

***Draft: Barking and Dagenham***

## **Appendix 1**



### **Better Care Fund planning template – Part 1**

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to:

[NHSCB.financialperformance@nhs.net](mailto:NHSCB.financialperformance@nhs.net)

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	<b>London Borough of Barking and Dagenham</b>
Clinical Commissioning Groups	<b>Barking and Dagenham CCG</b>
Boundary Differences	<b>None</b>
Date agreed at Health and Well-Being Board:	<b>Plan – 11 February</b>
Date submitted:	<b>14 February</b>
Minimum required value of ITF pooled budget: 2014/15	<b>£761,000.00</b>
2015/16	<b>£14,235,000.00</b>
Total agreed value of pooled budget: 2014/15	<b>£13,182,000.00</b>
2015/16	<b>£21,610,000.00</b>

## b) Authorisation and signoff

<b>Signed on behalf of the Clinical Commissioning Group</b>	Barking and Dagenham CCG
<b>By</b>	Conor Burke
<b>Position</b>	Chief Accountable Officer
<b>Date</b>	<date>

<b>Signed on behalf of the Council</b>	London Borough of Barking and Dagenham
<b>By</b>	Anne Bristow
<b>Position</b>	Corporate Director Adult & Community Services
<b>Date</b>	<date>

<b>Signed on behalf of the Health and Wellbeing Board</b>	Barking and Dagenham Health and Wellbeing Board
<b>By Chair of Health and Wellbeing Board</b>	Cllr Maureen Worby
<b>Date</b>	<date>

**c) Service provider engagement**

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Local Authority has developed a Market Position Statement where commissioning intentions and outcomes we are striving to achieve with service users and carers are made explicit for providers. Social care providers have been, and will continue to be provided with briefings on the Better Care Fund (BCF) so that they will work to common commissioning intentions and help shape service development, Provider Forums have been created in Barking and Dagenham to support a common approach. Besides the larger providers, micro providers who provide a very personalised approach are supported well through infrastructures in the Borough.

Health providers have engaged throughout the commissioning cycle, including

engagement via commissioning intentions, market events and contract negotiations.

The local community and mental health services provider, North East London Foundation Trust (NELFT) and the acute provider, Barking and Dagenham, Havering and Redbridge University NHS Hospitals Trust (BHRUT) are members of the Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Coalition (ICC). The ICC is the local health and social care vehicle for driving forward the 5 year strategic plan, so providers are engaged through this and in the BHR Integrated Care Steering Group in setting the overall strategic direction within which the BCF is being developed.

Within Barking and Dagenham, the Health and Wellbeing Board includes representatives from BHRUT and NELFT, and so brings commissioners and providers together to address wider health and wellbeing improvements from the full range of perspectives. The Health and Wellbeing Board have reviewed the BCF as well as approve the final plan. The development of the BCF has been overseen by the H&WB Integrated Care sub-group which equally has membership across health and social care as well as from key providers.

Providers have been closely involved in developing the operational aspects of the BCF for example the development of the service model and implementation plan for the Joint Assessment and Discharge service and the developments in intermediate care and community services which are currently being tested.

#### **d) Patient, service user and public engagement**

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Engagement around the BCF builds on work done in BHR over the period 2012-2013 to develop the local Case for Change for Integrated Care and the Integrated Care Commissioning Strategy which included wide stakeholder engagement, and which underpins many of the service developments that will be supported by the plan. There

have been ongoing discussions with patient and community representatives and groups around the BCF itself, most recently these include: the B&D CCG Patient Engagement Forum in November 2013; B&D CVS forum in December 2013 and a large (80 plus attendees) stakeholder event in January 2014 facilitated by Healthwatch. The latter event provided an opportunity for local stakeholders to review and comment on the plan and invited them to be part of its development in the future. The meeting had the opportunity to review implementation of the integrated care strategy to date and changes in intermediate care currently being tested. A full report from the event will be provided by Healthwatch (to follow) headline messages including a very positive response to the proposed integrated working of health and social care (to add once HW report available), with stakeholders feeling that broadly the services are needed and that more support to help people return / stay at home is welcomed.

**e) 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.

The documents that have been listed here are important in terms of background but do not give plans for each scheme or the national conditions.

<b>Document or information title</b>	<b>Synopsis and links</b>
BHR 5 year strategic plan	The headline transformation changes that are required across BHR to meet health outcomes and create a sustainable health and care economy.  Attachment 1
Health and Wellbeing Strategy	The high level strategy that sets out the way in which partners will work together to address the needs of the diverse, growing population of Barking and Dagenham. Our Strategy is based on four priority themes that cover the breadth of the frameworks and in which the priorities under consideration are picked up within. One of the three outcomes of our Health and Wellbeing Strategy is to

	<p>improve health and social care outcomes through integrated services.</p> <p><a href="http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf">http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf</a></p>
<p>Joint Strategic Needs Assessment</p>	<p>Integration is one of the themes of the JSNA 2013 and this paper is well aligned to address and follow up these priorities and the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.</p> <p>The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and this paper identifies which areas can be addressed in more integrated way to shape future sustainable strategies for the borough.</p> <p>Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular for:</p> <ul style="list-style-type: none"> <li>a) Supported living for older people and people with physical disabilities – see JSNA at <a href="http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-8.aspx">http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-8.aspx</a></li> <li>b) Dementia – see JSNA at <a href="http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-28.aspx">http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-28.aspx</a></li> <li>c) Adult Social Care <a href="http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-9.aspx">http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-9.aspx</a></li> <li>d) Learning Disabilities – <a href="http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-3.aspx">http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-3.aspx</a></li> </ul>

	<p>e) Mental health- Accommodation for People with Mental Illness  <a href="http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-7.aspx">http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-7.aspx</a></p> <p>f) End of Life Care  <a href="http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-31.aspx">http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-31.aspx</a></p> <p>The care of older people and end of life care including dementia, caring for the carers, discharge from hospital, and continuing care of patients with chronic conditions would be priorities for the BCF.</p> <p>The care of those with learning disability and mental health problems requires an integration of social care and health support, including health checks for both LD adults and mental health service users and help with employment as a priority.</p>
<p>Developing a commissioning Strategy for Integrated Health and Social Care services in Barking and Dagenham, Havering and Redbridge: Strategic outline case November 2012.</p>	<p>This established a vision for integration and services developed around people. This included:</p> <ul style="list-style-type: none"> <li>• Enabling people to live well and independently for as long as possible and ensure services are designed to manage frailty and disability;</li> <li>• Deliver services closer to home rather than in a hospital or residential / nursing home;</li> <li>• Identified areas for development – such as commissioning for improved delivery of proactive care.</li> </ul> <p>(Added as Attachment 2)</p>
<p>Integrated Care in Barking and Dagenham, Havering and Redbridge: the case for change</p>	<p>Established 'will dos' for our system which included:</p> <ul style="list-style-type: none"> <li>• Promote and support independence, personal responsibility and self management and personalised choice;</li> <li>• Have a clear understanding of population need and inequalities, the opportunities and challenges of providing services to a</li> </ul>

<p>August 2012</p>	<p>diverse population</p> <ul style="list-style-type: none"> <li>• Recognise that the user will be at the heart of developing our approach</li> <li>• Ensure health and social care resources are deployed as efficiently as possible to the most appropriate care setting at the lowest level of intervention</li> <li>• Ensure investment in community, social care and primary care capacity in order to shift activity and resources from hospitals and other institutions;</li> <li>• Not lose sight of the fact that prevention and early intervention strategies are needed to make changes in the longer term on the health and well-being of local people and support health and well-being strategies and commissioning strategy plans.</li> </ul> <p><a href="http://www2.redbridge.gov.uk/cms/care_and_health/adult_social_services/idoc.ashx?docid+06ccb1c9-6bd1-4ba-8efe-505a289c797a&amp;version=-1">http://www2.redbridge.gov.uk/cms/care_and_health/adult_social_services/idoc.ashx?docid+06ccb1c9-6bd1-4ba-8efe-505a289c797a&amp;version=-1</a>.</p>
	<p>Other identified documents:</p> <ul style="list-style-type: none"> <li>• EOLC H&amp;WB paper</li> <li>• JAD ICC paper</li> <li>• IRS ICC paper</li> <li>• H&amp;WB Re-ablement Paper</li> <li>• ICM project plan and outcomes dashboard</li> <li>• Market Position Statement</li> </ul>



## 2) VISION AND SCHEMES

### a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Commissioners and providers across health and social care in Barking and Dagenham are working together to look at how health and social care services can be made better for local people. With increased demand for our services, we need to:

- improve how people experience care and ensure the best possible quality to deliver the right care, in the right place, at the right time
- ensure the health and social care system is 'future proof' and able effectively to manage increasing demand and need, not only today, but in years to come
- ensure services are efficient and deliver value for money and are sustainable.

Barking and Dagenham CCG and Local Authority are committed to building responsive, integrated care designed around people's needs and delivered as close to home as possible. The development of the locality model – which aims to bring together clusters of General Practices with community health and social care professionals working together to assess, plan and coordinate the care of patients at high risk of admission to hospital – is at the heart of this approach. Six integrated health and social care localities have been established in B&D. We have built and developed this model over time both in terms of broadening the expertise and scope of the teams as well as ensuring these are operating at maximum efficiency. We are also working with NHSE to develop effective primary care development which underpins the effectiveness of the model.

Barking and Dagenham CCG and London Borough of Barking and Dagenham recognise that they need to work across a wider health and social care system to deliver some of the changes in service model and configuration they are seeking. As key partners in the Integrated Care Coalition they have worked with other partners in BHR to develop an Integrated Care strategy for health and social care. In it partners across health and social care are seeking to transform the relationship with individuals by placing them at the

centre of delivery, driving improvements to the quality of experience and outcomes. Where possible, local people want to be cared for and supported in their own homes, or closer to home, not in hospital. Family carers play a key role in supporting their loved ones, helping to promote their independence. We think, and evidence supports our thinking, that people spend too long in hospital, which can make it much harder for them to return home and live independently again.

The locality model in Barking and Dagenham fundamentally underpins the broader system wide integration work across BHR and focused on working with acute and community providers to enable better care and better outcomes for local people as we move away from bedded hospital care to locally delivered community based health and social care services with the focus on prevention, early intervention, focused rehabilitation/re-ablement and early intensive discharge. Service users, carers and providers contributed to the development of the model. We expect to see the benefits of this approach for patients and carers as well as ensuring the sustainability of health and social care services with reductions in acute activity and reductions in residential and nursing home placements.

The impact of this work over time will be that more and more care is provided to people either in their own home (for example Intensive Rehabilitation Service), or in community or locality settings through the Integrated Health and Social Care Teams – using bedded care as a ‘step – up’ rather than a ‘step down’ where needed and considering unplanned admissions as a marker of system weakness rather than a first port of call when things are going wrong for patients. Upstream work with patients and better discharge arrangements (through the Joint Assessment and Discharge Team) should also reduce the need for residential and nursing home placements as alternative options are explored including the provision of short term interventions. This will involve significant changes in terms of number of beds needed, building patient confidence in new models of service and developing local workforce to deliver more specialised care in locality/community based settings with a greater emphasis on the role of therapists in maintaining and returning people to independence.

These changes should deliver better outcomes for our patients and service users so that as well as changing the sort of care (from bed based and centralised to local and

ambulatory/home-based) and the focus of intervention (from unplanned and reactive to planned and preventative) and one which seeks to broaden choice in how on-going support needs might be met, we are able to improve how well supported patients feel in managing their LTCs.

This is in line with and a key enabler of the BHR system's overall acute A&E reconfiguration programme/modelling and the Long Term Financial Plan agreed across the system as well as changes in bedded intermediate care services aimed at providing more rehabilitation in the home setting reducing the number of rehabilitation beds needed as services in the community are developed. The commitment to develop King George Hospital as a centre of excellence for ambulatory care will be a key development in support of the overall strategic direction around the shift from bedded to community based/ambulatory care services and intensive rehabilitation.

#### **b) Aims and objectives**

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The overall aim for integrated care is to strengthen the community response to people's needs by bringing together health and social care and so reduce the need for hospital care, maximise independence and improve outcomes.

The specific objectives are drawn from the Integrated Care Commissioning Strategy:

- Integrated Health and Social Care working that improves arrangements for admission avoidance and discharge and therefore, our usage of costly acute resources and improved experiences for service users and patients
- Supporting a joint and strengthened commissioning role with provider services
- Improvements in primary care improving access to support and interventions in people's own homes with less reliance upon acute services.

- Improvements in prevention, keeping people well and healthy for longer and protecting support for carers.
- Improving End of Life Care which enables greater numbers of people to be effectively cared for at home or in the place of their choice.
- Protecting Social Care services

These objectives will be measured by way of overall aspirations against the national outcome measures as set out in more detail below. In essence we expect to see from the planned changes the following;

To be completed following finalisation of trajectories for outcomes:

1. A reduction in delayed transfers of care from 302.2 to 226.5 and to 175.4 by 2016
2. A reduction in avoidable unplanned admissions by *(to be inserted into final plan)*.
3. Maintaining the effectiveness of our re-ablement services so that we continue to ensure upper quartile performance and 91.5 to 91.67%.
4. Reducing the number of people who need residential or nursing home placements by 170 to 144.
5. Improving the number of people who feel supported to manage their long term conditions by *(to be inserted into final plan)*.
6. Reducing the number of injuries due to falls in people aged 65 and over by 53.2 from 514.50 to 461.24 per 100,000.

There are also a number of specific measures which apply to specific change programmes detailed in c) below.

### **c) Description of planned changes**

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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### **Scheme 1: Integrated Health and Social Care Teams**

Integrated health and social care teams are in place. These build on the integrated case management structure that is in place for people most at risk of hospital admission and will incorporate a wider range of services including Community Treatment Services (providing acute care to people at home who would otherwise require hospital admission) integration of mental health social worker support and long term conditions services. In the coming year the proposed focus will be on:

- Improving the efficiency of team and ensuring focus on appropriate acuity of patients
- Developing COPD and IV and other condition specific pathways
- Implementing the nursing home support scheme
- Developing Occupational Therapy service around falls and fracture management
- Aligning End Of Life Care work
- Integrating Mental Health Social Work support with a focus on avoiding A & E attendances and emergency admissions
- Developing governance arrangements around the team
- Developing shared workforce skills and capacity.

For illustration, the model provides for the following tiers:

Tier 1: Community Nursing, generic therapies

Tier 2: Integrated Case Management- planned care & support for people with Long Term Conditions

Tier 3:Community Treatment Team/ IRS – urgent care and specialist intensive home support

Tier 4: Bed based support.

Our development work should support delivery of further reduction in avoidable admissions particularly around the identified top 10 ICD10 codes identified as being highest for unplanned admissions in the borough. The scheme will continue to be closely monitored in terms of delivery not only in respect of service access and capacity but also in respect of quality and effectiveness of the service delivered. This is against a range of outcome measures developed in 13/14. A full project plan will be provided for final submission.

Weekly performance dashboards are in place to capture service performance effectiveness and outcomes of the Community Treatment Team element of service – given that this was a service innovation implemented and refined in 13/14.

### **Scheme 2: Admissions avoidance and improved hospital discharge**

A Joint Assessment and Discharge Service model has been developed to improve discharges from the acute hospital, supported by 7 day working and targeted care and support.

7 day working has been operationalised within our acute services providing an enhanced assessment and discharge capability across all days of the week and removing barriers that would ordinarily occur at weekends. This is already delivering improvements in user experience and in discharge flows across the week.

To strengthen our progress made in delivering 7 day working we are in the process of implementing the Joint Assessment and Discharge Service which will bring together in one team, discharge functions undertaken by acute trust staff and those undertaken by social care. Implementation is scheduled for the end of June 2014 (and approved by the Urgent Care Board on 10th December 2014). The service structure will be embedded into wards and Multi-disciplinary Discharge arrangements. We have now successfully recruited the Service Manager to assist in operationalising the service. The Local Authority will be the 'host' organisation for the service. The JAD team will have enhanced delegation and decision making, bringing this closer to individuals and their families and access to on-ward services.

In addition to having key service objectives - key measures (developed and having regard to the outcomes required within the JAD) will be:

- DTOC - number of people with a delayed discharge (days)

- Permanent admissions into residential/ nursing care placements for older people aged 65+
- numbers of assessments completed i.e. increase on current baseline
- number of discharges (over current baseline)
- number of continuing health care packages - broken down into community and placements
- the number of free nursing care cases
- numbers of referrals into community rehabilitation services
- improved user and patient experience

Service users assessed as having ongoing care needs and who are eligible for social care services are provided with personal budgets (wherever possible) or commissioned services. Wherever possible people are supported to direct their own care so that they have control over how their care is delivered and independence and choice are optimised.

### **Scheme 3: Rehabilitation**

An Intensive Rehabilitation Service (IRS) is being trialled which provides intensive support to people at home, rather than in an acute or intermediate care bed. This is linked to a programme of productivity improvement for intermediate care beds that is also underway to allow more people to maximise their independence in their own home.

The Intensive Rehabilitation Service aims to provide an alternative to community bed rehabilitation to enable the support of people in their own homes as appropriate. Intensive, in home support is provided by the team with between one and four visits per day depending on the needs of the individual. The team works closely with Integrated health and social care locality teams and the community bed inpatient units to ensure a smooth and seamless patient journey to recovery. The service is open 8am-8pm, seven days a week and is accessed via Integrated health and social care teams.

Key milestones to implementation as follows:

- Paper to Gov Bodies including performance of trial to date and outcome from engagement work- Jan 14.
- Assuming recommendation to extend trial is agreed we would be seeking to finalise the proposed model of intermediate care- June 14
- Formally consultation on any significant service changes- July-September 14
- Final decision paper to Gov Bodies- Nov/Dec 14
- Build changes in contracts 2015/16

In 2014/15, it is anticipated this service would contribute to the Better Care funding ambitions to:

- reduce the amount of time people spend avoidably in hospital through better and more
- integrated care in the community, outside of hospital, closer to home.
- increasing the proportion of older people living independently at home following discharge from hospital.
- increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and the

community.

Weekly performance dashboards capture service performance effectiveness and outcomes.

This scheme will also undertake further work to ensure that rehabilitation and re-ablement provided by social care are aligned so that outcomes are maximised.

#### **Scheme 4: Mental health support outside hospital**

This will bring together health and social care commissioned services that work to support people with mental health problems through talking therapies, primary care, social care, accommodation and employment and recovery services. The local authority approach fosters inclusion and access for service users to all community resources e.g. leisure and the Care and Support service directory for information and advice and



Personal Assistant Finder.

People with mental health problems would benefit from and would prefer support outside of acute care settings and in planned ways at early stages and with a focus on recovery. Through our review 'frequent attenders' at A & E we identified issues with dual diagnosis and substance use as potential gaps in our current locality working and as such have agreed to deploy some of current year re-ablement funding for social work input to address these specific issues. *(Re-ablement metrics are subject to sub group discussion on 3<sup>rd</sup> February 2014).*

We are working with NELFT to ensure delivery of better access and recovery outcomes for people needing IAPT services (talking therapies). Although this is a challenging target steady progress is being made to deliver current year (13/14 targets). The RAID model has also been identified as a proposed approach to improving psychiatric liaison in acute hospital care and ensuring people with mental health needs are appropriately cared for.

The CCG is undertaking a review of mental health recovery services with a view to working with LBBB to ensure a coordinated approach to provision in the borough and to ensure focus is on prevention and recovery, employment and independent living. This is yet to go through appropriate governance procedures.

Key success measures currently focus on access/recovery rates for IAPT and overall avoidable admissions data. These will need to be refined in year to demonstrate success particularly around level of admission avoidance – potentially using some of the learning from the Community Treatment Team dashboard.

#### **Scheme 5: Integrated commissioning**

An integrated commissioning approach will be developed to deliver the commissioning changes required in the BCF. We have agreement to commence with a jointly funded post from our base budget to support our next steps in developing our integrated commissioning and working towards an integrated commissioning unit over a five year

period.

Integrated Commissioning which will commission on outcomes – we will review commissioning arrangements within year 1 of the BCF to :

- Further establish our approach to Joint commissioning, sharing resources and working across Local Authority and CCG to support the strategic implementation of integrated commissioning of health and social care.
- This shared approach could include older people, Long Term Conditions, urgent care community services, family carers, mental health and learning disability services. Also potentially covering joint nursing home, care home commissioning and domiciliary care and personal budgets.
- Arrangements will be put in place to oversee the day to day operation of the Better Care Fund Plan and support performance and outcomes required, alongside reporting requirements to the Fund's governance arrangements within our system.

We will develop success measures and timeframes once proposal agreed in principle.

### **Scheme 6: Support for family carers**

We recognise that carers play a crucial role in supporting their loved ones to remain independent in their own home and also in supporting timely discharge from hospital.

Carers are often the experts in a patients care and working closely with carers is crucial to achieving better outcomes.

An integrated carers strategy to be developed with a focus on aligning BCF funding to support carers locally and to take into account the requirements of the pending Care Bill. Further work is needed to develop approach, milestones and outcome measures which will be done in 14/15. Carers will be key to developing a joint approach.

This will support the increased emphasis on carers assessments that will be required as part of the implementation of the Care Bill.

### **Scheme 7: Care Bill Implementation**

To include carers assessments, meeting national eligibility thresholds and statutory safeguarding board.

The Care Bill brings with it a range of new responsibilities and areas of focus, including those of deferred payments, revisions in financial thresholds and increased assessment activity. There will also be a specific emphasis on carers assessments, information and advice, advocacy and safeguarding boards becoming statutory with new responsibilities i.e. for reviews where lessons can be learnt from individual situations. These responsibilities align with most of the schemes putting service users/patients at the centre rather than the focus being upon the services themselves.

Our Strategic Needs Assessment has confirmed that Barking and Dagenham will see increased numbers of people aged 85 years of age and over. People over the age of 85 require at least 3 times as much social care support than 65 to 69 year olds we have also modelled a range of other factors including those of migration which will impact upon the need for support within the borough.

The Borough has a structured programme to prepare for the Care Bill in comparing current baseline with estimated costs of the care bill there is a cost pressure of £12.7 m with accuracy of our forecasting being a priority now that the legislation and its implications are better defined.

In ensuring an accurate understanding of the likely impact of the Bill we have identified steps within this plan that will positively impact upon demand. Further discussions are taking place between the Local Authority and CCG on the potential costs of implementation of the Care Bill, for these aspects deemed by the Department of Health to be included in national resources for the Better Care Fund and agreement on how these are to be funded.

### **Scheme 8: Prevention**

The Local Authority invests in preventative services to promote health and wellbeing with an emphasis on physical activity and falls prevention. Further work will be undertaken to evaluate the effectiveness of the services and how they align with and support the various schemes.

### **Falls Project overview**

The A&E audit showed that falls accounted for 25% of attendances in the over 75s. This project aims to reduce A&E attendances for falls by ensuring that the population has access to appropriate falls assessment and intervention.

This will be achieved by developing a shared vision/strategy for falls management for older people within BHR which will:

- Promote integration of falls services.
- Ensure appropriate and efficient utilisation of specialist falls services.
- Promote a whole systems approach, ensuring that falls assessment and intervention are seen as part of everyone's role.

### **Progress to date**

- Scoping of current provision (Mapping of falls services and shadowing key teams).
- Project Team/ Frailty Academy members being recruited.
- Falls event planning in progress.

### **Key milestones**

- Project plan agreed (December 2013).
- BHR falls event date and venue confirmed and invitation circulated (end January 2014).
- Mapping and analysis of current falls services conducted (end February 2014).
- BHR falls event (March 2014).
- Improvement initiatives identified (March 2014).
- Joint BHR falls strategy agreed (April 2014).

### **Outcome metrics to demonstrate success**

- Reduce A&E attendance for falls among the over 75s in BHR
  - Improved access to services and reduced waiting times for falls clinics
  - Further metrics specific to improvement initiatives
- Targeted work with Care Homes in identifying risks for falls and in prevention.

Outcomes as per Care Homes project.

**Scheme 9: End of life care**

Supporting training and service improvements across agencies and services, and integrating into cluster teams.

A paper jointly prepared across health and social care is due for consideration at the H&WBB on February 11, 2014, which sets out a range of actions to develop EOLC services and through better integration support patients to die in their place of choice. This includes training and support to enable generic service providers to better support those with end of life care and support needs. The timeframes for this work will need to be determined once the proposed actions have been approved. The proposed success measures specifically for EOLC being proposed include:

<b>Suggested Measures</b>
Number of patients on the GP practice end of life register
% of deaths in hospital/ usual place of residence
Number/% of Service Users on practice / care home end of life registers benchmarked against prevalence in population generally or comparable practices (This can be benchmarked by list size for GP practice -& /or could just look for growth on current level of performance )
Number/% of Service Users who have been offered (advanced care plans) ACPs and number of ACPs in place
Number/% of people who died with a recognised end of life status
Number/% of Service Users dying in place of choice (as specified in ACP).
Reduction in emergency admissions which result in death is a measure of success in all settings.

Reduction in excess bed-days.
Being pain free and having condition managed with medication.
Loved ones / informal carers experiences to end of life care such as being near friends and family.
Duration by condition and expected life expectancy against setting of care.
Reductions in people dying in care homes who were not previously resident as such six months prior to death

Priorities for our focus will be in relation to:

- Numbers of people with Advanced Care Plans in place
- Numbers of people who are able to die in the place of their choice
- Further work to consider the role of care homes
- Participation in GSF End of life Care training programme for generic service providers being rolled out across the borough.

This will play a key role in supporting overall outcome for the BCF of reducing unplanned admissions for people who can be better cared for in other care settings.

**Scheme 10: Equipment and adaptations**

Bringing together the commissioning and provision of equipment and adaptations that are required to support people in their homes.

Access to appropriate equipment to support care at home is a key element of patients and service users being able to manage independently at home with improved levels of self care. There are currently no integrated equipment facilities in Barking and Dagenham. Following agreement in principle to developing this together, this will provide a key underpinning ‘enabler’ to early and effective discharge, re-ablement, improved self care and rehabilitation and admission avoidance schemes outlined in this section. Timelines and key success measures will need to be developed but these will need to focus on timely access and link in with joint planning processes across health and social

care.

### **Scheme 11: Dementia support**

Improving early diagnosis and support to people with dementia.

We need to build on current work supporting people with dementia and their carers in the borough. We want to ensure that we have a comprehensive approach across health and social care including prevention and delaying onset, early identification and coping with the later stages of the condition. The services currently in place (dementia resource centre, memory clinic and older people's mental health services) provide a starting point for developing and implementing a joined up dementia strategy locally. The CCG is making progress against the CCG indicator for dementia diagnosis with some improvement toward trajectory in 13/14 but with more work to do. Timelines and success factors will need to be agreed but clearly the focus needs to be on early identification and managing later stages of the condition in a planned and appropriate way rather than through unplanned emergency admissions and late stage diagnosis in acute setting. We will therefore develop a local dementia action plan.

### **d) Implications for the acute sector**

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

There are opportunities to make better use of acute resources. Nationally emergency admissions account for more than 70% of hospital bed days and those with higher length of stays are predominantly over 65 (Poteliakhoff and Thompson 2011). If all areas achieved the rate of admission and average length of stay of those in the lowest 25<sup>th</sup> per centile 7,000 fewer hospital beds would be needed across England.

Overall the planned changes will result in a reduction in the number of emergency

admissions, A&E attendances and length of stay. The impact on acute contracts will be aligned with BHRUT's long term financial model.

. Detailed work is underway to quantify the impact of the schemes on emergency admissions and will be available for the final submission of the plan. This is a complex piece of work that requires alignment with contracts, with acute provider and other commissioners.

#### **e) Governance**

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Governance and leadership shall be exercised by the CCG Governing Body and the Health and Wellbeing Board, supported by the Integrated Care Sub-group of the Health and Wellbeing Board and sub-group of senior CCG and local authority officers who are overseeing the detailed and day to day work. The Integrated Care Coalition provides oversees strategic plan development of which BCF if a key element oversight across Barking and Dagenham, Havering and Redbridge and therefore provides consistency in approach and in developmental opportunities across local authority boundaries. It will provide oversight of the operation of the BCF, our performance against required outcomes and additional steps which may be required.

An integrated commissioning approach, supported by agreement to jointly fund a shared post between the CCG and the Local Authority, will be further developed that will focus on commissioning for the BCF outcomes. We will review commissioning arrangements within year 1 of the BCF to :

- Further develop our integrated commissioning arrangements, sharing resources and working across LA and CCG to support the strategic implementation of integrated commissioning of health and social care.
- This shared approach will initially consider older people, LTC, urgent care community services, family carers mental health and learning disability services. It could be further extended to cover joint nursing home, care home commissioning



and domiciliary care and personal budgets.

- Arrangements will be put in place to oversee the day to day operation of the Better Care Fund Plan and support performance and outcomes required, alongside reporting requirements to the Fund's governance arrangements within our system.

### 3) NATIONAL CONDITIONS

#### a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The development of the BCF will seek to protect identified services that benefit health across the two year period and across the two budget setting years. Key priorities are ensuring people are safe and that those with critical and substantial needs have them met.

This will ensure funding is in place to the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management, review and commissioned services to people who have substantial or critical needs and effective information, signposting to those who are not eligible to FACs (Fair Access to Care services). Investment in integrated health and care teams (clustered around general practice) will provide earlier identification and intervention for those are likely to need future support. Social care support can be critical to keeping people with complex needs and frailty safe, independent and with quality of life.

Social care plays a significant role within our extension of 7 day working arrangements, providing improved access to assessment and support where required.

Alongside opportunities identified above and through utilisation of the fund and the schemes within it that will positively impact upon such areas as admissions to bed based services we also recognise that there are areas of new activity for example, the new Care Bill requires additional assessments to be undertaken for people who did not previously access social care.

Please explain how local social care services will be protected within your plans

The BCF provides an opportunity for LBBB and B&D CCG to work together and in a

coordinated way to improve the way in which local services are used – focusing more on prevention and early intervention and improving outcomes for patients and pressures on services later in the care pathway – for example focusing on re-ablement and active rehabilitation which should reduce we think the net impact on residential and nursing home placements – as seen in other areas and release resources.

We will need to use the BCF in new and innovative ways to enable us to implement the Care Bill. A notional working sum for implementation has been identified but we will need to work through this together and also understand how other spend can be refocused to provide headroom for implementation.

We are also looking at how we can better support carers and maximise the way in which carers can work with health and social care services to improve outcomes and make the best use of our local resources. This will involve the development of a joint carers strategy as set out above.

The local Better Care Plan acknowledges within the schemes, financial allocations and priorities that will give us the best chance of sustaining local services that will best impact upon our system and current demand pressures

Modelling is underway in relation to the financial impact of the Care Bill and proposed re-investment by the CCG into key deliverables within the Better Care Fund.

### **b) 7 day services to support discharge**

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

7 day working has been operationalised within our acute services providing an enhanced assessment and discharge capability across all days of the week and removing barriers that would ordinarily occur at weekends. This is already delivering improvements in user

experience and in discharge flows across the week.

In addition, and to strengthen our progress made in delivering 7 day working we are in the process of implementing a Joint Assessment and Discharge Service which will bring together in one team discharge functions undertaken by acute trust staff and those undertaken by social care. Implementation is scheduled for the end of June 2014 (and approved by the Urgent Care Board on 10th December 2014). The service structure will be embedded into wards and Multi-disciplinary Discharge arrangements. We have now successfully recruited the Service Manager to assist in operationalising the service. The team will have enhanced delegation and access to on-ward services.

### **c) Data sharing**

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

In 2010 the Local Authority and PCTs (CCG's) Commenced a data sharing programme using a single data repository for reporting. The linkage within the database is NHS number, over the subsequent years this repository has grown to provide access to health and social care personal involved in direct patient care. Today the repository provides the basis for information to be used by the Joint Assessment and Discharge service, Integrated case management service and Rapid response and urgent care teams along with crisis information for A&E consultants and general practice.

Collection of the NHS number is embedded into our social care business processes. Following a project in 2011 when social care records were matched to NHS numbers by the NHS Tracing Service, it is now routinely collected by the allocated social worker or support planner as part of the assessment or review process; use of the NHS Number forms part of our internal audit standards, and in 2013 a total of 241 further NHS Numbers were collected using this method. Of those clients being case managed by the Integrated Care Cluster Teams, 99.9% [1340 out of 1341 cases] have their NHS Number recorded.

The Council's IT Strategy, adopted in June 2013, committed the organisation to making use of open standards for data management and transparency. However, it also committed to making use of 'off the shelf' software, rather than excessively tailored 'bespoke' solutions. Therefore, we continue to exploit the excellent relationships between the Council, social care IT suppliers and NHS partner IT managers to look for improved ways of linking data management software

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

NHS number is being used.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK).

In 2013 the PCT / CCG and local authority took part in a programme supported by the DoH to encourage the adoption of the interoperability toolkit standards. Currently the core system for sharing information is approved by the DoH to send and receive messages via ITK and this functionality is the basis for the Local Authority to share key elements of a patients social care record with Out of Hours, A &E and NHS 111 services.

As part of the Joint Assessment and Discharge work, an application programming interface (API) has been developed to enable Section 2 and section 5 information to be processed in the same format as the health service, Continuing Health Care process. This joining of systems and process all driven from a central combined health and social care repository ( aligned by NHS number) is a key element of our strategy as we progress toward joined up working.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The Council already complies with the IG controls set out in the IG toolkit and the PSN CoCo (Code of Connection). The Council's most recent PSN CoCo was granted in

November 2013. The IG Toolkit was last submitted in March 2013 and we are working towards the submission for March 2014. The corporate Information Governance Board includes Caldicott Guardians, and oversees the Council's continued adherence to information governance requirements and best practice, reviews breaches of information security, and ensures required organisational development activity

**d) Joint assessment and accountable lead professional**

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Integrated case management is in place in Barking and Dagenham. The population is risk stratified using the Combined Predictive Model. The top 1% of the population identified as being at highest risk of admission to hospital are targeted for integrated case management and provided with a joint care plan.

While the integrated care teams support coordinated care planning and an MDT approach to providing holistic patient care, the patient's registered GP is the 'lead primary care provider'. The patient's care co-ordinator is the first point of contact in the ICM model, but each patient has a named GP lead in their care plan. The coordinator role ensures continuity of care in all eventualities. This system will support the 'accountable GP for over 75s' initiative.

The risk stratification and care planning process is facilitated through the data repository described in section c above. This is a web based system that all providers (primary care, community care, social care, and secondary care) have access to allowing them to identify high risk patients. Targeting individuals at risk of acute admission and providing preventative interventions are key in reducing current usage of acute services and delivering savings in whole system costs. Multi-disciplinary care plans are also available on Health Analytics enabling all care providers real time access to care plans, which have the details of the accountable professional and opportunities for improved co-ordination.

As well as using the risk stratification tool to identify patients who could benefit from joint care planning to reduce risk of admission, we are also working with LTC services, EOLC services, and care homes to ensure that their patients can benefit from this where appropriate.

We are also promoting opportunities for improved levels of 'self care' through providing access through 'active aging', advice and information that may encourage lifestyle changes which promote improved health and wellbeing

As of 7<sup>th</sup> January 2014 ICM caseload is 1102, number of patients with an active care plan is 646.

#### 4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
<p><b>BHRUT quality and performance issues</b>- the local hospital trust faces substantial challenges to deliver quality care and financial sustainability. The intention to reduce expenditure on acute care will further impact upon the Trusts financial model.</p>	High	<p>Quality and performance contract management processes are key methods</p> <p>Special measures arrangements</p> <p>Urgent Care Board and system plan</p>
<p><b>Achieving financial balance and sustainable services through reconfiguration changes</b> that will be challenging to implement and will require stakeholder, community and public / patient support.</p>	High	<p>QIPP and BCF key elements along with related assurance and progress monitoring processes which have matured over year. Developing more robust partnership communications and engagement on key issues.</p>
<p><b>The introduction of the Care Bill</b> will result in significant increases in the costs of care provision that is at this point not fully quantifiable and will impact upon the sustainability of current social care funding and plans</p>	High	<p>We have undertaken an initial impact assessment of the effects of the care Bill and will continue to refine our assumptions around this as we develop our final response and begin to deliver upon the associated schemes</p>
<p><b>Maximising impact with scarce resources</b> – given the population need in Barking and Dagenham</p>	High	<p>Close monitoring of outcomes and plan deliverables through established governance</p>



<p>and the particular challenges that the population has in improving health outcomes in an area of high deprivation, there is a risk that the efforts of health and social care services will have a limited impact upon outcomes</p>		<p>arrangements will establish progress and additional actions required. This remains however a significant challenge in our area.</p>
<p><b>Further cashable savings and efficiencies</b> required from the Council and the pressures on CCG budgets due to over performance in other areas of health spend challenge planning assumptions and/or impinge on other areas of health and social care spend.</p>	<p>High</p>	<p>Activity within the plan reflects agreed local priorities and strategy for the Council and the CCG – including that of the Integrated care Strategy.</p> <p>The plan itself seeks to invest in preventative activity in order to reduce demand for higher cost services and seek similar benefits as those evidenced with LGA value cases 2013.</p>

Attachment 1: BHR five year strategic plan on a page (to be provided at final submission).

Attachment 2: Integrated care commissioning strategy November 2012 (to be provided at final submission).

## Part 2

### Better Care Planning Care template – Finance, outcomes and metrics

## Finance - Summary

*For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.*

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 £'000	Minimum contribution (15/16) £'000	Actual contribution (15/16) £'000
Local Authority Barking and Dagenham		11,567	1,180	8,555
CCG Barking and Dagenham		1,655	13,055	13,055
<b>BCF Total</b>		<b>13,182</b>	<b>14,235</b>	<b>21,610</b>

*Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.*

Barking and Dagenham has a clear strategy for integrated working aimed at bringing health and social care staff in the local primary and secondary sectors together, in order to provide more response patient centred care and to shift resources from the acute sector to the community. This is underpinned by an integrated care strategy which is overseen by the Integrated care Subgroup of the Health and Wellbeing Board. A programme of work is well underway, some initiatives already embedded locally. The programme consists of six established multi-disciplinary cluster teams organised around GP practices. The CCG has commissioned a community treatment team responding to emergencies in peoples homes and to encourage self care. There are targets against the provider contract which will be monitored by the CCG. The health provider trust, acute trust and local authority have jointly commissioned an assessment and discharge team comprising nurse and social workers which will support avoidance of admission where appropriate and timely discharge home. Seven day working across the acute trust has also been introduced. All new services are regularly monitored through an assurance system. It is hoped that some efficiencies will be made through service redesign and sharing of resources. The local acute trust is on special measures and quality and management of activity are risk factors locally. Performance is monitored by an Urgent Care Board chaired by the CCG Chief Officer. The BCF delivery will be monitored by the Integrated Care Subgroup of the Health and Wellbeing Board where progress, risks, performance and budget issues will be overseen. Further work is required before the final submission to develop a contingency plan to manage over performance on acute trust activity should the planned improvements

not be achieved.

<b>Contingency plan:</b>		<b>2015/16</b>	<b>Ongoing</b>
<b>Outcome 1</b>	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
<b>Outcome 2</b>	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non recurrent
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Scheme 1; Integrated Case Management	CCG	5,245	0			9,864	0		
Scheme 2: Admission Avoidance and Discharge from Hospital	Local authority	2,047	0			2,047	0		
Scheme 3: Rehabilitation	Local authority	700	0			3,143	0		
Scheme 4; Mental health support outside hospital	Local authority	840	0			1,006	0		
Scheme 5: Joint Commissioning	Local authority	220	0			220	0		
Scheme 6: Support for Family Carers	Local authority	925	0			925	0		
Scheme 7: Care Bill implementation	Local authority	100	0			1,184	200		
Scheme 8: Prevention	Local authority	1,221	501			1,221	308		
Scheme 9: End of life	Local authority	105	0			105	0		
Scheme 10: Equipment and Adaptations	Local authority	350	590			377	672		
Scheme 11: Dementia support	Local authority	338	0			338	0		
<b>Total</b>		<b>12,091</b>	<b>1,091</b>			<b>20,430</b>	<b>1,180</b>		

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total BCF allocation

<b>BCF Investment</b>	<b>2014/15 spend</b>	<b>2014/15 benefits</b>	<b>2015/16 spend</b>	<b>2015/16 benefits</b>
	£'000	£'000	£'000	
Scheme 1: Integrated Case Management	5,245	<i>To be completed</i>	9,864	<i>To be completed</i>
Scheme 2: Admission Avoidance and Discharge from Hospital	2,047	<i>To be completed</i>	2,047	<i>To be completed</i>
Scheme 3: Rehabilitation	700	<i>To be completed</i>	3,143	<i>To be completed</i>
Scheme 4: Mental health support outside hospital	840	<i>To be completed</i>	1,006	<i>To be completed</i>
Scheme 5: Joint Commissioning	220	<i>To be completed</i>	220	<i>To be completed</i>
Scheme 6: Support for Family Carers	925	<i>To be completed</i>	925	<i>To be completed</i>
Scheme 7: Care Bill implementation	100		1,384	<i>To be completed</i>
Scheme 8: Prevention	1,722	<i>To be completed</i>	1,529	<i>To be completed</i>
Scheme 9: End of life	105	<i>To be completed</i>	105	<i>To be completed</i>
Scheme 10: Equipment & Adaptations	940	<i>To be completed</i>	1,049	<i>To be completed</i>
Scheme 11: Dementia Support	338	<i>To be completed</i>	338	<i>To be completed</i>
<b>Total</b>	13,182		21,610	

## Outcomes and metrics

*For each metric other than the patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.*

### **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population**

For this indicator our 2012/13 baseline performance was 871 permanent admissions per 100,000 65+ population. This equates to 170 Barking and Dagenham residents aged 65 and over, admitted to residential care for that year. We have set what we feel is a realistic achievable target for the period underpinning the October 2015 payment of 738 admissions per 100,000 65+ population. Achieving this target would mean a reduction of 26 people being admitted throughout the financial year.

A number of schemes noted in the draft Plan will impact on this target.

#### Scheme 1

The integrated case management scheme is already an established way of working within Barking and Dagenham which involves a number of multi-disciplinary teams which are led by the locality GP. These teams have been set up to promote independence amongst the older population of the borough and those with complex conditions, by providing commissioned services and where possible services via a direct payment which in turn helps people to remain in their own homes for longer and maintain choice and control over the services they receive.

The Community Treatment Team(CTT) potentially helps to avoid unnecessary hospital admissions, It is provided by NELFT and works in an integrated way with health and social care staff to access emergency social care packages to keep people in their own home. Sustaining people at home by responding quickly to health crises can help to sustain them in their own homes for longer.

#### Scheme 6

The support for family carers scheme is being put in place to refresh the borough's carers strategy. This will encompass the requirements which have been identified in the upcoming Care Bill. In the borough we recognise the contribution of informal carers and that they are experts in caring for their loved ones which in turn enables them to remain living in their own home and to maintain independence. This can help to defer or avoid care home placement. The support for carers also helps to facilitate better pathways home from hospital, sometimes avoiding care home placement.

We have proposed a scheme for dementia, to improve the co-ordination of health and social care and work with family carers and better support those with dementia, living at home. Improved co-ordination of community services can enable

people with dementia to live longer independently at home, thus avoiding for some, care home placements.

### Scheme 3

The current changes being trialled in intermediate care where intensive rehabilitation in the home is being offered as an alternative to more traditional community bed-based care following hospital discharge, opens up the possibility of people being returned to independence more effectively after e.g. fractures following falls but has not been quantified in terms of nursing/residential homes admissions. A high proportion of care home placements nationally are known to be as a result of falls. .

### **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services**

Our baseline (2012/13) performance for this indicator was strong, of the older clients discharged from hospital into re-ablement/ rehab services between October and December 2012 91.5% were still living in their own homes after 91 days. This performance placed us in the top quartile of our comparator group and above both the England and London average (81.4% and 85.3% respectively). With this performance in mind we have set the target for the October 2015 payment to maintain current performance, we are also aware that as this only looks at a three month period there is a possibility that results may fluctuate.

### Scheme 3

The rehabilitation scheme will see services offered by the community health services provider trust (NELFT) moving towards providing intensive rehabilitation in the home setting reducing the number of rehabilitation beds needed as services in the community are developed. The scheme will also include the continuation of the Council's crisis intervention service which was introduced at the beginning of the 2012/13 financial year as a short term service to help people be assessed and receive the services they need as quickly as possible. We will also ensure that our local systems for rehabilitation and re-ablement join up well.

### **Delayed transfers of care from hospital per 100,000 population (average per month)**

For this indicator we have used the 2012/13 financial year data as the current baseline for which a total 4,892 delayed days were reported for the London Borough of Barking and Dagenham. This is the equivalent of a monthly average of 407.7 delayed days which becomes 302.2 when converted to a rate per 100,000 residents (18+). This is higher than both the London average (177.9) and the England Average (280.1). Taking this into consideration we have set the targets for this indicator as 225 for the period underpinning the April 2015 payment and 175 for the period underpinning the October 2015

payment. We feel that these are challenging but realistic targets and if achieved will bring Barking and Dagenham in line with the current London average performance.

#### Scheme 2

The scheme which will have the most noticeable impact on the performance of this indicator will be the Admissions Avoidance and Discharge from Hospital Scheme. One aspect of this scheme will see the introduction of a Joint Assessment and Discharge Service in the acute setting which aims to improve how patients leave hospital and go back to their own homes safely and with dignity and respect. The Admissions Avoidance and Discharge from Hospital Scheme will also see the development of 7 day working of social care staff in hospital to enable weekend hospital discharges. There are huge benefits to 7 day working from a patient experience point of view as well as helping to reduce the number of days lost due to delayed transfers of care. As stated above the support for family carers scheme will also have a positive effect on this DTOC indicator.

The Intensive Rehabilitation Service, currently being trialled, will also support people to move more rapidly home from hospital.

#### Scheme 10

The Equipment scheme, ensuring that equipment is coordinated and available in a timely way, will support timely discharge.

### **Avoidable emergency admissions (composite measure)**

#### Scheme 1

Barking and Dagenham CCG and LBBD have established joint working to provide Integrated Case Management (ICM), specifically targeted at people who are identified through predictive risk modelling as being at high risk of hospital admission. Teams of health and social care practitioners work together for a defined population, based on GP registration (localities of general practice). Health and social care are now working together to build on this well-established model in Barking and Dagenham by extending the approach which brings together a wider ranges of services into the localities, extending the opportunities for integration for service users. This range of services will include mental health workers and a wider range of long term conditions services.

Additional mental health social workers are being introduced to the integrated teams specifically to address the need to have improved mental health support for people identified as frequent attendees at A&E from our recent review.

The Community Treatment Team has been commissioned to specifically work with people requiring acute medical care who would otherwise require a hospital admission.



Scheme 8: Prevention activities including work to prevent falls and injuries following falls will reduce the number of admissions following falls.

Scheme 9: improvements in end of life care, combined with improved support for family carers (scheme 6) will help reduce the numbers of emergency admissions for people at the end of life, as they are provided with the support needed to die at home (according to their wishes).

Work is underway to quantify the impact of these schemes on emergency admissions and will be available for the final submission of the plan, This is a complex piece of work that requires alignment with contracts with acute provider and other commissioners.

### **Injuries due to falls for people aged 65 and over**

One in three people over the age of 65, and one in two of those over 80, will fall each year<sup>1</sup>. Falls and fractures among the over-65s take up four million hospital bed days each year in England, costing an estimated £2 billion. Injuries in the elderly due to falls can occur through inadequate assistance with personal care at home, particularly following discharge from inpatient hospital care for other health problems. Better social care support can reduce the number of hospital admissions due to injuries such as hip fractures and therefore the burden on the NHS.

It has been shown that implementing a falls prevention strategy can reduce the number of falls by between 15 and 30 per cent<sup>2</sup>; therefore, investing in social care could not only potentially reduce overall social and health care costs but also improve the lives of these vulnerable people and prevent avoidable suffering.

Barking and Dagenham hope to achieve the targeted reduction by developing a shared vision and strategy for falls management. The strategy will promote the integration of services for vulnerable people by promoting a whole systems approach, ensuring that falls assessment and intervention are seen as part of everyone's role. This will help to prevent falls

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<sup>1</sup> NHS confederation: Ambulance Service Network Community Health Services Forum (April 2012), Falls Prevention: New approaches to integrated falls prevention services

<sup>2</sup> Department of Health (2009), Falls and fractures: developing a local joint strategic needs assessment.

occurring.

*For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for the October 2015 payment. please see the technical guidance for further detail. If you are using a local indicator Please provide details of the expected outcomes and benefits and how these will be measured*

**Proportion of people feeling supported to manage their(long term) condition**

For the patient experience metric we have decided to use the ***Proportion of people feeling supported to manage their(long term) condition*** indicator. The outcome of this indicator is calculated using responses to the GP Patient Survey (GPPS). The current GP Patient Survey (GPPS) questionnaire asks:

*“Do you have any long-standing health problem, disability or infirmity? Please include anything that has troubled you over a period of time, or is likely to affect you over a period of time.”*

Respondents who answer ‘Yes’ (rather than ‘No’ or ‘Don’t know / Can’t say’) are then asked:

*“In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? (Please think about all services and organisations, not just health services)”*

Respondents have a choice of 5 options:

- Yes, definitely
- Yes, to some extent
- No
- I have not needed such support
- Don’t know / can’t say

This indicator was chosen as we feel the integrated care management scheme and the mental health support outside hospital scheme will enable us to improve the way in which patients perceive the support they receive in managing their long term conditions. This is an indicator which encompasses health and social care and is the ultimate test of what we are trying to achieve. It is an indicator that was chosen in 13/14 by the CCG, with support from the local authority, and enables us to have some continuity of measurement. This is a holistic indicator that can include how well patient's clinical symptoms are managed, how they feel about the outcomes they are achieving and how services are affecting their lives, not just their health.

*For each metric, please provide details of the assurance process underpinning the agreement of the performance plans.*

**Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population**

All permanent admissions into residential or nursing placements must receive sign off from the group manager or above before they can be authorised. The number of older people admitted into permanent residential care is monitored on a monthly basis by senior management as part of regular performance monitoring. This indicator is also included in our health and Wellbeing Board performance framework. The number of older people admitted into external residential placements is also scrutinised on a monthly basis as part of rigorous financial monitoring.

**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services**

Due to this indicator concentrating on a three month period this isn't something we can monitor on a monthly basis throughout the year. However the figures are thoroughly scrutinised before submission as part of the end of financial year statutory returns. In addition, outcomes of rehabilitation services offered via the provider trust are monitored by the CCG. The Local Authorities Crisis Intervention re-ablement service, provides up to 6 weeks intervention through the Integrated Care cluster model. These interventions can be clearly identified on the social care case management systems, so service users can be clearly identified and tracked, and performance of the Authorities crisis Intervention service is monitored monthly.

**Delayed transfers of care from hospital per 100,000 population (average per month)**

DTOC information is monitored in great detail throughout Adult Social Care. Any delayed days are discussed between the

main acute trust (BHRUT) and adult social care on a weekly basis, with necessary solutions and required steps and are agreed before any sign off takes place. Similar arrangements are being developed with our other principal neighbouring acute hospitals.

Both the number of people delayed (snapshot) and the total number of delayed days are monitored on a monthly basis at a senior level within social care and health.. The snap shot information is currently included in our Health and Wellbeing Board performance framework with plans to include this delayed days indicator from the start of the 2014/15 financial year. An in-depth look at DTOC performance is also presented at the borough's Urgent Care Board which is chaired by the Chief Accountable Officer for the three CCG's.

**Avoidable emergency admissions (composite measure)**

Performance arrangements still need to be worked through in detail but will be overseen by the B&D Integrated Care Group for locally delivered schemes and through the Integrated care Steering Group for BHR for system wide schemes. Some elements will be closely monitored through the UCB.

**Injuries due to falls for people aged 65 and over**

As this indicator is included in the Public Health Outcomes Framework this will be the subject of ongoing regular monitoring.

*If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template for the multiple HWB combined.*

Not Applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
<b>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</b>	<i>Metric Value</i>	871.0	N/A	738
	<i>Numerator</i>	170		144
	<i>Denominator</i>	19,517		19,517
		( April 2012 - March 2013 )		( April 2014 - March 2015 )
<b>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services</b>	<i>Metric Value</i>	91.50%	N/A	91.67%
	<i>Numerator</i>	110		165
	<i>Denominator</i>	120		180
		( April 2012 - March 2013 )		( April 2014 - March 2015 )
<b>Delayed transfers of care from hospital per 100,000 population (average per month)</b>	<i>Metric Value</i>	302.2	224.3	175.4
	<i>Numerator</i>	4892	2875	1530
	<i>Denominator</i>	134913	142419	145342
		( April 2012 - March 2013 )	( April - December 2014 )	( January - June 2015 )
<b>Avoidable emergency admissions (composite measure)</b>	<i>Metric Value</i>			
	<i>Numerator</i>			
	<i>Denominator</i>			
		( TBC )	(April - September 2014)	( October 2014 - March 2015 )
<b>Proportion of people feeling supported to manage their(long term) condition – to be used for the patient/service user experience measure</b>			N/A	
		( insert time period )		( insert time period )
<b>Injuries due to falls for people aged 65 and over</b>	<i>Metric Value</i>	tbc	N/A - Annual Indicator * targets for the periods underpinning future payments have yet to be set for this performance indicator. Currently the only data for this measure is for 201/11 & 2011/12 financial years. Historical data has been requested from the NE London	tbc
	<i>Numerator</i>	tbc		
	<i>Denominator</i>	tbc		
		(April 2011 - March 2012)		( April 2014 - March 2015 )

			<i>Commissioning Support Unit once this has been received work will be undertaken to set a realistic &amp; achievable target which will be agreed by both Public Health and the CCG.</i>	
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