Better Care Fund Plans 2016-17
High Level Plans Narrative and update

1.0 Introduction

Barking and Dagenham developed and agreed their Better Care Fund plan in 2014. The final submission of the plan was made in December 2014 having been signed off by the CCG and LBBD and following engagement with local communities, providers and other stakeholders. The following narrative should be read in conjunction with the 2014 submission.

The following narrative sets out:

- Updated BCF plans– in particular in the local vision, lessons learnt from 15/16 and refreshed metric trajectories.
- Details as to how the national conditions are met
- Confirmation of funding contributions – detail of this is included in the BCF planning return submission
- Scheme level spending plan – detail of this is included in the BCF planning return submission

2.0 Updated BCF plans

2.1 local vision

Since the BCF was agreed and submitted in December 2014, a number of developments have taken place, which will support and enable the aspirations set out in the original plan.

These include:

- Urgent and Emergency Care Vanguard – see Urgent and Emergency Care Value Proposition
- Accountable Care Organisation – see ACO bid
- Operating Plan and Sustainability and Transformation Plan
- Ambition 2020 – with increased focus on targeting services and integrating approaches
- Mental Health needs assessment and strategy development

The development of revised locality delivery networks based on the needs of populations of 50-70,000 residents is at the heart of transformation programmes described above and the BCF.

The content of the BCF revised plans for 2016/17 has been developed to take into account and align with the transformation work described above.

Stakeholder engagement and co-design in our emerging transformation programmes is at different stages but very much an integral part of each strand of work. Recent work has included an informal café style engagement afternoon, focusing on staying healthy and very much reflecting the prevention elements of the BCF plan.

2.2 Lessons learnt

We have achieved limited headway on our delivery of the non-elective admissions target for 15/16 which has led to significant further work to understand what is, locally, driving non-elective admissions and as a result how those might best be impacted upon. This has included a detailed review of admissions to understand in particular those areas that are more difficult to impact upon (examples being maternity and patient transfers) and where local work needs to align with wider system work taken forward through the Systems Resilience Group and the Integrated Care Coalition across BHR.

Testing hypotheses around admissions was explored with front line staff from a range of provider organisations at a stakeholder event in October 2015. This work was followed up with a specific piece on rising admissions in the 40-64 age group – not traditionally part of the elderly frail patients who are referred to Integrated Case Management.

This learning underpins the development of our refreshed scheme plans.

2.3 Revised Plans

One of the areas of learning from the previous year has been the management of the 11 BCF schemes described in the original plan. The number and variety of schemes proved unwieldy and introduced unhelpful barriers between related areas – for example equipment and Joint Assessment and Discharge. A number of projects have been, or are in, the final stages of completion. Based on this learning the schemes have been streamlined, refreshed and clustered under to demonstrate how each supports the key metrics – enabling an easier description of overall plans and better links between each scheme. There are now 3 themes, which provide a strategic focus for our work, and which are:

- Theme 1. Avoiding Admission to Hospital
- Theme 2. Integrated Support in the Community
- Theme 3. Discharge from Hospital

These provide a structure to the schemes of work which remain broadly consistent with those in the original plan:

- Scheme 1. Models of care
- Scheme 2. Dementia
- Scheme 3. EOLC
- Scheme 4. Carers
- Scheme 5. Mental Health
- Scheme 6. Prevention
- Scheme 7. Equipment and Assistive Technologies

Each Theme enables improvements across each scheme and is anchored to the key BCF outcomes. The following table sets out this approach in more detail and includes high level milestones for each element of the overall plan. Please see **Appendix 1** for details.

2.4 Revised metrics

Barking and Dagenham has worked hard to deliver its aspirations against its original trajectories for the BCF metrics but with limited success. Understanding the reason for this and using that information to inform planning, monitoring and setting aspirations for 16/17 has been a significant aspect of preparing to refresh the plan. A summary of metrics and rationale for setting them is set out in **Appendix 2.**

3.0 National conditions

3.1 Plans jointly agreed

Our existing plan delivers against a number of performance outcomes that will continue to be delivered against in the coming year, alongside areas of renewed focus. Previous work as part of the Better Care Fund has successfully delivered an integrated Joint Assessment and Discharge Service across health and social care partners, which is now at full operational capability and has robust governance in place. Integrated services such as these have supported our shared development of the workforce through joint training and development.

In the next year of the Better Care Fund we intend to extend the reach of the fund to encompass housing and the preventative role housing services play. There will also be a focus on early intervention, promoting self-care and delaying for as long as possible the need for high cost bed based services. We have identified the need to develop a shared approach to areas that can positively impact upon identified performance metrics (such as around DToC) and address emerging local priorities which include End of Life Care and Dementia Care. These priorities reflect those identified and endorsed by the Health and Wellbeing Board and reflect the views of partners, commissioners and providers.

Further detailed scoping will identify the investments that will be required to deliver the Better Care Fund for 2016/17. The current governance arrangements will provide an opportunity to share these further detailed steps, as well as the broader strategic context, alongside the impacts that these will have upon current arrangements and services which sit outside of the Better Care Fund pool.

In developing the Better Care Fund for 2016/17, partners have been aware of the need for longer term strategic integration between health and social care. As part of the London Health and Care Collaboration Agreement announced in December 2015, Barking and Dagenham, Havering and Redbridge were awarded a pilot to test the concept of an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.

This pilot work will identify whether delivery of an Accountable Care Organisation (ACO) will accelerate the delivery against the ambitions being set out by the partnership, which will be reflected as Barking & Dagenham, Havering and Redbridge's contribution to the Sustainability and Transformation Plan for north east London. If the business case suggests this is a viable model, then the eight statutory organisations that form BHR's Integrated Care

Coalition will take the decision on whether to proceed with an ACO from 2016/17. The emphasis of the business case development process is on a coherent strategic direction for the health and social care system across BHR, so that if an Accountable Care organisation is not deliverable, there will still be strong strategic direction articulated for the long term integration of services, including how to deliver the best outcomes for local people, future capacity and workforce requirements and implications for both local providers and the regulation of services as part of a potential set of devolution 'asks'. In 2016/17 Better Care Fund will continue in its role integrating services and contributing to the work around developing an Accountable Care Organisation and a system-wide vision.

3.2 Maintain provision of social care services

The review of our BCF seeks to protect identified services that have a health and or whole system benefit across the coming year. Key priorities are ensuring people are safe, healthy and well and that those needs under the Care Act are met.

The BCF will ensure that funding is in place for the Council to meet its duties under the Care Act. Particular emphasis is applied to interventions that improve outcomes for individuals, specifically actions to prevent, reduce or delay needs, improved information and advice and the delivery of appropriate and proportionate assessment. Without such steps there would be a marked and growing challenge to the ability of the Council to effectively manage demand pressures within a markedly reduced core budget. We will support a holistic approach, encourage and support self-assessment and self-care, improving and fully embedding integrated assessment and the consequent commissioning and delivery of services. We will further support the shift towards proactive, preventative early interventions.

As the result of a robust piece of market analysis, in 2015/16 the Council has taken the decision to radically reset its 'usual price' for residential and nursing care. This was explicitly to ensure compliance with the duty to ensure market sustainability, and will have the effect of increasing the cost of these services by over £1.8m per annum. It will also, however, enable the Council to foster stronger partnerships with the residential care sector to drive up quality and to bring them more fully into the work of the Better Care Fund around admissions avoidance and supporting rapid discharge. An investment from the Better Care Fund into mental health placements, allied to work to reprofile the available supported living services, will also contribute to the reduction in delayed transfers of care, and ensure improvements in timely care planning for people with eligible severe and enduring mental health needs.

Supporting carers through the delivery of assessment and services will ensure that we both better understand carers needs and that they are better supported in their caring role. Carers play a key contribution in helping people to remain in their own homes / place of their choice and delay for as long as possible, and reducing avoidable admissions to costly bed based care. Our investment in integrated health and social care teams is well established, providing early identification for those who are most likely to need future support. Social care services are recognised as being critical to keeping people with complex needs and frailty safe and in promoting independence, self-care and in improving wellbeing. Social care provides a key contribution to 7 day working arrangements, providing improved access to timely assessment and support where this is required. We maintain a focus upon regular review of both the impact of our BCF and opportunities for further development and improvement, including the development of improved services for people with dementia and for End of Life

Care which we have identified as a key local priority for integrated service development. through our utilisation of the fund and the flexibilities this provides, protecting social care services will positively impact upon avoidable admissions to bed based care and once there, ensuring that people can be discharged in a safe and timely way and don't remain in acute care for longer than necessary. The BCF partners will maintain the current level of investment into the fund for the coming year.

3.3 Agreement for the 7 day delivery of services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Seven day services are embedded with acute hospital services through the full operationalisation of the Joint Assessment and Discharge Services. We are undertaking further work to extend the reach of community based services to better, and more comprehensively, provide improved access across the week. Of equal importance is our work to provide, through services such as those of Integrated Case Management a pro-active approach with individuals at risk of admission, with specific targeting at those with long term conditions to build improved levels of self care and resilience so that crises can both be avoided and levels of health and well being improved.

The Barking and Dagenham, Havering and Redbridge System Resilience Group (a partnership of CCGs, providers, local authorities, GP Federations, out-of-hours provider PELC, London Ambulance Service, Healthwatch and Local Pharmaceutical Committee) has been granted national urgent and emergency care (UEC) Vanguard status, giving a platform from which to streamline and simplify the urgent care system and access for patients.

The UEC Vanguard has identified 7 day delivery of services as an important component in reshaping a UEC system that is simple for people to use and provides consistent services that are integrated and seamless. As part of this, the UEC Vanguard has identified where the BHR system is meeting the Keogh report's aspiration around providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments. Current 7 day provision accessible by Barking and Dagenham residents includes:

- Walk-in centres and UCCs
- Primary care access hubs HTT and CTT
- IRS
- EMHL services at Queen's

The UEC Vanguard will be based around a 'click, call, come in' approach, where a digital platform is accessible 24/7 either online or over the phone, providing a tool for assessing the patient's needs, clear advice, access by professional staff to appropriate clinical records and navigation and access to the most appropriate care, including a booked appointment.

The Vanguard will undertake work to create UCCs in the community which users see as a genuine alternative to the ED. This will be a single integrated front door so patients will be

met by a 24/7 streaming function ensuring a rapid accurate clinical assessment as well as support around other care needs.

The UEC Vanguard Value Proposition (additional documents submitted with this narrative) at the time of constructing the BCF plan it is not possible to assess the impact of recent announcements on the reduction in national funding to be provided to support the transformation ambitions of Vanguards, particularly the pace at which transformation may be achieved in order to deliver BCF ambitions.

In addition, work is being done to enhance our mental health crisis response offer by extending the clinical input within our 24/7 telephone help line Mental Health Direct and creating a link to this from 111 as well as increasing street triage where mental health clinical support is provided to police officers and now paramedics.

Last years BCF plan saw the full operationalisation of the Joint Assessment and Discharge Service across health and social care, within our acute hospital, bringing together formerly desperate teams into one integrated service. The service comprises differing staffing disciplines, single line management, accountability through monthly performance reporting to the partners against a single performance framework and full delivery across 7 days. Discharge planning begins close to the point of admission and support within MDTs. The model has been flexed at points of whole system demand to provide interventions and alternative pathway support, at the front end of the hospital, diversion where appropriate avoidable admissions.

3.4 Better data sharing between health and social care based on NHS number

As part of the December 2014 submission we confirmed that all essential agreements and systems were in place to enable shared care records to be maintained for those patients for whom it was relevant and who provided their consent.

In addition, as part of the Vanguard programme the CCG has committed to developing a digital platform to enable data sharing across care settings. The Vanguard is aligned to our existing strategic plan for technology development and builds on substantial existing developments including:

- The development of a full, real time shared care plan that is visible to patients and a wide variety of health system and care providers.
- Commissioning solutions to allow automated payment of Continuing Health Care and Nursing Care payments
- The London NHS 111 Patient Relationship Manager pilot which uses the NHS number to retrieve crisis information, care plans (including end of life plans) and Special Patient Notes and enables sharing of this key information with LAS

Over the next two years it is expected the following elements of the digital platform will be delivered, utilising the NHS number as the consistent identifier:

- Central architecture to support interoperability of systems – this is a core element to enable data to flow. It will manage real time data flows and integration to other systems' Application Programming Interfaces (APIs).
- Further integration with 111, scaling up provision of care plans and end of life plans

- Further integration with GP systems, rolling out read/write access of care plans and end of life plans as well as read/write access to the entire GP record
- Integration with acute systems, read/write access to the entire GP record
- Real time data transfer between health care providers and social care providers

IG and security specialists will be in place during the scoping and implementation phase, and will be part of development and testing ensuring confidential data is stored and shared securely; all elements of the platform will conform to the need for security through testing and audit.

From the user perspective, Data Sharing Agreements will be in place between care providers sharing and accessing data. This includes social care, individual GP practices and community services. The Data Sharing Agreements set out the common rules to be adopted by the various organisations and ensures patient information is handled responsibly and securely.

3.5 Joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional

Integrated Case Management (ICM) 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 care are targeted for integrated case management and provided with a joint care plan across health and social care. General practices also use their clinical judgement to identify patients at risk of hospital admission to the top 2% as they implement the unplanned admissions enhanced services.

The ICM approach provides a single point of access to a wider range of services including mental health, district nurses and long term conditions specialist nurses. The Integrated Care Teams are supported by a co-ordinator to direct the 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 who is the accountable lead professional in line with their normal responsibilities for patients. This system also supports the 'accountable' GP for over 75's initiative. The MDTs take place every two weeks for most practices (with some with very small registered list sizes operating on a monthly basis). At this meeting the care management plan is developed and this is available to all members of the MDT and to the hospital.

Targeting individuals at risk of acute admission and providing preventative interventions are important 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, ICM has also been developed further with input from secondary care consultants into MDT as part of the BHRUT CQUIN.

We are also promoting opportunities for improved levels of 'self-care' through providing access through 'active ageing', advice and information that may encourage lifestyle changes which promote improved health and well-being. We also commissioned a Whole Body therapy service in to reduce the incidents of falls, and long term effects from a fall therefore reducing admissions to hospital and reducing the need for extra care. It was a falls prevention exercise intervention aimed to improve people's independence through improving functional fitness, postural stability and reducing the fear of falling.

3.6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Our 16/17 plans are a refinement and refocusing of current schemes. Engagement with stakeholders including providers impacted by the plans has taken place through a range of mechanisms as follows:

- HWB and Integrated Care Sub-Group of HWB – which includes providers and commissioners – were involved in developing the plan and in receiving regular updates on progress.
- Engagement with providers in developing 5 year strategic plans through the BHR Integrated Care Coalition and associated sub-groups.
- System management discussions with providers focusing on for example acute activity and DTOC rates through the BHR System Resilience Group.
- Engagement with health providers in respect of impact on activity through annual operating plan finance and activity returns/contracting process. This year that will be a joint process designed to set trajectories.
- Engagement with community and other providers is through contracting mechanisms, including review and performance assessment.
- More broadly a stakeholder workshop focusing on admissions activity and testing out 3 hypotheses as to drivers of activity was widely attended by frontline staff, senior provider leaders and service users and has been used to shape aspirations for 16/17 and associated actions.
- The BCF plans are also being considered in the context of wider system transformation programmes – Urgent and Emergency Care (Vanguard) programme, primary care transformation and Prime Ministers Challenge Fund access programme and the Accountable Care Organisation/Place based commissioning programme. These programmes are made up of provider and commissioner representatives across BHR and will be the fundamental mechanisms through which activity reduction activities will be developed.
- Engagement with Social Care providers impacted through the development of the Councils Market Position Statement (MPS) through which engagement with service providers was facilitated to conclude the MPS. The MPS itself, sets out the Councils priorities going forward, key information about the local market and the types of services and service models required for the future. Key messages are providing clarity about the role that service providers play in promoting improved health and wellbeing, promoting independence and self-care, alongside a greater focus upon information and advice and how the market as a whole better responds to individuals making their own individual purchasing decisions as an alternative to traditionally

commissioned care and support. The MPS is an iterative process of further development and deepening across the coming year.

- Re-commissioning steps - including the re-commissioning of support at home (Home Care) has provided a further example of both provider engagement and in re-setting expectations, performance and desired outcomes for local people. We are now taking forward further and specific re-commissioning steps with Mental Health supported living services.
- Strategy development- the development of our joint carers strategy was facilitated by engagement by Carers UK with local stakeholders, including service providers.

The BCF includes mental health outside of hospital. This is being considered in the wider context of a local mental health and wellbeing strategy which will inform joint commissioning and development of integrated mental and physical health models. Engagement on the strategy has taken place in summer/autumn 2015 – again involving providers and commissioners as well as service users and carers. The CCG is also engaging the public on its overall commissioning priorities for 16/17 at a commissioning café event on 16 February – with a focus this year of staying healthy.

3.7 Agreement to invest in NHS commissioned out of hospital services which may include a wide range of services including social care

Our 15/16 plan placed an emphasis within its out of hospital arrangements upon improving discharges and accompanying processes in acute services which resulted in the full operationalisation of our Joint Assessment and Discharge Service (JAD) successfully bringing together disparate teams from partner organisations, removing structural barriers to effective collaborative working into a single service and management. Investment in this service will be maintained by the partners in the coming year. However, in consideration of situational analysis completed we have identified particular opportunities to improve current arrangements- notably in non-acute settings such as Mental Health services which were impacting upon overall system flow and people remaining in bed based services longer than was necessary. We are therefore developing steps to:

- Deliver improved support through the provision of a 6 bedded housing support offer
- Re-tendering for services provided to support people into employment and education, building resilience and wellbeing
- Agreeing additional investment in Mental Health out of hospital services and the identification of an additional £250,000 comprising a contribution of £70,000 (utilising the increase provided from the former S256), diversion of areas of anticipated under spend within the BCF and resources currently falling outside of the pool, to enhance individual provision for out of hospital support.

Steps will be confirmed in our final submission.

Our commitment to intermediate Care and specifically Intensive Rehabilitation Services will be maintained in 2016/17. Our evaluation of IRS has demonstrated a number of very positive outcomes which include:

- Consultation completed (this was 2014/15 suggest remove) Challenges to the consultation and new model (IRP initial assessment, Monitor complaint) not upheld
- First phase of bed moves (H&G to KGH) are complete. Second phase (Grays court beds) planned to move to KGH March 16. Ongoing discussion re: co-location of the wards within the KGH site (phase 3)
- IRS service mainstreamed April 15 continues to see referrals above target and the in-reach element of the service has reduced total length of stay for patients admitted by 9587 days in 2015 equivalent to a saving of 46 hospital beds
- CTT mainstreamed April 15 continues to see referrals above target. The acute part of the service has had no admissions to acute YTD. The community part of the service has seen 9% YTD admissions (673 of 7573 referrals)
- Model continues to be recognised as an example of best practice- national webinar 25.1.16, CTT shortlisted for Advancing Healthcare Award 2016
- New model has delivered 10 fold increase in intermediate care capacity and 35% increase in capacity in the rehabilitation specifically. Waiting times for rehabilitation continue to be less than 2 days on average and patient experience remains consistently high at 9 out of 10

We have used the BCF to commission a handyperson scheme in the Borough to complement a range of interventions which focus upon the individual, but are less able to address environmental and domestic risks that exacerbate the risk of falls (and the consequential impact of these) and living conditions that may contribute to reducing risk and improved wellbeing. The service is free to access – broadening its reach and ensuring that people not currently engaged in contact with Health and Social Care can benefit, remaining healthy and well for as long as possible.

We are utilising the BCF to continue our focus upon the prevention of falls within a target cohort who don't current engage in programmes such as Active Aging, but for whom risks are more immediate. We will in 2016/17 further focus the work to the provision of 1-1 interventions, exercise programmes and stamina building into peoples own homes. This service will also provide further continuity for interventions people may have received as a part of their acute hospital stay who are leaving hospital returning to their own homes.

We are reviewing our approach to low level interventions which encompass people with low level needs, but for whom a timely intervention can reduce both the risks of admission and where admission takes place, a timely return home. The earlier ' Take home and Settle' pilot with a voluntary sector partner yielded some positive individual outcomes (and a business case) and we will be taking further proposals through our BCF governance for an extension of this service ensuring that where appropriate, we ensure the lowest intervention, at the right time, for the right cost to an extend cohort of people.

3.8 Agreement on local action plan to reduce DTOCs

We have undertaken further work to better understand what is driving levels of DToC across all in patient settings. This plan therefore reflects both our situational analysis based upon local conditions and strategic steps undertaken which saw within the previous BCF plan delivery of integrated services such as the Joint Assessment and Discharge Service, designed to markedly change the way in which acute discharges were undertaken between

the partners. In 15/16 the majority of delays were drawn from acute hospital services, with a significant minority drawn from non acute beds at 45%.

Our situational analysis has shaped the key actions which include areas such as, specific steps to improve delays for people with mental health needs, with the use of both additional funding and housing related solutions and more broadly, testing opportunities for 'step down' / interim service provision and delivering innovation in respect to 'trusted assessor' roles and the delivery of low level preventative interventions to reduce the incidences and likelihood, of admissions in areas such as falls alongside further targeting of care homes where levels of acute admissions are comparatively high. The plan also reflects positive steps to improve areas such as the Councils ability to secure, where required, bed based placements through an improved fee which mitigates previous issues with inward price competition by other commissioners into the Borough. Accessing care home placements represents, for example, 18% of current delays (417 bed days). Analysis has also identified where there is a need for further development of processes and protocols alongside areas for further work by the partners and where some more intractable issues such as those of Continuing Health Care and neuro-rehabilitation, which require escalation within our broader BHR system and for which milestone plans are to be developed.

We have developed this plan in order to both provide a specific focus for local actions and to align with System wide strategic discharge planning which is currently in the process of final development across BHR.

The plan and its actions are broadly reflected within the BCF milestone plan but also includes broader steps beyond our BCF, and provides, 'at a glance', the range of actions we are taking forward to improve current performance for the system as a whole and deliver better outcomes for individuals

3.9 Confirmation of funding contributions

The BCF Pool in 2016/17 will be comprised of the CCG minimum required contribution to the fund, the Local Authority minimum contribution i.e. the Disabled Facilities Grant, and also the Local authority is making additional contributions over and above their required minimum. These are shown in the Finance template.

4.0 Overview of funding contributions

The scheme spending plan has been submitted as part of this return. As mentioned above the BCF Pool is made up of contributions from the CCG and Local Authority, meeting all of the financial requirements. This includes continuing to passport the ex - section 256 funding to the local authority, and the amount suggested in the Care Act "ready reckoner" supplied by NHSE. We have also exceeded the amount that is required to be spent on NHS Commissioned Out of Hospital services.

5.0 Scheme level spending plan

The scheme level spending is submitted in the BCF Planning Return Template. It details the full use of the spending of the pooled budget with details of the value commissioner and scheme type. There is a confirmation on the summary tab of the amount identified for the

protection of social care and explanation of a variance, please refer to the BCF Planning Return Template. The table below sets out the scheme level spending plan.

	Expenditure				
Scheme Name	Scheme Type	Commissioner	Provider	2016/17 Expenditure (£)	Total 15-16 Expenditure (£) (if existing scheme)
1- Model of Care - Community Health & Social Care Services	Integrated care teams	CCG	NHS Community Provider	£4,494,000	£4,486,000
1- Model of Care - Community Health & Social Care Services	Integrated care teams	Local Authority	Local Authority	£2,147,000	£2,147,000
1- Model of Care - Community Health & Social Care Services	Integrated care teams	Local Authority	Local Authority	£2,570,500	£2,525,100
1- Model of Care - Improved Hospital Discharge	Intermediate care services	Local Authority	Local Authority	£1,028,000	£993,000
1- Model of Care - Improved Hospital Discharge	Intermediate care services	Local Authority	Local Authority	£991,100	£991,100
1- Model of Care - New Model of Intermediate care	Intermediate care services	CCG	NHS Community Provider	£2,483,057	£2,443,000
1- Model of Care - New Model of Intermediate care	Intermediate care services	Local Authority	Local Authority	£700,000	£700,000
1- Model of Care - Integrated Commissioning	Other	Joint	Local Authority	£145,000	£170,000
1- Model of Care - Care Act	Other	Local Authority	Local Authority	£100,000	£100,000
2- Dementia Support	Personalised support/ care at home	Local Authority	Local Authority	£347,300	£347,300
3- End of Life	Personalised support/ care at home	Local Authority	Local Authority	£105,000	£0
4- Carers - Support for Family carers	Support for carers	CCG	Local Authority	£495,000	£495,000
4- Carers - Support for Family carers	Personalised support/ care at home	Local Authority	Local Authority	£430,000	£430,000
4- Carers - Care Act	Personalised support/ care at home	Local Authority	Local Authority	£517,000	£513,000
4- Carers - Care Act	Personalised support/ care at home	Local Authority	Local Authority	£200,000	£200,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	CCG	Charity/Voluntary Sector	£256,000	£256,000
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	Local Authority	Local Authority	£340,000	£357,877
5- Mental Health - Mental Health Support outside hospital	Personalised support/ care at home	Local Authority	Local Authority	£572,000	£537,245
6- Prevention	Personalised support/ care at home	Local Authority	Local Authority	£1,191,000	£1,499,000
6- Prevention	Personalised support/ care at home	Local Authority	Local Authority	£30,000	£12,500

7- Equipment and Adaptation	Personalised support/ care at home	Local Authority	Local Authority	£1,456,009	£1,251,000
7- Equipment and Adaptation	Personalised support/ care at home	Local Authority	Local Authority	£107,000	£107,000

6.0 Financial risk sharing and contingency

In 2015/16 the key performance target associated with the BCF was a reduction in non-elective admissions to hospital, which was subject to a payment for performance regime. As detailed in previous reports, due to the failure to achieve the target set the performance penalty was invoked resulting in a penalty of £710k, split equally between the CCG and Local Authority. In 2016/17 non-elective admissions to hospital will continue to be a key performance indicator, however without an attached performance penalty.

In the 2015/16 Section 75 Agreement, the CCG and Local Authority entered into a risk share agreement whereby if non-elective admissions did not fall below a 2014 calendar year baseline, both partners contributed to a risk share that was to be used by the CCG to pay for unplanned non-elective activity in acute hospitals.

The BCF guidance for 2016/17 set out that the CCG and Local Authority should consider risk share and contingency arrangements. Following discussions in developing the BCF Plans it was decided that a local risk-share would not be part of this year's BCF.

The CCG faces the same financial risks in 2016/17 associated with non-elective activity as in 2015/16. The overall financial risks for the CCG are heightened by the continuing growth in demand for services. As such and on the basis of performance in 15/16, discussions have taken place between partners around putting in place CCG a similar risk share in 2016/17.

In these discussions it is noted that both partners are facing great financial pressures in 2016/17 and are developing transformative approaches to addressing on-going sustainability. It is also noted that any risk share for 16/17 is likely to be counterproductive to these developments and that the development of the Accountable Care Organisation may represents the main mechanism through which rising activity/acuity risks may ultimately be mitigated.

Appendix 1 BCF Schemes

Narrative

One of the areas of learning from the previous year has been the management of the 11 BCF schemes described in the original plan. The number and variety of schemes proved unwieldy and introduced unhelpful barriers between related areas – for example equipment and Joint Assessment and Discharge. A number of projects have been, or are in, the final stages of completion. Based on this learning the schemes have been streamlined, refreshed and clustered under to demonstrate how each supports the key metrics – enabling an easier description of overall plans and better links between each scheme. There are now 3 themes, which provide a strategic focus for our work, and which are:

- Theme 1. Avoiding Admission to Hospital
- Theme 2. Integrated Support in the Community
- Theme 3. Discharge from Hospital

These provide a structure to the schemes of work which remain broadly consistent with those in the original plan:

- Scheme 1. Models of care
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Each Theme enables improvements across each scheme and is anchored to the key BCF outcomes. The following table sets out this approach in more detail and includes high level milestones for each element of the overall plan.

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
Outcomes	**Delivery the non-elective admissions target of 228 admissions in 2016/17.**	**Improve our reablement packages of care as well reduce admissions to residential and care home.**	**Deliver the 2% reduction of Delayed Transfers Of Care from the 2015/16 outurn.**
General scheme			
SCHEME 1 (S1) Model of Care	Work with key stakeholders to develop the locality based model to tackle admissions by working with cohort most likely to be admitted. **(S1,T1,1)** **Lead: Monga Mafu** Strengthening referral routes into the Community Treatment Team(CTT) in order to avoid hospital admissions and conveyance to A&E. **(S1,T1,2)** **Lead: Stasha Jan**	Improve the referral targeting of people to benefit from active aging programmes as well consider future commissioning of these services. **(S1,T2,1)** **Lead: Lewis Sheldrake** Clarify the locality model based vision of mental health strategy and utilisation. **(S1,T2,2)** **Lead: Lewis Sheldrake**	Review the BHR wide 'discharge to assess' pilot once completed and explore whether this can be extended and more widely implemented. **(S1,T3,2)** **Lead: David Millen/Andrew Hagger** Extend the trusted assessor model to reduce handoffs and delays in on-ward referrals. **(S1,T3,3)** **Lead: David Millen** Review the targeting of key cohort of people who have high bed days and assessment delays / multiple assessment episodes. **(S1,T3,4)** **Lead: Monga Mafu**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
Specific schemes			
SCHEME 2 (S2) Dementia	Identification and review of admissions data for those with possible dementia diagnosis to provide support and avoid possible future admissions. **(S2,T1,1)** **Lead: Gayathri / Carla Lubin**	Hold dementia awareness raising training sessions. **(S2,T2,1)** **Lead: Arabjan Iqbal** Identify, support and involve carers to build their awareness and confidence in support of people with dementia. **(S2,T2,2)** **Lead: Arabjan Iqbal** Enabling people with dementia to live well in the community by accessing services that help maintain their physical and mental health and wellbeing and promote independence. **(S2, T2,3)** **Lead: Stasha Jan**	Review hospital discharge support for dementia patients, and post diagnosis support in the community. **(S2, T3,1)** **Lead: Stasha Jan**
SCHEME 3 (S3) End of Life Care	Raise awareness and provide training for carers and nursing home staff to build confidence in managing EOLC patients without resorting to Acute settings. **(S3,T1,1)** **Lead: Michael Fenn**	Adopt a common DNR form across the borough to ensure patients are not unnecessarily moved to hospital when they are at home or in care homes. **(S3,T2,1)** **Lead: Stasha Jan**	Utilise Marie Curie staff and District Nurses to support patients within their own home, and share good practice with health and social care services. **(S3,T3,1)** **Lead: Stasha Jan**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
SCHEME 4 (S4) Carers **Leads as per Carers Strategy**	Promote and highlight the role of carers in supporting and helping patients avoid unnecessary hospital attendances and admissions to GPs. **(S4,T1,1)** **Lead: Arabjan Iqbal** Improve involvement and inclusion of carers in care planning and decision making. **(S4,T1,2)** **Lead: Arabjan Iqbal**	Utilise GPs and Pharmacies to identify, support and signpost carers. **(S4,T2,1)** **Lead: Arabjan Iqbal** Further develop the online resource Carers Hub in the development of care pathway to support assessment and referral of carers. **(S4,T2,2)** **Lead: Arabjan Iqbal**	Utilise the community treatment teams to support carers so they are better able to support people when they are discharged from hospital. **(S4,T3,1)** **Lead: Arabjan Iqbal**
SCHEME 5 (S5) Mental Health	Improve flow of resources in bed based Mental Health services. **(S5,T1,1)** **Lead: Michael Fenn/Cathie Kelly**	Review the current contract that supports people with mental ill health to remain well, free of crisis and on the way to gaining employment. **(S5,T2,1)** **Lead: Adrian Marshal**	Improve Independent Living beds and floating support service (supporting a 'step down' model) for people with mental health to reduce delays of transfers of care. **(S5,T3,1)** **Lead: Michael Fenn / Cathie Kelly**

	THEME 1 (T1) **Avoiding Admission to Hospital**	**THEME 2 (T2)** **Integrated Support in the Community**	**THEME 3 (T3)** **Improved Discharge from Hospital**
SCHEME 6 (S6) Prevention	Consider future commissioning of falls prevention of injuries and admissions due to falls for those at high risk. **(S6,T1,1)** **Lead: Lewis Sheldrake** Review local care packages and crisis interventions to prevent the early use of high cost care packages such as care homes. **(S6,T1,2)** **Lead: Michael Fenn** Strengthen links between the Care and Support hub and other signposting resources to better support patients and carers access to health information on what are the right services to access. **(S6,T1,3)** **Lead: Jolene Davis/Stasha Jan**	Improve early identification of people likely to need care home admission as part of assessment and discharge process. **(S6,T2,1)** **Lead: David Millen/Michael Fenn**	

	THEME 1 (T1) Avoiding Admission to Hospital	THEME 2 (T2) Integrated Support in the Community	THEME 3 (T3) Improved Discharge from Hospital
SCHEME 7 (S7) Equipment/Assistive Technology		Commission a review of the current utilisation of telecare and telehealth in Borough as well as options for improved use of telecare, telehealth, assistive technologies and other equipment. **(S7,T2,1)** **Lead: David Millen** Improve access to community equipment and daily living aids so service delays are minimised and the best procurement / store options are captured. This links with the 'trusted assessor' approach where access is less predicated upon 'professional assessment'. **(S7,T2,2)** **Lead: David Millen**	Review the current offer of rapid response equipment so that it supports reduced LOS and improved discharge planning. **(S7,T3,1)** **Lead: David Millen**

Appendix 2 National metrics

Metric	Comments
Non-elective admissions (General & Acute)	Target proposed is reduction of 228 admissions against an expected total admission of 2,405 in 2016/17. The target for BCF has been reduced in line with actual performance in 15/16 but still represents a challenging target and is based on impacting avoidable admissions. The BCF plan represents one element of the overall CCG operating plan for admission reduction. The BCF plan is focused on local joint actions most likely to impact admissions and is supported by wider system work through Systems Resilience Group.
Admissions to residential & care homes	Target proposed is 170. Previous target was 125 for 2015/16 and current forecast performance to be in the region of @180 admissions. Reviewing the last performance over the last 4 years (11/12 – 200, 12/13 – 170, 13/14 – 135, 14/15 – 179) has been on average has been 171 admissions. Local leads have suggested that the set target was an underestimation based on unusually low 2013/14 figure.
Effectiveness of reablement	Target proposed is 75%. The manual data collection presents distinct challenges and variability in collection of the data and its interpretation. Changes to the way this was approached for 2014/15 are a significant contributor to performance dropping so markedly to 67.2%, target had been set for 75%. Given the pressures that was experienced in 2015/16 is not changing it is more realistic to keep the target the same in 2016/17.
Delayed transfers of care	Target proposed is 2% reduction of our 2015/16 Outurn. The target in acute setting is being met at local hospital which suggests the Joint Assessment & Discharge team is having an impact. Areas which are negatively impacting the metric are in local acute Mental Health setting with patients awaiting discharge and specialist rehab. As there is clarity as to where changes need to be made, the target proposed is at same level as in 2015/16. A detailed DTOC plan is appears at appendix 2

London Borough of Barking & Dagenham

NHS
Barking and Dagenham
Clinical Commissioning Group

Appendix 2 DTOC plan

Barking and Dagenham Better Care Fund 2016/17
Delayed Transfers of Care improvement plan

Target improvement 2% reduction (from 2015/16 288)

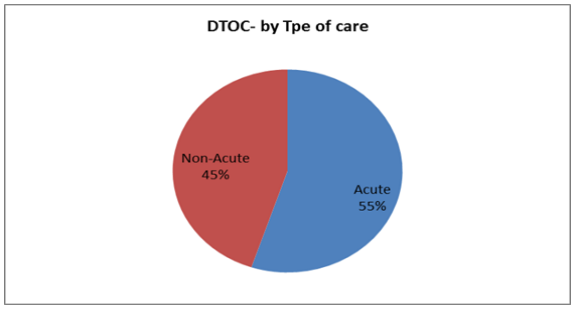
This plan reflects both our situational analysis based upon local conditions and strategic steps undertaken which saw within the previous BCF plan delivery of integrated services such as the Joint Assessment and Discharge Service, designed to markedly change the way in which acute discharges were undertaken between the partners. In 15/16 the majority of delays were drawn from acute hospital services, with a significant minority drawn from non acute beds at 45%.

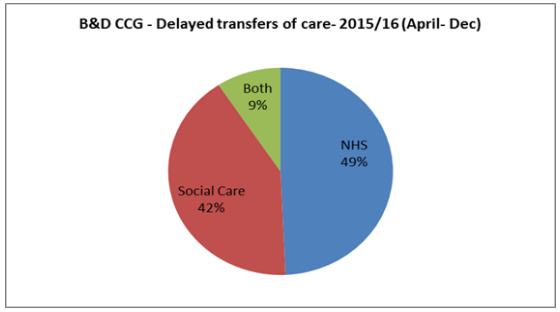
Our situational analysis has shaped the key actions which include areas such as, specific steps to improve delays for people with mental health needs, with the use of both additional funding and housing related solutions and more broadly, testing opportunities for 'step down' / interim service provision and delivering innovation in respect to trusted assessor roles and the delivery of low level preventative interventions to reduce the incidences and likelihood, of admissions in areas such as falls alongside further targeting of care homes where levels of acute admissions are comparatively high. The plan also reflects positive steps to improve areas such as the Councils ability to secure, where required, bed based placements through an improved fee which mitigates previous issues with inward price competition by other commissioners into the Borough. This represents, for example, 18% of current delays (417 bed days).. Analysis has also identified where there is a need for further development of processes and protocols alongside areas for further work by the partners and where some more intractable issues such as those of Continuing Health Care and neuro-rehabilitation, which require escalation within our broader BHR system and for which milestone plans are to be developed.

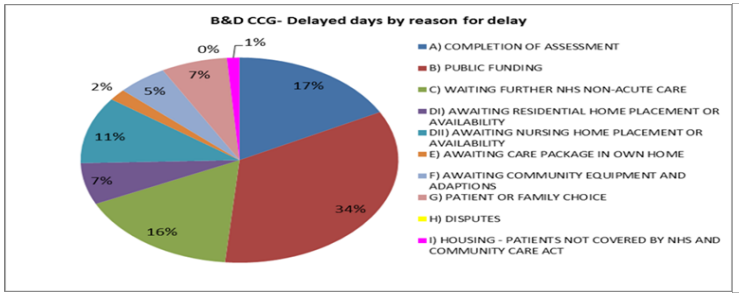
We have developed this plan in order to both provide a specific focus for local actions and to align with System wide strategic discharge planning which is currently in the process of final development across BHR.

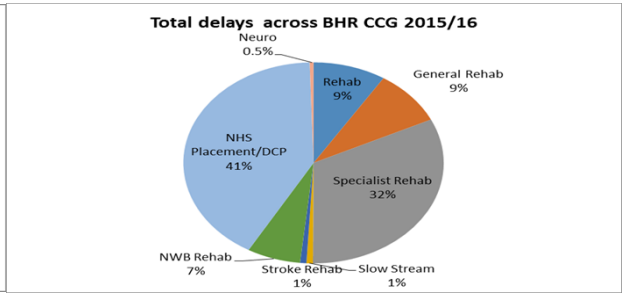
The plan and its actions are broadly reflected within the BCF milestone plan but also includes broader steps beyond our BCF, and provides, 'at a glance', the range of actions we are taking forward to improve current performance for the system as a whole and deliver better outcomes for individuals.

DTOC 15/16









	Rehab	General Rehab	Specialist Rehab	Slow Stream	Stroke Rehab	NWB Rehab	NHS Placement/DCP	Neuro
Total delays in 2015/16	57	56	203	5	5	42	260	3

Situational analysis	Actions	Impact % /numbers	Resources	Lead and milestone plan ref.
There is a need to shift reliance upon 'professional' assessment and allocation. This free up both resources and accelerate pace. Evidence of some individuals having multiple assessments and delays between referrals.	We will extend 'discharge to assess' and trusted assessor arrangements thereby reducing 'handoffs' and delays in onward referrals	The average time taken from referral to completion of assessment reduced	Staff time- 'discharge to assess' Protocols and process revisions. 3 month pilot to commence from 1st April 16.	BCF Delivery Group- DM/ AH (S1,T3,2) (S1,T3,3)
Insufficient focus upon throughput on Length of Stay (LOS) in secondary bed based services. Significant actions have been put in place to improve acute discharges and therefore non acute is an area of new priority.	Principles established within the JAD being considered within non-acute services- this would include our moving to establishing an indicative discharge date at (or closer to) the point of admission. Discharge protocols established. We will promote shared learning across trusts (incl. NELFT)	Bed day delays attributable to acute hospitals in 15/16- 1342 days (**55%**)	Development of revised protocols and working practices. This will include an agreed sign off process which will ensure that DToCs are accurately recorded and owned.in line with recently released revised guidance.	TW / DM

Delays are significant from other hospitals such as BARTS and WHIPs Cross	We will implement a new 'sign off' processes for hospital outside our health economy	Delays attributable to BARTs and WHIPs Cross. Bed days social care 75, NHS 321		
Due to significant financial pressures and the need to improve secondary provider performance blockages have occurred in secondary bed based MH services which have impacted upon our overall DToC position.	We will Improve flow of resources in bed based Mental Health services We will complete the delivery of housing based solutions to complement the existing offer		Improve resources available through both specific BCF allocation as an investment priority for the BCF partners drawing in specific 'ring fenced' 'out of hospital' funding agreed through BCF. (£70k allocation through BCF, deployment of under spends). Increased fund of £250k. Provision of 6 bedded house to provide a supported living/ interim housing based solution	MF/ DM BCF delivery Group (ST, T3,1)
Improvement needed in response times, alongside need for improved focus upon short term (time limited interventions). Too many people with both dementia and EoLC going into and dying within hospital based care.	We will undertake further deep dive analysis to confirm impact of EoLC and people falling outside of 'eligibility' criteria We will review hospital discharge support for people with dementia Consider and scope the provision of a community based rapid response service that would	Deep dive analysis to confirm: - delayed bed days attributable to people with dementia and EoLC -delayed bed days for people falling outside of Social Care / CHC etc..	Review existing provision such as the new support at home services and provision for rapid response and identify requirements for further capacity building *To be costed and commissioned as part of Out of Hospital Services*	BCF Delivery Group – DM (ST, T3,1)

Investment is heavily weighted in high end / high cost services	respond quickly to DToC and provide provisional support whilst on-going solutions were sought. This would support key target groups such as people with dementia and EoLC and those currently falling outside of eligibility criteria (already BCF schemes and priorities) leave hospital and thus remove such issues as access to services/ capacity as a cause of delay. We will increase our ability to divert people through lowest intervention at least cost necessary		<u>Out of hospital commissioned</u> 'take home and settle service'*£50 k 'take home and settle' service* Additional cost implications to be considered by the BCF partners through the Joint Executive Management Committee.	
We have identified a cohort of individuals who need to leave acute and non-acute bed based care but are not yet ready to return home	We will develop a business case for Independent Living beds and floating support service (supporting 'step down' model).	Costs to be confirmed with recommendations for the JEMC	Commissioning resources to scope and develop business case for a pilot number of 'step down' beds commissioned as a pilot	BCF delivery Group - DM
Delays in DToC due to care home availability. Migration into Borough absorbing capacity and reducing choice for local residents. Delays due to family	We will deliver improved capacity in care homes We will improve the early	Delayed days attributable to awaiting Residential home placement are currently 160 days (**7%)** Delayed days attributable to awaiting Nursing home placement are currently 257 days (**11%)**	New fee uplifts applied Assessment capacity	BCF delivery Group MF / DM (S6,T2,1)

choice	identification of people likely to need care home admission as part of assessment and discharge process	Delayed days attributable to Patient/ family choice 164 days (**7%**)		
An opportunity to improve access to both equipment and AT solutions, as part of universal offer	We will build upon the work to improve access to community equipment (including rapied response) and daily living aids so that as a jointly commissioned service delays are minimised and best procurement / store options are captured. Again this would link with 'trusted assessor' where access would become less predicated upon 'professional assessment'.		To be held within Equipment BCF scheme under development by the BCF commissioning partners.	BCF Delivery Group – DM (S7,T3,1) S7,T2,1) (S7, T2, 2)
A small number of individuals within our system disproportionately impact upon delayed days. Identified through our risk stratification Target cohort- delays due to 'neck braces'.. Therapy staff believe that on-going support post discharge is	We will undertake Deep dive analysis to support the 'targeting' of a key cohort of people who have high bed days and assessment delays / multiple assessment episodes. Analysis to better understand the characteristics of high intensity users We will agree processes and shared responsibility to improve discharge flow.	Deep Dive analysis to confirm the number of delayed days currently attributable to people receiving integrated cluster support	Cluster teams….. Improved requirement for in reach to provide **'pull through' discharge** and admission avoidance through proactive case management. In centivisation of primary care to improve support independent sector providers of bed based care To be developed through our BCF plan implementation.	BCF delivery Group - MM / DM (S1,T3, 4)

social cares responsibility and resolving dispute can result in bed days being lost				
There is a national focus upon the 'back end' i.e DToC . It is clear that for some individuals, an admission to hospital can have a very negative impact upon their independence and wellbeing.	We will draw in and evaluate our system wide admission avoidance steps, including the delivery of hubs, information and advice and specific activity within our BCF plan– on the key principle that if more admissions were avoided in the first place then there would be fewer people to discharge and hospital / bed based acquired dependency would be, where possible, avoided. We will review all existing schemes' impact upon admission avoidance and take further steps through the BCF and JEMC governance to enhance focus on avoidable admissions. We will enhance support to care homes by improving access to community nursing, GP review and support. We will undertake monitoring to Identify high referring homes for targeting of support. We will take steps to align our	Quantify avoidable admissions BCF – admission reduction plan for 16/17 - **228** Emergency admission reduction from care homes - 16/17 - **28 admission reductions** (Maintaining the same level of reduction as in 15/16)	Commissioning partners within the BCF to develop and confirm officer resources..	JEMC and BCF Delivery Group (S4,T1,1) (S4,T2,1) (S4,T2,2) (S5,T2,1) (S6,T1,3) (S6, T1,1) (S6,T1,2) (S6,T1,3) (S3,T1,1) (S2, T1,1) (S2,T1,1) (S2,T2.3) (S2,T3,1)

	voluntary sector offer – including impacts of social isolation, living alone etc.. on admission rates			
Neuro –rehabilitation currently has a very significant impact upon delayed bed days albeit affecting a small number of individuals.	This will be escalated through wider BHR governance	Bed days attributable to inter-hospital referral (3 in 2015/16)		SM
CHC process delays – people stay in hospital 2 weeks longer than required because of delays in undertaking assessments to decide whether FNC is payable or not.	Process re-design. Improvement options paper to be considered by BCF partners. This will be escalated through wider BHR governance	Bed days attributable to NHS placements		SM