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	**Royal Borough of Greenwich**
Clinical Commissioning Groups	**NHS Greenwich CCG**
Boundary Differences	**n/a**
Date agreed at Health and Well-Being Board:	**29/07/2014**
Date submitted:	**29/08/2014**
Minimum required value of BCF pooled budget: 2014/15	**£7.858m**
2015/16	**£7.858m**
Total agreed value of pooled budget: 2014/15	**£7.858m**
2015/16	**£19.771m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Greenwich Clinical Commissioning Group
By	Simon Hall
Position	Deputy Chief Officer
Date	29 August 2014

Signed on behalf of the Council	Royal Borough of Greenwich
By	John Nawrockyi
Position	Director, Adults and Older People's Services
Date	29 August 2014

Signed on behalf of the Health and Wellbeing Board	Greenwich Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Denise Hyland
Date	29 August 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**
Appendix 1 Pioneer test and learn case study.	Patient experience case study, outlining how the integrated care pilot improved the experience of frail 67 year old man with a history of mental illness, cycle of falls and hospital admissions.
Appendix 2 Programme and Project Plans	GANTT charts for BCF programme plan and separate projects (schemes outlined in Annex 1)
Appendix 3 Detailed BCF Funding Sources	A table outlining funding sources and investments in detail for the BCF in 2014/15 and 2015/16
Annex 1 Scheme information	Zipped document containing overview of 14 schemes.

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

Background and context

Our vision for health and care services in Greenwich is to build on our pioneering integrated care approach that was first launched in April 2011 in a way that involves primary care as a key part of the integration journey; our integration pioneer project, known as Greenwich Coordinated Care (GCC) is based on the agreed principles for integrated care which were developed by National Voices.

Our ambition for this programme was to move away from sporadic and isolated patterns of provision and to create seven-day multi-disciplinary and multi –agency '**communities of practice**' which pro-actively deliver '**a lifetime of care'** to the Citizens of Greenwich in order to improve individual and population wide health and social care outcomes and user experience.

Our first step was to re-model community health and social care services in order to create a whole-system response to intermediate care, hospital discharge, urgent care and community rehabilitation. Since implementation, this has accrued demonstrable benefits for the borough, particularly in terms of reductions in delayed transfers of care where Greenwich is in the top quartile of performance for London, and performing better than our IMD comparator boroughs and avoidance of unplanned hospital admissions where we are performing better than our IMD comparators and the England average.

Service user experience

Feedback on patient and user experience is also increasingly positive. On visiting the Royal Borough of Greenwich in November 2013 Norman Lamb MP, Minister of State for Care and Support, met with some of our local residents whose lives had been turned around by joined up working.

Builder Tom Ducey, 46, from Plumstead, had severe weight problems for two years, suffering leg ulcers and depression. He needed a Zimmer frame to walk and couldn't manage at home. He said: "It all started to change when my sister made just one phone call. The health and social care people stepped in. They changed my life completely, giving me exercises to do, with physio and occupational therapy, and a diet plan to follow. They kept with me to make sure I would be able to look after myself.

"Before they helped me I was more than 40 stone and hadn't worked for two years. I've now lost 21 stone and feel completely different, and I'm determined to go back to my job. The whole system worked for me, after just one phone call. It's an incredible service."

Tom Ducey, 46, Plumstead

Maureen Luxford, 75, from Eltham, faced the prospect of going into residential care after heart surgery meant she had difficulties living at home. But the pioneering service changed all that, with four daily visits.

"Immediately I came out of hospital the team came in to help me get up in the morning and get dressed, bring me lunch, and come again in the evening. It's a wonderful service and nothing is too much trouble for them. They have given me so much confidence."

Maureen Luxford, 75, from Eltham

Norman Lamb MP seated right, in conversation with our local residents Tom Ducey and Maureen Luxford, while Cllr John Fahy (standing) looks on.

Mr Lamb said: "To hear these stories about people getting great care is very inspiring".

We are therefore committed to using the Better Care Fund to secure and protect our progress in developing integrated care to date as well as to stretch and extend our improvement ambition.

Widening the reach of integrated care

Our Greenwich Coordinated Care Board has plans to consolidate, develop and extend the achievements to date as our integration project moves beyond the seven-day care of vulnerable older and physically disabled people to encompass service provision for adults and older adults with complex needs across all care groups, and pushes for greater integration across a wider range of services including the third sector and local business. The Better Care Fund provides us with an opportunity to extend the Pioneer test and learn pilot across the whole borough in the forthcoming 12 – 18 months, extending the reach of the integrated teams' caseload from 200 to 1000 service users/patients.

The BCF will support a range of preventative initiatives including services that follow up from the borough's successful Health Checks Plus programme, measures to tackle social isolation and a significant increase in support to carers, which will help to build resilience for patients/service users accessing our services.

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

Vision for patient and service user outcomes

By April 2016, we expect service users involved in Greenwich Coordinated Care to feel more in control of their care, understand what services are available to them, the next steps and to have a single point of contact. They will not be expected to see multiple people/services for assessment and will not have to repeat personal information and will understand how this is shared by health and care professionals involved in their care. Patient/service user satisfaction with their experience will be measured by improvements in the "I" Statements, and clinical/wellbeing scores.

By April 2020, ie after 5 years of BCF investment, we expect that the improvements in care and outcomes listed above, will be felt by users across the health and social care economy. Investment in technology and the use of a Virtual Patient Record by all services, including care homes, will ensure that any changes noted by a single agency can be seen by all professionals and personal preferences for care and key contacts will be available to all those involved in providing health and social care support.

Our Greenwich Coordinated Care model is designed to:

- Improve people's experience (as defined by the National Voices Narrative & Making it Real framework)
- Avoid unplanned admissions
- Reduce lengths of stay in hospital and delayed transfers of care
- Avoid admissions to residential care and nursing homes
- Improve health outcomes (it is unlikely that the schemes will improve health outcomes immediately; in the short/medium term, proxy indicators will be used to monitor GCCs impact on health outcomes.

Early feedback

A Pioneer 'test and learn site' has already been established in the Eltham area, one of our four established Local Care Networks (LCNs) (geographic clusters of GP practices in Greenwich), which has the highest proportion of older people in the borough. It is 'up and running'. An example of the service patients experience is outlined at Appendix 1. A full evaluation of the test and learn is due in December 2014 but early feedback from service users and patients via a survey and interviews conducted by Healthwatch Greenwich is positive and plans are in place to establish a second "test and learn" site in Woolwich where we expect the needs profile and complexity to include a younger and more diverse client group.

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?

Over-arching commissioning intentions

Our schemes for investment from the Better Care Fund will have the following focus:

- Supporting people to keep well
- Better care for adults requiring health and social care services
- Improving the capability and capacity of our workforce and infrastructure

Our integrated teams, which already work across 7 days of the week, have already had an impact on three of the national criteria and our ambitions for extending health and social care integration to include primary care will impact on avoidable unplanned hospital admissions, delayed transfers of care and effectiveness of reablement, while ensuring a greater increase in service user and family satisfaction, choice and control.

Our ambitions for the Better Care Fund also extend into the wider prevention agenda. We recognise that in the medium to long term demand for acute and specialised health and social care services can only be reduced at a population level through more effective approaches to prevention. This will involve a major programme of organisational development across our workforce as well as a remodelling of our public health services to ensure that they are at sufficient scale and well enough linked in to the wider health and social care system to enable them to be effective.

Our intention is to coordinate resources across acute, primary, and community health services, social care and importantly to work creatively with the third sector to build a holistic 'team around the person' for individuals with complex health and social care needs.

Integrated service configuration

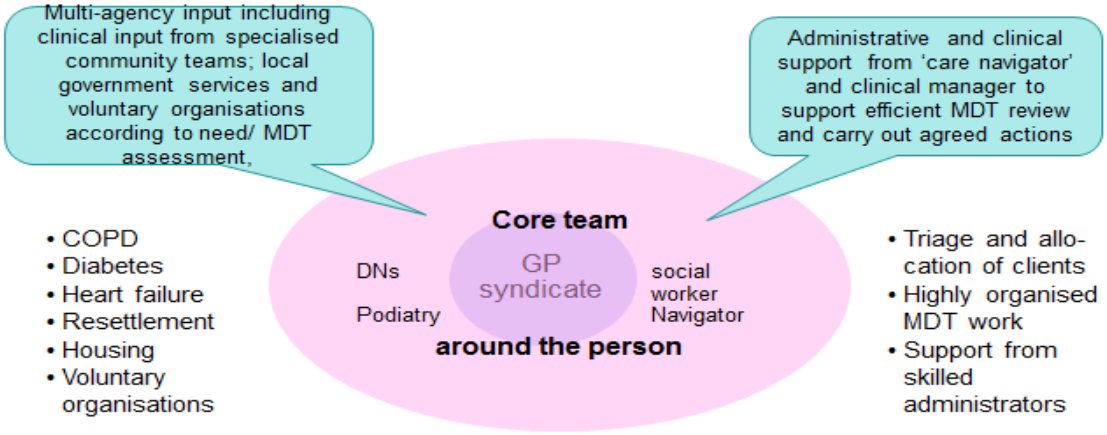
Local services will be grouped around the four Greenwich LCNs; which are viewed as 'communities of practice' with aligned health and social care services, the functions of which are:

- Complex and urgent treatment
- Utilisation of reablement and domiciliary care
- Multi-disciplinary care planning for high risk people with health and social care needs, recognising that one service can prevent admission but without a holistic focus of care coordination, may not make a difference to the individual's life
- Ensuring effective access to a range of high quality preventative, educational, and self-care services, many of which are provided by third sector organisations.

Team around the person

Each LCN will have a core team that will consist of GPs, clinical nurse team lead, district nursing, community matrons, continence, podiatry, IAPT, memory services, social care, housing, telecare/telehealth, domiciliary care, physiotherapists, occupational therapists and community psychiatric nurses (CPNs). Referrals to professionals will be via a single point of access.

What will the GCC test and learn look like?



Wider integration

In addition each core team will have:

- Named links from a range of long term conditions teams, specialist mental health services, specialist social workers, learning disability team, JET, secondary care acute services, and pharmacists in the Local Care Network (LCN). This extended LCN team will have strong bonds and shared values.
- A team/function responsible for identifying people who are high risk and reviewing their needs. Regular meetings to review the complex cohort will be coordinated by a borough-wide care navigator service. The care navigator will ensure that individuals in the risk stratified group have a named key worker from within the core or linked membership of the LCN team, to deliver a co-created care and support plan with each patient.
- Named links with local third sector organisations to facilitate their involvement in a multi-agency approach to care
- Named links to London Ambulance Service and Bexley and Greenwich Community Hospice
- Access to the medical diagnostic centre/ambulatory care at the acute trust and outreach specialist opinion.
- Access to social care staff to develop integrated personal budgets to maintain independence alongside a commitment to implement personal health budgets
- Clear pathways into Public Health public health prevention programmes, e.g. smoking cessation, exercise, healthy eating, expert patient programme, and will link healthy living services into the core team.
- The Local Authority will commission homecare services on a geographical basis to align with the span of the LCN and core teams. This will give staff within the Greenwich coordinated care system the opportunity to work closely with their local home care providers to develop person centred approaches to care.

We will know that LCNs are working effectively when the core team sees itself as responsible for the on-going prevention, treatment, care and support of their population.

Health promotion and prevention

The concept of 'discharge back to primary care' will be replaced with the expectation of the lifetime management of people's health and social care needs. This approach will encourage health promotion and prevention and help people manage their condition through self-management programmes. All LCN teams will focus on intervening early to prevent an escalation in health or social care need. This will only be achieved if LCN teams get to know their patch well, and use their local community and voluntary sector resources.

Supportive services, such as homecare will be commissioned to be geographically aligned to the LCN teams from 2015; funding from the BCF will be added to existing 3rd sector funding to commission services that will wrap around the LCN, creating a landscape of protective services to help build social capital and tackle social isolation. BCF funding will support a step-change in building the capacity and capability of health and social care professionals to "make every contact count" in terms of early identification of lifestyle or health-care needs.

An infrastructure of services to support carers will be commissioned with regard to developing a skilled workforce to manage increasing demand and ensure carers receive a personalised service with clear referral and assessment pathways no matter how and where they enter the system.

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.

Introduction

In this case for change we will present:

- The health and social care challenges facing Greenwich;
- The specific challenge presented by patients with long term conditions;
- Why in 2011 Greenwich decided that integration was the answer to these challenges, and the evidence base for this;
- The progress made since then, indicating that the approach taken works; and
- How the BCF schemes have been selected to improve further the standard of care in Greenwich through advancing integration.

Health and social care challenges facing Greenwich

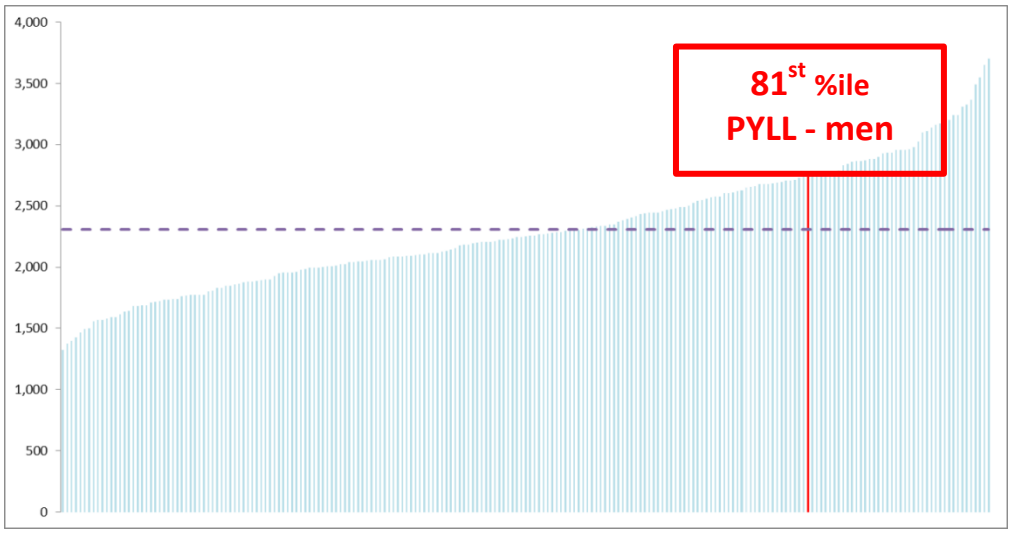
Greenwich is the 19th most deprived local authority in England, with great challenges for health and social care services in reducing avoidable morbidity and mortality. There have been recent improvements, but life expectancy is substantially shorter than the national average.

For example, from the NHS England Levels of Ambition Atlas, Greenwich has a high level of potential years of life lost per person – 2,365 in 2013, which puts the CCG in the highest 26% nationally.

PYLL, 2013, all CCGs, female

Greenwich is in the 57th percentile for PYLL from causes considered amenable to healthcare when the data is split to show females.

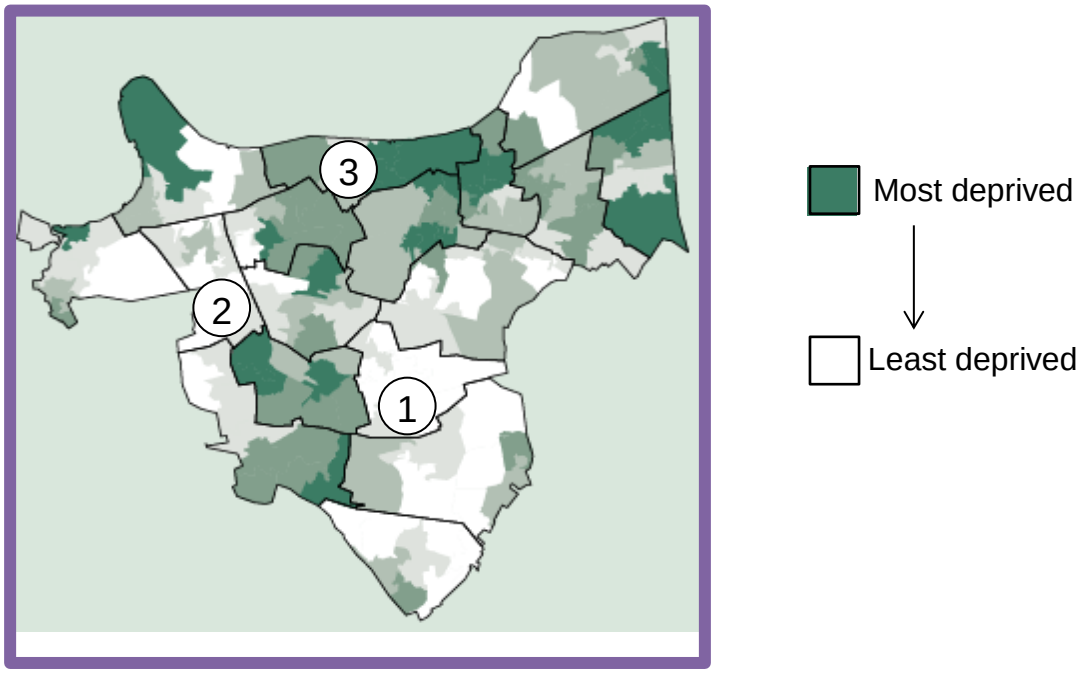
PYLL, 2013, all CCGs,



Greenwich is in the 80th percentile for PYLL from causes considered amenable to healthcare when the data is split by males.

There are also great inequalities in well-being, as indicated in the chart below. Two of the 17 Greenwich wards have greater well-being than the London average (1, 2); in the remainder, it is lower, the poorest well-being is in Woolwich Riverside (3): only six of London's 625 wards are worse.

Life expectancy in Greenwich



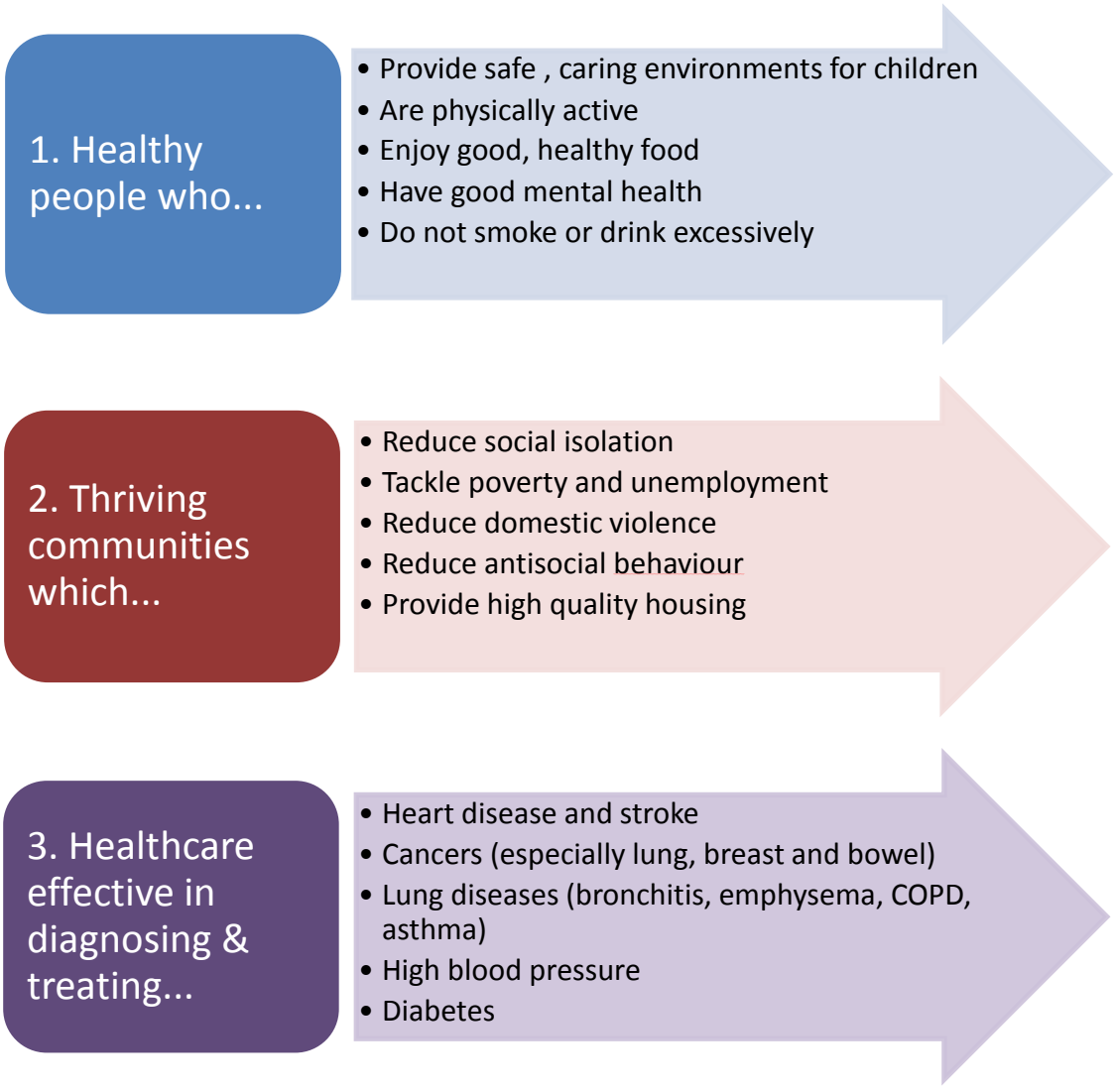
Some causes of death are potentially amenable to healthcare. Mortality due to these causes is slightly worse in Greenwich than the national and London average for males, and moderately worse for females. This does not explain the difference entirely.

The major disease contributors to poor life expectancy and healthy life expectancy in Greenwich are circulatory disease (coronary heart disease and stroke), cancers (with lung cancer being particularly important), and respiratory disease (particularly chronic obstructive airways disease).

The greatest burden reducing healthy life expectancy is mental disorders, particularly depression and anxiety. These also have an impact on life expectancy, but that impact is smaller.

Finally, the demographic composition of the borough makes equal and easy access to health and social care services an absolute priority and services must be delivered in acceptable ways for Greenwich's multi-ethnic community.

Therefore the Greenwich JSNA priorities are targeted to build thriving communities of healthy people and providing effective healthcare to treat sickness when people need it, as follows:

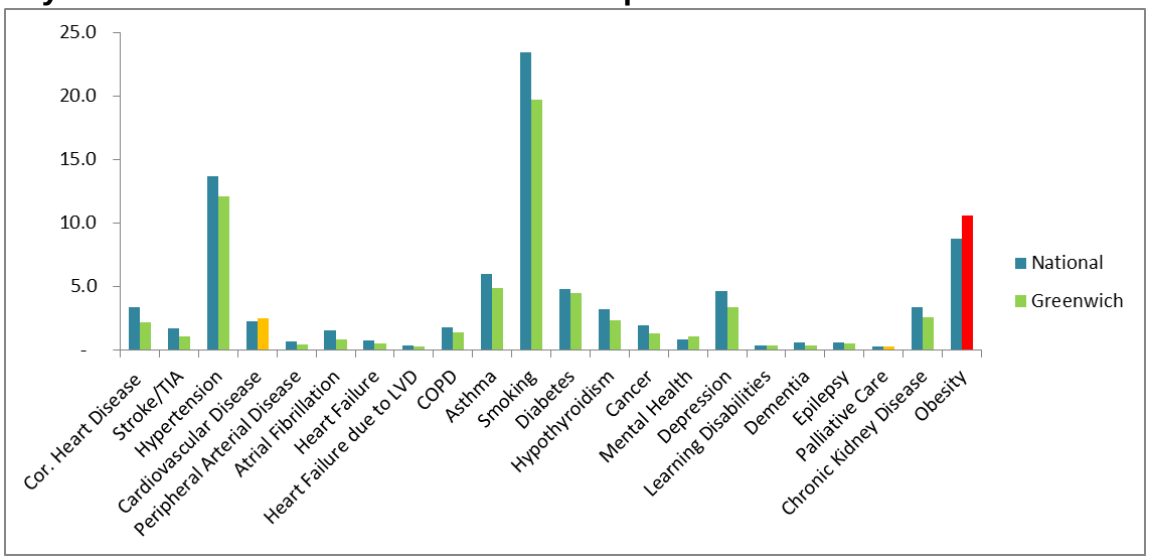


Focus on long term conditions

There is significant evidence to suggest that the prevalence and increasing acuity of patients with long term conditions is a significant issue currently facing Greenwich.

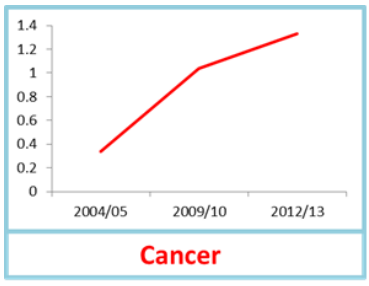
Overall, Greenwich compares well nationally against the national average prevalence rates for the conditions monitored as part of the Quality and Outcomes Framework (QoF), with only obesity levels showing a markedly higher prevalence among the local population compared to the national picture, as indicated in the chart below:

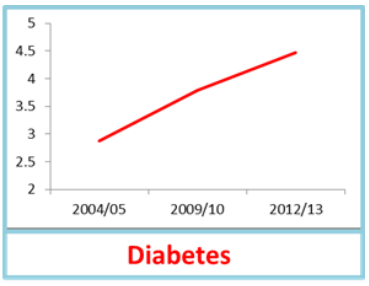
Quality and Outcomes framework condition prevalence

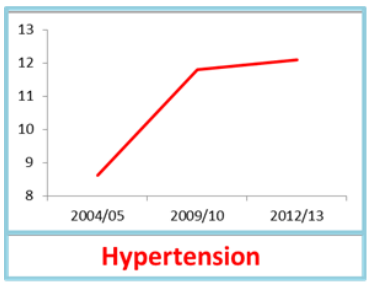


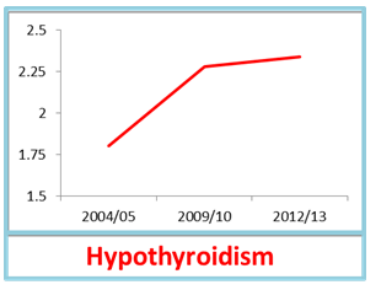
However, a number of these long term conditions have been showing a rapid and notable increase in prevalence over time, since QoF began in 2004/05 - notably Cancer, Mental Health, Diabetes, Hypertension, Hypothyroidism and COPD, as indicated in the graphs and table below:

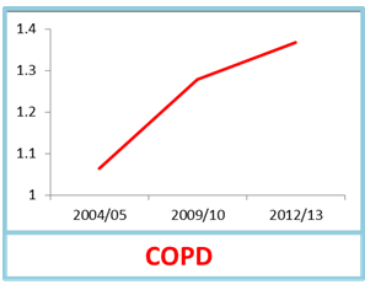
Quality and Outcomes framework condition prevalence, trend over time











Condition	Prevalence 2004/05	Prevalence 2013/14	Increase
Cancer	0.34%	1.04%	294%
Mental Health	0.61%	0.99%	77%
Diabetes	2.88%	3.79%	55%
Hypertension	8.62%	11.81%	40%
Hypothyroidism	1.80%	2.28%	30%
COPD	1.06%	1.28%	29%

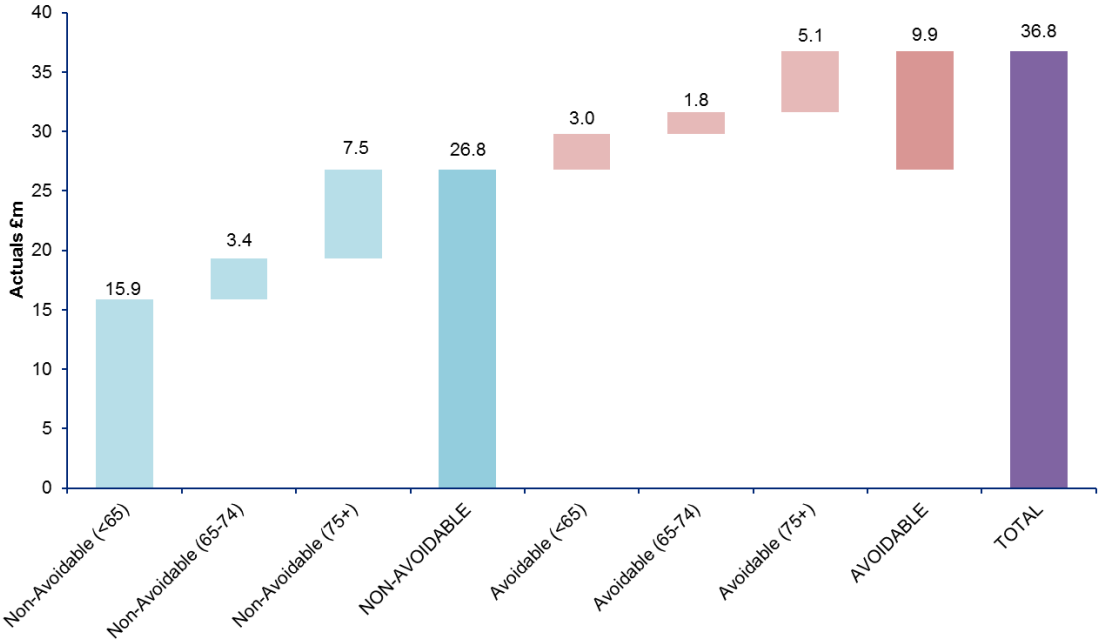
It is likely these trends are having a significant impact on rising emergency admissions in Greenwich.

When we analyse the CCG's emergency admissions in 2013/14 in the chart below, we see that in total emergency admissions in Greenwich cost £36.8m.

We have segmented this by a list of HRG codes that we could consider 'avoidable', predominantly those codes that relate to patients with long term conditions such as diabetes and COPD who could be managed more effectively in the community.

£9.9m of spend (27%) on emergency admissions could be considered avoidable. Of this, £6.9m of spend (70%) related to the over 65s.

Segmenting Greenwich's emergency admissions in 2013/14

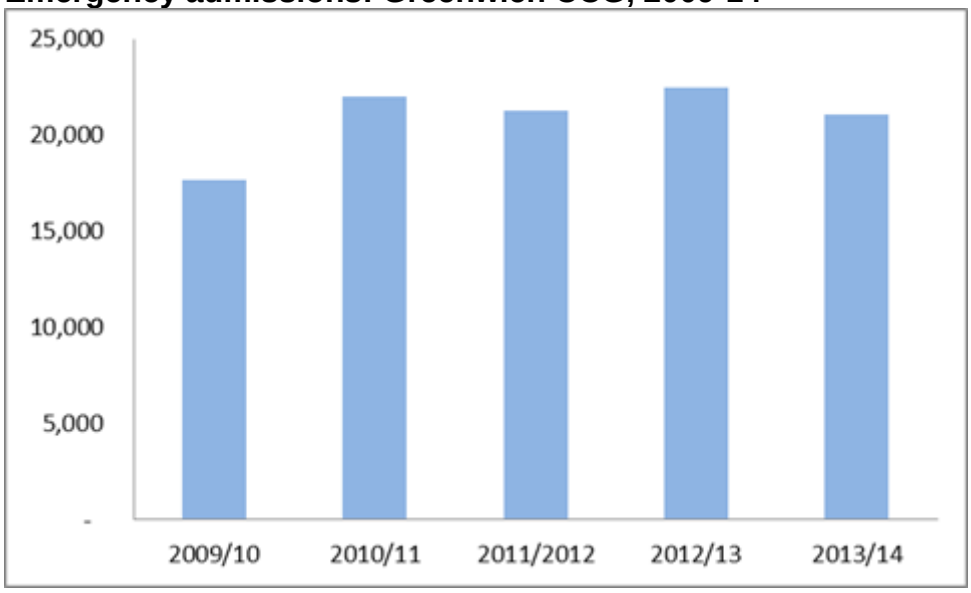


This suggests that the major challenge Greenwich faces is tackling the frail elderly pathway and those patients with long term conditions.

This is a particularly significant challenge for the Greenwich health economy, as non-elective acute admissions for the CCG have been increasing since 2009/10, due to the merger of Queen Mary's, Queen Elizabeth and Princess Royal hospitals to form SLHT, with a slight levelling out since 2011/12.

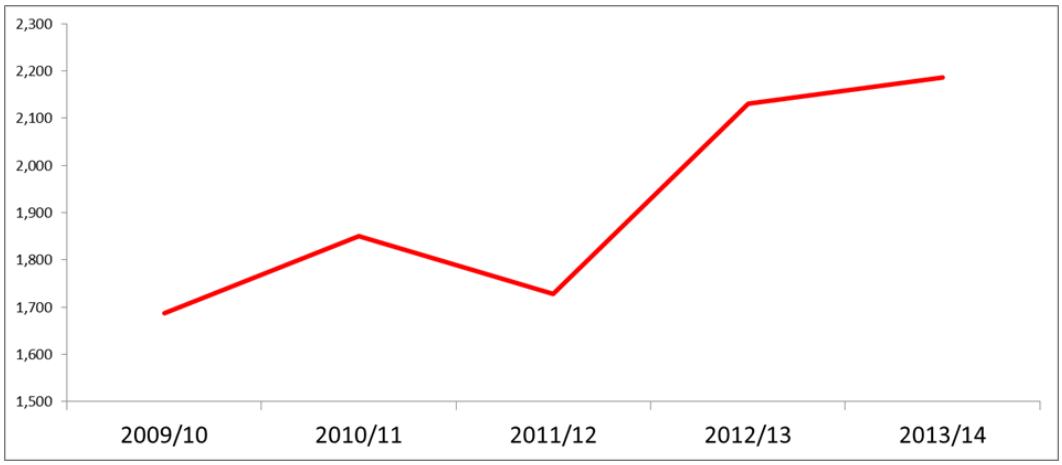
The CCG observed a reduction in emergency admissions in 13/14:

Emergency admissions: Greenwich CCG, 2009-14



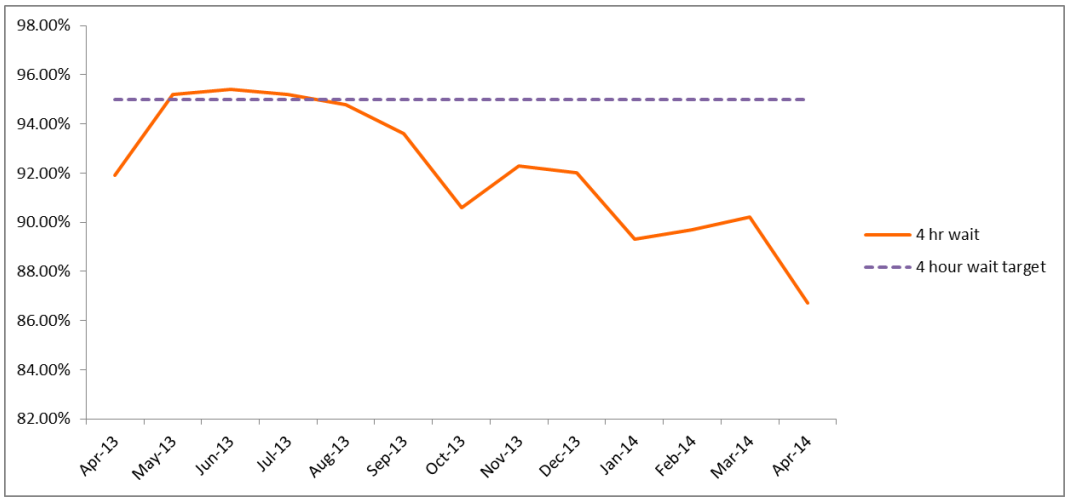
The increasing trend in long term condition prevalence could be driving this increase, particularly as there is a similar trend of growth for the number of composite avoidable admissions per 100,000 population:

Avoidable emergency admissions per 100,000 population for Greenwich CCG, 2009-14



Perhaps as a result of this increased activity, the acute provider is currently struggling with waiting times in A&E, with the emergency front door showing a steady deterioration in terms of waiting time performance since the middle of 2013; the Trust have not met the 95% four hour wait target since:

Lewisham and Greenwich NHS Trust 4 hour wait in A&E performance



Using ICD-10 diagnoses codes as defined by Better Care Better Value, we can analyse the three main groups of long term conditions for which there are associated emergency acute admissions. These include Greenwich's pressure areas of COPD and Diabetes.

Condition	Cost		
	Under 65s	Over 65s	Total
COPD & Asthma	£ 291,218	£ 831,098	£ 1,122,316
Congestive Heart Failure, Angina & Hypertension	£ 143,920	£ 679,830	£ 823,750
Diabetes	£ 190,615	£ 125,108	£ 315,723
TOTAL LTCs	**£ 625,753**	**£ 1,636,036**	**£ 2,261,789**

An additional £588k relates to admissions for influenza and pneumonia in patients with COPD.

Condition	Activity		
	Under 65s	Over 65s	Total
COPD & Asthma	17	12	29
Congestive Heart Failure, Angina & Hypertension	186	27	213
Diabetes	16	11	27
TOTAL LTCs	**219**	**50**	**269**

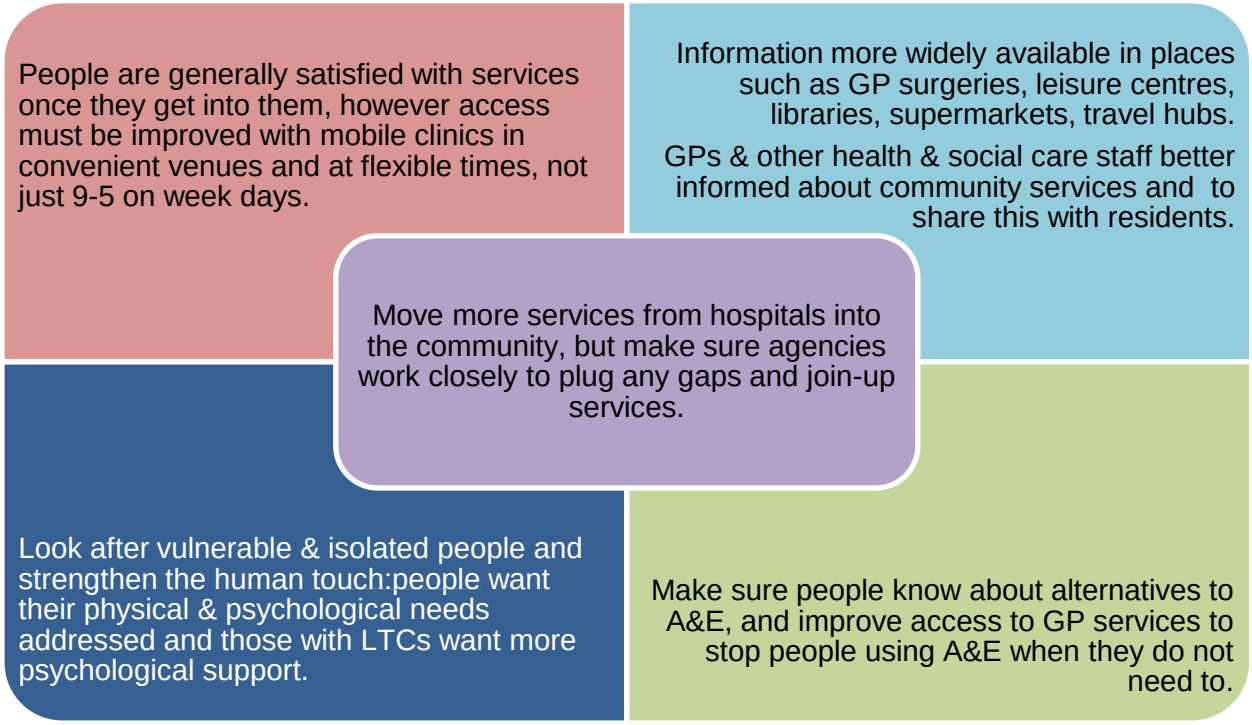
An additional 175 admissions were for influenza and pneumonia in patients with COPD.

Taken all together, these individual pieces of analysis demonstrate that Greenwich has a current problem with long term conditions, and the CCG, the Council and the local providers all share the same vision regarding how to address this problem: the answer is integration.

2011: The start of Greenwich's local integration journey

In establishing the case for change in Greenwich, we have considered the views of patients and service users, the public health analysis of priorities emerging from our JSNA and the current utilisation of health and social care services.

The potential benefits of integration have been recognised in Greenwich for some time.
Our local integration journey started back in January 2011, when NHS Greenwich and the Royal Borough held a number of significant events to provide an opportunity for local people to comment on services and health needs. There were some clear messages:



On this basis Greenwich Integrated Care was launched in April 2011 with the aim of maintaining independence in the community and preventing unnecessary A&E attendances, hospital and care home admissions and delayed discharges, with five (now four) integrated health and social care teams, based both in the community and in hospitals, providing a seven-day whole system response to intermediate care, hospital discharge, urgent care and community rehabilitation.

There is significant evidence that this is the right thing to do to tackle the problem of patients with long term conditions:

- It has received widespread support from organisations such as **The King's Fund** as it has been shown to improve clinical outcomes and reduce unscheduled hospital admissions.

- The benefits of integration have been summarised and published in the **LGA Integrated Care Value Case Toolkit**.

- The **QIPP Long Term Condition national workstream** agreed an integrated model of care for LTCs based on the 3 key principles, which are the fundamental features of all best practice LTC care programmes both here and abroad. The Greenwich model is firmly based on these principles, which are shown in the diagram below:

Risk Profiling	Integrated Community Teams	Self Care/ Shared Decision Making
Using validated risk profiling to support commissioners to understand the needs of their population and manage those at risk. A risk prediction tool will identify a list of patients (or virtual ward) that are at high and medium to high risk of accessing healthcare services. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised.	Creating a functionally integrated generic care team at a locality level comprising community services, AHPs, social services, specialist nurses and linked to GP practices. These integrated health and social care teams based around a locality (or neighbourhood) to provide joined up and personalised services. These generic teams pull in specialist services when necessary, but treat a patient holistically, regardless of their condition(s). Neighbourhood care teams provide a single main contact point for patients and carers. Each patient has a key worker within this team who co-ordinates their care and acts as the point of contact.	Empowering patients to maximise self-care, self-management and choice, through shared decision making and motivational interviewing. • Patients engage in shared decision making to co-produce a care plan • Both patients and their carers have access to appropriate information about how to manage their condition. • Patients are active participants in all decisions about their care • Patients have access to their medical records. This will require a cultural shift for both patients and clinicians whereby the importance and value of self care and patient education are truly understood and where shared decision making and supported self care are seen as an integral elements of LTC management.

When we review the quality of services provided in Greenwich, a similar message emerges that integration of services is the answer.

Risk stratification

As the legal basis of population level risk stratification has been in doubt since April 2013, and in the absence of legal authorisation to undertake such risk stratification, efforts in Greenwich have focused upon using case finding tools within health and social care to identify those most at risk, and also by publicising the services and the single point of access to maximise the appropriate uptake. Greenwich CCG has applied, along with other integration pioneers (notably Southend), for s251 approval to undertake risk stratification, and is awaiting the outcome of the Confidentiality Advisory Group's deliberations on this.

Greenwich: our integration success story so far

Experience from Greenwich since 2011 suggests that the elderly population maintain their independence longer, with fewer people entering full social care, fewer people requiring services after the completion of the pathway, fewer delayed discharges and reduced length of stay in intermediate care, as well as preventing A&E attendances and emergency admissions.

- In year one of operation of our integrated rapid response initiative, the Joint Emergency Team, **admissions to care homes reduced by 35%.** After reablement, over 60% of people required no care packages. This saved the Local Authority £900k. The number of avoided admissions continues to increase year-on-year.

- Greenwich is now ranked the **15th best performing borough nationally** for emergency admissions for people with conditions that could be treated in the community.

- Over the last two years there has been an **8% reduction each year** in the number of people supported with a social care package.

- Between 2011/12 and 2012/13, there has been a **7% reduction** in the number of people supported in long-term care placements throughout the year.

- There has been an increased number of people aged 65+ returned home following discharge from hospital through a reablement intervention and who are still at home 91 days later. During 2012/13, **89% were still at home at 91 days**, up from 79% in 2011/12.

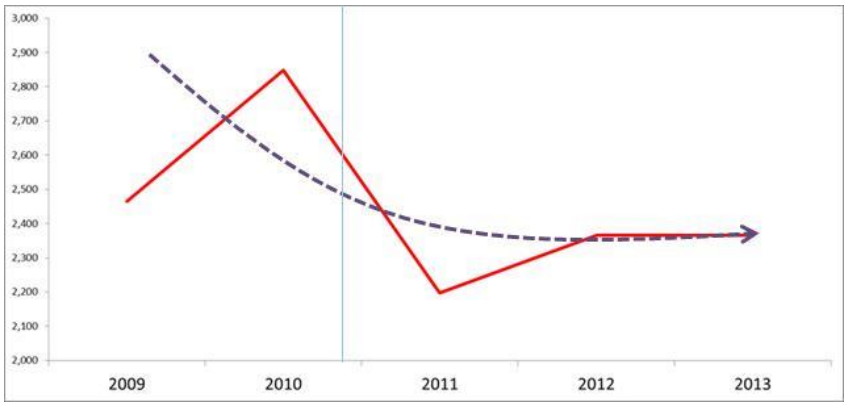
- During 2011/12, the number of people re-admitted to hospital within 14 days **reduced**; performance remains better than national and peer group figures.

- From the end of 2010/11, **the number of bed days spent in hospital has reduced** and fallen below national and peer group comparison.

An example of the positive impact the service is making in the lives of local people is outlined at **Appendix 1.**

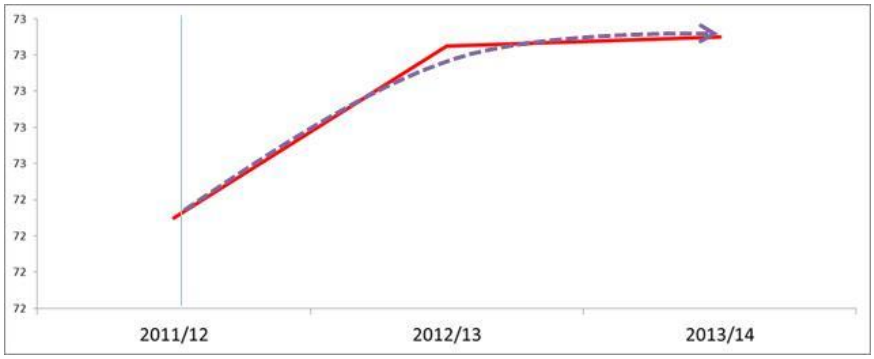
Finally, if we look at three key health outcomes, we will see that in each case performance has been improving over the past three years:

Outcome 1: Reduced potential years of life lost (PYLL) from causes considered amenable to healthcare



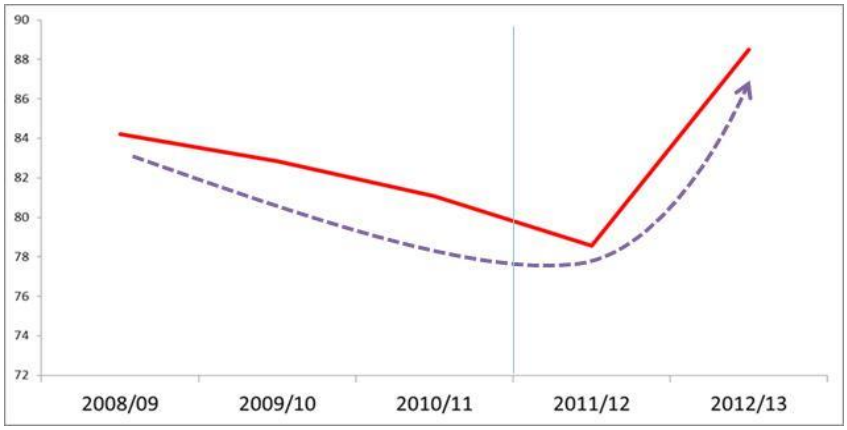
In this case a reduced number represents positive performance, and we can see a significant downward trend.

Outcome 2: Improved health-related quality of life for people with long-term conditions



In this case an increased number represents positive performance, and we can see a significant upward trend.

Outcome 3: Proportion of over 65s still at home 91 days after discharge from hospital into reablement or rehabilitation services



In this case an increased number represents positive performance, and we can see a significant upward trend.

Summary

All the evidence therefore shows that Greenwich is already seeing the benefits of integration and is following a tried and tested model on which we can build on through the Better Care Fund.

We therefore have a strong evidence base for our model both in theoretical, best practice terms, and in practical terms: we have proved that it works over the past three years.

Next steps: selection of the BCF schemes

In Greenwich we wish to build on what has worked in our integrated programme over the past three years and use the BCF to advance integration significantly, improving the quality of care across the borough.

We went through a rigorous process to select our schemes.

Two workshops were held in May and June 2013 bringing together nominated representatives across the social care and health system to hear about the preferred model of integrated care and work through the detail of how an early implementer site could be established in the borough and would work in practise. The group was also consulted about communicating with and engaging front-line staff and has become an implementation group that is involved in the "test and learn" site and meets quarterly with the project board.

As a result of this process, we have identified 14 schemes based on the existing integration evidence base both nationally and locally:

Scheme	Case study / Evidence base
Pioneer	North West London pilot
Virtual Patient Record	Integrated care for patients and populations: Improving outcomes by working together, The Kings Fund and Nuffield Trust, January 2012
Care Homes	Care Quality Commission review of health care in care homes
Social Isolation	Combating Loneliness; A guide for local authorities, March 2012
Nutrition	Somerset Partnership NHS Foundation Trust case study
LTCs	Tower Hamlets case study
Carers	National Strategy for Carers 2011
Making Every Contact Count	Wanless (2004) report
Protecting Social Care	JET / HID local evidence

Dementia	Advanced Dementia Service at NHS Oxleas
Telehealth	Portsmouth case study
Pressure Ulcers	NICE Guidance CG 29
End of Life	CMC national evidence
Alliance Contracting for Integrated Frail Elderly Pathway	London Borough of Camden. Proactive case management resulted in admissions decrease by up to 50%.

We are confident these schemes, which are grounded in the evidence base and adapted to suit local conditions, will have a significant impact on enhancing integration and improving the quality of care in Greenwich over the next two years.

We are also confident that these schemes will achieve the scale of change proposed by moving activity from acute to community settings, and these assumptions have been built into the CCG's overall five year strategy. This dovetails, and is supported by, provider strategies – particularly that of the Lewisham & Greenwich NHS Trust.

4) PLAN OF ACTION

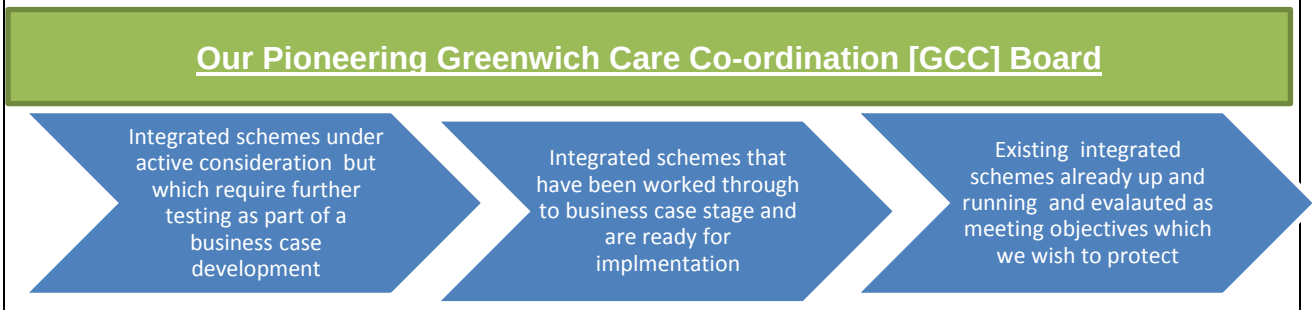
a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Programme Overview

Our programme management approach is not considered a static or 'one off' exercise. We are seeking to work with local people and our provider partners in order to create a continuous 'pipeline' of new, innovative and stretching schemes and approaches that will sit beneath the Pioneering Greenwich Care Co-ordination Board alongside those existing schemes which have been evaluated as effective.

All new schemes generated are subject to an agreed business case process enabling commissioning partner to test out with some degree of rigour that the scheme will deliver clearly described benefits to the population we serve and that the investment in 'upstream services' is matched by a similar or greater forecasted financial reduction in high cost 'downstream services'. The business case template considers the timeline for each scheme and the expected profile of financial flows. The template for our business cases has recently been adjusted to reflect the national conditions of the BCF so that we can be confident that each scheme addresses these.

At any given time then there will therefore be a range of improvement schemes in train each with their own specific set of deliverables and financial flows.



Project Planning

Business cases that have been developed in line with our agreed local approach are attached in Annex 1. It is our intention to commence implementation of these schemes in 2014/15.

Key success factors will relate to the outcomes listed above, as follows:

- Improved patient/service user experience
- Professionals involved in GCC work effectively as part of an integrated pathway
- Unplanned admissions are avoided
- Lengths of stay and delayed transfers of care are reduced
- Admissions to residential care and nursing homes are avoided
- People feel supported to manage their long-term conditions
- We continue to increase healthy life expectancy across the borough

We will ensure related activity will align by sharing commissioning plans through our joint commissioning groups for older people, adults with learning disabilities and mental health. The Greenwich Coordinated Care Project Board includes membership from RBG, Greenwich CCG; Oxleas Foundation NHS Trust, Lewisham & Greenwich NHS Trust, Greenwich Action for Voluntary Services and Greenwich Healthwatch. The project board will monitor performance targets and proxy measures for successful outcomes for the Better Care Fund.

Members of the project board sit on the Health and Wellbeing Partnership Group, which is developing the JHWS for the borough.

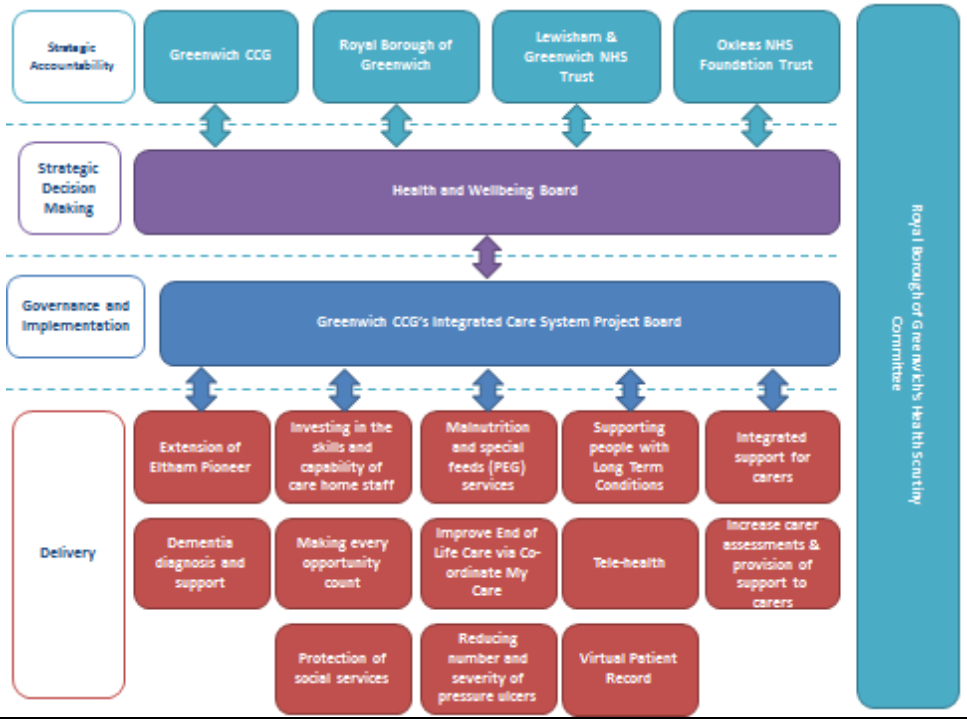
In order to provide further assurance of our delivery of our BCF programme, **Appendix 2** provides a programme plan for the BCF programme as a whole and also project plans for each individual scheme outlined in Annex One. These are in the form of Gantt charts in Excel.

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

Our Pioneer implementation Programme is overseen by the Greenwich Co-ordinated Care [GCC] Project Board and schemes developed through the Better Care Fund will be included in these programme arrangements.

The Greenwich Coordinated Care Project Board includes membership from RBG, Greenwich CCG; Oxleas Foundation NHS Trust, Lewisham & Greenwich NHS Trust, Greenwich Action for Voluntary Services and Greenwich Healthwatch. The project board will monitor performance targets and milestones and includes the partners required to take any corrective measures required to keep the schemes on track.

The governance structures are summarised in the diagram below:



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

Governance Structure

The CCG and Royal Borough will make use of an existing governance structure to oversee the delivery of the 14 BCF schemes, as indicated in section 4b above with responsibility for strategic decision making resting with the **Health and Wellbeing Board**.

Implementation

BCF leads from the CCG and RBG will be represented on the GCC project board which will:

- drive the delivery of all projects
- engage with senior staff to support and comply with the new standards
- assess project performance through highlight and exception reports
- manage delivery by exception
- produce a report for Health and Wellbeing Board Programme on status, immediate challenges and accountable actions.

The following **roles** will be assigned to each project:

- Executive Sponsor
- Programme and Project Manager
- Corporate Support (Finance and Information)
- GP Clinical Lead

Monthly Project Boards

Project delivery will be managed via local CCG programme boards and Royal Borough of Greenwich Joint Commissioning Boards.

Each project team will report against project impact and elements that are off track via the monthly Highlight Report.

BCF leads will report on BCF progress to the **Greenwich Coordinated Care Project Board**. Where necessary they will provide an exception report, confirming the reason for under-performance, how they will address this, and their revised forecasted trajectory, which will be discussed with the members of the Board, who will agree and support remedial action.

Project Tracking

A standardised monthly highlight report will be developed for each project team to track delivery:

Activity: Outturns to underlying Direction of Travel and patient impact for key metrics, including:

1. Avoidable emergency admissions
2. Permanent admissions of older people to residential and nursing care
3. Effectiveness of reablement for people 65 and over
4. Delayed transfers of care
5. Patient/service user experience
6. Proportion of people feeling supported to manage their long term conditions

Quality: Outcome Indicators not achieving the planned and profiled trajectories, including:

7. Process Measures - following coordinated care processes to meet the health and social care needs of the patients is likely to improve their overall health and wellbeing.
8. PROMS - patients who report improvement in their health status are likely to have improved their overall health outcomes measured by morbidity indicators such as emergency admissions to hospital.
9. Staff Experience – professionals satisfied with their work are likely to deliver high-quality care which subsequently affects the patients' health outcomes.

Financial: outturns not achieving forecasted monthly targets (both savings and investments)

10. Anticipated shifts in spending patterns. It is expected that the costs of community and social care will increase while the costs of acute hospital care will reduce. The extent of shifts in spending patterns indicates the degree of the success.
11. Improved health outcomes should lead to reduction in costs of health and social care; healthier population requires less input from professional health and social care services.

Risks: exceeding agreed tolerances for:

12. Quality in terms of impacts on the population and the proposed mitigating actions to remedy or reduce the risk.
13. Delivery of Projects due to delays or dependencies and the proposed mitigations with impact analysis.

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.

			Finances			Benefits				
Ref no.	**Scheme Name**	**Description**	**2015/16 Investment (£000's)**	**2015/16 Savings (£000's)**	**Emergency Admission Reduction**	**Reduction in admissions to residential care homes**	**Improved effectiveness of reablement**	**Reduction in delayed transfers of care**	**Reduction in avoidable emergency admissions**	**Improved patient/service user experience**
BCF020	Carers	Increase carer assessments & provision of support to carers to meet needs identified in assessment/ social prescribing, respite care, use of volunteers etc.	348	494	170	√	√	√	√	√
BCF024	Making Every Contact Count	Major implementation of Making Every Contact Count across the whole of Greenwich	499		0	√	√	√	√	√
BCF001	Pioneer	Implement and roll out the extended integrated Pioneer service being piloted in Eltham across the whole of Greenwich.	750	452	211				√	√
BCF027	Protecting Social Care	Protection of social services to continue work to ensure effective support in the community	750		20	√	√	√	√	√
BCF019	Long Term Conditions (LTCs)	Increase the scale of services to support people with Long Term Conditions	154	123	80	√	√		√	√
BCF010	Nutrition	Malnutrition and special feeds (PEG) services	530	694	82				√	√
BCF030	Dementia	Improving dementia diagnosis rates and scaling up support to meet needs	462	394	177	√	√	√	√	√
BCF032	Pressure Ulcers	Reducing number and severity of pressure ulcers	1,006			√			√	√
BCF002	Virtual Patient Record	Introduce a shared 'virtual patient record' allowing health and social care providers to access information about service users linked to NHS number	1,395	1,359	83	√			√	√
BCF003	Care Homes	Invest in the skills and capability of staff working in care homes so they are more able to support fail and vulnerable people without the need to attend hospital	9,858		n/a	√			√	√
BCF006	Social Isolation	Support for people who are isolated and lonely to improve their ability to live healthy lives through voluntary sector and developing neighbourhood community resilience scheme	550	127	22				√	√
BCF033	End of Life	Fully implement Coordinate My Care (CMC) by all providers in Greenwich to improve End of Life care	200	59	18				√	√
BCF031	Telehealth	Supportive technologies for self-management and telehealth	213	194	50	√			√	√
BCF034	Alliance Contracting for Integrated Frail Elderly Pathway	Deliver a more integrated, higher quality service for frail comorbid patients and reduce the number of emergency admissions in Greenwich by transforming the way in which services are commissioned, contracted and paid for to focus on outcomes for patients.	3,056			√			√	√
Total			**19,771**	**3,896**	**913**					

5) RISKS AND CONTINGENCY

a) Risk log

Summary of risk	Nature of risk	Relevant schemes	Probability	Severity	Risk Rating (PxS)	Mitigating Actions	Mitigating action undertaken by whom	Mitigating action undertaken by when
The acute hospital activity reductions [and associated financial cost reductions to commissioners] do not materialise as envisaged, primarily because emergency admissions continue to rise due to demography and acuity of patient need.	Financial to commissioner Delivery	BCF 001 BCF 019 BCF 027 BCF 034	3	5	15	Development of an agreed business case for each scheme setting out in some detail the expected financial flows and activity reductions based on the best evidence available. Tracking of overall emergency admission activity by GCC Board. Tracking of implementation milestones by the GCC Board with HWB informed of schemes which have a significant variance from plan. Active review of schemes that are not delivering to plan and where necessary adjustments to approach made. Where necessary the bringing forward of further schemes from the 'pipeline' to create a plan B. Creation of a contingency fund.	BCF Project Leads for sign off by HWB GCC Board, CCG Analytics Team GCC Board, PMO GCC Board with BCF Project Leads GCC Board Greenwich CCG	End of October 2014 On a monthly basis On a monthly basis On a monthly basis On a monthly basis March 2015
The BCF programme is ambitious and contains 14 projects. There is a risk that this represents too many major initiatives for the CCG, Council and partners to focus on at once, hampering delivery	Financial Delivery	All	2	5	10	Undertake a prioritisation exercise to establish which schemes should be prioritised. Undertake an assessment of capacity and capability across all schemes, considering whether this is sufficient for delivery.	GCC Board GCC Board GCC Board	October 2014 October 2014 On a monthly

						Active review of schemes that are not delivering to plan and where necessary adjustments to approach made. Create a realistic resourcing plan to deliver each project and be prepared to flex as appropriate.	 Project Leads	basis October 2014
Lewisham and Greenwich Trust will not be able to take out sufficient capacity and cost contemporaneously with the planned change in patients flows and in line with the associated income reductions.	Financial to provider	BCF 001 BCF 019 BCF 027 BCF 034	5	5	15	Full involvement of Lewisham and Greenwich Trust on GCC Board tracking implementation milestones. Transparency of commissioning business cases for each scheme. Internal governance arrangements within acute hospital Trust to manage consequences of BCF. Discussions between CCG and Trust on how the activity shift and income reductions can be phased.	LGT BCF project leads LGT	Monthly October 2014 March 2015 November 2014
There is a risk that the shift of activity from acute to community would result in Council over-spending on social care as a greater number of care packages are required.	Financial to Council	BCF 020 BCF 024 BCF 001 BCF 030 BCF 006	3	4	12	It is essential to keep track of all the costs (fixed, variable, set up, etc.) of the programme to ensure that the model is affordable when scaled up to incorporate the whole population. Consider investment requirements in a holistic way.	BCF Project Leads GCC Board, CCG, Council	By November 2014 Ongoing basis
The lack of capacity in primary care given rising patient numbers prevents the successful rollout of the schemes that require added primary care input.	Delivery	BCF 001 BCF 019	3	4	12	Consider whether further investment in primary care from the BCF is required; potentially exploring funding shifts through co-commissioning.	CCG	March 2015

The required cultural change in the workforce to enable greater integrated working does not take place due to an unwillingness or inability to work across organisations.	Delivery Financial	All	2	4	8	Create a thorough programme of training and development based on the Pioneer example.	GCC Board	March 2015
Barriers to NHS number roll out: there may be a risk to the integration project due to the range of data systems in operation in the borough.	Delivery	BCF 002	3	3	9	We will ensure we have a partnership wide understanding of agency barriers and potential solutions: cross- agency and cross-borough discussions have already started. RBG has developed a business case for a project manager to provide additional capacity for this work within the Council.	All stakeholders Council	March 2015 December 2014
Barriers to implementing a risk stratification process due to difficulties in obtaining patient identifiable data through the CCG.	Delivery	BCF 001	3	3	9	Reduce the impact by identifying a work-around procedure if possible. Identify high risk patients through a local process involving GPs assessing their patient lists.	BCF 001 project lead in conjunction with analytics support from CCG GPs	March 2015 March 2016
Not getting Information Governance right, including informed consent to share information would undermine potential IT solutions.	Delivery	BCF 001 BCF 002	3	3	9	The GCC project board is overseeing management of this risk. Develop and monitor a robust project plan for getting the required approvals.	GCC Board BCF 002 Project Lead	Monthly October 2014
Delays or barriers to partners reaching agreement on a shared performance management approach that demonstrates delivery of the vision, outcomes and financial requirements.	Delivery	All	2	3	6	Performance management and evaluation of the model is part of the test and learn with opportunities to identify and address issues through the project board before borough-wide implementation.	GCC Board All stakeholders	Monthly
Recruiting/retaining the right workforce: difficult to find the right skill-mix for the care navigators.	Delivery	BCF 001	2	3	6	Greenwich integrated teams have a stable and professional workforce and the reputation as a Pioneer borough should make recruitment and retention easier.	BCF 001 Project Lead Council	March 2015

						The Pioneer test and learn site has employed 2 care navigators; from the voluntary and statutory sectors – this is providing an opportunity to understand fully the mix of skills and abilities and training required.	CCG	
There is a risk that that the implementation of integration is likely to find additional patients' needs that were not addressed before. The cost of meeting these newly identified needs could mount on top of the overall costs of addressing the needs already identified in the population. In the short- and medium–term the costs will increase significantly as the overall reduction in spend from health outcomes' improvement might not be realised straight away.	Financial to CCG and Council	BCF 001 BCF 027 BCF 019	3	4	12	Close tracking of activity by GCC with business cases being revised as any increase in case identification arises. Creation of a contingency fund.	GCC Board CCG	Monthly March 2015
There is a risk that other service redesigns and integration initiatives create confusion for the integration.	Delivery	All	3	3	9	Ensure communications strategy takes this into account.	CCG / Council Communications Leads	March 2015
If we do not manage communication carefully, there is a risk that stakeholders do not know what is happening, when it is happening and how the service will work. Hostile relationships develop and undermine the implementation and reputation of the service.	Delivery	All	2	3	6	The GCC project board have agreed to refresh the stakeholder analysis and communications strategy.	CCG / Council Communications Leads	March 2015

The process of securing an appropriate office base for all of the core teams could delay implementation.	All	BCF 001	2	3	6	RBG has already started identifying potential accommodation for the teams across the borough which are managed or owned by RBG or partners involved in GCC.	Council	March 2015

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 between commissioners across health and social care and ii) between providers and commissioners.

Background

Our BCF plans are factored into 2-year operational and 5-year strategic plans and are in turn reflected in the 5-year strategy of the local acute trust (Lewisham & Greenwich NHS Trust – that have signed off this plan) and Oxleas NHS Foundation Trust (community and mental health). These have been considered and signed off by the Governing Body and the H&WB. NHS England, Monitor and the Trust Development Authority (TDA) are currently triangulating commissioner and provider plans including the management of risk and associated mitigations.

Our Plans clearly show a record of shifting activity to the community from the acute sector. We anticipate this will be further delivered as part of the Operational and Strategic Planning round.

Within the Greenwich Better Care Fund, the financial value of the non-elective admission saving/performance fund is calculated as £950,520pa, representing a 2.1% reduction in Greenwich CCG responsible activity, (and by extension a similar reduction for the four other contributing CCGs). We have set our ambition lower than the national expectation of 3.5% due to a number of factors:

- **The figure of 2.1% will be offset by anticipated population growth of 2.1%, a lower weighted figure than the 3.1% (1.9% in 14/15 and 1.2% in 15/16 anticipated against a national trend of 0.7%) given the large number of younger residents in Greenwich. Hence this is a real terms reduction of 4.2%, which is challenging.**

- **Our Annex One schemes have each been modelled to assess the impact they will have on reducing emergency admissions. This analysis is contained in the Annex One scheme templates. The schemes in total contribute to reducing 833 emergency admissions, a 4.2% reduction – therefore providing further assurance that the target is realistic and appropriate.**

- **Greenwich is already in the top quartile nationally for preventing avoidable admissions at 339.41 per 100,000 in 2013/14 Q4, and the top quartile relative to statistical neighbours. Further progress will therefore be difficult.**

The value of the NHS commissioned out of hospital services is greater than the ring-fenced fund of £4.25 million; we expect the P4P element to be fully met by a combination of the out of hospital commissioned services and the schemes within the H&WB element of the BCF, which include a combination of “quick wins” with longer term schemes that will have sustainable benefits beyond the course of the 5-year strategic plan. The view taken in Greenwich is that it will not be practicable either to withhold or ‘claw back’ funds that have been committed under the BCF if the anticipated result is not achieved in Year

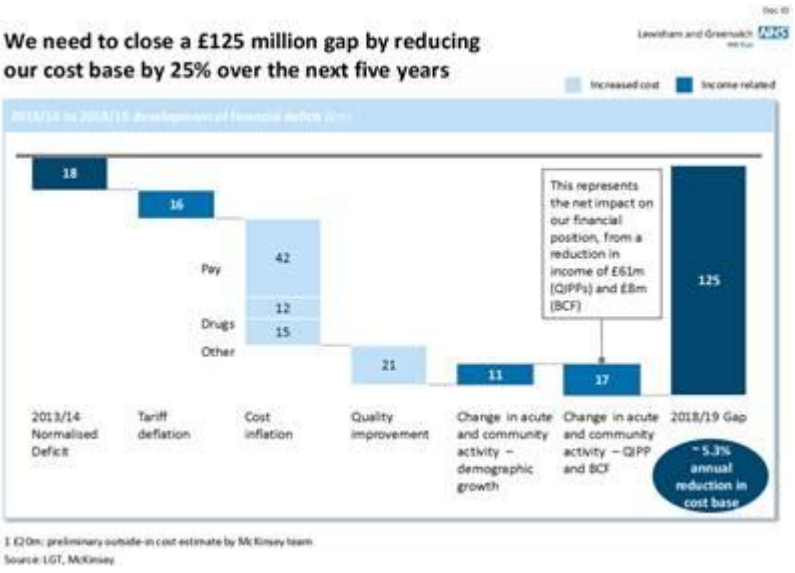
1 and that therefore the financial risk will sit with the CCG.

Risk sharing arrangements between providers and commissioners

Financial risk falls mainly on the CCG as commissioner, in that if the reduction in emergency admissions is not achieved, this would mean that the CCG will bear the cost of these admissions, as well as the cost of the investment in BCF initiatives. This risk is managed primarily through the setting of a QIPP target and a robust QIPP programme that treats BCF as a cost pressure and puts in place a broad range of initiatives to achieve efficiencies to match. We have established robust arrangements with our acute providers to monitor delivery of QIPP plans.

The CCG has established a range of internal mitigations (such as general and earmarked reserves) and also external risk sharing arrangements with other commissioners which it can draw upon.

In terms of the risk to providers, if the BCF is successful in reducing emergency admissions, there is a risk to providers that there will be some 'stranded costs', primarily fixed costs that the trusts may not be able to take out of the system immediately. These 'stranded costs' are already recognised in our local acute provider's plans (see provider level figure below).



6) ALIGNMENT

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

The BCF is viewed in the borough as part of a whole systems approach to health and social care integration, including our plans to implement the Care Act. The plans in our BCF submission align to a number of initiatives related to care and support; the integration of health and social care that has been underway in the borough since 2011, when health and social care services were brought together to create 5 integrated teams, two of which are based in the acute hospital and provide an integrated admission avoidance and planned discharge service; and three in the community, working specifically with frail older people and long term conditions. Since then, we have integrated older adults mental health, learning disability services, and are extending a pilot integration of OT services.

Underpinning the work of the integrated teams in Greenwich is a whole systems approach to assessment, care coordination and choice and control that provides support to people to stay as independent as possible in the community and enjoy the best quality of life. This includes a reablement service that provides a rapid access, time-limited intervention targeted to promote independence. For all people with social care needs, provision of a personal budget following assessment is key to ensuring that people have control over their circumstances and can make the best decisions about their own support, which could include telecare, community equipment and adaptations; homecare or a personal assistant or if required, a move to extra-care accommodation. All of these services already operate on a seven-day basis.

Our pioneer integration project extends the reach of health and social care integration to include primary care networks at its heart and to work with all client groups with complex needs. This integrated service will become part of the Greenwich landscape and will make use of existing care pathways and services,such as homecare which will be commissioned to be geographically aligned to primary care networks from 2015; the Greenwich directory of services, which will also be in place in 2015 and to a whole system approach to direct payments and personal budgets. Funding from the BCF will be added to existing 3rd sector funding to commission services that will provide a landscape of preventive services to help build resilience and promote recovery. BCF funding will support a step-change in building the capacity and capability of health and social care professionals to “make every contact count” in terms of early identification of lifestyle or health-care needs.

The importance of information as an enabler to transformation is also recognised and a Greenwich CCG information strategy will be drafted in the coming year which outlines, for example, the use of technology to improve access to care, to enable communications between health and care teams, and to increase the ability of patients to self-care. This will correspond to national and South East London strategies, for example, with relation to high impact innovations.

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

Our BCF plan is incorporated within Greenwich CCG's (GCCG) 2 year operational and 5 year strategic plans. The financial impact of the BCF has been included in the financial model, and is one of a number of factors driving the CCG's QIPP requirement of £32m over the 5 year period to 2018/19. Specifically, the CCG's QIPP target for 2015/16 is £7.3m of which the BCF will contribute £3.9m in efficiency savings that will be reinvested in the community. The breakdown of our 2015/16 QIPP programme is as follows:

Scheme Name	**Savings (£000's)**
Better Care Fund Projects (Annex 1)	3,900
Eltham Community Hospital	1,000
Community Contract	400
Prescribing	1000
CCG Running Costs	600
Total	**7,300**

The BCF is not viewed by the CCG as a standalone initiative, rather it is an integral part of our delivery plans, which taken in the round describe the changes necessary to deliver a modern model of integrated care, alongside other key system changes that are required to achieve high quality, sustainable services. A summary financial plan table demonstrates the financial alignment:

(£000's)	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Total Revenue	**338,929**	**357,252**	**356,379**	**362,241**	**368,191**
Planned Spend					
Acute	174,496	170,791	166,870	158,290	149,467
Mental Health	45,135	44,212	45,100	45,556	45,970
Community	32,710	32,473	35,996	40,360	44,727
Continuing Care	13,112	13,531	13,899	14,276	14,663
Primary Care**	39,770	41,069	43,418	45,897	48,518
Other Programme	12,851	22,649	18,414	25,037	31,873
Better Care Fund	6,097	18,010	18,010	18,010	18,010
Running Costs	6,543	5,884	5,880	5,877	5,875
Contingency	1,695	1,751	1,782	1,812	1,842

Total Costs	**332,409**	**350,370**	**349,369**	**355,115**	**360,945**
NHS Carry Forward	**6,520**	**6,882**	**7,010**	**7,126**	**7,246**
Net QIPP Savings (£32m over 5 years)	**8,600**	**7,300**	**4,300**	**6,000**	**6,000**

c) Please describe how your BCF plans align with your plans for primary co-commissioning (for those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads).

The model for co-commissioning is still under discussion in Greenwich and has yet to be finalised. As the details of the local implementation of co-commissioning become clearer, we will seek to optimise the role of primary care within the integration agenda, recognising that patient experience of primary care is key to successful integration.

However, the schemes outlined in the Better Care Fund all are contingent upon the use of the new Local Care Network structures, which are based around geographic clusters of GP practices – and enabling the GP to be at the heart of providing packages of care for patients (with patients at the heart of their care plan).

The health and social care Pioneer integration programme in Greenwich focuses on wrapping the right services around primary care to provide an effective, personalised and proactive approach to working with people with complex needs and extending this and maximising the impact of this approach is a key part of our strategy for the BCF. The BCF will build upon our pioneer work to ensure that we meet the aspirations set out in 'Transforming Primary Care' (Department of Health, 2014), for example by improving the integration of services for those most at risk of admission, by enabling information sharing through the Virtual Patient Record, and in supporting carers.

Greenwich CCG has submitted a combined expression of interest with South East London CCGs, outlining our commitment to explore co-commissioning based upon a set of principles and assumptions. An initial review suggests that co-commissioning may be beneficial by:

- Aligning the commissioning of services more directly to SEL strategy
- Harnessing local knowledge of member practices and involving the communities they serve in commissioning decisions.
- Aligning commissioning intentions directly to commissioning investment decisions.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF. 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)

Our objective in prioritising protection of social care services as a key element of the Better Care Fund submission is to ensure that services already in place that are supporting the acute sector and the CCG in reducing demand for hospital admissions, length of stay and the need for long term institutional care are maintained on a sustainable footing.

There is a range of approaches through which existing Greenwich social care service directly promote the key objectives of the BCF. These include what are known locally as the integrated teams, a group of integrated health and social care services that were brought together in 2011 to provide a proactive, whole system approach at key stages of community intervention and comprise:

- Joint Emergency Team
- Hospital integrated discharge team
- Community assessment and reablement teams
- Reablement service

Underpinning the work of the integrated teams is a whole systems approach to assessment, care coordination and choice and control that supports people to stay as independent as possible and enjoy the best quality of life. Provision of personal budgets is key to ensuring that people have control over decisions about their support in the community, which could include telecare, community equipment and adaptations, homecare or a personal assistant. All of these services already work on a 7-day basis.

Front line social care staff commission packages of community care through a streamlined process based on assessment of need and service user choice. We are committed to the principle that preventative services, support to maintain independence and support to carers is the right course of action, although the effectiveness of the integrated teams has created a cost pressure for Greenwich social care services. When the integrated teams were established, additional resource was used to ensure that good outcomes were maintained during winter pressures. Over the past two years, the pressure on the acute sector has been felt consistently throughout the year, so additional staff placed in the integrated teams to reduce waiting times have been maintained throughout the year. Use of the BCF allocation to protect social care services is seen in Greenwich as an investment that will ensure that we are able to maintain these services in response to demand.

As a result of this existing package of enhanced integrated services the latest available benchmarking on the national NHS “Better care Better value” website [2013/14 quarter 3] highlights that Greenwich ranks 26th best in the country out of 218 CCGs in respect of

preventing avoidable hospital admissions. We are therefore already operating at a level of delivery which is significantly better than the national average and very significantly better than our matched group of Peers.

The Greenwich Health and Wellbeing Board believes it is mission critical to secure this positive position as a starting point for our further improvement and hence we plan to set some of the BCF fund towards the protection of our existing enhanced social care services.

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

Using part of the BCF to protect social services will create a platform of community support services that address immediate physical support needs and the wider determinants of health to build resilience and prevent frail older people and those with long term conditions from requiring unplanned admissions or residential care. We have included a detailed project plan in Annex 1 setting out how the protection of social care will be funded.

Our other BCF schemes map onto the existing integrated health and social care services, for example, extending integration to include primary care, through the roll out of the Eltham pioneer test and learn scheme and providing an integrated approach to carers support. In addition the BCF has provided an opportunity to put more investment into preventative services that will tackle the wider determinants of health, and provide support to patients/service users at challenging times, such as following discharge from hospital or managing long frailty and long term conditions at home.

The role of the 3rd sector in providing a wide landscape of support for vulnerable adults in the community is well established in the borough and effective joined up work with health and social care services already exists. The BCF schemes provide an opportunity to build the capacity of 3rd sector services to work in partnership with the integrated teams and take a vital role in providing preventative and enabling services.

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 total amount allocated from the BCF for the protection of adult social care services in 2014/15 is £7,858k, this will be increased by a further £2million in 2015/16. A project plan, attached in Annex 1 (BCF027: Protection of social services to continue to provide effective support in the community) sets out more information on how this will be used and the benefits that will result. The following programmes can be attributed to the 14/15 spend:

- Community equipment and adaptations
- Telecare

- Integrated crisis and rapid response services
- Maintaining eligibility criteria
- Bed-based intermediate care services
- Early supported hospital discharge schemes
- Mental health services
- Other preventative services
- Social care packages
- Reablement services (Integration Payment)

Over the past two years, Greenwich has managed increasing demand on social care by using non-recurrent funding to build up the capacity of the integrated teams so that they are able to assess cases and put in packages of support without delay. This has enabled us to minimise waiting times, eliminate delays in transfers of care from hospital and respond effectively to admission avoidance. The element of non-recurrent funding has now reached £1million, so we view the BCF allocation to the protection of social care as an investment without which, there is a risk of greater pressure on acute services and poorer patient/service user outcomes.

(For information on BCF funding for our implementation of the new duties of the care act see the box below).

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

Our Better Care Fund schemes will be part of a whole system approach to improving health and wellbeing across the borough. A number of the BCF schemes have a clear read across to the new duties of the Care Act, particularly around new duties to carers; prevention and wellbeing; assessment and eligibility; care planning and personalisation. These are schemes to:

- Increase carers' assessments and provision of services and support to carers
- Implement of Make Every Contact Count to ensure that all professionals are trained in early identification of the behavioural causes of poor health
- Extend health and social care integration through our pioneer project to ensure the right professionals are working together with people with complex needs
- Provide services and support for people who are socially isolated
- Protect social services

These schemes account for £4.8million of the BCF allocation, which together with our £2million allocation to the protection of social services, is substantially more than the element of funding provided for the new duties in the Care Act. A project plan is in place to assure implementation of the Care Act, which is overseen by the Adults and Older People's Services directorate management team and an outline of the project subgroups is set out below; this will form part of the work programme of the HWB.

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

We have an ambitious plan to extend our programme of carers support in recognition of the vital role that carers play in the cared for person's well-being and in line with the new duties in the Care Act. We have mapped out new pieces of work that will increase carer assessments across the health and social care system and will have a focus on identifying carers not currently known to the Council. We are investing an additional £1.3million per year carer specific services and support. This project will:

- increase the number of carers identified;
- develop a skilled workforce to manage increased demand and ensure carers receive a personalised service.
- Develop referral pathways for carers that are accessible and streamlined
- provide time-limited support to carers who are assessed as having substantial need, or where support is required to prevent needs increasing.

For more details of the project please see BCF020: Integrated Support for Carers in Annex 1.

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

The element of funding under Payment for Performance is £951k. Achieving a change within the first 12 months of the start of a new service is always going to be challenging and the impact of holding this element of funding back will be felt by the commissioned services, many of which will be 3rd sector providers, with the risk that it will reduce on the services' ability or motivation to mobilise and deliver the change required.

Therefore, the view taken in Greenwich (As described above in the section on risk sharing) is that it will not be practicable either to withhold or 'claw back' funds that have been committed under the BCF if the anticipated result is not achieved in Year 1.

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

As a result of our work since 2011 we have already developed services that work to support discharge from, and avoiding admissions to, hospital on a seven-day basis. In order to improve the provision of 7 day routine services further, to support people being discharged and preventing unnecessary admission at weekend as part of current integrated care pathways, a project group set up with membership across health and social care reporting to a governance board to explore and scope: clinical issues (improving diagnostics, urgent/emergency care and self-care infrastructure); commissioning levers (contractual and regulatory arrangements; and provider models/redesign); workforce implications (changes to staff terms and conditions); and financial and costing implications. This continues to make progress.

The goal is to ensure routine service delivery (convenient, compassionate and responsive) through supporting acute, primary and community based services (hospitals, pharmacies, community equipment providers, telecare installations, home care agencies etc.) to be available to deliver high quality, responsive services both in and out of normal office hours seven days a week. It is anticipated that this will drive up clinical outcomes and improve patient experience through reducing the risk of morbidity and excess mortality following weekend and out-of-hours admissions/discharges in a range of specialities.

The outcome of extending 7 day working further into more “routine” services (particularly at weekends) will be to improve admission prevention/avoidance further, enable increased access to 7 day community assessment, diagnosis and treatment, reduced risk of emergency re-admission, better use of plant and expensive hospital equipment, avoidance of waste and repetition and service rationalisation to enable safe consultant staffing levels and other allied professions in the community and in our hospitals.

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 CCG was awarded Accredited Safe Haven (ASH) status (IG toolkit level 2) by Accredited Safe Haven by the HSCIC as well as controlled environment for finance status. From 2015/16 the expectation is that the NHS number will be used as the primary identifier within the local health economy.

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).

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

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

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.

NHS Greenwich CCG has well developed IG arrangements, and has been approved as an Accredited Safe Haven by the HSCIC (level 2). Building on this platform, and working with local partners on IG, both the CCG and the Local Authority are committed to putting in place a model for information sharing that satisfied all Caldicott 2 recommendations.

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

Between April 2011 and March 2013, Greenwich Joint Emergency Team, an integrated team which provides a multi-disciplinary response to emergencies arising in the community, received over 2,500 referrals per year; a 6-month audit of cases demonstrated that over 60% of referrals avoided admission into hospital. We anticipate that once it is fully up and running, GCC will be required to work with 800 - 1000 cases of individuals whose complexity and pattern of service use indicates risk that care needs will escalate to acute in-patient services if not managed. At present we have not predicted the churn of clients and numbers going through the system in one year, so working on the lower end of the range of service users per year going through GCC, in addition to JET admissions avoided of 1,500 per year, we have identified that 11.5% of the adult population in any one year is at risk of unplanned admission

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

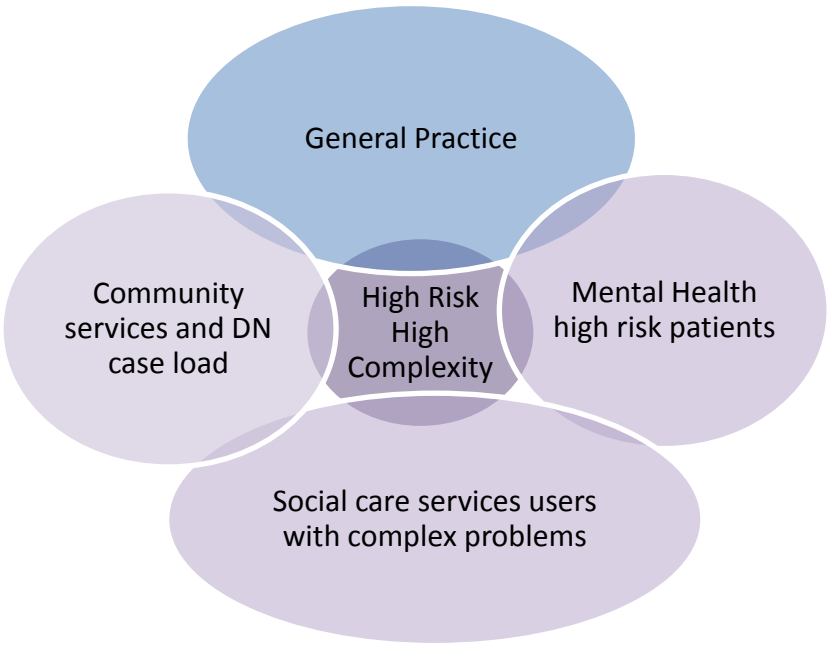
Our existing integrated teams bring together health and social care managers and front line staff into joint teams, delivering coordinated care with a clear focus on roles and responsibilities. Co-locating health and social care professionals has created a shared ethos and philosophy, underpinned by clear established protocols to assess risk and care needs and identify the most appropriate location for delivery of care.

The GCC model of integrated care based around GP LCNs will operate in the same way to identify a lead professional with the additional function of care navigators to coordinate multi-disciplinary care planning meetings and support individuals to access the right care.

Running through the integrated teams, key roles have been identified as a virtual admission avoidance team (VAAT) and the GCC model will align with the processes and protocols used by the VAAT.

The illustration below shows how people will be identified for the GCC model.

Which patients will GCC focus on?



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

All patients moving through the Pioneer test and learn pilot have joint care plans in place. A total of 73 since May 2014.

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

In response to the challenges set out by commissioners and by borough residents, local health and social care agencies came together to put in place an integrated care system in Greenwich. From its inception user involvement has therefore been core to the programme as a whole and to each strand of the programme, for example:

- The Chair of Greenwich Healthwatch is a full member of the GCC project Board overseeing the implementation and roll-out of Greenwich Coordinated Care.

- Healthwatch is involved in the evaluation of a Test and Learn Pioneer project, based in Eltham which is putting the principles of integrated, coordinated care into action. All service users/patients will be followed up by members of Healthwatch and asked about their experiences. The learning from the evaluation will inform the borough-wide roll out of Greenwich Coordinated Care

- The model for GCC is based on the agreed principles for integrated care which were developed by National Voices

- NHS Greenwich CCG met with stakeholders at an engagement event on the 20th November 2013 to introduce the new commissioning environment and the strategy for 2014-15 and to seek people's views through group feedback and individual written comments. 35 representatives from the Greenwich voluntary and community sector attended the event and provided feedback on current services and commissioning intentions. The feedback has been fed into NHS Greenwich commissioning plans and also back to the voluntary and community sector to highlight positive change.

- RBG has an Older People's Quality Board that meets quarterly, chaired by the lead cabinet member for Adults and Older People. The Board is made up of members of an active Pensioners Forum. We are currently looking at expanding the membership of the Board to include members of Healthwatch and to ensure it is representative of those who receive health and social care services in Greenwich. The Board is kept informed about and contributes to specific projects as well feeding back more generally on services. For instance, they have helped shape the recent home care tender that is being prepared and they will be consulted on BCF plans at the next Quality Board in March.

- Council officers regularly attend existing forums such as coffee mornings and drop-ins at Sheltered Housing, Extra Care schemes and Residential Care Homes. Though these settings are informal, service users and their relatives are able to talk about the services they have and direct service improvement.

- Our integration pioneer project targets patients and service users with the most complex needs; working with Healthwatch, we are ensuring that the views of

clients and their families are captured to inform the development of the project plan and roll out across the borough. Healthwatch developed a methodology to undertake in depth interviews with 10 patients and their families who were randomly selected from those taking part in the Test and Learn. The first set of interviews has been reported to the project board, and further interviews are scheduled for December 2014, to determine whether the model has improved the experience of care and achieved a sustainable outcome in meeting need.

- We have also engaged with hard to reach groups including the Nepalese community, members of the Learning Disabilities Forum, and our local BME on topics ranging from achieving better outcomes for those patients with long term conditions to their use of urgent care services and this has been taken into account in our BCF plans.

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

The establishment of the Better Care Fund in the Royal Borough of Greenwich builds on, and extends, the work undertaken for our recently successful bid to be a national Integration Pioneer, leading the way in health and social care reform. Our Pioneer approach was 'co-produced' with a wide range of providers; Oxleas NHS Foundation Trust and more recently Lewisham & Greenwich NHS Trust are members of the GCC project board and share responsibility for the project with Greenwich CCG and RBG. The GCC project board will be taking on the overall monitoring of the BCF (as outlined in this submission).

Two workshops were held in May and June 2013 bringing together nominated representatives across the social care and health system to hear about the preferred model of integrated care and work through the detail of how an early implementer site could be established in the borough and would work in practise. The group was also consulted about communicating with and engaging front-line staff and has become an implementation group that is involved in the "test and learn" site and meets quarterly with the project board. Whilst more focused on Oxleas and RBG, the group also brings in the views of third sector providers to the development of our integrated care work.

Our approach to engagement with Lewisham & Greenwich NHS Trust has been very much in the context of 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. Through this route, and the alignment of the CCG/SE London CCGs' Plans with Lewisham & Greenwich's Five Year Plan, we have engaged the Trust. Latterly this has been more explicitly about how the CCG will manage the financial risks inherent in the Plan in conjunction with the Trust, and elements of the BCF. Additionally, key schemes in the BCF (e.g. alliance contracting, Pioneer) are integral to the delivery of the out of hospital elements of our demand and capacity planning for A&E locally, and these align with our Bexley, Greenwich and Lewisham System Resilience Plan.

ii) primary care providers

Greenwich GPs have been engaged at various levels. The GPs elected to the CCG's Governing Body have been directly involved in the development of this plan, and key elements of the BCF schemes have been supported by GP colleagues working as clinical project leads (as part of our overall QIPP and Transformation Programme).

The broader membership of the CCG has been engaged through our four commissioning syndicates, at a local level, and through the quarterly Greenwich-wide Forum of all local practices. Moreover, Eltham GP practices where the Pioneer 'test and learn' site started have all been visited, involved in the development of the Pioneer's model of care, and are already making referrals to the Test and Learn team and in multi-disciplinary meetings. The Pioneer is now rolling out to the Network (Woolwich/Thamesmead) Syndicate, with Excel (Woolwich/Plumstead) and Blackheath/Charlton following soon after.

The development of our Local Care Networks has also come on apace in parallel with our work on the BCF. A number of the schemes (particularly long term conditions) are contingent on the development of our primary care providers. Locally four geographic Local Care Networks (mirroring the commissioning syndicate boundaries) are well developed now, and will all have formed limited liability partnerships by the end of September 2014 through which they will be able to provide services on a broader population basis.

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

Greenwich Action for Voluntary Services are members of the GCC project board and share responsibility for the project with Greenwich CCG and RBG.

NHS Greenwich CCG met with stakeholders at an engagement event on the 20th November 2013 to introduce the new commissioning environment and the strategy for 2014-15 and to seek people's views through group feedback and individual written comments. 35 representatives from the Greenwich voluntary and community sector attended the event and provided feedback on current services and commissioning intentions. The feedback has been fed into NHS Greenwich commissioning plans and also back to the voluntary and community sector to highlight positive change.

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:

- 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 submissions 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. The BCF particularly outlines the development of the work on frailty, MSK and COPD services through using an "alliance" model of commissioning, which in itself has been designed to ensure alignment and provider sign-up.

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 Descriptions attached separately

ANNEX 2 – Provider commentary

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

Name of Health & Wellbeing Board	Greenwich
Name of Provider organisation	Lewisham & Greenwich NHS Trust
Name of Provider CEO	Tim Higginson
Signature	Tim Higginson

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	21,554 (all providers)
	2014/15 Plan	21,064 (all providers)
	2015/16 Plan	20,636 (all providers)
	14/15 Change compared to 13/14 outturn	-2.3%
	15/16 Change compared to planned 14/15 outturn*	-2.0%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	107 – not solely from BCF
	How many non-elective admissions is the BCF planned to prevent in 15-16?	445 – not solely from BCF

*Please note that the figures above do not match the Part Two spreadsheet, because the above figures ask for 2014/15 and 2015/16 plans, whereas the Part Two spreadsheet asks for the period Q4 2014/15 – 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.

Appendix 3 – Detailed BCF Funding Sources

Greenwich Health and Well Being Board - Better Care Fund 2014/15 to 2015/16

	Better Care Fund 2014/15	Better Care Fund 15/16			Protecting Social Services
	Royal Borough of Greenwich	Royal Borough of Greenwich	NHS Greenwich CCG	Total 2015/16	Royal Borough of Greenwich
	£	£	£	£	£
Funding Transfer to RBG 2013/14 (s256):					
Community equipment and adaptations	350,000	350,000		350,000	350,000
Telecare	450,000	450,000		450,000	450,000
Integrated crisis and rapid response services	300,000	300,000		300,000	300,000
Maintaining eligibility criteria	450,000	450,000		450,000	450,000
Bed-based intermediate care services	250,000	250,000		250,000	250,000
Early supported hospital discharge schemes	350,000	350,000		350,000	350,000
Mental health services	150,000	150,000		150,000	150,000
Other preventative services	400,000	400,000		400,000	400,000
Social care packages	1,761,282	1,761,282		1,761,282	1,761,282
Sub Total	4,461,282	4,461,282	0	4,461,282	4,461,282
Reablement services (Integration Payment)	300,000	300,000		300,000	300,000
S 256 Agreement 2013/14	*4,761,282*	*4,761,282*	*0*	*4,761,282*	*4,761,282*
Transfer to LAs (£900m nationally) (Integration Payment)	811,000	811,000		811,000	811,000
Carers / Further Transfer (£200m nationally)	530,000	530,000		530,000	530,000
Other / Rounding	-5,282	-5,282		-5,282	-5,282
NHS Funded Other	**6,097,000**	**6,097,000**	**0**	**6,097,000**	**6,097,000**
Pioneer - roll out of the extended 'Pioneer' service for residents with complex conditions		348,000		348,000	
Virtual Patient Record - allows shared access to patient information across all providers		99,000	400,000	499,000	
Care Homes - invest in training and development of care home staff		375,000	375,000	750,000	
Pressure Ulcers - reducing their number and severity			750,000	750,000	
Social Isolation - support to live healthily for the isolated and lonely		154,000		154,000	
Nutrition - improving nutrition services			530,000	530,000	
Long Terms Conditions (LTCs) - increasing the scale of available support services			462,000	462,000	
MECC - ensuring every contact with services includes a conversation to improve health		1,006,000		1,006,000	
Carers - increase assessment and support for carers		1,395,000		1,395,000	
Protecting Social Care 15/16 additional investment		2,000,000		2,000,000	2,000,000
Dementia - improving diagnosis rates and scaling up support			550,000	550,000	
Telehealth - better use of technology for remote care monitoring			200,000	200,000	
End of Life - fully implement the national programme Cordinate My Care			213,000	213,000	
Alliance Contracting for Integrated Frail Elderly Pathway - transforming the way we work *		2,123,000	933,000	3,056,000	
Better Care Fund		**7,500,000**	**4,413,000**	**11,913,000**	**2,000,000**
NHS FUNDED	**6,097,000**	**13,597,000**	**4,413,000**	**18,010,000**	**8,097,000**
Local Authority Funded					
Disabilities Fund	1,020,000	1,020,000		1,020,000	1,020,000
Social Care Capital Grant	741,000	741,000		741,000	741,000
LOCAL AUTHORITY FUNDED	**1,761,000**	**1,761,000**	**0**	**1,761,000**	**1,761,000**
BETTER CARE FUND TOTAL	**7,858,000**	**15,358,000**	**4,413,000**	**19,771,000**	**9,858,000**

* Split TBC