Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

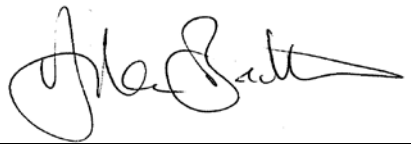
Local Authority	**LB Lewisham**
Clinical Commissioning Groups	**Lewisham Clinical Commissioning Group**
Boundary Differences	**None; local authority and CCG are co-terminous**
Date agreed at Health and Well-Being Board:	**Chair and Vice Chair approval action agreed by Board on 18/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£1.140m**
2015/16	**£21.114m**
Total agreed value of pooled budget: 2014/15	**£7.159m**
2015/16	**£21.842m**

b) Authorisation and signoff

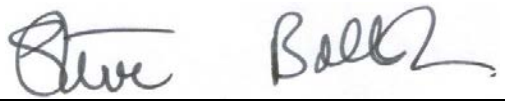
Signed on behalf of the Clinical	**Lewisham CCG**

Commissioning Group	
By	**Martin Wilkinson** 
Position	**Chief Officer NHS Lewisham Clinical Commissioning Group**
Date	**19/09/2014**

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	**Lewisham**
By	**Aileen Buckton** 
Position	**Executive Director for Community Services**
Date	**19/09/2014**

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	**Lewisham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	**Sir Steve Bullock** 
Date	**19/09/2014**

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

Document or information title	**Synopsis and links**
Lewisham Health and Wellbeing Strategy	Published in September 2013. Based on the JSNA evidence the board has identified nine priority outcomes for health and wellbeing in Lewisham, which highlights the commitment to integrated working. Health and Wellbeing Strategy
Pioneer Bid	Lewisham's expression of interest in becoming a Pioneer in health and social care integration outlining the history of integrated working in Lewisham and its plans to increase the scale and pace

	of integration.  Pioneer Expression of Interest.pdf
HWB Report – Integrated Adult Care Programme	The report outlined the vision for integrated care, covering all adults in Lewisham. The related PID provided more detail on the programme which seeks a step change in the way services are delivered, in patient experience and in performance and outcomes.
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment is an online information resource for everyone who commissions, provides or uses health, social or children's services in Lewisham. It also provides the evidence base for Lewisham's Joint Health & Wellbeing Strategy.
SEL Strategy	SEL Strategy
A Local Health Plan for Lewisham - NHS Lewisham CCG's Commissioning Strategy 2013-18	The CCG's Commissioning Strategy 2013-18 sets out the purpose, vision and understanding of the health needs of Lewisham residents and the plans to improve their health and wellbeing.
CCG Commissioning Intentions 2014/15 and 2015/16	NHS Lewisham CCG's Commissioning Intentions 2014/15 and 2015/16 is the framework for commissioning local health services over the next two years.
CCG Operating Plan 2014/15 and 2015/16	 Operating Plan.pdf
CCG Primary Care Development Strategy	 PC Development Strategy.pdf
Health and Wellbeing Performance Dashboard	 HWB Performance Dashboard.pdf
Case Study from Community Connections	Case Study

2) VISION FOR HEALTH AND CARE SERVICES

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

Our Vision
Better Health, Better Care and Stronger Communities in Lewisham

Lewisham is a diverse inner London borough with a growing population, projected to increase from 286,000 to 318,000 by 2021. Lewisham is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Around 26,000 residents are above 65 years of age and over 3,400 are aged over 85 years. This latter group is often the most complex and therefore bears a very high proportion of care costs.

The Index of Multiple Deprivation 2010 ranks Lewisham 31st of 326 districts in England and 9th out of 33 London boroughs. Small areas of the highest deprivation are found in Evelyn (the most culturally diverse ward in the borough) and Whitefoot and Bellingham (wards with the highest proportion of older people). People living in the most deprived wards have poorer health outcomes and lower life expectancy compared to the England average.

Social housing comprises just over a third of all households in the borough. The private rented sector, the fastest growing housing sector in the borough, comprises some 24% of all households. Lewisham has cheaper housing than other inner London boroughs and has high levels of poor condition, multi-occupancy private rentals and hostel accommodation which provide a home to groups of vulnerable or single people. There are nearly 40,000 one person households in Lewisham.

The Council and CCG have co-terminus borough boundaries with older residents accessing acute and community health care mainly from Lewisham and Greenwich NHS Trust and mental health care from South London and Maudsley Foundation Trust. Health and care work together in four geographical neighbourhoods as shown below.

Also we work in partnership across the South East London health economy as a whole, on the elements of our strategy that cannot be addressed at Borough level alone, or where there is common agreement that there is added value in working collectively.

GP Practices in Lewisham

North Lewisham Practices

1 Mornington
2 Queens Road
3 Kingfisher MC
4 Clifton Rise
5 New Cross Health Centre
6 Grove Medical Centre
7 Vesta Road
8 Amersham Vale Training Practice
9 Deptford Surgery
10 Dr Batra Surgery
11 Deptford Medical Centre

Central Lewisham Practices

12 Belmont Hill
13 Lewisham Medical Centre
14 Burnt Ash Surgery
15 Morden Hill
16 St Johns Medical Centre
17 Lee Road
18 Brockley Road
19 Hilly Fields Medical Centre
20 Honor Oak
21 Triangle
22 Rushey Green
23 Woodlands Health Centre
24 Nightingale
25 Hurley Group Practice

South East Lewisham Practices

26 South Lewisham
27 Torridon Road
28 Baring Road
29 ICO Moorside Clinic
30 Downham Family Practice
31 Winlaton
32 ICO Chinbrook
33 Parkview
34 ICO Marvels Lane Health Centre
35 Muirkirk Road
36 ICO Boundfield Road Medical Centre
37 Oakview

South West Lewisham Practices

38 Jenner
39 Sydenham Green
40 Woolstone Medical Centre
41 Sydenham Surgery
42 Wells Park
43 Bellingham Green
44 Vale Medical Centre

Lewisham's vision

Lewisham's vision is to deliver joined up and co-ordinated health and social care to all adults in the borough and to achieve:

- **Better Health – to make choosing healthy living easier** - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing.

- **Better Care** - **to provide the most effective personalised care and support where and when it is most needed -** giving all adults control of their own care and supporting them to meet their individual needs.
- **Stronger Communities** – **to build engaged, resilient and self-directing communities** - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

Our vision for integrated health and social care in Lewisham has both evolved and changed. The Council, CCG (Shadow)/PCT and the former Lewisham Healthcare Trust (acute and community service provider) agreed to develop and deliver an integrated health and social care model from November 2011. Our original approach was to focus on those with the most complex needs and, in particular, their access to health and social care services and their experience of admission into and out of the acute sector.

However it became evident that when undertaking the preparatory work for the Integrated Pioneer Bid in June 2013, that we required a more ambitious approach. We therefore decided to widen the scope of the integration programme to include all of Lewisham's resident adult population. This is reflected in our vision which now encompasses better health choices and making better use of resources in local communities which can support residents to self-care or self-manage their condition wherever possible.

The Lewisham adult integrated care programme has 10 workstreams. The 5 schemes outlined in this Better Care fund submission will help to quicken the pace and effectiveness of key elements of the programme.

Our achievements in 2012/13

- Readmission rates have improved - in Q1 2011/12, 15.6% patients were readmitted to hospital within 30 days of discharge. This reduced to 8.4% at Q4 2012/13. There are no or minimal delayed social care transfers of care month by month, whereas previous performance was in the bottom quartile.
- Patient/service users' satisfaction has improved significantly – see page 10.
- The level of unplanned hospitalisation for chronic ambulatory care sensitive conditions has reduced – see page 9.
- 87% of the people who were supported through Enablement Care Services were able to remain in the community at the end of the service provision.
- Although our older people population has risen, there has been a decrease in the numbers entering residential or nursing care. Therefore more people have remained in their own homes.

These achievements have been possible because of piloting work in the integration programme. In 2012/13 there has been a focus on streamlining discharge arrangements, improving our enablement offer and ensuring that our admission avoidance services works in a systematic and effective way. This work will be built on and incorporated into schemes 2, 3, and 4 of this Better Care Fund submission.

Feedback from our public indicated we needed to do more to change the whole system.

Barriers to improving health and care outcomes

Early feedback from local residents:

- Lack of organisational join-up, a lack of continuity between services, not knowing what opportunities are available and not having the time and space to consider which opportunities to access.
- Not knowing who to go to for help, advice or information.
- The complexity of the system
- The low take up of existing opportunities and activities provided within the community that support people's health and wellbeing.

Lewisham's approach to integration

Our approach to deliver successfully the transformation of health and social care is to encompass the whole adult population and widen the partnership to include a whole community approach to good health and well-being, whilst concentrating the clinical and professional core services where they could be used to greatest effect. Our approach is to commission person-centred care that can assist, through early intervention, in ensuring that residents living with long term conditions can have a good quality of life, others can help themselves to make choosing healthy living easier and assisting local people and neighbourhoods to do more for themselves and one another.

Lewisham's vision – key supporting principles:

The key support principles agreed by the Health and Wellbeing Board are:

Person centred:

- where the individual is supported and encouraged to take control of, and be responsible for, their health and wellbeing as far as they are able;
- where the individual is better equipped and uses their own skills to manage their own care and takes control in decision making; and
- where advice, support and care is co-ordinated around the whole person rather than on specific conditions and which gives the individual choice and control.

Use an outcome based approach to commissioning and delivery to ensure that advice, support and care is delivered earlier and more effectively resulting in:

- better quality and patient experience,
- improved health and care outcomes;
- a shift in resources to proactive, preventative care provided in the community;
- increased value for money.

Apply a population based approach using techniques of risk stratification, patient segmentation and evidence based care to ensure our collective, limited resources are most effectively used to meet the local health and care needs and challenges.

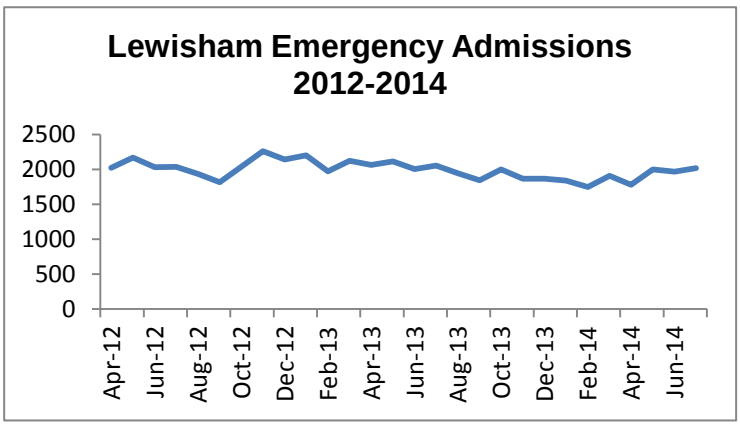
b) What difference will this make to patient and service user outcomes?

Our Ambition

Our ambition is that all service users will feel more in control of their care, understand what services are available to them and know how to access urgent support. Users will receive person-centred support and care provided closer to home, when required, which is provided by joined up teams of staff, working proactively, so reducing the need to attend or be admitted to hospital in an emergency.

How Lewisham's advice, support and care will look in five years' time	
Better Health	• Access to clear and high quality, personalised information • Consistent messages and integrated campaigns which raise awareness and encourage people to take action themselves • Effective advice and support (including advice on benefits entitlement) that promotes healthy living and self-care
Better Care	• Professional support to individuals and carers to enable them to exercise choice and control in relation to their health and wellbeing. • A continuum of joined up, flexible community based care to effectively support, maintain and regain independence including: o rapid delivery and installation of equipment, technology and housing adaptations o Effective support within appropriate settings to enable people to recover quickly and to respond quickly to unexpected deterioration and other health or care emergencies or crises o Intermediate tier of services to support people to stay at home : • shared approach to care management across health and social care including o sharing of information, so that individuals tell their story only once o single assessment and co-produced health and social care records and o single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible.
Stronger Communities	• Stronger resilient community networks working effectively to support people to live well and stay healthy • Effective links to community and neighbourhood support e.g. social networks to maintain recovery and independence • Activities and opportunities available locally to promote and support health and well being

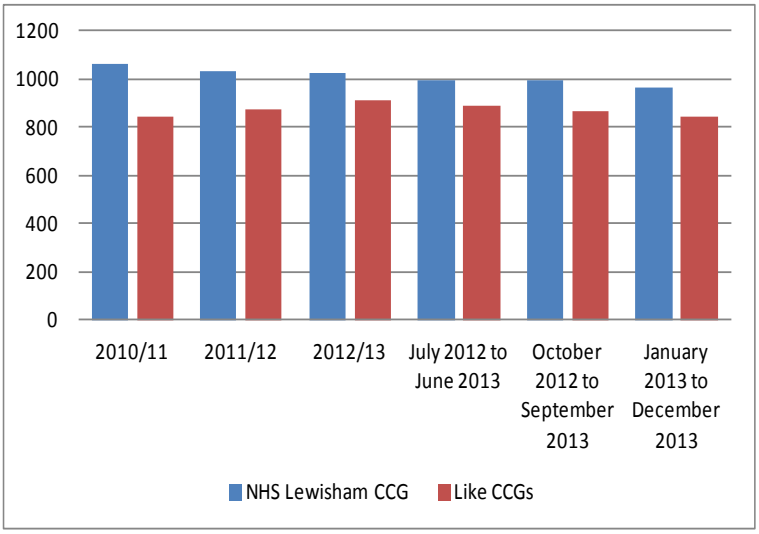
Our five year ambition is to change the way people can obtain advice care and support by providing more community based services, so reducing hospital emergency admissions. The graph below shows the trend for emergency admissions in Lewisham demonstrating some success in reducing admissions against an underlying local population growth of circa 2%. The partnership recognise further opportunities to address unnecessary admissions.



Our focus will therefore be on:

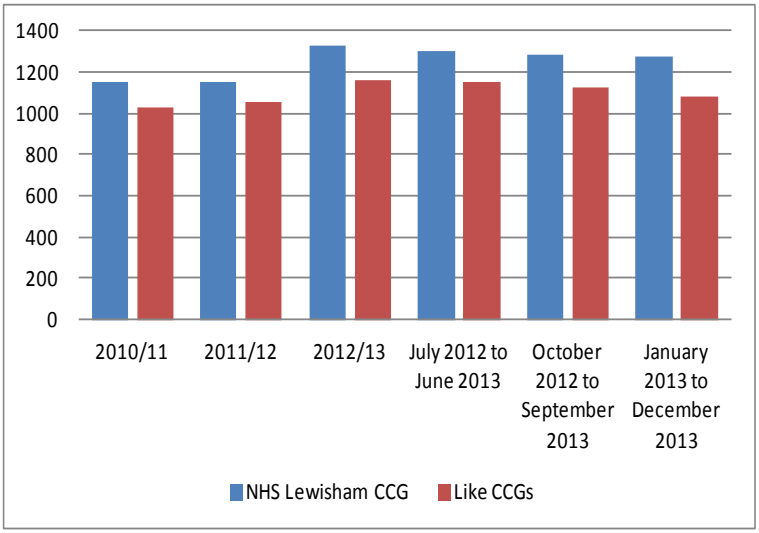
- Reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Reducing emergency admissions that should not usually be admitted to hospital
- Reducing emergency admissions for those over 65 years

Emergency Admissions – Unplanned hospitalisation for chronic ambulatory care sensitive conditions

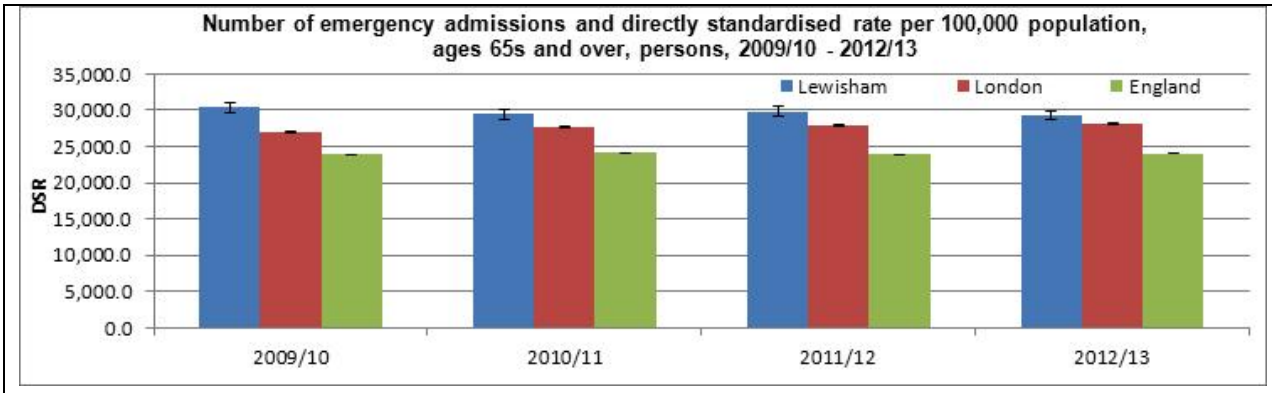


This indicator is concerned with reducing the amount of time people spend avoidably in hospital, through better and more integrated care in the community outside of hospital for nineteen 'ambulatory care sensitive condition.'[1] Currently the trend has been falling over time. But so have CCGs like Lewisham and there is still a 13% gap to achieve the average.

Emergency Admissions – Those that should not usually be admitted to hospital



This indicator is concerned with emergency admissions for conditions that should not usually be admitted to hospital. It is a directly standardised rate per 100,000 people registered. The trend has been falling over time since 2012/13. But so have CCGs like Lewisham and there is still a 15% gap to achieve the average.

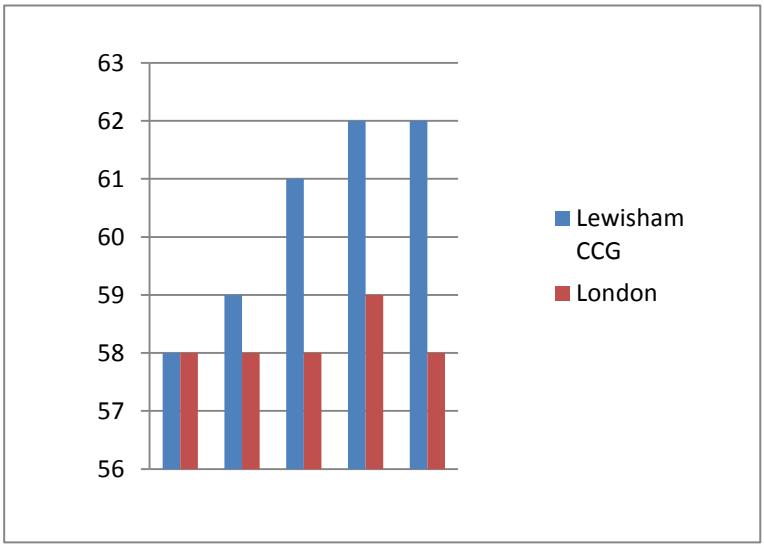


Lewisham has higher rates of emergency admissions rates for people over 65years in comparison to both London and England. In 2012/13 almost 8000 Lewisham people aged 65 years and over had an unplanned admission to hospital. The most common diagnosis for admission for the over 65 years was pneumonia, Urinary tract infections (UTI) and COPD.

Our five year ambition also is:

- To improve user experiences. Our intention is to increase the proportion of people who feel supported to manage their condition and achieve top quartile performance in this area.
- To increase the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (target 90%)
- To maintain low levels of delayed transfers of care from hospitals.

People Feel Supported with their Long-Term Conditions (GP Survey July 2014)



We will be measuring this through both the social care quality of life (ASCOF 1A) indicator and also the GP survey indicator measuring the percentage of people who report enough professional support to manage their long term condition (NHSOF 2.1).

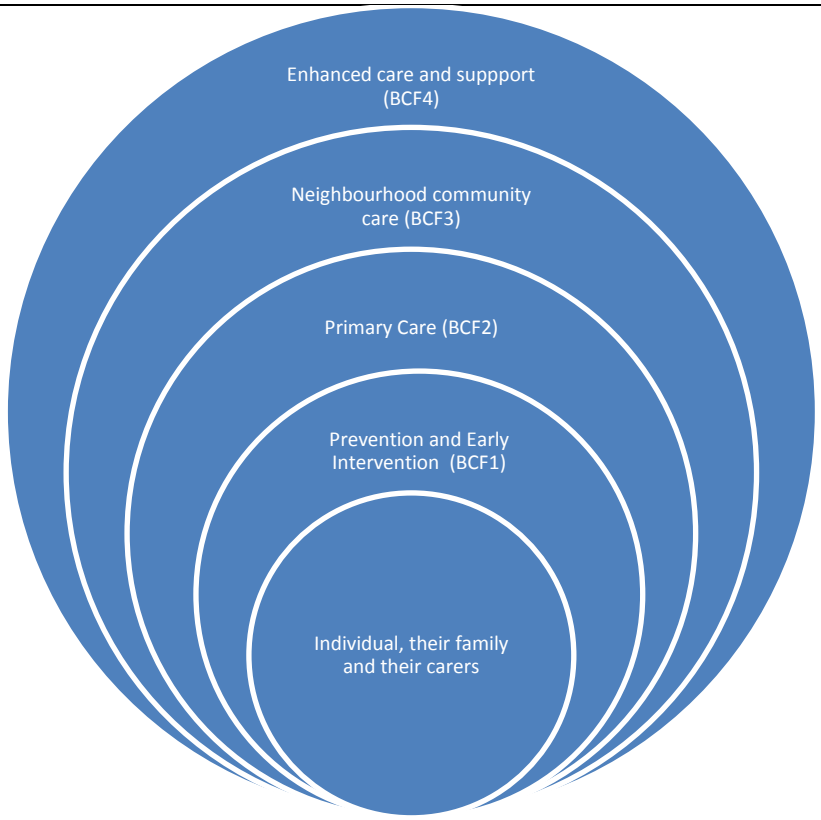
Our work is focused also on achieving improvements across a wider range of health and wellbeing indicators, as set out in the Health and Wellbeing Board's Performance Dashboard (see Section 1c - related documentation). This dashboard includes the above outcomes indicators specifically to measure the success of the Better Care Fund Plan.

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

The Adult Integrated Care Programme "Better Health, Better Care and Stronger Communities" is focused on the redesign and reshaping of services to transform the way in which residents are encouraged and enabled to maintain and improve their own health and wellbeing, transforming the way in which local health and care services are delivered within the borough, and transforming the way in which people access and are connected to the assets that are available within their own communities and neighbourhoods.

The five schemes planned to accelerate the achievement of our overarching vision and the reduction in emergency admissions, supported with investment from the Better Care Fund are:

- **Prevention and Early Intervention (BCF 1)** – (1) develop a borough wide information and advice gateway, including specialist advice for carers. (2) Mainstream our Community Connections programme that supports development of community resources to support vulnerable adults. (3) It is also planned to develop further preventative services through a programme of targeting unnecessary hospital admissions for Falls, Dementia, UTI's and COPD.
- **Primary Care (BCF 2)** – to provide a strong primary care, focused on population based commissioning to deliver improved outcomes, working in partnership with patients and in collaboration with practices in neighbourhood community teams.
- **Neighbourhood Community Care (BCF 3**)- to support and care for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care and maintain their independence.
- **Enhanced Care and Support (BCF 4)** – to refocus and redesign the current community based resource on supporting people to continue to live at home by preventing people requiring a hospital admission and delivery of enhanced co-ordinated services.
- **Supporting Enablers (BCF 5)** - to ensure that the necessary tools and infra-structure are in place to achieve the cultural changes and working practices required for effective integration.



BCF Scheme 1 - Prevention and Early Intervention

The Better Care Fund will be used to support service changes in the community to:

- provide a rationalised borough wide information and advice gateway, including specialist advice and signposting for carers. This information will support self-care and self- support and be the access point for care accounts.
- establish a single point of access to improve the coordination and provision of information and advice, with a single phone number for social care and health, it will provide more detailed information and advice, as well as triage referrals.
- support community networks by extension of Lewisham's Community Connections project. This connects people to local support and activities, reduces isolation, and improves wellbeing for patients/service users and carers.
- target preventative services and support to those cohorts of adults who are at high risk of hospital admissions from falls, dementia, UTI's and COPD. This will include low level equipment and telecare, minor housing improvements and handyperson schemes to support people to be able to stay in their own homes.

BCF Scheme 2 – Primary Care

The Better Care Fund will be used to support service changes in primary care to:

- increase the level of proactive, preventative care – 'every contact counts'; health checks, promoting immunisation and vaccination, to promote better health
- increase earlier identification, diagnosis and intervention for people over 75, diabetes, CVD, COPD, dementia and cancer, to improve health outcomes
- provide greater support to patient education and self-management of long term

conditions to increase individual choice and control

- ensure that patients have collaborative care plans working with neighbourhood community teams
- identify people who will benefit from continuity of care and ensure that they have a named professional accountable for their care

BCF Scheme 3 – Neighbourhood Community Care

The Better Care Fund will be used to support service changes in neighbourhood community care to:

- embed and enhance the effectiveness of the neighbourhood community teams which are aligned to GP clusters with the integration of mental health workers to co-ordinate both physical and mental health care. These multi-disciplinary teams have already brought together district nurses, all therapies, social workers and care workers. The functions of the neighbourhood teams are to provide
    - Preventative care through the early identification of risks and deterioration,
    - Admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans
    - Support following hospital discharge to remain well and supported in the community
    - Short-term enablement support to enhance independent living skills
- take a shared approach to care management across health and social care including
    - sharing of information, so that individuals tell their story only once
    - single assessment and co-produced health and social care records and
    - single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible

BCF Scheme 4 - Enhanced Care and Support

The Better Care Fund will be used to support service changes in neighbourhood community care to:

- provide additional community based support by responding rapidly to changes in circumstances and providing alternative services to acute hospital care, so maximising the opportunity for people to remain in their own home or within a community setting
- refocus and reshape existing community based care services that contribute to admission avoidance across Lewisham's health and care sector to improve their responsiveness, application and outcomes. This will include redesigning access to and pathways through such services. New approaches will be piloted over the winter period and where successful new contracts for services will be put in place from 15/16.
- review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced
- improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services.
- streamline the process and application for the Disabled Facilities Grant to ensure

that it is used to best effect to maximise the benefits for residents working with housing services

BCF Scheme 5 – Supporting Enablers

The Better Care Fund will be used to support service changes in neighbourhood community care to**:**

- support delivery of the Virtual Patient Record, to provide health and care professionals with more complete information about a person's needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions
- develop the Adult Social Care System so that it aligns with the Virtual Patient Record and fulfils the Care Act requirements
- support the overall management of Lewisham's integration programme to ensure implementation is paced and mainstreamed and evaluations are undertaken and learning shared

3) CASE FOR CHANGE

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

In establishing the case for change in Lewisham, we have considered:

- **public health analysis of priorities emerging from our JSNA**
- **the views of our public and service users**
- **the current utilisation of health and social care services**
- **evidence on the most effective models of care and interventions**

Public Health analysis of trends and challenges

Lewisham's population of 282,000 (Mid-2012 population estimate) is projected to grow across all age groups over the next five years. In this period the largest will be in the 20-64 year old age group. The ethnic profile of those aged 20-64 will be increasingly diverse with a greater proportion of people from Black and Minority Ethnic groups. However, over the next fifteen years the greatest percentage increase will be in the 65+ age group. The ethnic profile of the older population which had been previously predominantly white will also change.

The main health risks for adults living in Lewisham are:

- the increasing numbers of people diagnosed with long term conditions and their management, in particular, Diabetes, COPD, CVD and hypertension. It is estimated that there are approximately 15,000 people in Lewisham with undiagnosed diabetes, CVD and COPD. Furthermore people from Black and Minority populations are diagnosed with some of these diseases such as diabetes

and CVD approximately ten years earlier than the white populations.

- The level of mental health needs for both common and severe mental illness is higher for adults in Lewisham than comparative boroughs.
- Lewisham is only identifying 52.9% of people with dementia; the low diagnosis of diagnosis is a national challenge; the national rate is only 53.3% (August 2014)

The main health risks for older people living in Lewisham are:

- the likelihood to have a long term condition increases with age, with over 50% of those aged 75+ have two or more long term conditions.
- dementia as it increases markedly with age. In 2012/13 it was estimated that possibly under half of all people with dementia are undiagnosed in Lewisham.
- accidental falls - the rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000 in 2012/13

Further information is available from Lewisham's Joint Strategic Needs Assessment

Given this health profile, integrated care "an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring services are well coordinated around their needs"[1] - has been deemed essential to meet the needs of our ageing population, transform the way care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling and independent lives. It has also indicated that we need to do more to enable people to self-care and self-manage.

The public's views of our service

Lewisham Healthwatch recently provided an overview of the key messages from Lewisham residents during 2013-14. Also we have had specific events to engage the public, a local Quality in Health and Social Care: A People's Summit was held in July 2014. These activities reinforce the findings from previous engagement activity and highlighted in particular the need for transparency and access to performance monitoring data, the need for personal, caring and responsive health and care services and the need for adequate time and information to support patient and user understanding of their role in decision making.

[1] Report to the Department of Health and NHS Future Forum from The King's Fund and Nuffield Trust

How to improve health and care outcomes

Recent feedback from local residents:

- **More information** – the public in Lewisham want greater information on:
  - how to access services and activities - specific references to knowing how to access services out of hours and weekends; more information knowing how a services are performing against standards
  - how to do more self-care and manage their own care; there is a strong willingness to self-manage and support for 'every contact counts'; people want more information about their medication and discharge information
  - how to get involved in communities activities.
- **Caring staff** – local users want competent staff who are courteous and compassionate and treat the person as an individual; who listen and keep the user carers(unpaid) and family members informed throughout the planning, care and treatment
- **Better Coordination of services** –Lewisham public strongly supported joined up health and social care (including involving and supporting the voluntary sector), specifically improving the coordination between district nurses, care workers and other agencies

Work on developing a SEL case for change to support the SEL commissioning strategy is in progress.

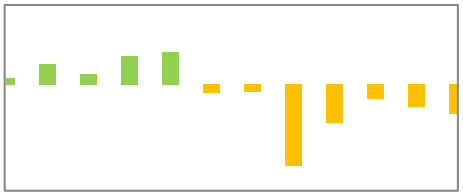
The current utilisation of health and social care services

Health and social services are under increasing strain to meet growing demands for health and social care and to contain escalating costs. There is clear evidence of this pressure locally:

The variability in the quality of care across all services

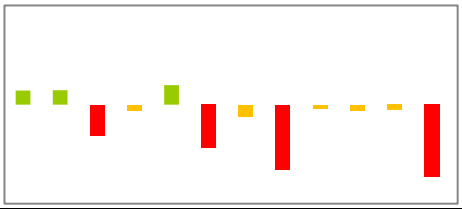
- The high number of A&E attendances and pressure on urgent and emergency care services
- Increasing pressure on adult social care for community care packages when the adult social care is required to make a substantial contribution to the Council budget savings programme - a provisional savings target of £25m over this period (against a net budget of £80m).
- Increased longer waiting times for inpatient care

18 weeks Referral to Treatment Times have not met the NHS standard for seven months for Lewisham people – Graph opposite shows trend between April 2013 and July 2014



- Difficulties in accessing primary care services
- Increased waiting times for cancer care

Waiting times for cancer treatment within 62 days are becoming challenging - Graph opposite shows trend between July 2013 – June 2014



These challenges are likely to present the biggest challenges to affordability and sustainability over the next five years.

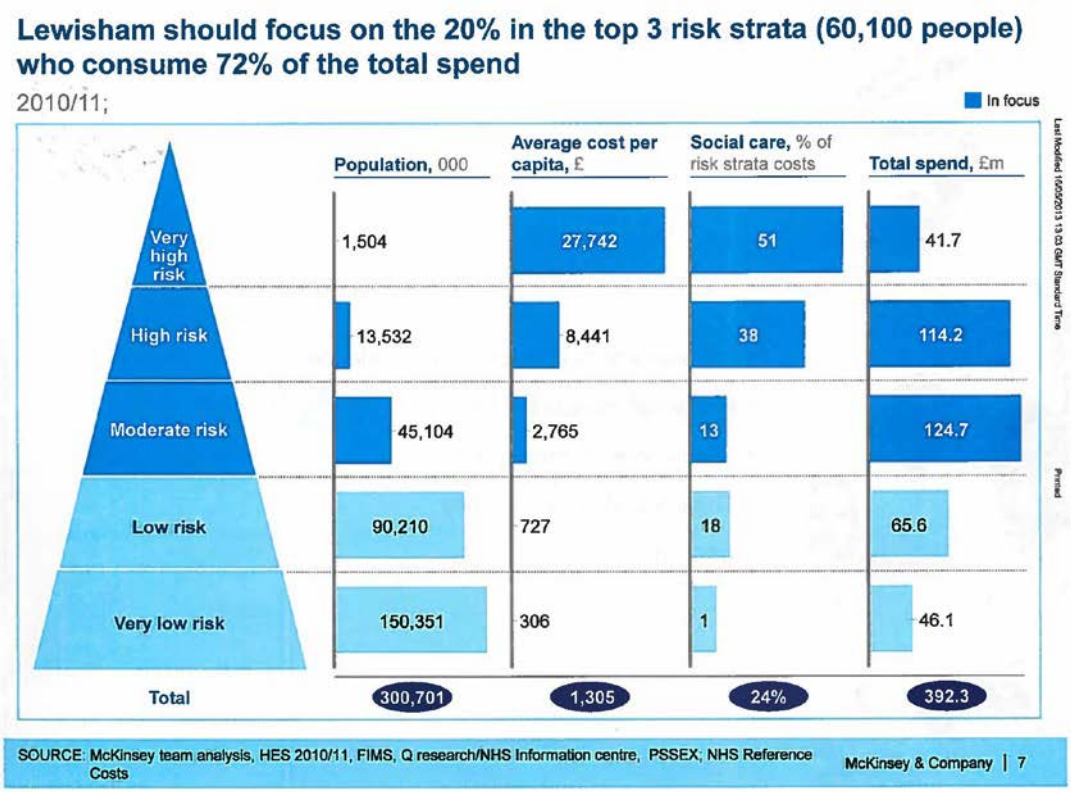
Overview of how the BCF will address Lewisham's key challenges

		Better Care Fund Schemes				
		Prevention and Early Intervention (BCF 1)	Primary Care (BCF2)	Neighbourhood Community Care (BCF 3)	Enhanced Care and Support (BCF 4)	Supporting Enablers (BCF 5)
Local Challenges – Need for Change	Reduction in emergency admissions	√	√√	√√	√√	√
	Improved patient experience for people with long term conditions	√√	√√	√√	√	√
	Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation	√	√	√√	√√	√
	Increased number of people with diagnosed long term conditions – including dementia	√√	√√	√	√	√

√√ Direct Impact
√ Indirect Impact

Our Better Care Fund Plan has also been informed by the conclusions of examination of use of resources using the high level risk stratification of the Lewisham registered population. It should be noted that this analysis used 2010/11 activity data and the former PCT costings, so include NHS England's commissioning costs for primary care and specialised services. With these caveats, the key conclusions are that

- Lewisham's population, who are categorised as very high risk and high risk categories with the highest demand, equate to about 5% of the population and accounts for 40% of the total health and care costs
- Lewisham's population, who are categorised as very high risk, high risk and moderate risk categories with high demands, equate to about 20% of the population and accounts for 70% of the total health and care costs



The above findings of our local risk stratification work very much mirrors the conclusions of the North West London Integrated Care pilot work (2012).[2]

A recent bed utilisation audit undertaken at the Lewisham Hospital has further supported our understanding of emergency admissions highlighting those patients that could have been managed through alternative arrangements rather than occupy an acute bed at the time of the survey.

Our intention is to transform the local health economy to support people to manage their own conditions at home, to keep well and remain out of hospital. Our intention is to re-balance the heath and care resource so that the highest demands and costs associated with small numbers of the population are reduced, to enable us to invest more resources in preventative advice, support and care for the whole community.

More detailed work is underway by GP Practices compiling a risk register of the top 2% of patients on their lists who are most vulnerable to a hospital admission. This register is also being compared to the top 2% indicated by the risk scores assigned by QAdmissions, which is a legally compliant risk stratification tool. Early findings indicate that there are some very high risk scores for patients who are not necessarily on the GPs' horizon as potentially high risk emergency care users. Also work is underway with community health services and adult social care to identify those at-risk patients on the practice-based 2% register against those known to other care providers.

Evidence on the most effective models of care and interventions

To inform both the development of our local strategies and plans and to contribute to the

[2] http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation

SEL strategy, a range of evidence and analysis has been collected and examined. This has included a review of available evidence on how to improve the care of people with long-term conditions[3] and Ambulatory Care Sensitive Conditions (ACSCs)[4]; the key messages and evidence review that was completed on *Frail older people in Lewisham* in August 2013[5]; and the evidence in two recent publications (2014)[6] [7] on what is required to improve the care of older people. In addition we have reviewed the evidence from *Evaluating Integrated and community based care*: *How do we know what works* published by the Nuffield Trust[8] 2013, the summary of findings from the Local Government Association Evidence Review 2013[9] and information and evidence from two tools available to support the work on Integrated Care.[10][11]

Our plan also reflects the case that has been made for the integration with adult social care. Lewisham's AICP takes account of the findings presented in the report on adult social care efficiency presented by the LGA which concludes that:

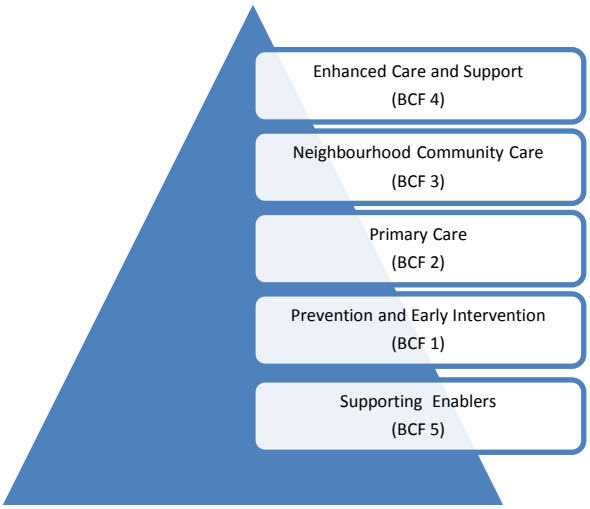
- Many people although not well enough to manage their own care when ill are likely, with the right help and treatment, to make a partial or full recovery.
- Giving a person care when they do not require it is costly and can accelerate their need for more care. When a person stops doing things to look after themselves, they are likely to deteriorate more rapidly.
- Enabling a person to get help when they need it but stopping that help when they have recovered is the most effective way of helping the person get the best outcomes.
- Old age, in particular, has 'ups and downs' in relation to ill health. It is important to gear services flexibly around both the better times and those times when a person may not be able to cope.[12]

[3] Long Term Conditions Compendium of Information Third Edition (2012) DH
[4] Emergency hospital Admission for ACSCs: identifying the potential for reduction (2012) The King's Fund
[5] Frail Older People In Lewisham. (2013) Ellen Pringle
[6] Better care for Older People-Working differently to improve care. (2014) Deloitte Centre for Health Solutions
[7] Making our health and social care systems fit for an aging population. (2014) The King's Fund
[8] Evaluating Integrated and community based care : How do we know what works? (2013) Nuffield Trust
[9] Integrating Care Evidence review (2013) Local Government Association
[10] Whole System Integrated Care and Support Toolkit: Local Government Association
[11] NHS England – Any town
[12] Adult Social Care Efficiency Programme – Interim Findings, Local Government Association, 2013

4) PLAN OF ACTION

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

Overview on how schemes fit together



The summary of the BCF programme below illustrates the high level key milestones by scheme for the delivery of the BCF. The project plan for each scheme can be found in annex 1.

Prevention and Early Intervention (BCF 1)	
Milestones	**Delivery Date**
Develop borough wide information and advice gateway, including specialist advice for carers: • Implement new web site including knowledge/information warehouse	Q4 2014/15
• Campaign to promote website and delivering training for front line professionals	Q4 2014/15
• The resources for the Carers Gateway and carers advice are part of the integration programme and are aligned to the BCF funding. These funds have already been pooled between health and social care and form part of the joint commissioning mainstream programme	Q4 2014/15
• Extend Community Connections preventative work within neighbourhoods	Q4 2014/15
Develop preventative programmes targeting unnecessary admissions for falls, UTI's and COPD: • Implement new falls pathway including referral guidelines	Q2 2015/16
• Implementing new falls assessment process and prescription tools.	Q2 2015/16

Primary Care (BCF 2)	
Milestones	**Delivery Date**
Launch of Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) to support collaborative practice working – specific focus on management of long term condition patients and self-management	Q2 2014/15
Interim review of LNPCIS outcomes to inform 15/16 approach	Q3 2014/15
4 primary care neighbourhood based networks formally established	Q4 2014//15
Extension of LNPCIS for further 12 months with continued focus on the management of long term condition patients and self-management	Q1 2015/16
Neighbourhood based networks across health and social care (incorporating	Q4 2015/16

primary care) integrated through the Adult Integrated Care Programme	

Neighbourhood Community Care (BCF 3)	
Milestones	**Delivery Date**
Extend access to primary care and community services and increased capacity for admissions avoidance	Q2 2014/15
Review model of carers assessments and support, including respite, in preparation for the implementation of the Care Act	Q3 2014/15
Improve discharge planning	Q3 2014/15
Continuation of Neighbourhood Facilitators and development of generic workers	Q4 2014/15
Integrate community mental health into neighbourhood model	Q1 2015/16
Further develop joint packages and joint care planning	Q1 2015/16

Enhanced Care and support (BCF 4)	
Milestones	**Delivery Date**
Develop a range of intermediate care tier services as alternative admission avoidance services	
• New approaches piloted and evaluated	Q4 2014/15
• Business case developed including a detailed analysis of bed needs and the additional support required at home and the benefits realised for additional investment	Q4 2014/15
• New contracts in place	Q2 2015/16
Redesign reablement and widen range of providers	
• Review completed	Q3 2014/15
• Redesign of enablement completed	Q4 2014/15
• Recommissioning of outcome based domiciliary care and non-nursing health related tasks completed	Q2 2015/16
• Develop community based provision for dementia patients to prevent unnecessary admissions	Q1 2015/16

Supporting Enablers (BCF 5)	
Milestones	**Delivery Date**
Social Care database development to include NHS number as main identifier. Renewal of Support and Maintenance Contract for social care database	Q4 2014/15
VPR Phase 1 complete. GP practices and Lewisham and Greenwich Healthcare Trust sharing wide range of care records. This will support better community care, improve admission avoidance and discharge planning	Q4 2014/15
VPR Phase 2 completed. Lewisham Social Care services sharing data with health partners. This will improve community care, GP and Social Care neighbourhood team working	Q2 2015/16
Self Assessment development on new referral tool embedded into Social Care IT System, with plan for development into development of the Care Account.	Q2 2015/16
AIC Programme completed	April 2018

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

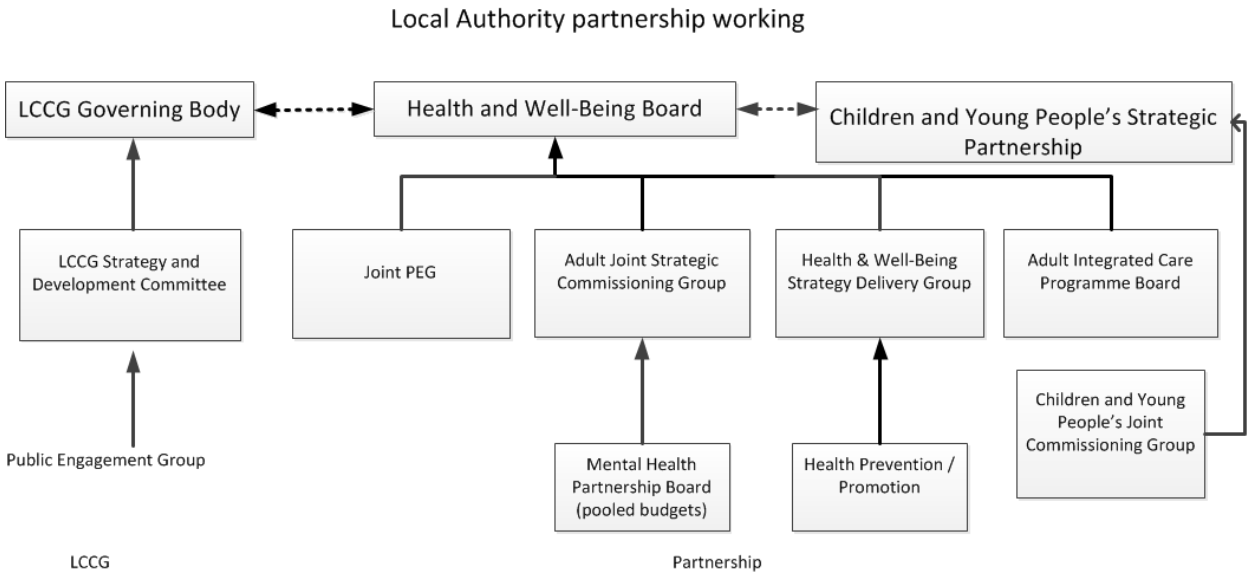
The following Boards ensure effective governance of Lewisham's Adult Integrated Care programme:

- Lewisham's Health and Well Being Board
- Adult Integrated Care Programme Board (AICPB)
- Individual Project Boards for each workstream/scheme

The Health and Wellbeing Board monitors the progress of the programme. To ensure that the progress of each individual workstream/scheme is more regularly assessed, the Health and Wellbeing Board is supported by the Adult Integrated Care Programme Board (AICPB).

The AICPB is accountable to the Health and Wellbeing Board for the delivery and evaluation of the Adult Integrated Care Programme. It has specific responsibility for overseeing the implementation, monitoring and evaluation of the programme and the activity within the Better Care Fund plan. It has representatives from the CCG, the Council and the NHS Trusts.

The AICPB sits alongside and works closely with Lewisham's Health and Wellbeing Delivery Group which ensures progress against the Health and Wellbeing Strategy Delivery Group, the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group.



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

Adult Integrated Care Programme Board (AICPB)

The Adult Integrated Care Programme Board (AICPB) has responsibility of overseeing the development and monitoring of the delivery of BCF plan and provides regular updates to the Health and Wellbeing Board. This is chaired jointly by the Chief Officer of Lewisham CCG and the Executive Director of Community Services, London Borough of

Lewisham (LBL). Board membership also includes the key stakeholders involved in taking forward the integration agenda including the Head of Housing of LBL and representatives from Lewisham and Greenwich NHS Trust and South London and Maudsley Foundation Trust.

The Adult Integrated Care Programme Board meets monthly and reviews the programme's action log, the risk register and the workstream activity to ensure appropriate progress is being made. Where delays or problems emerge, these are brought to the attention of the Board who decide on the most appropriate remedial action.

All decisions are recorded and circulated to key stakeholders, with regular progress reports to the Health and Wellbeing Board, including receiving the Health and Wellbeing Board's Performance Dashboard (see Section 1c - related documentation). This dashboard includes the indicators within the Better Care Fund Plan.

d) **List of planned BCF schemes**

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

Ref no.	Scheme
BCF 1	Prevention and Early Intervention
BCF 2	Primary Care
BCF 3	Neighbourhood Community Care
BCF 4	Enhanced Care and Support
BCF 5	Supporting Enablers

5) RISKS AND CONTINGENCY

a) Risk log

It is recognised that the successful transformation of adult health and care involves high risks, however the potential benefits achievable are estimated to be significant for Lewisham's population. Thus the effective management of risk is viewed by all partners as of paramount importance.

The Better Care Fund Programme Risk Register was developed initially during the planning phase with stakeholders in February 2014. Since then the Risk Register has been refined to ensure that it captures all the risks that threaten the successful delivery of the Adult Integrated care Programme and that appropriate risk responses (mitigating action) have been identified to manage the identified risks.

It is a 'live' register and updated as necessary, but at a minimum it is reviewed by the AICPB on a monthly basis.

AICP Risk Register

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
R1: Transformation: The service transformation required to achieve integration is not clearly defined.	Activity undertaken does not contribute effectively to achieving integration and changes happen in an uncoordinated and piecemeal fashion.	15 (5x3) RED	Monitoring of activity against overall programme plan. Scrutiny of monthly programme highlight report.	Specific workstream focused on managing the programme – worksteam 10. Workshop held for the Board to produce a detailed vision for the neighbourhood model. Outline programme plan produced.	Produce a detailed programme plan with key deliverables and timescales, showing the 'critical path' and interdependencies. Monitoring of workstream project plans to check alignment with programme plan. Workshop to be held for the Board to produce a detailed vision for intermediate care/ extra care / enablement. Communication and engagement plan to include sufficient and appropriate activities to ensure that workstream participants and service staff understand the programme and the new delivery models.
R2: Savings: (a) The Council and the LCCG do not make required savings (i) in terms of the required amount; and (ii) by the required time. Making savings in one area transfers pressures to other parts of the system. (b) The reinvestment required to pilot and	(a) If required savings are not achieved, and do not contribute to the required savings, the programme could be destabilised and be deemed ineffective. The Individual services covered by the programme may need to make savings in an unplanned and inefficient way. Making savings in one	20 (5x4) 15 (5x3) RED	Monitoring of overall programme plan against assumed and identified efficiencies. Scrutiny of monthly programme highlight report.	Robust ongoing scrutiny through existing governance arrangements - the AICPB, reporting to the Health and Wellbeing Board (and the Lewisham Future Board for Council savings). Established tight programme and project management arrangements.	Produce an overall programme plan with key deliverables and timescales, showing the 'critical path' and interdependencies. Undertake detailed financial mapping to align activity and spend and to assess the impact of proposed changes and new delivery models. Business Cases will be produced and approved for key schemes, identifying planned costs and benefits. Proposals within the Business Cases will be piloted to validate further the Business Case assumptions.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
implement new delivery models is not secured.	area might affect the achievement of savings in other areas if pressures are transferred to areas that are under resourced and trying the save money. (b) Lack of reinvestment may mean that the planned pace and scale of the programme is not realised and new models of delivery cannot be tested and evaluated.				Full evaluation of implications of the Care Act on programme resources.
R3: Reshaping / Redesigning services: The shift from acute to community services does not happen or happens, but in a way that does not allow for disinvestment from acute and mental health hospital based services.	Hospital based activity and capacity is not reduced and expected reductions in service requirements and spend across the wider system are not realised.	15 (5x3) RED	Schemes will be monitored against the benefit realisation plan to identify variances against plan.	Identified potential models and schemes which will be further evaluated and piloted.	Allocate resources based on where there is evidence that shift from acute to community services will be achieved and there will be a significant positive impact on improving outcomes and quality, based on approved Business Cases. Contractual levers will be used to incentivise reducing hospital demand and capacity. If target reductions in hospital activity are not met, contingency plans will be developed setting how the excess acute demand will be funded including risk share arrangements.
R4: Governance: Effective governance and leadership across all	Focus is on short term transactional benefits rather than long term transformation of the	10 (5x2) AMBER	Monitoring of overall programme plan against	Established a Board which fosters strong collaborative working to ensure commitment from all organisations and involves primary, community and secondary health and mental	Workshop for the Board to produce detailed vision for the neighbourhood model and for intermediate care/ extra care / enablement.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	**What will we do?**
organisations is not in place to give the programme sufficient momentum and to generate sustained and high levels of commitment.	whole system over five years and beyond. Improvements are not strategic, do not achieve longer term benefits and do not achieve the required system redesign.		key milestones, agreed outcomes and financial plans.	health providers; social care; and housing. Workshop held for the Board to produce a detailed vision for the neighbourhood model.	The Board will regularly scrutinise plans to ensure the focus remains on both quick wins and longer term strategic change.
R5: IT: An effective system for sharing information, data and resources is not developed.	Information, data and resources is not shared effectively and services are not significantly improved.	12 (4x3) AMBER	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams 2,3,4,5 & 6	Specific workstream on IT systems and process – Workstream 6. Commitment to Virtual Patient Record secured across organisations in Lewisham. The Virtual Patient Record system has been procured and will be delivered by Orion Healthcare. Information Governance working group established and meeting regularly. Current information sharing arrangements, including the secure transfer of information via *egress*, between practitioners are continuing.	Agree and sign information sharing protocols for the transfer of information via the Virtual Patient Record. Roll out the Virtual Patient Record to practitioners (and ultimately, the public).
R6: Risks/ monitoring / evaluation: Risks are not properly identified, evaluation is not able to clearly attribute outcomes to the programme, peer learning is not sufficiently exploited.	Poor identification of risks will damage programme integrity and may negatively affect organisational reputation. Difficulty in being able to directly attribute positive outcomes to	9 (3x3) AMBER	Monitoring of overall Programme plans against key milestones, agreed outcomes and financial plans.	Clear process for identifying and managing risks has been developed. Board considers 'RED' programme risks quarterly. The overarching outcomes framework, supporting the BCF, is monitored on a quarterly basis by the Board.	New models will be developed on best available evidence. Key areas will be piloted to allow for the further gathering of evidence to inform investment decisions.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	**What will we do?**
	the programme (due to the interrelated nature of the programme which interfaces with wider health and social care changes such as those arising from Dilnott) may mean that the success of the programme is not visible to the Public and key stakeholders. It will not be possible to target resources appropriately due to the lack of evidence suggesting where investment should be made and services redesigned.			'Deep dives' on specific workstreams by the Board, to understand the learning and to share good practice, to complement the tight programme and project management arrangements covering individual workstreams. Regular Leads and Coordinators meetings bring together best practice and collaborative working across PH, LCCG and LBL to enhance competencies, skills and capacity.	
R7: Cultural change: The workforce does not move to a new way of working with shared values and behaviours.	The integration of services is not achieved.	15 (5x3) RED	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams	Specific workstream focused on inspiring the workforce to develop a new common culture that will support new delivery models – worksteam 5. Successful bid to HESL to support cultural change (cognitive connections commissioned). Second bid to HESL to implement cognitive connections work also successful.	Using a 'bottom up' approach in involving staff to determine and design the changes required, as supported by the evidence on cultural change. Engagement plan to be developed with specific staff engagement events.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	**What will we do?**
			2,3,4,5 & 6.		
R8: Capacity: There is (a) insufficient capacity to manage and deliver the programme and (b) the workforce does not have the capacity to support the new model.	(a) The Programme does not achieve its outcomes within the agreed timeframe. (b) The workforce is not able to make effective contributions to improving the delivery and the integration of services.	15 (5x3) RED	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams 2,3,4,5 & 6.	Specific workstream focused on managing the programme – worksteam 10. Four project managers being appointed (two at the CCG and 2 at the Council) to support the programme.	Planned phased approach to changing the workforce starting with the current neighbourhood teams.
R9: Capability: The current workforce does not have (and does not develop) the knowledge and skills required to support the new model.	The workforce is not able to make effective contributions to improving the delivery and the integration of services.	15 (5x3) RED	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams 2,3,4,5 & 6.	Specific workstream focused on inspiring the workforce to develop – worksteam 5. Successful bid to HESL to support this work.	Planned phased approach to changing the workforce starting with the current neighbourhood teams. Using a 'bottom up' approach in involving staff to determine and design the changes required, as supported by the evidence on cultural change.
R10: Non-Statutory support: The programme does not utilise effectively	Statutory and public services remain the key providers of information, advice	15 (5x3) RED	Monitoring of overall Programme plan -	Investment in Community Connections made to support vulnerable adults and older people at a community level to prevent/reduce reliance on statutory services.	Development of a new model for information and advice to support self-care. Engagement plan to be developed with

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	**What will we do?**
existing VCS assets, knowledge and capacity.	and support in relation to adult social care and vulnerable adults remain reliant on health and social care services.		specifically the quality measure of people having confidence to manage their own (LTC) condition.	Community Connections work aligned to workstream 7 (building stronger communities) and a strategic steer for project provided. Workshop to explore the redesign of community transport services grant funded by the Council has taken place.	specific VCS engagement events.
R11: Commissioning: It is (a) not aligned to the programme or (b) aligned but creates perverse incentives which increase costs.	(a) Contracts are agreed which do not support the programme. (b)The contracting mechanisms within the commissioning system incentivise increased intervention by organisations.	15 (5x3) RED	Monitoring of overall Programme plan - specifically the activity measure of avoidable emergency admissions.	Specific workstream on commissioning– Workstream 8.	Joint review of contract types, levers and risk sharing to inform 2015/16 contracts. Joint commissioning intentions for adults services in Lewisham including considerations of moving away from Payment by Results to outcomes based and /or value added commissioning approaches to incentivise providers to implement new ways to organise services around the user and carer.
R:12 Mental Health: Mental health services are not sufficiently integrated into the programme.	Lack of integration between community based mental health services and other health and care services means that holistic services centred on the user are not created.	12 (4x3) AMBER	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans.	Involvement of SLaM on the Programme Board and in the early planning of workstreams.	Workforce development to improve generic understanding of physical and mental health needs and importance of integrate physical and mental health services. WS10 attendance at Mental Health Executive Board in October 2014.
R13: Communications: The effective involvement and buy-in of key stakeholders in	The integration of services is not achieved.	12 (4x3) AMBER	Monitoring of workstream plans against key milestones, agreed	Communications Plan has been developed covering initial activity including the programme launch, development of programme identity and key messages, stakeholder mapping and analysis, awareness-raising, and progress reporting.	Engagement plan to be developed with specific staff engagement events.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
delivering the programme's objectives is not secured.			outcomes and financial plans.	Communications Working Group established.	

b) Contingency plan and risk sharing

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

In Lewisham we have a mature multi agency approach to our strategies and plans. Our BCF plans are in line with the CCG's 2 year operational plans and 5 year strategic plans and the joint Lewisham Adult Integration Programme; all of which have been considered by the CCG Governing Body and the Health and Well-being Board. Consequently the BCF plans are reflected in Lewisham and Greenwich NHS Trust's 5 year plans for acute and community services. Lewisham And Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust are members of the Lewisham Adult Integrated Care Programme Board. NHS England, NHS Trust Development Authority and Monitor are currently triangulating commissioner and provider activity and financial plans; including risk identification, management and mitigation.

Our BCF plans indicate a shift of activity from hospital settings to community and home settings and an avoidance of unnecessary hospital admissions. This generates risk to all agencies and we will continue to develop plans and joint understanding of the impact of plans throughout 2014/15 and 2015/16 and align plans to the 2015/16 and 2016/17 contract rounds. Our BCF identifies a reduction in non elective admissions of 649 FCEs in 2015/16 (1.8%). This generates a reduction in CCG expenditure of £930k per annum and a corresponding reduction in NHS provider income. Our planned reduction in admissions is lower than the expectation in the national BCF guidance. In Lewisham there is an underlying 2% increase in the demand for admissions (broadly in line with population increases). We have had some success in holding this fairly flat through our local plans (e.g. QIPP) and effectively containing the population growth pressures. We know however that there are opportunities to improve further upon that from bed utilisation audits and comparisons of Lewisham performance in relation to conditions not normally resulting in admission or admissions for ambulatory care sensitive conditions. We are committed to managing the impact of our plans from a whole systems perspective.

The Council and CCG have well developed and formal joint commissioning structures underpinned by section 75 and section 256 agreements and exisiting risk arrangements. We will build on that history to ensure our governance arrangements for the BCF are robust and fit for purpose in design and in operation.

6) ALIGNMENT

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

The activity of the Health and Wellbeing Board is focussed on delivering the strategic vision for Lewisham as established in '*Shaping our future – Lewisham's Sustainable Community Strategy'.* Specifically the work of the Health and Wellbeing Board directly contributes to Shaping our future's priority outcome that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining*

and improving their health and wellbeing and the delivery of the Health and Wellbeing strategy

Thus the Board scope of responsibilities is wide including adults and children's services and is responsible for encouraging and supporting the advancement of the integration agenda, as set out in the Health and Social Care Act 2012, alignment of plans and strategies, identifying inter-dependency and cross fertilisation of ideas. Its broad membership ensures that the key stakeholders for taking forward the integration are proactively involved, including the main acute, mental health and voluntary sector providers, NHS England and Lewisham Healthwatch.

Key inter-dependencies for BCF are the local housing strategy and personal budgets implementation:

Housing

The Lewisham older people's housing strategy has been developed with a focus on creating choice and meeting need by developing a continuum of housing provision. The development of three Extra Care housing schemes across the borough will provide further opportunity to support people to remain living in the community.

The schemes provide for a range of needs from low level support to more complex intervention. They will accommodate and provide support in areas where we are seeing a growth in the need for services, such as to support people who have dementia or where some monitoring or support during the night is required thus reducing the need for residential care.

Personal budgets.

Adult social care has developed an approach to self directed support that promotes the use of Direct payments. The administration and monitoring is currently provided by a dedicated team. Meeting needs in this way has provoked positive change in the provider market to ensure that services available are more person centred and can accommodate more choice. The borough has been a pilot site for Personal health budgets where the approach to person centred care is evolving.

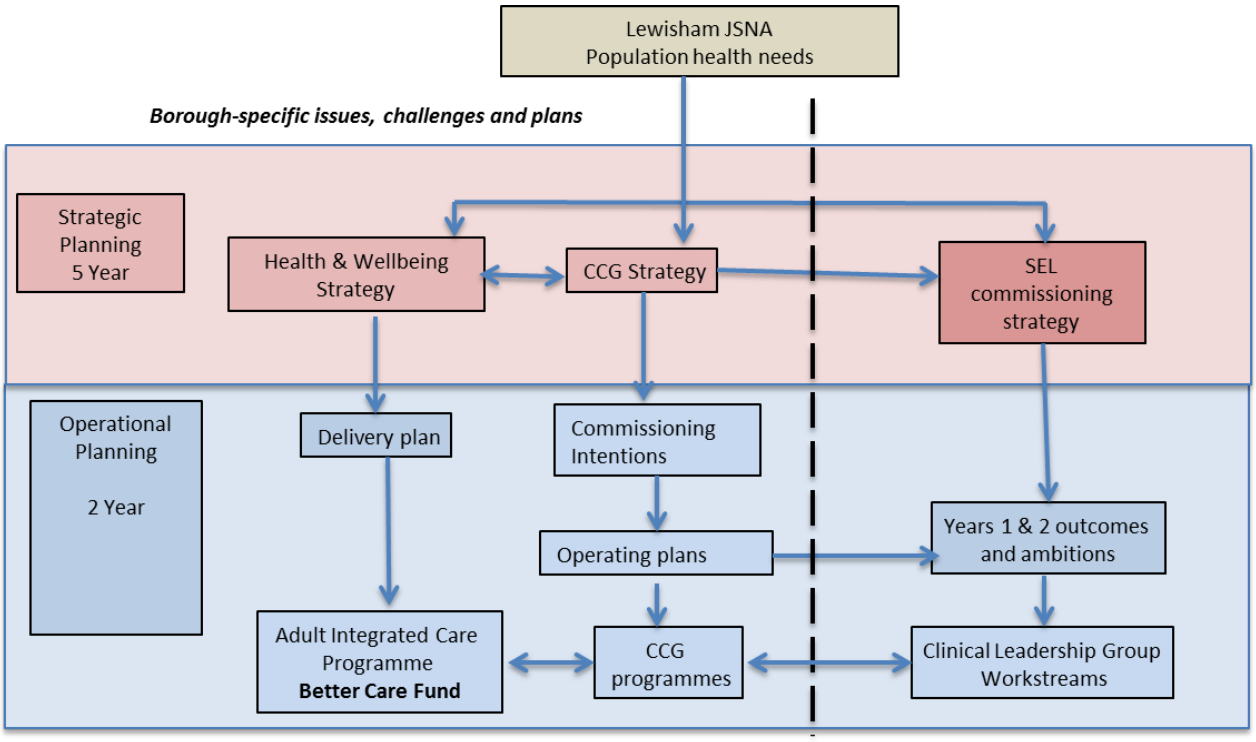
To help the Health and Wellbeing Board to deliver its key objectives, four supporting groups have been established: the Health and Wellbeing Strategy Delivery group, the Adult Integrated Care Programme Board (overseeing the BCF), the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group – see section 4 (c) for further details of the HWB's governance arrangement

The Adult Joint Strategic Commissioning Group is responsible for a number of important linked functions which underpin the BCF Plans for Action, including:

- the co-ordination of the joint commissioning intentions and plans across the Local Authority and Clinical Commissioning Group(CCG) on behalf of the Health and Wellbeing Board, ensuring that they align with other plans including South East London NHS Strategic Plan
- the management of the partnership agreements e.g. those under Section 75 of the NHS Act 2006. This includes identifying resources to meet joint strategic objectives and priorities agreed as part of these arrangements.

- the promotion of the effective use of resources. This will include formally agreeing respective contributions to pooled or aligned budgets, receiving financial reports on current performance of pooled budgets, providing oversight of the contracts register and agreeing the timetable for procurement; roll out of personal budgets
- the joint commissioning and procurement of quality services that achieve best value, in line the Adult Social Care Outcomes Framework, the Public Health Outcomes Framework and the NHS Quality, Innovation, Productivity and Prevention Framework (QIPP) and outcomes

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



Lewisham's Health and Wellbeing Strategy 'Achieving a healthier and happier future for all' (2013) outlines the key health and wellbeing challenges Lewisham Borough faces as well as the assets, skills and services that are available locally to support people to stay healthy and be happier. It identifies two strategic themes for action over the next 10 years, which provides the foundation of our integration programme. These key strategic themes are:

- **Health prevention** - achieving a healthy weight; improving immunisation uptake; improving sexual health; preventing the uptake of smoking among children and young people and reducing the numbers of people smoking; reducing alcohol harm; improving mental health and wellbeing; increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
- **Long term conditions** - delaying and reducing the need for long term care and support; reducing the number of emergency admissions for people with long-term conditions.

The CCG's 5 year Strategic Plan (2013) was informed by Lewisham's Joint Strategic Needs Assessment (JSNA) and the Lewisham's Health and Wellbeing Strategy. The CCG's Strategic Plan identifies three strategic themes:

- Healthy Living for All –help people to live healthy lifestyles, make healthy choices and reduce health inequalities
- Frail and Vulnerable People - support and care for with dignity and respect
- Long Term Conditions – empower users with greater choice to manage their condition

The CCG's Commissioning Intentions and the CCG's Operating Plan set out the commissioning priority areas for 2014/15 -2015/16. The priority areas are cancer, maternity and end of life care and people with long term conditions including people with mental health problems. As a result of an ongoing dialogue with the public, the CCG's members and local stakeholders during 2013/14, it was concluded that the current way of providing and procuring services, with the expected increase in level and complexity of demand, would not provide the best quality of care for our priority areas and would not be affordable. So the challenge was we had to 'do things differently together' in primary and community care setting to achieve system wide change. These conclusions have been reiterated in the more recent South East London commissioning strategy.

The work of the Adult Integrated Care Programme and the Better Care Fund Plans for Action has taken forward the CCG's priorities for **all adult care** by focusing our collective effort on 'doing things differently' to transform way advice, support and care is provided in five different schemes:

- Prevention and Early Intervention - BCF Scheme 1
- Primary Care – BCF Scheme 2
- Neighbourhood Community Care – BCF Scheme 3
- Enhanced Care and support – BCF Scheme 4
- Enhanced Enablers – BCF Scheme 5

The CCG's Operating priorities which are not included within the Better Care Fund schemes are:

- integrated children's and adolescent services, for example CAMHs, which is being taken forward in partnership with the Lewisham Council's Children's and Young People's directorate
- the wider Primary Care strategy including addressing variation in care and accessibility of services in hours and out of hours. The work on primary care co-commissioning is being taken forward in collaboration with the other five CCG's in South East London as part of the South East London Strategy
- the management and redesign of urgent care services, including the operational resilience work co-ordinated by the Bexley, Greenwich and Lewisham Urgent Care working Group
- the development of maternity services, although the establishment of new community midwifery model has a link with the development of neighbourhood

community care

All the above priorities are included within the CCG's refreshed Strategic Plan and the draft joint Commissioning Intentions which are currently being developed.

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

The CCG Primary Care Development Strategy provides the local framework to the delivery of proactive care, accessible care, coordinated care and continuity of care and is the basis of the BCF Scheme 2. Key enablers to support the delivery of this strategy are:

- A population based commissioning approach, based on the four neighbourhoods in Lewisham which are also being used as the basis for the integrated neighbourhood model (BCF scheme 3)
- Collaborative practice working to deliver population based services
- Reduction in variation across practices
- Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) to directly support practices to deliver in key clinical focus areas – this will follow on from the scheme launched in August 2014.

Primary care co-commissioning presents an opportunity to work in closer partnership with the NHS England the key commissioner for primary care. The potential to work more closely with NHS England is being explored by Lewisham CCG with the five CCGs in South East London to support the local work to improve quality of primary care, address health inequalities, and help to establish a sustainable health and care service. So primary care co-commissioning has the potential to support BCF scheme 2

The CCG already has a close working relationship with NHS England and is working with this commissioner in determining where additional services, established and funded through improvement initiatives can reasonably be included when the primary medical services contracts are reviewed. This will allow for simplifying contractual agreements with individual practices.

Lewisham CCG also is working with NHS England to determine the growing opportunities in delivering services through Community Pharmacy. This will be through contractual arrangements and encouraging closer partnership working with general practice in facilitating the development of comprehensive primary care based services.

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

Adult social care services continue to have a focus on the provision of preventative services and a range of personalised services that connect people to their communities and support them to live as independently as possible.

Lewisham is redefining its approach to manage the demand for Social care services by further developing information and advice, delivering preventative services and developing a new contract with service users and carers that recognises the importance and promotes self-management.

The focus on preventative services has been developed in partnership with health. These services provide a range of care and support that have reduced the need for acute care intervention. It is our intention to build on this capacity in order to divert people away from formal care packages when appropriate thereby reducing the pressure on demand for both health and social care resources.

The integrated service delivery model will ensure that both health and social care share key objectives for the future, such as reducing duplication and improving the experience for customers whilst protecting and valuing the functions of adult social care.

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

The Adult Integrated Care Programme and the activity and funding aligned to the BCF schemes will help to support adult social care - through joint working and the amalgamation of roles and services - to streamline and improve service provision, reduce the need for high cost services, release efficiencies and improve user experience and outcomes.

To achieve efficiencies and to ensure that support and care is provided in a consistent and equitable way for all client groups, we will:

- Encourage people to take more responsibility for their own care and to use their existing resources, whether financial, social or otherwise, where appropriate, to achieve their stated outcomes. We will help people to help themselves by promoting and simplifying access to universal services and by linking them to support available to them within their own families and communities
- Develop the use of prevention and short term early intervention services which enable people to maintain and regain independence reducing people's need for and reliance on long term care and support
- Establish different delivery models through outcome based commissioning and market development - enabling people to have more control and choice through personal budgets and direct payments
- Implement an assessment model that takes account of personal assets and the contributions an individual can make to ensure their needs are met in ways which they prefer and choose for themselves
- Ensure all assessment and support planning staff and providers work with service users in ways that reduces dependency and promotes independence, ensures safety, and supports recovery

- Ensure the right level of support is offered in the most cost effective way according to a person's assessed eligible needs

Our plans seek to rebalance the overall health and social care spend, by shifting resources to proactive, preventative care provided in the community, so reducing the demand for acute and mental health bed.

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

The amount allocated from the BCF to protecting adult social care is £6.8m in 2014/15 and £10.3m in 2015/16. Additionally the BCF identifies £800k towards the council's Care Act implementation responsibilities

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

A Task and Finish Group has been established to implement the Care Act within the Adult Integrated Care Programme. The Group has oversight of activity undertaken by AICP workstreams to deliver the requirements of the Care Act to manage the complex set of interdependencies and prevent duplication. The Group is working with the leaders of the integrated social work functions to ensure compliance within the South London and Maudsley-led integrated mental health services. Areas that sit outside of existing structures are being co-ordinated directly by the Task and Finish Group and Care Act Project Manager.

Some of the key areas of activity to implement the Act are set out below:

Workforce Development:

- A training plan, based on national learning resources being developed by Skills for Care, will be implemented to ensure social work practice is compliant and supports the new approach to support planning.
- A learning and development plan for commissioners will ensure they have the skills and knowledge in place for the delivery of the Act.
- A communications plan will be delivered with key partners and stakeholders to provide information for staff aligned to adult social care, for example in Housing, NHS services and the voluntary sector.

In addition to the BCF funding, this activity will be resourced in part from the existing 2014/15 allocation towards Care Act implementation and through reprofiling existing budgets.

Carers Services:

Lewisham is developing its commissioning response to meet the new duties in preparation for the final statutory guidance. Using the recent DH model based on the Lincolnshire tool, Lewisham's additional recurring carers' costs were forecast at £844k per annum. These costs can only be met in part from reprofiling existing resources for carers which are set out elsewhere in the BCF. Activity will include:

- A new process for assessments will be developed to enable the Council to deliver the increased volume of carers' assessments anticipated.
- A new market of services will be developed for carers to meet needs under the national eligibility criteria and purchased using personal budgets.
- Respite care services will be provided to the cared-for person, and as such will sit on the client's personal budget not the carers. Local consultation will be undertaken regarding this change.

Assessment, Support Planning & Personalisation

We anticipate a significant increase in demand for assessment and support planning services from self-funders and are in discussion with DH around the modelling of costs. The tool initially forecast costs of £695k and it was anticipated that this would be revised downwards. However, as the DH model does not include one-off or recurring costs incurred during the BCF period relating to IT and informatics, system redesign, meeting needs not previously eligible or general increases in activity as people test their needs against the new eligibility criteria, we believe this remains a reasonable guide to annual cost pressures. Activity will include :

- IT systems are being reviewed to ensure they deliver compliant practice for 2015/16 and for 2016/17 when the Council will roll out Care Accounts.
- Support Planners, a new role in the system, will be in place following the restructure of Assessment and Care Management to deliver holistic 'asset based' approach to care and support planning.
- Resource Allocation Systems to generate indicative personal budgets for social care will be updated and in place for all client groups including carers.

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

Lewisham Council and Lewisham CCG each commission a range of services from voluntary and community sector partners designed to support carers; assessments, breaks, support. These services are currently aligned to the BCF as supplementary commitments without specifically forming part of the BCF in 2015/16.

Additionally the BCF includes voluntary services commissioned from grant funding of £250k (e.g. Community Connexions) as well as specific council commitments arising from the implementation of the Care Act 2014.

Further work will be undertaken in 2015 to review the full range of carers support services and integrate into the wider BCF plans.

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

Lewisham Council is required to make savings of £95m from its revenue budgets between 2014/15 and 2017/18. As the largest service area, adult social care is required to make a substantial contribution to this and has a provisional savings target of £25m over this period (against a base net budget of £80m). Although integrated working has already delivered efficiency savings and reshaped services, adult social care needs to meet the challenge of unprecedented financial pressures and, as mentioned previously,

needs to respond to increases in the level and complexity of demand and meet the new obligations introduced by the Care Act. These additional costs are set out Section 7 (iv).

As the majority (87%) of the Adult Social Care Net Budget is spend on the provision of care to individuals, either in their own homes or in community settings, the BCF plan recognises that the shift to proactive, preventative care provided in the community with the delivery of health provision closer to home could increase the pressure on this budget and will need to be recognised in our application of resources to community based working.

b) 7 day services to support discharge

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

A whole system approach to planning for 7 day services has been agreed by partners in Lewisham as well as working across the wider South East London economy. Lewisham is committed to improving 7 days a week access to urgent and emergency care services, and their supporting diagnostic services, so that they are delivered in a way that addresses equitable access, care and treatment whatever day someone is admitted or where appropriate discharge and support services are needed. Extended services also improve clinical outcomes, support our BCF outcomes metrics and provide for a better patient experience. Although 7 day services go beyond urgent and emergency care, the BCF focuses on this area.

Lewisham and Greenwich Trust has shared with local partners their detailed self-assessment and outline plans for the Lewisham Hospital site against the national 7 day clinical standards which have been submitted as part of the London Quality Standards programme. The 7 day services clinical standards have been published through the initial report of the NHS Services Seven Days a Week Forum (December 2013).
Local discussions have begun to assess community health and social care service provision across the levels of service provision suggested through NHS Improving Quality report 'NHS services – open seven days a week: every day counts' (Nov 2013) to ensure appropriate and financial sustainable services are delivered when needed and to identify those services where the BCF would support an integrated 7 days a week offer across local organisations. The CCG has registered its interest with NHSIQ in its 7 day service self-assessment toolkit to see how this could support our 7 day service integration planning.

Appropriate weekend working will be the initial focus for Lewisham services so that active acute care is delivered at weekends and so that community, mental health and social care services are available to deliver weekend support services as well as enabling safe discharge ensuring local urgent and emergency care services operate effectively and efficiently across the whole week. A series of weekend audits between acute, community and social care services in Q1 will help inform our planning for community based 7 day services as well as learning from 2013/4 winter schemes.

A local CQUIN has also been agreed as an additional incentive to transform the way services are provided and assist in the assessment of the current position in terms of 7 day working across acute and community services and develop a programme of

implementation that identifies areas to support admission avoidance and early discharge over 2 years.

As highlighted previously, we will ensure that appropriate social care and support services can be put in place out of normal office hours and at weekends to facilitate timely discharges from hospital. This will include resources being made available to undertake assessments at weekends and, during 14/15, introducing the ability to access enablement, home from hospital services and access to care packages of the weekend.

c) Data sharing

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

The NHS number is already used as the primary identifier between Lewisham and Greenwich NHS Trust acute services and social care services (ASC) provided by Lewisham Council. More work is underway to extend the use of the NHS number as the primary identifier across social care, primary care and the South London and Maudsley NHS Trust (SLaM)through the Adult Integrated Care Programme.

Lewisham healthcare providers (hospital, community and general practice) is working with a range of healthcare providers within the borough, hosted by Lewisham and Greenwich NHS Trust, to establish a Virtual Patient Record (VPR) which uses the NHS number as the prime identifier. The VPR has been rolled out within health organisations in Lewisham and work is underway to include SLaM and ASC as part of the database procurement process that will be completed by December 2015

Discussions are also under way with an expectation that by 2015/16, the VPR solution that has been procured by Lewisham and Greenwich NHS Trust, will include Greenwich providers of health and social care in.

Additionally, NHS Lewisham CCG has entered into a London wide Application Programming Interface (API) agreement via the introduction of the electronic patient care planning system, Coordinate My Care (CMC), for patients with life limiting conditions.

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

The systems we have and are seeking to establish are all based on Open APIs and Open Standards, as confirmed by our suppliers. As part of Scheme 5 we will be deploying these standards as we further integrate data, and as part of preparation for the Care Act we will explore data exchange with other authorities as necessary to ensure complete care records can be maintained when people with personal care records move to another authority.

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

All partners are committed to appropriate IG controls and standards.

The Council has achieved compliance with the PSN framework which includes N3 code of connection. We are currently considering the best approach to establishing an RA for connection to the NHS spine for access to Patient Demographic Services.

The CCG was ranked 14th highest (out of 221) for the 2013/14 CCG IG toolkit scores and operates a comprehensive risk based approach to IG. Lewisham and Greenwich Trust identified some IG challenges in 2013/14 when the new organisation took control of Queen Elizabeth Hospital. A comprehensive action plan is in place and achievement of IG toolkit standards are expected for 2014/15.

Each organisation operates its own information governance, security, management and quality policies.

There is a commitment to developing joint information governance frameworks, building on the existing joint commissioning structures across the council and CCG, the joint provision arrangements across the council and Lewisham and Greenwich Trust and also associated with the local virtual patient record programme that is enabling health and social care partners in Lewisham to connect patient/client records.

These arrangements will cover applicable UK law, NHS Standard Contract requirements, IG Toolkit standards, professional clinical practice and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional for high risk populations

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

In June 2013 Mc Kinsey undertook a high level risk stratification of the Lewisham registered population using 2010/11 data. This showed that:

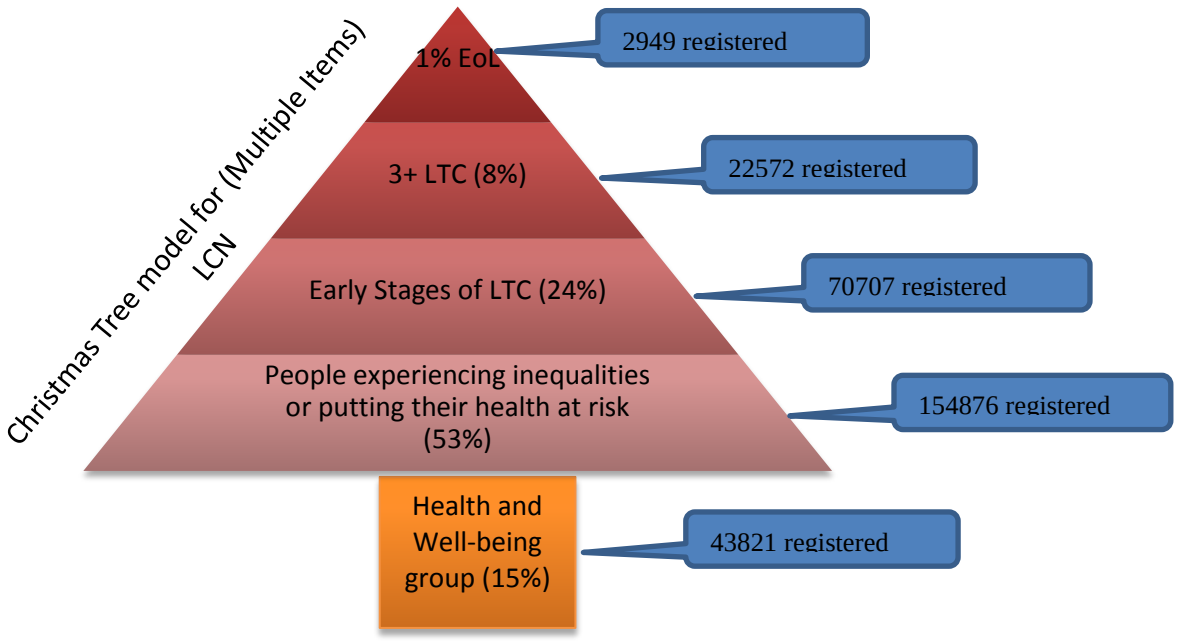
- Lewisham's population, who are categorised as very high risk and high risk with the highest demand, equate to about 5% of the population and accounts for 40% of the total health and care costs
- Lewisham's population who are categorised as very high risk, high risk and moderate risk categories with high demands, equate to about 20% of the population and accounts for 70% of the total health and care costs

The detailed analysis is shown at page 18.

Recently more detailed modelling work has been undertaken by South East London to further segment our population using the primary care data set. This modelling work identifies a similar size cohorts for the different risk categories as previous risk stratification work. About 9% of our population are people at the end of their life or with three or more long term conditions. People who are of moderate risk or are at early stages of long term conditions equate to a further 24% of the population.

We are exploring how best we can use this patient segmentation modelling tool at a neighbourhood level, recognising the limitations of the data, to support GP practices with their neighbourhood community teams to more effectively support people with long term conditions.

Lewisham CCG Practices – Risk Profile



Already GP Practices are compiling a risk register using QAdmissions of the top 2% of patients on their lists who are most vulnerable to a hospital admission. This work is being enhanced by the work underway with community health services and adult social care to match those at-risk patients on the practice-based 2% register against those known to other care providers.

Our ambition is to roll out this work incrementally to target all those patients in the high risk and moderate risk category (the top 10-15%) to improve their primary and community support and care so that hospital admissions are avoided.

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

The joint process that is being introduced is that patients will be accurately identified through risk stratification (and other mechanisms), which includes criteria to identify early dementia and mental health issues. The patient is then proactively managed according to the level of their risk. In the controlled environment of care co-ordinated by the GP a single assessment is undertaken and then the person is streamed to one of these pathways:

- GP management with a care plan, including self-care
- Neighbourhood ‘s multi-disciplinary team management, co-ordinated by the GP, with a single care plan, including self –care
- Proactive Primary Care, co-ordinated by the GP, with a care plan and including self-management

The accountable lead professional is the patient's GP but the GP may choose to delegate this role to a more appropriate member of the multidisciplinary team. This will be clearly communicated to the patient so that the patient knows who to contact when they need to and can get timely decisions about their care

Collaborative care plans are delivered to all patients with an LTC, those identified as living with frailty syndrome and other complexity (including mental health and learning disabilities).

Collaborative care plans will be developed across the whole system for patients who are at risk of deterioration and subsequent hospital admission, involving the sharing of information and the common approach across the system.

Once the high risk patients are identified through the risk stratification process, the MDT (community, practice and social care staff and medicines management where appropriate) will assess the patient's needs and develop the care plan. Some of those higher risk or frailer patients will be part of a virtual ward and offered regular home visits, but most patients will be assessed and managed within the practice. The GP remains the overall lead for these patients and referrals to other health services including hospital services medical teams will be made by him/her.

Mechanisms are to be developed for sharing information across organisations through 'view only ' or download exchange, as well as access to portable web access for patients records and care plans. This will help to create an integrated approach to enable both health and social care professionals across the system to share care planning and self-management, which will reduce duplication and improve patient experience.

The intention is that there will be a single review undertaken by trusted reviewer on behalf of health and social care whenever possible.

Patient empowerment and training programmes to be developed (Health Foundation bid) plus GP and practice staff training. Community staff and social care staff will be undergoing supported learning in both joint care planning and complex team working/ dynamics as part of the community team integration programme (for which there is an action plan developed with an initial focus on neighbourhoods 1 and 2).

Project officers from both the LBL and LCCG have been assigned to lead on the community team integration process (with the action plan above) and this work is supported by the Workforce Development work steam on the Integration project Board.

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

We are working towards achieving 4,000 care plans agreed with GPs, many of which will require next steps carried out by the MDT.

8) ENGAGEMENT

a) Patient, service user and public engagement

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

The Lewisham Public Engagement approach is to develop, design and deliver meaningful engagement in Lewisham – in multiple ways to include the views and aspirations of as many people as possible. We are committed to responsive, open and transparent engagement and putting the views of public at the heart of everything we do. Through involving and engaging the public we believe we will be better able to commission high quality services that meet the health needs of our local population. Effective engagement will not only help to improve health outcomes, it will also help to make the best use of public money.

In developing Lewisham's Health and Wellbeing Strategy, the CCG's Commissioning Strategy and Intentions, we have demonstrated how the views expressed by local residents, including service users and their carers, have informed and influenced the key priorities for action and commissioning of specific services.

More recent engagement has focused on gathering views to improve existing services and to identify key priorities for the Adult Integrated Care Programme and has taken place through a Quality Summit, workshops, focus groups and a range of consultation meetings with service users and their carers, and through the Voluntary Sector's Health and Social Care Forum, working closely with Lewisham Healthwatch.

Our approach to engagement, fundamentally builds on existing community strength and infrastructures, resulting in us working with many voluntary organisations in Lewisham to contribute to the shaping our joint commissioning plans and the AICP including :

- Health and Social Care Forum – brings together voluntary and community sector service providers and services.
- Healthwatch Patient Reference Group Meetings - holds bimonthly thematic public discussions on such issues as Mental Health, Care.data Transfer and the South East London Strategy conversations.
- Voluntary Sector Compact Steering Group - provides the standard of frameworks that guides the Council and its partners to work well with the Voluntary and Community Sector.
- Community Connections Steering Group membership - comprises key third sector organisations to provide community development approaches to connect our residents to community and voluntary sector services and to assist well being

Focus Groups have been held with different specific community groups (reflecting our seldom heard and equalities protected characteristics groups) as part of developing the CCG's Commissioning Strategy and using 'Lewisham Life'; a quarterly magazine to reach every home in the borough.

As part of the Adult Integrated Care Programme to which the BCF aligns, a stakeholder

mapping exercise has been undertaken. This ensures that all key stakeholders are appropriately engaged with the individual workstreams and help to shape and redesign services. In addition, workstreams are using a range of existing fora, such as Lewisham's Positive Ageing Council and Local Assemblies, to engage with the public more widely.

Three voluntary sector members sit on the Health and Wellbeing Board. To support the Board in its engagement and consultation activity, a Joint Public Engagement Group has been established which brings together representatives from the voluntary sector and Lewisham Healthwatch, and officers from the CCG, Council and the acute trusts, to inform the integrated care agenda.

The Joint Public Engagement Group (JPEG) will continue to co-ordinate the public engagement work across Lewisham and to provide assurance to the Health and Wellbeing Board that effective engagement is being undertaken.

Currently joint commissioning intentions are being developed to take forward the adult integrated care programme from 2014/15 onwards. The joint Commissioning Intentions will be a public document for wider engagement with the public, local providers and other stakeholders. The joint Commissioning Intentions will set out the pace and scale of the changes Lewisham commissioners wants to see in the way in which specific services are commissioned to deliver our vision, 'Better Health, Better Care, Stronger Communities' and seeks to align the desired deliverables in relation to adult services with the resources available through the Better Care Fund, the Council's (Adult Social Care and Public Health) and Lewisham CCG's budgets.

An engagement programme and communication plan will be put in place during October – December 2014, to further test that the Adult Intergrated Care Programme is focused on the right priorities and actions to deliver the maximum benefits to Lewisham people over the next two years.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

Lewisham established an Adult Integrated Care Programme in January 2014. The programme builds on the considerable work to join up services which began in 2011. It is a partnership between the Council (including Adult Social Care, Public Health, Housing and Cultural and Community Development) the CCG, Lewisham and Greenwich Healthcare Trust and South London and Maudsley NHS Foundation Trust.

During 2014, a series of multi-agency workshops have taken place bringing together stakeholders across health and social care, including local GPs, Lewisham and Greenwich Healthcare Trust, South London and Maudsley NHS Foundation Trust, Housing partners and the local voluntary sector. The aim of these workshops has been

to develop further the vision and ambition of specific aspects of the BCF programme and to co-produce the new delivery models of care. These workshops have included:

- Mapping key pathways (April 2014)
- Neighbourhood working (June 2014)
- Prevention of falls (August 2014)
- Information and advice – current and future provision (August 2014)

Lewisham partners have also been working across South East London through an integrated workstream of SEL CCG's Community Based Care Strategy to share learning and develop joint work where value can be added under the 'shared standards, local delivery' philosophy. This work is now being subsumed within the wider SEL CCG/NHS England development of a 5 year strategy.

For Lewisham and Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust, the above engagement has been underpinned by our contractual relationship as two significant providers of local community, acute and mental health services. These joint contractual discussions have focussed on how to secure the transformational changes we jointly wish to deliver using the contractual levers, for example, CQUINs and outcomes- based service specifications, innovative risk sharing arrangements and the greater flexibilities within PbR now available to commissioners.

Also these contractual discussions have included agreeing the finance and activity levels as part of the CCG's overall contract, and in developing our two year Operational and five year Strategic Plans. The BCF is an integral element of these plans and has always been part of the CCG's QIPP planning with the Trust.

More recent work is being undertaken on a South East London basis to align the CCG/SE London CCGs' Plans with Lewisham & Greenwich's Five Year Plan.

So in conclusion the engagement with our local NHS Foundation Trusts and NHS Trusts on the BCF and the wider integration agenda has been at many different levels – at a strategic level, locally and across south east London, to develop a shared vision, at an operational level to redesign models of care and at a contractual level to secure agreed changes.

ii) primary care providers

Lewisham GPs have been engaged also at various levels in the development of the Better Care Fund submission.

The GPs elected to the CCG's Governing Body have been directly involved in the development of the BCF plan as members of the Health and Wellbeing Partnership, the Adult Integrated Care Programme Board and the Adult Joint Strategic Commissioning Group.

Clinical Directors, on behalf of the GP members, have been involved greatly in developing the vision, ambition and approach for each BCF scheme, with a specific focus on establishing strong primary care (BCF scheme 2) and neighbourhood community teams (BCF 3) in 2014/15. Also working with other colleagues across South East

London to develop the South East London strategy

The broader membership of the CCG has been engaged regularly through our Membership forum meetings and our four neighbourhood meetings. A particular focus for discussion has been how the future 'collaborative working' will be taken forward locally through population based commissioning;

At an individual GP level the changes to the General Medical Services (GMS) contract from April 2014 has supported the implementation of the underlying principles of the BCF - more proactive integrated and personalised care through:

- Ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs
- Giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working
- with out-of-hours services

Locally the Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) has directly supported practices to deliver in key BCF areas including:

- Long term conditions to ensure appropriate identification (through risk stratification) and management (supported by collaborative care planning) of these patients in Primary Care
- Prevention and early detection including cancer, health checks and immunisations
- Flu and pneumonia vaccinations to ensure high levels of population coverage
- Primary Care access to support reduced A&E attendances through 7 days, 8-8pm access and redirection from A&E
- End of life

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

As with other key stakeholders social care and voluntary and community sector providers have been engaged with the BCF at various levels.

At a strategic planning level, Lewisham Council's Executive Director for Community Services is a member of the Health and Wellbeing Board and jointly chairs the Adult Integrated Care Programme Board. The Health and Wellbeing Board includes 3 representatives from the voluntary and community sector. The voluntary sector is also represented on the CCG Board. Both social care and voluntary sector providers have worked in partnership with the CCG to develop the South East London 5 year Strategic Plan.

Adult social care co-ordinated key multi agency activity (outlined in 8b i). Voluntary sector providers were involved in each workshop undertaken to further develop the vision and ambition of specific aspects of the BCF programme and co-produce the new delivery

models of care.

A Joint Public Engagement Group (JPEG) was established in March 2014 to support a more co-ordinated approach to communicating and engaging the wider voluntary and community sector about the BCF vision and aims. JPEG's membership includes representatives from Lewisham Healthwatch and Voluntary Action Lewisham. Engagement activity has also been undertaken with the voluntary and community sector through the Health and Social Care Forum co-ordinated by Voluntary Action Lewisham. The quarterly forum brings together voluntary and community organisations with an interest in health and social care.

Operationally, a consortium of voluntary and community sector providers delivers Community Connections, a key part of the neighbourhood modelproviding preventative and early intervention activity, building social capital and developing volunteering. An important element of the Community Connections project is the development activity with local community groups (see case study for Community Connections).

c) Implications for acute providers

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

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

The overall impact of CCG allocations and BCF and QIPP requirements over a five year period is already modelled within the operational planning submission made by the CCG for the 2014/15 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. The CCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Lewisham & Greenwich's NHS Trust's financial sustainability. Lewisham and Greenwich Trust is the provider of a wider range of community services in Lewisham and therefore a key player in delivering the shift.

Local provider plans are consistent with commissioner plans to the extent that both forecast a reduction in non-elective activity over the five year planning period. However, they are not fully consistent in that the provider has adopted a different approach to setting a baseline for activity, and is planning for a more modest reduction in non-elective activity. Consequently, a significant gap remains between provider and commissioner plans.

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

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
1
Scheme name
Prevention and Early Intervention
What is the strategic objective of this scheme?
Scheme 1 has three strands. The advice and information workstream within the AICP will develop as part of a wider prevention programme: • Develop borough wide information and advice gateway, including specialist advice for carers • Extend our well established Community Connections programme to support development and use more effectively community resources to support vulnerable adults. • Develop preventative programmes targeting unnecessary admissions for falls, UTI's and dementia.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
1) We intend to implement an integrated information and advice model across Lewisham that will comprise the following elements: • A Care Act compliant, comprehensive, up to date website to enable people to plan their own care choices. • An information warehouse and directory of services, this will be used by Community Connections to make best use of our community based assets. This will assist effective support planning and the use of community resources which are both home and community based. • Telephone support (with a single number covering social care and health) • Advertising materials (leaflets, videos, magnets) and training for front line staff, to increase the impact of the 'every contact counts' campaign • Face to face support at a community level in libraries and community Hubs (Citizen Advice Bureau) • Development of a Carers' Gateway Service (Carers Lewisham) Adult social care alone received 12,000 contracts per year requesting information and advice. A detailed analysis has shown that over 50% could have been dealt with satisfactorily with a good information system. The new information gateway will look to reduce telephone calls by 50% that need to be answered and lay the foundation for self-assessment and self-management. The Technology to enable self-assessment will be

completed in 2016, although the information website will be available from 2015.

User groups will be working to build and test out the information and advice gateway to ensure that it is user friendly, empowering, encouraging self-management and takes a problem solving approach.

Telephone support, that sits behind the website, with a single phone number for social care and health, will provide more detailed information and advice, but will also undertake triage, filtering cases that do/don't require full assessment. To ensure the website is well used and the telephone support is appropriately used, we will ensure we have a good communications campaign. In addition, we will run training sessions for front line professionals, carers and the public on how to navigate the site.

The 2011 census found that there are approximately 22,000 carers living in Lewisham. It is expected that simplifying the pathway for identifying carers and linking them into services, will see a much greater proportion of carers in Lewisham supported to continue with their caring role. The Advice, Information and Prevention Service will be linked into the Neighbourhood Model to ensure that all carers, but especially of patients most at risk of hospital admission are offered ongoing support to avoid unplanned admissions to hospital or residential care.

The Carers' Gateway service will be a first port of call for carers support and most carers' needs should be dealt with by this service. The emphasis of the service will be to draw on community, social and personal strengths/assets to reduce need and risks. Following an initial screening, assessment goals and outcomes will be set with the carer and they will be encouraged to develop their own support plan and link in with universal services. If more complex needs are identified fuller assessments will be available for those seeking more intensive support.

2) The Community Connections project, a pilot preventative community development project,was funded by the council in 2013. The project is delivered by a consortium of voluntary sector organisations. It operates within works alongside the neighbourhood teams and has 3 core elements:

- Support Facilitators work to connect people at the threshold of requiring care services to existing opportunities in their communities.
- Community Development Workers work with the voluntary and community sector to develop new services to meet identified needs that encourage and enable people to stay independent for longer.
- Volunteer Co-ordinators create new opportunities for volunteering and connect individuals to these opportunities.

Performance data gathered to date indicates that the project is having a positive impact on the health and wellbeing of the target group. Additional resources will enable the pilot to be mainstreamed, enabling it to expand its reach. The project is aligned to Public Health's Health Improvement Team but there are opportunities to integrate further, for example in relation to brief interventions. Over 250 residents have been placed or supported through this scheme over the last 6 months.

Community Connections has established a database of services that is kept up to date. The "service directory" includes users reviews and referral mechanisms. This will be

integrated into the new borough wide Gateway to facilitate one point of access and improve access to localised neighbourhood services. This will be of particular help to GP's, health check referrers and other professionals.

3) A recent bed utilisation audit was undertaken in partnership with LGHT. This in conjunction with Social Care allocation analysis June/July 2014 indicates some prevalent long them conditions led to unnecessary admissions (Dementia, Falls and UTI's). This scheme will therefore develop a preventative programme for each of these conditions. The planning will take place from October 2014 to April 2015 and will include:

- Patient identification/risk stratification. This is to be piloted in Neighbourhood 1 from October 2014.
- Promote screening/early diagnosis as appropriate
- A multi-disciplinary action plan in each neighbourhood to be agreed.
- Implement the falls prevention pathway agreed in July 2014.

Our Public Health reports show that the number of people with 2 or more long term conditions rises in our 75+ population. In line with this, our emergency admissions rates rise for the same age group, for the highest diagnosis areas of Dementia, Falls and UTI's. Emergency admissions rates for falls in 2013/14 was 1427, 52.7% of the total 75+ admissions. Following on from this, this group of people also spend longer in hospital; this was substantiated by the recent UHL bed audit.

We intend to re-design and implement an evidenced based falls prevention pathway in line with NICE recommendations, and align funding to further investment in activities to reduce falls and in the rehabilitation and reablement of people following a fall. We will commission evidence based falls prevention interventions (e.g. strength and balance training) for individuals and groups identified as at medium and high risk of falls.

The plan is based on the following data:

The prevalence of falls based on the estimates given by the Department of Health (2009)[13] and applied to the local population.

	Percentage	Number
Number of 65+ **registered** in Lewisham (2014)		26,393
People over 65 falling each year	34%	8974
People over 65 falling twice or more each year	15%	3,959
People over 65 attending the Urgent Care Centre following a fall	5%	1,320
People over 65 sustaining fractures	3%	791
People over 65 sustaining hip fractures	0.8%	211

A review of provision and access to preventive services and equipment has identified significant potential to achieve far greater cost-effective utilisation of existing resources, but also potential to reduce demand on care and support services by extending provision of preventive services. This will be achieved through investment in minor housing improvements such as those achieved through "warm homes" and handyperson

[13] Prevention Package for Older People DH 2009 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

schemes, and investment in basic low level equipment to support and maintain health and wellbeing, such as telecare.

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

The council will provide the information and advice web resource, and will co-provide a telephone support service with Lewisham & Greenwich NHS Trust (community nursing component will be commissioned by Lewisham CCG). Face to face support (including training) at a community level will be commissioned by the council and provided by the voluntary sector (e.g. through the community connections project) and by trained front line staff across a range of providers (e.g. Libraries, pharmacies, GP practices).

The falls prevention pathway will be implemented through a partnership between the council, CCG and Lewisham and Greenwich NHS Trust, with additional community based interventions commissioned from the voluntary and community sector and private providers.

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

An information and advice mapping exercise was undertaken with over 30 local stakeholders, and a separate exercise planned with members of the public. Benchmarking review of information and advice provided by other local authorities and a market analysis of website providers was undertaken. The selection and design of the integrated information and advice model was validated against Care Act requirements. The development of a falls prevention pathway was undertaken through a review of NICE guidance, analysis of local data and mapping of existing processes, and benchmarking against falls prevention pathways in other local authorities.

Further evidenced based used:

- Making best use of the Better Care Fund (The King's Fund)
- NICE clinical guideline NICE (2013). Falls: assessment and prevention of falls in older people. NICE clinical guideline 161 (December 2013)
- For the economic case for investing in falls prevention, see 'Fracture prevention services: an economic evaluation' (Department of Health, 2009)
- Campbell et al (2013), which evaluated the impact of Northamptonshire Crisis response service
- LGA Evidence Review: 'Integrated care evidence review, November 2013'
- Department of Health (2009). Fracture prevention services: An economic evaluation. London: The Stationery Office.

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

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

headline metrics below
The following benefits are planned: • Reduction in emergency admissions in falls UTI and COPD • Improved public satisfaction with greater information availability • People feeling more connected to their community • Improved patient experience for people with long term conditions
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This scheme will be monitored and managed via the joint Adult Joint Integrated Care Programme Board and associated work streams and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.
What are the key success factors for implementation of this scheme?
• Comprehensive advice and information database that receives excellent satisfaction feedback from the public and staff. • Channel shift of people now using various call centres to access information and advice. • Reduction in duplicate referrals to health and social care • Increase in the numbers of people supported by community schemes designed to address isolation and improve wellbeing. • Reduction in the people being admitted to hospital for Falls, Dementia, UTI's and COPD

Scheme ref no.
2
Scheme name
Primary care
What is the strategic objective of this scheme?
The Strategic aim is to provide strong primary care focused on delivering continuity of care which is proactive and co-ordinated and delivers improved outcomes, working in partnership with patients and in collaboration with other practices in neighbourhood community teams
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The primary care model of care is to provide care to the whole population registered with the GP practice - proactive, accessible, co-ordinated and continuity of care - which is set within the wider context of the CCG's draft Primary Care Development strategy. The specific focus for the Better Care fund scheme 2 is to support changes in series to improve continuity of care, which is proactive and co-ordinated: **Proactive Care** • Neighbourhood networks in Lewisham to ensure that every contact counts, seeing each contact with a patient as an opportunity to address preventative health needs, to provide brief interventions or to sign post the person to other services within the network. The information will be recorded on a virtual patient record. • Primary care to empower people to take responsibility for their own health, to remain healthy and to stay connected with their communities by being able to identify the kind of services that would be most beneficial to them. • Primary Care providers to ensure that their patients have a personal health plan to help them lead a healthier life style. This will be developed with patients including sign posting to appropriate supporting services. • Practices to work in partnership to improve public health outcomes, such as increasing the coverage of screening and immunisation across the population as a key preventative activity. **Co-ordinated care** • Practices to systematically identify people who will benefit from co-ordination of care and a care plan. • Patients to have collaborative care plans, working with the neighbourhood

community schemes that:

- will be co-designed with them
- set out agreed goals and improve self-management
- Can act as a patient passport with health services
- promotes a proactive, integrated, co-ordinated and holistic approach to patient care.
- Will be managed by a co-ordinator when necessary.
- Will be reviewed regularly or when needs change.

- Practices to utilise appropriate technology to share the care plan across organisations to allow for care to be delivered in a co-ordinated way. This will be supported by agreed policies and processes to safeguard patients information.

Continuity of Care

- Practices to identify people who would benefit from continuity of care. They will work with the patient and their carer to co design a care plan with the patient, and with their carer if appropriate.
- Practices to ensure good care by having a named skilled professional accountable for a person's care. The patient will be made aware of the role of this person and how to contact them.
- Co-ordinator to work with the named accountable professional to co-ordinate the co designed care plan and support the patient by navigating them through the system.

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

The commissioning landscape now enables a number of partners to commission services from primary care. These include NHS England who commission the core services from the primary care providers, the Local Authority who commission and contract a range of enhanced services from primary care providers, as well as Lewisham CCG who commission other enhanced services from primary care providers. It is therefore essential that commissioners work in partnership to ensure a comprehensive range of joined up services are developed and delivered to meet the needs of local people.

At a local level, all GP practices in Lewisham are members of the CCG. GP member practices work closely in local neighbourhood groupings to have clinically led discussions relating to common problems that are arising and to explore how local services can be improved and co-ordinated better, driving the commissioning agenda of the CCG as a whole.

The CCG already has a close working relationship with NHS England and will work with this commissioner in determining where additional services, established and funded through improvement initiatives can reasonably be contractualised when the primary medical services contracts are reviewed. This will allow for simplifying contractual agreements with individual practices.

There are plans to align local authority and CCG primary care commissioning to ensure that the uses of resources are optimised and services are delivered in an integrated way. This increased scope will ensure that the CCG is in a better position to commission services for the whole population which is outcomes based.

The evidence base

Please reference the evidence base which you have drawn on

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

- South East London Primary Care Strategy
- Emerging London GP Development Standards
- Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' Quality Watch, The Health Foundation, Nuffield Trust
- Purdy S (2010). Avoiding hospital admissions: what does the research evidence say? London: The King's Fund. Available at: www.kingsfund.org.uk/publications/avoiding-hospital-admissions (accessed on 19 December 2013).
- De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation

Investment requirements

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

Impact of scheme

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

- Reduction in emergency admissions - It is planned that collectively the schemes identified in this programme will directly support reducing emergency admissions. Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions for example Diabetes, COPD and Heart failure, which relates to the Primary Care (BCF Scheme 2) and the Neighbourhood Community Care (BCF Scheme 3)
- Reduction in A&E attendances
- Improved patient experience for people with long term conditions
- Increased proportion of older people still at home after discharge from hospitals into reablement or rehabilitation
- Maintain the current low level of delayed transfer of care
- Reduction in permanent admissions to residential homes

Feedback loop

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

- Overall progress of implementing the Primary Care strategy will be monitored

through the CCG Developing Primary Care steering group and the CCG's Strategy and Service Development Committee

- The specific BCF scheme will be monitored via the joint Adult Joint Integrated Care Programme Board and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including receiving the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.
- The key performance indicators are also monitored by the CCG's Delivery Committee on a monthly basis together with the planned reductions in emergency admissions.

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

- GP Engagement
- Collaborative working amongst GP practices
- Primary Care workforce development
- Interoperability of IT
- Developing a cohesive strategy for estates to deliver services

Scheme ref no.

3

Scheme name

NEIGHBOURHOOD COMMUNITY CARE

What is the strategic objective of this scheme?

The integration programme in Lewisham has 10 workstreams as shown in section 1.3 (Pioneer Bid). These all have action plans, and the following work is in progress and will be completed by end of March 2015. This will provide the foundation of the integration model by April 2015.

- Single point of access/referral into all community based care and health services.
- Co-located multi-disciplinary teams in each of the 4 neighbourhoods (Social Workers, District Nurses, all Therapies, Healthcare Assistants, Mental Health Workers)
- Neighbourhood networks established with agreed ways of working with said neighbourhood teams, pharmacists, domiciliary care services, Community Connections and health trainers.
- One line of management/co-ordination in each neighbourhood, and protocols agreed for working arrangements with the relevant GP clusters.
- Risk stratification of patients completed.
- Contract agreement for Community Connections programme 2015/16, including new volunteer recruitment targets. (Provider consortium – Age UK, Volunteer Centre, Voluntary Action Lewisham.)
- Neighbourhood model established for carers gateway offer (Carers Lewisham)
- Neighbourhood advice points established (Citizen Advice Bureau)
- Neighbourhood patient/service users groups established (Voluntary Action Lewisham & Healthwatch)

The BCF scheme will therefore be able to sustain the above developments.

The strategic objective is for locally based multi-disciplinary teams to provided co-ordinated support and care for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care, where possible and maintain their independence.

The drivers for this change are:

- The provision of care at scale but also at a sufficiently local level to be genuinely responsive to local need
- The provision of care according to need and not according to organisational structure (and therefore constraint)
- The provision of comprehensive, co-ordinated care, using connected patient information, to enable the quickest and smoothest delivery to the patient of all

health and social support requirements, with all relevant professionals working together

- Enhanced patient experience of services, including the confidence that all professionals involved in the care are working together towards the same agreed outcomes
- The delivery of healthcare for each patient, with full consideration of the social context in which it exists
- The engagement of the patient in their healthcare and their empowerment to support their own stabilisation, recovery and maintenance.
- More efficient use of resources, to generate savings that can be reinvested in enhancements and innovations
- The improvement of services through the delivery of proactive as well as responsive care, as part of a whole system strategy to identify patients at risk of deterioration and hospital admission

Overview of the scheme

The aim of the Neighbourhood Community Care scheme is to establish a system-wide network of health, social care and voluntary sector professionals, based around neighbourhood community teams, into which GPs, community services and the local hospital can refer, via a single point of access. Also the aim is for the neighbourhood community teams to have a shared approach to care management across health and social care to underpin the multi-disciplinary team work.

The single point of access team will triage all referrals and ensure that the request is forwarded to the relevant neighbourhood's Care Co-ordinator. The Co-ordinator will refer the patient details to the most appropriate professional in the team (who will act as the patient's keyworker) and organise the relevant MDT meetings, tracking that the next steps have been carried out and ensuring that any further care is enlisted from the wider network. This will be carried out in close liaison with the referring GP practice or hospital team, and will incorporate prioritisation strategies according to identified risk and complexity.

The development of the neighbourhood network model will be supported by Project Managers, who will liaise with all stakeholder teams to help unblock operational issues and escalate problems requiring strategic input.

The majority of referrals to the neighbourhood network will be for patients identified as at risk through the GP practice risk stratification initiative, comprising mainly of the elderly (especially those living with frailty syndrome), those with one or more long-term conditions (LTCs) and those whose social context is not conducive to optimal mental and physical health.

The risk stratification initiative will be expanded incrementally until a system-wide process for identifying patients at risk is in place, in which a common assessment can be made at every entry-point to the system so that patients are uniformly risk assessed and enter into the relevant pathway for their type and level of risk.

The scheme will focus on key segments of the top 10 - 15% of the adult population deemed to be at very high risk, high risk or (some) at moderate risk. Segmentation initiatives will identify where this spend is concentrated and how pathways can be improved to reduce it and improve the patient's journey back to optimum mental, physical and social health.

The neighbourhood community teams will provide:

- Preventative care through the early identification of risks and deterioration,
- Admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans
- Support following hospital discharge to remain well and supported in the community
- Short-term enablement support to enhance independent living skills

Underpinning the delivery of neighbourhood support via the neighbourhood community teams is a shared approach to care management, supported by:

- single assessment on behalf of health and social care, whenever possible
- collaborative care plan, in which the patient is encouraged and empowered to become a full partner in the decision-making process about the health and social care support that they receive and in which the full range of necessary health, social care and voluntary sector professionals collaborate to work towards common outcomes for the patient.
- a more targeted approach to conditions such as UTI's will be addressed by bringing together other staff such as Health Care Assistants, Domiciliary Care Staff and Nurse Prescribers, to be able to identify early and deal with low level conditions that could escalate and result in hospital admission.
- sharing of information, so that individuals tell their story only once
- single reviews undertaken by trusted reviewers on behalf of health and social care, whenever possible

Disabled Facilities Grants (DFGs) is relevant to Disabled people who want to remain as independent as possible within their own home. It provides access to funding for adaptations to the homes of owner occupier disabled people. The grants are given as a result of a statutory duty imposed by legislation that is administered by the local authority.

The scheme is ongoing and the way it is delivered is very prescriptive due to the legislative basis. The potential for change therefore is limited. Disabled Facilities Grants provide adaptations to enable a disabled occupant to access their dwelling and use of all facilities within it. This prevents the need for people to be supported in more institutional settings and meets the Outcomes of promoting independence and wellbeing..

The service is quite unusual in that the authority is both the commissioner and the providers of the service. This cannot be changed due to the statutory nature of the service. Similarly, the involvement of the Occupational Therapists who assess individuals from the local authority is a statutory requirement.

The delivery chain

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

Within the framework of the Adult integrated Care Programme (via the Adult Joint Integrated Programme Board) in Lewisham, the various system partners (London Borough of Lewisham Council, Lewisham & Greenwich NHS Trust, SLAM, Lewisham CCG and the Voluntary Sector) will contribute to the scheme as follows:

- BCF will fund the adult social care component of the neighbourhood teams.
- Lewisham & Greenwich NHS Trust will fund the community nursing component of the neighbourhood teams.
- SLAM will fund the neighbourhood-based mental health teams who will work closely with the neighbourhood teams.
- BCF will fund the Care-Coordinators and Project management costs.
- Lewisham CCG will provide the risk stratification investment.

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

- North West London Integrated Care Programme (Bardsley et al 2013)
- Evaluating integrated and community-based care (Nuffield Trust 2013)
- Integrated Case Management (Halton PCT)
- Poteliakhoff E, Thompson J (2011). Emergency bed use: what the numbers tell us. London: The King's Fund.
- Integrated care value case toolkit (LGA)
- Making best use of the Better Care Fund (The King's Fund)
- NHS England, Transforming participation in health and care 2013,

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

See part 2.

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

It is planned that collectively the schemes identified in this programme will directly support the reducing emergency admissions.

Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions for example Diabetes, COPD and Heart failure, which relates to the Primary Care (BCF Scheme 2) and the Neighbourhood Community Care (BCF Scheme 3)

Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing other emergency admissions using effectively the neighbourhood community teams (BCF Scheme 3) and increasing admissions avoidance via the Enhanced Care and Support (BCF Scheme 4)

In addition the following benefits are planned:

- Reduction in A&E attendances
- Improved patient experience for people with long term conditions
- Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation
- Maintain the current low level of delayed transfer of care
- Reduction in permanent admissions to residential homes

Feedback loop

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

This scheme will be monitored and managed via the joint Adult Joint Integrated Care Programme Board and associated work streams and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.

The key performance indicators and the planned reductions in emergency admissions. are also monitored by the CCG's Delivery Committee on a monthly basis Patient and public feedback about their experience of co-ordinated local care:

- GP feedback about the coherence of the neighbourhood teams
- Development of robust Key Performance Indicators to include;
    - admissions avoided through risk stratification, care planning and co-ordinated local care
    - re-admissions avoided through enablement and supported discharge
    - enhanced patient experience of health and social care
    - patients that feel confident to self-manage their long term condition
    - GP Quality Alerts about the services individually and about the neighbourhood teams as a coherent body and delayed discharges

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

- Engagement and culture change across wider health economy: GPs, community and adult social care teams
- Workforce development, recruitment and retention
- 'Physical' co-location of neighbourhood teams
- Integrated ICT tools and systems
- Development of contracting mechanisms to commission for outcomes to deliver the model across all commissioners

Scheme ref no.
4
Scheme name
Enhanced Care and Support
What is the strategic objective of this scheme?

The strategic objective is to refocus and redesign the current community based intermediate tier of services to better provide enhanced care to support people to continue to live at home by preventing people requiring an unplanned hospital admission and ensuring effective structured discharge to avoid re-admission

Whilst the primary focus within this scheme is on admission avoidance and a rapid response team (RRT) to prevent admissions as far as possible, elements of this scheme will also seek to improve the structures around discharge planning and its associated services.

We will be reviewing the existing community based care services that contribute to admission avoidance across Lewisham's health and care sector and by developing and enhancing those services improve their responsiveness, application and outcomes. This will include redesigning access andpathways through such services. New approaches will be piloted over the winter period and where successful, new contracts for services will be put in place from 15/16.

Taking the case for change there is a clear rationale for our approach of:

- Provide better coordinated person centred care.
- Have measurable improvement in outcomes for our target populations.
- Support care closer to home (right place, right support, right time).
- Actively support the health and care needs of carers.
- Promote independence, health and wellbeing for all Lewisham people.
- Develop a health and care system based on the needs of local people not organisations.
- Ensure the system is safe, effective, efficient, affordable and sustainable.

We will deliver this by:

- Empowering and equipping our Workforce with the skills to deliver coordinated care.
- Connecting systems and people with up to date information.
- Ensuring we have quality buildings providing multi agency support and care.
- Creating a movement for social change, engaging with the whole of Lewisham's population, to provide a new paradigm for how people view their health.

Overview of the scheme

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

This scheme aims to bring together all the elements of care which contribute towards avoiding admissions and the provision of support closer to home. This will be achieved in part through targeting resources to maximise the impact.

Enhanced services will provide a cohesive and seamless service to the patients. This will include:

Admissions Avoidance Service (AAS)

The scheme will expand the existing AAS ensuring that the correct professionals are working within a multi-disciplinary team to cover a seven day a week service. This service will also provide a Rapid Response aspect within 2 hours and this is being linked in with the newly developed Appropriate Care Pathways (ACPs) that are being developed. We have just launched the Falls ACP and will shortly be launching both COPD and Diabetes ACP going forward. Also AAS covers assessments of need, home preparation services and night sitting services.

The AAS service is based both within the community to pick up patients who require a "Step Up" response and also within our acute provider within ED, 'Step Down' to support discharge. In addition to this we have commissioned a small number of recuperative beds where patients can stay for up to 72 hours within the acute setting, in order to prevent an acute admission. Following this they either go home with no care, home with care or to bed based rehabilitation.

We will expand the AAS further, after we have undertaken health economic modelling to ensure we have the right service to meet the needs of our population.

Clinical Nurse Specialists

Over winter we are piloting Clinical Nurse Specialists (CNSs) for Asthma and Diabetes working in ED at weekends, to support the patients in NOT being admitted, if they can be cared for at home. We currently already have this for COPD. Again these links to the development of ACPs going forward. The nurses will pick patients up both within ED and via LAS/ACP to prevent an admission. If successful these roles will form part of the admission avoidance service going forward.

Single Point of Access

We will shortly have in place a "single point of access" in order to enhance our admission avoidance services linked to the development of community networks (Scheme 3). There will also be a single referral form for all professionals to use in order to streamline the process of referrals. We already have mechanisms in place within the acute setting to identify those patients that are "medically fit" for discharge but that require enablement or rehabilitation and provide supportive discharge to that cohort of patients, releasing acute capacity and delivering care at home or bed based for rehabilitation if appropriate.

Rehabilitation Beds

Lewisham currently has 22 beds for rehabilitation (intermediate care) within a Care Home

and the scheme will support the expansion to 25 beds over the next few months to be fully in place by April 2015. There is also the capacity for this service to take a small number of “Double Handed” patients for up to 14 days prior to starting on a rehabilitation programme for up to 6 weeks. These beds are in addition to the community service that supports patients at home with a rehabilitation programme, again for up to six weeks. However, with further health economic modelling, the CCG will be able to determine and define the type of rehabilitation beds and extra care housing required in order to support patients.

Enablement Service

To support effective admissions avoidance and discharge of patients the Enablement Services will need to be enacted. These include the above and the use of intermediate care /rehabilitation service, both bed based and community based at Brymore

Development of a Virtual Ward

The CCG are currently developing in partnership with Lewisham & Greenwich Trust an acute GP visiting service as part of the AAS, to identify those patients earlier in the day who are at risk of an admission and maintain them at home with support from community services. This would then become a virtual ward going forward. This will not only support discharging patients sooner, but will also support the AAS going forward in preventing acute admissions.

Ambulatory Care Unit

Lewisham and Greenwich NHS Trust together with commissioners are also working on the development of an Ambulatory Care Unit and are part of the National Programme for the Ambulatory Emergency Care Network for this year. Again this will support admissions avoidance going forward as this team will be able to access the ACU thus preventing an unnecessary admission.

This scheme also links to the planned development of extra care housing which is a key part of Lewisham’s Housing Strategy. Funding from the BCF will be used to ensure that the provision of additional support services is available within these settings.

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

- The AAS services and the supportive discharge services are predominantly commissioned by Lewisham LCCG with additional funding from the London Borough of Lewisham (LBL).
- LBL also funds the Enablement Services.
- LBL is coterminous with LCCG and has a strong track record of working together. The services are then commissioned from Lewisham and Greenwich NHS Trust and LBL.
- We are also working closely with the voluntary sector across a variety of areas.

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

- to drive assumptions about impact and outcomes

- AAS Pilot: Lewisham CCG this scheme (AAS) as an initial pilot in 2013/14, which demonstrated averted admissions (approximately 20 per month).
- Rapid Response teams at front end of A&E; Sutton and Merton PCTs.
- Early Supported Discharge: (National Audit Office 2010)
- Making best use of the Better Care Fund (The King's Fund)
- Oliver D, Foot C, Humphries R (forthcoming). Making our health and care services fit for an ageing population. London: The King's Fund.

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

See Part 2.

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

Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing other emergency admissions using effectively the neighbourhood community teams (BCF Scheme 3) and increasing admissions avoidance via the Enhanced Care and Support (BCF Scheme 4)

In addition the following benefits are planned

- Reduction in A&E attendances
- Improved patient experience for people with long term conditions
- Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation
- Reduction in delayed transfer of care
- Reduction in permanent admissions to residential homes

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

This scheme will be monitored and managed via the joint Adult Joint Integrated Care Programme Board and associated work streams and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.

The key performance indicators are also monitored by the CCG's Delivery Committee on a monthly basis and the planned reductions in emergency admissions. The scheme will be fully evaluated to ensure they meet the Key Performance Indicators (KPIs) in place. The outcome evaluation will determine if we proceed to fully commission or change the model. KPIs will include;

- the numbers of patients supported via enablement

- the numbers of admissions avoided
- numbers of patients supported via rehabilitation in the Care Home
- numbers of patients supported via rehabilitation in their own homes.
- numbers of reduced care packages following enablement.
- numbers of reduced care home placements following enablement.
- numbers of patients accessing enablement services.
- numbers of emergency admissions from care homes
- numbers of adaptations for homes and use of equipment at home
- Patient experience of health and social care.
- Increased numbers of patients supported to live independently.
- Number of patients that feel confident to self-manage their long term condition.

We will also be collecting data of the developing ACPs to identify the numbers of patients with an avoidable admission effectively using the ACPs.

We have effective patient feedback from bed base rehabilitation but need to ensure that this in place across all community services to ensure a positive user experience.

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

- Development and ensuring right skill mix/competencies for all staff across health and social care.
- Engagement and culture change within acute setting and teams.
- Development of contractual mechanisms for all providers.
- Ensuring the whole system has appropriate alternatives to an acute setting.

Scheme ref no.
Scheme 5
Scheme name
Supporting Enablers
What is the strategic objective of this scheme?
The strategic objective is to ensure that the necessary tools are in place to achieve the cultural changes and working practices required for effective integration. This includes data sharing between social care and health to provide professionals with more complete information about a person's needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions. The Adult Social Care Database and associated systems will be developed so that they align with the Virtual Patient Record and fulfil Care Act requirements. The scheme also includes the overall management of Lewisham's integration programme to ensure progress is maintained.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Data Sharing Close working in partnership with Lewisham and Greenwich Healthcare Trust (LGT) has resulted in the development of a Virtual Patient Record (VPR). The initial phase saw a tender let to Orion Healthcare to provide a technical solution from Feb/Mar 2015. This includes a Master Patient Index, In/Outpatient activity including discharge summaries, lab results, radiology, PACS, immunisations, Community referrals and GP detailed care records. The next phase, planned for July 2015, will add birth and antenatal data, endoscopy, GP Out of Hours service data, Community Care Plans and medications. Following this, work will start on adding Mental Health data, social care data (children and adults) and data from opticians, pharmacists and dentists. The project will impact on all 280,000 residents of the borough, and the adult social care element will link the records of about 4-5,000 active and recently active users. Information Governance arrangements will be required to ensure there is compliance and that data is only shared on the basis of informed consent of the patient/ service user. Following this, records from all the necessary systems will be linked securely through N3, using the NHS number as a common identifier, to build a comprehensive health and social care picture for each person. **IT Systems** As part of the Adult Integrated Care Programme, a project team is working on developing

a new support and maintenance contract with our existing Adult Social Care Database and finance software providers.

A number of enhancements to the system are being procured to address the integration programme and the Care Act. This includes using connectivity Application Programme Interfaces (APIs) and software tools to support data exchange, NHS number loader and Demographic Batch System lookup software using N3 code-of-connection as well as FACE assessment tools for personal budget and support planning.

Also being introduced is a Londonwide product called CarePlace.org, which helps find providers of adult social care, and MySupportBroker, which works with vulnerable adults to make the best use of their personal budget.

Additional software will be required to support self-assessment, possibly purchased from our current Social Care finance software provider. This will impact the approx. 100-200 users of these systems across health and social care, with potentially more once VPR is established.

Self Assessments

As part of our drive to improve access to information and advice, ensuring that we have electronic tools where people can self-assess and refer into Health and Social care is key to give further choice and control to our patients/service users. Both the Care Act and our integration programme focus on the most cost effective way of delivering service provision, which will maximise the use of all available resources including online assessments. In Lewisham we will be looking to develop in the first instance, tools to support the dialogue around referral and start the process towards either council funding or applying for care accounts.

Adult Integrated Care Programme

A small element of the scheme includes the programme management capacity necessary to ensure delivery of all the projects. This is a complex programme and requires consideration of the fit between local and national priorities, including the need to deliver high quality services in the context of significantly reduced resource levels.

The delivery chain

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

Data Sharing

Lewisham and Greenwich Healthcare Trust (LGT) has taken the lead, and have already procured Orion through Insight as the provider of the VPR and Nautilus as an implementer. Strong programme management arrangements are in place, including a board representing all parties to ensure compliance, to deliver the various phases of the project. Highlight reports are used to monitor progress, with exception reporting and use of a regularly reviewed risk register.

IT Systems

LB Lewisham is the lead organisation, but as part of the Adult Integrated Care

Programme, the project is monitored closely by a board comprising health and social care representatives. In addition, there is a project delivery team to ensure different aspects of work are joined-up and support each other, tracking the interdependencies and making essential links to drive the project forward. Procurement is from a number of providers, in some instances through sub-contracts. So LiquidLogic are main database suppliers, but through them Oxford Computer Consultants (OCC) supply Social Care finance software. Other providers include CarePlace and MySupport Broker.

Self Assessments

Lewisham has established a Care Act task and finish team to deliver the required changes. The requirements are split into the workstreams, which are led by a named Manager(s). These workstreams feed back into the Integration Programme Board.

Adult Integrated Care Programme

Work is being undertaken by all partners involved in the programme. This includes CCG, LBL and LGT and SLaM.

The evidence base

Please reference the evidence base which you have drawn on

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

The projects are designed to support and facilitate other schemes, so the focus is on establishing an infrastructure that ensures frontline professionals have all the information they need to make fast, accurate diagnosis of both medical and social care needs. In addition, systems will need to support reporting, planning and commissioning to ensure that services are reviewed and developed to ensure cost-effective, high quality care is provided at the right point to minimise or eliminate long-term support needs.

As already confirmed – project management arrangements are strong and well monitored plans exist for delivery.

Work has been undertaken with frontline staff and managers across Lewisham to identify key gaps in knowledge and work on the VPR in particular is intended to provide as much information as possible, subject to the necessary information governance protocols. In addition, systems have been demonstrated and tested with staff to ensure suitability in terms of interface and useability.

A cost/benefit analysis has been developed to ensure that all organisations taking part in the Virtual Patient Record project will receive suitable benefits that will offset the costs of deployment. Some will be immediately cash-releasing, but many may involve cost avoidance or quality improvements.

Investment requirements

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

Impact of scheme

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

This scheme contributes to the success delivery of other BCF schemes so will contribute to the delivery of the following benefits:

- Reduction in Emergency Admissions
- Improved patient experience for people with long term conditions
- Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation
- Maintain the current low level of delayed transfer of care
- Reduction in permanent admissions to residential homes

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

This scheme contributes to the other BCF schemes and has clear deliverables within the associated projects.

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

The scheme will require a number of IG and technical hurdles to be overcome. Evidence from other areas demonstrates that success is achievable, but local requirements will need to be considered carefully by the delivery teams to ensure that all parties keep pace with the required activity to deliver within expected timescales.

Other key success factors are the capacity and capability of the workforce to utilise fully the potential of VPR.

ANNEX 2 – Provider commentary

NHS England / LGA guidance for completing the "Provider commentary" in Annex 2 below

One of the key changes is that we are asking all areas to ensure they have shared their planned non-elective activity reductions with their relevant providers. In particular, we are looking for acute providers to submit commentary explicitly stating whether they recognise the emergency admissions activity reductions and agree with them. We do not expect providers to sign-off BCF plans, but we do expect to see evidence of provider engagement. A template is provided in annex 2 which should be shared with acute providers for commentary and should be submitted alongside the BCF plans in September.

Although we only require explicit written commentary from acute providers to be submitted alongside the BCF plans, you may wish to conduct a similar exercise with out-of-hospital providers to ensure they are prepared for any impact of planned emergency admissions reductions.

A good provider commentary will:

- Confirm detailed and meaningful provider involvement in the development of the
- plans, from the major acute providers locally
- Demonstrate clear alignment between the overarching BCF plan and the provider plans
- Provide triangulation to provide reassurance that the projected reductions in planned emergency activity are feasible
- Confirm that providers are implementing their own risk management and action plans to respond to the planned change in activity
- Demonstrate a shared understanding of the critical path to successful delivery
- Articulate local risks and cross reference with the risk log in Section 4

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

Name of Health & Wellbeing Board	Lewisham
Name of Provider organisation	Lewisham & Greenwich NHS Trust
Name of Provider CEO	Tim Higginson
Signature (electronic or typed)	Tim Higginson

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	24,329 (all providers)
	2014/15 Plan	24,840 (all providers)
	2015/16 Plan	24,272 (all providers)
	14/15 Change compared to 13/14 outturn	2.1%

	15/16 Change compared to planned 14/15 outturn	-2.3%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	N/A
	How many non-elective admissions is the BCF planned to prevent in 15-16?	459

*** Note: These above figures do not match the part two spreadsheet as the above figures are planned figures for 2014/15 and 2014/16 whereas the part two spreadsheet figures are Q4 2013/14 to Q3 2014/15 and Q4 2014/15 to Q3 2015/16.**

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Lewisham and Greenwich NHS Trust support the planned reductions of non-elective admissions targeted through the BCF, integrated in a wider programme of pathway change aimed to keep people out of hospital.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Lewisham and Greenwich NHS Trust are working with partners to reduce demand on A&E and inpatient admissions which is over our capacity at this time, and this reduction in non-elective admissions is entirely consistent with our own service objectives.