Authorisation and Signoff

Signed on behalf of Lewisham Clinical Commissioning Group	
	Martin Wilkinson
Position	**Chief Officer**
Date	

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

Signed on behalf of Lewisham Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	**Sir Steve Bullock**
Date	

The BCF Plan has been shared with Lewisham Health and Care Partners which includes both commissioners and providers.

Better Care Fund Plan 2017-19

1. High Level Summary

1.1 Lewisham Health and Care Partners (LHCP) share a collective vision for a sustainable and accessible health and care system in Lewisham by 2020 that better supports people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when they need it.

Lewisham Health and Care Partners include:

- Lewisham and Greenwich NHS Trust (LGT);
- London Borough of Lewisham (LBL);
- NHS Lewisham Clinical Commissioning Group (LCCG);
- One Health Lewisham (Pan-Lewisham GP Federation);
- South London and the Maudsley NHS Foundation Trust (SLaM);

1.2 The Lewisham BCF Plan 2017/18 and 2018/19 is an evolution of the 2016/17 Plan and continues to fund activity in the following areas:

- Prevention and Early Action
- Community based care and the development of neighbourhood care networks and neighbourhood community teams
- Enhanced Care and Support to reduce avoidable admissions to hospital and to facilitate timely discharge from hospital.

1.3 The total BCF pooled budget for 2017/18 is £30.002m and for 2018/19 £33.381m. The financial contribution to the BCF from the CCG in 2017/18 is £20,525m and in 2018/19 is £20.915m in accordance with the published CCG allocations. The financial contribution from the Council in 2017/18 is £1.882m and in 2018/19 is £1.996m. The IBCF grant funding has been pooled into the BCF and totals £7.595m in 2017/18 and £10.470m in 2018/19.[1]

1.4 The table below shows a summary of the BCF and IBCF expenditure plan.

[1] Financial figures rounded to the nearest thousand exact contributions are available in the planning template.

Summary Expenditure Sheet			
Scheme	**Areas of Expenditure**	**2017/18**	**2018/19**
Assistive Technologies	Improved Use of Equipment Care Act Implementation	£479,000	£483,351
Care navigation / coordination	Single Point of Access	£517,120	£531,067
Carers services	Carers breaks	£564,320	£488,792
DFG - Adaptations	DFG	£1,146,852	£1,240,624
Domiciliary care	Provider inflation Demographic growth Protection of current level of packages of care	£1,680,000	£3,510,149
Integrated care planning	Co-ordinated Care Service Transitions	£1,992,000	£1,671,298
Primary prevention / Early Intervention	Community Falls Service Sail Connections Self-Management support	£744,331	£758,474
Personalised healthcare at home	Neighbourhood Community Teams Neighbourhood Community Teams Community Mental Health	£5,540,064	£5,825,217
High Impact Change Model for Managing Transfer of Care	Integrated Primary & Urgent Care Hospital Discharge Provision (Rapid Response Team, Discharge to Assess, Emergency Discharge Team & Supported Discharge Service) Development of trusted assessor model with Care Home providers Social Care Delivery	£3,786,160	£4,282,751
Intermediate care services	Enablement Services	£4,843,560	£4,960,188
Residential placements	Extra Care Provision Transitions Maintaining level of mental health provision	£2,334,398	£2,944,552
Wellbeing centres	Neighbourhood Hubs	£132,000	£53,458
Enablers for integration	Programme Management Population Health System Connect Care	£543,839	£849,976
Other	GP Streaming Continuing Health Care Winter Capacity Development of community support services	£5,066,620	£5,181,454

	Learning disability supported accommodation		

2. The current position and case for change

2.1 Lewisham Health and Care Partners continue to recognise that Lewisham's health and care system needs to change. The current system is not sustainable and we are not yet achieving the health and care outcomes we should:

- Too many people die early from deaths that could have been prevented by healthier lifestyles:
- Cancer is now the main cause of death (28%), followed by circulatory disease (21%), respiratory disease (16%) and dementia (9%) in Lewisham among all ages in Lewisham.
- The life expectancy at birth was 76.7 years for women and 72.3 years for men in 1991-93; in 2013-15 it had increased to 83.1 years and 78.8 years respectively. However, for both men and women life expectancy remains lower than the England average.
- There are even greater differences in life expectancy rates in different wards within the borough. Life expectancy is 7.7 years lower for men and 6.6 years lower for women in the most deprived areas of Lewisham than in the least deprived areas.

2.2 There are significant health inequalities in Lewisham:

- People living in the most deprived wards, in Lewisham, have poorer health outcomes and lower life expectancy compared to England's average. For example premature death rates are significantly higher in Lewisham Central, Bellingham and New Cross wards compared to the Lewisham average.
- Lewisham is one of the most ethnically diverse areas of the country. The Department of Health has highlighted ethnicity as the major inequality in Severe Mental Illness. In Lewisham BME service users are overrepresented in crisis and acute wards and teams that support people in the community, such as promoting recovery teams and home treatment teams. However there is an underrepresentation in IAPT and Assessment and Liaison Services.

2.3 Too many people live with ill health:

- More people have one or more long term conditions - 29% of Lewisham's population have 1 LTC; about 86,570 people.

- The likelihood of having a long term condition, including dementia, increases with age; over 50% of those aged over 75 are likely to have two or more long term conditions

2.4 Demand for care is increasing, both in numbers and complexity:

- Lewisham's over 60 population is projected to increase by around 33,000 by 2040 which will increase demand for the health and care services
- 14.4% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities. That is equivalent to around 39,000 people.

2.5 Furthermore, high quality care is not consistently available - the quality of care that patients receive and the outcome of their treatment can vary depending on when and where they access care services.

2.6 The activity supported by the BCF will contribute to addressing the changes required. Lewisham Health and Care Partners are focused on improving quality and performance across the system, particularly in relation to the performance metrics and national conditions of the BCF.

3. Progress so Far

3.1 During 2016/17, the BCF supported the development of Prevention and Early Intervention tools, the delivery of Community Based Care including the development of Neighbourhood Community Teams and the Neighbourhood Care Networks and the redesign of services to deliver Enhanced Care and Support.

3.2 Prevention & Early Action

3.2.1 Preventative interventions are critical to managing the increasing demand in health and social care services, reducing the overall burden of disease in the population and have the potential to underpin financial sustainability. It is well evidenced that by investing more in prevention and early action, costs can be reduced further down the care pathway and improve outcomes for individuals.

3.2.2 Through the Better Care Fund we have funded a range of services to make it easier for everyone, including professionals, to access the right information and services:

- The 'Single Point of Access' for Health and Social Care provides one number that acts as a gateway for contacts to district nursing and social work services. During 2016/17 significant work was undertaken to improve demand management and reduce the level of abandoned calls.
- The development of a social care and health digital directory provides information, advice and signposting to more effectively manage demand, prevent the escalation of need and encourage behaviour change.
- The development of two online self-assessment forms. The wellbeing self-assessment is for people who think they may need care or extra help. The

short questionnaire assists people to identify what support they may need, whether they are likely to be eligible for adult social care support and provides tailored information to help people to self-manage their own health and care. There is also a self-assessment for carers, which helps carers to identify their support needs.

3.2.3 Through the Better Care Fund we have supported people to live in their own homes safely and independently by funding:

- SAIL (Safe and Independent Living) Connections, which is a quick and easy way for vulnerable older people (60 plus) and those supporting them to access a broad range of coordinated support and/or information to help keep people safe and independent in their own home. SAIL was launched in February 2017 and had received 97 referrals by the end of Q4 2016/17.
- Community Connections, a preventative community development programme aimed at supporting vulnerable adults over 18 who are resident in Lewisham and who may benefit from services to improve their social integration, health and wellbeing and also reduce isolation. Over 800 individuals in 2016/17 have been supported through person centred plans with 86% reporting an improvement in their overall wellbeing.
- A Community Falls Service has been established to proactively manage those at risk of falling as well as providing a range of physical activity interventions and care coordination to reduce repeat falls.
- Improved use of community equipment through the launch of the Transforming Community Equipment Services online learning tool to help staff order equipment more efficiently and minimise waste.

3.2.4 Through the Better Care Fund we have funded a range of information, advice and care to support people with long term conditions to make it easier for people to self-manage their own health and wellbeing:

- Primary care, through the Lewisham GP Federation, was commissioned to deliver the Co-ordinated Care Service 2016-18. The overarching aims of the Coordinated Care Service are to deliver an enhanced level of primary care in the community and reduce avoidable emergency activity. The service provides an enhanced level of coordinated care with a focus on long term conditions (LTCs) and the vulnerable and has delivered the following outcomes:
  a) Closing the gap between recorded versus expected prevalence for LTCs. Across the borough LTC registers have increased by more than the average annual growth figures. Since 1 April 2016 diabetes registers have increased by 593 patients, the COPD register by 268 patients and the hypertension register by 1179.
  b) 20% of all patients newly diagnosed with COPD since April 2016 have stopped smoking.
  c) The Federation has established a team to review and coordinate care to proactively manage those patients who frequently attend A&E.
  d) GP Practices are also participating in patient centred multi-disciplinary team working with neighbourhood community teams.
- A two year pilot to deliver a tailored approach to self-management education activities for people with long term conditions. The pilot offers a ‘menu’ of evidence based flexible self-management activities tailored to an individual’s

health and social care complexity as well as their individual learning needs. The pilot addresses a major gap for those residents who have long term conditions who face barriers to accessing mainstream structured self-management education as well as building an evidence base for a future integrated approach to self-care and self-management in Lewisham.

3.3 Neighbourhood Care Networks and Community Based Care

3.3.1 Our work on Community Based Care and Neighbourhood Care Networks is being informed by the plans and priorities of the south east London Sustainability and Transformation Plan (SEL STP), developed in collaboration with south east London's commissioners and providers.

3.3.2 A neighbourhood care network is the way in which people and organisations, both statutory and voluntary, build connections and links between them so that people receive the right advice, support and care to improve and maintain their health and wellbeing.

3.3.3 In Lewisham we are focusing on building connections across our four neighbourhood areas, enabling all those working to maintain and improve people's health and wellbeing to connect up more easily and deliver care in a joined up way.

3.3.4 LHCP have organised a range of health and care services on a neighbourhood footprint based around GP registered lists in the following geographical areas: (1) North Lewisham (2) Central Lewisham (3) South East Lewisham and (4) South West Lewisham.

3.3.5 Networks are being developed through multi-disciplinary meetings which bring health and care staff together to support people with complex care needs. All GP practices hold regular multi-disciplinary meetings (MDMs) to agree how best to co-ordinate care for people with complex health and care needs. Practice based MDMs provide a mechanism to enhance and improve inter professional working to maintain people in the community and prevent unnecessary admission to hospital or long term care. A Standard Operating Procedure for practice based MDMs has been developed which sets out the approach to MDMs in Lewisham.

3.3.6 Multidisciplinary Neighbourhood Community Teams (NCT) cover each of the neighbourhoods bringing together district nurses, social workers, occupational therapists and physiotherapists. These virtual teams are aligned to the four GP Federations and community mental health services. This has enabled more holistic care to be provided as well as greater sharing of information and collaboration. During 2016/17 workshops to improve joint working and joint training sessions have taken place. Work to co-locate the NCTs is on-going.

3.3.7 Neighbourhood Co-ordinators (one in each neighbourhood) have been in post since November 2015. The Co-ordinators support multi-disciplinary working, liaising between professionals within the NCT and with services outside it. Funded by the BCF, the Neighbourhood Co-ordinators work across health and social care to improve multi-disciplinary working for those people with complex health and social care needs. The team facilitates effective liaison between formal and

informal health and care providers across Lewisham. Feedback from all professionals has been very positive. The Co-ordinators received 1254 'referrals' (requests for support) in 2016-17. These 'referrals' range from straightforward signposting or information chasing to supporting the co-ordination of case conferences for more complex cases. The Co-ordinators have improved communication and information sharing between professionals, reduced time spent by professionals chasing information and enabled more effective signposting to support person centred care.

3.3.8 To further strengthen networking across the neighbourhoods, four Neighbourhood Community Development Partnerships have been established. These neighbourhood partnerships bring together voluntary and community sector organisations and groups in that area to support community development, to work with statutory partners in the area and to build stronger, healthier communities.

3.3.9 Through the BCF in 2016/17 we have also funded a range of community health and care services to enable the management of people with more complex health and social care needs out of hospital. These include:

- The Care Home Intervention Team (CHIT) which supports the mental health needs of patients in care homes and day services in Lewisham. It provides a community in-reach service for older adults who display behavioural and psychological symptoms of dementia. The team works on a one-to-one basis with patients as well as with organisations to develop best practice. Over 2016/17 the Team has reduced the prescribing of anti-psychotic medication, avoided placement breakdowns and emergency admissions to hospital.
- The Home Treatment Team (HTT) operates 7 days a week, 8am-9pm for direct support and 9pm-8am for telephone support, and provides a rapid response and assessment for a mental health crisis. The Team also supports early facilitated discharge for patients by offering care and treatment at home following an inpatient admission. In 2016/17 the HTT supported 609 people, 92% of whom did not require a subsequent admission to hospital. The HTT also supported 263 people for early discharge.
- The Enablement Services deliver enablement and rehabilitations services to people identified as needing support to prevent admission to hospital or to facilitate discharge from an acute bed. The numbers of people being supported through the service has increased from 100 to 125 at any one time through better scheduling, flexibility of staff and expanding trusted assessor roles.

3.4 **Enhanced Care and Support**

3.4.1 Lewisham's non-elective pathway is characterised, in terms of patient volume, by a significant number of people attending the emergency department, who could have been appropriately treated elsewhere and a smaller number of patients with more complex needs who could, with the appropriate interventions, avoid a hospital admission.

3.4.2 In response to the increase in non-elective activity in 2015/16 and the refresh of One Version of the Truth (a diagnostic of what was happening along the urgent and emergency care pathway), Lewisham & Greenwich NHS Trust, Lewisham

CCG and the London Borough of Lewisham worked in partnership to support the redesign and development of the Emergency Department Discharge Team, the Community Discharge and Support Team and the Rapid Response Team.

3.4.3 Due to the challenges facing the entire system including invest to save and the SEL STP QIPP requirements for Enhanced Care and Support, the need to reduce avoidable admissions, support discharge and improve flows to reduce length of stay, further work needed to be done to refine the activity modelling and proposed impact. Therefore the redesigned services have been implemented later than originally planned and the expected benefits were not fully realised in 2016/17.

3.4.4 The remodelled Emergency Department Discharge Team is a dedicated 7 day a week, 8am-8pm service that identifies patients presenting at the Emergency department who are at risk of an admission to hospital and aims to prevent an unnecessary admission linking patients to other services. The service plans to reduce avoidable admissions by 1,082 per year. The phased commencement of the service began in December 2016.

3.4.5 The remodelled Community Discharge and Support Team has been enhanced to incorporate the discharge to assess pathway to help facilitate patient flows in Lewisham Hospital and facilitate the early discharge of patients. The phased commencement of the service began in March 2017 operating 8am-8pm, 7 days a week.

3.4.6 The remodelling of the Rapid Response Service began in 2016/17. Currently there are two Rapid Response Services, one delivered by Lewisham and Greenwich Trust as part of a wider admissions avoidance programme and one developed to support winter capacity to receive referrals from GPs and Care Homes. The proposal is to review these services in light of the additional investment in GP services and the ACU to deliver a more integrated approach to support frailty.

3.4.7 The Integrated Primary and Urgent Care (IPUC) Model is still being developed. The borough wide GP federation commenced delivery of the seven days per week, 8am till 8pm GP access component of the IPUC service on 1st April 2017. The GP streaming pilot (at the front door of Urgent Care Centre) component of the IPUC commenced on 3rd October 2016. Between service start and December 2016, 2679 patients were managed by the service with 1171 patients ‘seen and treated’ and 501 redirected to alternative services.

3.4.8 The BCF funds Social Care Staff to be available 7 days a week, 8am-8pm in the Emergency Department at Lewisham Hospital and in the Enablement Services in the community. Over the winter period (November 2016 – March 2017) staff have been available 7 days per week to undertake complex assessments and liaise with families to bring forward discharges. This has had a significant impact on the Ready for Discharge List which reduced from 55 in June 2016 to 7 at February 2017.

3.4.9 The redesigned Continuing Healthcare (CHC) pathway brings together health and social care resources for CHC assessments and reviews, to create a single CHC team. This new team has focused on providing a single point of access to improve

processing times to reduce the time spent in hospital for patients who are medically fit for discharge. The team has been place since May 2016. All checklists go through the team and all fast track patients are seen within 24 hours. The referral to assessment times have reduced to the statutory 28 maximum and are being managed within an average 10 days at Lewisham Hospital. The percentage of deferred decisions has been reduced from 20% to 10%. The redesigned pathway has significantly contributed to the reduction in delayed transfers of care reported by LGT.

3.4.10 Extra Care Provision has been provided at Conrad Court comprising of 78 units. Over the last year the service has supported 8 people who have stepped down from care homes and 3 people who were stepped down from hospital remained in tenancies at Conrad Court who may otherwise have gone into residential or nursing homes. There are also high levels of satisfaction of people using the scheme.

3.5 Enablers

3.5.1 'Digital' technology has a significant role to play in the sustainability and transformation of the local health and care system. The BCF has been used to fund the development of technology that will change the way care is delivered and to achieve improved and consistent patient care, better prevention and allow more care to be delivered in the community.

3.5.2 Connect Care is a local electronic record which allows patient information from separate records to be viewed quickly and safely by front line professionals, such as GPs, hospital staff, district nurses and social workers, directly involved in patient care. Currently the portal receives feeds from GP practices in Bexley, Greenwich and Lewisham, out of hours services based at the Queen Elizabeth Hospital and University Hospital Lewisham, Oxleas Mental Health Trust and Lewisham Community Services.

3.5.3 Assessments have taken place to identify the development or refurbishment needs in relation to estates to support new ways of working and shared use.

3.6 Performance on national metrics in 2016/17

3.6.1 During 2016/17 targets were achieved for non-elective admissions and reablement; targets were not achieved for Admissions to Residential Care and delayed transfers of care (DToC) although performance in the latter improved over the course of the year.

3.6.2 In 2016/17 non-elective admissions were 4.6% below plan for the year.

Non-Elective Admissions	**2016/17**			
	Q1	**Q2**	**Q3**	**Q4**
Plan	6526	6745	6740	6642

Actual	6395	6206	6340	6472
% Variation	-2.0%	-8.0%	-5.9%	-2.6%

3.6.3 In 2015/16 Lewisham had one of the highest performances for reablement with 98.1% of people remaining at home 91 days after discharge from hospital. In 2016/17, 92.8% of people remained at home 91 days post discharge. Whilst this is a slight decrease in last year's performance, performance remains higher than the target set.

Reablement (Proportion of older people (65 & over) who were still at home 91 days after discharge)	**14/15**	**15/16**	**16/17**
Plan	88.0%	88.0%	88.0%
Actual	87.9%	98.1%	92.8%
Variation	-0.1%	10.1%	4.8%

3.6.4 The number of people feeling supported with their long term condition has increased from 59.1% in 2014/15 to 60.1% in 2015/16 and we are on track to meet the target set for 2016/17.

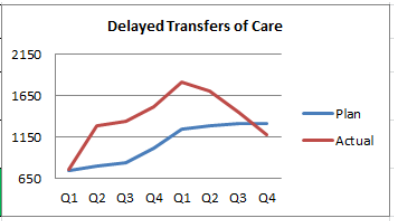
3.6.5 The 2016/17 target for admissions to residential care was not met. The outturn for 16/17 is expected to be 698 per 100,000 population compared to a target of 551 per 100,000 population. Although more people have been admitted to care in 2016/17 they have had shorter lengths of stay due to higher acuity. In year we continued to see an increase in elderly mentally ill placements in both nursing and residential care. We are working with families and Extra Care providers to explore more complex packages of care at home and this has started to show signs of success.

Residential Admissions (Long-term support needs of older people met by admission to residential and nursing care homes per 100,000 population)	**14/15**	**15/16**	**16/17**
Plan	525.8	526.1	551
Actual	566.2	1164.8	698
% Variation	7.7%	121.4%	26.7%

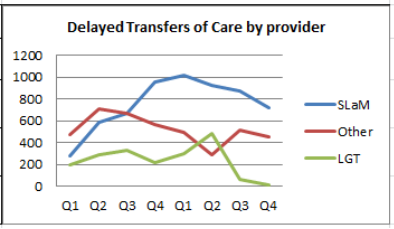
3.6.6 The 2016/17 target for delayed transfers of care was not met. However significant improvement was made throughout the year and Q4 was 9.8% below plan. Over 2015/16 there was a significant increase in the number of days delayed reported to LB Lewisham by South London and Maudsley NHS Foundation Trust (SLaM) and this continued into 2016/17. The rise in the number of DToC reported by SLaM

for Lewisham was significant, rising from 279 days in Q1 2015/16 to 1016 days in Q1 2016/17.

Delayed Transfers of Care (Total days delayed 18 and over)	2015/16				2016/17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Plan	740	803	839	1019	1240	1289	1320	1310
Actual	755	1289	1340	1521	1810	1703	1454	1181
% Variation	2.0%	60.5%	59.7%	49.3%	46.0%	32.1%	10.2%	-9.8%



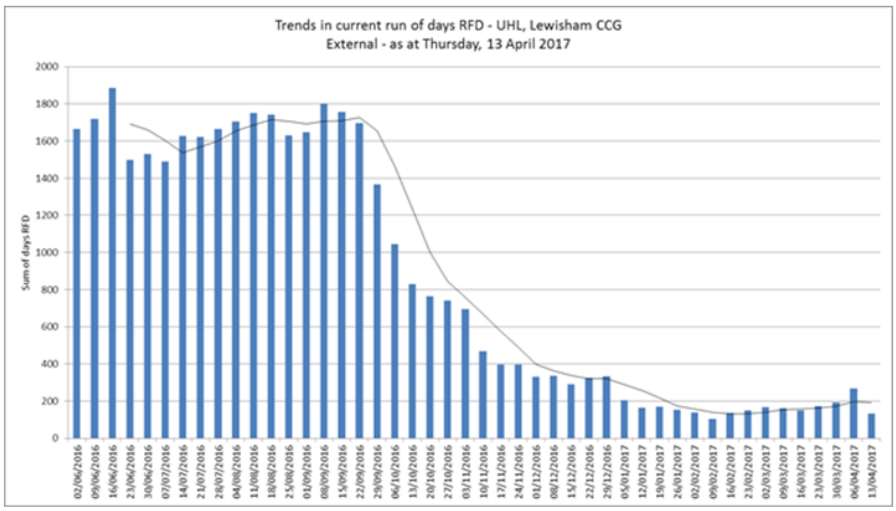
Delayed Transfers of Care by provider	2015/16				2016/17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SLaM	279	582	669	954	1016	930	874	716
LGT	198	291	332	213	301	484	63	9
Other	476	707	671	567	493	289	517	456



3.6.7 Lewisham's Joint Commissioners have worked with Social Care and SLaM to fully understand and address the reasons for the delays. The main reasons for the delays in discharge include a lack of respite provision, issues accessing accommodation for patients who have a dual diagnosis, a difficulty accessing placements for a small number of very complex patients which meet their physical and psychological impairments and occasional slow panel process. The interventions to support the reduction in delayed transfers of care include, twice daily "gold" and "silver" meetings to review bed state, weekly surge calls to scrutinise activity and agree actions, the appointment of a Head of Borough for inpatient services, the implementation of the estimated date of discharge onto the electronic patient journey system, a continued focus on length of stay and agreement to a refined clinical and operational process for delayed transfers of care.

3.6.8 In addition local work to support Winter Resilience at Lewisham and Greenwich Trust was initiated to support and improve flow for complex patient discharges. This reduced hospital delays for people ready for discharge, avoiding delayed transfers of care and reducing excess bed days. The recovery programme included; the appointment of a Nurse Flow Manager to co-ordinate discharges across the system for University Lewisham Hospital, increased complex care brokers and the review of the local Discharge Policy and associated patient 'choice' letters. Reducing the 'ready for discharge' complex patient list also supports the delivery of the A&E 4 hour constitutional standard.

3.6.9 This system approach has had a significant impact on the list of complex patients ready for discharge. The number of days delayed has continued to decline from Q2 2016/17. However we recognise that there is further work to do with both the health and care economies to sustain this.



- The chart opposite provides actual reductions in bed days for Lewisham CCG patients from 2nd June 2016 to 13th April 2017.
- There has been a reduction in accumulative number of RFD from 1000 days in October to under 200 days.
- This correlated with the discharge or transfer of a group of long stay patients who had been RFD for a significant period of time.
- Source: Lewisham & Greenwich Trust – Trend Reports

4. Vision for Health & Social Care Integration

4.1 Lewisham Health and Care Partners (LHCP) share a collective vision for a sustainable and accessible health and care system in Lewisham by 2020 that better supports people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when they need it.

4.2 The BCF activity identified for delivery during 2017-19 will contribute to Lewisham Health and Care Partners' overall objectives 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 enable them to choose how best to improve their health and wellbeing, explicitly addressing health and care inequalities including parity of esteem between physical and mental health.

Better Care - to provide the most effective personalised care and support where and when it is most needed - giving people 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.

Better value for the Lewisham pound – by focusing on delivering population-based health and wellbeing outcomes and higher levels of service quality whilst containing costs over the five year period.

4.3 Transforming Community Based Care (CBC) to be more accessible, proactive, preventative and coordinated is a critical part of achieving the vision. Lewisham's Neighbourhood Care Networks (see the diagram at Annex A) bring together local care networks (delivered by Lewisham's health and care partners) and the

networks of voluntary and community sector organisations to transform the way in which community based care is delivered.

4.4 As envisaged within the SEL STP, a local care network has been developed in each neighbourhood; (1) North Lewisham (2) Central Lewisham (3) South East Lewisham and (4) South West Lewisham to deliver support and care which is:

Proactive and Preventative – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need and the activities, opportunities and support available, to maintain their health and wellbeing and to manage their own health and care more effectively.

Accessible to all – so that adults have improved access to local health and care services, and so that children have increased access to community health services and early intervention support. And for everyone to have clear access to urgent care when needed;

Co-ordinated – so that people receive personalised care and support, closer to home, which integrates physical and mental health and care services, to help them to live independently for as long as possible.

4.5 Alongside the local care networks sit the other key element of Lewisham's Neighbourhood Care Networks, the voluntary and community sector. Lewisham's well-established voluntary and community sector has a major role in building strong and resilient communities and in supporting residents' health and wellbeing.

4.6 Lewisham will continue to strengthen and develop connections both within and across its local care networks, as envisaged by the SEL STP and build stronger links within and across the voluntary and community sector, through the neighbourhood community development partnerships.

4.7 The LHCP envision health and care being delivered around the needs of the population and the individual, irrespective of the existing institutional arrangements, that is provided in a joined up, safe, effective and sustainable way. LHCP are exploring new governance and partnership arrangements between the statutory partners that enable joint decision making and joint accountability for the delivery of community based care. The proposed arrangements, detailed at annex B, illustrate the strong relationship between three key elements which are necessary for the successful delivery of community base care: collective decision making and oversight; accountability for the public value; and accountability for quality and for delivery with the right capacity and resources.

4.8 The proposed direction of travel has been agreed by the Health and Wellbeing Board and aligns with the expectations set out in the NHS Five Year Forward View which called for better integration across the health and care system and for an acceleration of local integration and partnership arrangements. The need to bring organisations more closely together and address the fragmentation and duplication across the system is further reiterated in the STP for South East London.

5. BCF 2017-19 Plan

5.1 During 2016/17, the BCF supported the development of Neighbourhood Care Networks and the delivery of Community Based Care, the development of Prevention and Early Action tools, support and opportunities, and the redesign of services to deliver Enhanced Care and Support.

5.2 The 2017-19 BCF plan is an evolution of the 2016/17 Plan and continues to fund activity in the following areas:

- Prevention and Early Intervention
- Community Based Care and the development of Neighbourhood Care Networks and Neighbourhood Community Teams
- Enhanced Care and Support.
- Estates and IMT

5.3 Prevention

5.3.1 We aim to embed prevention in all our services to promote health and wellbeing (primary prevention) and to prevent the need for treatment and care (secondary prevention), that is evidence based and based on best practice, cost effective and sustainable.

5.3.2 The 2017-19 BCF will continue to support the improved provision of information. Digital is becoming more important and relevant as people are increasingly going online for information. This trend suggests that using online sources will become the primary way for the public to access information about care and support in the future. We plan to:

- Extend the reach of the existing health and social care website to offer bespoke information to support self-navigation, provide personalised information and offer a good user experience.
- Develop a fully integrated marketplace or platform with transactional capabilities so that people are able to autonomously identify and purchase their own care package, access information and guidance, buy care services, access self-help tools and apps.
- Develop the Single Point of Access to expand its scope to act as a communication link into community based care.

5.3.3 The 2017-19 BCF will continue to support people to live in their own homes safely and independently. We plan to

- Continue the community development approach through Community Connections by assisting community organisations to develop their capacity, build community based resources and promote partnership working.
- Fully establish the community falls team to provide an integrated pathway to reduce the incidence of falls and falls related injuries, establish a physical activity programme for people who have fallen or who are at risk of falls and provide proactive outreach into the community, primary care and care homes.

5.3.4 The 2017-19 Better Care Fund will continue to support people with long term conditions:

- The Co-ordinated Care Service in 2017/18 has been contracted through the borough-wide GP Federation. This is in line with the Primary Care Strategy 2016-21 and commissioning services at scale on a population basis. Amendments to the service specification for 2017/18 include the establishment of a central call/recall function, supporting referrals to the diabetes prevention programme and the addition of a COPD clinical outcome measure.
- A formal review of the tailored approach to self-management education activities for people with long term conditions pilot and the development of a full sustainability plan to commission at scale in 2018/19.

5.4 Community Based Care and the development of Neighbourhood Care Networks and Neighbourhood Community Teams

5.4.1 In 2017-19, LHCP will continue to work with other key stakeholders in Lewisham to develop and deliver high quality community based care, supported by effective neighbourhood care networks.

5.4.2 As part of the direction of travel towards an ACS, at the end of 2016/17 LHCP began exploring new governance and partnership arrangements for the development and delivery of community based care which would provide the necessary mechanisms for partners to have the authority to take joint decisions and be held accountable for the delivery of sustainable, high quality and outcome based population health and care in Lewisham.

5.4.3 Over 2017-19 LHCP will seek formal approval of the proposed arrangements from the sovereign organisations and work towards the establishment of the agreed new governance and partnership arrangements for the delivery of community based care.

5.4.4 In 2017-19 we also want to further develop the NCTs to provide high quality, proactive, cost effective person centred care and support when it is needed. Four virtual NCTs comprising social care staff (social workers and occupational therapists) and district nursing staff, working with GPs have been established and have been operating since 2015.

5.4.5 Our ambition is to develop our Neighbourhood Community Teams to:

- Better co-ordinate care and support across organisations and services
- Offer better value for the Lewisham pound
- Recognise and draw on an individual's assets
- Provide holistic, person centred care and support
- Improve the person's experience of care and support

5.4.6 Over 2017-19 we will:

- Develop a joint assessment and care planning process for those people with both nursing and social care needs. A 12 week PDSA pilot commenced in May 2017 to test a joint assessment process for patients / service users with both nursing and social care needs involving professionals operating as trusted assessors.

- N4 NCT has developed an action plan to support staff to operate more effectively as a team. The team has committed to a range of activities such as joint meetings to build a stronger team culture. This work will be replicated in the other neighbourhoods.
- Co-locate NCTs in their respective neighbourhoods
- Strengthen multi-disciplinary working with mental health by aligning mental health services more clearly to the NCTs and develop shared systems with mental health services to better support residents with complex health and care needs.
- Develop new roles to provide a holistic, person centred approach to care and support.

5.4.7 The Neighbourhood co-ordinator role will be reviewed to explore how the role can build on achievements to date and develop to meet the needs of the developing NCTs. There is potential for some tasks currently undertaken by health and care professionals to be undertaken by Co-ordinators which would realise some efficiencies.

5.4.8 Lewisham's devolution pilot offers a significant opportunity to accelerate specific elements of our overall transformation plan and contribute to the delivery of our vision. Informed by a visit to the Netherlands to learn more about the 'Buurtzorg' model, workforce development is one of the two key strands of activity within the Devolution Pilot.

5.4.9 Our intention, as set out in the Devolution Pilot Outline Business Case, is to establish combined health and care roles. Initially this will focus on combining and flexing the roles of those health and care professionals who visit and support people in their own homes. Building on the achievements to date within the existing neighbourhood community teams, we aim to develop a more flexible workforce with new roles that focus on outcomes and bridge organisational differences.

5.4.10 We are aware that Buurtzorg expects its nurses to deliver the full range of medical and support services to clients. If something similar could be adopted we would expect, as in Buurtzorg, high patient and employee satisfaction and the provision of high-quality care delivered at home potentially at lower cost. In conjunction with mobile working, good IT infrastructure, a local base and maximum use of the neighbourhood care networks; this approach is expected to release efficiencies.

5.4.11 The BCF will continue to fund the community health services supporting the management of people with more complex health and social care needs out of hospital that were funded in 2016/17. Plans to develop these services in 2017/18 include:

- To develop and facilitate a model of multi-disciplinary working between the Care Home Intervention Team, GPs, care homes and adult social care. This work follows on from a short single-site pilot completed in 2016/17. The pilot demonstrated that care plans better meet the patients' needs and a significant reduction in antipsychotic medication prescribing. It is further anticipated that through the multi-disciplinary working approach breakdown of care placements and emergency admissions to hospital can be prevented.

- Closer working relationships will be developed between the Home Treatment Team and the Mental Health Older Adult Social Work Team to enable patients to be discharged through an early supported discharge approach whereby patients can continue their treatment in their own homes.
- Linked to the Enhanced Care and Support Programme a small "Enhanced Care Team" will be developed as part of the Enablement Service. The new team will support the Rapid Response and Emergency Department Discharge Teams with admission avoidance. The small team will be able to respond within 2 hours to support people in their homes with care and support for up to 5 days whilst under clinical supervision. The team will be resourced to support 10 people at any one time whilst on-going assessments are undertaken. This will support more people at home who will not have to be admitted into an acute environment and aid recovery in a more appropriate setting.

5.4.12 In 2017/18 the BCF will also fund a 12 month pilot of enhanced community support for the full pre and post dementia diagnosis pathway. This will include:

- Clinical nurse specialists working in the community to offer pre- and post-diagnostic support to enable the provision of more in-depth clinical care co-ordination including advance care planning and end-of-life support. This will support patients and their carers to prevent crisis and enable them to live independently for as long as possible.
- Additional specialist social work capacity to ensure timely access to adult social care as well as case management duties.
- Temporary access to time-limited respite and night-time homecare options as and when needed to facilitate early supported discharge and avoid admissions. Patients with an underlying diagnosis of dementia in Lewisham remain in hospital for 12.1 days on average longer than patients without an underlying diagnosis of dementia. To facilitate an early discharge it is anticipated that patients will likely require approximately 10 days of 24h care to allow them to recover and settle back in their own home.
- Befrienders will support service users that currently have no support network to prevent social isolation of house-bound service users.
- An online training module for primary care practitioners.

5.5 Enhanced Care and Support

5.5.1 Our aim is to commission enhanced care and support across the system which is co-ordinated, consistent and clear for people with urgent or elevated care needs.

5.5.2 Simplifying urgent and emergency care, providing accessible alternatives and supporting people appropriately when they have to access A&E is one of the high impact areas of the SEL STP.

5.5.3 As explained above in paragraphs 3.4.1-3.4.6 the Emergency Department Discharge Team and Community Discharge and Support Team have been remodelled and delivery of projected outcomes is expected from April 2017. These services will begin as Plan Do Study Act (PDSA) pilots which will allow the services to be developed, tested and changed based on what does and doesn't work over an 18 month period.

5.5.4 A Discharge to Assess PDSA was launched in March 2017 to speed up hospital discharge times at Lewisham Hospital and improve outcomes for older people. The pilot has been developed in partnership between Lewisham CCG, Lewisham and Greenwich NHS Trust and Lewisham Council and ran initially for 14 weeks, 8am-6pm over 7 days per week. The Discharge to Assess team consists of LGT therapy staff, LBL enablement staff and a discharge co-ordinator. A review has been completed; initial findings from the pilot indicate changes in the model are required to enable the anticipated numbers of patients to be achieved. The plan is to extend the PDSA to include more complex patients on the D2A pathway and to include simple out of borough discharges.

5.5.5 The Integrated Primary and Urgent Care (IPUC) Model will replace existing access to A&E for all walk in attendances, provide extended hours access to primary care and deliver rapid clinical assessment and appropriate redirection of patients. Components of the model have already commenced including the delivery of the seven days per week, 8am till 8pm, GP access and the GP Streaming Pilot. The focus of 2017-19 is to improve and integrate urgent care technology bringing together out-of-hour numbers, clinical hubs and integrate Urgent Care (formally NHS 111) services to provide better access and information to patients. This will reduce the number of patients attending A&E for non-urgent conditions.

5.5.6 The BCF 2017-19 will continue to fund Social Care staff to be available 7 days a week, 8am-8pm in the Emergency Department at Lewisham Hospital and in the Enablement Services in the Community.

5.5.7 The BCF 2017-19 will continue to fund the redesigned Continuing Healthcare (CHC) pathway. The focus of 2017 will be to embed the new team, information systems and sustain the activity levels that have been established in 2016/17.

5.6 **Enablers**

5.6.1 Knowledge is a key driver in delivering exceptional health and care services. Over 2017-19 LHCP will build on what has been achieved through the Connect Care Programme to develop a full population health management system. This will include:

- A population health data repository with feeds from social care, primary care, mental health, community and acute data sources
- Create a common health and social care record for people in Lewisham.
- Support common care pathways and risk stratification to deliver common programmes of health and social care and directed prevention programmes, including the development of five disease registries for long term conditions
- Capability and analytical tools to utilise ‘big data’ from the repository to support health and social care planning, service delivery and research.
- Individual access to their own records via a web portal and mobile devices.

5.6.2 Across the borough, LHCP are aiming to create neighbourhood hub premises to support the delivery of community care. These hubs will provide fit-for-purpose, flexible, adaptable and accessible premises for the delivery of health and care and, by bringing services together, support networking across the system. This includes

clarifying the services for children and young people to be delivered from the hubs and ensuring clear links with the children's centre and health visiting neighbourhood model.

6. Overview of Funding Contributions

6.1 Overview

6.1.1 In 2016/17 the financial contribution to the BCF from the CCG was £20.164m this has been increased in 2017/18 to £20.525m and in 2018/19 to £20.915m in accordance with the published CCG allocations, and was subsequently agreed by the CCG Governing Body when approving the CCG budget. The financial contribution from the Council in 2016/17 was £1.781m, this has been increased in 2017/18 to £1.882m and in 2018/19 to £1.996m. The IBCF grant to Lewisham Council has been pooled into the BCF and totals £7.595m in 2017/18 and £10.470m in 2018/19. The total BCF pooled budget for 2017/18 is £30.002m and for £33,381m in 2018/19.

6.1.2 The financial contributions to the BCF have been agreed by the CCG and Council and agreed through the CCG's and Council's formal budget setting processes.

6.2 Disabled Facilities Grant

6.2.1 The Lewisham Council contribution to the BCF includes DFG allocation of £1.147m in 2017/18 and £1.241m in 2018/19.

6.2.2 Disabled facilities grants assist owners and tenants of the property to help fund disabled adaptations in and around their home to improve their access and retain independence. An Occupational Therapist is consulted on the works needed to meet the needs of the disabled resident and the type of works covered by this grant are:

- To facilitate access to the dwelling
- To make the dwelling safe
- To facilitate access to a family room, bedroom or bathroom/toilet
- To provide or improve any heating system
- To provide access to controls to provide heating, lighting, power or amenities
- To facilitate access around the dwelling to enable care of a resident
- To enable access to a garden

6.2.3 Grants are means tested, with the exception of disabled children cases, and cover the cost of eligible work up to a maximum of £30,000.

6.2.4 During 2016-17, 72 households received disabled facilities grant funding. The service recently undertook a telephone survey of 40 DFG clients. Of these, 95% were either 'very satisfied' or 'satisfied' with the overall service.

6.3 Care Act 2014

6.3.1 Funding of £250k in 2017/18 and £250k in 2018/19 has been allocated to support the implementation of the Care Act 2014. Funding has been invested in our local Carer Centre, to provide first-line information, advice and appropriate support to carers. Their work involves engagement with professionals in a range of settings to support improved identification, signposting and front-line staff awareness. Through this engagement the organisation has engaged with over 500 new carers in 2016/17.

6.4 Reablement

6.4.1 Funding of £4.844m in 2017/18 and £4.960m in 2018/19 has been allocated to support the enablement service. The service provides short term targeted intervention to support people following a hospital admission or to prevent an admission by providing an individual plan to promote recovery and independence. Increased staffing levels have resulted in service users being discharged from hospital over the weekend and bank holidays. The service is actively involved in the Discharge to Assess pilot.

6.5 Carers' Breaks

6.5.1 Funding of £564k and £489k has been allocated so that carers can have a break.

6.5.2 Statutory assessments are undertaken by the neighbourhood community teams to identify any support needs or replacement care that is required to provide breaks for the carers. Residential and non-residential breaks for over 100 carers are provided at any one time. Maintaining caring arrangements through the provision of breaks is a key part of our work to maintain service users living in their own homes.

6.6 Improved Better Care Fund Grant

6.6.1 The IBCF grant to Lewisham Council has been pooled into the BCF and totals £7.595m in 2017/18 and £10.470m in 2018/19.

6.6.2 The IBCF funding has been allocated across the purposes outlined in the grant conditions and in particular to areas where there are on-going budget pressures and where investment could be made to pump-prime early intervention activity upstream to reduce on-going spend in the longer term.

6.6.3 Plans for use of the IBCF funding have been locally agreed and the plans for the spend against the purposes outlined in the grant conditions is available at annex C.

7. NC1: Signed off by the HWB and other CCG/LA committees

7.1 Activity supported through the BCF has been developed jointly by commissioners and providers. The BCF Plan 2017-19 has been shared with Lewisham Health and Care Partners who are listed in paragraph 1.1.

7.2 In agreeing the priorities and activity within the BCF plan, specifically that aligned with the A&E Plan, Lewisham and Greenwich NHS Trust has supported the activity aimed at reducing average length of stays, reducing the number of admissions to ED and reducing the number of non-elective admissions to maximise the utilisation of acute beds for the most acutely ill people. These changes have been agreed as part of the 2017/18 contracts. Similarly, the local authority supports the activity within the plan to maintain people at home, thus reducing the number of admissions to residential and nursing homes, and the activity funded through BCF such as falls support, enablement and equipment which aims to reduce the costs of on-going long term support.

7.3 The BCF Plan 2017-19 was signed off by the Health and Wellbeing Board on 6 September 2017.

8. NC2: Maintaining the Provision of Social Care Services

8.1 In line with the Policy Framework the NHS contribution to adult social care has been maintained in line with inflation. In 2017/18 £8.519m and in 2018/19 £8.684m has been allocated to ensure adult social care continues to be protected. The BCF will be used to maintain and, where appropriate, enhance adult social care's contribution to the achievement of the integrated programme's priority objectives and, in particular, the contribution it makes to the BCF metrics on non-elective admissions, DToC and admissions to residential homes. The table below shows those schemes which are to be funded from the CCG minimum contribution as compared with planned expenditure in 2016/17.

	2016-17 **£000**	**2017-18** **£000**	**2018-19** **£000**
Single Point of Access	512	517	531
Neighbourhood Community Teams	2631	2912	2988
Joint Packages	250	0	0
Sail Connections	250	303	309
Integrated Management Posts	97	0	0
Enablement Services (LA)	3056	3087	3170
Extra Care Provision	525	534	545
Social Care Delivery	101	352	403
Hospital Discharge Provision	110	0	0
Care Act Implementation	800	250	250
Carers Breaks	0	564	489

	8332	**8519**	**8684**

8.2 The BCF in 2017-19 will continue to support the adult social care resource within the Neighbourhood Community Teams, Enablement Teams and the adult social care element of the Discharge to Assess Pilot, Emergency Department Discharge Team, Community Discharge and Support Team and Rapid Response Team. By maintaining the provision of social care in these and other areas, social care is able to continue to contribute to the overall achievement of the programme aims and to the national BCF conditions.

8.3 In terms of eligibility, Lewisham continues to meet the eligibility criteria as set out in the Care Act 2014.

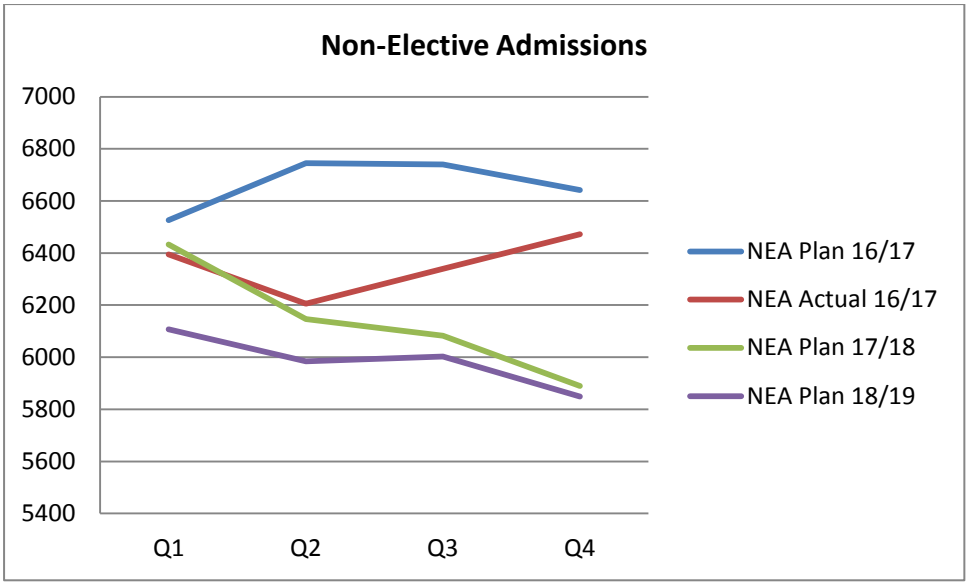
9. National Condition 3: NHS Commissioning out-of Hospital Services

9.1 The BCF Plan 2017/18 commits £10.128m and in 2018/19 £10.490m to NHS commissioned out-of-hospital services.

9.2 Through the BCF, investment will be made in the following NHS Commissioned out-of hospital services. These include

- Primary Care
- Community Based Falls Team
- Community Mental Health Services including enhanced community support for the dementia pathway, Home Treatment Team and Care Home Intervention Team
- Rapid Response Team
- Enablement Services

9.3 No additional target has been set for non-elective admissions. The target for 2017/18 is already stretching requiring a reduction of 2.4% (605 fewer non-elective admissions) from the 2016/17 actuals. As outlined in section 12 a contingency fund has been established to mitigate the financial risk associated with emergency activity above plan.



10. National Condition 4: Managing Transfers of Care

10.1 All partners are committed to reducing delayed transfers of care (DToC) for Lewisham residents. The system approach to reducing DToC in 2016/17 resulted in a continued decline in the number of days patients were delayed in hospital from Q2 onwards. To sustain and further improve patient flow and processes for discharge LHCP are working together to implement the High Impact Change Model for managing transfers of care. Lewisham's joint self-assessment and action plan for managing transfers of care is at annex D. The main areas of development for 2017-19 include:

- **Early Discharge Planning:** In emergency care robust systems are in place which allow an expected date of discharge to be set within 48 hours. A Discharge to Assess PDSA, developed in partnership between Lewisham CCG, Lewisham and Greenwich NHS Trust and Lewisham Council, was launched in March 2017. The evaluation of the pilot will be completed by the end of June 2017 and will inform longer term modelling.
- **Systems to Monitor Patient Flow:** An Associate Director for Patient Pathways has been appointed to monitor complex patient ready for discharge and assessment lists. A review of Community Beds across Bexley, Greenwich and Lewisham has been commissioned and is due to be completed by July 2017.
- **Multi-disciplinary Teams:** Bi-weekly diamond multi-disciplinary team meetings are in place. The redesigned Continuing Healthcare pathway brings together health and social care resources for continuing health care assessments and reviews, to create a single Continuing Health Care team. The discharge to assess team consists of health and social care professionals.
- **Home First:** A Community Assessment and Therapy Team is in place and will be reviewed as part of the discharge to assess pilot evaluation.
- **Seven-Day Service:** Acute, community, primary care, and social care staff work 7 days week. Assessments are carried out and care restarted at weekends.
- **Trusted Assessors:** A Trusted Assessor Model is being scoped across South East London.

- **Focus on Choice:** A robust patient choice policy is place. The Advocacy Pilot will be evaluated and reviewed by the end of July 2017.
- **Enhancing Health in Care Homes:** Contracts are in place offering GP enhanced support to nursing and residential homes. A review will be undertaken in 2017/18 regarding the need to commission additional community nurse, podiatry and tissue viability services for care homes. The Care Home Support Team, a specialist mental health older adult team, supports residential and nursing homes in managing people with dementia.

10.2 Funding for the agreed actions has been agreed through the BCF and IBCF.

11. Maintaining Progress Against Former National Conditions

11.1 The whole system approach to planning for 7 day services continues to be developed by Lewisham Health and Care Partners and is aligned with the work taking place across South East London. Support services in the hospital, primary, community and mental health settings are available seven days a week including:

- Social care staff form part of admission avoidance and discharge services operating 7 days per week to prevent admissions and ensure the timely discharge for patients.
- The Crisis Resolution Home Treatment Team provides a rapid response and assessment for mental health crisis 7 days a week.
- GP and nurse appointments are available 8am-8pm, 7 days a week, including bank holidays through the GP Extended Access Service.
- From 2017/18 the Emergency Discharge Team and Supported Discharge Service started operating from 8am-8pm 7 days per week with increased therapy staffing levels.

11.2 The BCF in 2017/18 will continue to support the roll out of Connect Care to achieve better data sharing for direct care. Furthermore the LHCP are pursuing the development of a population health management system to support the transformation to population based delivery of health and social care in conjunction with local people.

11.3 Joint assessments and care plans are being developed in the Neighbourhood Community Teams. Multi-disciplinary meetings ensure the engagement in care plans of primary care, mental health, social care and the voluntary and community sector. The aim remains for joint assessments and care plans to be fully integrated to address physical and mental health and social care needs. Two 12 week PDSA pilots are being undertaken to test a joint assessment process for patients / service users with both nursing and social care needs involving professionals operating as trusted assessors. An evaluation report is expected in October 2017 with recommendations for wider implementation.

12. National Metrics 2017-19

12.1 The BCF schemes have been aligned to the national performance metrics as shown in Annex E.

12.2 The non-elective admission planning figures for 2017/18 are based on a planning assumption of 1.7% unmitigated growth. Through the schemes identified in the BCF plan and wider WSMC Programme schemes these figures have been mitigated to around 2.4% reduction which reflects the NHS Lewisham CCG Operating Plan.

12.3 An assessment of the impact of the schemes funded by the BCF on the non-elective activity has been undertaken and the activity shifts included in the contract plan with Lewisham and Greenwich NHS Trust.

BCF Scheme	**NEL Activity – Emergency Admissions and A&E Attendances**
Community Falls Team	83
Rapid Response Team	1,657
Primary Care Co-ordinated Care Service	310
Emergency Department Discharge Team	1,082
Primary Care Streaming	1,453

12.4 Lewisham achieved its targeted reduction in emergency admissions in 2016/17. In 2016/17 the financial risk to the CCG was mitigated by a block contract for emergency admissions for the first 2 quarters. The increase in financial risk from the cost and volume contract agreed with the CCG's main provider in 2017-19 is recognised by the increase in the contingency fund in 2017/18 to 2.8% of the total Better Care Fund.

12.5 The BCF plan includes a contingency of £632k in 2017/18 and £300k in 2018/19 which will be utilised if necessary to mitigate the financial risk associated with emergency activity above plan and to apply the principle that the CCG does not pay twice for the same services. The S75 Partnership Board will make decisions on releasing the contingency fund on a quarterly basis, to either cover the costs of additional non-elective activity or to fund additional out-of-hospital services if the target is met.

12.6 In setting the plan in relation to admissions to residential and care homes, consideration was given to the increasing demand that is being experienced for dementia placements which require complex support and the challenges faced in providing support for some users in the community. Our plan of 197 admissions in 2017/18 and 158 admissions in 2018/19 is based upon maintaining the previous performance in 2016/17 before reducing it further in 2018/19. This takes account

of demographic growth, the growing acuity and age of people needing long term care and our work with Extra Care providers to explore more complex packages of care at home.

12.7 Our plan for enablement is to maintain the excellent performance achieved in recent years. The plan for 2017/18 and 2018/19 is to keep 90% of people age 65 and over at home 91 days after discharge from hospital. This remains a challenging target given the complex needs of patients upon discharge from hospital.

12.8 In setting the plan for DToC, consideration was given to improved performance over the course of 2016/17, partly a result of the impact of BCF initiatives, and our plan for implementing the high impact change model for managing transfers of care . The plan set meets the Government expectations for reducing DToCs published on 3 July 2017.

12.9 The Lewisham, Bexley and Greenwich A&E Delivery Board has agreed a 30-60-90 day plan, which is currently being refreshed ahead of winter 2017/18 (annex F). A number of the BCF initiatives including discharge to assess, effective GP Streaming at the Emergency Department front door and the establishment of a multi-agency discharge team support the ambition set out in the A&E Improvement Plan and are also aligned to the High Impact Changes.

13. Programme Governance

13.1 The BCF arrangements are underpinned by pooled funding arrangements with a section 75 agreement.

13.2 The Health and Wellbeing Board monitors the progress of the Better Care Fund. The latest report progress report was received by the Health and Wellbeing Board in July 2017.

13.3 To ensure that progress is more regularly assessed the BCF S75 Partnership Board, comprising of senior representatives from Lewisham CCG and the London Borough of Lewisham, meets monthly to maintain a detailed overview of the BCF Plan, financial targets and performance. The terms of reference for the BCF S75 Partnership Board are attached.

Terms of Reference
Section 75 Agreemen

13.4 The BCF S75 Partnership Board receives monthly finance reports showing expected spend against budget. Overspends require approval and are identified in advance via the finance reports. Performance of the BCF schemes is reported on a quarterly basis via performance reports. The BCF schemes have been aligned to the BCF objectives and national metrics and performance indicators for each scheme identified. The performance report includes an overview of each scheme, performance against the national indicators and scheme indicators to ensure the S75 Partnership Board has oversight and can assess performance of

the BCF throughout the year. Where underperformance is identified the S75 Partnership Board requests an exception report which analyses the root cause and proposes remedial actions.

13.5 The Lewisham Health and Wellbeing Strategy sets out the key priorities to bring about significant population level improvements and reduce health inequalities. The Strategy aims to accelerate the integration of care, to prevent ill health, promote independence and to support healthy and resilient communities in order to improve and maintain health and wellbeing and reduce inequalities.

13.6 Addressing the wider determinants of health is key to reducing health inequalities. Wider determinants of health include housing and social relationships. In addition to the DFG the BCF has funded the Warm Homes Healthy People project and a Community Falls Team to support people to live safely and independently in their own homes. The BCF has also been utilised to support Lewisham's well-established voluntary and community sector to improve health and strengthen resilience. Using a community development approach Community Connections assists community organisations to develop their capacity, build community based resources and promote partnership working. In addition each scheme or service funded by the BCF has regard to the need to reduce inequalities in access to care and outcomes of care. For example the enhanced dementia service will specifically target awareness raising and case finding exercises to improve diagnosis rates in currently underrepresented BME groups, service users with language barriers will have access to all services with the support of an interpreter and an escorting service will be available to all service users along with a befriending service to prevent social isolation of house-bound service users.

14. Risk Management

14.1 Agreed financial risk management arrangements are set out in schedule 3 of the S75 BCF agreement. This provides for financial risks arising within the commissioning of services from the pooled funds. The overarching principles governing these arrangements will remain in place for 2017-19 and the S75 Agreement updated once the BCF plan is agreed.

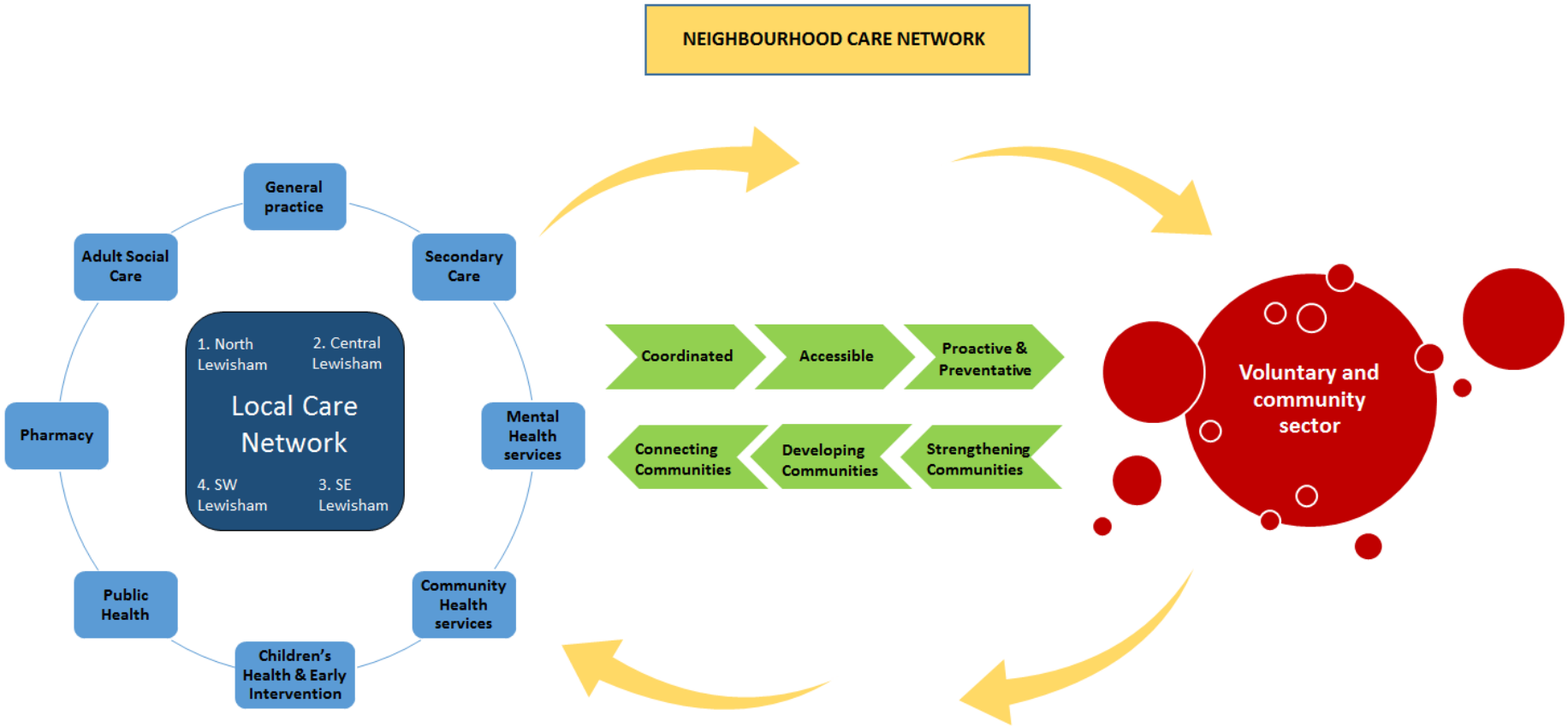
14.2 A contingency fund of £632k in 2017/18 and £300k in 2018/19 has been earmarked within the expenditure plan, which will be utilised if necessary to mitigate the financial risk associated with emergency activity above plan. In addition a contingency fund of £300k in 2018/19 has been allocated from the IBCF to support adult social care activity within the High Impact Change Model. The use of the contingency fund will be governed by the S75 Partnership Board in accordance with schedule 3 of the BCF Section S75 Agreement.

April 2016 BCF S75 - Signed.pdf

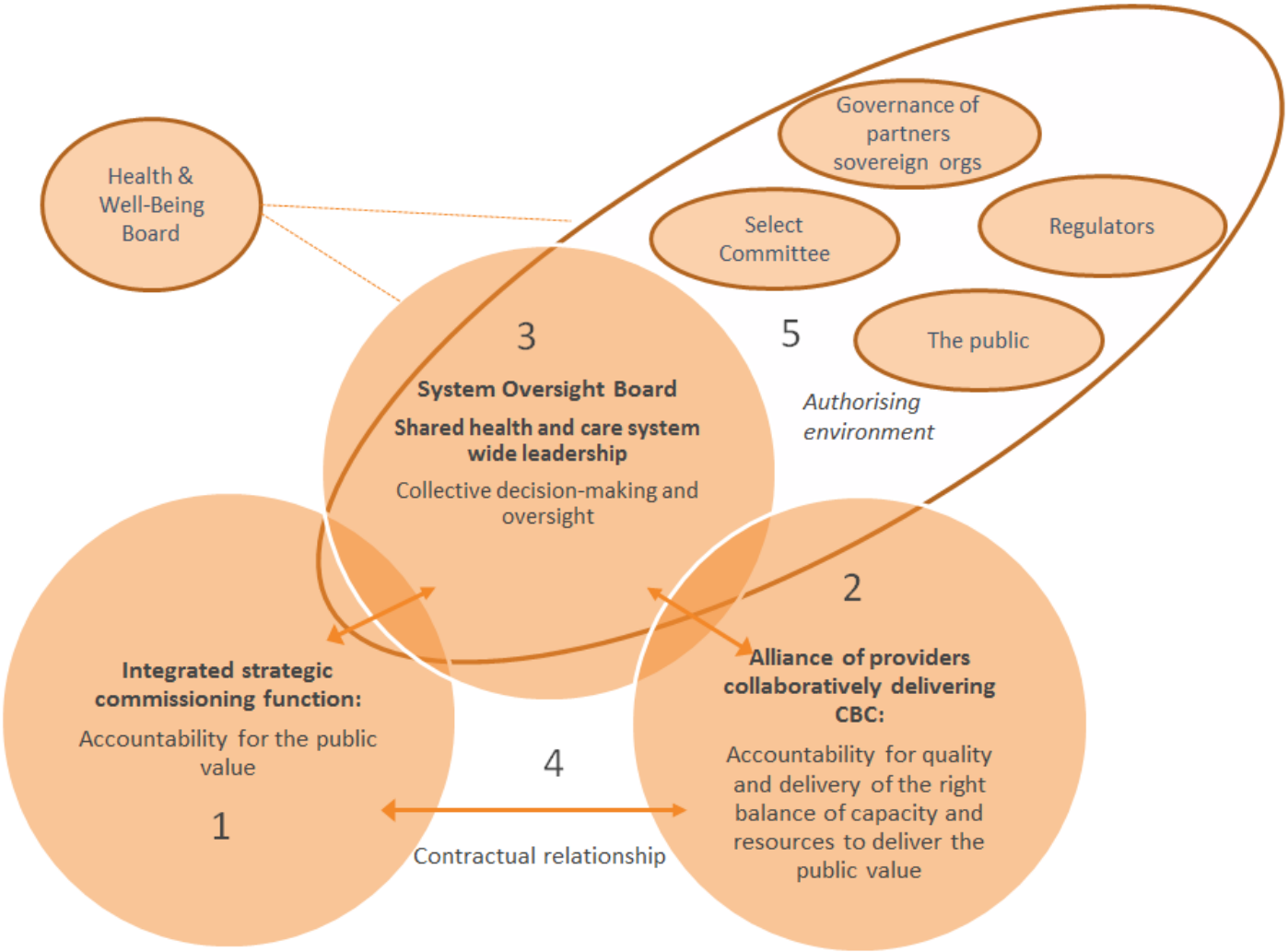
14.3 The BCF risk register sets out the main risks to delivery of the BCF plan included below.

BCF Risk Register 17_18 1.3..xlsx

Annex A


NEIGHBOURHOOD CARE NETWORK
General practice
Secondary Care
Mental Health services
Community Health services
Children's Health & Early Intervention
Public Health
Pharmacy
Adult Social Care
1. North Lewisham
2. Central Lewisham
Local Care Network
4. SW Lewisham
3. SE Lewisham
Coordinated
Accessible
Proactive & Preventative
Connecting Communities
Developing Communities
Strengthening Communities
Voluntary and community sector

Annex B


Health & Well-Being Board
Governance of partners sovereign orgs
Select Committee
Regulators
The public
5
Authorising environment
3
System Oversight Board
Shared health and care system wide leadership
Collective decision-making and oversight
2
Alliance of providers collaboratively delivering CBC:
Accountability for quality and delivery of the right balance of capacity and resources to deliver the public value
Integrated strategic commissioning function:
Accountability for the public value
1
4
Contractual relationship

Annex C

Area of Spend	Plan	Planned Spend 2017/18 £	Planned Spend 2018/19 £
1. Meeting Adult Social Care needs			
Mental Health	Action 1: To sustain placements at the current level. Pressures exist in the mental health placement budget. This is because a significant number of patients have a high level of needs at the time of placement. Action 2. Working with SLaM (South London and Maudsley Trust) to invest and develop quicker step down into community support services to reduce in the future the number of long term Mental Health placements.	500k	500k
Learning Disabilities	Action 3. To work with Supported Living suppliers to increase the number of available units for younger adults, and provide services that will support day activities and breaks. Action 4. To develop the Adult Home Finding service, including recruiting carers who will provide both long term support and respite breaks.	160k	160k

Transitions	Action 5. To support the year on year increase and on-going budget pressures. The year on year increase in the numbers of complex young adults transferring to Adult Social Care, along with the Education Act changes that now allows Children with a Special Educational need to access education and support until the age of 25, has created an on-going budget pressure. Action 6. To recruit a new transitions team to manage all 14-25 year olds who have complex health and education need. The service will work with the young person and their carers to develop life plans for Education, Health and Adulthood. This will ensure that young adults are supported to maintain their independence and wellbeing, remain living in their own homes and to study locally within the Lewisham area.	1.45m	2.2m
Packages of Care and Supported Accommodation Care costs	Action 7. To protect the current level of spend on packages of care in the community to reduce the need for residential care.	1.68m	1.68m
2. Reducing pressures on the NHS, including activity to address "delayed transfers of care"			

High Impact Changes • **Home first/discharge to assess** • **Seven-day services** • **Trusted assessors** • **Focus on choice**	Action 8. To increase funding in D2A so that more complex people can be taken home with enhanced levels of support, thus reducing DTOC and length of stays. Action 9. To develop a trusted assessor model with Care Home providers so that assessments and discharges are able to take place at weekend and bank holidays	1m	1.4m
Contingency (High Impact Changes)	Contingency to support Adult Social Care activity within the High Impact Change Model.		300k
3. Ensuring that the local social care provider market is supported			
Home Care and Care Home Providers	Action 10. To maintain levels of funding to the home care sector and offset the Council's savings requirements in this area. Action 9: To develop, with Home Care Providers, the trusted assessor model and night support and to implement the provision of new packages of care at weekends and bank holidays. This will further improve adult social care services and impact positively on hospital discharges and enablement care.	2.805m	4.230m

Annex C

Annex D

Impact Change	Where are you	What do you need to do	When will it be done by	How will you know it is successful
Early Discharge Planning	Lewisham & Greenwich Trust (LGT) are setting discharge dates within 48 hours.			
	The pilot Discharge to Assess model (D2A) allows for early identification of patients through an MDT (Multi-Disciplinary Team approach) who may be suitable for discharge through D2A; the model should improve patient outcomes and patient flow.	Evaluate impact and plan to evolve or sustain the D2A model.	The PDSA pilot will be completed at the end of June 2017, and the outcomes evaluated providing recommendations for longer term modelling.	Achievement of discharge numbers against the trajectory and / or meeting the estimated financial outcomes. Potentially with evolvement of the model to support the discharge of more complex patients.
Systems to Monitor Patient Flow	Associate Director for Patient Pathways appointed to monitor complex patient ready for discharge (RFD) and assessment lists and support discharge of complex patients; also reviewing patient discharge pathways.	Further develop and simplify pathways within integrated models of care.	There is on-going review of the complex patient (RFD) list, other pathways are due to be reviewed and evaluated during the next 6 months. The standard operating procedure for Lewisham community beds on Sapphire ward has been implemented.	The RFD is (in the main), and will continue to be sustained at 14 patients or less for Lewisham CCG**.**
	Standard Operating Procedure for Lewisham CCG community beds.	Demand and Capacity Review of Community Beds (bedded and non-bedded) for across the Bexley, Greenwich and Lewisham Systems commissioned by the 3 respective CCGs.	The standard operating procedure for Lewisham community beds on Sapphire ward has been implemented. Demand and capacity review will be completed by July 2017 and reports into the BGL A&E Delivery Board.	The standard operating procedure will support the maintenance of the RFD list. The outcomes will support future planning of community capacity to meet the needs of the population.

Annex D

	Senior Borough Managers have daily overview of all patients on RFD and Assessment Lists; this is monitored closely to ensure blockages are resolved.	On-going work with local care providers to support timely discharges.		
Multi-Disciplinary Teams	Bi-weekly Diamond (RFD) review meetings including all partners	Reflect on lessons learnt and apply accordingly.	Diamond meetings continue, with the terms of reference revised as needed.	Success for the RFD is measured by consistently managing the number of patients medically fit for discharge but remaining in acute beds.
	Redesigned CHC into single pathway with additional resourcing.		A review of the CHC pathway for Lewisham hospital will be completed by the end of July 2017.	The CHC team are in the second year and will continue to build on improvements already made to ensure a streamlined process.
	D2A team is a multi-agency team (health and social care professionals).		D2A staff meet daily to review patients and weekly with Lewisham CCG. These meetings will be reviewed as part of the PDSA evaluation, with additional staff such as neighbourhood social care staff attending.	The D2A model will facilitate the discharge of a minimum of 20 patients per week for the assessment of need in the community.
	A&E and Supported Discharge Teams in place providing multi-disciplinary support.			
		Neighbourhood Community Team multi-disciplinary pilot projects to be undertaken and evaluated	Evaluation due October 2017	Neighbourhood Community Teams will look to support complex discharges by in-reaching into the hospital, this will reduce delays and handovers between teams.
Home First Discharge to Assess	See D2A above.	Continue to release capacity for acute based therapists through use of D2A.	See above – D2A.	

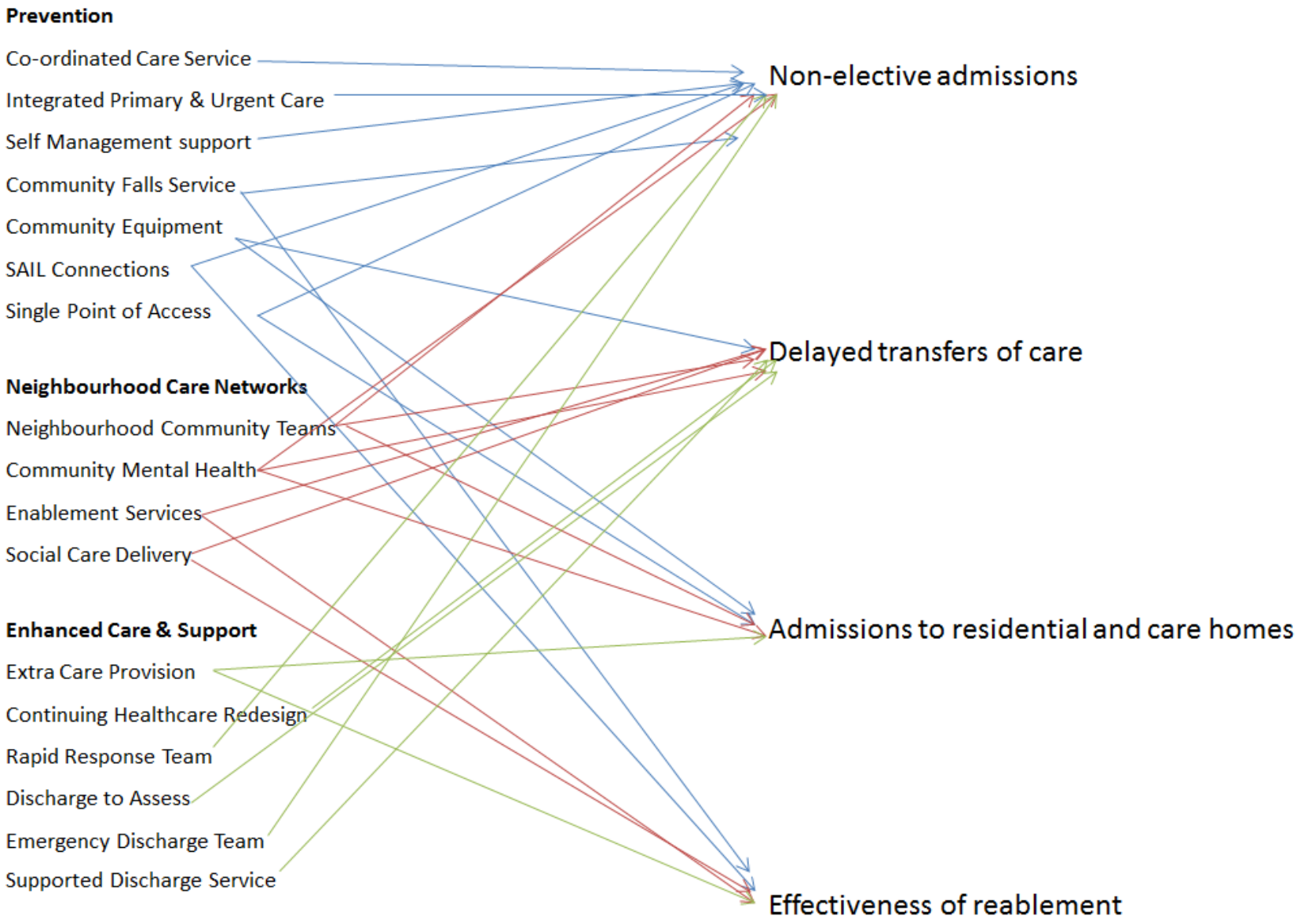
Annex D

	Community Assessment and Therapy Team formerly the Supported Discharge Team (CATT) in place.	The CATT team will be reviewed as part of the D2A project evaluation		As capacity is released for acute based therapists, they will input into patient care at an earlier stage. Patient outcomes should improve; measured through checkpoint data against KPI's.
Seven-Day Service	Rapid Response Team and a service in place for 5 days per week.	Develop single integrated service.	It is envisaged that the parallel services will be reviewed and aligned within year – 2017/18 to provide 7 days per week.	Provision of a single integrated service within year.
	GP Extended Access, Emergency Department Discharge Team, Community Discharge & Support Team and Enablement Care Services operate 7 days per week.			
Trusted Assessors	Enablement Referrals have been using a Trusted Assessor model across LGT and out of borough hospitals for over 2 years			
	The D2A model for the CCG, Lewisham & Greenwich Trust and LBL is starting to use the *trusted assessor model.*	Trusted assessor models need to be reviewed and considered across South East London (SEL). Joint commissioning managers are in discussion with care providers regarding future "Trusted Assessor" models.	There is a programme of work that has now started across SEL; trusted assessor modelling is part of this programme and scoping has commenced. Joint trusted assessor role across Lewisham, Greenwich and Bexley is being worked through with Care Home providers.	Trusted assessor models will be used in Lewisham, reducing delayed transfers of care whilst increasing capacity through reduction of duplication and streamlined ways of working.
Focus on Choice	Advocacy pilot has reduced time from referral to advocacy access and therefore has supported the	Review pilot outcomes and commission a service that	Pilot outcomes will be reviewed by end of July 2017	Service will continue to support complex RFD maintenance, with

Annex D

	reduction of the numbers of complex patients on the RFD list.	continues to support timely access to advocacy services.		input for patients under D2A where appropriate.
	Patient choice policy is in place.	Patient choice policy needs to become embedded in practice.	The policy is already in use through LGT.	Patient choice policy will be used in a business as usual manner.
Enhancing Health in Care Homes	Contracts are in place offering GP enhanced support to both nursing and residential homes.	Review in 6 months with regards to any need to commission additional Community Nurse, Podiatry and Tissue Viability services for all care homes in 2017 – 19	Within year, the potential need for further commissioning of services will have been identified and progressed should these additional services be required.	People in both nursing and residential homes will have access to services that improve their health outcomes.
	The Rapid Response Team provide support to Care Homes			
	Regular Provider Forums take place			
	The Care Home Support Team, a specialist mental health older adult team, advises and supports residential homes to manage people with dementia			

Annex E


Prevention
Co-ordinated Care Service
Integrated Primary & Urgent Care
Self Management support
Community Falls Service
Community Equipment
SAIL Connections
Single Point of Access
Neighbourhood Care Networks
Neighbourhood Community Teams
Community Mental Health
Enablement Services
Social Care Delivery
Enhanced Care & Support
Extra Care Provision
Continuing Healthcare Redesign
Rapid Response Team
Discharge to Assess
Emergency Discharge Team
Supported Discharge Service
Non-elective admissions
Delayed transfers of care
Admissions to residential and care homes
Effectiveness of reablement

Annex E

National Metric	Schemes
Non-elective admissions	Co-ordinated Care Service Integrated Primary & Urgent Care Self-management Support Community Falls Service SAIL Connection Single Point of Access Neighbourhood Community Teams Community Mental Health Rapid Response Service Emergency Discharge Team
Delayed transfers of care	Community Equipment Neighbourhood Community Teams Community Mental Health Enablement Services Social Care Delivery Discharge to Assess Pilot Supported Discharge Team
Admissions to residential and care homes	Community Equipment Single Point of Access Neighbourhood Community Teams Community Mental Health Extra Care Provision
Effectiveness of reablement	Community Falls Service SAIL Connections Enablement Services Social Care Delivery Extra Care Provision

Annex F

Our 30-60-90 day plan

Other areas to note:

- Alternate LAS Care Pathways
- Case Management of High Intensity Users
- Extended NHS 111 Provision
- Extended Primary Care Access