per weighted patient.
(iii) Extension to the existing PMS Premium KPIs at the same funding level of £4.99 per weighted patient.
(iv) Introduction of additional KPIs commensurate with the additional amount of investment (£4.16 per weighted patient

	after equal distribution) that is currently not specified, to ensure value for money is secured from this funding stream.	
6.	**Care Homes Supplementary Network Service – Extension** *As per Item 5, SD and CA left the meeting as they were conflicted on this item and other GPs and PCN representatives were asked to leave MS Teams and re-join at 3.25 pm.* SD handed over the chairing to JB. **Sarah Birch, Head of Primary Care (Bexley), NHS SEL ICB,** outlined the background of this request to voting members. Following endorsement at the meeting of the Primary Care Delivery Group on 1st March 2023, this paper seeks approval of the recommendation to the Bexley Wellbeing Partnership Committee that the current Care Homes SNS specification be extended with a minor variation, for a further 12 months from 1st April 2023 until 31st March 2024. The current service expires on 31st March 2023. This locally commissioned service supplements the national Enhanced Health in Care Homes (EHCH) service specification which is one of the seven service specifications that forms part of the Network Directly Enhanced Service (DES). The Network DES ends on 31st March 2024 and details of the subsequent scheme are yet to be published. During 2023/24, the commissioning intention is to undertake a more comprehensive review of the SNS service to determine the optimum model from April 2024 onwards. This review can only be undertaken once there is greater clarity on the future requirements of the scheme that supersedes the national Network Contract DES, from 1st April 2024. This paper also seeks for approval for the financially incentivised KPIs that form part of the SNS to be modified to ensure further quality improvements in the delivery of the SNS during its final year. Prior to 30th December 2022, there were 1,320 nursing and residential care home beds in Bexley, compared to 1,304 currently due to 2 care home closures. The EHCH Network DES funds PCNs £120 per care home bed, per annum. The Bexley Care Homes SNS specification pays PCNs (who in turn pass the funding to the relevant member practice/s) £177 per care home bed, per annum. £60 of this payment is incentive driven. Achievement of the incentive driven payment is measured by KPIs. Service providers are required to report twice a year against the KPI requirements of the scheme. SaB stressed that this was not a request for additional funding, but to seek some small-scale changes to enhance the value for money (VFM) currently received from this contract and some further quality improvements deigned with colleagues across partnership, such as longer timeframe to avoid hospital admissions and keep residents in care homes.	**SaB**

In addition, from 1st April 2023 the proposal is to introduce two new KPIs to replace KPIs 5 and 7. These are:

- To provide an opportunity for families to meet and engage with the GP, the named visiting GP to attend a resident/ family meeting, in person at the care home, twice per year.
- The practice to undertake a survey of experiences of residents, residents' families and care home staffs in regard to the primary care support provided to the care home. The survey will be developed by the Bexley Primary Care Team to ensure consistency in approach. An agreed minimum number of responses will be required based on the size/occupancy of the home.

It is also proposed that a fairer payment model for the incentivised KPIs is adopted and that the scheme moves from a "per bed" allocation to a "per care home" allocation. This enhances VFM from the contract given that the resource required to deliver these KPIs is no different for practices irrespective of the size of the care homes they serve.

An extension to the current arrangements is being sought to align with the national DES and to allow sufficient time to assess the effectiveness of the current operating model (delivered by multiple providers) and consider options for alternative evidence-based models e.g., whether a single provider model would improve patient care and provide value for money in the longer term for Bexley. The other 5 SEL boroughs all deliver enhanced primary care support to their care homes using a single provider model.

JB queried if there was a piece of evaluation work being carried out on the effectiveness of a single provider versus multiple providers and what provision would be put in place if the current model fails and the alternative model was found to be more effective. SaB confirmed that, as Bexley has a different model to SEL, the pros and cons are yet be weighed up, either by using an external company or through our own analysis, and the workload that would be involved if a switch to a single provider took place. SaB appreciated that there are advantages in having a single provider, but also disadvantages with resilience if something goes wrong.

DT had seen a shift in care homes around the amount of interim beds being used to support some of the acute sector and suggested it may be beneficial to have a further evaluation over the next year to compare the medical support required for interim beds as opposed to long-term residents in care home beds.

There will be no change this year, but the team is awaiting clarity on the PCN DES and is currently linking in with borough colleagues who are coming to an end with their single provider contracts. In the meantime, SaB has been fully engaging with partners and integrated and quality assurance teams pending the new DES announcement and meeting the needs of our care home residents. Once the new

	national directive is issued, it is hoped to start understanding the exact direction of travel, the funding which comes with that and whether to consider a procurement process. JB led the voting process and all 6 voting members in the room approved the 5 recommendations below. On the recommendation of the Primary Care Delivery Group, the Bexley Wellbeing Partnership Committee: (i) **APPROVED** the recommendation to extend the Bexley Care Homes Supplementary Network Service (SNS) Specification for Nursing & Residential Care Homes for 12 months from 1st April 2023 to 31st March 2024. (ii) **APPROVED** the extension of the completion timeframe requirement from two to four weeks for KPI 2. (iii) **APPROVED** the amendments to the incentive driven KPIs as detailed in Appendix 2. (iv) **APPROVED** the change in payment models for incentive driven KPIs from a "per bed" to "per home basis". (v) **SUPPORTED** the intention to undertake a wider review of the contract and service model during 2023/24 once there is greater clarity on the future of nationally commissioned enhanced services requirements that relate to the delivery primary care support to care homes from April 2024.	
7.	**South East London Integrated Care Board – Joint Forward Plan: Bexley** SD returned to continue chairing the meeting. **Diana Braithwaite, Chief Operating Officer (Bexley), NHS SEL ICB**, gave a brief overview of the purpose of the paper on behalf of Stuart Rowbotham which aimed to do the following: (a) Set out the approach taken for the development of the South-East London Integrated Care Board Joint Forward Plan, the local and national timelines and engagement programme. (b) The development of the draft Bexley 3 Year Plus Integrated Improvement Plan Actions for inclusion in the Joint Forward Plan. <u>SEL 5-year Joint Forward Plan</u> It is a national requirement for Integrated Care Boards (ICBs) to prepare a Joint Forward Plan (JFP) for 2023/24 and NHS England has asked for the final plan to be shared by 30th June 2023, with the stipulation that the refresh of the plan will need to be completed before the start of each financial year. It is therefore the expectation that the process for engagement on the draft plan will be undertaken from 1st April 2023 to 30th June 2023. The ICBs must engage with their stakeholders during this time including the Integrated Care Partnership, NHS England, Local	**DB**

Authorities, voluntary and community sector and local communities. ICBs must involve all relevant Health & Wellbeing Boards in preparing and revising the plan and this will include sharing a draft with each Board and consulting them on whether the Joint Forward Plan takes proper account of each relevant joint local health and wellbeing strategy. Each borough's Health & Wellbeing Board will need to provide confirmation that this has taken place.

The paper sets out the SEL high-level objectives and aspirations and actions to be taken over the next couple of years to meet the needs of its residents, but DB referred those in attendance to the last 6 pages of the document which summarised the particular Bexley aspects. From a Bexley perspective, the key 3 priority objectives for integrated improvement in Bexley are as follows:

1. Improving people's health and wellbeing across the life journey;
2. Improving access to our health and care services; and
3. Addressing health and care inequalities. Our aim is to support residents across their entire life course 'start well, live well and age well'.

Through our Joint Local Health & Wellbeing Being Strategy together with residents we have prioritised 4 key priority areas across the life course: Children and Young People, Frailty, Obesity and Mental Health. Cross-cutting themes include focus on personalisation, early prevention and population health.

- Giving children and young people the best possible start and prevention
- Supporting old and frail residents to age well
- Tackling obesity
- Transforming community and mental health services

A greater piece of work will be required to engage with Bexley residents and how best to utilise the restricted amount of funding it will receive to achieve their needs. NHS (Bexley) is currently working with its various teams across the partnership in Bexley London Borough, community providers, Bromley Healthcare and Lewisham & Greenwich NHS Trust. There are certain national "must dos" and SEL requirements, but Bexley can also decide on its own agenda/priorities outside of those stipulations.

RaM queried the reference to pooled budgets and DB informed him that there needs to be more detailed work around this. Work is taking place with Steven Burgess (Policy & Strategy Officer, LBB) and AR around the Better Care Fund which outlines positive examples of Bexley's aspirations. The partnership now has to review where the funding lies, where it can be matched and how to maximise the funding amount from a place point of view.

JB queried the obesity strategy and if there were any plans in place to work with local industries, food outlets, transport companies, etc as

	the data for children was stark, i.e. 1 in 6 children who start school in Bexley are already either overweight or obese. Some of this work will emanate from national guidance and, whilst it is recognised as a system-wide issue, DB is hopeful that something fruitful can be carried out at place and MR is publishing a section in the Health & Wellbeing Strategy targeted at work at local level with various independent businesses. MR referred to the local School Superzones initiative, whereby 6 schools have been allocated funding to work with these local businesses as it is not so much about the availability and price of healthy food, but how to make the best impact and ensure residents have the knowledge and confidence to make the necessary changes. JB has worked with the University of Cambridge who produced positive evidence around what can be achieved and she encouraged Bexley to read their results, although she was equally pleased to hear about Bexley's addressing of the issue. **Action: DB/MR to review outside of meeting.** <u>Draft Bexley 3 Year Plus Integrated Improvement Plan Actions for inclusion in the Joint Forward Plan</u> The SEL 5-year document will be incorporating one complete summary of the 6 boroughs' individual plans, but DB proposes to extract the Bexley summary and use it for its 3-year plus plan. This is here for endorsement as the national timeline is the end of March. It will come back here for Committee sign-off and then by the Health & Wellbeing Board. It was noted that AR needed to make some slight amendments to the Start Well slide wording. **Action: AR.** The Bexley Wellbeing Partnership Committee: (i) **NOTED** the South-East London Integrated Care Board's approach, timelines and engagement programme for the Joint Forward Plan. (ii) **REVIEWED** and **ENDORSED** the summary actions for the draft Bexley Wellbeing Partnership 3 Year Plus Integrated Plan as part of the South-East London Integrated Care Board's Joint Forward Plan.	
8.	**Month 10 Finance Report** **David Maloney, Director of Corporate Finance, NHS SEL ICB** presented this item on behalf of Julie Witherall (AD of Finance (Bexley). **<u>Place</u>** • Small overspend of c.45k which has been driven almost entirely by overspend due to national pressures, not just in the case of Bexley. • Prescribing largely being offset, and expecting prescribing pressures to be non-recurrent and new financial year issues to be resolved.	**DM**

	• Forecast outturn overspend for borough is c£400k and Prescribing again is the key driver. **ICB** • The ICB's position is replicated across the SEL boroughs as, at M10, the key area of pressure was Prescribing and, overall, there is an approximate £6.5m overspend with a forecast of c.£10m by year end. The overspend is anticipated to be mitigated by the underspend position and the ICB have therefore predicted a forecast break-even position at year end. **ICS** • The ICS position includes both the ICB, but also the 5 providers in the SEL system – GSTT, King's, LGT, Oxleas and SLAM. There is a reported position of c.£51m as adverse to plan, but is reporting outturn of breakeven. There is not a great deal of non-recurrent funding to achieve the 2022/23 financial balance position and as is a once-only opportunity, there will be a fairly large overspend for 2023/2024. **Action: Group to e-mail DM with any questions.** • KW queried the Bexley budget position in terms of approving the budget for next year. DM told KW that the plan is for the ICB to take the overall Borough budgets to the SEL ICB meeting on 19th April and, once approved, will come here in May for approval. The Bexley Wellbeing Partnership Committee: (i) **DISCUSSED** & **NOTED** the Month 10 (January 2023) financial position for NHS South-East London ICS, NHS South East London ICB and Bexley Borough. (ii) **NOTED** the details of the 2022/23 allocations (programme and running costs) received and expenditure to date for both NHS South-East London ICB and Bexley Borough. (iii) **DISCUSSED** & **NOTED** the key risks identified for NHS South-East London ICB and NHS South East London ICS and how they relate to Bexley Borough. (iv) **NOTED** the details of the savings requirements for NHS South-East London ICB, NHS South East London ICS and Bexley Borough.	
9.	**Place Risk Register** **Simon Beard, Associate Director of Corporate Operations, NHS SEL ICB** noted the following risks on the Bexley risk register: • Risk 401 reflects the limitations on service delivery due to the non-recurrent nature of funding for winter schemes, meaning long term solutions cannot be put in place and built upon. • Risk 402 highlights the risk to residents discharged under Home First arrangements into the community where staffing and funding of community services are challenged. • Risk 423 identifies the risk that the borough will not be able to achieve financial balance in the financial year ending 31 March	**SiB**

	2023 on its delegated budget – principally due to increases in medicine costs and the lack of available stock meaning more expensive alternatives are being sourced. Risks 401 and 402 are rated as "very high" at 20, and risk 423 is given a medium risk scoring of 12. Our concern is that, for all 3 risks, the inherent and current risk scores are the same, indicating that the controls identified are not mitigating the effect of the risk. Since the last Committee meeting in public, risk 315 relating to the impact of resourcing on Learning Disability Continuing Healthcare Services has been closed on the Bexley risk register and replaced with a new risk relating to the wider impact across south east London and therefore added to the SEL-wide risk register. In addition, a further risk is in the process of being scoped, around the impact on service delivery for IAPT services following a change in criteria for secondary adult mental health services from GP registration to borough of residence. JB queried what constitutes a risk to before it is put on the register and felt there were possibly other local risks which should be included. SiB told JB that this is being debated and the risk management framework is currently being refreshed which deals with the wider system risks and how local risks are escalated to the SEL register. It is not a black and white process as there is a degree of individual assessment whereby risk-owners identify their concerns for their particular area of service delivery for the borough. It is hoped that the revised framework will make the process stronger and more transparent. JB suggested that the local risk register shows the criteria at the top of the page. **Action: SiB to consider.** DB agreed that consistency in descriptions is needed across all of the 6 boroughs and recognised that the NHS register is currently not sufficient for fully identifying/reporting risks. A Bexley risk-owner training session is taking place on 11th April led by the SEL Assurance Team and JB suggested the inclusion of the word "risk" in that training as risks may be being under-reported due to fear from using that particular expression. DB felt the suggestion was helpful, but pointed out that we are not delivering direct services which may put patients in danger. We are merely administrators and risk-owners. The Bexley Wellbeing Partnership Committee: (i) **NOTED** the risks on the risk register, and those closed/ proposed in the period since the last report to Committee (ii) **NOTED** the risk management process **(iii)** **CONSIDERED** if further mitigating controls could be put in place to reduce the impact of the risks and support reduction of the current risk score	
10.	**Public Questions** **Philippa Norris, Danson Youth Trust, Bexley MVP** said she had enjoyed the women's health section, but was disappointed that	**SD**

	there was nothing around maternity and post-natal health in the borough. Bexley does not have its own hospital and therefore these services are commissioned, and care varies depending on the individual trusts. The lived experiences do demonstrate the barriers in maternity and post-natal care. DB would be happy to accommodate a maternity item on a future agenda. **Action: DB.** **Terry Murphy** had 2 points: 1) He queried why the Lloyd's Pharmacy in Crayford was closing next month and why the residents were not given prior warning, as many residents require repeat prescriptions. RaM confirmed that all Lloyd's pharmacies in the Sainsbury stores will close, but a pharmacy needs assessment was carried out in Bexley which showed there will still be sufficient capacity to support Bexley residents. RaM assumed that Lloyd's will be advising all patients on its closures and said that they also provide an online service called Lloyd's Direct. RaM did say, however, that repeat prescriptions are done electronically and therefore patients can walk into any pharmacy for this service. SD reiterated that GP practices do not hold lists of pharmacies which patients use for their prescriptions. 2) TM felt that the wording contained within the slides could be enlarged as he had difficulty reading this on the screen and had to rely on the speakers presenting the slides to comprehend the content.	
11.	**Any Other Business** • SD queried that, as a voting member, was there any liability from them in or the organisation in the decision-making process. DB responded that this is a prime committee of the SEL ICB and it is us who are giving them assurances and therefore they are liable. • The technical issues experienced today were noted and will be addressed, particularly as the SEL Chief Executive Officer will be attending the next meeting in public in May. The Chair then closed the meeting.	**SD**
12.	**Glossary** These glossary terms were noted.	
13.	**Date of next meeting** Thursday 25th May 2023, 2:00pm to 4.00pm, Council Chamber, Civic Offices, 2 Watling Street, Bexleyheath, DA6 7AT.	

Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

Item: 5

Enclosure: C

Title:	**General Practice Premium Service**
Author:	Marina Moores, Primary Care Service Delivery Manager (Bexley), NHS South East London Integrated Care Board
Executive Lead:	Diana Braithwaite, Chief Operating Officer, (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	The purpose of this paper is to seek approval from the Bexley Wellbeing Partnership Committee of the recommendation from the Primary Care Delivery Group to commission a new GP Premium Service, which would run from 1st July 2023 to 31st March 2026. The new GP Premium consists of several additional service interventions delivered by individual GP Practices. Each of the service intervention has an associated Key Performance Indicators to ensure and measure delivery and impact. The service interventions reflect the priorities and challenges as set out by the Bexley Wellbeing Partnership. This new GP Premium amounts to an investment of circa £2m into GP Practices delivering primary care services if successfully delivered in full.	Update / Information	
		Discussion	
		Decision	***X***
Summary of main points:	The purpose of a GP Premium Service is to commission individual GP practices to deliver 'additional' service interventions to patients, which are above and beyond any national core contracts for primary care services. GP Premiums are used to focus and target additional GP resources on local priorities. This paper details the proposal to commission a new GP Premium for the period from 1st July 2023 to 31st March 2026, with details for the period of 1st July 2023 until 31st March 2024. These new service areas and associated Key Performance Indicators have been developed to: • Support the implementation of the national Fuller Stocktake Report. • Align with the Joint Local Health & Wellbeing Strategy and the Bexley Wellbeing Partnership three-year improvement plan. • Support the COVID recovery and pressure on the wider system. • Support the reduction of health inequalities in Bexley. The new GP Premium has been co-produced to accurately reflect the key areas of focus for primary care and to strategically align with the wider system priorities. During the development process engagement took place with key stakeholders through a series of individual meetings and task and finish		

groups. In addition, engagement too place with wider partners through existing forums such as the Mental Health Transformation Group, Local Care Partnership Forum, Primary Care Transformation & Development Group and the Local Medical Committee.

This document provides a summary of the proposed commissioning requirements for GP practices to achieve 100% of the allocated funding from 1st July 2023 to 31st March 2024.

It is not envisaged that there will be significant changes to these commissioned interventions in subsequent years – however, there will be a review of the indicators to ensure the GP Premium continues to be aligned with local priorities. Where changes are needed, the governance process outlined in this document will be adhered to.

The following service interventions are included in the new GP Premium and there are 10 Key Performance Indicators (See Appendix A) underpinning delivery and measuring outcomes:

- Patient Experience of General Practice

  Rationale: During the COVID pandemic reported patient experience via the National GP Patient Survey on GP Practices has deteriorated. From an average of 78% of those surveyed rating their experience as 'good or very good' in 2021, which dropped to an average of 63% in 2022. The NHS SEL ICB average is 82%.

  Intervention: GP practices via this premium are being incentivised to improve patients reported experience of General Practice to the SEL average of 82% of patients reporting their experience of GP practices as 'good or very good'.

- Early Detection & Prevention

  Rationale: GP Practices have a vital role to play in system-wide improvement efforts to increase the proportion of cancers diagnosed early, supporting the NHS Long Term Plan ambition to diagnose 75% of cancers at stages 1 and 2 by 2028. Data for September 2022 (latest national data) Bexley is at 68% for Bowel Screening and for Breast Screening 60%, which has dropped 7% from previous year.

  The aim of the cancer interventions is to improve the uptake of the national Bowel and Breast screening programmes by eligible adults, particularly those who have never been screened and those in under presented cohorts such as patients on the learning disability register and patients recorded as having serious mental illness.

  Intervention: GP Practices will be commissioned to improve the take up of Bowel and Breast Cancer Screening for eligible adults but also to ensure this happens for people with Learning Disabilities and Serious Mental Illness. In addition, funding will be provided to support collective discussions across all practices on Cancer and Palliative Care.

- Proactive and Personalised Care

  Rationale: Adopting proactive and pesonalised approaches to patients care, improves health and clinical outcomes, increases access to access to care, enables better health literacy and self-care and increases satisfaction with care.

Intervention/s: Personalised Care Plan – GP Practices will be commissioned to developed personalised care plans for patients with frequent attendances to primary care. The purpose is to; (i) identify and enable access to holistic support where needs are non-medical/clinical; and (ii) where needs are medical/clinical that timely reviews and support are provided.

Universal Care Plan – Universal Care Plans enable clinicians across London to co-create and share urgent and advance (End of Life) care plans across clinical and organisational boundaries, integrating with electronic record systems that are already used by clinicians (e.g., EMIS), and the London Care Record (the digital record of care accessible across all London health and care settings). GP Practices in Bexley will be commissioned create and publish care plans for the relevant patients.

- Improving Referral Management

  Rationale: Primary Care clinician refer fewer patients to hospital if they get timely special input first from secondary care. This means that patients get the right care first time. Rapid Advice & Guidance provides Primary Care Clinicians with access to relevant advice and tools to manage more patients in primary care.

  Intervention: GPs will be incentivised to use the Consultant Connect platform to seek advice from secondary care specialist to support making better informed decisions on referrals to hospital.

- Older and Frail People and End of Life

  Rationale: Bexley has an ageing population with 41,000 people aged 65 years and over. Proportionally Bexley has the third-highest proportion of people aged 65 years and over in London (16.6%).[1] In Bexley there are an estimated 23,500 people in aged 50 years and over with frailty. Around 17,000 mild, 4,300 moderate, 1,800 severe.[2] Frailty is mostly associated with the ageing process, where older people with frailty are more at risk of unpredictable deterioration and a severe long-term impact to health from a relatively 'minor' health or stressor event.

  Intervention/s: Frailty Reviews – GP Practices will be commissioned to undertake comprehensive quarterly reviews of patients with moderate frailty or vulnerable patients, which will include assessments for falls, incontinence, and carers support.

  Dementia Diagnosis – GP practices will be incentivised to increase Dementia Diagnosis rates for those over 64 years. Getting a timely diagnosis of dementia provides patients with a better understanding of the condition and what to expect.

  Mental Health

  Rationale: Bexley adults have a relatively low self-reported wellbeing compared to London and there has been an increase in children and young people in mental health crisis over the last few years, exacerbated by the pandemic.[3]

[1] Productive Healthy Ageing Profile - Data - OHID
[2] Census 2021, Royal College of General Practitioners
[3] Mental Health and Wellbeing JSNA - OHID

	Intervention: GP practices will be commissioned to increase the number of Serious Mental Illness Annual Health Checks – the national standard is 60% and Bexley at the last reporting period was at 49%. • <u>Obesity</u> *Rationale*: Obesity is a significant health issue and one of the biggest health challenges in Bexley. Bexley has among the highest rates of obesity in London across all age ranges.[4] There are key health inequalities in Bexley related to obesity, with the highest prevalence mainly in the north of the borough. Childhood overweight and obesity is a significant challenge for children in Bexley, alongside increasing acute presentations in mental health services. *Intervention*: This is a new requirement and GP Practices will be commissioned to appoint a GP Obesity Lead, attend additional obesity training and develop an action plan for implementation. • <u>Safeguarding</u> *Rationale*: Over the past 12 months Bexley has seen a significant increase in serious safeguarding incidents for children. There has also been an increase in Safeguarding Adult Reviews (SAR's) and Domestic Homicide Reviews (DHR's). Common safeguarding themes across both adults and children include self-neglect, domestic abuse, mental health, drugs and alcohol. GP Practices are the common denominator for all serious incidents because of the information they hold for all of the family. By creating a register for the more vulnerable patients this would enable the GP's to proactively identify those patients most in need of support and offer a more personalised care to individuals as required. *Intervention*: GP Practices will be commissioned to develop a 'safeguarding risk register' on their clinical systems, proactively identify, review and support those individuals with a multidisciplinary approach. • <u>Improving Treatment and Care in Primary Care</u> *Rationale*: This package of interventions will provide improve care and access to patients with Diabetes, attention deficit hyperactivity disorder (ADHD) and those requiring post-operative wound care. *Intervention/s*: Insulin Initiation – Insulin therapy is an important component of treatment of diabetes. Evidence indicates that early initiation of insulin therapy improves beta-cell function and mass by inducing 'beta-cell rest'. GP Practices will be commissioned to undertake full diabetes conversations and initiation with patients. Would Care – GP Practices will be commissioned to provide post-operative would care for patients. Medicines Management – GP practices will be commissioned to improve prescribing and monitoring of patients with ADHD in primary care.
Potential Conflicts of Interest	There is a *pecuniary* conflict of interest for GP representatives holding national General and Personal Medical Services contracts, who will be direct recipients and beneficiaries of PMS Premium funding.

[4] Obesity Profile - OHID

	In mitigation, the chair for this item will pass to another voting member of the committee and GP representatives/Primary Care Networks Clinical Leads will not vote and will be asked to leave the room for this item.	
Other Engagement	Equality Impact	The purpose of the GP Premium is to deliver additional and improved patient outcomes, over and above the requirements of national core Personal, and General Medical Services GP contracts. The GP Premium will specifically target known health inequalities within Bexley. It is therefore anticipated that the proposals will have a positive impact on reducing health inequalities at a population level and any unwarranted variation between GP practices.
	Financial Impact	The funding for these service interventions are within allocated budget and therefore there are no additional financial impacts for the NHS SEL ICB.
	Public Engagement	Not required for the purposes of this paper, however commissioners will seek to ensure engagement with patient group representatives and people with lived experiences in finalising proposals for any revised GP Premium.
	Other Committee Discussion/ Engagement	This new GP Premium has been co-produced with a wide range of key stakeholders, including clinicians, commissioners, and public health: • 25th January 2023 – Clinical Care & Professional Clinical Leads. • 17th February and 5th March 2023 – Local Care Partnership Forum. • 6th, 10th, 22nd, 23rd, 27th February 2023, 1st, 2nd, 4th, 17th, 20th, 24th, 27th March 2023 – Public Health and London Borough of Bexley. • 23rd March 2023 – Primary Care Development & Transformation Sub-Group. • 5th April 2024 – Primary Care Delivery Group. • 12th April and 20th April 2023 – Local Medical Committee (endorsement). • 26th April 2023 – Local Medical Committee Sub-group. • 3rd May 2023 – Primary Care Delivery Group (recommendation to approve – with the caveat to review the requirements for the obesity interventions at 6 months).
Recommendation:	The Primary Care Delivery Group recommends that the Bexley Wellbeing Partnership Committee: (i) Approve the commissioning of a new GP Premium for GP Practices and the associated Key Performance Indicators. (ii) To endorse the caveat that the Obesity requirements and associated Key Performance Indicators are reviewed at six months – given that this is the	

first of its kind to be included in a Bexley premium to ensure an early evaluation of outcomes and value for money.

Introduction

In May 2017, Bexley Primary Care Commissioning Committee approved the Personal Medical Services (PMS) premium Key Performance Indicators (KPIs) that would be in addition to all primary care contract types (Personal, Alternative or General Medical Service) for the period, from April 2017 to March 2021. This formal approval followed an extensive period of engagement with the Local Medical Committee on commissioning intentions, the associated specifications, monitoring arrangements and payments. Personal Medical Service Premiums commissions GP practices for services that exceed the requirements of the national core contract.

During the COVID pandemic, elements of the PMS Premium were suspended or adapted to support GP practices to focus on the pandemic response during the period from April 2020 to July 2021. The PMS Premium was fully re-instated from July 2021 and subsequently extended, with minor changes until June 2023 as agreed by Bexley Wellbeing Partnership Committee on 23rd March 2023.

The proposal to commission a new GP Premium for the period from 1st July 2023 to 31st March 2026, that has been developed to:

- Support the implementation of the national Fuller Stocktake Report recommendations.
- Align with and support, implementation and delivery of the Joint Local Bexley Health & Wellbeing Strategy and the Bexley Wellbeing Partnership three-year improvement plan.
- Support the COVID recovery and pressure on the wider system.
- Support the reduction of health inequalities in Bexley.

The new GP Premium has been co-designed to accurately reflect the key areas of focus for GP practices and to strategically align and deliver wider local health and care system priorities. Table 1 below sets out the service interventions of the new GP Premium and how they reflect and align with the Bexley Wellbeing Partnership local priorities and enable some national requirements.

During the co-development process engagement took place with key local health and care stakeholders – through a series of individual meetings, task and finish groups and with wider partners by joining the existing forums such as Mental Health Transformation Group, Local Care Partnership Forum and the Primary Care Transformation & Development Group.

Table 1 shows how this new GP Premium supports the relevant Bexley priorities.

Table 1 – GP Premium & Bexley Wellbeing Partnership Priorities

GP Premium elements	Bexley Wellbeing Partnership 3 Year Integrated Improvement Plan	Joint Local Health & Wellbeing Strategy	Fuller Stocktake Report
1. Patient Experience of General Practice:	Improving Access to Primary Care		Streamlining access to care and advice to meet the needs of infrequent users of health care services.
2. Bowel and Breast Cancer Screening.	Prevention		Helping people to stay well for longer, through a joined-up approach to prevention.
3. Treatment of Patients in General Practice (Shared Care, Wound Care, and Insulin Initiation)	Long-term Condition Management		Providing more proactive, personalised and multi-disciplinary care for people with more complex needs.

GP Premium elements	Bexley Wellbeing Partnership 3 Year Integrated Improvement Plan	Joint Local Health & Wellbeing Strategy	Fuller Stocktake Report
4. Referral Management	Improving Access to Primary Care		Streamlining access to care and advice to meet the needs of infrequent users of health care services.
5. Personalised Care Plans	Integrated Same Day Urgent Care & Improving Access to Primary Care		Streamlining access to care and advice to meet the needs of infrequent users of health care services.
6. Universal Care Plan	Older & Frail People Proactive & Personalised Care	Older & Frail People	Providing more proactive, personalised and multi-disciplinary care for people with more complex needs.
7. Frailty and End of Life (Early Dementia Diagnosis, frailty reviews)			
8. Mental Health (Serious Mental Illness Health Checks)	Proactive & Personalised Care Older Frail People	Mental Health	
	Long-term Condition Management	Mental Health	Helping people to stay well for longer, through a joined-up approach to prevention.
9. Obesity (Child and Adult)	Prevention Obesity/Children & Young People		
10. Safeguarding	Proactive & Personalised Care		

Funding Principles and Allocation

Funding for each Key Performance Indicator will be allocated based on the following principles:

- The allocated budget is determined based on the historical activity (2022/23 or pre-COVID 2019/20) and expected time required to complete required tasks, considering different staff groups.
- Actual activity numbers taken from either national data or EMIS Enterprise.
- The majority of KPIs have a qualitative element and completion of improvement or action plan will be required. Budget was also uplifted based on this additional requirement.
- Some KPIs are paid based on % achievement whilst others based on activity, as shown in Appendix A.
- Staff rates applied are as follows:
  - GP hourly rate £110
  - Nurse hourly rate £40
  - Admin hourly rate £25

The GP Premium investment of £9.15 and the allocation is shown in Table 2 to below.

Table 2 – GP Premium Allocation

No.:	New GP Premium	Per patient based on Weighted List Size	%	Total
1	Patient experience – National Patient Survey	£0.40	4.4%	£94,003.46
2	Bowel & Breast Screening; CRT meetings	£1.00	10.9%	£235,008.65
3	Shared Care & DMARDs	£1.65	18.0%	£387,764.27
	Insulin initiation in general practice	£0.20	2.2%	£47,001.73
	Wound Care	£0.40	4.4%	£94,003.46
4	Referral Management	£0.20	2.2%	£47,001.73
5	Frequent Users of General Practice	£0.90	9.8%	£211,507.79
6	Universal Care Plan	£0.80	8.7%	£188,006.92
7	Frailty and end of life	£1.20	13.1%	£282,010.38
8	Mental Health (Dementia and Serious Mental Illness)	£0.90	9.8%	£211,507.79
9	Obesity (Adults and Children)	£1.00	10.9%	£235,008.65
10	Safeguarding	£0.50	5.5%	£117,504.33
	Total	**£9.15**	**100%**	**£2,150,329.15**
	List Size for April 2023	235,009		

Engagement

The has been co-developed with the support and input of relevant stakeholders including clinicians, commissioners, public health, and key stakeholders. The list below sets out the dates and governance process undertaken:

- 25th January 2023: Meeting with Bexley clinical leads with further communication via email as agreed.
- 17th February and 15th March 2023: Early drafts were presented to the Bexley Local Care Partnership Forum.
- 6th, 10th, 22nd, 23rd, 27th February 2023; 1st, 2nd, 8th, 17th, 20th, 24th and 27th March 2023: Meetings were held with commissioners and specific elements clinical leads (including Public Health and London Borough of Bexley colleagues).
- 23rd March 2023: The first draft was presented to the Primary Care Development & Transformation Sub-Group.
- 5th April 2024: Engagement with the Primary Care Delivery Group took place on the first draft.
- 12th April and 20th April 2023: Informal engagement meeting with Local Care Medical committee with a formal submission to the Local Medical Committee for endorsement.
- 26th April 2023: Follow up meeting with Local Medical Committee representatives on the final draft.
- Regular email correspondence with all stakeholders on ongoing changes.
- 3rd May 2023: Final proposal was endorsed by the Primary Care Delivery Group for recommendation to the Bexley Wellbeing Partnership Committee for approval.

Reviews and Governance

To ensure that the new GP Premium is delivering on the agreed principles, the Key Performance Indicators will be reviewed periodically as follows:

End of financial year – At the end of each year Key Performance Indicators will be reviewed to determine how well they are meeting the expected outcomes (where applicable) and if they continue align with the Bexley Wellbeing Partnership priorities.

Changes to national contracts (General Medical Services, Personal Medical Services, Directed Enhanced Specifications and Quality Outcomes Framework) – Once any national changes are issued to core contracts, Key Performance Indicators will be reviewed to ensure that are no duplications of requirements and associated funding.

Changes to or release of new NHS SEL ICB incentives – Periodically, NHS SEL ICB is awarded funding, which is released to Primary Care Networks and/or GP practices for SEL specific programme delivery. The GP Premium will be reviewed will be reviewed against those programmes to ensure that are no duplications of requirements and associated funding.

The proposed changes will follow the usual approval process, however where changes are not significant and approval timeline does not align with the meeting schedule, email approval will be sufficient.

Payment

As previously agreed, the total yearly GP Premium funding will remain unchanged at £9.15 per weighted patient. Each practice will receive 75% of funding in 12 equal monthly payments. Achievement will be monitored quarterly and reconciled at year and. Outstanding monies will be paid at the end of the year or clawed back as soon as is practical.

Conflicts of Interest

Whilst it is important to ensure there is clinical input into schemes of this nature – it is important that the correct and proportionate balance is struck and demonstrated to manage what are essentially pecuniary conflicts of interest for all GPs.

In mitigation, the chair for this item will pass to another voting member of the committee and GP representatives/Primary Care Networks Clinical Leads will not vote and will be asked to leave the room for this item.

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Appendix A

Summary of the Key Performance Indicators (KPIs) & Payment

<table>
<tr><th>KPI No.:</th><th>Description</th><th>Funding allocation</th><th>Data submission requirement</th></tr>
<tr><td>1</td><td>Improving Patient Experience of GP Practice – National GP Patient Survey

a) 40% of incentive payment for activities relating to improvement.
b) 60% Payment for achieving 82% (rating good & very good) or 5% improvement from previous year (for 23/24 performance will be shared when data is published in July 2023) for National GP Patient Survey overall rating as below.
Past performance:
<table><tr><td>Average</td><td>2021</td><td>2022</td><td>2023 – baseline</td></tr><tr><td>Bexley average</td><td>78%</td><td>63%</td><td>TBC</td></tr><tr><td>SEL average</td><td>82%</td><td>70%</td><td>TBC</td></tr></table></td><td>£0.40 (pro rata) per weighted patient. Payment based on achievement for part b.</td><td>NHS SEL ICB will use national submissions to determine achievement for part b).</td></tr>
<tr><td>2</td><td>Cancer

GP Practices are asked to conduct activities to encourage patients to respond to the national breast and bowel cancer screening programme. This KPI is split as follows (pro rata for weighted patient):
a) £0.36 for activities relating to the call and recall of patients.
b) £0.25 for Bowel screening uptake for all eligible patients (excluding Learning Disabilities and Serious Mental Illness) of 75% or 5% improvement compared to previous year.
c) £0.11 for Bowel screening uptake of Learning Disabilities and Serious Mental Illness patients of 75% or 5% improvement compared to previous year.
d) £0.13 for Breast screening uptake for all eligible patients (excluding Learning Disabilities and Serious Mental Illness) of 75% or 5% improvement compared to previous year.</td><td>£1.00 (pro rata) per weighted patient.</td><td>NHS SEL ICB will extract data from EMIS Enterprise, for Vision report submission will be required.</td></tr>
</table>

KPI No.:	Description	Funding allocation	Data submission requirement
	e) £0.05 for Breast screening uptake of Learning Disabilities and Serious Mental Illness patients of 75% or 5% improvement compared to previous year. f) Attendance at the Cancer and Palliative Care Roundtable meetings – £250 per meetings and sharing learning with the practice staff. (These meetings must be attended by at least one clinician per practice.)		
3	**Improving treatment of patients in General Practice** **i. Drug prescribing and monitoring** Practiced are incentivised to prescribe and monitor patients as per Shared Care Agreement for – attention deficit hyperactivity disorder (ADHD) Prescribing: a) Monitoring of Patients on Specified Disease Modifying Anti-Rheumatic Drugs (DMARDs) b) Administration of Gonadorelin Analogue Injections and Review of Discharged Prostate Cancer Patients	**£1.65 (pro rata)** per weighted patient. Payment for service provision. GP Practices will be required to provide coding for activity monitoring purposes.	
	ii. Insulin Initiation GP Practices will be paid for every patient that has had a full insulin conversion within primary care, for people with type 2 diabetes including providing a service to other Tier 1 practices, following accredited training. This also includes patients on GPL1s. All above patients to be referred to XPERT insulin education programme via Book and Learn.	**£200** per patient Payment based on activity.	NHS SEL ICB will extract quantitative data from EMIS Enterprise, for Vision report submission will be required.
	iii. Post-operative wound care GP Practices are required to see patients in General practice for post-operative wound care as follows: • General post-surgical wound care • Removal of wound closures • Wound dressings • Assessment of wounds for healing progress and infection • Antibiotics assessment or similar • Management of complications	**£0.40 (pro rata)** per weighted patient. Payment for service provision. GP Practices will be required to provide coding for activity monitoring purposes.	

KPI No.:	Description	Funding allocation	Data submission requirement
4	**Referral Management** GP Practices will be incentivised to utilise Consultant Connect mobile phone application and/or eRS Advice & Guidance tools to discuss suitable cases with the secondary care consultant prior to making a referral. To be eligible for payment practices must achieve a 10% usage increase compared to previous years and record 90% of Consultant Connect outcomes for eligible contacts. Guidance documents will be provided.	**£0.20 (pro rata)** per patient on weighted list size. Payment based on submission of evidence.	TBC
5	**Personal Care Plans** a) Practices are required to utilise the Apex Edenbridge tool and **quarterly** review the list of patients who have had 5* or more attendances in the last 90 days (*or less if required numbers cannot be met). Identify and review patients and create a personalised care plan. These patients should have a follow up in an appropriate timeframe based on clinical need. This element is worth 80% of the total KPI funding. Consider referrals into support services such as: Social Prescribing, MIND in Bexley and Carers Support and others. b) GP Practices are required to run a search at the end of the year to determine how well the actions they have implemented for individual patients have had an impact on their attendances. Submit an end-of year report to Bexley Primary Care team. (Template will be provided). This element is worth 20% of the total KPI funding.	**£0.90 (pro rata)** per patient on weighted list size. Payment based % achievement for part a). The required number of quarterly reviews are 0.15% of practice weighted population.	NHS SEL ICB will extract data from EMIS Enterprise, for Vision report submission will be required.
6	**Universal Care Plan** a) New entries GP Practices will create and publish universal care plan for the expected number of patients who would benefit from creating such record (please note this excludes patient residing in a care home). GP Practices will also need to: • Identify and select suitable patients including. Consider people on end of life, multiple hospital admissions, several long-term conditions, coded as having severe frailty and those identified under Frequent Service users of services.	Expected funding allocation**:** **£0.80 (pro rata)** per patient on weighted list size. Allocation based on the following: **£70** per new published patient record	NHS SEL ICB will extract data from EMIS Enterprise, for Vision report submission will be required.

KPI No.:	Description	Funding allocation	Data submission requirement
	• Discuss the entry with the patient and offer patient a copy of their record and/or Advanced care Plan. • Load the required number of records onto the database, in line with minimum data set. **Record review** Practices to review records created more than 12 months ago. The record should be updated, as a minimum once a year and updated to include place of death once deceased. The register should be updated to show any key changes in condition or needs. All updates need to be published.	**£50** per updated and published patient record. Payment based on activity.	
7	**Patient reviews with moderate frailty** a) Practices to **quarterly** review required number of patients with moderate frailty or vulnerable patients (based on practice intelligence) who are NOT residing in a care home. Practices can use the electronic Frailty Index (e-FI) to search for patients (moderate frailty 0.24 – 0.36) or other ways to find suitable patients. This element is worth 80% of the total KPI funding. The review should include (where appropriate): - Previous hospital admissions in last 12 months - Advance Care planning including treatment escalation planning. - Falls risk assessment. - Mini mental health test 6 CIT test/ Dementia screening. - Medication review - Continence review - BP (lying and standing) – where possible. - Height and weight - Physical, functional, and social problems - Carer assessment - Understanding of likely prognosis/ progression **Review must result in an agreed care plan and appropriate care plan code to be added to patient notes. Please consider internal MDT discussion where needed.** Review may result in onward referral: - Frailty Clinic - Memory Clinic - IAPT - Specialist Palliative Care Referral - Community services for nursing or rehabilitation	**£1.20 (pro rata)** per patient on weighted list size. The required number of quarterly reviews are 0.275% of practice weighted population.	ICB will extract data from EMIS Enterprise, for Vision report submission will be required.

<table>
<tr><th>KPI No.:</th><th>Description</th><th>Funding allocation</th><th>Data submission requirement</th></tr>
<tr><td></td><td>- Community Connect, or direct referral to appropriate voluntary sector support/ befriending.
- Social care via local authority or One Bexley
- Signposting for simple equipment

Payment based on % achievements as follows:
<table><tr><th>Band A</th><th>Band B</th><th>Band C</th></tr><tr><td>≥90%
of expected activity

100% payment</td><td>≥50%
of expected activity

Payment based on %</td><td><50%
of expected activity

No payment</td></tr></table>
b) Practices are required to run a search at the end of the year to determine how well the actions they have implemented for individual patients have had a positive impact, and where this wasn't successful, submit an improvement plan to Bexley Primary Care team. (Template will be provided). This element is worth 20% of the total KPI funding.</td><td></td><td></td></tr>
<tr><td>8</td><td>Mental Health
1.Dementia Diagnosis
Practices are required to improve the current Dementia Diagnosis rate for Bexley population by undertaking search to identify patients aged 64 years and above who have Dementia but do not have Dementia diagnosis code on their record. To achieve this KPI practice must ensure all patients records are reviewed and appropriate patients coded, and searches conducted on a quarterly basis. (Detailed guidance will be provided).</td><td>£0.20 (pro rata) per patient on weighted list size.</td><td>NHS SEL ICB will run a search to evidence that this work has been completed.</td></tr>
<tr><td></td><td>2. Serious Mental Illness Annual Health Checks
GP Practices will be incentivised to achieve above 60% as per banding below (60% achievement is in IIF and individual elements of the AHC are in QOF). Practices are encouraged to review patients throughout the year.
<table><tr><th>Band A</th><th>Band B</th><th>Band C</th></tr><tr><td>≥70%
of expected activity

100% payment</td><td>≥65%
of expected activity

Payment based on %</td><td><60%
of expected activity

No payment</td></tr></table></td><td>£0.70 (pro rata) per patient on weighted list size.</td><td>ICB will extract data from EMIS Enterprise, for Vision report submission will be required.</td></tr>
</table>

KPI No.:	Description	Funding allocation	Data submission requirement
9	**Obesity (Children and Adults)** a) In Year 1 practices are required to undertake the following: • Appoint a GP Practice obesity lead. • Complete online training by 31st December 2023 (training to be determined by the Public Health). Training details, number of hours and staff requirement will be shared. • Attending obesity workshop - organised by the public health colleagues. • Complete an action plan – practices would be required to submit an action plan based on training sessions they have participated in on how to support the obesity agenda (separate child and adult plan will be required); these would have to be SMART plans with details of how they plan to measure the success of their plan. Document shared no later than 31st March 2024. (Template will be provided). b) Year 2 and year 3 requirements will be mainly focusing on practices implementing and measuring their action plan.	**£1.00 (pro rata)** per patient on weighted list size.	Payment based on submission of required evidence.
10	**Safeguarding** Practices are required to: 1. Undertake a piece of lead-in work to search for and then apply a specific code to, any vulnerable adult that met specified criteria (i.e., homeless, domestic abuse). Safeguarding team to support practices to identify patients. This could be worded as “safeguarding register”. 2. Organise a practice level MDT meeting and discuss patients on a regular basis. 3. Design a process for ensuring new registrations “safeguarding status” is captured. This will provide a benchmark for Year 2 & Year 3 KPI achievement.	**£0.50 (pro rata)** per patient on weighted list size.	

Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

Item: 6

Enclosure: D

Title:	**Primary Care Delivery Group Business Report – Q4 2022/23**
Author/Lead:	Graham Tanner, Associate Director Primary Care (Bexley), NHS South East London Integrated Care Board
Executive Sponsor:	Diana Braithwaite, Chief Operating Officer (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	The Bexley Primary Care Delivery Group (PCDG) is established as a sub-group of the Bexley Wellbeing Partnership (BWP) Committee. Under adopted Terms of Reference, the PCDG has two main functions that support the Bexley Wellbeing Partnership Committee in enacting the delegated function of primary care services: (i) To Support the delivery of the vision for integrated primary care as defined by the Next steps for integrated Primary Care, Fuller Report . (ii) Support the Bexley Wellbeing Partnership Committee by considering all primary medical services (PMS), general medical services (GMS), primary care network (PCN), local premium/incentives, out of hours GP services, alternative medical services (APMS) and contractual matters and providing recommendations for decision. The BWP Committee cannot formally 'double delegate' its decision-making accountability as a prime committee of the NHS South East London Integrated Care Board (ICB) but it is also not practical for each and every business item of Primary Care Delivery Group requiring a 'decision' to be fully reported and transacted within BWP Committee meetings. This is particularly the case when these items and the Group's recommendations and endorsements have no direct impact on non-GP system Partners or the partnership as a whole. It is therefore proposed that individual PCDG business items are reported to the BWP Committee in public by exception only (e.g., the	**Update / Information**	*x*
		Discussion	
		Decision	*x*

	GP Premium item discussed on 23rd March 2023) and that all other business is reported within a consolidated quarterly Business Update Report in the enclosed format. This includes items for the BWP Committee to formally note and approve on the basis of the recommendation and endorsement of PCDG. Under this proposed arrangement, the BWP Committee could, at its discretion, 'call in' any such items for additional consideration and/or request further clarification from the Associate Director, Primary Care.		
Summary of main points:	The enclosed paper details all items of business discussed and transacted by the Primary Care Delivery Group during Q4 2022/23 at its meetings held on: • Thursday 12th January 2023 • Wednesday 1st February 2023 • Wednesday 1st March 2023 Also, by exception, an item from 3rd May 2023 in order to expedite timely follow up with the GP Practice. All the above meetings were Quorate in line with the adopted Terms of Reference. The Committees attention is drawn to the following decision items endorsed by PCDG and requiring the formal approval of the BWP Committee. **1st March 2023** • **Belvedere Medical Centre Boundary Application –** Recommendation to approve. • **Personal Medical Services Premium Extension & 2023/24 GP Premium Development Plan** – Recommendation to approve (discussed and approved at the BWP committee meeting in public on 23 March 2023) • **Extension to the Bexley Care Homes Supplementary Network Service (SNS) Specification for Nursing & Residential Care Homes for 12 months (to commence 1st April 2023)** – Recommendation to approve (discussed and approved at the BWP meeting in public on 23 March 2023) • **Bexley Medicines Optimisation Programme 2023/24 –** Recommendation to approve. **3rd May 2023** • **Ingleton Avenue Surgery Boundary Application** - Recommendation to approve.		
Potential Conflicts of Interest	All GP voting members of PCDG and the BWP Committee are conflicted due to pecuniary interests associated with the four items highlighted above. The recommendation for BWP Committee approval is therefore based on the endorsement of non-conflicted voting members of the PCDG. GP voting members of the BWP Committee will also not be permitted to vote on approval of these items. The views of the Local Medical Committee (LMC)		

	and Local Pharmaceutical Committee (LPC) have been sought in relation to all four items, as applicable.	
Other Engagement	Equality Impact	None directly relating to this report.
	Financial Impact	All items with financial implications are deliverable within existing delegated primary care budgets.
	Public Engagement	None directly relating to this report.
	Other Committee Discussion/ Engagement	This report highlights business transacted by the Primary Care Delivery Group, in consultation with the Local Medical Committee and Local Pharmaceutical Committee as applicable.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) Note the report. (ii) Formally ratify those items noted as requiring the approval of the BWP Committee under NHS SEL ICB delegated authority.	

Bexley Wellbeing Partnership

South East London Integrated Care System

Agenda Item: 6

Enclosure: D(i)

Primary Care Delivery Group Business Report – Q4 2022/23

Bexley Wellbeing Partnership Committee – 25th May 2023

Graham Tanner – Associate Director, Primary Care (Bexley)

The Bexley Primary Care Delivery Group [PCDG] is established as a sub-group of the Bexley Wellbeing Partnership Committee.

Under adopted Terms of Reference, the PCDG has two main functions that support the Bexley Wellbeing Partnership Committee in enacting the delegated function of primary care services:

i. To Support the delivery of the vision for integrated primary care as defined by the Next steps for integrated Primary Care, Fuller Report .

ii. Support the Bexley Wellbeing Partnership Committee by considering all primary medical services (PMS), general medical services (GMS), primary care network (PCN), local premium/incentives, out of hours GP services, alternative medical services (APMS) and contractual matters and providing recommendations for decision.

Bexley Wellbeing Partnership

South East London Integrated Care System

Primary Care Delivery Group convened on three occasions January to March 2023, on the following dates:

- **Thursday 12th January 2023**
- **Wednesday 1st February 2023**
- **Wednesday 1st March 2023**

All meetings were quorate in terms of representation and voting members.

Key decisions made during PCDG meetings are reported through the Primary Care Business Update report at the Bexley Wellbeing Partnership Committee. Where PCDG does not have the authority to decide, it will vote on agreement with a recommendation to the Bexley Wellbeing Partnership Committee for consideration

The following table sets out the core business of those meetings and highlights any associated decisions or endorsements/recommendations for determination by the BWP committee.

Questions or points of clarification relating to this report and enclosures are invited from BWP Committee members and members of the public in line with the BWP Terms of Reference.

Bexley Wellbeing Partnership

South East London Integrated Care System

12th January 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Primary Care Networks DES – Finance & Funding Streams	The purpose of this paper was to provide transparency in relation to PCN Network DES 2022/23 allocations. 1. Outline the uses and management of key funding streams (that are in addition to core GMS/PMS/APMS contracts) which support the development of general practice, PCNs and the GP Federation in Bexley. 2. Provide an update on utilisation of the ARRS budget within 2021/22 and 2022/23 financial years. 3. Update on PCN Investment and Impact Fund (IIF) achievement during 2021/22 (performance based). 4. Seek endorsement of the plan for the GP Transformation fund element of the 2022/23 Strategic Development Fund, Bexley allocation.		**Approved**		The Primary Care Development Group resolved to: (i) Note the content of the report. (ii) Note the critical importance to the Bexley system of ensuring that the Additional Roles Reimbursement Scheme is used to maximum effect as this funding can only be drawn down if PCNs are able to effectively recruit to the roles. (iii) Endorse the distribution of GP Transformation fund element of the 2022/23 Strategic Development Fund.
Primary Care Networks Enhanced Access – Monitoring	The purpose of this paper was to set out a proposed local monitoring regime for the contractual requirements of Enhanced Access contained within the Network Contract DES, together with any additional locally agreed assurance arrangements		**Approved**		The Primary Care Development Group resolved to: (i) Note and agree the proposed monitoring regime for Enhanced access. (ii) Agree Quarterly reporting to Primary Care Delivery Group.

Bexley Wellbeing Partnership

South East London Integrated Care System

12th January 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
National GP Access Data @ 22.12.2022	This paper provided an overview of individual GP Practice Access Data published by NHS England at individual practice level for the first time on 24 November 2022. The PCDG was also asked to agree the best approach to supporting individual GP Practices with potential data anomalies in the published national data, sharing good practice and/or addressing indications of challenged performance	✔			The Primary Care Development Group resolved to: i. Note the publication of the national data on 24 November 2022 relating to GP appointments, practice payments and complaints. ii. Note the availability and functionality of the SEL GP Access Dashboard as presented and accepted by the PCDG on 07.09.2022, which sources the same data from GP clinical systems via Discovery in a more refined and user friendly format. iii. Agree to utilise the SEL GP Access Dashboard to share good practice and support challenged performance.
Primary Care Risk Register	This paper is presented as a standing item at Primary Care Delivery Group and is intended to track and monitor any identified risks which have the potential to negatively impact the delivery of universal and good-quality Primary Care within Bexley in the short, medium and long term. The scope will reflect delegated commissioning and contracting functions within the Integrated Care System (ICS).		**Approved**		The Primary Care Delivery Group resolved to: i. Note the recorded risks and mitigations and agree scores.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st February 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Belvedere Medical Practice Boundary Change Application	Dr Bhalla, Belvedere Medical Centre (the Contractor) has submitted an application to reduce his inner practice boundary and remove a discretionary outer boundary as defined within their Personal Medical Services (PMS) contract. This change requires the approval of the commissioner and a variation of contract.		**Deferred to 01.03.23**		Primary Care Delivery Group noted the following mitigations: (i) The practice is finding it increasingly challenging to provide the full range of services afforded by ARRS and expanded workforce within existing space limitations, further list size growth at the current rate, would exacerbate this situation. (ii) There are a number of surrounding practices who have open lists and are taking on new registrations, Lakeside Medical Practice, in particular, has capacity to expand. (iii) The proposal will not impact on patients already registered with the practice and/or children/immediate family members who will continue to be registered with the practice and be entitled to all services, including home visits. Primary Care Delivery Group sought further assurance and additional conditions, including that: (i) In line with PMC contract regulations, registered patients who subsequently fall outside of the new agreed area, but who are within the original practice area (main and outer boundary) can only be removed from the list if one or more of the provisions of the relevant regulations/directions that relate to removal of patients from the practice's patient list apply. The same applies to children and partners of those registered patients. (ii) Prior to review and determination by the Bexley Wellbeing Partnership Committee, Belvedere Medical Centre must evidence engagement with the North Bexley PCN Governing Body and its constituent practices, LMC, Patient Participation Group and Healthwatch, citing any additional issues/concerns raised.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st February 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Practice Visit schedule	This paper sets out to share information and provide assurance on our process and purpose for completing annual Practice Visits with all our GP healthcare settings. Practice Visits facilitate a two-way conversation to enable the ICB Primary Care team to understand issues relating to individual Practices and to disseminate and share good practice. Collaborative agenda planning helps the team to understand: • how care is delivered in line with contractual requirements • how different needs are managed activity/performance data • Quality • estates issues • workforce planning	✔			Primary Care Delivery Group resolved to: i. Note the practice visits update/information and ii. Provide feedback / further input as applicable. Periodic thematic reporting relating to practice visits will be scheduled for future PCDG meetings.
Primary Care Risk Register	This paper is presented as a standing item at Primary Care Delivery Group and is intended to track and monitor any identified risks which have the potential to negatively impact the delivery of universal and good-quality Primary Care within Bexley in the short, medium and long term. The scope will reflect delegated commissioning and contracting functions within the Integrated Care System (ICS).		**Approved**		The Primary Care Delivery Group resolved to: i. Note the recorded risks and mitigations and agree scores.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st February 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
SEL ICS 5YFV & 2023/24 Primary Care Operating Plan Requirements	This paper provided an overview of the key Strategic and Operational Planning Processes underway for 2023/24 and, in particular, elements that relate to delegated Primary Care and will require further input and engagement in line with national and regional assurance requirements and deadlines.	✓			The Primary Care Delivery Group resolved to: i. Note the three main strategic and operational planning processes described and the timescales for each key element.
Primary Care Appointments Dashboard	This paper was a standing item provided key screenshots and highlights from the SEL GP Access Dashboard with a verbal update on identified issues and trends.	✓			The Primary Care Delivery Group resolved to: i. Note the report.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st March 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Belvedere Medical Centre Boundary Application	This paper was a deferred item from the meeting of PCDG on 07.02.23. Dr Bhalla, Belvedere Medical Centre (the Contractor) has submitted an application to reduce his inner practice boundary and remove a discretionary outer boundary as defined within their Personal Medical Services (PMS) contract. This change requires the approval of the commissioner and a variation of contract.			**Recommend for Approval**	Following further clarification of additional conditions proposed at PCDG on 1 February. Primary Care Delivery Group resolved to endorse the application in light of agreed conditions and supporting evidence. Reasons for the recommendation: • The practice is finding it increasingly challenging to provide the full range of services afforded by ARRS and expanded workforce within existing space limitations, further substantial list size growth would exacerbate this situation. • There are a number of surrounding practices who have open lists and are taking on new registrations, Lakeside Medical Practice, in particular, has capacity to expand. • The proposal will not impact on patients already registered with the practice and/or children/immediate family members who will continue to be registered with the practice and be entitled to all services, including home visits. • No objections have been received from neighbouring practices, LMC, Healthwatch or the practices Patient Participation Group. • Belvedere Medical Centre accepts the Conditions proposed by the PCDG on 1 February 2023.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st March 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Personal Medical Services Premium Extension & 2023/24 GP Premium Development Plan	The purpose of this paper was to seek Primary Care Delivery Group (PCDG) endorsement on the interim proposal to be determined by the Bexley Wellbeing Partnership Committee on 23rd March 2023. The proposal described the short-term interim arrangements for the Personal Medical Services Premium 1st April until 30th June 2023, whilst the Bexley Wellbeing Partnership undertakes a more comprehensive review of funding and KPIs currently allocated within the PMS Premium.			**Discussed and approved at BWP committee on 23rd March 2023.**	The Primary Care Delivery Group resolved to endorse the following for determination by the Bexley Wellbeing Partnership Committee. i. Equal distribution of the PMS premium funding across all contract types which will amount to a new GP premium of £9.15 per weighted patient. ii. Extension to the existing PMS Premium KPIs at the same funding level of £4.99 per weighted patient. iii. Introduction of additional KPIs commensurate with the additional amount of investment (£4.16 per weighted patient after equal distribution) that is currently not specified, to ensure value for money is secured from this funding stream. iv. Interim extension of the PMS Premium from 1st April 2023 to 30th June 2023

Bexley Wellbeing Partnership

South East London Integrated Care System

1st March 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Extension to the Bexley Care Homes Supplementary Network Service (SNS) Specification for Nursing & Residential Care Homes for 12 months (to commence 1st April 2023)	This paper sought endorsement of the recommendation to the Bexley Wellbeing Partnership Committee that the current Care Homes SNS specification be extended with a minor variation, for a further 12 months from 1st April 2023 until 31st March 2024. The current service expires on 31st March 2023. This locally commissioned service supplements the national Enhanced Health in Care Homes (EHCH) service specification which is one of the seven service specifications that forms part of the Network Directly Enhanced Service (DES). The Network DES ends on 31st March 2024 and details of the subsequent scheme are yet to be published. During 2023/24 the commissioning intention is to undertake a more comprehensive review of the SNS service to determine the optimum model from April 2024 onwards. This review can only be undertaken once there is greater clarity on the future requirements of the scheme that supersedes the national Network Contract DES, from 1st April 2024. This paper also seeks for approval for the financially incentivised KPIs that form part of the SNS to be modified to ensure further quality improvements in the delivery of the SNS during its final year.			**Discussed and approved at BWP committee on 23rd March 2023.**	The Primary Care Delivery Group resolved to: (i) To endorse the recommendation to the Bexley Wellbeing Partnership Committee to extend the Bexley Care Homes Supplementary Network Service (SNS) Specification for Nursing & Residential Care Homes for 12 months from 1st April 2023 to 31st March 2024. (ii) To approve the extension of the completion timeframe requirement from two to four weeks for KPI 2. (iii) To approve the amendments to the incentive driven KPIs as set out. (iv) (To approve the change in payment models for incentive driven KPIs from a “per bed” to “per home basis”. (v) Support the intention to undertake a wider review of the contract and service model during 2023/24 once there is greater clarity on the future of nationally commissioned enhanced services requirements that relate to the delivery primary care support to care homes from April 2024.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st March 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Bexley Medicines Optimisation Programme 2023/24	The purpose of this paper was to detail the key areas of focus for this financial year aiming to improve best practice and cost-effective/best value prescribing in Bexley borough. • It is proposed that the Medicines Optimisation Programme (MOP) is continued in Bexley to help with the implementation of the Bexley QIPP plan for 2023/24. The 2023/24 QIPP plan is currently being developed but looking at the 5 proposed QIPP areas included in the MOP, self-care alone is estimated to produce £150k savings. The Medicines Optimisation Programme also aims to improve prescribing safety and quality through a clinical audit. • The scheme has been developed and 'clinically' approved by the Bexley Medicines Implementation Group in February 2023. • A total of £160k has been identified for this scheme for GP practices in Bexley.			**Recommend for Approval.**	The Primary Care Delivery Group resolved to: Endorse the 2023/24 Medicine Optimisation Programme – noting that formal approval will be required by the Bexley Wellbeing Partnership Committee at its next meeting in public.

Bexley Wellbeing Partnership

South East London Integrated Care System

1st March 2023

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Primary Care Network Contract Directed Enhanced Service and IIF 2022/23 Monitoring and Assurance	The purpose of this paper was to: i. Clarify the monitoring and assurance requirements for the Primary Care Network (PCN) Contract Directed Enhanced Service (DES) and Investment and Impact Fund for 2022/23. ii. For payment purposes, to set out the detail of those specifications that require manual intervention, how this is declared i.e. via Calculating Quality Reporting Service (CQRS), the proposal for validation/assurance, and any actions that need to be taken to release the payment. iii. Agree the use of monitoring templates supplied by NHSE London Region for the purpose of data collection.		**Approved**		Primary Care Delivery Group resolved to: i. Note the monitoring and assurance requirements for the PCN Network Contract DES and Investment and Impact Fund for 2022/23. ii. For payment purposes, to note the detail of those specifications that require manual intervention, how this is declared i.e. via CQRS, the proposal for validation/assurance, and any actions that need to be taken to release the payment. iii. Agree the use of monitoring templates supplied by NHSE London Region for the purpose of the necessary data collection and assurance
South East London Five Year Forward View and Bexley Three Year Plus Integrated Improvement Plan: Primary Care Strategic Priorities and Deliverables	This paper introduced a template to be submitted by Bexley ICB as part of the development of an Integrated SEL Five Year Forward View (5YFV) Strategy. It also recommends that the framework and content of that Five Year Forward View submission be endorsed as the basis of the Primary Care section within the DRAFT Bexley Three Year Plus Integrated Improvement Plan.	✓			Primary Care Delivery Group resolved to: i. Review and comment on the Five-Year View Template and agree whether the content is appropriate for inclusion within the Bexley Three Year Plus Integrated Improvement Plan in so far as it relates to Primary Care. ii. Collectively agree any additional recommendations or amendments for inclusion.

Bexley Wellbeing Partnership

South East London Integrated Care System

3rd May 2023 (Item included by exception)

Agenda Item	Key Considerations and Recommendations	Info. only	PCDG Decision	Recommendation to BWP	Outcome and applicable mitigations/conditions
Ingleton Avenue Surgery Boundary Change Application	The purpose of this paper was to: i. Seek endorsement of an application from Ingleton Avenue Surgery to reduce their practice boundary as they do not intend to grow their practice workforce in line with current rates of list size growth. Over the last few years they have seen an increase in the number of patients wishing to register at their practice, which they consider is being driven by high performance in the GP patient survey and the good access and continuity of care they offer to their patients. ii. The paper set out an assessment of the likely impact the proposed boundary change would have on patients and surrounding practices. iii. It also set out a number of improvement recommendations for practices in the vicinity of Ingleton Surgery, which would reduce the turnover of patients moving between local practices and re-registering.			**Recommend for Approval**	Primary Care Delivery Group resolved to: ENDORSED the Ingleton Avenue Surgery Boundary Change Application subject to the conditions noted below: • That, in line with their GMS contract existing patients and dependants will not be deregistered. • There will be further consultation with and dialogue with other neighbouring practices. • A commitment to ongoing participation by the practice in the development of the wider Bexley Health and Care System e.g. Local Care Networks. • Ongoing assurance that Ingleton Avenue Surgery patients are not disadvantaged due to, for example, non participation in the PCN Network DES

Bexley Wellbeing Partnership

South East London Integrated Care System

Thank you.

If you have any questions, please contact Graham Tanner on the details below.

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South East London Integrated Care System

Bexley Wellbeing Partnership

Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

Item: 7

Enclosure: E

Title:	**Draft Better Care Fund Plan 2023-25 and End of Year Return**
Author:	Steven Burgess, Policy and Strategy Officer, London Borough of Bexley Alison Rogers, Director of Integrated Commissioning, NHS South East London Integrated Care Board/London Borough of Bexley
Executive Lead:	Stuart Rowbotham, Bexley Place Executive Director/Director of Adult Social Care and Health, NHS South East London Integrated Care Board/London Borough of Bexley

Purpose of paper:	**To consider and endorse the Draft Bexley Better Care Fund Plan 2023-25 (Appendices A & B) on behalf of the NHS South East London Integrated Care Board.** **To authorise the Chief Operating Officer (Bexley), on behalf of NHS South East London Integrated Care Board, to finalise and jointly agree the BCF Plan 2023-25 with the Council, prior to Bexley Health and Wellbeing Board on 15th June 2023.**	Update / Information	
		Discussion	
		Decision	***x***
Summary of main points:	• The BCF Policy Framework and Planning Requirements 2023-25 were published on 5 April 2023. NHS South East London Integrated Care Board (ICB) and the London Borough of Bexley (the Council) are required to agree a joint plan for using the BCF pooled budget to support integration. The plan must be signed off by the Bexley Health and Wellbeing Board and submitted to NHS England by 28 June 2023. • The policy objectives remain the same as in 2022/23 and a separate National Condition has now been set for each one within the BCF Policy Framework: (i) Enable people to stay well, safe and independent at home for longer and (ii) Provide the right care in the right place at the right time. • BCF objectives link to priorities on reducing pressure on Urgent and Emergency Care and social care, as well as tackling pressures in delayed discharges. • The fund continues to require a minimum spend level on adult social care and NHS commissioned out of hospital services from the minimum NHS contribution. • Capacity and demand planning is an integral part of the BCF this year. This covers health and social care capacity for intermediate care and short-term care to prevent admissions and support discharge. It should complement wider capacity planning relating to the Market Sustainability and Improvement Fund and Urgent and Emergency Care capacity plan. • The plan covers the two-year period 2023/24 and 2024/25. Some aspects of Year 2 spending plans are provisional and the metric and capacity and		

	demand plans only cover Year 1. A review point is therefore envisaged later in the year to update plans for Year 2. • The BCF Planning Template collects information on the activity that the BCF will fund, including expected outputs from scheme types related to discharge, intermediate care, unpaid carers and housing. • Subject to the ICB and Council agreeing a joint plan, the Bexley Health and Wellbeing Board will be asked to sign-off the plan at their meeting on 15 June 2023. • As the timing of the next meeting of the Bexley Wellbeing Partnership Committee falls after 15 June 2023, it is proposed that the Committee authorises the Chief Operating Officer (Bexley), on behalf of NHS South East London ICB, to finalise and jointly agree the BCF Plan 2023-25 with the Council. • Once submitted, the plan will be subject to a regional assurance and moderation process with the possibility that further changes or actions may be needed to address specific issues and secure plan approval from NHS England. • Any issues arising from the assurance process will be addressed by the Authorised Officers on behalf of the Council and ICB in line with the Bexley Health and Wellbeing Board's existing protocol for the operational management of BCF submissions. • Officers will report back to future meeting(s) of the Committee to keep the Committee informed and updated.
Potential Conflicts of Interest	There are two scenarios in which a perceived or potential conflict of interest for Directors in integrated roles arise: (i) The Bexley Place Executive Director and Director of Adult Social Care and Health is the Executive Sponsor of this report in both roles and is recommending the draft plan be endorsed by the Bexley Wellbeing Partnership Committee on behalf of the NHS South East London ICB. (ii) Changes may need to be made to finalise and jointly agree the plan between the London Borough of Bexley and NHS South East London ICB and secure its approval from NHS England, under appropriate delegation. Firstly, this may give the perception that Directors in integrated roles will be negotiating on behalf of both the Council and the ICB to finalise and agree the plan. Secondly, a potential conflict of interest may arise when the duties of a postholder in connection with the furtherance of integrated working conflict with the duties owed by that postholder to the appointing party. In order to mitigate the perceived or potential conflicts of interest: (i) The joint role of the Bexley Place Executive Director and Director of Adult Social Care and Health will not partake in decisions or recommendations by the Committee to endorse or agree the plan on behalf of the ICB; (ii) In the event that an integrated working conflict arises, and which affects the ability of Directors in integrated roles to act in the best interests of both Parties, the postholder will as soon as possible inform the ICB's Chief Operating Officer (Bexley) and the Council's Monitoring Officer that an integrated working conflict exists.

	(iii) On receiving notice of a potential conflict of interest, which affects the ability of Directors in integrated roles to act in the best interests of both Parties, the Council and the ICB shall make alternative arrangements for decision making on those areas notified. (iv) Any negotiations required to help with finalising and agreeing the BCF Plan 2023-25 will be supported by the Chief Operating Officer (Bexley), on behalf of NHS South East London ICB, and the Deputy Director of Adult Social Care, on behalf of the London Borough of Bexley.	
Other Engagement	Equality Impact	Our draft plans include consideration of the Core20 PLUS5 framework, where required. Section 11 of the Draft Bexley BCF Narrative Plan 2023-25 (Appendix A) considers our local priorities for addressing health inequalities and equality for people with protected characteristics, and how BCF-funded services are being delivered to address these. We have some further work to review and update this section of the Draft Plan, subject to further engagement with colleagues across the Council, ICB and partners.
	Financial Impact	The indicative value of services within the scope of the BCF Pooled Fund in 2023/24 is approximately £83.0m of which the ICB funds around £48.8m and the Council funds around £34.2m. This is estimated to increase to approximately £83.7m in 2024/25. The proposed spending plans cover two years with plans for 2024/25 provisional. Bexley's ICB allocation from the Discharge Fund in 2024/25 has yet to be confirmed. The Draft BCF Planning Template (Appendix B) includes further details of the schemes being funded and the indicative expenditure proposed on each scheme. This is subject to final scheme values being confirmed as part of a jointly agreed plan between the Council and ICB and signed off by the Bexley Health and Wellbeing Board. The BCF Pooled Fund is governed by a section 75 Agreement between the Parties and the schedules to the Agreement will need to be updated by 31 October 2023 once the plan has been approved by NHS England.
	Public Engagement	We consulted on the original proposals to enter into the section 75 agreement in 2020/21, which included the arrangements for the Bexley BCF Pooled Fund.
	Other Committee Discussion/ Engagement	We have attended meetings of the Bexley Wellbeing Partnership Executive, Bexley Home First Board and Home First Operations Group. We will continue to engage with officers across the Council, South East London ICB and our key partners as we work towards the BCF planning submission deadline of 28 June 2023.

		We are working with the Council's Housing Services and the Grants Team Manager to support the development of a strategic, joined up plan for Disabled Facilities Grant spending. The Council's Corporate Leadership Team will consider a report on the Draft BCF Plan 2023-25 on 18 May 2023. Officers will report back to Bexley Health and Wellbeing Board and the Bexley Wellbeing Partnership Committee on the delivery of the plans during the course of the financial year. Quarterly BCF reporting will commence from Quarter 2 in 2023/24 and will cover progress in implementing the BCF plan, progress against metrics and ongoing compliance with the requirements and conditions of the fund. These reports will need to be signed off by the Bexley Health and Wellbeing Board (or signed off on the Board's behalf with appropriate delegation). These arrangements are further described in Schedule 5 of the section 75 Agreement. As the BCF Plan submission is happening now, the next review of our BCF Plan is expected to take place ahead of winter and before the start of 2024-25.
Recommendation:	The Bexley Wellbeing Partnership Committee is asked/recommended to: (i) Consider and endorse the Draft Bexley Better Care Fund Plan 2023-25 (Appendices A & B) on behalf of the NHS South East London ICB. (ii) Note the requirement for the BCF Plan to be agreed by the ICB (in accordance with ICB governance rules) and the Council's Chief Executive and signed off by Bexley Health and Wellbeing Board (the latter is taking place on 15 June 2023). (iii) Authorise the Chief Operating Officer (Bexley), on behalf of NHS South East London ICB, to finalise and jointly agree the BCF Plan 2023-25 with the Council. (iv) Request that Officers report back to the Committee (meeting in private) on 22 June 2023 and/or to the Committee (meeting in public) on 27 July 2023 to keep them informed and updated. (v) Note the requirement for the section 75 Agreement to be updated by 31 October 2023 once the BCF Plan 2023-25 has been approved by NHS England. (vi) Note the draft BCF End of Year Return 2022/23 (Appendix C), which confirms that Bexley continued to meet the requirements of the BCF during 2022/23.	

BEXLEY WELLBEING PARTNERSHIP COMMITTEE

THURSDAY 25th MAY 2023

DRAFT BETTER CARE FUND PLAN 2023-25 AND BCF END OF YEAR RETURN 2022-23

1. INTRODUCTION

The BCF Policy Framework and Planning Requirements 2023/24 were published on 5 April 2023 (see **List of Background Documents**). NHS South East London Integrated Care Board (ICB) and the London Borough of Bexley are required to agree a joint plan for using the BCF Pooled Fund to support integration. In order to meet the external deadline for submission, the plan must be considered by the Bexley Health and Wellbeing Board on 15 June 2023 with a view to signing off the final plan and submitting this to the national Better Care Fund Team by 28 June 2023.

The purpose of this report is to ask the Bexley Wellbeing Partnership Committee to consider and endorse the Draft Bexley Better Care Fund Plan 2023-25 (Appendices A & B) on behalf of the NHS South East London ICB.

As the timing of the next meeting of the Bexley Wellbeing Partnership Committee falls after 15 June 2023, it is proposed that the Committee authorises the Chief Operating Officer (Bexley), on behalf of NHS South East London ICB, to finalise and jointly agree the BCF Plan 2023-25 with the Council. Officers will report back to the Committee (meeting in private) on 22 June 2023 and/or to the Committee (meeting in public) on 27 July 2023 to keep the Committee informed and updated. The BCF Pooled Fund is governed by a section 75 Agreement between the Council and ICB and the schedules to the Agreement will need to be updated by 31 October 2023 once the plan has been approved by NHS England.

This report also provides feedback on the performance of the BCF Pooled Fund. At the time of writing this report, the BCF End of Year Return (see draft return at Appendix C) was being prepared for submission on 23 May 2023. The return confirms that Bexley continued to meet the requirements of the BCF during 2022/23.

2. BETTER CARE FUND 2023-25: NATIONAL CONDITIONS

The BCF Policy Framework sets out four national conditions that the BCF plan must meet to be approved. These are:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board. Plans must be agreed by the ICB (in accordance with ICB governance rules) and the Council's Chief Executive, prior to being signed off by the Bexley Health and Wellbeing Board.
- Plans must set out how the services the area commissions will support people to remain independent for longer and, where possible, support them to remain in their own home.
- Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time.
- NHS contributions to adult social care and NHS commissioned out of hospital services to be maintained in line with the uplift to NHS minimum contribution to the BCF. The Draft BCF planning template (Appendix B) will confirm whether the minimum expectation has been met.

3. OVERVIEW OF BEXLEY'S DRAFT BCF PLAN 2023-25

3.1 Bexley Draft BCF Narrative Plan 2023-25:

The Draft Narrative Plan reflects how we will work together in 2023-25 to continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider services locally. It describes:

- How we have involved stakeholders in preparing the plan;
- The governance arrangements for the BCF plan and its implementation in our area;
- Key themes and funding contributions;
- Key changes since our last BCF plan;
- National Condition 1 - Our overall BCF plan and approach to integration, including our joint priorities for 2023 to 2025, alignment to our other plans and strategies, approaches to joint/collaborative commissioning, and how BCF funded services support our approach to integration;
- Implementation of the BCF policy objectives to enable people to stay well, safe and independent at home for longer (National Condition 2) and provide the right care, in the right place at the right time (National Condition 3);
- How the BCF plan and BCF funded services are supporting unpaid carers;
- Our strategic approach to using housing support, including DFG funding, that supports independence at home;
- How activity in BCF plans will support equality and address health inequalities.

The Draft Narrative Plan reflects and builds on previous plans. We have focussed on reviewing and updating the content of the plan in response to the BCF National Conditions and Planning Requirements. There is still some work needed to refine some sections of the plan and this is the subject of further engagement with colleagues across the Council, ICB and partners over the course of the next month or so. We can also make an optional draft BCF planning submission to seek feedback from BCF Regional Leads. In London, the BCF Regional Leads will accept draft plans up to 9 June 2023 upon which they would then provide feedback.

3.2 Bexley Draft BCF Planning Template 2023-25:

We are developing a draft joint spending plan to meet the national conditions and planning requirements, subject to further discussions and agreement between the Council and ICB. The Draft Planning Template includes:

- A draft intermediate care and short-term care capacity and demand plan. This initially covers the 12 months from April 2023 to March 2024 with refreshed plans required ahead of winter and before the start of 2024-25.
- Funding contributions to the draft plan and BCF Pooled Fund for 2023-25, including the minimum NHS contribution to the BCF, the Disabled Facilities Grant and improved BCF, the Discharge Fund, and additional voluntary contributions from the Council and ICB;
- An indicative scheme-level expenditure plan, which mainly reflects our existing schemes, and includes information about how the schemes are funded and the types of services they are providing;
- Our proposed performance plans, subject to further consideration of our local ambitions for each of the BCF metrics in 2023/24;
- A checklist to confirm that the national conditions and other planning requirements are met.

4 BETTER CARE FUND METRICS

The BCF Planning Requirements set out five metrics for monitoring and reporting (see below). Our draft metric plans for 2023/24 are included in Bexley's Draft BCF Planning Template (Appendix B). It should

be noted that these draft ambitions are subject to further discussions and agreement as to whether they are appropriate. The proposals are based on an initial analysis of data but may require further iteration, taking into consideration how BCF-funded activity will impact on key metrics. As the Draft Bexley BCF Planning Template is an Excel template, it is not easy to publish this information and so we have summarised our metric ambitions below:

4.1 Avoidable admissions:

The metric on avoidable admissions measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. This is an indicator of how successfully we manage long-term or chronic conditions. Subject to further discussions and final agreement, our proposed plan for 2023/24 is based on stabilising the rate at no more than 764.6 avoidable admissions per 100,000 population and preventing further increases, where possible.

4.2 Falls:

Data for this metric from the Public Health Outcomes Framework currently shows that there were 1045 emergency hospital admissions due to falls in people aged 65 and over in Bexley in 2021/22. There were more injuries from falls among people in the over 80's age group (720), than among the 65–79-year-olds (320). The overall rate of emergency hospital admissions due to falls in people aged 65 and over was 2187 in London and 2100 in England in 2021/22. In comparison, Bexley's rate was 2400 per 100,000 population.

As the inclusion of this metric is a new requirement for BCF plans in 2023/24 and 2024/25, we are working with the ICB's Business Intelligence and Analytics Team to consider baseline data and will add this into the BCF dashboard report to support monitoring of this indicator during the year. Subject to further discussions and final agreement, our proposed plan is to prevent further increases in the rate of emergency hospital admissions due to falls in people aged 65 and over. Our proposed target for 2023/24 is for the indicator value to be no higher than the position in 2021/22. This is considered stretching within the context of predicted increases in the number of emergency admissions due to falls.

4.3 Discharge to Usual Place of Residence:

This metric measures the percentage of people, who are discharged from acute hospital to their usual place of residence. There is evidence that recovery and independence for people who have been admitted to hospital are improved if they are discharged to their own home. Within the context of system pressures, our proposed plan for 2023/24 is to maintain existing good performance in Bexley at over 90%. Subject to further discussions and final agreement, our proposed ambition is to ensure that 91.7% of people, resident in the Health and Wellbeing Board area, are discharged from acute hospital to their normal place of residence. If achieved. this would represent an improvement on our expected performance in 2022/23 (91.5%).

4.4 Reablement:

This metric measures the proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation. Reablement seeks to maximise an individual's level of independence and to minimise their need for ongoing support and dependence on public services. Subject to further discussions and agreement, a provisional target rate of 90.7% is proposed based on maintaining existing good performance, similar to pre-pandemic levels of performance.

4.5 Residential Admissions:

This metric measures the annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. Subject to further discussions and final agreement, we have set out a proposal in the draft plan similar to last year's ambition, which was to return to levels of admission that are no greater than the London average. The London average in 2021/22 is a rate of 401.2 per 100,000 population aged 65+.

5 THE BCF END OF YEAR RETURN 2022/23

The BCF End of Year Return 2022/23 (Appendix C) provides monitoring information and narrative sections to capture the overall progress made to deliver our BCF Plan 2022/23. It reflects the following:

5.1 Confirmation of BCF national conditions

The BCF End of Year Return 2022/23 confirms that all BCF national conditions were met. The BCF Plan 2022/23 was jointly agreed by the Council and ICB and signed off by the Bexley Health and Wellbeing Board on 5 September 2022. The plan was approved by NHS England in January 2023. Our section 75 agreement was updated and agreed by all parties by the end of January 2023. This took into account some additional changes in-year to pool the ASC Discharge Fund 2022/23 and ICB Health Inequalities funding.

Compliance with the conditions on maintenance of social care and NHS commissioned out of hospital expenditure was confirmed to the Bexley Health and Wellbeing Board on 5 September 2022 and this was assured through the BCF Planning Template for 2022/23.

We have continued to support the delivery of the BCF Policy Objectives to (i) enable people to stay well, safe and independent at home for longer and (ii) provide the right care in the right place at the right time through a range of existing schemes and initiatives. We have provided year-end feedback in the BCF End of Year Return and reflected on our progress and learning in the Draft BCF Plan 2023-25.

Our staff have worked closely with the hospitals to help meet the substantial demands from hospital discharges. We received positive feedback from acute hospitals about Bexley's performance and how we have worked collaboratively to ensure people are supported to be discharged, relieving pressure on emergency departments.

5.2 Assessment of progress against the national metrics:

We have reported that we are on track to meet our targets for 2022/23 against two of the four national metrics:

Avoidable Admissions – not on track:

Our local monitoring via NHS South East London ICB suggests that the rate has decreased from 761.0 avoidable admissions per 100,000 population in 2021/22 to 751.9 (-1.2%) in 2022/23. However, this was above the target rate of 739 per 100,000 population.

Table 1 - Avoidable admissions (rate per 100,000 population), 2022/23

Indicator	Q1	Q2	Q3	Q4
Indicator value (Plan)	187	167	192	193
Indicator value (Actual)	189.3	176.0	189.7	196.9
Number of admissions	470	437	471	489
Population	248,287	248,287	248,287	248,287

Source: NHS South East London ICB, May 2023.

Discharge to usual place of residence – on track:

Our local monitoring via NHS South East London ICB suggests that we are maintaining existing good performance in Bexley above 90%. In the period April 2022 to February 2023, 91.5% of people were discharged from acute hospital to their normal place of residence. This compares to a target for the year as a whole of 90.8%. At the time of writing this report, March 2023 data was not yet available.

Table 2 - Discharge to usual place of residence, 2022/23

Quarter	Q1	Q2	Q3	Q4
Plan	**91.5%**	**91.1%**	**90.5%**	**90.2%**

Numerator	4,665	4,459	4,283	3,986
Denominator	5,100	4,897	4,734	4,418
Actual	**91.5%**	**91.8%**	**91.3%**	**TBD**
Numerator	4,668	4,738	4,563	TBD
Denominator	5,101	5,160	5,000	TBD

Source: NHS South East London ICB, May 2023.

Admissions of older people (65+) to care homes – not on track:

Provisional data for 2022/23 shows a rate of 444.2 new admissions to residential and nursing care homes per 100,000 population (65+). This is calculated based on 187 older people whose long-term support needs were met by admission to residential and nursing care homes. This is a lower rate than was recorded in 2021/22 (545.9). However, the provisional rate of 444.2 new admissions is higher than our BCF target rate of 430.0. Final outturns will be published later in the year.

Table 3 - Admissions of older people (65+) to care homes.

Indicator		**2021/22 Actual**	**2022/23 Plan**	**2022/23 Provisional**
Long term support needs of older people (aged sixty-five and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	545.9	430.0	444.2
	Numerator	224	181	187
	Denominator	41,033	42,097	42,097

Source: LB Bexley, May 2023 and ONS 2018-based Sub-National Population Projections.

Effectiveness of reablement – on track:

Table 4 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Indicator		**2021/22 Actual**	**2022/23 Plan**	**2022/23 Provisional**
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.1%	87.1%	90.5%
	Numerator	172	183	277
	Denominator	202	210	306

Source: London Borough of Bexley, May 2023.

Provisional data for 2022/23 shows that 90.5% of older people (65 and over), who were discharged from hospital into reablement, were still at home in the 91-day follow-up period for each case. This is calculated on the basis of those older people who were discharged from hospital into reablement between October and December 2022 and the outcomes achieved during the 91-day follow-up period (January to March 2023). The provisional rate of 90.5% is better than our BCF target rate of 87.1%. Final outturns will not be published until later in the year.

5.3 Confirmation of income and expenditure during the year:

The return includes confirmation of income and expenditure during the year. This has been summarised in **Section 8.1** below.

5.4 Year-end feedback on the delivery of the BCF:

The return gives year-end feedback on the delivery of the BCF and highlights how we have been working together across health, social care, housing and other services to provide better joined up and integrated community-based care. This includes:

- Continued delivery of a range of prevention and early intervention services, including social prescribing, provision of information, advice, and advocacy, support for carers, and help for people with a disability to access healthcare services.
- Housing adaptations, equipment schemes and wheelchair services to help people to maintain independence and to live independently within their own home. During 2022/23, the Council carried out a review of its approach to housing adaptations, repair and improvements. A new Housing Assistance Policy was adopted at the end of March 2023, which sets out the mandatory and discretionary assistance that the London Borough of Bexley wishes to offer, including conditions and eligibility criteria.
- The new arrangements for 'Care at Home' commenced in April 2022 and a gradual mobilisation has taken place over the course of the last year, moving from multiple providers to three new providers aligned with our Local Care Networks. Our new model for care at home includes three Recovery and Reablement Providers, where each provider is aligned to one of three LCNs. This enables providers and partners to work together collaboratively.
- Our 'Home First' approach has supported the provision of better care, closer to home. Partnership working around the acute hospital systems and our year-round offer has continued to offer several options to prevent admission to hospital by our residents and to support safe discharge.
- Partners are working collaboratively, including through the Integrated Care System, Bexley Wellbeing Partnership and our Bexley Care Partnership, to improve the health and wellbeing of our residents. This is focussed on delivering joined up health and care services, tailored to individuals, through Local Care Networks, Multi-Disciplinary Team (MDT) working and Community Integrated Case Management meetings.
- Existing local enhanced services through the pooled fund ensure care home residents receive dedicated medical services and supports a more proactive approach to care planning. Our successful virtual MDT model, coordinated by Bexley Care, supports care homes with issues, such as medication reviews, fluids, mobility, falls and behaviour management; all of which helps to avoid admission to hospital;
- Personalised services for people with a learning disability are ensuring that they can exercise greater choice and control through Self Directed Support. The Council recently held an event with Think Local Act Personal about Individual Service Funds. ISFs are proving popular with young people and we now have 10 new providers on our framework. We have seen good uptake of annual health-checks for people with a learning disability during the course of the year. Personal Health Budgets continue to be promoted (e.g., wheelchair personal budgets) and PHBs are also considered in CHC plans. We are continuing a lot of work to get people out of hospital quickly and preventing admissions. The outcome is minimal people in Assessment and Treatment Units.

5.5 ASC Discharge Fund 2022/23:

In December 2022, a spending plan was agreed between the Council and ICB in respect of the ASC Discharge Fund 2022/23. This made available an additional £1.7m in the London Borough of Bexley to help reduce delays in discharge from hospitals and support those who are fit to leave hospital so that they can continue their recovery in the most appropriate location. The spending plan comprised a range of schemes to provide additional capacity and to support the delivery of discharge care options. Reporting of additional activity as a result of the ASC Discharge Funding was undertaken on a fortnightly basis. We have reflected on the learning from the ASC Discharge Fund in the Draft BCF Plan 2023/24 (pages 42-43).

6 PROPOSED TIMESCALES

Milestone	Date
BCF report and draft plan to Bexley WPC (in public)	25/05/2023
Optional draft BCF planning submission	09/06/2023
BCF report and draft plan to Bexley Health and Wellbeing Board	15/06/2023
Option to provide an update to Bexley WPC (in private) if required	22/06/2023
BCF planning submission deadline	28/06/2023
Approval letters issued	08/09/2023
Prepare revised schedules to section 75 Agreement	w/c 11/09/2023
Consult Cabinet Member for ASC and Health on changes to section 75 Agreement	September 2023
Section 75 Agreements / change authorisations signed and in place	31/10/2023

7 LEGAL IMPLICATIONS

The statutory and financial basis of the Better Care Fund (BCF) is described in the BCF Policy Framework and the BCF Planning Requirements (see **List of Background Documents**). The BCF Pooled Fund is governed by a section 75 Agreement between the London Borough of Bexley and NHS South East London ICB and the schedules to the Agreement will need to be updated by 31 October 2023 once the proposed Bexley BCF plan for 2023-25 has been jointly agreed by the Parties, signed off by the Bexley Health and Wellbeing Board, and approved by NHS England. The BCF End of Year Report for 2022/23 has been prepared in line with national guidance.

8 FINANCIAL IMPLICATIONS

8.1 Better Care Fund Outturn 2022/23

Financial contributions to the BCF Pooled Fund under the section 75 agreement have taken place from the approved budgets/financial plans of the Council and NHS South East London ICB and are subject to regular financial monitoring, annual review and audit. We have maintained records of spending against schemes funded through the BCF and have reported actual income and expenditure in the BCF return. Bexley's BCF Pooled Fund for 2022/23 is summarised in Table 5:

Table 5 – Summary of Funding Sources, Bexley BCF Pooled Fund 2022/23

Funding Source	Planned Income	Actual Income	Difference (Actual minus Planned)
Disabled Facilities Grant	£2,964,977	£2,964,977	£0
Improved Better Care Fund	£6,616,137	£6,616,137	£0
Minimum NHS Contribution	£18,455,329	£18,455,329	£0
Additional NHS Contribution	£30,174,109	£30,531,109	£357,000
Additional Local Authority Contribution	£23,660,000	£23,660,000	£0
Total BCF Pooled Budget 2023/24	**£81,870,552**	**£82,227,552**	**£357,000**
ASC Discharge Fund (ICB)	£941,558	£941,558	£0

ASC Discharge Fund (Local Authority)	£773,646	£773,646	£0
ASC Discharge Fund Total	**£1,715,204**	**£1,715,204**	**£0**
Total BCF plus ASC Discharge Fund	**£83,585,756**	**£83,942,756**	**£357,000**

The total value of services within the scope of the BCF Pooled Fund in 2022/23 increased from £81.871m to £83.943m of which the ICB funded £49.928m and the Council funded £34.015m. Schedules to the section 75 Agreement were updated in January 2023 to reflect the approved BCF Plan 2022/23 (£81.871m), the agreed ASC Discharge Fund 2022/23 (£1.715m), and the Health Inequalities Fund (£0.357m).

Bexley's expenditure against the BCF Pooled Fund for 2022/23 is summarised in Table 6**:**

Table 6 – Summary of Expenditure, Bexley BCF Pooled Fund 2022/23

Funding Source	Planned Expenditure	Actual Expenditure	Difference (Actual minus Planned)
Disabled Facilities Grant	£2,964,977	£2,964,977	£0
Improved Better Care Fund	£6,616,137	£6,616,137	£0
Minimum NHS Contribution	£18,455,329	£18,455,329	£0
Additional NHS Contribution	£30,174,109	£30,230,940	£56,831
Additional Local Authority Contribution	£23,660,000	£23,660,000	£0
Total BCF Pooled Budget 2023/24	**£81,870,552**	**£81,927,383**	**£56,831**
ASC Discharge Fund (ICB)	£941,558	£941,558	£0
ASC Discharge Fund (Local Authority)	£773,646	£900,554	£126,908
ASC Discharge Fund Total	**£1,715,204**	**£1,842,112**	**£126,908**
BCF plus ASC Discharge Fund	**£83,585,756**	**£83,769,495**	**£183,739**
Additional NHS Contribution - Health Inequalities Fund		-£56,831	-£56,831
BCF plus ASC Discharge Fund	**£83,585,756**	**£83,712,664**	**£126,908**

Actual expenditure in 2022/23 was £81.927m against the original planned BCF Pooled Fund of £81.871m (not accounting for the ASC Discharge Fund). This was +£0.57m higher due to additional expenditure on ICB-funded health inequalities projects, which has been met by the additional NHS contribution from the Health Inequalities Fund. The remainder (c£0.300m) of the original (£0.357m) Health Inequalities Fund was carried forward to be used in 2023/24.

In December 2022, the Council and ICB agreed a Spending Plan for the ASC Discharge Fund (£1.715m), comprising a Local Authority allocation of £0.774m and an ICB allocation of £0.941m. The Council has reported additional expenditure of £0.127m in the monitoring returns for the ASC Discharge Fund 2022/23 that was not covered in full by the grant funding received. Further details have been provided in 'Tab 7 - ASC Discharge Fund' of the BCF End of Year Return.

The 2023/24 carry-forward of iBCF ASC grant and balances in respect of ICS transformation projects are still being discussed by the Finance Leads and once agreed an update will be provided.

8.2 Provisional Bexley BCF Pooled Fund 2023/24 and 2024/25

The indicative value of services within the scope of the BCF Pooled Fund in 2023/24 is approximately £82.963m of which the ICB funds around £48.794m and the Council funds around £34.169m. This is

estimated to increase to approximately £83.721m in 2024/25. The proposed spending plans cover two years with plans for 2024/25 provisional. The Draft BCF Planning Template (Appendix B) includes further details of the schemes being funded and the indicative expenditure proposed on each scheme.

This is subject to final scheme values being confirmed as part of a jointly agreed plan between the Council and ICB, signed off by the Bexley Health and Wellbeing Board.

A summary of the funding sources for the Bexley Health and Wellbeing Board area is shown in Table 7 below:

Table 7 – Summary of Funding Sources, Bexley BCF Plan 2023-25

Funding Source	2023/24	2024/25
Minimum NHS Contribution	£19,499,901	£20,603,595
Discharge Fund (ICB)	£964,000	TBD
Additional NHS Contribution	£28,330,109	£28,330,109
Sub-Total (ICB contribution)	**£48,794,010**	**£48,933,704**
iBCF	£6,616,137	£6,616,137
DFG	£2,964,977	£2,964,977
Discharge Fund (Local Authority)	£927,572	£1,545,953
Additional Local Authority Contribution	£23,660,000	£23,660,000
Sub-Total (Local Authority contribution)	**£34,168,686**	**£34,787,067**
Total BCF Pooled Budget	**£82,962,696**	**£83,720,771**

Section 8e of the Draft BCF Narrative Plan (Appendix A) confirms that funding from the minimum ICB contribution for reablement (£1.3m), carer-specific support (£463k), and Care Act duties (£545k) have been identified in our indicative spending plans**.**

9 RISKS AND MITIGATION MEASURES

Risk	Mitigation Measure
The pressure on acute hospitals and expectations around prioritising discharge do not diminish in the short term. The additional discharge funding is not sufficient to facilitate discharge from hospital at the scale required. The impact of additional demand arising from earlier discharge from hospital results in additional costs to the ASC budget, over and above the current discharge funding available.	Talk to partners and establish whether any more funding is likely to be available in 2023/24 and 2024/25. Work with our partners to plan hospital discharge arrangements that are affordable from core NHS and local authority expenditure in 2023/24 and 2024/25. Use Capacity and Demand Planning to help understand the challenges and to support system change. Consider other initiatives to reduce the pressure on the Emergency Department and hospital beds and to provide targeted care for people in the community (e.g., virtual wards).
Bexley's BCF plan for 2023/24 is not approved.	Ensure Bexley's BCF plan meets the BCF planning requirements. Access support to achieve approval as soon as possible. Consider escalation, where appropriate, to

	assist in reaching agreement on a compliant plan.
BCF schemes are not delivered as planned and/or metric ambitions are not achieved.	We have set out clear plans to support the achievement of local ambitions in 2023/24. The Integrated Commissioning Team jointly manage the contracts for services to support the realisation of the outcomes and benefits.

10 SUMMARY OF OTHER IMPLICATIONS

Equal Opportunities

Section 11 of the Draft Bexley BCF Narrative Plan 2023-25 (Appendix A) sets out our local priorities for addressing health inequalities and equality for people with protected characteristics, and how BCF-funded services are being delivered to address these. We have some further work to review and update this section of the Draft Plan, subject to further engagement with colleagues across the Council, ICB and partners.

HR Implications

There are no HR implications arising from this report.

Community Safety

There are no community safety implications arising from this report.

Environmental Impact

There are no environmental impact implications arising from this report.

Human Rights

There are no human rights implications arising from this report.

Health and Well-Being of the Borough

BCF-funded schemes and services are expected to have a positive impact on the health and wellbeing of the Borough.

Data Privacy

There are no data privacy implications arising from this report.

Asset Management

There are no asset management implications arising from this report.

Local Government Act 1972 – section 100d
List of background documents

Better Care Fund Planning Requirements 2023-25, NHS England, 4 April 2023:
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2023-25/

Better Care Fund Policy Framework 2023 to 2025, Department of Health and Social Care and Department for Levelling Up, Housing and Communities, 4 April 2023:
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025

Better Care Fund 2023-25: minimum NHS contributions from integrated care boards, NHS England, 4 April 2023: https://www.england.nhs.uk/publication/better-care-fund-2023-25-minimum-nhs-contributions-from-integrated-care-boards/

Social care funding: grant determinations for 2023-24, Department for Levelling Up, Housing and Communities, 29 March 2023: https://www.gov.uk/government/publications/social-care-funding-grant-determination-for-2023-to-2024

DFG allocations, published on Foundations website: https://www.foundations.uk.com/library/dfg-allocations/

Hospital discharge and community support guidance, Department of Health and Social Care, 31 March 2022: https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance

Disabled Facilities Grant (DFG) delivery: guidance for local authorities in England, Department for Levelling Up, Housing and Communities and Department of Health and Social Care, 28 March 2022: https://www.gov.uk/government/publications/disabled-facilities-grant-dfg-delivery-guidance-for-local-authorities-in-england

Managing transfers of care – A High Impact Change Model: Changes 1-9, Local Government Association: https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high/about

Contact Officers:	Alison Rogers, Director for Integrated Commissioning, London Borough of Bexley and NHS South East London ICB (Bexley), 020 8298 6025 Steven Burgess, Policy & Strategy Officer, LB Bexley, 020 3045 5242
Reporting to:	Stuart Rowbotham, Place Executive Lead (Bexley)/Director of Adult Social Care, NHS South East London Integrated Care System/London Borough of Bexley

Appendix A – Draft Bexley Better Care Fund Narrative Plan 2023-25
Appendix B – Draft Bexley Better Care Fund Planning Template 2023-25
Appendix C - Draft Bexley BCF End of Year Return 2022/23

Agenda Item: 7; Enclosure: E(i) – Appendix A

Bexley Better Care Fund Plan 2023-25

Draft: 17 May 2023

Contents

1) Health and Wellbeing Board(s)

This is the Better Care Fund Plan for Bexley Health and Wellbeing Board.

2) Our partners

a) Partners involved in preparing the plan

Partner involvement/engagement is currently underway on the draft plan.

- London Borough of Bexley.
- NHS South East London Integrated Care Board.
- Bexley Health and Wellbeing Board.
- Bexley Wellbeing Partnership Committee.
- The main acute and non-acute trusts, including Lewisham and Greenwich NHS Trust; Dartford and Gravesham NHS Trust; King's College Hospital NHS Foundation Trust; and Oxleas NHS Foundation Trust.
- GPs, including Primary Care Network Clinical Directors, and the GP Federation (Bexley Health Neighbourhood Care Community Interest Company).
- Healthwatch Bexley, Bexley Voluntary Service Council and a range of third sector organisations with whom we work directly.

b) How have we involved these stakeholders?

The draft plan was considered by the Bexley Wellbeing Partnership Committee on 25 May 2023 and Bexley Health and Wellbeing Board on 15 June 2023.

In preparing the plan, we have engaged with officers across the Council, South East London Integrated Care Board and our key partners. Our plans, including demand and capacity planning, metric plans and ambitions, have been discussed by the Bexley Wellbeing Partnership Executive, Bexley Home First Board and Home First Operations Group. The Home First Board includes Director-level representation and gives leadership to our Home First approach, which includes activity to support admission avoidance and

discharge funded by the BCF. Implementation and delivery of our approach is managed via our weekly multi-agency Home First Operational Meeting.

We have engaged with the Council's Housing Services and DFG lead on BCF planning. Housing services have contributed to our BCF Plan, approving all housing-related narrative and scheme-level expenditure in order to ensure a joined-up approach to improving outcomes across health, social care, and housing. Officers participate in regional DFG Champions Workshops and regular meetings are being held between Housing and Adult Social Care and Health.

We have reflected our priorities for addressing inequalities, taking account of the contribution of existing schemes in our BCF plan. This has included consideration of the Core20PLUS5 framework.

3) Governance

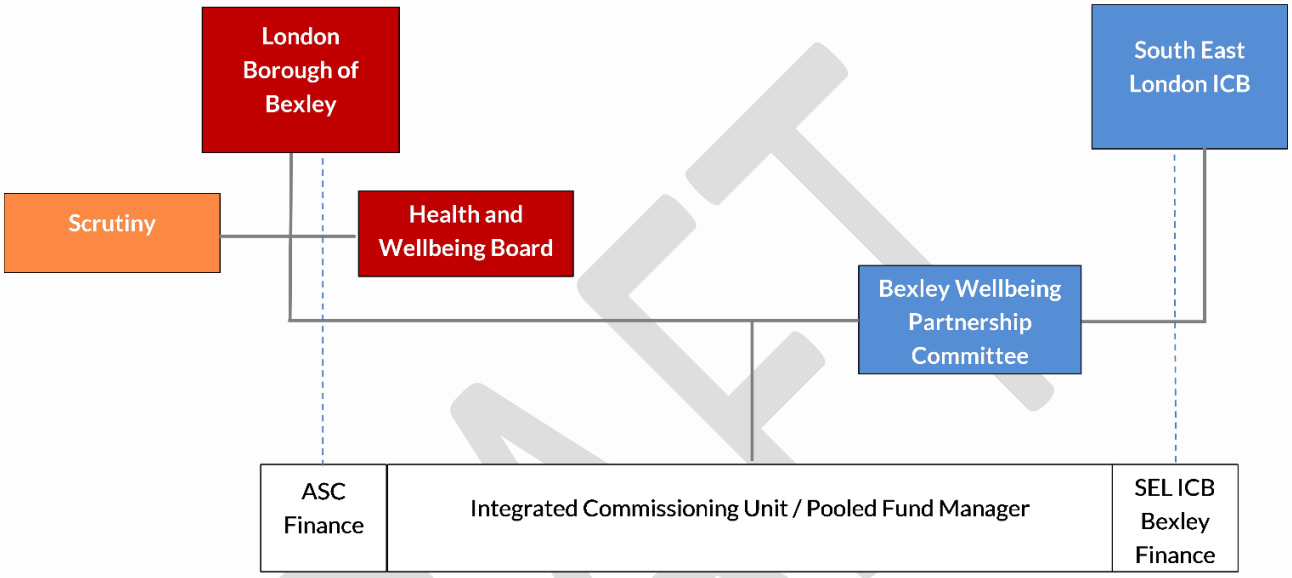
The governance arrangements for the Better Care Fund support joint working and reflect the roles of the Bexley Wellbeing Partnership Committee, the Bexley Health and Wellbeing Board and the Integrated Commissioning Team (see Figure 1). Through the section 75 agreement, the Council and NHS South East London ICB (as the successor body to NHS South East London Clinical Commissioning Group) have jointly agreed how the BCF pooled fund is governed and used to deliver shared outcomes in accordance with the formal legal framework.

The governance arrangements ensure there is transparency, accountability, and the ability to scrutinise and challenge through public meetings of the Bexley Health and Wellbeing Board, the Bexley Wellbeing Partnership Committee, the NHS South East London ICB and through the Council's Cabinet and scrutiny function.

The NHS South East London ICB has established the Bexley Wellbeing Partnership Committee as a prime committee of the ICB with delegated executive powers. Members of the committee are held to account by the ICB for undertaking duties for agreed areas of delegated responsibility.

The Bexley Health and Wellbeing Board is the accountable body for the BCF and integration work being undertaken under the section 75 agreement between the Council and the ICB, which includes responsibility for signing off local BCF plans and submissions.

Figure 1 – Section 75 Governance Arrangements



The Bexley Wellbeing Partnership Committee and the Bexley Health and Wellbeing Board receive reports on the BCF Pooled Fund. The Director of Integrated Commissioning is the Pooled Fund Manager and will work with other Directors in integrated roles, the Finance Leads, and the Integrated Commissioning Team to oversee the preparation of relevant information, including BCF quarterly and end of year reports.

The Integrated Commissioning Team will be responsible for commissioning services to meet the health and wellbeing needs of the local population and managing the service contracts. The Team is jointly accountable through the Pooled Fund Manager to the Council and ICB. They work together with providers towards the achievement of the aims and outcomes of our BCF plan.

4) Overview of key themes and funding contributions

The pooled budget for the BCF mainly comprises resources for existing schemes in Bexley and includes a significant level of additional voluntary contributions from the partners (see Table 1 below). This enables a more strategic, outcomes-based approach to be taken through one large, BCF pooled fund.

Table 1 – Provisional Summary of Funding Sources, Bexley BCF Plan 2023-25

Funding Source	2023/24	**2024/25**
Minimum NHS contribution	19,499,901	20,603,595
Additional NHS contribution	28,330,109	28,330,109
ICB Discharge Funding	964,000	TBD
Improved BCF contribution	6,616,137	6,616,137
Disabled Facilities Grant	2,964,977	2,964,977
Additional Local Authority contribution	23,660,000	23,660,000
Local Authority Discharge Funding	927,572	1,545,953
Total BCF Pooled Budget*	**82,962,696**	**83,720,771**

*subject to agreement of the BCF Pooled Fund between the Parties.

The ICB portion of the Discharge Funding is allocated nationally based on an ICB footprint. This means that the ICB should agree with the relevant local Health and Wellbeing Boards how ICB routed funding is apportioned in individual BCF plans. Below we have set out the proposed approach to allocating this funding:

The ICB received a recurrent funding uplift to support system wide discharge improvement totalling £8.785m. The ICB has proposed that, on a system wide

basis, South East London makes recurrent provision of £1.111m for the homeless discharge offer, which was funded non recurrently in 2022/23.

After taking account of the above, the split of the balance of the ICB's Discharge Funding will be applied on a weighted population basis across South East London's six Local Care Partnerships.

Some of the funding sources are estimated or have yet to be confirmed:

- Additional Voluntary Contributions are estimated based on 2022/23 scheme values and will need to be confirmed by the ICB and Council Finance Leads.
- For planning purposes, the Local Authority's Discharge Funding allocation shown in the BCF Planning Template for 2024/25 has been estimated based on applying the national increase for 2024/25 to the 2023/24 allocation. The ICB Discharge Funding allocation for 2024/25 has yet to be confirmed.
- For planning purposes, we have assumed that the 2024/25 Disabled Facilities Grant (DFG) allocation is based on the distribution remaining the same.
- Additional DFG funding over 2 years has been announced to fund supplementary services that are agile and timely to help people stay independent. The details of how this funding will be made available are currently being finalised. More information on this will be provided in summer 2023.
- The value of the iBCF in 2024/25 is indicative only. We have planned on the basis that the grant allocation will be consistent with the approach taken in 2023/24.

The total value of services within the scope of the BCF Pooled Fund in 2023/24 is approximately £83m of which the NHS South East London ICB funds around £48.8m and the Council funds around £34.2m. This is expected to increase to approximately £83.7m in 2024/25 but the partners will need to confirm final 2024/25 plans towards the end of the year.

The existing services in the BCF Pooled Fund include:

- Prevention and early intervention services, including support to carers.
- Learning disability services
- Integrated physical disability and sensory support service
- Housing adaptations
- Integrated older people services
- Discharge to Assess home care
- Enhanced health in care homes
- Bexley Community Health Services
- Winter resilience funding
- End of Life Care services.

The arrangements will enable the Council and NHS South East London ICB to work together more creatively with partners to deliver on our shared ambitions for integration. A breakdown of BCF planned expenditure by theme is shown in Table 2.

Table 2 –Funding allocated by theme

Theme Number	Theme title	2023/24 £m	%	2024/25 £m	%
Theme 1	Prevention and early intervention	2.3	2.8	2.3	2.7
Theme 2	Enabling people to stay well, safe, and independent at home for longer	5.0	6.0	5.0	5.9
Theme 3	Developing a more proactive and integrated out-of-hospital offer with a focus on anticipatory care, admission prevention and discharge support	7.6	9.1	7.2	8.6

Theme 4	Personalised health and social care at home or in the community	8.3	10.0	8.3	9.9
Theme 5	Deliver care closer to home, ensuring optimum management of long-term conditions in the community	31.6	38.1	31.6	37.8
Theme 6	Transforming care and helping people with a learning disability and/or mental health needs to have a good life in the community	24.7	29.7	24.7	29.5
Theme 7	Enabling people in the last months and days of life to be well-cared for	1.6	1.9	1.6	1.9
Theme 8	Integrated commissioning	1.9	2.4	3.0	3.7
Totals		**83.0**	**100**	**83.7**	**100**

5) Key changes to Better Care Fund plan

a) Key changes to our BCF Plan during 2022/23

Our BCF Plan 2022/23 was submitted to the national BCF Team in September 2022 and was approved by NHS England in January 2023. At the time the plan was submitted, the Government also announced its Plan for Patients on 22 September 2022. This committed £500 million nationally for the latter part of 2022/23 to support timely and safe discharge from hospital into the community.

Further details regarding the ASC Discharge Fund followed in November 2022. This made available an additional £1.7m in the London Borough of Bexley to help reduce delays in discharge from hospitals and support those

who are fit to leave hospital so that they can continue their recovery in the most appropriate location. A spending plan was completed for the Bexley Health and Wellbeing Board and agreed between the Council and NHS South East London ICB. This was submitted on 16 December 2022 and it comprised a range of schemes to provide additional capacity and to support the delivery of discharge care options. Reporting of additional activity as a result of this funding has taken place on a fortnightly basis.

At the same time, we also included the Health Inequalities Funding (**Scheme 7**), allocated to the Bexley Wellbeing Partnership by the ICB, in the local BCF section 75 agreement (£0.357m for 2022/23 and £0.536m thereafter).

Our section 75 agreement, covering the whole of the BCF plan including the Health Inequalities Funding and the Adult Social Care Discharge Fund monies, was updated and agreed by all parties by the end of January 2023.

In 2022/23, the total value of services within the scope of the BCF Pooled Fund increased from £81.9m to approximately £83.9m of which the ICB funded around £49.9m and the Council funded around £34.0m.

b) Key changes to our BCF Plan 2023/24 and 2024/25

The most significant change between 2021/22 and 2022/23 was the end of the national discharge funding (£5.3m in 2021/22) with effect from 1 April 2022. The ending of this funding was highlighted as a key challenge in our end of year report in 2021/22 and again in our 2022/23 BCF Plan. To help mitigate the risk of disruption, our BCF Plan for 2022/23 included £2.4 million from the NHS South East London ICB to support the transition to a more sustainable hospital discharge scheme within the financial resources available. As this funding from the ICB was non-recurrent, it will not be available to support hospital discharge beyond 2022/23.

In recognition of the immense challenges being faced by the NHS and social care, £1.8m has been allocated from the Discharge Fund in 2023/24, comprising £0.928m (via the Local Authority) and £0.964m (via NHS South East London ICB) (**Schemes 20-28**). We propose to use the Discharge Fund allocations in 2023/24 and 2024/25, where appropriate, to continue to

support investments made in services from the ASC Discharge Fund in 2022/23.

An important consideration in our planning is the fact that the ASC Discharge Fund in 2022/23 only covered a 15 week period from 16 December 2022 to 31 March 2023, whereas the Discharge Fund 2023/24 covers 12 months, but the funding allocated is at a similar level. The additional funding is, therefore, unlikely to be sufficient to facilitate discharge from hospital at the scale required by the NHS and government.

In the short term, we do not expect the pressure on acute hospitals to diminish and anticipate that we will face a shortfall against the discharge funding available if demand keeps its pace. We have highlighted this risk and the learning from the ASC Discharge Fund 2022/23 in our submissions to Government and with national partners so that this can inform policy and planning. The risk has also been reported to the Bexley Health and Wellbeing Board and the Bexley Wellbeing Partnership Committee, and we will continue to consider with partners what else we can do locally to mitigate this.

In the meantime, health colleagues have been briefed on the reduced resources available in 2023/24 and how Bexley intends to maintain a supportive discharge system within the budget available.

We have continued to make some provision in our plan to help meet cost and demand pressures (**Scheme 61**). In addition, the uplift from the Minimum NHS contribution in both years of our BCF Plan (**Schemes 62 & 63**) will be allocated by the partners to individual schemes.

6) National Condition 1 - Overall BCF plan and approach to integration

a) Our joint priorities for 2023-25

Our 2023-25 BCF Plan focuses on adults aged 18 years and over and those with the greatest needs, including older people, people with a disability

and/or mental health needs, people with long term conditions, and their carers.

Our BCF plan sets out the financial resource pooled within the BCF (see Table 1) to enable the delivery of integrated community-based care for the Bexley population.

Our joint priorities for 2023-25 have been expressed as eight key themes, which encompass a wide range of schemes and activities:

Theme 1 – Prevention and Early Intervention (Schemes 1-7): This theme comprises investment in Prevention and Early Intervention Services including grant funding for a range of third sector organisations. The services range from providing information, advice, and advocacy through to support for carers and helping people with a disability to access healthcare services. They aim to improve the health and wellbeing of communities, particularly by maintaining the independence of vulnerable adults and those who care for them in the community in order to prevent, delay or reduce reliance on support from statutory social care and health services.

Social Prescribing (**Schemes 5 and 6**) is well developed in Bexley. Community Connect, our social prescribing service led by Bexley Voluntary Service Council, has operated Borough-wide since October 2017. Since 1 October 2022, the contract for social prescribing has been held by the ICB. This means that the Council pays the ICB its contribution, rather than vice versa.

In 2022/23, the Council and ICB agreed to pool the Health Inequalities Fund into the BCF. The aim of this funding is to address health inequalities by providing a targeted approach to the most deprived 20% population, focussing on the Core20PLUS5 framework. Bexley was allocated approximately £357k in 2022/23 and a recurrent £536k per annum. This funding (under **Scheme 7**) is being used to support a range of initiatives, including carers counselling, support for people experiencing or recovering from domestic abuse, children's social prescribing pilots, cook and eat classes, food bank bike storage, NHS health checks, smoking in pregnancy outreach,

and activity in school's superzones. Other proposals for spend will also be considered in support of efforts to tackle health inequalities.

Theme 2 – Enabling people to stay well, safe, and independent at home for longer (Schemes 8-15): This theme covers provision of Integrated Community Equipment Services (including pressure relieving equipment), the Bexley Emergency Link Line (BELL), Assistive Technologies and Housing Adaptations. These schemes support our residents to live independently in their own homes for longer. Equipment can reduce the likelihood of hospital admission and can assist in timely discharge from hospital. 24-hour alarm monitoring services, such as BELL, enable help to be summoned in an emergency. Wheelchair Services aim to meet the needs of individuals with long-term mobility problems and associated postural needs with Personal Health Budgets available to support people's choice of wheelchair. Further information about DFGs and Housing Adaptations is provided in **Section 10**.

Theme 3 – Developing a more proactive and integrated out-of-hospital offer with a focus on anticipatory care, admission prevention and discharge support (Schemes 16-33): Investment in integrated care provides integrated crisis and rapid response, hospital integrated discharge, intermediate care and integrated rehabilitation, and Community Geriatrician. This supports urgent care needs, admission avoidance and timely and safe transfers of care. We are using the Discharge to Assess/Home First funding in our BCF plan to support the best outcomes for people leaving hospital. The Care Homes Trusted Assessor facilitates timely and safe discharges from hospital to care homes, ensuring effective liaison between health, social care and care homes. This helps to deliver personalised outcomes for our residents, whilst preventing unnecessary lengths of stay. In addition, existing enhanced services to care homes are helping to prevent inappropriate conveyances and admissions to hospital.

Where appropriate, we plan to use Bexley's allocation of additional discharge funding in 2023/24 and 2024/25 to continue to support investments made in services from the ASC Discharge Funding in 2022/23. The schemes align to the aims of the funding with a focus on supporting timely and safe

discharge from hospital into the community (see **BCF Planning Template**). Further information about how the additional discharge funding is being used is provided in **Section 8a**.

Theme 4 – Personalised health and social care at home or in the community (Schemes 34-45): Maintaining social care services on a sustainable footing is a key priority. Financial provision has been made against the iBCF and BCF to cover inflationary pressures to the adult social care market and provide extra capacity to help meet demand. Funding for home care supports the provision of additional packages of care to meet adult social care needs.

Theme 5 – Deliver care closer to home, ensuring optimum management of long-term conditions in the community (Schemes 46-49): A range of community health services have been included in the BCF Pooled Fund, including Oxleas Community Health Services, the Community Dietetics Service, and the Pulmonary Rehabilitation Service. Through such services, we can ensure optimum management of a person's long-term or chronic conditions in the community with patients engaged in decisions about their care and encouraged to self-manage their condition(s), wherever possible. The right mix of community-based services and support is critical to preventing hospital and care home admissions. By providing better care, closer to home, we can avoid admissions and help people to maintain their independence.

Theme 6 – Transforming care and helping people with a learning disability and/or mental health needs to have a good life in the community (Schemes 50-54): We will continue to deliver an improved local community-based offer for people with a learning disability. The pooled funding provides personalised services to Bexley people with a learning disability. It covers a range of provision from day opportunities and transport through to supported living and residential care placements. Wherever possible, people are enabled to choose their own care and support providers using Individual Service Funds. We are also continuing to promote and develop day opportunities for people with a learning disability. Some funding has also

been allocated to provide an enhancement to support personalisation in Bexley more generally (**Scheme 54**).

Theme 7 – Enabling people in the last months and days of life to be well-cared for (Schemes 55-56): Our BCF Plan includes schemes to provide high quality end-of-life care from Greenwich and Bexley Hospice Services and adult community health services in Bexley. The providers work in partnership with GPs, Integrated Rapid Response Services and other services to ensure that people who need end of life care can be cared for and are enabled to die in their place of preference and are not admitted to hospital unnecessarily. Cruse Bereavement Counselling (part of **Scheme 2**) also offers support to bereaved people.

Theme 8 – Integrated commissioning (Schemes 57-61): The schemes under this theme focus on 'enablers for integration'. We have utilised funding to provide commissioning capacity to manage the 'Care at Home' implementation and contract management, support Winter Resilience over the winter period and to cover additional staffing costs and management arrangements. We also have a flexible fund (**Scheme 60**) for meeting any unforeseen costs or requirements and have continued to make some provision in our plan to help meet cost and demand pressures (**Scheme 61**). In addition, the uplift from the Minimum NHS contribution in both years of our BCF Plan (**Schemes 62 & 63**) will be allocated by the partners to individual schemes.

b) Alignment to our other plans and strategies

The priorities of our BCF plan 2023-25 continue to reflect and align with our plans and strategies at system, borough and neighbourhood-level, including:

The Joint Local Health and Wellbeing Strategy

The Joint Local Health and Wellbeing Strategy has recently been reviewed and will be presented to the Bexley Health and Wellbeing Board on 15 June 2023. The new strategy builds on previous work that was completed on a draft strategy in 2019 and has taken into account changes since December

2019, which include the legacy of the COVID-19 pandemic, changes to the health and care landscape, and current socio-economic challenges.

The strategy describes how we will work together to improve people's health and reduce health inequalities in Bexley. There are four priority areas in the strategy covering: obesity; mental health; children and young people; and frailty. These priorities were chosen following wide stakeholder engagement led by local data and need. The new strategy will be used to inform investment to improve health and reduce health inequalities over the next 5 years.

In order to achieve impact across all parts of the Borough, the three Local Care Networks (LCNs) for North Bexley, Clocktower and Frognal will recommend how the aims of the strategy can best be achieved in each locality, working closely with NHS primary and community services and the voluntary sector in each locality.

London Borough of Bexley's Corporate Plan 2022-26

Making Bexley Even Better: Our Bexley Plan 2022-2026 sets out the Council's vision and strategic medium-term priorities. Our refreshed aim is to make Bexley even better by 2026 by supporting residents to live the best lives possible and to reach their potential. The plan identifies three key priorities:

- Aspiration for our residents
- Ambition for our Borough
- An Efficient and Effective Council

The plan also contains our principles, which include working in partnership for a fairer Bexley, a commitment to prevention and early intervention., embracing change, and focussing on delivering impact for our residents. The Corporate Plan guides our strategies and policies across the Council's directorates, including in Adult Social Care and Public Health. The following priority outcomes are particularly relevant to our BCF Plan 2023-25:

Happy, healthy and resilient lives: This highlights the importance of working collaboratively with partners, including through the Integrated Care System,

Bexley Wellbeing Partnership and our Bexley Care Partnership, to improve the health and wellbeing of our residents through joined up health and care services that are tailored to individuals.

Your life, your choice - working together towards the life you want: This highlights our commitment to enabling people in Bexley to make their own informed choices to live independent, healthy lives, remaining in their own homes for as long as possible. It includes the delivery of strengths-based and assets-based approaches and reflects an ongoing commitment to personalise care and support. In line with the Government's vision for adult social care, we want to ensure that people with care and support needs have choice and control on how their needs are met, recognising how important this is in supporting people to live the life they want. The connections between health, housing and care are emphasised and the Corporate Plan includes our ambition to create lifetime neighbourhoods.

Good growth supported by better transport: All new developments should be high quality and sustainable and enhance existing neighbourhoods with investment in infrastructure, such as parks, playgrounds and GP surgeries to meet existing and future needs.

People and communities feel safe and inclusive: This highlights the role of Bexley's Safeguarding Adults Board, which aims to safeguard all adults in Bexley who have care and support needs and are experiencing or at risk of abuse or neglect against which they are unable to protect themselves because of their needs.

Rigorous procurement and contract management to get the best services: This highlights the importance of managing our contracts carefully, working collaboratively to identify opportunities to transform the way we work and focussing rigorously on contract monitoring, and on achieving the outcomes we have specified.

Attract, retain and develop an efficient, diverse and inclusive workforce, including in our adult social care service at the heart of an integrated health and care system.

Bexley Wellbeing Partnership Borough Plan

The Bexley Wellbeing Partnership Borough Plan identifies three priority objectives for integrated improvement in Bexley:

- Improving people's health and wellbeing across the life journey;
- Improving access to our health and care services; and
- Addressing health and care inequalities.

The aim is to support residents across their entire life course to 'start well, live well and age well'. The plan focuses on the four key priority areas across the life course that have been identified in the Joint Local Health & Wellbeing Being Strategy (mentioned above). Cross cutting themes include a focus on personalisation, early prevention and population health.

The Integrated Care Strategic Priorities 2023-28 for South East London

The Integrated Care Strategic Priorities 2023-28 for South East London were published in February 2023. The strategy was the result of extensive engagement with partners and the public in 2022. It sets out a vision for future health and care in South East London, focusing on the shift to preventative action, ensuring convenient, joined-up, whole-person care, addressing health inequalities, working in partnership, and securing sustainability. It also sets out five immediate priorities for joint working across the system covering:

- Prevention and wellbeing;
- Support for children and families in the early years;
- Children's and young people's mental health;
- Adults' mental health;
- Primary care and people with long term conditions.

These priorities are reflected in the draft South East London Joint Forward Plan, which is due to be agreed by July 2023. The Joint Forward Plan has also been informed by Local Care Partnership Borough Plans, Care Pathway Programme/Service Plans and Enabler Programmes across South East London.

Work programmes and implementation plans for the five strategic priorities are being developed, drawing on expertise from across the system, including existing cross-system forums. Coordinated action and sharing of learning will take place across the system, including action at a South East London level, where required. However, it is envisaged that much of the implementation for these priorities will take place through Local Care Partnerships, involving multiple partners at a borough level.

National guidance and good practice

In developing our plans, we have taken account of national guidance and good practice, including:

- BCF Policy Framework and Planning Requirements;
- Hospital discharge and community support guidance;
- Developing a capacity and demand model for out-of-hospital care;
- Delivery plan for recovering urgent and emergency care services;
- People at the Heart of Care: adult social care reform white paper;
- Disabled Facilities Grant delivery: guidance for local authorities in England;
- Fuller Stocktake Report;
- Core20PLUS5 approach to reducing healthcare inequalities;
- Reducing preventable admissions to hospital and long-term care – A High Impact Change Model;
- High Impact Change Model for Managing Transfers of Care.

We recognise that the above areas represent significant workstreams in their own right; towards which our BCF plan and schemes contribute to varying degrees. Achieving progress in these areas will require a continued focus over the course of the next two years. We will, therefore, continue to engage with relevant partners to further consider how the BCF can support our system's response to these agendas.

c) Approaches to joint/collaborative commissioning

Our approach continues to support the development of a whole-system, integrated model of community-based care. This model operates across the different levels of 'neighbourhood', 'place' and 'system'.

Our ICS brings together all organisations involved in delivering health and care in South East London via the Integrated Care Board (ICB) and Integrated Care Partnership (ICP). In Bexley, the ICB continues to be co-located with the Council, which helps to consolidate our partnership through increased opportunity for face-to-face interaction.

The Integrated Care Strategic Priorities 2023 to 2028 for South East London were published in February 2023. The Integrated Care Partnership will be responsible for making sure we deliver on these commitments, holding the ICB and the partner organisations that make up our Integrated Care System to account for doing so.

In Bexley, we are working collaboratively and proactively with partners to integrate care around the person. The Bexley Wellbeing Partnership (BWP) brings together 16 local partner organisations with a shared goal of supporting and improving the health, care and wellbeing of local people and communities.

The Bexley Wellbeing Partnership Committee has been in place since 1 July 2022 as a committee of the South East London ICB and reflects the member organisations of the Bexley Wellbeing Partnership. The Committee is responsible for the effective planning and delivery of place-based services to meet the needs of the local population in line with the ICB's agreed overall planning processes. There is a specific focus on LCNs delivering community-based care and integration across primary care, community services and social care.

The Director of ASC and Health is the South East London ICB Bexley Place Executive Director. The Executive Leadership Team of the Bexley Wellbeing Partnership support the Place Executive Director in delivering on delegated and joint system functions at place-level. The Executive Leadership Team

brings together key partnership Directors and senior officers at borough-level and meets weekly.

Through the Bexley Place Executive Director, the Bexley Wellbeing Partnership Committee manages the place delegated budget and takes action to meet agreed performance, quality and health outcomes. There is also a focus on communication and engagement with local communities and further developing the Bexley Wellbeing Partnership.

During 2022/23, work has been undertaken to revisit and refresh the Bexley Wellbeing Partnership's vision and a new Health and Care Roadmap has been developed that expresses what kind of place the partnership wants Bexley to be. The refreshed vision demonstrates an evolution of the partnership, including:

- An appreciation of collaborative working;
- The importance of broader determinants of health and wellbeing;
- A renewed emphasis on prevention and tackling inequalities;
- Giving children and young people the best possible opportunities and acting as champions of change;
- Working with the Voluntary and Community and Social Enterprise sector as equal partners;
- Enabling integrated working at place and at LCN level;
- Making best use of digital and information capabilities, and population health management techniques.

The Bexley Wellbeing Partnership will readopt its shared vision and values on 25 May 2023.

The Bexley Health and Wellbeing Board has a statutory duty to prepare a Joint Strategic Needs Assessment and a Joint Local Health and Wellbeing Strategy. It also continues to have responsibility for signing off the BCF plan for the local area and providing governance for the BCF pooled fund. We will continue to report into the Bexley Health and Wellbeing Board on the BCF in line with our local governance arrangements (see **Section 3**).

Our approach continues to focus on transforming services to improve health and wellbeing outcomes for residents, whilst ensuring there is local democratic accountability for the delivery of health and social care. It is within this context that our joint and integrated commissioning takes place. We will also work more productively with a strong focus on value for money and think creatively about how we use our resources and assets (i.e., the Bexley £) to support our local communities. This will mean that we can make a bigger difference by helping people live healthier, more independent, and happier lives.

The third sector, including Healthwatch Bexley, are represented on the Bexley Health and Wellbeing Board and are an integral part of the work being carried out across the health economy to ensure residents have a voice and are at the heart of new and evolving services. We also work directly with a range of third sector providers to ensure their activity is aligned to achieving the best possible health and social care outcomes for our population.

Further details about our approach to joint and integrated commissioning are set out in the Section 75 agreement between the London Borough of Bexley and NHS South East London CCG, which is dated 26 January 2022 and provides the legal framework for the partnership. As a result of the Health and Care Act 2022, all statutory functions have transferred from the CCG to the ICB as the successor body. The section 75 agreement covers the establishment and contribution of funds by NHS South East London ICB and the London Borough of Bexley into the BCF Pooled Fund for the purpose of commissioning services for the benefit of the people who live in the London Borough of Bexley and/or are registered with a Bexley GP.

The day-to-day management of issues related to the partnership arrangements in relation to the services is managed through the Integrated Commissioning Team, who are jointly accountable through the Director of Integrated Commissioning to the Council and NHS South East London ICB.

The schedules of the section 75 agreement will be updated following approval of Bexley's BCF Plan for 2023-25.

d) How BCF funded services support our approach to integration

We have seen year-on-year investment in integrated 'out of hospital care' since 2013, which represents a significant and ongoing investment in integrated care services in Bexley. Our integration journey over the last nine years has been well-documented in previous BCF plans. Our track record provides the evidence for this, which has included but is not limited to:

- A re-designed model of intermediate care and year-on-year investment in integrated 'out-of-hospital' care since 2013.
- Residents can access treatment closer to home, including a range of treatment options and services at Queen Mary's Hospital site and outreach services at Erith Hospital.
- Integrated '7 day a week' care services provide urgent and unscheduled care, including through Urgent Care Centres.
- GP Enhanced Access (weekdays 18:30-20:00) and Saturday (09:00-17:00) and a Virtual Clinical Assessment Service (VCAS) providing telephone appointments on Sundays and Bank Holidays. Both provisions offer disposition support to NHS 111.
- Delivery of the Primary Care Strategy to improve coordination of care, access to services and take a more proactive approach to patients' health and wellbeing, including through an improved digital offer and ongoing self-care promotion.
- The establishment of four Primary Care Networks (PCNs) as of July 2019, aligned and working in tandem with three LCNs to provide the foundation for the healthcare system locally.
- Bexley Care was established in April 2017 and their service delivery model is aligned through three Multi-Disciplinary Teams (MDTs) to virtual LCN working. The partnership arrangements are formalised through the Bexley Care Section 75 Agreement between London Borough of Bexley and Oxleas NHS Foundation Trust, providing the legal basis to support the further development of integrated services.
- The Bexley Local Care Partnership (now rebranded the Bexley Wellbeing Partnership) – a collaboration of partners working together

around a shared vision and values for transforming health and care in Bexley. This has led LCN development and key initiatives, such as full social prescribing roll-out and Integrated Case Management.

- During the pandemic, we further demonstrated the strength of our integrated arrangements and our ability to work effectively across health, care and the third sector to directly benefit our communities.

The BCF provides ongoing funding to support delivery of our year-round offer, which comprises several options to prevent admission to hospital by our residents and to support safe discharge as early as possible, including:

- Bexley Urgent Community Response Service (UCR) (**Scheme 16**), which provides the first port of call in most instances to support with both sudden deterioration or a more gradual decline for someone at risk of a hospital admission. The UCR service can assess and direct the person to the most appropriate community provision as well as provide direct support for people in urgent need.
- Discharge to Assess (**Schemes 18 & 19**) which ensures that people do not remain in hospital awaiting assessment for home care once they are medically fit for discharge.
- In-patient rehabilitation beds at Meadow View on the Queen Mary's site in Sidcup (part of **Scheme 47**).
- Integrated reablement and rehab pathways including therapy and home care to get people back on their feet. Patients are discharged direct from the hospital ward onto goal-based therapy-led reablement. The provision of reablement to people with higher complex needs can also help to reduce dependency on long-term home care services.

Our BCF Plan also includes funding for 'Enablers for Integration', which:

- Provides commissioning capacity to manage the Care at Home procurement (**Scheme 57**)
- Supports Winter Resilience (**Scheme 58**)
- Provides staff and management capacity to support delivery of key workstreams and transformation (**Scheme 59**)

- Provides a flexible contingency fund (**Scheme 60**) and helps meet cost and demand pressures (**Scheme 61**).
- The uplift from the Minimum NHS contribution in both years of our BCF Plan (**Schemes 62 & 63**) will be allocated by the partners to individual schemes.

7) National Condition 2

a) Enabling people to stay well, safe and independent at home for longer

We want our residents to live healthy, fulfilling, and independent lives with the opportunity to be active citizens within strong communities and with access to good quality health and social care services should they need them.

Our integration plans in Bexley and wider South East London are key to ensuring that health and social care services are placed on a more sustainable footing and able to respond to the increasing disease burden and demand on services that a growing and ageing population brings. Our aim is to achieve better outcomes for our residents through person-centred and coordinated care, whilst ensuring we make best use of our combined resources. This includes harnessing the assets and resources of individuals and organisations within our communities to support more people to live independently in their own homes for longer, delay their need for long-term support and, where possible, prevent this altogether.

People prefer to receive their care in a setting where they feel most comfortable, and for many this is the home environment. We are building on existing ways of working and our 'Home First' approach to provide better care, closer to home. We want services to be developed with the person at the centre, coordinated and tailored to the needs and preferences of the individual, their carers and family. By ensuring that the most appropriate community health and care services are in place, we can help people to remain independent at home. In terms of our BCF Plan 2023-25, a focus of joint health and social care work is to support people to live independently in their own home and prevent avoidable stays in hospital.

Steps to personalise care and deliver asset-based approaches

Review this section and update/Further input needed.

The mobilisation of our new 'Care at Home' contract linked to the further development of LCNs is a good example of how we are working more closely together with our partners and providers to ensure joined up health and social care for our residents.

Funding from the iBCF provides commissioning capacity to help manage the 'Care at Home' procurement, implementation, and contract management (**Scheme 57**). We have commissioned a new model for care at home, where providers are aligned to one of three LCNs to enable providers and partners to work together collaboratively. Our aim is to transform the quality and responsiveness of care at home for the 1300 people whose care the Council and ICB fund and those who ask us to arrange their care but fund it themselves. Through the new arrangements, we are moving away from 'time and task' hour(s) and the associated 'clock watching' to an outcome-based model of care at home.

The new arrangements commenced in April 2022 and a gradual mobilisation is taking place as we move from 42 providers over to three new providers. The new arrangements involve moving to commissioning care on a population-based approach, where providers take responsibility for a geographical area and its associated budget. They will work within the budget for the area to assess and review Care Act eligible needs of residents and provide the care to individuals. This will involve working flexibly with the resident and their relatives and carers to agree and achieve the outcomes they want. The providers will join the Integrated Case Management meetings in each area. This sees a variety of services working together to proactively prevent physical deterioration and escalation of need.

The providers will also work especially closely with One Bexley - a consortium of eight third sector organisations - to help people with care needs and their family carers find the right support to maintain their independence and quality of life in the community. These organisations bring a variety of expertise and reach across local communities, giving

opportunities to work more closely together in providing person-centred services that build on people's existing strengths, support networks and local community assets.

Through the BCF Pooled Fund, the Council and ICB make a significant investment in Learning Disability Services (**Schemes 50-53**). These schemes provide personalised services to people with a learning disability, support alternatives to day care, and provide section 117 aftercare services. A key priority is to ensure people with a learning disability and their carers can exercise greater choice and control, including through Self Directed Support. Our aim is to maximise their independence, wherever possible, including opportunities to develop the skills needed for independent living and employment.

Implementing joined-up approaches to population health management and proactive care

Our BCF plan 2023-25 continues to invest in NHS commissioned out of hospital care and the maintenance of adult social care to support the shift in our system away from a reactive, disease-focussed, and fragmented model of care towards one that is more proactive, preventative, and integrated.

MDT-based working via LCNs and PCNs and across specialisms will enable the coordination and planning of care that focuses more on preventing ill-health, enabling independence, and promoting wellbeing. Data profiles for each LCN have been prepared and will be published online shortly. This will help ensure that we have a good understanding of demand and need in each of the localities and that we have the right skills-mix and capacity in extended community teams to respond.

We are working to ensure best use of resources and increased clinical focus on keeping people well, informed by risk stratification and population analytics across our networks and practices. This will enable us to respond proactively in areas of greatest need to improve population health.

Multi-disciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake

The Bexley Wellbeing Partnership are developing an Integrated Improvement Plan which takes account of the vision set out in the Fuller Stocktake. A key recommendation from the stocktake is that systems should support an approach to enable all PCNs to evolve into neighbourhood integrated teams with a blended generalist and specialist workforce drawn from all sectors. This gives partners the opportunity to further develop integrated community-based services locally, supporting better continuity and preventive healthcare, as well as access. It will involve local level collaboration and system wide work to positively impact the outcomes for our residents.

Our Bexley Care Partnership is a collaboration between the London Borough of Bexley and Oxleas NHS Trust to provide integrated community health, mental health and social care. It is already arranged over the LCN footprint with each of the three LCN's having a dedicated Associate Director who directly manages integrated teams for those services. This provides a platform to engage with PCNs to achieve MDT working with primary care on a neighbourhood geography.

Bexley Wellbeing Partnership already has a number of system and partner services commissioned and active in LCN footprints delivered by neighbourhood teams. Community Integrated Case Management Meetings in each LCN bring together Bexley Care staff across adult social care and adult community and mental health services with GPs, social prescribers and other third sector partners; working in the locality to support individuals with complex health and care needs in the community. Our newly mobilised 'Care at Home' contract has also been commissioned to align with our LCNs.

The three LCNs will have a common core offer and a local offer in response to new and existing priorities. Those priorities will be derived from key strategies and plans, the LCN Data Profiles, professional knowledge and insights, as well as community engagement.

How work to support unpaid carers and deliver housing adaptations will support this objective

Further input needed. Also see **Sections 9 & 10**.

b) Demand and capacity for intermediate care to support people in the community

Learning from 2022/23

Our learning from experience of the past year is that the need for intermediate care is changing, with more need for slow stream rehabilitation in more homely settings and less requirement for an in-patient rehabilitation approach. Funding structures do not support this however, especially as discharge funding to ASC is reduced in this planning year, and we will need to work together to address this challenge as a partnership as part of our capacity and demand modelling.

Approach to estimating demand, assumptions made and gaps in provision identified

Our approach to estimating demand and the assumptions made are set out in our Capacity and Demand Plan in the BCF Planning Template.

How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in wider plans

Further input needed.

c) How BCF funded activity will impact on the following metrics

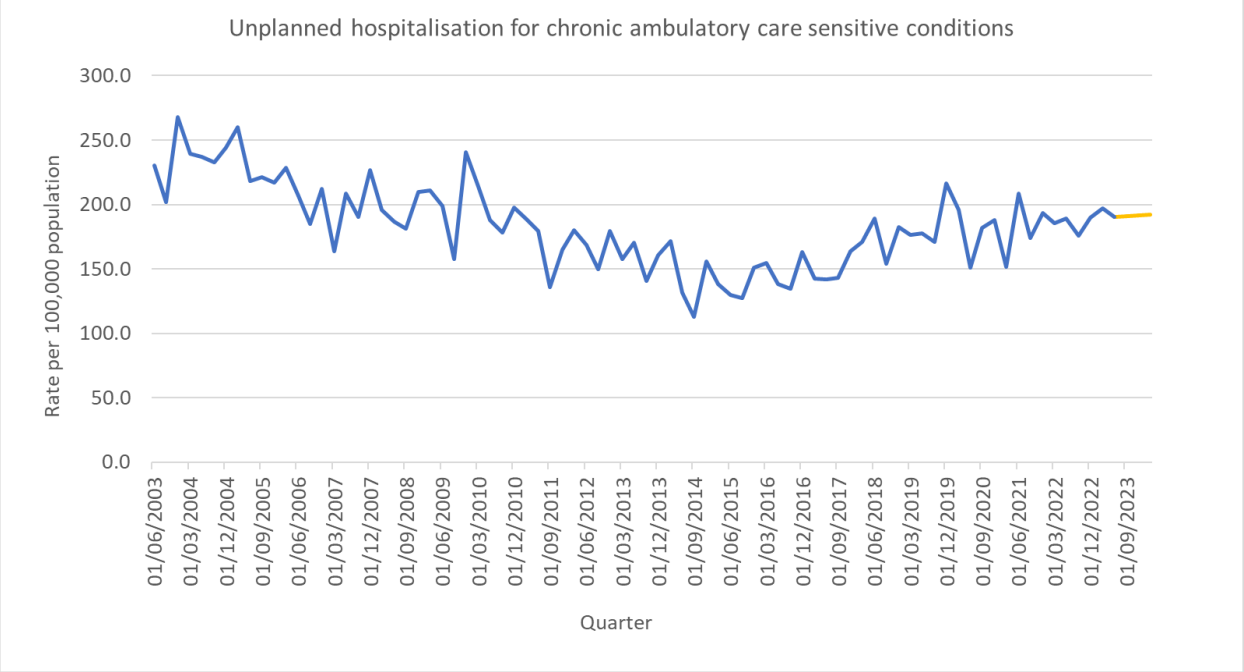
Unplanned admissions to hospital for chronic ambulatory care sensitive conditions

This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency.

The overall rate of admissions per 100,000 population increased from 538.2 avoidable admissions per 100,000 population in 2014/15 to 760.1 in 2019/20. This was followed by a reduction in the rate to 672.3 in 2020/21 (-11.6%). Our local monitoring suggests that the rate increased to 761.0 (+13.2%) in 2021/22 and we are currently forecasting an outturn in 2022/23 of 751.9 avoidable admissions per 100,000 population (-1.2%). Taking account of the quarterly trend since 2018/19, our plan for 2023/24 is to

stabilise the rate at 764.6 and prevent further increases, where possible. This ambition reflects our plan to influence this metric over a longer timescale.

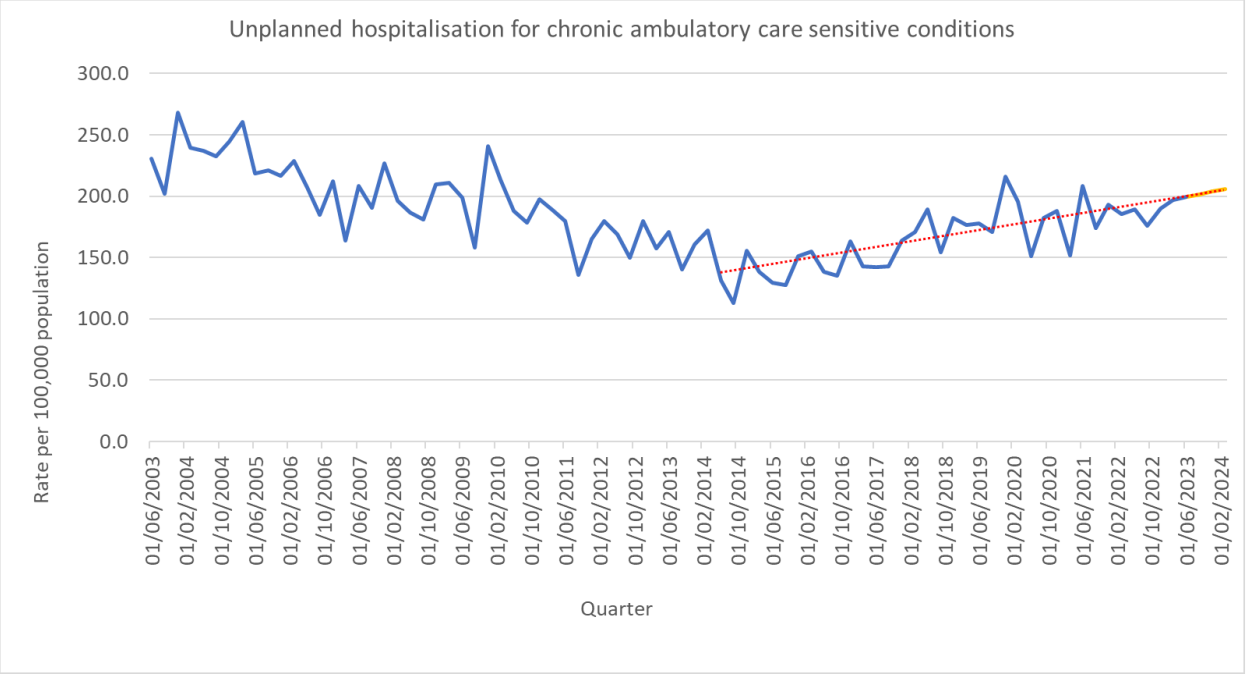
Figure 2 - Avoidable Admissions per 100,000 population (Ambition)



Source: NHS Digital, March 2022 and NHS South East London ICB, March 2023.

Within the context of current challenges, this is considered to represent a stretching ambition. Our modelling (Figure 3) reflects the general upward trend since Q2 2014/15. Based on this, our forecast for the period 1 April 2023 to 31 March 2024 is 2,012 avoidable admissions in 2023/24 (810.4 avoidable admissions per 100,000), which would equate to a 7.8% increase in the rate when compared to our current projected outturn for 2022/23 (751.9). Our ambition to stabilise the rate over the coming year reflects our plan to influence this metric over a longer timescale.

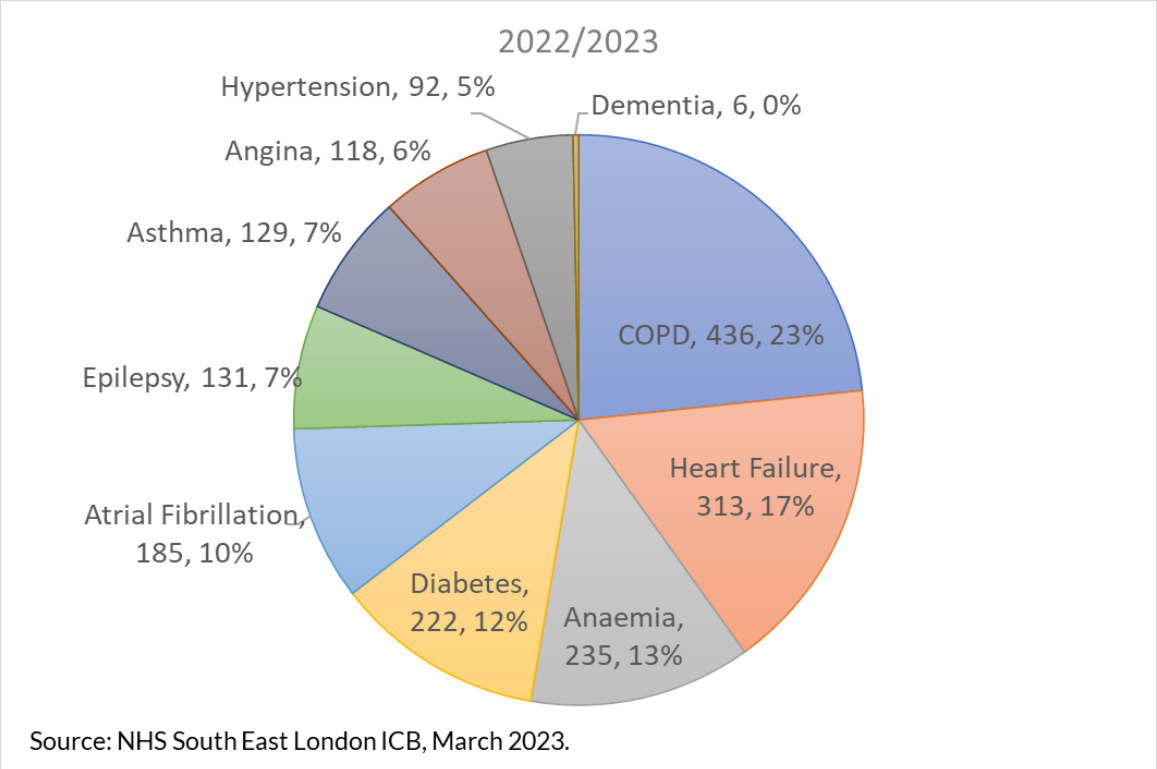
Figure 3 – Avoidable Admissions per 100,000 population (Forecast)



Source: NHS Digital, March 2022, and NHS SEL ICB, March 2023, plus Trendline.

Figure 4 gives a further breakdown of admissions per Ambulatory Care Sensitive Conditions Diagnosis Category in 2022/23. The top three diagnosis categories related to COPD, Heart Failure, and Anaemia.

Figure 4 – Admissions by ACSC Diagnosis Category, 2022/23



Source: NHS South East London ICB, March 2023.

Collaborative working across primary, community and acute services will support the management of appropriate demand through referral optimisation, A&E diversion and maximising the utilisation of community-based alternatives. We will explore what else needs to be done or done differently to avoid hospital admissions in the first place. For example, this includes:

- focussing on health improvement and reducing health inequalities;
- taking a more proactive and anticipatory approach to population health, using risk stratification tools and comprehensive frailty assessment to identify and assess those most at risk;
- planning ahead to ensure optimum management of a person's long-term or chronic conditions in the community with patients engaged in decisions about their care and encouraged to self-manage their condition(s);
- enabling people in the last months of life to be well-cared for, wherever possible outside an acute environment and to end their lives in their preferred place of care.

Below we have reflected on the contribution of BCF schemes, alongside other non-BCF funded initiatives, to the delivery of this metric:

- Prevention: The Council and ICB fund several third sector organisations and providers to deliver a range of prevention and early intervention services (**Schemes 1-6**). This includes continued delivery of social prescribing, provision of information, advice, and advocacy, support for carers, and help for people with a disability to access healthcare services.
- Health Inequalities: We are seeking to address health inequalities through a range of ICS-funded projects (under **Scheme 7**). This funding is being used to provide a targeted approach to the most deprived 20% population, focussing on the Core20PLUS5 framework.
- Public health and other preventative interventions (e.g., non-BCF-funded services such as Stop Smoking Service; NHS Health Checks; Bexley's Weight Management Referral Service) will continue to be used to help promote lifestyle change, reduce risk behaviours (e.g., smoking) and the

prevalence of chronic diseases (e.g., diabetes; COPD) over the longer term.

- Vaccination: In Bexley, vaccination programmes for both COVID-19 and Flu remain a focus of our plans because this will provide the greatest protection from both these serious illnesses.
- Our continued delivery of housing adaptations, equipment schemes and wheelchair services (**Schemes 8-15**) helps people to maintain independence, live independently within their own home and/or community.
- Local Care Networks and Integrated Case Management meetings: The virtual LCN multi-disciplinary teams cover mental health, physical health and social care. They also involve wider partners, such as the third sector and independent sector providers. The LCNs are using Integrated Case Management (ICM) as a key approach to MDT working. These ICM meetings discuss anyone over 18 at risk of a crisis if no action is taken and enable person-centred, community-based solutions to be found.
- Access to Primary Care: General practice supports people with both unplanned 'same day' appointments and proactive management of long-term conditions. This includes a diversified and blended offer including face to face, online and telephone consultations and expanded multi-disciplinary teams. The Delivery Plan for Recovering Access to Primary Care was published on 9 May 2023 with a focus on recovering access to primary care. Supported by investment, this plan responds to patient feedback and sets out measures that will make a difference now to staff and patients, focusing efforts on taking pressure off teams, and supporting general practice to manage the 8am rush, and restore patient satisfaction with improved experience of access. This plan provides details of how NHS England and ICBs will support practices and Primary Care Networks to deliver on the requirements of the 2023/24 GP contract. Proposals to expand the vital role of community pharmacies by consulting on a 'Pharmacy First' service and the oral contraception and

blood pressure services are also included in the plan. The nationally mandated 'Enhanced Access' offer ensures access to the full range of primary care services during 'network standard hours' (18:30 to 20:00 Monday to Friday) and 09:00-17:00 on Saturdays, in addition to some early morning appointments.

- Enhanced Health in Care Homes: All our care homes receive primary care input and have a named clinical lead to help ensure continuity of care. In addition, the ICB continues to maintain existing local enhanced services through the pooled fund (**Scheme 29**). This provision ensures care home residents receive dedicated medical services and supports a more proactive approach to care planning. A successful virtual MDT model, coordinated by Bexley Care, supports care homes with issues, such as medication reviews, fluids, mobility, falls and behaviour management; all of which helps to avoid admission to hospital.
- Reablement services: Our plan for 2023-25 also includes approximately £1.3m per annum for reablement services (across **Schemes 36–40**). There is strong evidence that reablement leads to improved outcomes by supporting people to maximise their level of independence. It also provides value for money by helping to minimise the need for ongoing support and dependence on public services.
- The Pulmonary Rehabilitation programme (**Scheme 48**) helps to prevent hospital admissions and readmissions. It consists of a six-week course of exercise and education for people with breathing problems including COPD, Asthma, Interstitial lung disease and others. The aim is to improve the quality of life and exercise capacity of participants, as well as inform them about how they can better manage their condition. The programme helps to improve both cardiovascular and strength fitness levels which in turn makes activities of daily living easier.

Emergency hospital admissions following a fall for people aged over 65

Falls are a leading cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g., being a major precipitant

of people moving from their own home to long-term nursing or residential care.

There is a time lag in the publication of this data, which forms part of the Public Health Outcomes Framework. The data currently shows that there were 1045 emergency hospital admissions due to falls in people aged 65 and over in Bexley in 2021/22. There were more injuries from falls among people in the over 80's age group (720), than among the 65–79-year-olds (320).

The overall rate of emergency hospital admissions due to falls in people aged 65 and over was 2187 in London and 2100 in England in 2021/22. In comparison, Bexley's rate was 2400 per 100,000 population.

Our plan is to prevent further increases in the rate of falls per 100,000 population and our target for 2023-24 is for the indicator value to be no higher than the position in 2021/22. This is considered stretching within the context of predicted increases in the number of emergency admissions due to falls.

Our opportunity to influence this metric is limited to what we can achieve through our existing schemes. In particular, our care homes admission avoidance virtual MDTs include a falls prevention OT to support our care homes to prevent falls risks in the individuals identified. Emergency lifting cushions and associated training in some of our care homes could be used to lift people who have fallen, minimising moving, handling and transfer risks. We have explored the potential to offer this option to care homes where people are discharged from hospital and identified as a Frequent Faller.

The development of any future proposals will need to be informed by evidence of what works and carefully coordinated with partners. We propose to review the target in light of the 2022/23 data, when this becomes available.

People aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population

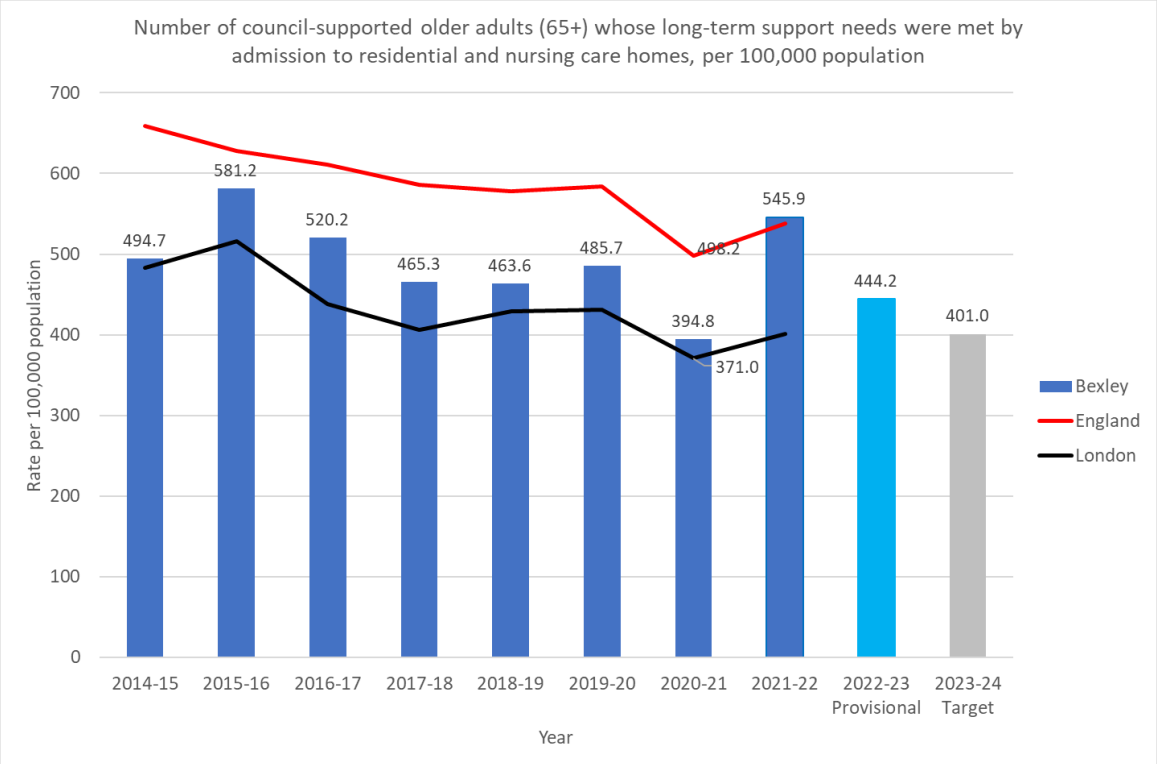
During 2022/23, our provisional data shows that 187 older adults aged 65+ had their long-term support needs met by admission to residential and

nursing care (a rate of 444.2 admissions per 100,000 population aged 65+). This compares to 224 new admissions for older adults in 2021/22 (a rate of 545.9 per 100,000 population aged 65+).

We want to achieve a further reduction in the rate of residential admissions per 100,000 population (aged 65+) from 444.2 in 2022/23 to 401 in 2023/24 (see Figure 5). The rationale for this ambition is to reduce levels of admission so that they are no greater than the London average in 2021/22 (a rate of 401.2 per 100,000 population aged 65+).

Going into a care home is a big decision and people should try not to make the decision when they are in hospital, or after a crisis such as a fall. Strength based assessments are used to support people to live at home where possible.

Figure 5 – Admissions to residential and nursing care homes



Source: London Borough of Bexley, May 2023.

8) National Condition 3

a) Provide the right care in the right place at the right time

Ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support in line with the Government's hospital discharge and community support guidance.

Our Home First service, led by the Hospital Integrated Discharge Team, operates across all three of our main acute systems. Since winter 2020/21, our Home First model has provided more home care capacity and additional therapy resources, older people mental health capacity to support people on dementia pathways, and clinical support from primary care. This enhanced model, which was facilitated through the national discharge funding, continued to operate throughout 2021/22. The national discharge fund ended on 31 March 2022 and so we have used the learning gained to help shape how we are working to continue as much of this approach as possible in the context of reduced funding. We have continued to develop and strengthen our relationships with hospital staff on the wards and our focus on discharge pathways continues to support the acute system with rapid discharges, once medically optimised patients are referred.

The Home First Project Board provides the leadership to support this transformation in our local system. Implementation and delivery of our approach is managed via our weekly multi-agency Home First Operational Meeting. Essential elements of the model remain in place and this includes:

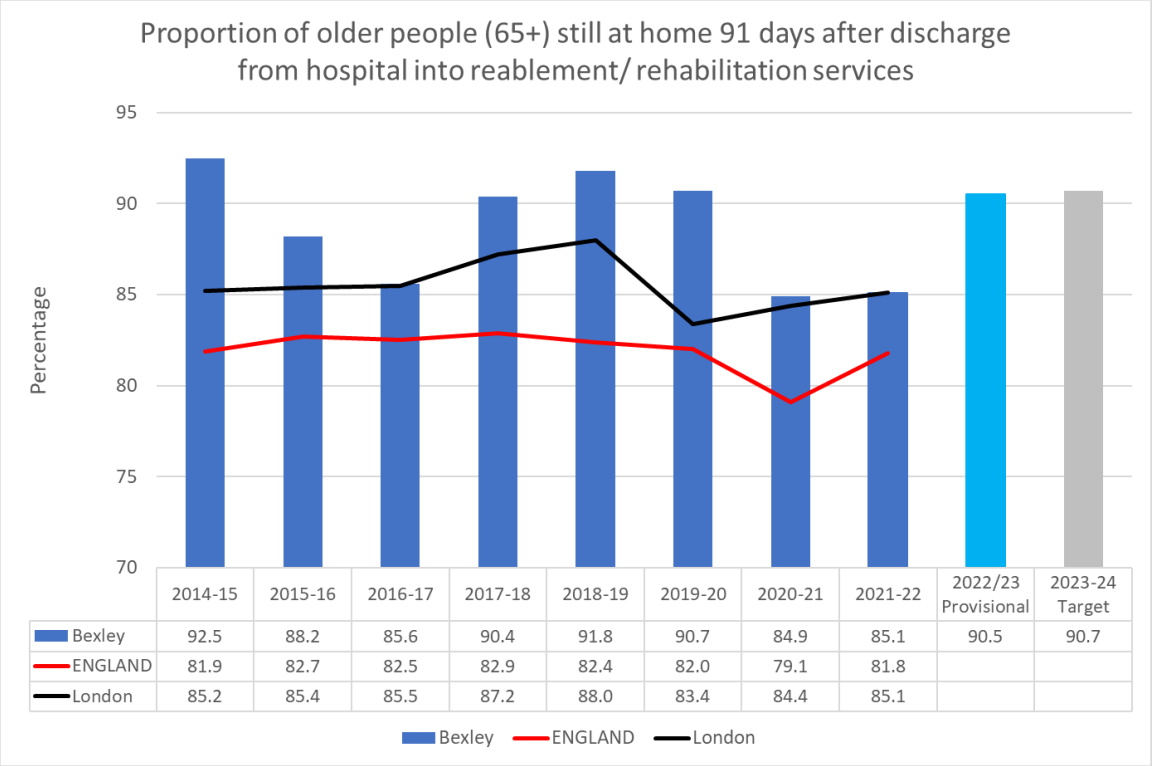
- Funding for existing levels of reablement and home care services as part of the Home First programme through the core Better Care Fund.
- £2.28m on Early Supported Hospital Discharge (**Scheme 17**),
- A contribution of £1.39m towards the staffing and care package costs of Discharge to Assess/Home First to help ensure patients do not stay in hospital for longer than necessary (**Schemes 18 & 19**),
- £0.928 of additional Local Authority Discharge Funding in 2023/24 and an estimated £1.5m in 2024/25 (**Schemes 20-24**).

- £0.964m of ICB Discharge Funding in 2023/24 (**Schemes 25-28**). ICB Discharge Funding allocations to 'Place-level' for 2024/25 have not yet been confirmed.
- £100k for the Care Home Trusted Assessors (**Scheme 30**).

Our BCF plan 2023-25 also includes some non-recurrent funding to deliver additional capacity in the system over the winter period (**Scheme 58**), providing flexibility to utilise this funding where it is most needed.

We are supporting earlier discharge onto reablement for more older people and have made further progress in reversing the trend towards poorer outcomes during the course of the last year. For 2022/23, our provisional data shows that 277 out of 306 older people, who were discharged from hospital into reablement between October and December 2022, were at home 91 days later (90.5%). This represents an improvement on performance in previous years, whilst at the same time responding to an increase in demand for reablement. Our metric ambition has been set on the basis that we wish to maintain existing good performance, similar to pre-pandemic levels of performance.

Figure 6 – Effectiveness of reablement



	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022/23 Provisional	2023-24 Target
Bexley	92.5	88.2	85.6	90.4	91.8	90.7	84.9	85.1	90.5	90.7
ENGLAND	81.9	82.7	82.5	82.9	82.4	82.0	79.1	81.8		
London	85.2	85.4	85.5	87.2	88.0	83.4	84.4	85.1		

Source: London Borough of Bexley, May 2023.

Our new model for care at home includes three Recovery and Reablement Providers, where each provider is aligned to one of three LCNs. This enables providers and partners to work together collaboratively. We will continue to work with providers to embed the Reablement role with a focus on 'doing with' rather than 'doing for'.

Our BCF Plan 2023-25 continues to support the deployment of community equipment and assistive technology in care processes. In particular, the provision of equipment will be used to facilitate timely transfers of care from hospital and assist people with their recovery.

How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

Our proposed spending plan comprises a range of schemes to provide additional capacity and support the delivery of discharge care options.

Bexley has been allocated a total of £1.8m from the Discharge Fund, comprising a direct grant to the local authority of £0.927m and £0.964m via the ICB. This will be used to support timely and safe discharge from hospital

into the community with the aim of reducing the number of people delayed in hospital awaiting social care.

We plan to use Bexley's allocation of additional discharge funding in 2023/24 and 2024/25 to continue to support investments made in services from the ASC Discharge Funding in 2022/23. The scheme types align to the aims of the funding with a focus on supporting discharge. This comprises:

- Assistive Technologies and Equipment – where necessary the Discharge Fund will be used to pay for the bulk purchasing of stock to secure continuous supplies to support timely hospital discharge.
- Home care hours – The funding will be used to maintain as far as possible the number of packages of care at times of peak demand, enabling social care to respond to fluctuating levels of hospital discharge. It is envisaged the focus will be on paying for new short-term packages of care (without reablement input) to support the flow of discharges.
- Bed-Based Intermediate Care Services - The funding will maintain as much community capacity as possible to facilitate quicker discharges from hospital of people with dementia, delirium and other complex care and support needs;
- Reablement in a person's own home - Reablement packages of care are supported throughout the year via the BCF pooled fund. The Discharge Fund will be used to pay for the on-going increase in reablement activity in response to additional demand that cannot be met from existing BCF schemes;
- Residential Placements – The funding will help to meet demand for short term residential care home placements (i.e., additional respite and interim placements);
- Workforce recruitment and retention schemes – Additional or redeployed workforce capacity will be used to prioritise discharge support, including social care assessments for people being discharged from hospital. We will also continue to deliver local initiatives to improve recruitment across the social care workforce.

Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow

The health and care system across South East London has been under pressure throughout 2022/23 with pressures felt across all areas of service provision, including acute care emergency departments, primary care, mental and community health services, and social care. These pressures were exacerbated by seasonal pressures, alongside planning for and managing the impact of industrial action. This has not only resulted in challenges in acute trusts, but also across the NHS and social care more widely. These challenges are being felt in systems across the country and are not unique to Bexley or South East London.

In March 2023, the ICB held a system discharge summit which brought senior leaders from across our system together to discuss discharge, or the transfer of care process, focussed on understanding the challenges and opportunities around discharge and the setting of clear commitments and objectives to secure improvement in both process and outcomes for the year ahead.

The summit affirmed a commitment to working collaboratively over 2023/24 to secure timely and high-quality transfers of care and improvements to discharge processes and outcomes.

The ICB's Discharge Solutions Improvement Group, which has representation from across health and care, has developed a system-wide discharge improvement plan. It aims to define our mission, objectives and the measures by which we will deliver improvement over the next two years (2023-2025), aligning to BCF plans.

This includes a set of recommendations following a review of the South East London Transfer of Care Hubs, which coordinate the transfer of care for more complex patients who require ongoing support post discharge. The expectation is that this plan will drive improvement across our system to the benefit of our residents.

Partnership working around the acute hospital systems will remain critical to the successful delivery of our discharge plans. The Bexley and Greenwich system meeting (known as Resplendent) will help to co-manage our response for both the Queen Elizabeth Hospital system, and the other systems which are used by Bexley residents (Darent Valley Hospital in Dartford and the Princess Royal University Hospital in Bromley). A system-wide approach will also be taken to winter planning in 2023/24 and 2024/25.

On 3 May 2023, our Home First Board took stock of our current plans, including plans held as an Integrated Care System:

- The local Urgent and Emergency Care (UEC) delivery plan in response to the UEC Recovery Plan;
- Resplendent high impact actions;
- South East London Front Door Peer Review action plan;
- South East London Discharge Improvement Plan;
- South East London ToCC recommendations linked to the Discharge Improvement Plan;
- ECIST 5 Point Plan (Lewisham and Greenwich Trust and through Resplendent).

Partners have contributed to the Bexley and Greenwich Sub-System Delivery Plan for 2023/24. The Delivery Plan has been structured using the key UEC metric headings and this includes consideration of prevention and primary care; community and urgent response; hospital pathways, processes and flow; ToCC and social care pathways.

The Home First Board also considered the connections with the BCF Plan and Year 3 of our Home First programme. Proposals under discussion for development in the coming year include the potential options of prioritising Care Navigation in the Emergency Department and exploring Third Sector approaches to supporting Pathway 0 discharges.

b) Demand and capacity for intermediate care to support discharge from hospital

Learning from 2022/23

Schemes funded from the ASC Discharge Fund in 2022/23 had to be mobilised at very short notice. Our efforts focussed on building on existing initiatives by putting in more resource and capacity, rather than commissioning new initiatives from scratch. As a result, we were successful in optimising the use of the additional funding to support a higher volume of people to be discharged from hospital.

Our staff have worked closely with the hospitals to help meet the substantial demands from hospital discharges throughout the winter period. Although workforce recruitment was challenging, our staff were diverted as necessary to prioritise discharge support. Our staff continue to attend discharge meetings daily to support our acute and community colleagues and we also attend Board Rounds with clinical colleagues to plan for the person's discharge as early as possible.

We provided additional homecare hours that enabled our integrated teams to provide responsive care packages to support hospital discharge. Equipment stock was also purchased to ensure supply so that this was available to be promptly ordered and delivered in support of a person's discharge home. This enabled additional equipment deliveries to take place to support people with reablement, rehabilitation or longer-term care needs.

We worked with our care home providers to enable people with dementia care and support needs to be discharged from hospital more quickly into an appropriate setting that was able to further support their recovery.

Additional interim beds were utilised, which helped to facilitate hospital discharges for people who would otherwise have remained in hospital for longer. This allowed more time for recovery and for a long-term care assessment to be completed outside an acute hospital environment. However, the additional demand arising from earlier discharge from hospital has resulted in additional costs to the ASC budget that are not fully covered by the funding received.

We experienced difficulties in recruiting additional agency, qualified Social Worker and Occupational Therapy staff. The workforce challenges being felt

across the sector have contributed additional costs to the system (e.g., some people remaining on short term care packages, pending an assessment of their longer-term care and support needs).

We utilised other self-contained initiatives and short-term sources of funding to optimise the outcomes for people in the most effective way possible. These included the NHS additional discharge funding (announced in January 2023) and access to the virtual wards for appropriate patients meeting the relevant criteria. Both these initiatives were subject to specific criteria and separately monitored.

We received positive feedback from acute hospitals about Bexley's performance and how we have worked collaboratively to ensure people are supported to be discharged, relieving pressure on emergency departments.

The learning from 2022/23 is being used to inform our planning and delivery of these arrangements in 2023/24, including around the duration of short-term packages of care, timing of assessments and planning of the transition to long term care and support arrangements, where required.

Certainty of funding is needed over the longer term to support the planning and delivery of more sustainable solutions on the scale required. The current focus within plans on tackling immediate pressures in delayed discharges should not be to the detriment of the other aims of protecting adult social care, supporting prevention and community-based support, and promoting integration.

Approach to estimating demand, assumptions made and gaps in provision identified

Further input needed. Our approach to estimating demand and the assumptions made are set out in our Capacity and Demand Plan in the BCF Planning Template.

Planned changes to your BCF plan as a result of this work

Our plan is to continue to deliver the schemes specified in our BCF Plan 2023-25 to support discharge from hospital and wider system flow within the financial resources available. The deployment of additional Discharge

Funding will help in responding to some of the immediate pressures in delayed discharges and we remain focussed on delivering our Home First approach.

In light of recent experience during 2022/23, we are interested in further exploring the market position in relation to use of short-term interim beds in the community and intermediate care provision. This will give the opportunity to reflect on any learning about how those pathways are currently working and may help to further inform our demand and capacity planning. It is proposed to undertake this work with partners via our Home First Board and Home First Operations Group.

We will investigate opportunities to evaluate the impact of Home First. This is subject to developing a suitable proposal and securing external funding and support to do so.

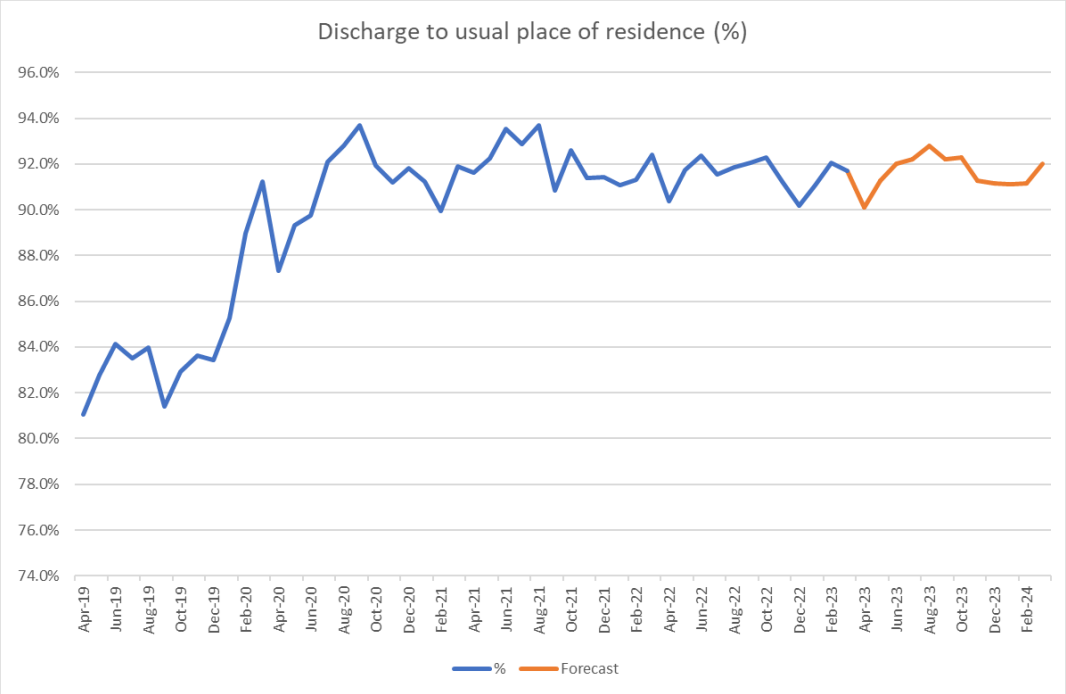
c) How BCF funded activity will impact on the following metrics

Discharge to usual place of residence

Within the context of system pressures, our plan for 2023/24 is to maintain existing good performance in Bexley at over 90%.

Across the year as a whole, our ambition is to ensure that 91.7% of people, resident in the Health and Wellbeing Board area, are discharged from acute hospital to their normal place of residence. This represents an improvement on our expected performance in 2022/23 (91.5%). The quarterly percentage is generally lower in Q3 and Q4 each year and our forecast, therefore, reflects this seasonality.

Figure 7 – Discharge to Usual Place of Residence, Bexley (Monthly)



Source: NHS South East London Integrated Care Board, February 2023.

We have also considered Bexley's split for discharge location and looked at the categories that make up the % of those that are not counted in the % of patients who are discharged to usual place of residence. Approximately 2.23% related to 'NHS other hospital provider - ward for general patients or the younger physically disabled', 1.5% to 'NHS run care home' and 0.6% to 'Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment'). The data suggests that there may be some factors that are not within our direct control and that there may only be limited opportunities for improvement.

Our 'Home First' D2A schemes enable people to go home as soon as possible after acute treatment. We will continue to take a 'Home First' approach, wherever possible. A key objective is to ensure that people are discharged onto the most appropriate pathway and receive the right care in the right place at the right time.

Our plan also includes provision of a range of Community Equipment and Assistive Technology options. Such schemes play a key role in helping to facilitate earlier discharges from hospital by providing equipment to people in their own homes. This in turn reduces the need for interventions such as

home care, residential and nursing care home placements, and can prevent readmissions to hospital (e.g., from falls).

Under the Council's Housing Assistance Policy, discretionary support schemes can be accessed via the Council's Disabled Facilities Grants Team. Minor adaptations are also provided and include rails, intercoms and steps, which supports independent living and assists hospital discharge.

d) High Impact Change Model for managing transfers of care

We confirm that we have reviewed and updated our self-assessment against the High Impact Change Model for Managing Transfers of Care (Appendix A) and this identifies actions for improving future performance. Further input needed/Review Appendix A.

e) Contribution towards delivery of duties under the Care Act 2014

Our Care Act funding (**Scheme 35**: £545k) is being used as a contribution to help off-set an increase in home care provision since the Care Act 2014 came into force. We have also continued to allocate funding for carers' services (**Scheme 1**: £463k).

Continued investment of approximately £1.3m (**Schemes 36–40**) is planned for reablement services in Bexley to maintain current reablement capacity in the local authority, community health services and the independent sector to help people regain their independence and reduce the need for ongoing care.

Responsibility for the DFG sits with the London Borough of Bexley and use of the DFG (**Schemes 14 & 15**: £2.96m) has been agreed with the Council's Housing Services. DFG funds will be used to support mandatory grants for home adaptations and to offer other discretionary assistance (see **Section 10** for further details).

The annual value of Bexley's grant from the iBCF is currently £6.6m and the iBCF grant conditions state that the grant may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures

- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

The iBCF funding does not replace and has not been offset against the Minimum NHS contribution to adult social care. We confirm that these arrangements are in place and we have agreed plans for use of iBCF money that meets some or all of the purposes set out in the grant conditions.

9) Supporting unpaid carers

We have continued to allocate funding for carers' services from the Minimum NHS Contribution (**Scheme 1**: £463k). This helps to provide a range of direct support to unpaid carers, including information and advice, carers' counselling, carers breaks, and carers support services from the third sector.

The Carers Partnership Board have continued to focus on the key priorities of carers in the London Borough of Bexley through the delivery of a Carers Action Plan. The Carers Action Plan has been co-produced and there is ongoing engagement with carers in the partnership. Focus groups led by third sector partners are continuing to work on priority areas, including 'health and wellbeing' and 'communication and engagement'.

The Carers Partnership have launched a new website, funded by the Bexley Wellbeing Partnership, to help people find information to support them in their caring role. It includes details of local organisations, as well as information on things such as benefits, Carers Assessments, Carers rights and much more. This is another example of the work the Carers Partnership is doing within the wider Carers Action Plan to improve the lives of Carers in Bexley and support the health and wellbeing of local people.

The Council collects information on the number of unpaid carers receiving direct support during the year as part of its Short and Long Term (SALT) Statutory Return. This covers both support for new carers and support for those already known to the Council. Carers who receive ongoing support during the year are also included, even if no review of their arrangements has

taken place. Furthermore, carers assessed during the year but provided with no support are included in our SALT return. In 2022/23, 1660 carers received 'direct support to carer' and 342 received 'no direct support'.

We also count a subset of the above figures to capture any support that is arranged by the Council for the cared-for person for the benefit of the carer. This shows that 389 people also received Respite or Other Forms of Carer Support delivered to the cared-for person during 2022/23.

10) Disabled Facilities Grant and wider services

a) What is our strategic approach to using housing support, including DFG funding, that supports independence at home?

During 2022/23, we have continued to use the DFG allocation to support major home adaptations, enabling disabled people to live independently at home for longer. There were XXX approvals in 2022/23 and XXX completions, which include mandatory and discretionary grants and loans. XXXX minor works were also completed, which include rails, intercoms and steps.

The main housing elements in our BCF Plan 2023-25 relate to the provision of funding from the DFG. DFG funding will be used over the next two years to support major home adaptations, enabling disabled people to live independently at home for longer.

This support is means tested to ensure those most in need get the most help. Major adaptations range from stairlifts and level access showers to bedroom bathroom extensions. The Council provides a full support service to clients assisting with proofs, form filling, drawing plans, obtaining consent and quotations, overseeing the work and making payments. Minor adaptations include rails, intercoms and steps. This work all supports independent living and assists hospital discharge. The Council also offers a range of discretionary help and support including grants to move and interest free loans to top up DFG funding and help with client contributions.

In March 2022, the Government published guidance for local authorities on the effective delivery of the DFG, including recommended best practice. During 2022/23, the Council carried out a review of its approach to housing adaptations, repair and improvements. A new Housing Assistance Policy has been adopted, which sets out the mandatory and discretionary assistance that the London Borough of Bexley wishes to offer, including conditions and eligibility criteria. The Council consulted on the policy between 3 January and 14 February 2023. The Council agreed and published the policy at the end of March 2023. This now means we can implement the policy from the start of this financial year (April 2023).

The Housing Assistance Policy supports work that the Council is progressing to deliver broader service outcomes and to ensure services are properly joined up across housing, social care and health. Our Integrated Triage Hub have started to utilise Level 4 Trusted Assessors to carry out assessments and recommendations for non-complex adaptations. This has enabled the speeding up of the delivery of standard DFG works, such as wet rooms and stairlifts. The Council will also be using the new DFG guidance to help shape the structure of the grants team moving forwards with a view to implementing recommendations around case management and joint working.

An Equality Impact Assessment of the Housing Assistance Policy gives further information about the Council's DFG services and presents supporting evidence for the policy. It describes the local context for the changes and reflects data on the prevalence of health conditions and demographic trends related to age and levels of disability. It shows how the policy supports and links to our wider strategic objectives, including: the Council's Corporate Plan 2022-26; the Bexley Growth Strategy; and the Council's Housing Strategy which was informed by the Strategic Housing Market Assessment.

Officers are continuing to work across housing, social care, and health to ensure services are properly joined up. Interaction takes place through 'business as usual' activity across social care and the DFG team. We also

engage via professional networks and regional workshops (e.g., Foundations) to share learning and good practice.

b) Have we made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2022 (RRO)?

Yes.

c) What is the amount allocated for these discretionary uses?

£TBC.

11) Equality and health inequalities

Review this section/ update content.

a) Priorities for addressing health inequalities and equality

South East London Population Health and Equality Programme: Our Healthier South East London Integrated Care System (ICS) will maintain a focus on preventing ill-health and tackling health inequalities, building on the Core20PLUS5 approach introduced in 2021/22.

The ICS has a Population Health & Equality programme of work, which encompasses activities that are best placed at a pan-South East London level, due to either benefits of scale or a need for consistency. This programme has three 'cogs' of work, which are interrelated.

Cog 1 - Population Health Management: This includes a focus on restoring NHS services inclusively and ensuring that datasets are complete and timely. South East London ICS will establish Population Health Management as the way of working in South East London, using data and local insights to improve population health and delivery of care and health equity.

Cog 2 - Prevention and inequalities: This relates to Core20PLUS5 & the Vital 5 and focuses on accelerative preventative programmes. This involves working with the Directors of Public Health across South East London to target the key drivers of poor outcomes and inequalities through enhanced health promotion and prevention, starting with Core20PLUS5 and the Vital

5 (smoking, high blood pressure, obesity, mental ill-health, and alcohol consumption). Additional priorities include diagnosing more people with cancer at an earlier stage, addressing inequalities in vaccine uptake, and a continued focus on health checks for people with a learning disability.

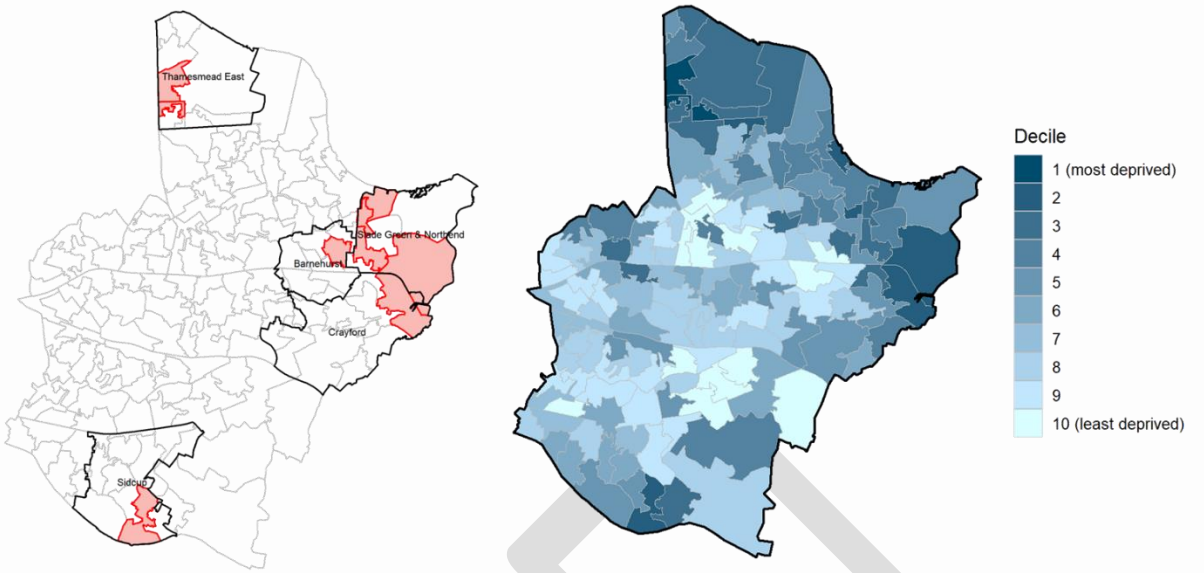
Cog 3 - Make the most of our assets/ Health in All Policies: This includes mitigating against 'digital exclusion' and working with our communities. South East London ICS will spotlight the many great things that are happening locally and will continue to establish an 'Anchor system', which recognises our assets of population, staff and organisations. The focus of this cog is to identify potential partners, with whom to explore collaboration on specific work streams aligned to the goals of the South East London Population Health and Equality Programme.

Our Healthier South East London Inequalities Fund: The aim is to address health inequalities by providing a targeted approach to the most deprived 20% population, focussing on the Core20PLUS5 framework. Bexley has been allocated £530k per annum. In January 2023, the section 75 Agreement between London Borough of Bexley and NHS South East London ICB was updated to pool this funding into the BCF Pooled Fund.

Bexley COVID Impact Assessment 2022: The COVID-19 pandemic exposed pre-existing health inequalities and exacerbated these. A Health Inequality Audit looked at the "Vital 5" factors (smoking, high blood pressure, obesity, mental ill-health, and alcohol consumption). The "Vital 5" factors, already identified as key to inequality, were chosen to give the report clear focus and relevance to health and care planning by the Local Care Partnership. The report comprises 16 chapters, identifying key findings and general recommendations.

What do we know about Health Inequalities in Bexley: Overall Bexley is not very deprived. It is the 9th least deprived local authority in London; however, inequalities exist within Bexley. The most deprived areas of Bexley are clustered into three places (see map below):

Figure 8 – Map of Bexley



Source: ONS Indices of Multiple Deprivation 2019

Around 15,000 people (about 6% of the Bexley population) live in the most deprived areas of Bexley. People living in the most deprived areas have a shorter life expectancy than people living in the least deprived areas of Bexley.

Higher smoking rates in more deprived areas are linked to worse smoking-associated health outcomes. This includes a higher rate of emergency admission for COPD, higher incidence of Lung Cancer, and higher mortality from all cancers due to smoking.

Higher levels of obesity in more deprived areas are linked to worse obesity-associated health outcomes. This includes an increased risk of heart disease compared with healthy people of normal weight.

b) Changes from previous BCF plan

Our approach to equalities and health inequalities in our BCF Plan 2023-25 is consistent with the approach taken in our previous BCF plans. There is a strong strategic focus across our ICS on health inequality and the BCF is one of the levers to be deployed as part of our 'whole system' response.

c) How inequalities are being addressed through the BCF plan

Our BCF Plan 2023-25 contributes to addressing health inequalities and inequalities for people with protected characteristics through the delivery of a range of interventions and approaches, including but not limited to:

- Community Connect (**Schemes 5 & 6**), Bexley's social prescribing scheme, supports local people to improve their health and wellbeing by connecting them with activities, support, and services in the community. This can help to decrease primary care use following intervention, reduce physical inactivity, decrease levels of anxiety, improve mental health and wellbeing, and increase people's feeling of belonging to their community.
- Prevention and early intervention funding to third sector organisations to respond to local need (**Schemes 2 & 3**), focussing on general wellbeing as well as providing targeted support to specific population groups who are at risk of poor health or face the most barriers. For example, this includes but is not limited to:
    - Support to sight-impaired Bexley residents and services for people with hearing loss.
    - Self-advocacy, social activities, and support to access health services (e.g., health checks) for people with a learning disability.
    - Carers services to provide information, advice, carers breaks and support to carers in Bexley, including a peer support programme to help carers build up their support networks.
    - Support groups and activities for people with dementia and their carers.
    - Support services to individuals affected by an acquired brain injury.
- We are continuing to invest in prevention services funded from the iBCF (**Scheme 4**). This recognises that the third sector can offer significant value to commissioners in terms of financial return on investment and in social value.

- Supporting best practice through the national Enhanced Health in Care Homes model to ensure people in care homes have equitable access to primary care and community services. Through the pooled fund, the ICB continues to maintain existing enhanced services in care homes (**Scheme 29**), which helps prevent inappropriate prescribing, and inappropriate conveyances and admissions to hospital.
- Continued investment in End-of-Life Care service improvements (**Scheme 56**) to increase the ability for our population to be supported to die in their normal place of residence. Better care planning will give our population more control and decision making and help to avoid unnecessary admissions in the last 12 months of life.
- DFG provision (**Schemes 14 & 15**) is fundamentally about redressing the inequality faced by people living within a disabling home environment. Our approach to delivery of mandatory DFG adaptations and other discretionary support in Bexley seeks to implement individualised solutions to enable people to live more independently in their own home.

Appendix A – High Impact Change Model for Managing Transfers of Care

Bexley Action Planning Template

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	**Established** - EDDs are routinely set within 48 hours of admission to hospital, however these often need to be changed because of the person's fluctuating condition, which can impact on care capacity. - Elective admissions are discharged via the established pathways. - Regular meetings between ASC, community partners and acute hospital discharge teams to discuss medically optimised/complex cases, ensuring ownership of discharge dependent actions and accountability. - Established rapid response team in place in Bexley (integrated between health and social care) to prevent unnecessary admissions, access to home first mental health post particularly for input around dementia and delirium, where people perhaps do not fit under CMHT/IHTT pathways.	- Participation in system events looking at "blockers" to timely discharge. Use such events to identify mechanisms to earlier highlight those with more complex needs who require community input to facilitate timely discharge. - Closer working between acutes and community teams/ASC, including developing improved pathways for information sharing about "the person" rather than medical model to support seamless transition into the community. - Monitoring to ensure that system workforce and community capacity meets the demand for hospital discharge planning to reduce delays. - Review and refresh Red Bag	Ongoing. Regular MADE, Perfect Week and similar events scheduled throughout the year.	- Reduction in the numbers of long stay medically optimised patients. - More EDDs being met/reduced numbers not meeting the criteria to reside on a daily basis. - Reduction in discharge delays.

	- Clear escalation pathways are shared across the system to ensure any delays can be picked up and addressed early. - Red Bag scheme is still in place, but post-Pandemic needs to be reviewed and refreshed so that it can be used effectively by a wide range of partners, including care homes. - Currently there is an integrated and flexible approach to facilitate discharges and ensure good flow through the acute setting. - Established D2A model in place across pathways 1-3, including D2A bedded units. - Increasingly proactive approach to discharge planning through staff attending the wards and board rounds, which enables better discharge planning at an earlier stage in the patient journey. However, earlier notification to community teams is required to speed up the discharge processes for those with complex needs. - Integrated case management and care home MDTs in the community identify those at high risk of admission and enable a more proactive approach to community care and reduce the risk of unnecessary ED attendance/hospital admission. - We have positive relationships with all our	scheme. - Continued delivery of our Care Homes MDT. Peace Plans, etc. All these things help to prevent conveyances and admissions to hospital.		

	care homes and extensive training of staff (e.g., Falls, Vital Signs) to ensure that people can be supported in the care home rather than conveyed to hospital.			
Change 2: Monitoring and responding to system demand and capacity	**Mature** - Systems are in place to monitor demand vs capacity in the community, including regular borough level operational meetings around Home First and Patient Flow Manager role. - Single point of contact for all discharges (excluding fast track) via ASC able to monitor demand for Pathways 1 to 3, and as a system we are able to monitor demand for all pathways. - Regular meetings between system partners to monitor flow and ensure timely discharge, this also acts as a mechanism to identify potential capacity issues. - We are responsive to any issues arising. There is commissioned capacity for D2A bedded care. There are an extensive range of services for the home-based pathways including enhanced care within the agreed financial envelope. - Increased demand on acute services including for in-patient beds and the shift to earlier discharge from hospital has	- Ongoing monitoring of demand vs capacity to ensure sufficient capacity is available in the community. - Reablement work on outcomes. - ASC have developed a recruitment strategy to attract and retain staff. This will be rigorously monitored to ensure it continues to meet its objectives, including consideration of pay and conditions.		- Reduction in the numbers of long stay medically optimised patients. - More EDDs being met/reduced numbers not meeting the criteria to reside for external reasons on a daily basis. - Reduced community waiting lists. - Improved reablement outcomes.

	resulted in some challenges. - Increased demand can occasionally have an impact on waiting times. - The reablement pathway has been strengthened, providing the opportunity for residents to regain as much independence as possible following a hospital admission. We provide a reablement service from the date of discharge from hospital. This early intervention has resulted in positive outcomes for our service users and prevented readmission to hospital. - Funding available for a number of Home First initiatives, including additional AHP and social care resource, however workforce/recruitment remains a challenge.			
Change 3: Multi-disciplinary working	**Mature** - MDT input to discharge planning, TOCC/medically optimised calls attended by acute and hospital teams. Discussion takes place to ensure the best pathways for people. - D2A model for Pathways 1-3, included trusted assessment for bedded ICB and discharges into care homes. Full assessment of need undertaken outside of the acute hospital when people have had a chance to stabilise in a non-acute setting	- Reviewing wraparound support to those discharged via D2A, particularly bedded pathway, and ensuring optimum benefit of resources available. - Review the mental health Home First role in place to ensure maximum benefit to Bexley residents. - Through our HID model, we are in-reaching to the wards to support with complex cases and		- Improved Reablement outcomes. - Improved outcomes from D2A bedded pathway. - Increase in referrals into mental health Home First service. - Improved quality of referrals to HID.

	(preferably their home). - Therapy and mental health team input into D2A model to support people to return home and optimise outcomes.	understand people's needs holistically. We attend board rounds and also provide updated training sessions to clinical colleagues in the acute hospital. - Education around pathways available, ongoing work on quality of referrals taking a more strength-based approach.		
Change 4: Home first	**Mature** - Home first approach is taken to support hospital discharges in Bexley via D2A. Discussions at TOCC with constructive challenge to ensure people are discharged home where at all possible. Social workers presence on the wards enables them to identify people with very complex needs and explain the range of non-bedded services available to them. - Use of enhanced care to support those identified as requiring 24 hour at home rather than to a bedded pathway. - Bedded D2A pathway (P2) to enable assessment of need in a more appropriate setting and allow time for recovery to provide the bed opportunity for people to return home. - Dedicated MDT input into D2A pathways. Recruitment has been a challenge for some roles but progress made in recent months.	- Explore Third Sector approaches to supporting Pathway 0 discharges. - Dementia/delirium pathway work to support more people in their own homes and care homes with long term residents who may cognitively deteriorate. - Continue to work at South East London level (e.g., the Discharge Improvement Group) regarding Sitrep reports data quality and criteria to reside reporting to provide a more accurate understanding of discharge pathways/delays to discharge. - Consolidate the ongoing education needed including for NHS clinical colleagues around available pathways and Home First support available. - Tracking and monitoring longer		- Improved quality of referrals to HID. - Improved identification of people's needs at an earlier stage of their admission through HID's direct presence on the wards and at ward rounds. - Reduction in hospital admissions for those with needs arising from dementia and delirium, particularly from care homes. - Reduction in acute Length of Stay for those with complex needs that arise as a result of

	- The expectation is that Continuing Health Care assessments of long-term need are not completed in the acute setting but are conducted instead in the community once the patient has reached their optimal recovery. - Settling service available for Bexley residents discharged from QEH, but not other local acutes currently. - ICM and care home MDTs for those at high risk of admission in the community. - Data quality regarding reason to reside and discharge destinations is acute led and we have local arrangements in place to ensure that what is reported nationally can be validated or challenged according to local information systems.	term outcomes at 6 months post discharge (Currently 90-day measure via ASCOF) to ensure long term outcomes. - Will look at the Placement Without Prejudice arrangement for CHC that operated pre-COVID. - Use and improve our understanding of data regarding admission avoidance and readmissions to evaluate the effectiveness of interventions and to identify areas of improvement. - Review how quickly people are discharged once being identified as Medically-Optimised – are we meeting EDDs, if not, why not?		dementia/delirium. - Improved outcomes for those with complex needs through the enhanced care pathway, including for people with dementia or delirium who can be supported to recover in their familiar home environment.
Change 5: Flexible working patterns	**Established** - There continues to be a 7-day service in Adult Social Care (08:00-18:00 + Out of Hours emergency line), with a single point of contact via HID duty line. The level of cover has been stepped down from the height of COVID and is a reduced service at weekends. Not all services are operating on a 7-day service and weekend discharges from the Acutes remains significantly lower than weekdays. Overall demand for the weekend service has been	- Continue to review the benefits of a 7-day service in HID which would need to be aligned with changes in the acute setting so that more discharges were agreed by senior clinicians. - System-wide review of 7/7 services to ensure maximum benefit to flow. - Recent review by SEL acute hospitals of weekend discharges on Pathways 0 and 1 shows a		- Increased number of weekend discharges for those with care and support needs.

	low and we continue to keep its benefits under active review. - Restarts of POCs available 7/7 and the new home care contracts that have just been mobilised expect care providers to accept new packages of care at weekends. Some care homes do accept weekend admissions. We continue to commission additional contingency provision from home care and care home providers at bank holiday periods. - We have a well-established Rapid Response team, working 7/7, which is integrated across health and social care. Rapid Response is deployed in the community, which includes liaison with GPs and support to care homes to prevent unnecessary A&E presentations and hospital admissions in the first place.	range of internal processes at acute trusts that need development. - Continue to work with care providers and care homes around the potential for 7-day discharges with new POCs + care home discharge.		
Change 6: Trusted assessment	**Mature** - Care home trusted assessor in place who undertakes assessments on behalf of the local care homes, facilitating timely discharges. - Trusted assessor model in place for ICB bedded referrals. - D2A model in place for pathways 1-3, initial assessment of need undertaken by hospital MDTs with fuller assessment undertaken post discharge. - Single referral document for all D2A	- One Bexley/Trusted Partner work: Expanding our ASC Pathways re-design work. Stage 2 of contract began in October 2022. Our third sector partners undertake a range of assessment and case management functions on our behalf including support to family carers, many of whom become carers following a hospital admission of a relative.		- Timely discharges via pathways 1-3 with minimal external delays.

	pathways. - ASC pathways re-design work / Trusted Partners.			
Change 7: Engagement and choice	**Established** - Clear explanation of the D2A process provided by hospital discharge teams and ASC contact patients/relatives prior to discharge to explain the discharge process and manage expectations. - Adult social care is supporting clinical staff to make sure that people are not given the wrong information about long term services that may not be appropriate or necessary to meet a person's needs (e.g., permanent admission to a care home when a person could be supported at home or in the community). - Long term decisions are not usually made in hospital, but choices offered following assessment once someone is in a community setting. - Bexley continues to offer advice and support to those who are self-funders.	- Continued work with acute hospitals around the choice policy to ensure that this works as effectively as possible. - Training, education and comms around discharge pathways and processes to both staff and patients/relatives/carers. - Development of Settling Service, ensuring it can provide signposting to appropriate third sector services. - Involvement of family carers in discharge planning will be supported and monitored to ensure that we fulfil the requirements of section 91 of the Health and Care Act 2022.		- Consistent implementation of choice policy where appropriate. - Improved referrals from acute hospitals to appropriate services. - Settling Service available for Bexley residents in hospital. - Continued use of D2A model, with choice offered once assessment completed.
Change 8: Improved discharge to care homes	**Established** - Care home task force and care home forum both in place, providing an opportunity for regular dialogue between care homes and system partners. - Some care providers will accept weekend admissions, however generally assessments will need to be undertaken	- Review of dementia care/delirium wraparound support to care homes and investment in care home MDTs. - Ongoing monitoring and work with homes who have high admissions and decline for residents to return due to		- Reduction in admissions from high referring care homes. - Improved quality of discharges to care homes (evidenced via feedback from homes).

	on a weekday to facilitate this. - Trusted assessor supports to provide quality information and facilitate quality discharges. - For those discharged into care homes under D2A process, wraparound support available from therapies and mental health team as required. HID have increased the social work capacity to support people moving on from this service so that discharges can be made in a more timely way. - Care home MDTs take place, ongoing work to target care homes with high admissions to identify and address causes. - All care homes have dedicated primary care support and can refer to Rapid Response. - Docobo provides remote monitoring data for GP practices enabling them to make informed decisions from the practice and to prioritise patients appropriately.	needs arising from dementia/delirium. - Monitor care home admissions and the impact of targeted interventions via care home MDTs. - Work with providers around 7-day admissions.		- Able to discharge 7 days a week into more care homes.
Change 9: Housing and related services	**Plans in place/Established** - Housing issues are not consistently identified early on in admission which can build in delays to discharge. - This can sometimes lead to people being stepped down to more dependent settings than is required (i.e., residential care) to free up acute hospital capacity. There are flats available for those with housing and	- Evaluation of existing services and pathways that are used to support those with housing and care needs. Modification of criteria/pathways may be required. - Review of existing provision for furniture moves, deep cleans, minor adapts, keysafe		- Clearer links and pathways with housing colleagues. - Fewer delays for adaptations/cleans, etc. particularly for hospital discharge. - Reduced use of care home beds for those

	care needs, however there is often not capacity. Alternatives then need to be sourced which can sometimes mean a temporary placement in a residential care home. - Work being done at a South East London level to look at housing support across the Integrated Care System. - Home adaptations and equipment is available to support hospital discharge. - Queen Elizabeth Hospital has a Homeless Support Officer (not just Bexley patients but anyone deemed homeless when they are an inpatient there). This also provides some input to people with No Recourse To Public Funds.	installation. Consider alternative service provision as appropriate (e.g., use of DFG). - Earlier identification of complex needs (See Change 1 actions). - Participate at a South East London level around housing and homeless developments/ initiatives. - Building pathways and links in with local housing team and ensure processes are conducive to timely hospital discharge.		who do not require residential care due to housing issues.

High Impact Change Model for Managing Transfers of Care: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high/about

- Not yet established: Processes are typically undocumented and driven in an ad hoc reactive manner.
- Plans in place: Developed a strategy and starting to implement, however processes are inconsistent.
- Established: Defined and standard processes in place, repeatedly used, subject to improvement over time.
- Mature: Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show.
- Exemplary: Fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Bexley
Completed by:	Alison Rogers, Director of Integrated Commissioning, London Boro
E-mail:	Alison.Rogers@selondonics.nhs.uk / Steven.Burgess@bexley.gov.
Contact number:	020 8176 5365 / 020 3045 5242
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Thu 15/06/2023 << Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor Baroness	Teresa	O'Neill OBE	Teresa.O'Neill@bexley.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Andrew	Bland	Andrew.Bland@selondonics.nhs.uk
	Additional ICB(s) contacts if relevant	Ms	Diana	Braithwaite	Diana.Braithwaite@selondonics.nhs.uk
	Local Authority Chief Executive	Ms	Jackie	Belton	Jackie.Belton@bexley.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Stuart	Rowbotham	Stuart.Rowbotham@bexley.gov.uk
	Better Care Fund Lead Official	Ms	Alison	Rogers	Alison.Rogers@selondonics.nhs.uk
	LA Section 151 Officer	Mr	Paul	Thorogood	Paul.Thorogood@bexley.gov.uk
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	No
5. Income	No
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	No

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Bexley

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,964,977	£2,964,977	£2,964,977	£2,964,977	£0
Minimum NHS Contribution	£19,499,901	£20,603,595	£19,499,901	£20,603,595	£0
iBCF	£6,616,137	£6,616,137	£6,616,137	£6,616,137	£0
Additional LA Contribution	£23,660,000	£23,660,000	£23,660,000	£23,660,000	£0
Additional ICB Contribution	£28,330,109	£28,330,109	£28,330,109	£28,330,109	£0
Local Authority Discharge Funding	£927,572	£1,545,953	£927,572	£1,545,953	£0
ICB Discharge Funding	£964,000	£0	£964,000	£0	£0
Total	**£82,962,696**	**£83,720,771**	**£82,962,696**	**£83,720,771**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,541,319	£5,854,957
Planned spend	£11,296,258	£11,296,258

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,887,973	£8,334,432
Planned spend	£10,335,401	£10,335,401

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	190.3	190.9	191.4	192.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,583.6	2,399.5
	Count	1060	1045
	Population	41028	41028

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.2%	92.4%	91.6%	91.4%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	546	401

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.7%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	
	PR2	
	PR3	
NC2: Social Care Maintenance	PR4	
NC3: NHS commissioned Out of Hospital Services	PR5	
NC4: Implementing the BCF policy objectives	PR6	
Agreed expenditure plan for all elements of the BCF	PR7	
Metrics	PR8	

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Bexley

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	
	DEMAND - COMMUNITY:
	Social support (including VCS): It has not been possible to estimate the expected demand for 'Social Support including VCS' in connection with intermediate care services. In Bexley, we do fund or commission a range of VCS services as part of our Prevention and Early Intervention offer (see BCF Planning Template). These services are monitored but we do not have sufficient data to evidence the

	Complete:
3.1	No
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
(Please select Trust/s.....)	Reablement at home (pathway 1)												
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
Totals	Total:	0	0	0	0	0	0	0	0	0	0	0	0

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	214	214	214	215	215	215	215	215	215	215	215	215
Urgent Community Response	120	120	120	120	120	120	120	120	120	120	120	120
Reablement at home	28	28	28	28	28	28	28	28	28	28	28	28
Rehabilitation at home	61	61	61	61	61	61	61	61	61	61	61	61
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	1	1	1	1	1	1	1	1	1	1	1	1
Other short-term social care	14	14	14	14	14	14	14	14	14	15	15	15

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
														ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	16	16	16	16	16	16	16	16	16	16	17	17	0%	100%	0%
Reablement at Home	Monthly capacity. Number of new clients.	46	47	47	47	47	47	47	47	47	47	47	47	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	77	77	77	77	77	77	77	77	77	77	77	77	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	29	29	29	29	29	29	29	29	30	31	31	31	79%	21%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	22	22	22	22	22	22	22	22	22	22	22	22	100%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	14	14	14	14	14	14	14	14	14	14	14	14	0%	100%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	12	12	12	12	12	12	12	12	12	12	12	13	50%	50%	0%

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
														ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	214	214	214	215	215	215	215	215	215	215	215	215	0%	100%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120	100%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	13	13	13	13	13	14	14	14	14	14	14	14	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	50	50	50	50	50	50	50	50	50	50	50	50	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	14	14	14	14	14	14	14	14	14	15	15	15	0%	100%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	5	5	5	5	5	5	5	5	5	5	5	5	100%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Bexley

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Bexley	£2,964,977	£2,964,977
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,964,977**	**£2,964,977**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Bexley	£927,572	£1,545,953

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS South East London ICB	£964,000	
Total ICB Discharge Fund Contribution	£964,000	£0

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Bexley	£6,616,137	£6,616,137
Total iBCF Contribution	**£6,616,137**	**£6,616,137**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Bexley	£23,660,000	£23,660,000	Additional local authority contribution, subject to agreement of the BCF Pooled Fund for 2023/24 and 2024/25 between the Parties.
Total Additional Local Authority Contribution	**£23,660,000**	**£23,660,000**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South East London ICB	£19,499,901	£20,603,595
Total NHS Minimum Contribution	**£19,499,901**	**£20,603,595**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS South East London ICB	£28,330,109	£28,330,109	Additional NHS South East London ICB contribution, subject to agreement of the BCF Pooled Fund for 2023/24 and 2024/25 between the Parties.
Total Additional NHS Contribution	**£28,330,109**	**£28,330,109**	
Total NHS Contribution	**£47,830,010**	**£48,933,704**	

	2023-24	2024-25
Total BCF Pooled Budget	**£82,962,696**	**£83,720,771**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Disabled Facilities Grant: In the Adult Social Care White Paper, 'People at the Heart of Care', the Government announced that nationally £573 million was being made available for the DFG in each year from 2022-23 to 2024/25. For planning purposes, we have assumed that the 2024/25 DFG is based on the distribution remaining the same. In April 2023, the Government announced in 'Next steps to put People at the Heart of Care' the investment of an additional £102 million over 2 years, to help fund additional services that will supplement the core DFG by providing agile and timely home improvement support to help people stay independent. The DHSC is currently finalising the details of how this will be made available. More information on this will be provided in summer 2023.

Improved Better Care Fund: Final decisions on the 2024/25 iBCF grant allocation will be made as part of the 2024/25 Local Government Finance Settlement. For planning purposes, pending that decision, we have planned on the basis that the grant allocation will be consistent with the approach taken in 2023/24.

Discharge Fund: The ICB received a recurrent funding uplift to support system wide discharge improvement totalling £8.785m. It is proposed that on a system wide basis South East London makes recurrent provision of £1.111m for the ICS's homeless discharge offer, which was funded non recurrently in 2022/23. The need to continue with this service has been endorsed in a number of South East London meetings including the Discharge Solutions Improvement Group, albeit with no source of funding specifically identified through these discussions. The ICB, therefore, propose to continue with the service in 2023/24 funded from the £8.785m. We will then collectively review for 2024/25. After taking account of this, it is proposed that the split of the balance of the discharge funding will be applied on a weighted population basis across South East London's six Local Care Partnerships. Bexley LCP's proposed allocation in 2023/24 is £0.964m. National allocations of Discharge Funding will increase from an additional £600m in 2023/24 to £1bn in 2024/25 (+66.7%) allocated across ICBs (£500m) and Local Authorities (£500m). For planning purposes, the Local Authority's Discharge Funding allocation shown in the BCF Planning Template for 2024/25 has been estimated based on applying the national increase for 2024/25 to the 2023/24 allocation. The ICB Discharge Funding allocation for 2024/25 has yet to be confirmed.

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Bexley

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,964,977	£2,964,977	£0	£2,964,977	£2,964,977	£0
Minimum NHS Contribution	£19,499,901	£19,499,901	£0	£20,603,595	£20,603,595	£0
iBCF	£6,616,137	£6,616,137	£0	£6,616,137	£6,616,137	£0
Additional LA Contribution	£23,660,000	£23,660,000	£0	£23,660,000	£23,660,000	£0
Additional NHS Contribution	£28,330,109	£28,330,109	£0	£28,330,109	£28,330,109	£0
Local Authority Discharge Funding	£927,572	£927,572	£0	£1,545,953	£1,545,953	£0
ICB Discharge Funding	£964,000	£964,000		£0	£0	£0
Total	**£82,962,696**	**£82,962,696**	**£0**	**£83,720,771**	**£83,720,771**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,541,319	£11,296,258	£0	£5,854,957	£11,296,258	£0
Adult Social Care services spend from the minimum ICB allocations	£7,887,973	£10,335,401	£0	£8,334,432	£10,335,401	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	Yes

>> Incomplete fields on row number(s):

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Planned Expenditure: Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Care Act - Carers	This scheme contributes towards the provision of a range of direct support to unpaid carers: • Information and advice. • Carers' Support Worker. • Authority-commissioned support. • Carers services from the third sector. • Carers' Counselling Service. • Respite services offering flexible breaks and phased care. • Personal budgets and direct payments.	Carers Services	Carer advice and support related to Care Act duties		2000	2000	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£463,000	£463,000	100%
2	Preventative & Early Intervention Services (ICB)	ICB contribution to the joint commissioning of a range of prevention and early intervention services, mainly delivered by the third sector.	Prevention / Early Intervention	Other	PEI Funding to Third Sector Organisations				Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£473,210	£473,210	26%
3	Prevention & Early Intervention Services (LBB)	LB Bexley contribution to the joint commissioning of a range of prevention and early intervention services, mainly delivered by the third sector.	Prevention / Early Intervention	Other	PEI Funding to Third Sector Organisations				Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£403,000	£403,000	22%
4	Prevention	Funding from the iBCF to develop our capacity within the Borough to prevent or delay demand that causes pressure on the health and care system.	Prevention / Early Intervention	Other	Develop the capacity of the independent and third sectors				Social Care		LA			Charity / Voluntary Sector	iBCF	Existing	£200,000	£200,000	11%
5	Social Prescribing	Social Prescribing in Practices to help people find support for many non-medical issues, outside of the usual care that a GP or nurse may be able to provide.	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	iBCF	Existing	£50,000	£50,000	3%
6	Social Prescribing	Social Prescribing in Practices to help people find support for many non-medical issues, outside of the usual care that a GP or nurse may be able to provide.	Prevention / Early Intervention	Social Prescribing					Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£150,000	£150,000	8%
7	Health Inequalities (ICS Funded Projects)	Health Inequalities Funding has been allocated to the Bexley Wellbeing Partnership by the ICB. Focussing on the Core20PLUS5 framework, it is intended that Local Care Networks will form recommendations for targeting the funding at those parts of Bexley where health inequalities are greatest.	Prevention / Early Intervention	Other	Health Inequalities				Other	Health Inequalities	NHS			Local Authority	Additional NHS Contribution	Existing	£536,000	£536,000	30%
8	Integrated Community Equipment Service	ICB contribution to the Integrated Community Equipment Service, which provides a range of high quality, responsive, cost effective equipment to people with health and social care needs, who live in Bexley or have a Bexley GP.	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£283,200	£283,200	14%

9	Integrated Community Equipment Service	LB Bexley contribution to the Integrated Community Equipment Service, which provides a range of high quality, responsive, cost effective equipment to people with health and social care needs, who live in Bexley or have a Bexley GP.	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£651,000	£651,000	32%
10	Community Equipment	Provides the Bexley Emergency Link Line (BELL) alarm monitoring service.	Assistive Technologies and Equipment	Assistive technologies including telecare				Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£163,000	£163,000	8%
11	Assistive Technologies	LB Bexley employs an Assistive Technology Coordinator.	Assistive Technologies and Equipment	Assistive technologies including telecare				Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£60,000	£60,000	3%
12	Equipment	A pressure relieving equipment service that responds to local need and ensures that residents living with physical impairments are receiving the equipment that they need.	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£199,520	£199,520	10%
13	Wheelchair Service	We assess for, purchase and provide wheelchairs and associated mobility equipment in line with NHS criteria to meet the postural and independent mobility needs of the population served by NHS South East London ICB (Bexley). People can choose to purchase their own wheelchair using their Personal Health Budget.	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£660,000	£660,000	32%
14	Housing Adaptations	The Disabled Facilities Grant allocation supports the delivery of major home adaptations for disabled people to enable them to live independently in their own homes for longer. LB Bexley provides a full support service to clients assisting with proofs, form filling, drawing plans, obtaining consent and quotations, overseeing the work and making payments.	DFG Related Schemes	Adaptations, including statutory DFG grants		211	211	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	Existing	£2,964,977	£2,964,977	100%
15	Housing Adaptations	The Disabled Facilities Grant allocation supports the delivery of major home adaptations for disabled people to enable them to live independently in their own homes for longer. LB Bexley provides a full support service to clients assisting with proofs, form filling, drawing plans, obtaining consent and quotations, overseeing the work and making payments.	DFG Related Schemes	Discretionary use of DFG				Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	New			0%
16	Integrated Crisis and Rapid Response	Integrated crisis and rapid response to situations where an individual requires an urgent health and/or social care intervention. This is a multi-disciplinary team that produces multi-disciplinary assessments and care planning. The team also provides an expert resource to other community and hospital clinicians in managing crisis. The BCF contributes to the staff costs of providing this service.	Urgent Community Response						Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£736,000	£736,000	100%
17	Early Supported Hospital Discharge	Provision of personal care packages to facilitate early supported hospital discharge.	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,285,000	£2,285,000	61%
18	D2A	Discharge to Assess has streamlined the care pathway and ensures patients do not stay in hospital for longer than necessary. The BCF contributes to staff and care package costs.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£690,000	£690,000	18%
19	D2A	Discharge to Assess has streamlined the care pathway and ensures patients do not stay in hospital for longer than necessary. The BCF contributes to staff and care package costs.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF	Existing	£700,000	£700,000	19%
20	Discharge Fund (LA contribution)	Discharge Fund	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		76	127	Packages	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£84,000	£140,000	2%
21	Discharge Fund (LA contribution)	Discharge Fund	Home-based intermediate care services	Reablement at home (to support discharge)		58	96	Packages	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£92,800	£153,600	9%
22	Discharge Fund (LA contribution)	Discharge Fund	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		7	11	Number of Placements	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£303,000	£505,000	100%
23	Discharge Fund (LA contribution)	Discharge Fund	Residential Placements	Short term residential care (without rehabilitation or reablement input)		9	15	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£321,572	£536,353	73%
24	Discharge Fund (LA contribution)	Discharge Fund	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£126,200	£211,000	58%
25	Discharge Fund (ICB contribution)	Discharge Fund	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		NHS			Local Authority	ICB Discharge Funding	Existing	£92,515		2%
26	Discharge Fund (ICB contribution)	Discharge Fund	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		279		Packages	Social Care		NHS			Local Authority	ICB Discharge Funding	Existing	£308,385		2%

27	Discharge Fund (ICB contribution)	Discharge Fund	Residential Placements	Short term residential care (without rehabilitation or reablement input)		9		Number of beds/Placements	Social Care		NHS			Local Authority	ICB Discharge Funding	Existing	£318,320		27%
28	Discharge Fund (ICB contribution)	Discharge Fund	Workforce recruitment and retention						Social Care		NHS			Local Authority	ICB Discharge Funding	Existing	£244,780		42%
29	Care Homes - Local Enhanced Services	Continues to provide existing enhanced services to Care Homes. This ensures care home residents receive dedicated medical services and supports a more proactive approach to care planning that helps prevent inappropriate prescribing, and inappropriate conveyances and admissions to hospital.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Primary Care		NHS			Private Sector	Minimum NHS Contribution	Existing	£236,400	£236,400	1%
30	Care Homes Trusted Assessors	This supports delivery of the trusted assessor model with the care home sector through the employment of Care Home Trusted Assessors.	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			Local Authority	iBCF	Existing	£100,000	£100,000	3%
31	Spot Purchase	Homecare hours for rapid deployment to prevent Emergency Department attendance and hospital admission.	Home Care or Domiciliary Care	Domiciliary care packages		7044	7044	Hours of care	Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£135,600	£135,600	2%
32	Plaster of Paris	Joint funding arrangements for Plaster of Paris cases to help get people out of hospital with support. It offers a short term package of care until the plaster comes off or until the person concerned is transferred onto a long term package of care.	Home Care or Domiciliary Care	Domiciliary care packages		2930	2930	Hours of care	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£56,400	£56,400	1%
33	Integrated Care LBB	Investment in integrated care, which provides Integrated rapid response, hospital discharge, intermediate care, integrated rehabilitation, and Community Geriatrician Service.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£758,000	£758,000	2%
34	Winter Care Packages	Additional homecare hours that enable our integrated teams to provide responsive care packages, including D2A, reablement and long-term home care.	Home Care or Domiciliary Care	Domiciliary care packages		47226	47226	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£928,000	£928,000	14%
35	Care Act	Contribution to help off-set increase in home care provision since Care Act 2014 came into force.	Care Act Implementation Related Duties	Other	Home Care or Domiciliary Care				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£545,000	£545,000	100%
36	Other preventative - Reablement	Contribution towards reablement packages of care. This maintains current reablement capacity to help people regain their independence and reduce the need for ongoing care.	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		191	191	Packages	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£304,000	£304,000	21%
37	Reablement funding to Oxleas	Part of Older People Integrated Care Contract. This maintains current reablement capacity to help people regain their independence and reduce the need for ongoing care.	Home-based intermediate care services	Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)		0	0	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£105,000	£105,000	7%
38	Reablement funding to LB Bexley	Staffing and reablement care packages. This maintains current reablement capacity to help people regain their independence and reduce the need for ongoing care.	Home-based intermediate care services	Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)		400	400	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£716,000	£716,000	50%
39	Reablement additional contribution to care costs	Additional contribution towards reablement care costs. This maintains current reablement capacity to help people regain their independence and reduce the need for ongoing care.	Home-based intermediate care services	Reablement at home (to support discharge)		76	76	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£121,000	£121,000	9%
40	Reablement additional contribution to staff costs	Additional contribution towards staff costs. This maintains current reablement capacity to help people regain their independence and reduce the need for ongoing care.	Home-based intermediate care services	Reablement at home (to support discharge)		0	0	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£50,000	£50,000	4%
41	Additional ASC packages of care	This enables the home care market to accommodate the increased volume of care resulting from less care home placements and earlier discharge from acute hospitals. These additional ASC packages of care support people to live in their homes for longer.	Home Care or Domiciliary Care	Domiciliary care packages		148831	148831	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£2,865,000	£2,865,000	42%
42	Additional contribution to care package costs funded from iBCF	This enables the home care market to accommodate the increased volume of care resulting from less care home placements and earlier discharge from acute hospitals. These additional ASC packages of care support people to live in their homes for longer.	Home Care or Domiciliary Care	Domiciliary care packages		15819	15819	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£304,516	£304,516	4%
43	Maintaining eligibility criteria	Personal care packages (contribution) plus inflation	Home Care or Domiciliary Care	Domiciliary care packages		26649	26649	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£513,000	£513,000	7%
44	Develop Social Care Market	This pays for an uplift in provider fees and helps to address associated cost pressures, ensuring that we can continue to secure the supply of care. It supports the sustainability of the home care market and workforce, and enables us to work with providers to help them overcome barriers.	Home Care or Domiciliary Care	Domiciliary care packages		51948	51948	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£1,000,000	£1,000,000	15%

45	Additional ASC Packages of Care funded from Minimum NHS Contribution	This pays for an uplift in provider fees and helps to address associated cost pressures, ensuring that we can continue to secure the supply of care. It supports the sustainability of the home care market and workforce, and enables us to work with providers to help them overcome barriers.	Home Care or Domiciliary Care	Domiciliary care packages		41662	41662	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£802,000	£802,000	12%
46	Oxleas Community Contract	• Integrated practice based Adult Community Nursing Services to provide care for people aged over 18 years with a physical health care need within the community who are predominantly housebound or have complex health care needs (not including mental illness) and are unable to access their GP; or to facilitate an early discharge back into their community. • Long Term Condition (LTC) Management and Therapy Services with specialist teams such as respiratory nurses, diabetes nurses, continence service, community podiatry and SALT providing timely and responsive support. • Community Health Rehabilitation Team provides therapy assessments and treatment to prevent unnecessary admissions, support hospital discharges, and therapy management of LTCs. • It also includes Bexley MSK, which is an MDT of health professionals providing care for MSK conditions from one of their clinic locations based across the borough. • This is part of Oxleas contract and subject to block financial regime at present.	Community Based Schemes	Other	Oxleas Community Contract				Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£24,827,072	£24,827,072	74%
47	Oxleas Community Contract	This is part of Oxleas contract and subject to block financial regime at present. NHS minimum contribution towards: • Integrated Care Services (Oxleas); • Meadow View Intermediate Care Services; • Oxleas Neuro Rehabilitation.	Community Based Schemes	Other	Oxleas Community Contract				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£6,382,928	£6,382,928	19%
48	Pulmonary rehabilitation	Pulmonary rehabilitation is a nationally recognised treatment programme, which has been specifically designed for people with breathing problems, including COPD, Asthma, Interstitial lung disease and others. The programme consists of a 6 week course of exercise and education, which aims to improve the quality of life and exercise capacity of patients. The programme helps to improve both cardiovascular and strength fitness levels which in turn makes activities of daily living easier. Participants are actively encouraged to work at their own level whilst teaching methods of how to cope with breathlessness. The educational component of the programme uses the British Lung Foundations Self-Management Booklet to inform patients as to how to better manage their condition. It combines spoken sessions with supplementary written material.	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£154,712	£154,712	23%
49	Community Dietetics - Bromley Healthcare	A community-based nutrition and dietetic service to prevent avoidable infections and complications in Bexley patients with enteral feeding.	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£280,800	£280,800	41%
50	Learning Disabilities - cost per case	Packages of care for people with a learning disability entitled to S117 aftercare funded 50:50 by health and social care. This may include support in a residential care home or supported living setting, or people can choose how they get their care and support through a Personal Budget, Individual Service Fund or direct payment.	Personalised Budgeting and Commissioning						Mental Health		NHS			NHS	Additional NHS Contribution	Existing	£1,099,706	£1,099,706	4%
51	LB Bexley - Learning Disabilities (formerly in the learning disability pooled fund)	This is the ICB's contribution to providing personalised services for Bexley people with a learning disability. It covers a range of provision as detailed below (see Scheme 42).	Personalised Budgeting and Commissioning						Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£867,000	£867,000	4%

52	LB Bexley - Further Learning Disabilities (formerly in the learning disability pooled fund)	This funding provides personalised services to Bexley people with a Learning Disability. It covers a range of provision from day opportunities and transport through to supported living and residential care placements, wherever possible enabling people to remain living locally in Bexley, close to their loved ones and support networks. Wherever possible, people are enabled to choose their own care and support providers using Individual Service Funds, which separate the care provision from the property management. Where appropriate provision is not available locally, there is still a need for out of borough residential placements but we are working continuously to transform our local offer to minimise such placements.	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	Additional LA Contribution	Existing	£22,606,000	£22,606,000	92%
53	Learning Disability Modernisation	Alternatives to day care, such as the day opportunities provided by Charlton Athletic and other providers.	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	iBCF	Existing	£44,000	£44,000	0%
54	Personalisation	Enhancement to support personalisation	Personalised Budgeting and Commissioning						Social Care		NHS			Local Authority	Minimum NHS Contribution	Existing	£53,000	£53,000	0%
55	Greenwich and Bexley Hospice	The Hospice provides care and support in people's own homes, care homes, Queen Elizabeth Hospital and at the Hospice. The ICB makes a contribution towards the cost of providing the Hospice's support and services. The Provider works with people who receive palliative care and their carers, aiming to achieve the highest possible quality of life. Community personal care is provided as part of a coordinated service to enable people, who are approaching the end of life, to remain in their place of choice.	Community Based Schemes	Other	Hospice Services				Other	Hospice Services	NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£1,323,821	£1,323,821	4%
56	End of Life Care	The aim is to enable adult community health services in Bexley to provide high quality end of life care including out of hours on evenings and weekends. The provider is required to work in partnership with GPs, Integrated Rapid Response Services and Bexley and Greenwich Hospice to ensure that people who need end of life care can be cared for in their place of preference, are not admitted to hospital unnecessarily and are enabled to die in their place of preference.	Personalised Care at Home	Other	End of Life Care				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£246,000	£246,000	36%
57	Home Care Commissioning	Commissioning capacity to manage the 'Care at Home' procurement, implementation, and contract management.	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	iBCF	Existing	£40,000	£40,000	2%
58	Winter Resilience	Delivers additional capacity in the system over the winter period. This is a fixed budget but non recurrent in terms of what it funds each year (i.e., not the same spend year on year – it is a flexible pot).	Enablers for Integration	Other	Supports winter resilience and provides flexibility to utilise the				Other	Various	NHS			NHS	Additional NHS Contribution	Existing	£107,998	£107,998	4%
59	Additional staff costs	Staff in integrated commissioning. Also, additional costs of management arrangements in Bexley Care (AD Bexley Care).	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF	Existing	£325,000	£325,000	13%
60	Flexible Fund	A contingency fund to be used for meeting any unforeseen costs or requirements.	Enablers for Integration	Other	Contingency Fund				Social Care		LA			Local Authority	iBCF	Existing	£59,621	£59,621	2%
61	Cost and demand pressures 2022/23	Uplifts to schemes that experience cost or demand pressures	Enablers for Integration	Other	Cost and demand pressures				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£401,071	£401,071	16%
62	Uplift to NHS Minimum Contribution 2023/24	To be allocated by the partners	Enablers for Integration	Other	Uplift to NHS Minimum Contribution 2023/24										Minimum NHS Contribution	New	£1,044,572	£1,044,572	41%
63	Uplift to NHS Minimum Contribution 2024/25	To be allocated by the partners	Enablers for Integration	Other	Uplift to NHS Minimum Contribution 2024/25										Minimum NHS Contribution	New	£0	£1,103,694	22%

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Bexley

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	188.4	170.7	182.9	193.0	This metric measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. Our performance against this metric will help us to consider how successfully we manage to reduce emergency admissions for all long-term conditions where optimum management can be achieved in the community. We have taken account of published baseline figures for the NHSOF 2.3i indicator covering the period 2003/04 to 2020/21. Our metric plan for this indicator has also been informed by local baseline monitoring from South East London Integrated Care Board. The overall rate of admissions per 100,000 population increased from 538.2 avoidable admissions per 100,000 population in 2014/15 to 760.1 in 2019/20. This was followed by a reduction in the rate to 672.3 in 2020/21 (-11.6%). Our local monitoring suggests that the rate increased to 761.0 (+13.2%) in 2021/22 and we are currently forecasting an outturn in 2022/23 of 751.9 avoidable admissions per 100,000 population (-1.2%). Taking account of the quarterly trend since 2018/19, our plan for 2023/24 is to stabilise the rate at 764.6 and prevent further increases, where possible. Our modelling reflects the general upward trend since Q2 2014/15. Based on this, our forecast for the period 1 April 2023 to 31 March 2024 is 2,012 avoidable admissions in 2023/24 (810.4 avoidable admissions per 100,000), which would equate to a 7.8% increase in the rate when compared to our current projected outturn for 2022/23 (751.9). Within the context of current challenges, this is considered to represent a stretching ambition. Our ambition to stabilise the rate over the coming year reflects our plan to influence this metric over a longer timescale.	Our plan reflects the contribution of BCF schemes but we recognise that reducing admission rates requires a whole-systems approach. In particular, we are helping people to avoid hospital admissions in the first place through the coordination and implementation of a range of interventions, strategies and plans across local partners that seek to: • Focus on health improvement and reducing health inequalities, for example by promoting engagement in preventative interventions (e.g., smoking cessation; healthy eating; exercise and weight management programmes). • Take a more proactive and anticipatory approach to population health, using risk stratification tools and comprehensive frailty assessment to identify and assess those most at risk; • Plan ahead to ensure optimum management of a person's long-term or chronic conditions in the community with patients engaged in decisions about their care and encouraged to self-manage their condition(s); • Enable people in the last months of life to be well-cared for, wherever possible outside an acute environment and to end their lives in their preferred place of care. Over the course of the next two years, we will continue to work collaboratively across primary, community and acute services to support the management of appropriate demand through referral optimisation, diversion from the Emergency Department and the utilisation of community-based alternatives. Bexley has well-established integrated admission prevention and discharge support services for acute hospitals, which operate year-round. The Bexley Integrated Crisis and Rapid Response Service provides the first port of call in most instances to support with both sudden deterioration, or a more gradual decline for someone at risk of a hospital admission. The service can assess and direct the person to the most appropriate community provision as well as provide direct support for people in urgent need. Our three Local Care Networks are aligned with four Primary Care Networks of GP practices to provide the foundation for the healthcare system locally. The virtual LCN multi-disciplinary teams cover mental health, physical health and social care. They also involve wider partners, such as the third sector and independent sector providers. General practice supports people with both unplanned 'same day' appointments and proactive management of long-term conditions. This includes a diversified and blended offer including face to face, online and telephone consultations and expanded multi-disciplinary teams. The Delivery Plan for Recovering Access to Primary Care was published on 9 May 2023 with a focus on recovering access to primary care. Supported by investment, this plan responds to patient feedback and sets out measures that will make a difference now to staff and patients, focusing efforts on taking pressure off teams, and supporting general practice to manage the 8am rush, and restore patient satisfaction with improved experience of access. This plan provides details of how NHS England and ICBs will support practices and Primary Care Networks to deliver on the requirements of the 2023/24 GP contract. Proposals to expand the vital role of community pharmacies by consulting on a 'Pharmacy First' service and the oral contraception and blood pressure services are also included in the plan. The nationally mandated 'Enhanced Access' offer ensures access to the full range of primary care services during 'network standard hours' (18:30 to 20:00 Monday to Friday) and 09:00-17:00 on Saturdays, in addition to some early morning appointments. All our care homes receive primary care input and have a named clinical lead to help ensure continuity of care. In addition, the ICB continues to maintain existing local enhanced services through the pooled fund. We will monitor the data to give a further breakdown of admissions per Ambulatory Care Sensitive Conditions Diagnosis Category and use this to review the effectiveness of interventions and care pathways. The top three diagnosis categories between April 2022 and February 2023 related to COPD, Congestive Heart Failure, and Anaemia.We will use this information to explore what else needs to be done or done differently to avoid hospital admissions in the first place.
	Number of Admissions	478	433	464	-		
	Population	248,287	248,287	248,287	248,287		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	190.3	190.9	191.4	192		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,399.5	2,583.6	2,399.5	Falls are a leading cause of emergency hospital admissions for older people and significantly impact on long term outcomes, e.g., being a major precipitant of people moving from their own home to long-term nursing or residential care. By including this as a local indicator in our BCF Plan, we can measure the success of services in preventing falls and work together to tackle issues locally. There is a time lag in the publication of this data, which forms part of the Public Health Outcomes Framework. The data currently shows that there were 1045 emergency hospital admissions due to falls in people aged 65 and over in Bexley in 2021/22. There were more injuries from falls among people in the over 80's age group (720), than among the 65–79-year-olds (320). The overall rate of emergency hospital admissions due to falls in people aged 65 and over was 2187 in London and 2100 in England in 2021/22. In comparison, Bexley's rate was 2400 per 100,000 population. According to data from the Projecting Older People Population Information System, the number of people aged 65 and over predicted to be admitted to hospital as a result of falls is projected to increase from 1447 in 2022 to 1459 in 2023 (+0.8% or +12 admissions due to falls) and from 1459 in 2023 to 1490 in 2024 (+2.1% or +31 admissions due to falls). Nationally, research published by Public Health England in August 2021 has considered the wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults. This highlighted an increase in the number of inactive older people, reduced average duration of strength and balance activity and that older people in the most deprived groups were more likely to be inactive than the least deprived group. The modelling predicted an increase in the number of older people projected to have at least one fall per year and additional cost to the health and social care system related to falls. Our plan is to prevent further increases in the rate of falls per 100,000 population and our target for 2023-24 is for the indicator value to be no higher than the position in 2021/22. This is considered stretching within the context of predicted increases in the number of emergency admissions due to falls. This also takes account of the fact that the BCF Pooled Fund is continuing to support the delivery of existing schemes and we are not proposing any new schemes focussed on falls prevention. This means our opportunity to influence this metric is limited to what we can achieve through our existing schemes. Learning from some of our previous falls prevention initiatives has shown little or no impact. The development of any future proposals will need to be informed by evidence of what works and carefully coordinated with partners. We propose to review the target in light of the 2022/23 data, when this becomes available.	Our BCF Plan for 2023/24 and 2024/25 includes a range of existing schemes that contribute towards preventing emergency admissions due to falls in older people. The ICB and the Council continue to invest in integrated care from the pooled Better Care Fund. This provides integrated crisis and rapid response, hospital integrated discharge, intermediate care and integrated rehabilitation, and Community Geriatrician. We continue to ensure a co-ordinated, person-centred approach to care planning. This includes working as part of Multi-Disciplinary Teams to carry out assessments of care needs and support integrated care planning. In addition, BCF funding for social care is supporting the provision of integrated packages of care. GP practices are identifying high risk patients and cases are discussed in Multi-Disciplinary Teams, which is helping to prevent admissions to hospital because of very pro-active management. All our care homes receive primary care input and have a named clinical lead to help ensure continuity of care. The ICB continues to maintain existing local enhanced services through the pooled fund. This provision ensures care home residents receive dedicated medical services and supports a more proactive approach to care planning. Our care homes admission avoidance virtual MDT includes a falls prevention OT to support our care homes to prevent falls risks in the individuals identified. The provision of community equipment and technology-enabled care is also being utilised to help manage falls risk and prevent falls. In April 2023, the Council adopted the Housing Assistance Policy, which will now enable discretionary assistance to be provided from the Disabled Facilities Grant. This includes a range of options, such as minor adaptations, safe and secure grants, and home repairs and help to make homes safer so that people can return home from hospital.
	Count	1,045	1060	1045		
	Population	41,028	41028	41028		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.0%	92.1%	91.7%	90.2%	We have looked at the data for this metric stretching back to Q1 2019/20, when the percentage of people who were discharged from hospital to their normal place of residence was 82.7%. Performance has improved in the period since then reaching 92.9% in Q2 2020/21. Our forecast has been informed by a baseline taken from April 2020 to February 2023, reflecting a more consistent profile of performance above 90%. In preparing the targets for 2023/24, we have added together the monthly forecast data for each quarter to arrive at our quarterly target. The quarterly percentage is generally lower in Q3 and Q4 each year and our forecast, therefore, reflects this seasonality. We have also considered Bexley's split for discharge location and looked at the categories that make up the % of those that are not counted in the % of patients who are discharged to usual place of residence. Approximately 2.23% related to 'NHS other hospital provider - ward for general patients or the younger physically disabled', 1.5% to 'NHS run care home' and 0.6% to 'Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment'). The data suggests that there may be some factors that are not within our direct control and that there may only be limited opportunities for improvement. Across the year as a whole, our ambition is to ensure that 91.7% of people, resident in the HWB, are discharged from acute hospital to their normal place of residence. This represents an improvement on our expected performance in 2022/23 (91.5%). This ambition needs to be viewed within the context of current system pressures, where we have experienced no let up in hospital discharge demand, but have significantly less discharge funding being made available to us from the government and the NHS than in 2021/22 (circa £5.5m less). Our BCF Plan 2022/23 included an additional NHS contribution of £2.4 million from the NHS South East London Integrated Care Board to support the transition of our Hospital Discharge Scheme, following the end of National Discharge Funding in April 2022. This was non-recurrent funding and is no longer available to support hospital discharge. Bexley was allocated £1.7m from the ASC Discharge Fund in 2022/23, which was fully utilised during the five month period between December 2022 and March 2023 to enable people to be discharged from hospital to an appropriate setting with adequate and timely social care support. The Discharge Fund in 2023/24 covers 12 months, but the funding allocated is at a similar level. If demand keeps its pace, we are concerned that this funding will not be sufficient to facilitate discharge from hospital at the scale required by the NHS and government. This is a key reason why we cannot set a more ambitious target and it is possible that we may face a deterioration in performance as a consequence.	We are continuing to work with our partners to plan hospital discharge arrangements that are affordable from core NHS and local authority expenditure in 2023/24 and 2024/25. Within the context of system pressures, our plan for 2023/24 is to maintain existing good performance in Bexley at over 90%. Examples of schemes include the Integrated Community Equipment Store, Community Equipment and Telecare, and Assistive Technologies. Such schemes play a key role in helping to facilitate earlier discharges from hospital by providing equipment to people in their own homes. This in turn reduces the need for interventions such as home care, residential and nursing care home placements, and can prevent readmissions to hospital (e.g., from falls). Minor adaptations are also provided through the DFG and include rails, intercoms and steps, which supports independent living and assists hospital discharge. Our 'Home First' D2A schemes enable people to go home as soon as possible after acute treatment. We will continue to take a 'Home First' approach, wherever possible. A key objective is to ensure that people are discharged onto the most appropriate pathway and receive the right care in the right place at the right time.
	Numerator	4,636	4,714	4,536	3,986		
	Denominator	5,039	5,117	4,947	4,418		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	91.2%	92.4%	91.6%	91.4%		
	Numerator	4,390	4,878	4,793	4,422		
	Denominator	4,816	5,280	5,233	4,836		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	545.9	430.0	444.2	401.0	The provisional target rate of 401 new residential admissions per 100,000 population is based on no more than 171 older people aged 65+, whose long term support needs are met by admission to residential or nursing care in the year. This has been calculated using ONS 2018-based Sub-National Population Projections. It should be noted that the ASCOF metric uses the ONS Mid-Year Population Estimate.The rationale for this ambition is to reduce levels of admission so that they are no greater than the London average in 2021/22 (a rate of 401.2 per 100,000 population aged 65+).	Strength based assessments will be used to support people to live at home where possible. Permanent care home placements will only be considered once all community alternatives are exhausted; approval for permanent placement rests on examination of why less restrictive options cannot meet the person's identified needs. Individuals approved for permanent placement usually have a range of very complex health and/or significant social care needs including mental health issues, with associated high risks requiring considerable support to ensure their safety and wellbeing. All placements agreed at Strength-Based Forum will be reviewed by the Director and must show options/plans in relation to step down and time frames for follow up. In 2022/23, we saw a number of permanent admissions following emergency respite, enhanced care and interim placements. We also saw an increase in clients discharged with more complex needs. The "long reach" of COVID could have impacted the resilience of older people and their carers. To mitigate this, clients in short-term recovery beds and on short-term enhanced or flexible packages of care will receive more input from Multi-Disciplinary Teams (Physio and OT) to maximise their potential to regain independence and return or remain at home. We have also seen an increase in permanent admissions for self-funders with depleted funds. To mitigate this, information on the Bexley website will be improved to help people understand all of their care options and make good choices. Care homes will also be reminded to direct self-funders to good information about how long funds will last and to consider approaching the Council for advice and guidance.
	Numerator	224	181	187	171		
	Denominator	41,033	42,097	42,097	42,647		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.1%	87.1%	90.5%	90.7%	A provisional target rate of 90.7% is proposed based on maintaining existing good performance, similar to pre-pandemic levels of performance. However, the main difference is the reduced amount of reablement capacity available in 2023/24, which reflects the overall reduction in available discharge funding since 1 April 2022. Adult Social Care reablement funding supports approximately 668 people per year based on an average package of care of 14 hours for 6 weeks. The average cost per person (based on care provision costs only) is estimated to be £1,600 per episode of care. 668 packages of care will cost approximately £1,068,800. In 2022/23, we spent £87,531 from the Local Authority allocation of the ASC Discharge Fund on reablement at home. This accounted for 9.9% of expenditure against the ASC Discharge Fund in 2022/23. If funding for reablement at home from the Discharge Fund was maintained at a similar level in 2023/24, this would equate to £92,800. Overall, our estimated reablement capacity is equivalent to 726 reablement packages of care in 2023/24 or 181 packages of care per quarter. In 2022/23, our provisional data is showing that 91.7% of completed reablement episodes related to people aged 65 and over, and that 77.6% of reablement episodes had a route of access of discharge from hospital. We have applied these proportions to our estimates of total reablement capacity in 2023/24 (approx. 726 people), which results in estimated capacity of 563 people with a discharge route of access of which 516 are estimated to be older people. From this, we have estimated quarterly capacity of approximately 129 reablement packages of care for older people with a route of access of discharge from hospital. To achieve our target ambition of 90.7%, 117 out of 129 older people would need to still be at home 91 days after discharge from hospital into reablement services. The indicator values can be adjusted to reflect any changes in the funding allocated to reablement schemes in the BCF Pooled Fund, subject to any amendments being agreed by the partners.	For 2022/23, our provisional data shows that 277 out of 306 older people, who were discharged from hospital into reablement between October and December 2022, were at home 91 days later (90.5%). This represents an improvement on performance in previous years, whilst at the same time responding to an increase in demand for reablement. Reablement activity increased by 33% in the period covered by the ASC Discharge Fund when compared to the October 2022 baseline. In the short term, we do not expect the pressure on acute hospitals to diminish. If demand keeps its pace, we are concerned that the community resources available will not be sufficient to facilitate discharge from hospital at the scale required by the NHS and government. There is also a risk that we could see an increase in discharge delays and a deterioration in performance against key metrics. Our response to key issues and challenges arising during the year will be appropriately managed via our usual escalation processes at a local and system level. We feel it is important to flag up the risks involved so that this can be taken into account by the Government, NHS England and other national partners when considering their policies and plans. A further shift in community resources is required to help manage the demand from earlier discharges from hospital. Further discussions across our local health and care system may need to focus on how to ensure we have the right resources in the community to support reablement in the future. In the meantime, we have been working with our partners to plan affordable arrangements in 2023/24 and 2024/25 to mitigate the risks to the BCF Pooled Fund and the Council's adult social care budget. Our plan for 2023/24 is to focus on maintaining our improved performance on reablement outcomes at above 90%. Our model for care at home includes three Recovery and Reablement Providers, where each provider is aligned to one of three Local Care Networks to enable providers and partners to work together collaboratively. Work is allocated in an LCN style so that the specific care agencies have a regular worker who they can liaise with to discuss clients to improve their outcomes. Our benchmarking shows that our performance of 85.1% against this metric in 2021/22 was above the England average of 81.8% and in line with the London average of 85.1%. Our target in 2023/24 of 90.7% is considered to be a stretching target, when compared to these benchmarks within the context of current challenges.
	Numerator	172	183	277	117		
	Denominator	202	210	306	129		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist Complete:
Health and Wellbeing Board:	Bexley		Yes
Completed by:	Alison Rogers / Steven Burgess		Yes
E-mail:	alison.rogers@selondonics.nhs.uk / steven.burgess@bexley.gov.u		Yes
Contact number:	020 8176 5365 / 0203 045 5242		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Tue 23/05/2023	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Bexley

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Bexley

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	**Checklist** Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	739.0	Not on track to meet target	Our local monitoring from NHS South East London ICB gives a further breakdown of admissions per Ambulatory Care Sensitive Conditions Diagnosis Category in 2022/23. The top three diagnosis categories in the	Our local monitoring via NHS South East London ICB suggests that the rate has decreased from 761.0 avoidable admissions per 100,000 population in 2021/22 to 751.9 (-1.2%) in 2022/23. However, this was	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.8%	On track to meet target	We have considered Bexley's split for discharge location and looked at the categories that make up the % of those that are not counted in the % of patients who are discharged to usual place of residence.	Our local monitoring via NHS South East London ICB suggests that we are maintaining existing good performance in Bexley above 90%. In the period April 2022 to February 2023, 91.5% of people were	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	430	Not on track to meet target	The indications are that we have been successful in reducing the rate of new admissions to older adult care homes in 2022/23, compared to the previous year. This was not sufficient to reach our BCF	Provisional data for 2022/23 shows a rate of 444.2 new admissions to residential and nursing care homes per 100,000 population (65+). This is calculated based on 187 older people whose long-term support needs	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	87.1%	On track to meet target	Reablement packages of care are supported throughout the year through the BCF Pooled Fund. However, we found that there was a 33% increase in reablement activity during the ASC Discharge Fund period,	In 2022/23, we have supported earlier discharge onto reablement for more older people and have made further progress in reversing the trend towards poorer outcomes. Our provisional data shows that	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Bexley

Income

	2022-23					
Disabled Facilities Grant	£2,964,977					
Improved Better Care Fund	£6,616,137					
NHS Minimum Fund	£18,455,329					
Minimum Sub Total		£28,036,443				
	Planned		Actual			
NHS Additional Funding	£30,174,109		Do you wish to change your additional actual NHS funding?	Yes	£30,531,109	
LA Additional Funding	£23,660,000		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£53,834,109				£54,191,109

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£81,870,552	£82,227,552

	ASC Discharge Fund					
	Planned		Actual			
LA Plan Spend	£773,646		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£941,558		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£1,715,204				£1,715,204

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£83,585,756	£83,942,756

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	The total value of services within the scope of the BCF Pooled Fund in 2022/23 increased from £81.871m to £83.943m of which the ICB funded £49.928m and the Council funded £34.015m. Schedules to the section 75 Agreement were updated in January 2023 to reflect the approved BCF Plan 2022/23 (£81.871m in 2022/23), the agreed ASC Discharge Fund 2022/23 (£1.715m in 2022/23), and the Health Inequalities Fund (£0.357m in 2022/23). The NHS Additional

Expenditure

	2022-23
Plan	£81,870,552

Do you wish to change your actual BCF expenditure?	Yes
Actual	£81,927,383

	ASC Discharge Fund
Plan	£1,715,204

Do you wish to change your actual BCF expenditure?	Yes
Actual	£1,842,112

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	Actual expenditure in 2022/23 was £81.927m against the original planned BCF Pooled Fund of £81.871m (not accounting for the ASC Discharge Fund). This was +£0.57m higher due to additional expenditure on ICB-funded health inequalities projects, which has been met by the additional NHS contribution from the Health Inequalities Fund. The remainder (c£0.300m) of the original (£0.357m) Health Inequalities Fund was carried forward to be used in 2023/24.

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Bexley

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Partners have continued working collaboratively, including through the Integrated Care System, Bexley Wellbeing Partnership and our Bexley Care Partnership, to improve the health and wellbeing of our residents. This is focussed on delivering joined up health and care services, tailored to individuals, through Local Care Networks, Multi-Disciplinary Team	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	Over the course of the last year, we have continued to deliver positive outcomes, as indicated by our performance against the BCF metrics. Whilst we may not have met our BCF target ambitions for avoidable admissions and new admissions to care homes for people aged 65 and over, our provisional data for the year is showing reductions in both	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The Council and ICB have continued to provide joint grant funding for third sector organisations, which has enabled delivery of a range of prevention and early intervention services. The services range from providing information, advice, and advocacy through to support for carers and helping people with a disability to access healthcare services.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	8. Pooled or aligned resources	Our BCF Plan 2022/23 was submitted to the national BCF Team in September 2022 and was approved by NHS England in January 2023. Our section 75 agreement was updated and agreed by all parties by the end of January 2023. This covered the whole of the BCF plan and took account of Health Inequalities funding and the Adult Social Care Discharge Fund monies, which were added into our BCF Pooled Fund. This meant that the total value of services within the scope of the BCF Pooled Fund increased from £81.9m in our original plan to approximately £83.9m of which the ICB funded around	Yes
Success 2	9. Joint commissioning of health and social care	Personalised services for people with a learning disability are ensuring that they can exercise greater choice and control through Self Directed Support. The Council recently held an event with Think Local Act Personal about Individual Service Funds. ISFs are proving popular with young people and we now have 10 new providers on our framework. We have seen good uptake of annual health-checks for people with a learning disability during the course of the year and achieved the government target to offer 75% of patients aged 14 and over on a GP register with learning disability the opportunity to	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	The health and care system has been under pressure throughout 2022/23 with pressures felt across all areas of service provision, including acute care emergency departments, primary care, mental and community health services, and social care. These pressures were exacerbated by seasonal pressures, alongside planning for and managing the impact of industrial action. This has not only resulted in challenges in acute trusts, but also across the NHS and social care more widely.	Yes
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Current challenges around the cost of living and the subsequent impact on workforce are major concerns for Bexley providers. Recruitment and retention issues are leading to high turnover and vacancy rates. Providers are also communicating concerns around rising costs of heating, utilities, and insurance costs, leading to increased risk of market exit and lack of financial resilience particularly for smaller providers. We are also currently exploring the potential impact of ULEZ for our providers.	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Bexley

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.
The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.
1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techenologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
Additional Dietetic Support to prevent failed discharges - increasing community capacity	Other		£23,000	£23,000	0	N/A	No		Yes	This scheme provided additional dietetic support to care homes, focussing on those patients with new or changed enteral feeding needs following a hospital stay. This enabled these	No
Discharge Care Options - Increasing community capacity to support the discharge of	Residential Placements	Care home	£204,500	£288,027	18	Number of beds	Yes	Initially, we planned to fund 6 extra beds in addition to the 12 beds we already had. We originally estimated that the beds would be occupied for 6 weeks at a time, giving the opportunity	Yes	The care home providers involved in the scheme provided clinical support and relevant expertise, including provision of complex dementia care. This has enabled safe and speedier	Yes, we have learning relating to how we have worked with our care home
Ensuring efficient use of market capacity and staff availability to support the flow of discharges	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£340,892	£321,830	4,159	Hours of care	Yes	This scheme gave enhanced rates to providers over Christmas and the New Year bank holiday period (£242,176), which delivered additional capacity in the system in support of	Yes	(i) Incentive payments/enhanced rates: This helped to secure the supply of care; (ii) Flexible Care Packages: Initially, we planned for a fewer number of larger packages. Rather than	Yes, we ensured that we had robust plans in place, which meant that we did
Improving recruitment across the social care workforce (ICB contribution)	Local recruitment initiatives		£40,000	£10,000	1	number of additional staff	Yes	We have paid for a national recruitment campaign with the funding. We have had to divert some of the planned funding towards care costs.	Yes	This supported local recruitment initiatives, which have helped to raise awareness of social care as a career choice and the job opportunities available in the London Borough of Bexley. We	No
Increasing community capacity for holisitic care at home that maximises staff productivity	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£421,808	£392,006	19,298	Hours of care	Yes	We used the majority of this funding (£301,645) to pay for new short term packages of care (Rapid, Enhanced, D2A), rather than to provide additional long term care hours for people	Yes	We provided additional homecare hours that enabled our integrated teams to provide responsive care packages to support hospital discharge. The additional investment in	Yes, the learning from 2022/23 will be used to inform our planning and
Mental Health Discharges - Additional social care workforce capacity (ICB contribution)	Additional or redeployed capacity from current care workers	Costs of agency staff	£60,000	£14,858	488	hours worked	Yes	Reduced spending due to recruitment challenges. We had hoped to recruit 2 agency staff for 15 weeks. However, we recruited one internal Oxleas OT for 15 weeks (of which 2	Yes	Role was to look at the pressures on inpatient services in discharging Mental Health clients from ward to community and better understand delays and interventions required. OT	1. Requires hospital discharge and placement review team to be
Multi-disciplinary staff to aid recovery and assessment of people accessing D2A services -	Additional or redeployed capacity from current care workers	Costs of agency staff	£202,250	£78,000	2,700	hours worked	Yes	We have been successful in recruiting to some of our key posts but there remain significant challenges in workforce recruitment, including to social work, social care and to	Yes	Staff supported discharges from all the main acute hospitals where Bexley residents receive in-patient care. Feedback on Bexley's performance from our main acute sites has been very	Yes, we experienced difficulties in recruiting additional agency, qualified
Workforce initiatives to free-up and support the frontline - Additional social care workforce	Additional or redeployed capacity from current care workers	Costs of agency staff	£422,754	£10,240	320	hours worked	Yes	We experienced delays in recruitment or were not able to recruit to other planned posts. We have developed recruitment and retention proposals, which have been agreed corporately	Yes	Staff have worked additional hours every weekend and bank holiday, which supported discharges or prevented readmission over the weekends. We have also re-allocated other work in	Yes, the short-term nature of the discharge funding in 2022/23 meant that we had

Schemes added since Plan											
Reablement	Reablement in a Person's Own Home	Reablement to support to discharge – step down	£87,531	£87,531	4,449	Hours of care	Yes	Our original plan primarily focussed on the workforce initiatives outlined above, including therapy staff, etc. Reablement packages of care are supported throughout the year via the BCF	Yes	Impact in terms of the number of older people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services is still being	No
Care Home Placements	Residential Placements	Other	£616,620	£616,620	98	Number of beds	Yes	This scheme comprised all the short term residential care home placements (i.e., respite and interim placements) funded by the Discharge Fund during the period. This helped to secure	Yes	The purchasing of additional interim beds has helped to facilitate hospital discharges for people who would otherwise have remained in hospital for longer. This has allowed more	Yes, the additional discharge funding is not sufficient to facilitate

Planned Expenditure	£1,715,204
Actual Expenditure	£1,842,112
Actual Expenditure ICB	£941,558
Actual Expenditure LA	£900,554

Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

Item: 8

Enclosure: F

Title:	**Local Care Partnership Supplementary Performance Data Report**
Author:	Graham Tanner, Associate Director, Primary Care (Bexley), NHS South East London Integrated Care Board Alison Rogers, Director of Integrated Commissioning (Bexley), NHS South East London Integrated Care Board/London Borough of Bexley
Executive Lead:	Diana Braithwaite, Chief Operating Officer (Bexley), NHS South East London Integrated Care Board

Purpose of paper:	The aim of this paper is to report the latest positions on areas of performance that have been delegated to the Bexley Wellbeing Partnership via the NHS South East London Integrated Care Board (NHS SEL ICB). The metrics covered in this report are also drawn from national performance frameworks, such as the NHS System Oversight Framework and Long-Term Plan. The content of the report is continuously reviewed to reflect the latest NHS planning guidance and any changes in delegated functions. The report provides the definition and latest performance position for each metric and a brief narrative of the central SEL context and an explanation of the current performance position. Benchmarking data has also been reported where available. The paper reports mitigating actions to address areas of underperformance and also highlights areas of good performance and best practice. Performance is Red, Amber, Green (RAG) rated against the delivery of nationally mandated standards or agreed trajectories. Performance is red rated where there is variance against target and green rated where the target is achieved.	Update / Information	*X*
		Discussion	
		Decision	
Summary of main points:	The latest available report (April 2023) presents a strong overall position for Bexley with performance above the Q4 2022/23 trajectory in all but one metric. Performance is below the required trajectory for the delivery of annual health checks for people with Severe Mental Illness (SMI). The national target is 60% and the Bexley position is 49.0% (SEL average 54.2%).		

	Delivery against the physical health check target within 2023/24 remains a challenge across SEL for several reasons including capacity within teams to carry out the physical health checks and issues with data completeness/sharing across different systems. A steering group was set-up in 2021 to develop and deliver an improvement plan. Action plans are now in place and non-recurrent funding has been allocated to support their implementation. Incentivisation for completion of SMI health checks, over and above the 60% target, has also been proposed as part of the new GP Premium. A verbal update on the Bexley action plan will be provided at the meeting.	
Potential Conflicts of Interest	This report is for information only. There are no conflicts of interest.	
Other Engagement	Equality Impact	The stated mission of the South East London ICS is to help people in South East London to live the healthiest possible lives. The Bexley Wellbeing Partnership (BWP) supports this through helping people to stay healthy and well, providing effective treatment when people become ill, caring for people throughout their lives, taking targeted action to reduce health inequalities, and supporting resilient, happy communities as well as the workforce that serves them. The BWP is committed to leading work at place to reduce the premature mortality among people living with severe mental illness (SMI). People with severe mental illnesses are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Ensuring all patients with SMI have access to a good quality annual physical health check (with appropriate follow on support) is therefore a high priority for the SEL ICS and Bexley Wellbeing Partnership.
	Financial Impact	This report if for information only. There are no financial impacts.
	Public Engagement	The majority of the information provided in this report is publicly available via NHS Digital.
	Other Committee Discussion/ Engagement	This report and any required mitigations are discussed at the SEL ICB Board and Bexley Wellbeing Partnership Executive. It is being reported to the Bexley Wellbeing Partnership Committee for information.
Recommendation:	The Bexley Wellbeing Partnership is recommended to:	

	(i)	Note the report and a verbal update in relation to the performance position performance on the delivery of Serious Mental Illness Health Checks.

South East London Integrated Care System

NHS South East London

Bexley Local Care Partnership
supplementary performance data report

April 2023

Contents

Overview of report

Outline and structure of report

- The aim of this report is to report the latest positions on areas of performance that have been delegated to the Local Care Partnership via the SEL ICB board. The metrics covered in this report are also drawn from national performance frameworks, such as the NHS System Oversight Framework and Long Term Plan.
- The content of the report will be continuously reviewed to reflect the latest NHS planning guidance and any changes in delegated functions.
- The report provides the definition and latest performance position for each metric and a brief narrative of the central SEL context and the definition and SEL context and an explanation of the current performance position. Benchmarking data has also been reported where available.
- The paper reports mitigating actions to address areas of under performance and also highlights areas of good performance and best practice.

Rating performance

- Performance is RAG rated against the delivery of nationally mandated standards or agreed trajectories. Performance is red rated where there is variance against target and green rated where the target is achieved.

Bexley performance overview

Standard	Trend since last period	Target	Current performance	Risk of delivering year end target
SMI Physical Health Checks	↑	National standard **60%**	49.0%	Performance is significantly below target.
Personal health budgets	↑	Q4 2022/23 **Trajectory - 563**	617	Performance is above the Q4 2022/23 trajectory
NHS CHC assessments in acute	↔	National standard No more than **15%**	0%	Performance is on target as at Q4 2022/23
NHS CHC 28 days assessments	↑	Completed within 28 days **Trajectory – Q4 65%**	65%	Performance has met the Q4 2022/23 trajectory
NHS CHC 12 weeks referrals	↑	Q4 2022/23 **Trajectory – no more than 1 per borough**	0	Performance trajectory has been met for Q4 2022/23
Childhood immunisations in primary care	↓	Above the London average for all 7 metrics	Above the London average for 7 out of 7 metrics	Performance being met for all of the metrics, but % decreasing.
LD and Autism – annual health checks	↑	February 2022/23 **Trajectory - 670 health checks**	672	Performance is above the February trajectory.
CQC overall ratings	↔	No target	4.8% (1) Outstanding 85.7% (18) Good	4.8% (1) Requires Improvement 4.8% (1) No Rating

South East London Integrated Care System

NHS South East London

Performance data

SMI Physical Health Checks

Description of metric and SEL context

- South east London is committed to leading work to reduce the premature mortality among people living with severe mental illness (SMI). People with severe mental illnesses are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease.
- The NHS has committed to ensuring 60% of people on the **SMI register receive a full and comprehensive physical health check**. As at **Q4 2022/23 54.2%** of people on the SMI register had received a full comprehensive physical health check for all six components.
- Whilst the 2022/23 Operating Plan target ambition was not met, improvements have been reported for all of the six boroughs and overall SEL performance is **up by 14.2%** compared to Q3 2022/23. Performance has also **significantly improved** since **2021/22** by **53.3%**.
- Borough level plans are in place to address the under-performance and further improvements are expected to be reported in 2023/24.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Proportion of people on the SMI register receiving a comprehensive physical health check in the last 12 months (Q4 2022/23) – target 60%							
% patients receiving check	49.0%	56.8%	50.3%	59.5%	48.0%	59.6%	54.2%
Trend since last quarter	+9.5%	+15.8%	+15.7%	+16%	+11.9%	+13.6%	+14.2%

Personal Health Budgets

Description of metric and SEL context

- As of **March 2023, 3,477 PHBs** were in place in SEL which is **628 below the Q4 target of 4,105**. Bexley and Bromley are the only boroughs in SEL performing above their planned Q4 trajectory.
- The personal wheelchair budgets offer has been restarted across SEL and more PHBs for mental health service users will be introduced through the South London Partnership.
- New PHB offers have been introduced including PHBs for people with learning disabilities that are at risk of admission to hospital, across SEL ICS.
- The personalised care team is part of the continuing healthcare working group, ensuring that PHBs are considered in future CCC/CHC plans.
- There is ongoing support to LCPs to implement the personalisation agenda and expand their PHB provision. A 'Community of Practice' has been developed to support the workforce to implement personalised care across the ICS.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Number of PHBs provided – Q4 2022/23							
Target – Q4 2022/23	563	805	698	778	644	617	4,105
Q4 2022/23	617	1290	579	387	151	453	3,477

NHS Continuing Health Care (1 of 2)

Proportion of assessments taking place in an acute setting

- ICSs are required to provide assurance that NHS Continuing Healthcare (CHC) assessments are taking place at the right time and in the right place as set out in the NHS National Framework for NHS Continuing Healthcare and NHS funded Nursing Care. The framework sets out that it is preferable for eligibility for NHS CHC to be considered after discharge from hospital when the person's long-term needs are clearer, and for NHS-funded services to be provided in the interim.
- ICSs are required to ensure no more than 15% of assessments take place in an acute setting. In **Q4 2022/23 SEL reported 1%,** meeting the required standard. The **target is being met by all boroughs** and continue to work to local discharge to assess arrangements.

Percentage of assessments completed in 28 days

- ICSs are expected to make a decision about eligibility for a full assessment for NHS continuing healthcare within 28 days of an initial assessment or request for a full assessment.
- Performance across SEL ICS varies significantly against the Q4 trajectory of 65%. Bexley, Bromley and Southwark achieved the trajectory for Q4 2022/23. **SEL achieved 61%.**

NHS CHC referrals exceeding 12 weeks

- ICSs are expected to minimise the number of incomplete NHS CHC referrals exceeding 12 weeks.
- Performance against the **Q4 2022/23 trajectory has improved greatly** since Q3 2022/23. As at **Q4 2022/23** there were **8** incomplete referrals over 12 weeks in SEL, against a **target of 4**. Bexley, Bromley, Greenwich and Southwark are meeting the target.

NHS Continuing Health Care (2 of 2)

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Proportion of NHS CHC full assessments in an acute setting Q4 2022/23 – Target no more than 15%							
Quarter 4 2022/23	0%	2%	0%	3%	0%	0%	1%
Trend since last reported period	↔	↓	↔	↓	↑	↔	↓
Percentage assessments completed in 28 days Q4 2022/23 – Trajectory at least 65%							
Quarter 4 2022/23	65%	74%	38%	30%	61%	74%	61%
Trend since last reported period	↑	↑	↑	↓	↑	↑	↑
Incomplete referrals over 12 weeks Q4 2022/23 – Trajectory no more than 1 per borough and 4 SEL							
Quarter 4 2022/23	0	0	0	3	4	1	8
Trend since last reported period	↑	↑	↑	↑	↑	↑	↑

Childhood immunisations: MMR

Description of metric and SEL context

- The NHS vaccination schedule is in place to support parents and carers to ensure that their children are offered the best protection in their early years and promote a strong immune system. By monitoring the progress of the screening programme we are able to identify vulnerable groups and those that have not been able to access the vaccination programme.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 24 months – Q3 2022/23									
% patients	87.8%	91.5%	85.6%	86.2%	83.9%	85.9%	86.8%	82.5%	89.0%
Trend since last quarter	↑	↑	↑	↑	↑	↑	↑	↑	↓
Children receiving MMR1 at 5 years – Q3 2022/23									
% children	89.2%	92.9%	88.1%	86.8%	87.6%	88.1%	88.9%	86.9%	92.9%
Trend since last quarter	↓	↑	↓	↑	↑	↑	↑	↑	↔
Children receiving MMR2 at 5 years – Q3 2022/23									
% patients	78.4%	86.8%	81.2%	79.2%	79.7%	81.7%	81.4%	74.1%	85.2%
Trend since last quarter	↓	↑	↓	↑	↓	↑	↑	↑	↑

RAG rated against the London average

Childhood immunisations: six-in-one vaccination rate

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months – Q3 2022/23									
% patients	91.3%	94.1%	91.5%	90.6%	89.4%	85.9%	90.5%	87.4%	91.9%
Trend since last quarter	↑	↓	↑	↑	↓	↓	↑	↓	↓
Children receiving DTaP/IPV/Hib % at 24 months – Q3 2022/23									
% children	90.4%	93.3%	90.7%	91.0%	88.2%	91.6%	90.8%	88.5%	93.0%
Trend since last quarter	↓	↑	↑	↑	↓	↑	↑	↑	↑
Children receiving pre-school booster (DTaPIPV%) % at 5 years – Q3 2022/23									
% patients	80.1%	83.4%	77.8%	76.7%	75.8%	76.0%	78.4%	73.8%	84.0%
Trend since last quarter	↓	↑	↑	↑	↑	↑	↑	↑	↑
Children receiving DTaP/IPV/Hib % at 5 years – Q3 2022/23									
% patients	91.2%	93.0%	91.1%%	90.6%	89.8%	88.7%	90.7%	88.8%	93.5%
Trend since last quarter	↑	↑	↑	↑	↑	↓	↑	↑	↔

RAG rated against the London average

Learning disabilities and autism – annual health checks

Description of metric and SEL context

- People with a learning disability often experience poorer physical and mental health outcomes but this does not need to be the case. South east London is committed to offering 75% (5,815) of patients aged 14 and over on a GP register with learning disability the opportunity to have an annual health check by the end of March 2023. An annual health check will aid earlier detection of any health issues, which may need further investigation and appropriate interventions made.
- In south east London **5161** annual health checks were completed between **April and February 2023** exceeding the February trajectory of 5124. Workforce challenges continue to impact on the delivery of health checks in primary care. However, improvements can be seen across south east London with 4 out of 6 boroughs exceeding the February trajectory.
- Resources have been made available by NHS England for the most challenged areas, which will be used to fund additional staff hours or training where possible.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Annual Health Checks February 2022/23							
February 2022/23	672	710	931	1076	985	787	5161
Local trajectory February 2022/23	670	820	865	997	1032	740	5124

CQC overall ratings

Description of metric and SEL context

- The CQC is responsible for monitoring, inspecting and regulating GP practices. The inspections gather information and evidence from people accessing the services and assess the standard of care that is provided.
- Practices will receive one of five assessment outcomes; Outstanding, Good, Inadequate, Requires improvement and No rating.
- **Bexley** is the only borough to have **one Outstanding** practice, with all other boroughs with the exception of Southwark having more than 90% of their practices rated as **Good**.

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Summary of latest published CQC ratings – January 2023							
Outstanding	4.8% (1)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0.5% (1)
Good	85.7% (18)	95.2% (40)	93.5% (29)	97.4% (38)	97.0% (32)	75% (24)	91% (181)
Inadequate	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	3.1% (1)	0.5% (1)
Requires improvement	4.8% (1)	2.4% (1)	6.5% (2)	2.6% (1)	3% (1)	15.6% (5)	5.6% (11)
No rating	4.8% (1)	2.4% (1)	0% (0)	0% (0)	0% (0)	6.3% (2)	2.0% (4)

* Number of practices reported in ()

South East London Integrated Care System

Bexley Wellbeing Partnership

Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

Item: 9

Enclosure: G

Title:	**Month 12 Finance Report**
Author:	Julie Witherall, Associate Director of Finance (Bexley), NHS South East London Integrated Care Board
Executive Lead:	David Maloney, Director of Corporate Finance, NHS South East London Integrated Care Board

Purpose of paper:	**This paper is to provide an update on the financial position of Bexley (Place) as well as the overall financial position of the ICB and the ICS as at Month 12 (March) 2022/23.**	Update / Information	
		Discussion	*X*
		Decision	

Summary of main points:

Bexley Position

At month 12, Bexley Place reported an underspend against budget of £334k compared to an expected FOT position of circa £400k overspend. The main reasons for the movement were;

- £100k deterioration in the prescribing position, a continuation of the trend during the year which is driven by circumstances outside of the control of the local medicines management team;
- £250k improvement in the CHC position due to no new retrospective claims to account for and also no significant increase in activity over the winter period;
- £250k improvement in the community services position due to prior year accruals being taken back at Place level;
- £200k improvement in Mental Health position partly due to some prior year accrual reversals but also due stable cost per case spend in the year and contract negotiations being successful;
- £150k improvement in Corporate position due to ongoing vacancies, an underspend in some non-pay lines and some prior year accrual reversals.

Bexley Place achieved all of its savings targets in year with the exception of the prescribing target as predicted in previous months.

This is a significant achievement and the Bexley Place team who have helped to achieve this financial out-turn should be thanked for their support throughout what has been a challenging year financially.

ICB Position – Refer Appendix 1

As per the national NHS year-end timetable, the ICB was required to submit its draft annual accounts and supporting documentation by 9am on 27 April. This high-level report summarises the overall ICB financial position for the 9 months ending 31 March 2023. The financial position of the Places will be reported through their local governance.

	The final ICB financial allocation for the Month 4 to 12 period was £3,121,225k. As at Month 12, the ICB delivered a £16k surplus against its total allocation. As previously reported, the key financial pressure within the ICB financial position related to the prescribing budget, which was £12,687k overspent. Prescribing data is received two months in arrears, so the latest information we have relates to January 2023. An estimate for prescribing expenditure for February and March has been accrued into the ICB financial position. The overspend is driven by both activity and price pressures. Activity (based upon the number of items prescribed) for the first 10 months of 2022/23 compared to the same period for last year, has increased by circa 3.4%. The ICB has also been impacted by increases in price driven by issues outside of its direct control – including the short supply of specific drugs and the price of Category M drugs which are nationally set. All ICBs have been similarly impacted. In reporting this Month 12 position, we are pleased to report that the ICB has delivered all of its financial duties: • Surplus positions against its overall Resource Limit (£16k) and Running Cost Allowance (£748k); • Delivering all targets under the Better Practice Payments code; • Subject to the usual annual review, delivered its commitments under the Mental Health Investment Standard; and • Delivered the month-end cash position, well within the target cash balance. The draft ICB accounts are now subject to the usual external audit process. Deadline for submitting the audited accounts is 30 June. **ICS Position – Refer Appendix 2** **Revenue Expenditure (I&E)** South East London ICS is reporting a £0.25m surplus for the financial year 2023/24. 4 out of 5 providers reported a surplus, offsetting the £20m deficit reported at King's. The system has delivered £176.9m of efficiencies for the year against a plan of £207.2m. £78.5m (44%) of the efficiencies were delivered non-recurrently. **Capital expenditure** At year end the system has spent its system capital allocation in full. At time of the system IFR submission the recorded charge against system allocation exceeded the allocation by £33k, however work is underway to ensure the allocations is not overspent.	
Potential Conflicts of Interest	None arising as a direct result of this paper.	
Other Engagement	Equality Impact	None, all Bexley residents have the same levels of access to healthcare
	Financial Impact	The external audit of our 2022/23 accounts has now begun and the only risk to these reported numbers is

		if a material mis-statement is identified as part of their work.
	Public Engagement	Finance is reported to public borough based board meetings and also the position is reported by SE London ICB at the public Governing Body Meetings
	Other Committee Discussion/ Engagement	The month 12 financial position is discussed at SE London level at the Planning and Delivery Group, locally, it has been discussed at Bexley SMT and the LCP Executive.
Recommendation:	The Bexley Wellbeing Partnership Committee is asked to: 1. DISCUSS & NOTE the Month 12 (March 2023) financial position for NHS South East London ICS, NHS South East London ICB and Bexley Place.	

South East London Integrated Care System

Agenda Item: 9
Enclosure: G(i)

Bexley Wellbeing Partnership Committee

Financial Year 2022/23

Month 12 Finance Report – March 2023

Contents:

1. Summary of Bexley Borough's Financial Position as at Month 12

Overall Position

	Bexley
	£'000s
Final Year Position	
Acute Services	-490
Community Health Services	1,044
Mental Health Services	515
Continuing Care Services	567
Prescribing	-1,838
Other Primary Care Services	43
Other Programme Services	-20
PROGRAMME WIDE PROJECTS	0
Delegated Primary Care Services	0
Corporate Budgets	513
Final Borough Position	**334**

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- £250k improvement in the CHC position due to no new retrospective claims to account for and also no significant increase in activity over the winter period;
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- £150k improvement in Corporate position due to ongoing vacancies, an underspend in some non pay lines and some prior year accrual reversals

Bexley Place achieved all of its savings targets in year with the exception of the prescribing target as predicted in previous months.

2. Summary of Key Messages for NHS SE London ICB's Financial Position as at Month 12

- As per the national NHS year-end timetable, the ICB was required to submit its draft annual accounts and supporting documentation by 9am on 27 April. This high-level report summarises the overall ICB financial position for the 9 months ending 31 March 2023. The financial position of the Places will be reported through their local governance.

- The final ICB financial allocation for the Month 4 to 12 period was **£3,121,225k.** As at Month 12, the ICB delivered a **£16k surplus** against its total allocation.

- As previously reported, the key financial pressure within the ICB financial position related to the **prescribing** budget, which was **£12,687k** overspent. Prescribing data is received two months in arrears, so the latest information we have relates to January 2023. An estimate for prescribing expenditure for February and March has been accrued into the ICB financial position. The overspend is driven by both activity and price pressures. Activity (based upon the number of items prescribed) for the first 10 months of 2022/23 compared to the same period for last year, **has increased by circa 3.4%.** The ICB has also been impacted by increases in price driven by issues outside of its direct control – including the short supply of specific drugs and the price of Category M drugs which are nationally set. All ICBs have been similarly impacted.

- In reporting this Month 12 position, we are pleased to report that the ICB has **delivered all of its financial duties**:
  - Surplus positions against its overall Resource Limit **(£16k)** and Running Cost Allowance **(£748k);**
  - Delivering all targets under the **Better Practice Payments code**;
  - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
  - Delivered the **month-end cash position**, well within the target cash balance.

- The draft ICB accounts are now subject to the usual external audit process. Deadline for submitting the audited accounts is 30 June.

2. Summary of Key Messages for NHS SE London ICB's Financial Position as at Month 12

	Month 12			Rating
	Target	Actual	Under/(Over) Spend	
	£'000s	£'000s	£'000	
Expenditure not to exceed income	3,157,551	3,157,535	16	
Operating Under Resource Revenue Limit	3,121,225	3,121,209	16	
Not to exceed Running Cost Allowance	30,569	29,821	748	
Month End Cash Position	4,338	281		
Operating under Capital Resource Limit	0	0		
95% of NHS creditor payments within 30 days	95.00%	99.97%		
95% of non-NHS creditor payments within 30 days	95.00%	98.10%		
Mental Health Investment Standard (Annual)	404,710	405,460		

- The above table sets out the ICB's performance against its key financial duties as at Month 12. We are pleased to confirm that all financial duties have been delivered for the 9 month period to 31 March 2023.
- The ICB delivered a **£16k** surplus against its total Revenue Resource Limit (£3,121.2m) and a **£748k** surplus against its Running Cost Allowance (£30.5m).
- As reported in previous finance reports, the key area of financial pressure related to the prescribing budget. Year-end prescribing expenditure was £179.2m, generating an overspend of £12.7m. This overspend was mitigated by underspends in other ICB service areas – including acute, community, mental health and corporate budgets.
- The ICB has delivered its financial duties with respect to its cash limit (final cash balance was **£281k**, well within the target), paying invoices in a timely manner (both for NHS and Non-NHS creditors, the actual performance exceeded the **95%** target) and expenditure against the Mental Health Investment Standard (MHIS) exceeded the target by **£750k –** as set out in Appendix 1.

3. High Level Summary of NHS SE London ICS's Financial Position as at Month 12

The values in this report are subject to change as final year-end figures are not confirmed until after the audit process is completed.

Only high-level information is reported due to detailed information not yet being available.

Revenue Expenditure (I&E)

- South East London ICS is reporting a £0.25m surplus for the financial year 2023/24.
- 4 out of 5 providers reported a surplus, offsetting the £20m deficit reported at King's.
- The system has delivered £176.9m of efficiencies for the year against a plan of £207.2m. £78.5m (44%) of the efficiencies were delivered non-recurrently.

	M12 YTD & Outturn		
	Plan	Actual	Variance
	£m	£m	£m
GSTT	0.0	13.1	13.1
KCH	(0.0)	(20.0)	(20.0)
LGT	0.1	3.5	3.5
Oxleas	(0.0)	3.5	3.5
SLaM	0.0	0.1	0.1
SEL Providers	**0.1**	**0.2**	**0.2**
SEL ICB	**0.0**	**0.0**	**0.0**
SEL ICS total	**0.1**	**0.3**	**0.2**

Capital expenditure

- At year end the system has spent its system capital allocation in full.
- At time of the system IFR submission the recorded charge against system allocation exceeded the allocation by £33k, however work is underway to ensure the allocations is not overspent.

	Charge against System Capital Allocation		
	Plan	Actual	Variance
	£m	£m	£m
GSTT	111.0	121.7	(10.7)
KCH	50.0	50.5	(0.5)
LGT	38.5	21.5	17.1
Oxleas	16.0	14.3	1.7
SLaM	24.6	23.4	1.2
SEL Providers	**240.1**	**231.3**	**8.8**
System Allocation	*231.3*	*231.3*	*(0.0)*

NHS
South East London

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SEL ICB Finance Report

Month 12 2022/23

Contents

NHS
South East London

1. Executive Summary

NHS South East London

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  - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
  - Delivered the **month-end cash position**, well within the target cash balance.

- The draft ICB accounts are now subject to the usual external audit process. Deadline for submitting the audited accounts is 30 June.

2. Key Financial Performance Indicators

	Month 12			Rating
	Target	Actual	Under/(Over) Spend	
	£'000s	£'000s	£'000	
Expenditure not to exceed income	3,157,551	3,157,535	16	
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- The ICB has delivered its financial duties with respect to its cash limit (final cash balance was **£281k**, well within the target), paying invoices in a timely manner (both for NHS and Non-NHS creditors, the actual performance exceeded the **95%** target) and expenditure against the Mental Health Investment Standard (MHIS) exceeded the target by **£750k –** as set out in Appendix 1.

3. Debtors and Creditors Position

NHS South East London

- At the end of the financial year, the ICB had total debtors of £9.457m, 96.3% of which were less than three months old. The ICB has continued to increase its focus on debtors and as consequence the value of invoices outstanding continues to decrease month on month. As at 31 March 2023, the largest balances outstanding are with NHS England (£3.5m) and £4.1m across five London Boroughs. There are no disputes in relation to these outstanding invoices.
- As at year-end, total aged creditors were £49.276m. The overall level of creditors increased by 13% in-month as a result of a rise in billing by local organisations. Largest balances of invoices outstanding included £22.0m with Local Authorities (Lewisham £9.7m, Lambeth £5.5m, Greenwich £3.0m, Bromley £2.0m, Southwark £1.5m and Bexley £0.8m); £5.2m with Bromley Healthcare CIC, £1.8m with GSTT, £1.2m with SLAM and £1.0m with NEL ICB. Invoices are being validated and some of these have already been paid in April.

Aged debtors

Customer Group	Aged 0-30 days £000	Aged 1-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121+ days £000	Total £000
NHS	1,167	871	2,203	4	91	92	4,428
Non-NHS	3,393	836	361	273	34	132	5,029
Total	**4,560**	**1,707**	**2,564**	**277**	**125**	**224**	**9,457**

Aged creditors

Customer Group	Aged 0-30 days	Aged 31-60 days	Aged 61-90 days	Aged 91-120 days	Aged 121-180 days	Aged 181+ days	Total £000
NHS	3,840	996	93	1,213	525	70	6,737
Non-NHS	32,075	8,345	752	521	566	280	42,539
Total	**35,915**	**9,341**	**845**	**1,734**	**1,091**	**350**	**49,276**

4. Cash Position

NHS South East London

- The Maximum Cash Drawdown (MCD) as at Month 12, after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing expenditure) was **£3,854.9m**.

- As at month 12, the ICB had drawn down 99.6% of the available cash for the year. In March, there was a £62,140k supplementary draw down that the ICB utilised. The cash key performance indicator (KPI) was achieved in all months for this year, showing continued successful management of the cash position by the ICB's Finance team to achieve the target cash balance. The final cash balance at the end of Month 12 was **£281k**, well within the target set by NHSE.

Annual Cash Drawdown Requirement for 2022/23	2022/23 AP12 - MAR 23	2022/23 AP11 - FEB 23	2022/23 Month on month movement
	£000s	£000s	£000s
ICB ACDR (M4-12)	3,120,178	3,071,213	48,965
CCG ACDR (M1-3)	964,003	964,003	0
Capital allocation			
Less:			
Prescription Pricing Authority	(225,909)	(206,713)	(19,196)
Other Central / BSA payments-HOT	(2,504)	(2,268)	(236)
Pension uplift 6.3%	(2,038)	(2,038)	0
PCSE POD charges adjustments	1,246	1,041	205
Remaining Cash limit	**3,854,976**	**3,825,237**	**29,739**

Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of CCG cash requirement %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
CCG							
Apr-22	290,000	27,000	317,000	34.93%	3,625	2,830	0.98%
May-22	292,000	0	609,000	67.10%	3,650	1,254	0.43%
Jun-22	287,000	0	896,000	98.72%	3,588	856	0.30%
ICB							
Jul-22	295,000	15,000	310,000	10.48%	3,688	253	0.09%
Aug-22	310,000	0	620,000	20.95%	3,875	197	0.06%
Sep-22	335,000	0	955,000	32.27%	4,188	690	0.21%
Oct-22	305,000	12,000	1,272,000	44.10%	3,813	1,918	0.63%
Nov-22	317,000	0	1,589,000	99.62%	3,963	919	0.29%
Dec-22	302,000	0	1,891,000	65.70%	3,775	185	0.06%
Jan-23	320,000	0	2,211,000	76.50%	4,000	509	0.16%
Feb-23	327,000	0	2,538,000	87.30%	4,088	1,761	0.54%
Mar-23	347,000	62,140	2,947,140	99.60%	4,338	281	0.08%
	3,727,000	**116,140**					

South East London Integrated Care System

Mental Health Investment Standard (MHIS) – Month 12 update

28 April 2023

MENTAL HEALTH INVESTMENT STANDARD (MHIS)

South East London Integrated Care System

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 21/22 outturn by a **minimum of the growth uplift of 5.52%**. This spend is subject to annual independent review.
- MHIS excludes:
  - Spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
  - Out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements
  - Spend on SDF and other non recurrent allocations
- The MHIS target is measured for the financial year 2022/23 and therefore brings together the Q1 CCG 22/23 and the SEL ICB Q2-Q4 22/23 reported position
- Slide 3 summarises the SEL ICB reported month 12 position for the delivery of the Mental Health Investment Standard (MHIS). The ICB is reporting that it will deliver the target value of **£404,710k** with a forecast of **£405,460k (£750k over delivery).** Within this position, mental health prescribing is overspent by £1,609k (17.2%) with Cat M and No Cheaper Stock Obtainable (NCSO) drugs continuing to have a significant impact.
- Slide 4 sets out the position by ICB budgetary area.

Ongoing risks to delivery

- We continue to see an increase in spend in some boroughs on mental health, for example on S117 placements and LD placements which are not included in the MHIS definition.
- For ADHD, although it is outside the MHIS definition and is therefore excluded from this reported position, we are seeing a significant cost pressure resulting from increasing demand of approximately £1.6m. This cost is managed within the overall mental health budgets. Work is underway to understand and manage the drivers for this demand.
- Prescribing spend is volatile within and across years – in 21/22 we saw a reduction in spend on Sertraline of approximately £2m on a total plan of approximately £11.7m (17%). In 22/23, spend is increasing as described above.

SUMMARY MHIS POSITION M12

South East London Integrated Care System

Mental Health Spend By Category	Category Reference Number	Total Mental Health (per recategorisation exercise) Plan 31/03/2023 Year Ending £'000	Planned Spend - NHS Plan 31/03/2023 Year Ending £'000	Planned Spend Non-NHS Plan 31/03/2023 Year Ending £'000	Outturn Spend - NHS Actual 31/03/2023 YTD £'000	Outturn Spend - Non-NHS Actual 31/03/2023 YTD £'000	Outturn Spend - NHS Forecast 31/03/2023 Year Ending £'000	Outturn Spend - Total Forecast 31/03/2023 Year Ending £'000	Total Mental Health Variance 31/03/2023 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	*38,119*	34,851	3,465	38,316	35,004	3,398	38,402	(283)
Children & Young People's Eating Disorders	2	*2,773*	2,773	0	2,773	2,784	0	2,784	(11)
Perinatal Mental Health (Community)	3	*8,790*	8,790	0	8,790	8,814	0	8,814	(24)
Improved access to psychological therapies (adult and older adult)	4	*31,824*	25,345	5,921	31,266	25,432	6,268	31,700	124
A and E and Ward Liaison mental health services (adult and older adult)	5	*15,786*	15,786	0	15,786	16,084	0	16,084	(298)
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	*12,035*	12,035	0	12,035	12,072	0	12,072	(37)
Adult community-based mental health crisis care (adult and older adult)	7	*30,014*	29,553	361	29,914	29,620	328	29,948	66
Ambulance response services	8	*942*	942	0	942	943	0	943	(1)
Community A – community services that are not bed-based / not placements	9a	*108,044*	95,904	10,848	106,752	96,208	11,483	107,691	353
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	*21,850*	10,724	8,004	18,728	12,083	9,012	21,095	755
Mental Health Placements in Hospitals	20	*6,331*	5,820	602	6,422	5,830	688	6,518	(187)
Mental Health Act	10	*6,341*	0	5,643	5,643	0	5,826	5,826	515
SMI Physical health checks	11	*743*	522	39	561	798	26	824	(81)
Suicide Prevention	12	*0*	0	0	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	*107,601*	107,601	0	107,601	107,860	0	107,860	(259)
Adult and older adult acute mental health out of area placements	14	*3,631*	2,828	491	3,319	2,828	653	3,481	150
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		***394,824***	**353,474**	**35,374**	**388,848**	**356,360**	**37,682**	**394,042**	**782**
Mental health prescribing	16	*9,345*	0	10,954	10,954	0	10,954	10,954	(1,609)
Mental health in continuing care (CHC)	17	*541*	0	288	288	0	464	464	77
Sub-total - MHIS (inc CHC, Prescribing)		***404,710***	**353,474**	**46,616**	**400,090**	**356,360**	**49,100**	**405,460**	**(750)**
Learning Disabilities	18a	*0*	0	0	0	0	0	0	0
Autism	18b	*0*	0	0	0	0	0	0	0
Learning Disability & Autism - not separately identified	18c	*27,701*	11,432	15,059	26,491	11,466	16,540	28,006	(305)
Dementia	19	*13,852*	12,015	1,468	13,483	12,083	1,555	13,638	214
Sub-total - LD&A & Dementia (not included in MHIS)		***41,553***	**23,447**	**16,527**	**39,974**	**23,549**	**18,095**	**41,644**	**(91)**
Total - Mental Health Services		***446,263***	**376,921**	**63,143**	**440,064**	**379,909**	**67,195**	**447,104**	**(841)**

SUMMARY MHIS POSITION M12 – position by budgetary area

South East London Integrated Care System

Mental Health Investment Standard (MHIS) position by budgetary area

Mental Health Investment Standard Categories:	Category number	Month 12 Outturn position for the financial year ended 31 March 2023					
		Annual Plan	SEL Wide Spend	Borough Spend	All Other	Total	Variance (over)/under
		£000s	£000s	£000s	£000s	£000s	£000s
Children & Young People's Mental Health (excluding LD)	1	£38,119	£34,830	£3,572	£0	£38,402	-£283
Children & Young People's Eating Disorders	2	£2,773	£2,784	£0	£0	£2,784	-£11
Perinatal Mental Health (Community)	3	£8,790	£8,814	£0	£0	£8,814	-£24
Improved access to psychological therapies (adult and older adult)	4	£31,824	£25,438	£6,262	£0	£31,700	£124
A and E and Ward Liaison mental health services (adult and older adult)	5	£15,786	£16,084	£0	£0	£16,084	-£298
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	£12,035	£12,072	£0	£0	£12,072	-£37
Adult community-based mental health crisis care (adult and older adult)	7	£30,014	£29,620	£328	£0	£29,948	£66
Ambulance response services	8	£942	£943	£0	£0	£943	-£1
Community A – community services that are not bed-based / not placements	9a	£108,044	£96,228	£11,463	£0	£107,691	£353
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	£21,850	£12,069	£8,820	£205	£21,095	£755
Mental Health Placements in Hospitals	20	£6,331	£5,830	£688	£0	£6,518	-£187
Mental Health Act	10	£6,341	-£235	£6,062	£0	£5,826	£515
SMI Physical health checks	11	£743	£798	£26	£0	£824	-£81
Suicide Prevention	12	£0	£0	£0	£0	£0	£0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	£107,601	£107,860	£0	£0	£107,860	-£259
Adult and older adult acute mental health out of area placements	14	£3,631	£2,828	£653	£0	£3,481	£150
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**£394,824**	**£355,963**	**£37,874**	**£205**	**£394,042**	**£782**
Other Mental Health Services:							
Mental health prescribing	16	£9,345	£0	£0	£10,954	£10,954	-£1,609
Mental health continuing health care (CHC)	17	£541	£0	£0	£464	£464	£77
Sub-total - MHIS (inc. CHC and prescribing)		**£404,710**	**£355,963**	**£37,874**	**£11,623**	**£405,460**	**-£750**
Learning Disability	18a	£0	£0	£0	£0	£0	£0
Autism	18b	£0	£0	£0	£0	£0	£0
Learning Disability & Autism - not separately identified	18c	£27,701	£11,335	£13,395	£3,277	£28,006	-£305
Learning Disability & Autism (LD&A) (not included in MHIS) - total	**i**	**£27,701**	**£11,335**	**£13,395**	**£3,277**	**£28,006**	**-£305**
Dementia	19	£13,852	£12,080	£1,119	£439	£13,638	£215
Sub-total - LD&A & Dementia (not included in MHIS)		**£41,554**	**£23,415**	**£14,513**	**£3,716**	**£41,644**	**-£90**
Total Mental Health Spend - excludes ADHD		**£446,264**	**£379,377**	**£52,388**	**£15,339**	**£447,104**	**-£840**

- Approximately 85% of MHIS spend is delivered through SEL wide contracts, the majority of which is with Oxleas and SLaM
- Borough based budgets include voluntary sector contracts and cost per case placements spend
- Other spend includes mental health prescribing and a smaller element of continuing health care

South East London Integrated Care System

NHS South East London

Agenda Item: 9
Enclosure: G(iii)

South East London ICS High-level Finance Report – 2022/23 (provisional)

25 May 2023

High-level finance summary

The values in this report are subject to change as final year-end figures are not confirmed until after the audit process is completed.

Only high-level information is reported due to detailed information not yet being available.

Revenue Expenditure (I&E)

- South East London ICS is reporting a £0.25m surplus for the financial year 2023/24.
- 4 out of 5 providers reported a surplus, offsetting the £20m deficit reported at King's.
- The system has delivered £176.9m of efficiencies for the year against a plan of £207.2m. £78.5m (44%) of the efficiencies were delivered non-recurrently.

	M12 YTD & Outturn		
	Plan	Actual	Variance
	£m	£m	£m
GSTT	0.0	13.1	13.1
KCH	(0.0)	(20.0)	(20.0)
LGT	0.1	3.5	3.5
Oxleas	(0.0)	3.5	3.5
SLaM	0.0	0.1	0.1
SEL Providers	**0.1**	**0.2**	**0.2**
SEL ICB	**0.0**	**0.0**	**0.0**
SEL ICS total	**0.1**	**0.3**	**0.2**

Capital expenditure

- At year end the system has spent its system capital allocation in full.
- At time of the system IFR submission the recorded charge against system allocation exceeded the allocation by £33k, however work is underway to ensure the allocations is not overspent.

	Charge against System Capital Allocation		
	Plan	Actual	Variance
	£m	£m	£m
GSTT	111.0	121.7	(10.7)
KCH	50.0	50.5	(0.5)
LGT	38.5	21.5	17.1
Oxleas	16.0	14.3	1.7
SLaM	24.6	23.4	1.2
SEL Providers	**240.1**	**231.3**	**8.8**
System Allocation	***231.3***	***231.3***	***(0.0)***

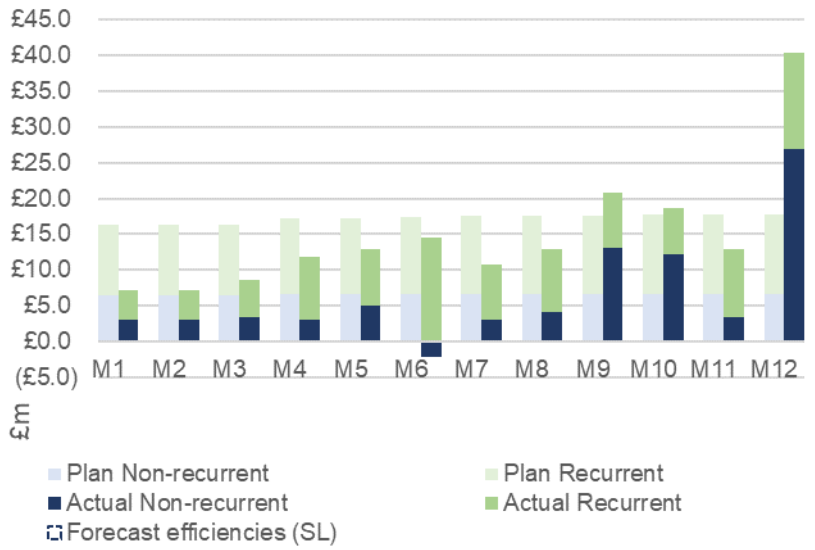
Efficiencies

- The SEL ICS breakeven plan included an efficiency savings plan of £207.2m.
- At year end the system **delivered £176.9 of efficiencies**, 14.6% (£30.3m) behind plan. At month 11 system efficiencies were £53.7m behind plan (28.3%).
- In month 12 the system delivered £40.4m of efficiencies. The average delivery per month between M1 and M11 was £12.4m.
- **£78.5m (44%) of the efficiencies were delivered non-recurrently**, which has consequences for the exit run-rate and the challenge for 2023/24. Work is underway to develop the efficiency programme across SEL for 2023/24.

Efficiencies by organisation

	Full-year			*Of which is*		
	Plan	Actual	Variance	Recurrent	Non-recurrent	NR %
	£m	*£m*	*£m*	*£m*	*£m*	*%*
GSTT	80.1	71.1	(9.1)	23.3	47.8	67%
KCH	55.0	38.5	(16.5)	29.1	9.4	24%
LGT	21.6	21.6	0.0	12.5	9.1	42%
Oxleas	13.5	13.5	0.0	5.9	7.6	56%
SLaM	15.0	11.8	(3.2)	9.8	2.0	17%
SEL Providers	**185.2**	**156.5**	**(28.7)**	**80.6**	**75.9**	**48%**
SEL ICB	**22.0**	**20.4**	**(1.6)**	**17.8**	**2.6**	**13%**
SEL ICS	**207.2**	**176.9**	**(30.3)**	**98.4**	**78.5**	**44%**

Phasing of efficiency delivery



Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

Item: 10

Enclosure: H

Title:	**Place Risk Register**
Author/Lead:	Simon Beard, Associate Director of Corporate Operations, NHS South East London Integrated Care Board
Executive Sponsor:	Stuart Rowbotham, Place Executive Lead (Bexley)/Director of Adult Social Care/NHS South East London Integrated Care Board/London Borough of Bexley

Purpose of paper:	**To update the committee on the current risks on the Bexley place risk register and actions to mitigate those risks in the context of the boroughs risk appetite.**	**Update / Information**	
		Discussion	***x***
		Decision	

Summary of main points:	Following a review of the Bexley Place Risk register for the new financial year, two finance risks are being reported. • Risk 442 - Risk of overspend on delegated Place budget in financial year 2023/24. • Risk 443 - Risk of specific overspends due to ongoing cost pressures in prescribing, plus the impact of uplifts on cost-per case budgets in financial year 2023/24. Mitigating actions are detailed in the following report. Further work is ongoing to consider other risks within the local system which will be reported as appropriate to future meetings.	
Potential Conflicts of Interest	There are no conflicts of interest.	
Other Engagement	Equality Impact	None identified.
	Financial Impact	Both risks reported concern financial risks which may impact the ICBs ability to meet its statutory duties.
	Public Engagement	These risks are highlighted in the regular report which is provided to the BWPC at their meetings held in public.
	Other Committee Discussion/ Engagement	Risks as a whole are considered at the ICBs risk forum, which meets monthly. The Board reviews the Board Assurance Framework at each meeting and is provided with an update on

		actions taken by other committees in relation their specialty associated risks.
Recommendation:	The Bexley Wellbeing Partnership Committee is recommended to: (i) Review the risks and consider the mitigations detailed. (ii) Assess whether, in the committee's view, there are other mitigations that the risk owners could enact to reduce the risk score or acknowledge acceptance of the risk if no other actions can be taken. (iii) Note that work on identification and management of risks is ongoing.	

Bexley Place Risks – report to the Bexley Wellbeing Partnership Committee

Thursday 25th May 2023

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1. Introduction

NHS South East London ICB manages its risk through a robust risk management framework, which is supported by a range of risk registers as follows:

- Board Assurance Framework – reporting those high scoring risks which represent a risk to the achievement of corporate objectives
- South East London Risk Register – recording risks by specialty/ function (e.g. quality and nursing, finance etc) that relate to corporate south east London wide risks affecting multiple boroughs or directorates
- Place based risks registers – reporting borough/ place specific risks

The purpose of this report is to highlight the Bexley Wellbeing Partnership Committee members the risks currently reported in the Bexley Place Risk Register.

2. Governance and risk management

Risk ownership is assigned to the most appropriate person within the relevant Bexley team at the time of raising the risk.

Risk review is a four tier process comprising:

1. **Individual risk owner management** and review of the risk on a regular basis to ensure the risk register reflects the current status of the risk and any changes in circumstances are reflected in the score. This process includes a monthly scheduled review of all Bexley risks by the senior management team.
2. The opportunity **to benchmark against risks held on risk registers for other boroughs** in south east London, and against risks held on the south east London risk register in a monthly risk forum, which comprises risk owners and risk process leads from across the ICB to discuss and challenge scoring of risks and the mitigations detailed.
3. **Monthly review of the Bexley borough risk register** by members of the Bexley Wellbeing Partnership Committee, which holds a meeting held in public every other month, ensuring transparency of risks.
4. **Regular review of the Board Assurance Framework** by the ICB Board at meetings held in public, together with **review of directorate risks** by Board committees.

Risks are recorded on the Datix system, which enables regular automatic prompting to risk owners when risks are due for review and allows risk owners to update risks at any time. An audit trail of changes to risks is retained in the system to enable the risk owner to record how the risk has evolved over time and whether controls in place are having the desired impact on reducing a risk, or gaps in controls have been addressed.

3. Bexley Place Risks

The Bexley Place risk register has been fully reviewed for the new financial year, a process which is still ongoing. Consequently, the Place risk register presented today includes two risks relating to finance, however other issues particularly in commissioning of services are under review which may result in additional risks as time progresses.

The finance risks reported on the register relate to:

- Risk 442 - Risk of overspend on delegated Place budget in financial year 2023/24.
- Risk 443 - Risk of specific overspends due to ongoing cost pressures in prescribing, plus the impact of uplifts on cost-per case budgets in financial year 2023/24.

Both of these risks have been classified as “high” risks, scored at 9 (3x3) and 12 (3x4) respectively. These risk scores are calculated as likelihood x consequence.

It should be noted that the inherent and current risk scores are the same, indicating the uncertainty at present that the controls in place will have an impact on reducing the risk that is presented. Further work is required to obtain assurance on the impact of the controls and identify further action that can be taken to mitigate the risk.

For further details on the risks, please see **Appendix A** for the Bexley risk register in full.

4. Next steps

Regular opportunities to review the risks have been scheduled in on both a one-to-one basis with the risk owners, and as part of a broader review of the Bexley place-based risks by the local senior management team. Where issues are identified through liaison with colleagues in the local authority or other borough teams that may impact Bexley, local leads will be consulted to discuss whether additional risks should be raised on the Bexley risk register, or a risk escalated to the SEL-wide corporate risk register, as appropriate.

Any questions or queries in relation to the risk register can be referred to the borough governance team in the first instance.

Simon Beard
Associate Director for Corporate Operations
NHS South East London ICB

18 May 2023

Risk ID	Risk Owner	Risk Soonsor	Risk Title	Opened Date	Risk Description	Risk Type	Risk Subtype	Services	Initial Likelihood	Initial Consequence	Initial Rating	Control Summary	Gaps in Control Summary	Assurance in Place	Gaps in Assurance	Current Likelihood	Current Consequence	Current Rating	Next Review Date	Target Consequence	TagetRating	Target Likelihood
442	Julie Witherall	David Maloney	Failure to Identify and Achieve Required Level of Savings with Bexley Place	04/05/2023	There is a risk that Bexley Place will be unable to either identify or achieve the required level of savings which may cause Bexley Place to overspend on its delegated budget resulting in Place Executive not managing within delegated resource which may impact the ability of the ICB to achieve it's statutory duties	Finance	Budget overspend / unbudgeted expenditure / lack of funding	Financial Planning & Management	3	3	9	The savings target has been identified and as part of 23/24 budget setting thorough review undertaken which has identified a significant amount of the savings target which is either already delivered or is achievable Budget for 23/24 has been agreed and signed off,				3	3	9	30/06/2023	2	3	6
443	Julie Witherall	David Maloney	Risk of Overspending against Delegated Budget for Bexley Place	04/05/2023	There is a risk that Bexley Place will overspend against it's delegated budget due to the ongoing costs pressures in prescribing plus the impact of the uplifts requested within CHC and Mental Health Cost per Case budgets which could result in an impact for the ICB to deliver it's stautory financial duties.	Finance	Budget overspend / unbudgeted expenditure / lack of funding	Financial Planning & Management	3	4	12	there are 1% reserves in place to try to assist with prescribing and CHC pressures plus a central reserve for prescribing. Teams are working to minimise the impact of AQP bed prices and inflationary uplifts with high value items having to be agreed				3	4	12	30/06/2023	2	4	8

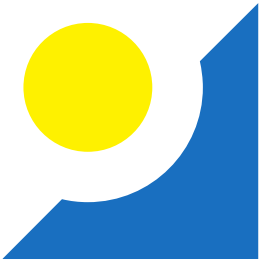
South East London Integrated Care System

Bexley Wellbeing Partnership

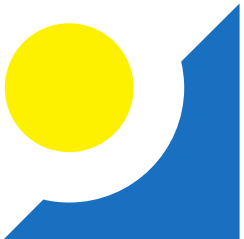
Agenda Item: 13
Enclosure: I

Bexley Wellbeing Partnership Committee

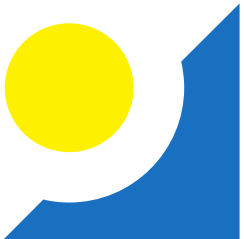
Glossary of NHS Terms



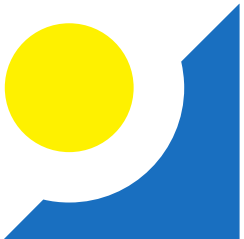
A&E	Accident & Emergency
AHC	Annual health Checks
AAU	Acute Assessment Service
ALO	Average Length of Stay
AO	Accountable Officer
APMS	Alternative Provider Medical Services
AQP	Any Qualified Provider
ARRS	Additional Roles Reimbursement Scheme
ASD	Autism Spectrum Disorder
BAME	Black, Asian & Minority Ethnic Group
BBB	Borough Based Board
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CAN	Accountable Cancer Network
CAG	Clinical Advisory Group
CCG	Clinical Commissioning group
CEG	Clinical Executive Group
CEPN	Community Education Provider Networks
CHC	Continuing Healthcare
CHD	Coronary Heart Disease
CHYP	Children and Young People's Health Partnership
CIP	Cost Improvement Plan
CLDT	Community Learning Disability Team
CMC	Coordinate My Care
CoIN	Community of Interest Networks
CoM	Council of Members
COPD	Chronic Obstructive Pulmonary Disease
Covid-19	Coronavirus
CRG	Clinical Review Group
CRL	Capital Resource Limit
CQC	Care Quality Commission
CQIN	Commissioning for Quality and Innovation
CSC	Commissioning Strategy Committee
CSU	Commissioning Support Unit
CTR	Care Treatment Review
CSP	Commissioning Strategy Plan
CVD	Cardiovascular disease
CVS	Cardiovascular System
CWG	Clinical Working Group
CYP	Children and Young People
DBL	Diabetes Book & Learn
DES	Directed Enhanced Service
DH	Denmark Hill
DHSC	Department of Health and Social Care
DPA	Data Protection Act



DVH	Darent Valley Hospital
DSE	Diabetes Structured Education
EA	Equality Analysis
EAC	Engagement Assurance Committee
ECG	Electrocardiogram
ED	Emergency Department
EDS2	Equality Delivery System
EIP	Early Intervention in Psychosis
EoLC	End of Life Care
EPR	Electronic Patient Record
e-RS	e-Referral Service (formerly Choose & Book)
ESR	Electronic Staff Record
EWTD	European Working Time Directive
FFT	Friends and Family Test
FOI	Freedom of Information
FREDA	Fairness, Respect, Equality, Dignity and Autonomy
GB	Governing Body
GDPR	General Data Protection Regulation
GMS	General Medical Service
GP	General Practitioner
GPPS	GP Patient Survey
GPSIs	General Practitioner with Special Interest
GSF	Gold Standard Framework
GSTT	Guy's & St Thomas' NHS Trust
GUM	Genito-Urinary Medicine
HCA	Health Care Assistant
HCAI	Healthcare Acquired Infection
HEE	Health Education England
HEIA	Health and Equality Impact Assessment
HESL	Health Education England – South London region
HLP	Healthy London Partnership
HNA	Health Needs Assessment
HP	Health Promotion
HWBB	Health and Wellbeing Board
IAF	Improvement Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
ICU	Intensive Care Unit
IFRS	International Reporting Standards
IG	Information Governance
IS	Independent Sector
JSNA	Joint Needs Assessment
KCH	King's College Hospital Trust
KHP	Kings Healthcare Partnership
KPI	Key Performance Indicator
LA	Local Authority



LAS	London Ambulance Service
LCP	Local Care Provider
LD	Learning Disabilities
LES	Local Enhanced Service
LGT	Lewisham & Greenwich Trust
LHCP	Lewisham Health and Care Partnership
LIS	Local Incentive Scheme
LOS	Length of Stay
LMC	Local Medical Committee
LQS	London Quality Standards
LTC	Long Term Condition
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
NAQ	National Audit Office
NDA	National Diabetes Audit
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
MH	Mental Health
MIU	Minor Injuries Unit
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NICU	Neonatal Intensive Care Unit
OHSEL	Our Healthier South East London
OoH	Out of Hours
PALS	Patient Advice and Liaison Service
PBS	Positive Behaviour Support
PHB	Personal Health Budget
PPE	Personal Protective Equipment
PPI	Patient Participation Involvement
PPG	Patient Participation Group
PRU	Princess Royal university Hospital
PCNs	Primary Care Networks
PCSP	Personal Care & Social Planning
PHE	Public Health England
PMO	Programme Management Office
PTL	Patient Tracking list
QEH	Queen Elizabeth Hospital
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RTT	Referral to treatment
SEL	South East London
SELCA	South East London Cancer Alliance
SELCCG	South East London Clinical Commissioning Group
SELDOC	South East London doctors On Call
SLaM	South London and Maudsley Mental Health Foundation Trust
SLP	Speech Language Pathologist



SMI	Severe Mental Illness
SMT	Senior Management Team
SRO	Senior Responsible Officer
STPs	Sustainability and Transformation Plans
TCP	Transforming Care Partnerships
TCST	Transforming Cancer Services Team
THIN	The Health Improvement Network
TOR	Terms of Reference
UHL	University Hospital Lewisham
UCC/UTC	Urgent Care Centre of Urgent Treatment Centre
VCS	Voluntary and Community Sector/Organisations
WIC	Walk-in-Centre