HEALTH AND WELLBEING BOARD

17 SEPTEMBER 2013

Title:	Allocation of Barking & Dagenham Reablement Funding 2013/14
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Author: Bruce Morris, Divisional Director, Adult Social Care Sharon Morrow, Chief Operating Officer, B&D CCG	**Contact Details:** Tel: 020 8227 2749 E-mail: bruce.morris@lbbd.gov.uk
Sponsor: Cllr Reason, Cabinet Member for Adult Services and HR	

Summary:

This report gives an overview of the proposals for the reablement allocation transferred from Barking and Dagenham's Clinical Commissioning Group (CCG) to the Council. These proposals have been put forward from the Integrated Care Sub-group to the Health and Wellbeing Board to agree expenditure.

Recommendation(s)

The Health & Wellbeing Board is asked to:

(i) Agree the expenditure of £650,000 for the proposals as set out in sections 2.2 and 2.3 of the report to improve re-ablement services and outcomes for residents.

Reason(s)

Agreeing these proposals will contribute to the better health of residents of the borough.

1. Background and Introduction

1.1. The Reablement allocation has already transferred from the Barking and Dagenham's Clinical Commissioning Group (CCG) to the Council. In previous years joint agreement was required from the PCT and local authority on how the funding would be committed prior to transfer. It has been agreed locally that proposals to spend this allocation in 2013/14 will be put forward from the Integrated Care Sub-group to be agreed by the Health and Wellbeing Board.

1.2. Overall £650,000 in-year funding has provisionally been identified to support expenditure in social care that will benefit the health of local residents. Similar amounts have been identified in the two previous years, all announced as one-off

allocations. In these years funding was transferred in the final quarter of the year. By addressing this earlier, we have the opportunities to plan for new initiatives which will support priorities. Recent announcements by the government suggest that there will be further funding of this nature in future years though this is likely to be rolled up into other pooled grants.

1.3. Sections 2.2 and 2.3 of this report outline the proposals to spend this allocation.

2. Proposal and Issues

2.1. Proposals have been developed based on priorities emerging through the work of the Integrated Care Coalition and issues emerging from a better understanding of cluster/locality working between GPs and adult social care. The priorities locally are to prevent avoidable hospital admissions, to reduce pressure on A&E departments and to facilitate hospital discharge. Due to the short term nature of the funding the proposals have been designed to support additional capacity over one full year.

2.2. A - Increase Mental Health Social Work Capacity in Clusters

2.2.1. Background

2.2.1.1. Barking and Dagenham CCG has utilised winter funding money to complete a clinical review of patients with six or more presentations to A & E over an eight month period. The review identified a significant number of patients who presented with underlying mental health problems and/or drug and alcohol problems. A number of patients had previously been known to Community Mental Health services and some recently were under their care, and some people may have benefitted from treatment from specialist drug or alcohol services. These patients were not engaged with services.

2.2.2. Description

2.2.2.1. Dedicated mental health and substance misuse social work support will be introduced in all six clusters employed directly by the Council and managed through the existing integrated clusters. The service will not be an Approved Mental Health Professional service undertaking mental health act assessments and is not intended as a replacement for secondary mental health services or existing primary care mental health services. The additional capacity in clusters will provide practical and emotional support for people with mental health problems/ drug and alcohol problems who are not regarded as eligible for specialist North East London Foundation Trust provided services. They will have a clear interface with existing mental health teams such as the Home Treatment Team

2.2.2.2. Social workers will be directly available to GPs and will receive referrals via the cluster meetings. The social workers will need to work flexibly and innovatively to support the needs of service users. They will play a key role in helping service users receive support either directly or from other programmes including detox/rehab programmes, and the relevant support.

2.2.2.3. Given the time limited nature of the posts it is important to recruit staff with the knowledge and experience of mental health and drug/alcohol problems. This is best delivered through recruiting qualified social workers. The social work profession demands specific personal attributes and qualities that can best meet the challenges presented by people with mental health and/or substance misuse issues. Skilled social work can avoid the need for compulsory intervention, to enable people to

remain in their own homes. The clusters require the professional credibility of social workers, which will also ensure appropriate referrals are made to specialist mental health services provided by NELFT.

2.2.3. **Outcomes**

2.2.3.1. The specific outcomes of the social worker posts will be detailed and monitored by the Integrated Care Project Manager, a post which is further discussed in section 2. The post will develop performance metrics for the new social worker role but outcomes will need to include

- Reduced admission to A&E
- More people supported in Localities (clusters)
- Reduced likelihood of crisis
- Improve access to and maintenance in drug/alcohol treatment plans

2.2.4. **Funding required**

— £277,000 (6 x social worker post) - full year effect. If the social workers are recruited in the autumn the posts will be funded for 12 months to the following autumn.

— £10,000 - training to support the role

— £ 5,000 - 0.5 days a week monitoring the outcomes of the social worker posts.

2.3. **B - Integrated Care Targeted Programmes and Monitoring**

2.3.1. **Background**

2.3.1.1. Integrated Care is a well established model in Barking and Dagenham. The organisation of services around GP practices including social workers and some community health staff has been achieved. However, there is more work to be done to ensure shared goals and objectives across specific projects in health and social care are achieved. Furthermore, there is a pattern of unnecessary admissions to acute care that can be further resolved alongside existing work to reduce admissions.

2.3.1.2. The targeted support described below will see:

- Care homes, home carers, informal carers and PAs better able to manage more complex conditions, including residents on end of life care pathways outside of acute settings
- Care homes, home carers, informal carers and PAs better equipped with the strategies to reduce chance of falls
- Increased care and support in individual's homes to reduce readmissions to hospital

2.3.2. **Description**

2.3.2.1. Improved end of life provision via training - Roll out funding for the Gold Standards Framework for Care Homes (GSFCH) accreditation across the borough. The GSFCH Programme, supported by the Department of Health End of Life Care Strategy, is one

of the biggest, most comprehensive programmes undertaken to enhance end of life care in care homes. It is based on best available evidence, real grass roots experience and shared learning. Most care homes have started the training and this funding will enable homes to take the next step and be accredited.

2.3.2.2. Falls prevention training and other targeted interventions - The care homes in the borough do not, in general, deliver specific falls prevention training. Given the number of falls and resulting admissions into hospital, the roll out of quality falls prevention training will help ensure care staff know the best strategies to prevent falls. This training will also be utilised by home care staff and the growing number of Personal Assistants in the borough. The opportunity for a community exercise programme will also be explored and commissioned if evidence suggests the outcomes are positive.

2.3.2.3. Targeted care support - For people coming out of hospital who require further support, there will be the facility to increase care packages and introduce support for a period without waiting for a full review/assessment. This targeted intervention will support residents at home, in care homes or in Extra Care settings. This funding pot will enable additional resources to be introduced quickly to give the best possible care and support to help people remain at home.

2.3.2.4. We will be utilising some rehabilitative interventions alongside more traditional support. There will be links with the proposed new Joint Assessment and Discharge service being developed currently with the emphasis on home assessments.

2.3.2.5. Integrated Care Project Manager - This post will primarily support implementation and monitor the agreed integrated activities such as the additional social work capacity and end of life care, falls and targeted support. The post will also be a resource to lead on the work plan of the Integrated Care sub group of the Health and Wellbeing Board.The post will be hosted by the Council and will work closely with the six clusters and CCG commissioners.

2.3.3. The work plan is flexible but it is envisaged that full time post's time will be split as follows:

Activity	Time allocated per week
Monitoring of social work posts	10%
End of life care monitoring and strategy	20%
Fall prevention training development and strategy	20%
Targeted care support managing and monitoring	10%
Lead on work plan of Integrated care sub group	30%

Develop joint proposals for funding opportunities	10%

NB: this is indicative only and does not take into account annual leave, training, etc.

2.3.4. **Outcomes**

2.3.5. **Improve end of life provision via training:**

- Increase in use of End of Life care plans
- Service providers know who to contact to ensure co-ordinated and dignified end of life care and support
- Increased proportion of people die in place of choice
- Increased recording of preferred place of care
- Decrease in number of hospital admissions

2.3.6. **Fall prevention:**

- Reduced hospital admissions for falls
- Service users feel more independent following targeted support intervention

2.3.7. **Targeted care support:**

- Increased percentage of people with Section 2s with no readmission in the year
- Increased proportion of older people (65+) who are still at home 91 days after discharge from hospital
- Reduced admission to residential care
- Service users feel more independent following targeted support intervention

2.3.8. **Funding required:**

- Improve end of life care provision - £15,000
- Fall prevention training - £30,000
- Target Care Support - £263,000
- Integrated Care Project Manager - £55,000 (subject to grading)

3. Summary of Proposals

Increase Mental Health Capacity in Clusters	Social worker posts	£277,000
	Training and evaluation	£10,000
	Monitoring	£5,000
Integrated Care Targeted Programmes and Monitoring	Improved end of life provision via training	£15,000
	Falls prevention	£30,000
	Targeted care support	£263,000
	Integrated Care Project Manager	£55,000
	TOTAL	**£650,000**

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

4.1.1. The aims reflect JSNA priorities including improving mental health, decreasing falls & consequences of falls and ensuring that more people can die in their chosen place. Avoidable hospital readmissions were also identified as needing addressing.

4.2. Health and Wellbeing Strategy

4.2.1. The plans deliver some aspects of the Established Adults and Older Adults components of the Health & Wellbeing Strategy. Specifically, it should deliver improved integration of services allowing people to live independently for longer and to die with dignity in a planned way. Residents will also, potentially, have more control & choice over their care.

4.3. Integration

4.3.1. See paragraph 4.2.1

4.4. Financial Implications

4.4.1. In 2013/14 £650,000 of funding has provisionally been identified to support expenditure in social care that will benefit the health of local residents. This funding is an in year transfer from Barking and Dagenham's Clinical Commissioning Group and does not form part of the Council's baseline funding. For this reason, and to minimise the risk to the Council, the proposals within this report are for one year only. For those proposals which relate to staffing, the proposed posts will be employed for one year only on fixed term contracts.

4.4.2. The £650,000 provisional funding is for the 2013/14 financial year. As the proposed use of the funding will not be agreed until at least mid financial year it is assumed the funding can be carried forward into 2014/15.

(Implications completed by: Dawn Calvert, Group Manager, Finance)

4.5. **Legal Implications**

4.5.1. There are no legal implications arising from this report.

(Implications completed by: Dawn Pelle, Adult Care Lawyer)