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NHS
Tower Hamlets
Clinical Commissioning Group

Appendix 1

Integrated Care Board								Enclosure
Date of meeting	18 February 2016							
Agenda item								
Title of report:	**The Better Care Fund in Tower Hamlets: Review of Progress to Date, and Summary of Changes for 2016 – 17**							
Author(s):	Josh Potter, Deputy Director of Commissioning and Transformation, NHS Tower Hamlets CCG Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, Tower Hamlets Council							
Presented by: **Sponsor (if different):**	NA							
Executive summary	• Updates the Board on progress with agreed BCF initiatives in 2015-16 • Outlines the proposed BCF programme for 2016-17.							
Recommendation (place an ' X' in one only)								
Information	☐	**Approval**	☒	**To note**	☐	**Decision**	☐	
Key issues	There is a requirement to undertake an annual review of the BCF programme. There is also a need to agree a programme for 2016-17.							
Report history	The report is a standing item on the agenda.							
Patient and Public involvement	The Integrated Care Strategy has been developed and delivered with significant PPI activity. The BCF is a pooled budget to facilitate this ongoing delivery							
Risk implications	The CCG and LBTH require a Section 75 to be in place to govern pooled funds. An agreed BCF assists with compliance with the Operating Framework standards							
Impact on Equality and Diversity	N/A The Integrated Care Strategy was subject to an EQIA in 2014/15							
Resource requirements	N/A							
Next steps	A similar report will be presented to the Mayor's Advisory Board on 8 March 2016, the Health and Well-Being Board on 15 March, prior to sign off by the Executive Mayor and the CCG.							

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1. **Introduction**

1.1 This report is to seek the approval from the Integrated Care Board, CCG Governing Body, and Mayor's Advisory Board of the proposed 2016-17 Better Care Fund (BCF) programme, prior to its consideration at the Health and Well-Being Board on 15 March 2016 and its anticipated sign-off by the Mayor. The report also briefly summarises progress to date on the BCF programme in 2015-16 for information and comment.

1.2 The Board is asked to:

(i) note progress with the BCF programme in 2015-16;
(ii) approve the proposed BCF programme for 2016-17, and
(iii) note that the proposed 2016-17 programme will be considered at the 15 March 2016 meeting of the Health and Well-Being Board, prior to its anticipated formal sign-off by the CCG and by Individual Mayoral Decision in the council.

2. Background

2.1 The Better Care Fund was introduced in the 2013 Spending Round. The Government announced a national £3.8 billion pooled budget for health and social care services, building on the existing NHS transfer to social care services of £1 billion (usually referred to as S256 funding). The aim of the BCF is to deliver better outcomes and greater efficiencies in health and social care through more integrated health and social care services.

2.2 In 2014, the London Borough of Tower Hamlets, and Tower Hamlets Clinical Commissioning Group (CCG) submitted a jointly agreed Better Care Fund application to NHS England and Local Government Association. This was approved without conditions on 07 January 2015 by NHS England and came into effect on 1 April 2015. The total value of the fund in 2015-16 for Tower Hamlets was £21.577m.

2.3 The BCF programme is governed by a formal agreement between the council and the Tower Hamlets CCG under Section 75 of the NHS Act 2006. In recent weeks, the CCG and the council have been developing a proposed BCF programme for 2016-17. This will be reported to the Health and Well-Being Board (HWBB) on 15 March. The Health and Well-Being Board (HWBB) terms of reference state that it should be 'involved in the development of any CCG commissioning plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan'. However, it is not empowered formally to commit the resources of the CCG or the Council.

2.4 The Section 75 agreement governing the BCF, therefore, requires separate formal decisions to be made by both organisations. It is anticipated that the CCG and the Mayor will formally 'sign off' the programme shortly after the meeting of the HWBB.

3. Review of 2015/16 Better Care Fund Schemes

(i) Integrated Care Network Improved Service (ICNIS)

What is the purpose of the scheme?

3.1 The introduction of the IC NIS aims to incentivise an integrated care approach for patients in the top risk levels in Tower Hamlets.

3.2 Two levels of integrated care packages were introduced:

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- **"level 1"** package of integrated care will include many of the desirable features of the Avoidable Unplanned Admissions Direct Enhanced Service (AUA DES) (such as crisis plan and named clinician) – currently, given the undertaking by the CCG to make no changes to the disease specific NISs a person under for example, the diabetes care package, can also be in receipt of level 1
- **"level 2"** package of integrated care will deliver the remainder of the specification of the previous Co-ordinated Care NIS (including personalised care planning and where appropriate anticipatory care planning). Patients under the level 2 package will exit from disease specific care packages for the purpose of payment (i.e. their data will not contribute to payment outcome measures). However, practices will still be expected to provide the components of care as specified in these packages for as long as is clinically appropriate.

Have any changes been made to the scheme since the original proposal was made?

3.3 For 2016/17 the CCG has undergone a review of the Network Improved Services within Tower Hamlets. The review has resulted in a new structure to this incentive scheme, within the same overall cost:

- The scheme now focuses on clinical stratification (rather than using the risk of admission score). Therefore the population is divided into: complex (i.e. people with complex needs such as palliative), LTCs and a 'healthy' cohort (i.e. the remaining of our patients).
- Based on the above, the IC NIS will be divided into IC1 which will include the complex group and IC2 which will include people with LTCs who were previously under care packages (Diabetes, CVD, Hypertension, COPD and cancer).
- The AUA DES, if it is still funded by NHSE, will be replaced by the IC1 Admission Avoidance component of the NIS which will incentivise a comprehensive review within 3 weeks of the day of discharge of patients who are admitted due to MI/stroke/HF or patients over 65 years admitted with hypoglycaemia, falls and fractures or gastrointestinal bleeding/ COPD/vascular ulceration/gangrene.

What has the scheme achieved?

3.4 The ICNIS contributes towards the delivery of the Integrated Care Strategy as a whole. Please see "Integrated Community Health Team" for a description of achievements to date

3.5 In terms of process indicators, performance at January 2016 is:

	Entry Level Consent	Crisis Plan	Account GP	1st PAM	2nd PAM	Patient Centred Care Plan
Borough	1636	2435	1192	390	22	1847
The One Network	92	318	60	40	0	177
East End Health Network	236	449	263	0	0	312
Stepney and Whitechapel Network	283	166	83	35	0	131
The Highway Network	162	251	166	23	0	220
Bow Health Network	212	298	146	159	12	234
Mile End East and Bromley By Bow Network	326	329	155	131	10	274

Poplar and Limehouse Network	320	467	253	2	0	317
Healthy Island Network	5	157	66	0	0	182

(ii) Rapid Assessment Interface and Discharge (RAID)

What is the purpose of the scheme?

3..5 Rapid Assessment Interface and Discharge (RAID) is a service open to all patients with mental health and drug and alcohol problems over the age of 16 presenting at the Royal London Hospital and all associated Barts Health sites in Tower Hamlets.

3.6 The service offers a comprehensive range of mental health specialities within one multi-disciplinary team. The role of this team is to provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff.

3.7 The model emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on inpatient wards. This focus on prompt assessment and intervention is intended to improve patient experience and outcomes, support diversion and discharge from A&E and facilitate early discharge from inpatient wards. The RAID service is available 24 hours a day.

Have any changes been made to the scheme since the original proposal was made?

3.8 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

- Since its launch in April 2014, there has been a 40% increase in patients seen by RAID in A&E and a 62% increase in patients seen by RAID in inpatient wards.
- As of August 2015, the service reported seeing 93% of patients in A&E within 1 hour of referral and 94% of patients within inpatient wards within 24 hours of referral.
- Over 1,200 staff have been trained face to face by the RAID team.
- An interim evaluation of the four RAID services across East London (including Tower Hamlets) by UCLP partners indicated that, when outliers were excluded, the combined overall impact of RAID across all hospitals was as follows:
  - There is evidence of an overall decrease in length of stay for patients with mental health and drug and alcohol problems since the introduction of RAID. This is largely driven by a reduction in bed usage for non-elective patients, especially for those with dementia, substance misuse and severe mental illness. It is estimated that this reduction has in total saved approximately 2833 bed days in the 2014/15 financial year
  - According to the data available, the introduction of RAID does not appear to have had any impact on excess bed days for patients with mental health or drug and alcohol problems. It also appears that the percentage of readmissions for mental health and drug and alcohol patients has increased since the introduction of RAID.

(iii) Integrated Community Health Team

What is the purpose of the scheme?

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3.9 The integrated community health team provides health and social care input to all patients over the age of 18 graded as being at very high risk, high risk or medium risk of admission of a hospital admission. The service offers a comprehensive range of specialities within one multi-disciplinary team, including nursing, therapies, social care, mental health and case management. There is also specialist input from a community geriatrician and palliative care nurse. The teams are divided into 4 localities across the borough. The focus of the service is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and providing personalised, co-ordinated care in the community. The emphasis is upon improving patient experience and outcomes, supporting self-care, preventing A&E attendances and hospital admissions and facilitating timely discharge from inpatient wards. The service is available 24 hours a day (between 8pm-8am, this is comprised of nursing provision only).

Have any changes been made to the scheme since the original proposal was made?

3.10 No, and we would like to continue with the service in its current form. It should be noted that as a key part of a service subject to recommissioning, the mobilisation of any new Community Health Services contract may result in amendments being made to the day to day operations of the Community Health Teams

What has the scheme achieved?

- In March 2015, the integrated community health teams had over 1000 people from the integrated care pathway on their caseload.
- On average, across the four locality teams in March 2015, the service reported:
  - Responding to 98% of rapid response referrals within 2 hours
  - Providing input/putting in place packages of care for 97% of urgent referrals within 24 hours
  - Providing input/putting in place packages of care for 96% of routine referrals within 5 days
- Following a number of recruitment drives, the vacancy rate has significantly reduced and is expected to reach 95% posts filled over the next few months.
- The service, together with other key players across the integrated care pathway, has played a central part in reducing A&E attendances and emergency admissions:

Description	Annual Target Savings	Risk Band	YTD Actual Achieved £	FOT Savings Achieved £	FOT Variance (Savings Achieved) £
Inpatient	£1,183,031	**Very high**	£649,259	£3,105,369	**£1,922,338**
		High	£1,119,190		
		Moderate	£560,578		
Outpatient	£276,198	**Very high**	£64,816	£473,549	**£197,351**
		High	£185,052		
		Moderate	£105,294		

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A & E	£95,089	**Very high**	£43,744	£72,487	**-£22,602**
		High	£7,146		
		Moderate	£3,475		
	£1,554,318		**£2,738,554**	**£3,651,405**	**£2,097,087**

(iv) Community Health Team (Social Care) (CHT SC)

What is the purpose of the scheme?

3.11 This scheme seeks to improve the experience and outcomes for those with long term conditions, at the highest risk of hospital admission or readmission. The service works with those who are in the Integrated Care Pathway (ICP) target cohort; their families and Carers. The overall aim is to decrease the risk of hospital admission, reduce or postpone the need for long term care and prevent Carer breakdown.

Have any changes been made to the scheme since the original proposal was made?

3.12 It was evident that to deliver on the overall BCF CHT SC integrated operational and strategic aims, that a more robust management structure was needed. The staffing structure was reconfigured to address this issue and the team is now almost fully recruited to and operational.

What has the scheme achieved?

3.13 CHT SC Managers are working on specific operational and strategic areas in partnership with Health colleagues. These include planning and implementing procedures, WELC - Care Planning, Vanguard - Single Point of Access, THIPP and TST End of Life work. They are Continuing Health Care (CHC) Panel and Joint Funding meeting members and are proactive in improving CHC processes. They are responsible for the management of the team including operating a Duty/Safeguarding service for those in the target cohort.

3.14 Senior Practitioners each have a responsibility for 2 Localities and 4 Primary Networks; they attend Locality Board meetings in a liaison role. They act as a resource for CHT colleagues, around social care issues, legislation and safeguarding. A Senior Practitioner post is embedded in the Assessment and Intervention team leading on integrated working in the Adults service.There are now 10 Social Work posts in the team. Each has a responsibility for either a Primary Network or Central CHT Neuro rehabilitation work. They attend MDT meetings for their designated area. They carry out joint visits with health colleagues. This involves supporting the individual to self- assess; carrying out Carers' and joint assessments. They use a person-centred model in doing so, and also respond to crises to prevent a person being admitted to hospital or Carer breakdown. Each worker is allocated to approximately 24 people at any one time, plus others on a duty basis. Full co-location has not been possible due to ICT and telephone issues. However a successful bid to Vanguard was made for IT systems, equipment and mobile devices will be made available and this will support co-location becoming a reality. (There is a target of mid-2016.)

3.15 Outcomes include:

- Over the period June 2015 to January 2016, the number of clients at highest risk of hospital admission that are on the ICP list and receiving long term care service has risen from 891 to 1326.

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- The proportion of clients who are assessed as being at high risk has fallen from 28% to 24% in the same period.
- Joint intervention highlights where the client requires rehabilitation and/or an equipment solution, to reduce risk.

Measure	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Number ICP clients receiving long term social care services			891			1179	1254	1274	1307	1326
Number/% ICP cohort assigned to a social care team						747 (63.4 %)	871 (69.4 %)	881 (69.12%)	900 (68.85%)	949 (71.6 %)
Number/% ICP clients allocated to CHT			422			464	500	484	475	525
			47.40%			39.40%	39.90%	38.00%	36.40%	39.60%
Social Care Episodes Completed for ICP Cohort	*534*	*524*	*742*	*685*	*555*	*726*	753	*634*	*243*	*696*
ASCOF 1C - % of cohort receiving self-directed support			70.9			68.5	68.8	59.8	60.3	61.1
ASCOF 2A - permanent admissions of cohort to residential and nursing care 65+ (in last 12 months)			11			15	19	16	13	16
% clients in community care setting			779 (87.4 %)			%	1107 (88.3 %)	1132 (88.85%)	1164 (89.06%)	1178 (88.8 %)

(v) <u>Seven Day Hospital Discharge/ Avoidance</u>

What is the purpose of the scheme?

3.16 Unnecessary delays in discharging patients can lead to delays in admissions, transfers and cancellation of operations. An acute bed is estimated to cost the approximately NHS £500 per night. The goal is for timely, effective and appropriate discharges, which maximise the outcomes for individuals and support families and carers.

3.17 It is not in a patient's best interest to remain in an acute hospital bed longer than necessary; the risks include exposure to hospital-acquired infections, loss of functional independence and depression.

3.18 The BCF scheme supports the extension on the role of social workers to 7 days per week within Bart's Health NHS Trust, with particular attention to the Royal London Hospital, the Trust's trauma centre. The scheme expands the operating hours that social workers assess and discharge patients deemed medically fit for discharge. The area of the hospital covered initially was A&E and wards 11E and 11F.

Have any changes been made to the scheme since the original proposal was made?

3.19 The scheme has progressed due to its success in creating vacant beds at the Royal London Hospital. It now covers the entire hospital, apart from children's wards. We have introduced two designated social workers to be based in A&E and 11E/F the

area known as AAU – Acute Assessment Unit. A development for 2016-17 is to seek a move for social workers to be ward-based, as part of our integration program. This will lead to efficiencies in assessment turnaround times and improved multi-disciplinary working. We are continuing to develop our work with the Home from Hospital scheme in AAU regarding admission avoidance work. We also work closely with CHT – Community Health Team – in identifying people who are frequent visitors to hospital, via the ICP – Integrated Care Pathway list.

What has the scheme achieved?

3.20 There is a quick turnaround of cases, and good working relationships have been developed with health colleagues. Since the introduction of the Patient Flow Coordinators, there has been an increase in the number of referrals but also added pressure on social work staff. For the 7-day service, we are now able to both receive and assess patients on the acute wards who are deemed medically fit at weekends and bank holidays, and reduce the throughput of assessment time, thereby facilitating earlier discharges from acute beds.

Measure	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Total**
Number of referrals to Out of hours	65	88	87	59	81	82	83	81	115	88	829
Number of referrals From Acute and Assessment Unit to Out of hours to prevent Hospital Admission	21	17	34	16	30	20	32	21	35	26	252
Total Number of discharges completed to reduce hospital length of stay	31	47	43	26	34	41	33	38	45	35	373
Total Number of discharges completed to prevent hospital Admission	9	10	17	9	17	12	16	15	26	19	150
Accelerated discharges completed to prevent hospital admission as a % of all referrals	42.9%	58.8%	51.5%	56.3%	56.7%	60.0%	50.0%	71.4%	74.3%	73.1%	
Accelerated discharges completed to reduce hospital length of stay as a % of all referrals	47.6%	53.4%	49.4%	44.1%	42.0%	50.0%	39.8%	46.9%	56.20%	56.40%	
Assessments undertaken and services needed identified	53	65	79	36	68	56	54	59	95	65	630

(vi) <u>Reablement Team</u>

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What is the purpose of the scheme?

3.21 Reablement services aim to help people with illness or disability cope better by learning or re-learning skills necessary for daily living. These skills may have been lost through deterioration in health and/or increased support needs. The focus is on helping people do as much for themselves as possible, rather than resolving health issues as such.

3.22 Reablement Services are generally provided for a period of up to six weeks. Some people meet their goals in a far shorter period of time, while others, such as stroke survivors, may need a much longer reablement and rehabilitation period. Typically, people receiving reablement services have suffered an acute illness/event (e.g. a fall), have a long-term condition, and/or are growing frail. The service is large, with approximately 60 employees, including its own dedicated Out of Hours Service.

3.23 *Joint working with Community Health Team Therapies***:** Reablement and CHT joint working agreements were set up by Lead Reablement OT and Lead CHT Physiotherapist to streamline service users journey through intermediate care services, promote integration and partnership working across health and social care, maximise functional outcomes for service users, target resources to services users likely to benefit most and prevent duplication. Initially, three target user groups were identified and pilot joint working agreements were set up for each target group.

Have any changes been made to the scheme since the original proposal was made?

3.24 Functional disorder joint working cases with CHT has been stopped due to the complex nature of the user group and negative functional responses by this user group to therapeutic input.

What has the scheme achieved?

3.25 The following relates to mainstream Reablement activity.

- Referrals for 2015-16 are on average 55 per month, with 54% of these referrals coming from the Hospital Social Work Team.
- The waiting list for an allocated worker in Reablement is at present 43 people, with the longest wait for an 'assessment' being 42 days. The average wait for an 'assessment' in Reablement is approximately 25 days.
- All urgent support packages within Reablement are started within 24-48 hours (for example, for hospital discharges or urgent request from Assessment and Intervention (A&I) Social Care Team).
- There have been 41 Community Physiotherapy cases to date since July 2015 and this joint working stream is going well, Physiotherapists are working with Reablement Officers to implement exercise programmes, practice outdoor mobility and progress independence in mobility aid (e.g. walking frame to stick).
- *Discharge to Assess/Home Assessment Pathway* – This is a new scheme running from November 2015 to March 2016. Its primary focus is safely to discharge medically stable patients, who are in the Royal London Hospital and aged over 65 years, either to an extra care sheltered flat, or home. The Reablement Service will be offering the option for this service to access Reablement Officer support to help support the therapy staff in the team to meet agreed treatment goals for this user group during the 28 day 'rehabilitation' period. There will be an option for these users to access the Reablement pathway following this period, where appropriate. As of the end of January 2016 the service has supported 26 users within this pathway, with 12 being referred in January 2016.

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Measure	April	May	June	July	Aug	Sept	Oct	Nov
Number of referrals to reablement	41	47	49	45	57	39	64	56
Number of referrals from hospital team	23	28	22	30	32	25	37	20
Number of referrals from community teams	18	19	27	15	25	14	27	27
Number of independence plans completed	31	46	43	36	24	36	36	
Number completed reablement episodes	36	33	45	44	45	30	36	19
Average length of time in service (referral to conclusion) weeks	10	12.7	13.6					

(vii) Independent Living (Assistive Technology Project)

What is the purpose of the scheme?

3.26 The objective of the Assistive Technology (AT) Project is to integrate the use of assistive technology into mainstream health and social care provision, to enable residents to live independently in their own homes. It uses a range of training and communication methods to raise staff awareness, giving them the knowledge, confidence and support to prescribe appropriate assistive technology equipment for their service users.

3.27 The project also included the evaluation and development of an Independent Living Service (ILS) to look at the integration of a number of teams to rationalise processes and improve service provision.

Have any changes been made to the scheme since the original proposal was made?

3.28 The development of the ILS now forms part of a larger review of Adult Services, which is now underway.

What has the scheme achieved?

- Since April, operational staff across a wide range of health and social care teams have continued to receive training in the use of AT to support independent living. AT Implementation Officers have provided further support by having a presence in 18 operational teams across nine separate locations. They deliver awareness sessions, hold surgeries at area offices, and attend team meetings. The total number of training sessions delivered so far this year is 15 and has involved 104 staff, 37 from health and 67 from social care.
- Systems have been put in place to enable health and social care staff to prescribe appropriate items of assistive technology equipment and 1:1 support is provided to assist them, where appropriate. For April 2015 to January 2016, the number of requests for AT was 434, and installations was 472. Requests for AT were received from 14 different teams, 5 of which are hospital or community based teams. This illustrates that awareness has been raised across a range of social care and health professionals in various locations.
- Between April and December there were avoided costs of £235,230, in 21 cases, as a result of assistive technology. This does not include continuing avoided costs validated from previous periods. For the 21 cases, the projected annual avoided costs are £289,513. The avoided costs for cases identified in January cannot be validated yet and so no figures for this period have been included.

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Measure	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Total
Number of requests for AT equipment made per month	30	52	43	40	54	36	39	42	51	47	434
Number of installations of AT equipment	46	48	51	33	55	49	44	44	57	45	472
Number of health and social care staff trained	16	7	19	8	3	12	0	8	5	26	104

(viii) Better Care Fund Enablers

What is the purpose of the scheme?

3.29 This scheme involves four additional officers within the council's Children and Adult Services', Policy, Programmes and Community Insight service, to perform the following functions:

- Programme managing and monitoring BCF schemes
- Co-ordinating the council's involvement in a range of programmes and processes concerned with the integration of health and social care
- Improvement of joint information management systems to facilitate more effective service delivery involving health and social care providers.

Have any changes been made to the scheme since the original proposal was made?

3.30 The scheme was formally added to the BCF programme by the Integrated Care Board in December 2015.

What has the scheme achieved?

3.31 The Team:

- provides a programme management office for all of the council's work to integrate social care and NHS services.
- leads on the development of a strategic vision for the council's approach to integration, including the engagement of council members.
- has developed Service Level Agreements for all approved BCF schemes for which the council is the lead commissioner
- has established and maintains performance management and monitoring systems for BCF-funded initiatives within the council
- has strengthened the council's involvement in a range of partnership bodies concerned with the integration of health and social care, including the Tower Hamlets Integrated Provider Partnership (THIPP), the Vanguard New Care Model, the WELC Pioneer and Transforming Services Together (TST)
- has contributed to the development of data sharing arrangements between the council and Health sector organisations.

(ix) Capital Schemes - Disabled Facilities Grant/ Social Care Capital Grant

What is the purpose of the scheme?

3.32 The Council has a statutory duty to provide Disabled Facilities Grants (DFGs) to eligible disabled residents for the adaptation of their home environment, to enable

them to continue to live as independently and safely as possible. DFGs are mandatory for necessary adaptations to provide better movement in and around the home and access to essential facilities. Social Care Capital Grant is used for the same purposes as DFG. Types of work eligible for grant funding are:

- to make it easier to get into and out of the dwelling - for example, by widening doors and installing ramps;
- ensuring the safety of the disabled person and other occupants - for example, via improved lighting to ensure better visibility;
- to make access to the living room easier;
- improving access to the bedroom, and kitchen, toilet, washbasin and bath (and/or shower) facilities - for example, by installing a stair lift or providing showering facilities;
- to improve or provide a suitable heating system in the home;
- to adapt heating or lighting controls to make them easier to use;
- to improve mobility around the home to enable the disabled person to care for another person who lives in the property, such as a spouse, child or another person for whom the disabled person cares;
- to improve access to and from the garden of the home, where feasible.

Have any changes been made to the scheme since the original proposal was made?

3.33 No. The Grant will continue in 2016-17. The funding allocation is still awaited.

What has the scheme achieved?

3.34 The main outcomes are summarised in the table, below.

Adaptation	No of Approvals (1.4.15 – 31.1.16)	No of Completions (1.4.15 – 31.1.16)
Wet floor shower	100	123
Stairlifts	29	29
Ramps	8	18
Ceiling track hoists	12	17
Steplifts	5	5
Other (incl. Through-floor lifts, over-bath showers, door widening, door openers etc.)	8	9
Total	**162**	**201**

(x) <u>Care Act Duties</u>

What is the purpose of the scheme?

3.35 The 2014 Care Act placed a number of new duties on the local authority, including a requirement to assess and meet the needs of carers on a similar basis to people cared for.

3.36 This scheme covers funding of two main areas: 2014 Care Act Implementation and new duties in relation to Carers. The aim of the scheme is to set the needed infrastructure in place and deal with the extra demand arising from the new duties of the Care Act.

3.37 The council has created additional capacity within social care services to support and put carers on a par with users for assessment, review and provide carer services and packages (for carers and social care clients). In addition, the council is working on

improving services such as Safeguarding Adults Board, advocacy and legal literacy training as well as investing into much needed IT systems.

3.38 The Carers Hub provides a range of personalised services and support to carers, and in so doing seeks to prevent, reduce or delay the requirement of more intensive, publicly-funded care services. The Carers Centre also supports the wellbeing of the carer, enabling them to continue in their caring role. The services support the main adult carer, who is a Tower Hamlets resident or who is caring without payment for someone who lives in Tower Hamlets.

3.39 The service offers a range of person-centred information, advice and advocacy, including statutory independent advocacy, as defined by the Care Act 2014. It also provides supported carer's assessments and referrals for statutory assessments and supporting services, as appropriate.

3.40 The key services provided are:

- signposting to other available universal services in the borough
- specialist information, advice and independent advocacy, including statutory advocacy, as defined for carers by the Care Act 2014
- where appropriate, support a referral to the council for a full, statutory carer's assessment, which may lead to a Carer's One Off Direct Payment (CDP) or carers' breaks
- information and advice and access to other services, as appropriate, that support carers to prevent, delay or reduce social care needs
- support for carers on hospital admission/ discharge, and forming links with primary care and Public Health to support carers of those with long term conditions, including carers of people with mental ill health and of end of life care needs
- information and support for carers to manage their own health and wellbeing needs
- services and activities to alleviate and manage stress and provide a break from caring
- representing and supporting carers' views in local authority and CCG planning, and acting as the voice of carers and building partnerships with other organisations
- outreach and support for hidden carers
- the development and delivery of a range of carers' training and awareness programmes and production of a quarterly newsletter aimed at carers, with news and updates on available services, policy or legislative changes.

Have any changes been made to the scheme since the original proposal was made?

3.41 Yes, the Carers' Hub contract was varied to better fit with the Care Act 2014 and we would like to continue with the service in its current form.

What has the scheme achieved? *(Quarters 1 to 3, 2015-16)*

- Over 1,000 carers accessed specialist information and advice; 137 accessed non-statutory advocacy and 29 accessed statutory independent advocacy; as defined by the Care Act 2014.
- 260 carers (target 300) were supported through carers' assessments and/or referred to the council for a full statutory carer's assessment
- 206 carers were referred to other services to support them to prevent, delay or reduce social care needs.
- Services and activities to alleviate and manage stress and/or provide a break from caring: 315 carers attended a relaxation therapy (target 225), 303 attended

a Relaxation Day, 141 attended an Eid celebration, 93 attended a Carers' Christmas Party, 502 accessed emotional support, and 27 took part in a Carers' Week coach trip.

- The Carers Centre enabled 41 carers to participate in Local Authority and CCG planning/consultation events. The service works with a wide range of agencies, building partnerships facilitate the meeting carer's needs.
- Outreach and support for hidden carers: the service reached 437 new carers who have not received the service previously or in the last two years.
- The Carers Centre enabled 81 carers to access training on manual handling, managing stress and managing challenging behavior.

(xi) Dementia Cafes

What is the purpose of the scheme?

3.42 BCF funding enables the Dementia Café Service to support people with Dementia and their carers to stay well for longer in the community. The Alzheimer's Society delivers four cafes per month in two community venues. Two cafes are inclusive and two are aimed specifically at the Bangladeshi community. The service aims to reduce social isolation, increase knowledge of the dementia pathway and increase take-up of other services.

Have any changes been made to the scheme since the original proposal was made?

3.43 No, and we would like to continue with the service in its current form.

What has the scheme achieved?

3.44 The success of the scheme can be seen from the performance data from the first three quarters of the year. The cafes were attended by 265 individual people with Dementia and 249 individual carers. The cafes are structured into information sharing and activities that are beneficial for the health of people with Dementia. For example, the past quarter saw the inclusive cafe deliver information sessions led by Safer Transport Team, Healthwatch, Talking Point, Stay Well this Winter campaign and the promotion of the Dementia-friendly swimming sessions. Activities at the inclusive café in quarter 3 included Singing for the Brain, the Connaught Opera, Strictly Come Dancing, Smell Reminiscence and an arts session led by the Geffrye Museum.

3.45 The following represents the number of individual people who attend any of the cafes during the quarter:

Unique users & carers	**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**	
	user	**carer**	**user**	**carer**	**user**	**carer**	**user**	**carer**
Target Inclusive Café 1	18	17	18	17	18	17	18	17
ACTUAL	25	22	25	21	36	32		
Target Inclusive Café 2	18	17	18	17	18	17	18	17
ACTUAL	23	17	25	19	30	27		
Target Bangladeshi Café 1	15	15	15	15	15	15	15	15
ACTUAL	14	14	17	21	18	22		
Target Bangladeshi Café 2	15	15	15	15	15	15	15	15
ACTUAL	17	16	18	20	17	18		

3.46 The impact of the service can be measured in part through its outcome monitoring. Quarter 3 of 2015/16 saw 96.8% of people from the inclusive café and 95.83% of people from the Bangladeshi Café indicate positive social engagement. Social isolation is especially damaging to the health of people with dementia. This service enables them to continue to access the community and activities targeted at making them feel included. A side effect of the cafes is that carers also feel supported and are able to network and share experiences with other carers. Keeping carers healthy is essential to keeping people well supported at home and not in hospital.

3.47 90.6% and 83.33% of people from the inclusive café and Bangladeshi cafe espectively reported a higher take up of local services. Often older people within the Bangladeshi community dislike accessing mainstream health services. The Alzheimer's Society manages this through bringing services into the café. A Quarter 3 case study details how the services work together. The Dementia Inclusion Service found an older Bangladeshi woman in the community with worries about her memory. Through their support she was able to get a formal diagnosis at the Memory Clinic and attend the café. At one of the café's health visiting sessions the optician was able to correctly attribute her deteriorating vision not to her vascular dementia but to her eye sight. Glasses thus restored her sight making the risk of falls much lower.

3.48 Finally, 90.6% and 87.5% of people from the inclusive café and Bangladeshi cafe respectively indicate better understanding of dementia and dementia care pathway. A better understanding of the services available to support someone with Dementia is necessary for diverting people away from emergency services to community based options.

3.49 Future plans for the scheme include ensuring that the services have maximum geographical reach. If the research suggests that there are people from areas of Tower Hamlets who do not access the service, there is an option of adding further venues if necessary. We are also exploring how to use assets in the community to instigate social support and networks between the formal café sessions and to use the current client base to facilitate this.

(xii) <u>BME Dementia Inclusion Service</u>

What is the purpose of the scheme?

3.50 The BCF funding enables the BME Dementia Inclusion Service to increase the proportion of people from Bangladeshi and other BME backgrounds with dementia who receive a formal diagnosis. The Alzheimer's Society delivers this service through case finding in the community, casework with individuals and their families, working with GPs, making referrals to diagnostic/support services and awareness-raising to communities which have little knowledge of Dementia.

3.51 Tower Hamlets has the fifth highest BME population in London and the largest Bangladeshi population in the UK. The proportion of older people from these groups is steadily increasing. The borough's population is set to grow by over 25% by 2026, with the 50-65 age groups increasing by 67% and 65+ by 38% (GLA). It is predicted that the number of people with dementia from BME groups will continue to rise. 6.1% of all people with dementia among BME groups being young onset, compared with only 2.2% for the UK population as a whole. Some BME groups may also have much higher incidences of vascular dementia which, has been linked to lifestyle and diet.

Have any changes been made to the scheme since the original proposal was made?

3.52 No, and we would like to continue with the service in its current form.

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What has the scheme achieved?

3.53 By increasing diagnosis, the scheme is achieving BCF objectives and reducing unplanned admissions as follows:

- By helping to explain problems people are experiencing crisis access of the health service is reduced
- There are other causes, such as depression, which exhibit similar symptoms that it is important to diagnose and treat, which prevents escalation of other health issues
- Advice on dementia prevention lifestyle changes helps keep people well and out of health services for longer.
- It allows access to medication which can maintain independence for longer.
- Post-diagnosis management of cardiovascular risk factors can help delay progression.
- After diagnosis people and their carers and families can access information and carer/ peer support through services such as Dementia Advisor, social care and Cafes making them more likely to understand pathways and less likely to access services in crisis.
- We can advise people on future planning which again prevents crisis accessing of costly services, such as accident and emergency.

3.54 The successes of the scheme can be seen in the performance monitoring data. Quarter 3 saw the BME Inclusion service meet the SLA targets. The Alzheimer's Society found 39 people from the BME community with possible dementia, who they are now supporting into diagnostic services; undertook casework with 40 people from the BME communities including the Bangladeshi community; and organised 8 awareness raising events.

SECTION A: Activity Description: Bangladeshi	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
(a) Case Finding *Definition: identifying and making contact with individuals/carers with memory problems*	28	27	25	29	
For commissioner's info only: (b) New clients referred for case work to BME Inclusion service DSW *Can be from case finding as part of this service, DA, etc.*	N/A For info only	4	**5**	4	
(c) Casework *Definition: one-to-one support – open cases. Carers can be reported as a separate number if dedicated individual support is being provided to them separate from the PWD to support them in their caring role*	25	27	29	29	
(d) Awareness Raising events held	4	4	4	5	

SECTION B: Activity Description: Other BME communities	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
(a) Case Finding *Definition: identifying and making contact with individuals/ carers with memory problems*	10	8	9	10	
For commissioner's info:	N/A For	2	**3**	2	

(b) New clients referred for case work to BME Inclusion service DSW *Can be from case finding as part of this service, DA, etc.*	info only				
(c) Casework *(one-to-one support – open cases)*	8	8	11	11	
(d) Awareness raising events held	3	0	3	3	

3.55 Services such as this which increase dementia diagnosis have had a huge impact on our national performance. The dementia diagnosis rate has increased in Tower Hamlets from below the national target of 2/3 to over 80% of people with dementia receiving a formal diagnosis. Tower Hamlets now has the 4th best diagnosis rate in London.

3.56 Future plans for the scheme include a targeted focus on ensuring other communities, in addition to the Bangladeshi community, are robustly supported by the service.

(xiii) <u>Adult Autism Diagnostic and Intervention Service</u>

What is the purpose of the scheme?

3.57 The Adult Autism Diagnostic and Intervention Scheme is designed to support the council and the NHS to meet specific statutory duties under the Autism Act and the Care Act. The Autism Act Statutory Guidance published those duties in March 2015:

> *Local Authorities and NHS bodies should jointly: Ensure the provision of an autism diagnostic pathway for adults including those who do not have a learning disability and ensuring the existence of a clear trigger from diagnostic to local authority adult services to notify individuals of their entitlement to an assessment of needs. NICE guidance and NICE Quality Standard on autism represent best practice when developing diagnostic services and related services.*

3.58 The Adult Autism Diagnostic and Intervention service (ASD service) provides a service for high functioning adults (aged 18 years and over) with suspected Autism Spectrum Disorder (ASD) in Tower Hamlets. It also raises awareness within other agencies, including other parts of the Council and NHS. It sub-contracts a local Third Sector provider (JET) to provide employment support options for people diagnosed with ASD and facilitates appropriate referral and signposting to other services, where needed.

3.59 The service includes the following:

- A core diagnostic team to provide assessment of adults with potential ASD in Tower Hamlets, in line with NICE clinical guidelines for care of adults with autism
- Sign posting and referral to other services should a primary condition be other than ASD (e.g. mental health) or a risk be identified (e.g. self-harm or harm to others) that may require in-patient treatment
- Post-intervention support to adults with ASD (high functioning) including Cognitive Behavioural Therapies and assistance with developing social relationships
- Locally-based sub-contracted support service which enables user access to employment, training and advocacy.

3.60 The service is founded on the principles of a person-centred approach, with an emphasis on helping individuals to develop (or rediscover) their own unique skills through active engagement and participation. This includes a proactive approach in

utilising resources that are available within the service and the community to meet individuals' needs and aspirations.

Have any changes been made to the scheme since the original proposal was made?

3.61 No, we would like to continue with the service.

What has the scheme achieved?

3.62 The outcome of the 2014 Autism Self-Assessment Framework received in January 2016, confirmed that Tower Hamlets only received two Green ratings: one for the Autism JSNA produced by Public Health and one for the diagnostic pathway.

Service Outcome:	***Indicator:***	***Total***
Referrals	Total number of referrals (including self-referrals)	186
	Total number of people receiving a screening.	100%
	% of service users reporting they are satisfied/very satisfied with the diagnostic process. Bi- Annually Reporting	100%
Assessment and information on possible support options	Total number of people receiving a screening assessment assessed for coexisting physical health and mental health problems	69
	Total number of people approved for diagnostic assessment	51%
	Total number of people signposted to other services	25%
	Total number of basic health checks delivered	51%
	Total number of direct referrals to Mental Health Services	0.40%
	Total number of direct referrals to Community Learning Disability Services	0.10%
Case management	% of service users who are satisfied with the objectives set out in their care plan have been achieved	100%
Transitional support and planning	Total number of young people assessed as eligible to access the service. 18-25years	29
Employment, training and volunteering	Number of service users referred into Tower Project Employment Service to support into access employment and training	20
Awareness raising sessions	Number of ASD awareness raising sessions delivered to external agencies	32
Autism Carer Drop-in	Number of carers attending Autism Carers Drop in	29
	Number of Autism Carers Drop-in sessions delivered per annum	30
Service user surveys	Number of complaints	0
	Number of focus groups held	4

(xiv) <u>Social Worker input into Memory Clinic</u>

What is the purpose of the scheme?

3.63 A social worker working as an integral member of the Diagnostic Memory Clinic Team offers community assessments under the Care Act 2014, carers' assessments, organises packages of care, and provides signposting, advice and information and support. The inclusion of social care in the Diagnostic Memory Clinic (DMC) provides an integrated model of care throughout the dementia pathway in Tower Hamlets.

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Access to social care in the Diagnostic Memory clinic helps improve service users' journeys at a vulnerable and anxiety-provoking time in their lives.

3.64 The scheme aims to achieve:

- An earlier assessment of service users in need of social care support, and earlier signposting of those not in need of social care input, without referring service users onto another team/ service.
- A more seamless service, greater efficiencies and a reduction in 'hand-offs' and changes of key team/worker for service users.

Have any changes been made to the scheme since the original proposal was made?

3.65 There have been no significant changes to the scheme since it was first proposed. Some small changes were made following a Pilot scheme in 2014-15, but the scheme has run the same way for the past year, with the social worker being fully embedded in the team, and, therefore, able to give advice to team members and input into the Multi-disciplinary Team discussion at an earlier stage in the diagnostic process.

What has the scheme achieved?

3.66 The Pilot scheme had already shown greater service user satisfaction. The aim in 2015-16 has been to build on this and consolidate this improved level of service user satisfaction. The scheme is on track to meet the majority of its targets (see table, below).

Service Outcome:	***Activity:***	***Indicator:***	***Annual Target: Please insert figures and not % unless relevant***
Social Work Input into the Diagnostic Memory Clinic	Assessment of the social care needs of service users of the Diagnostic Memory Clinic	Number of referrals to the Memory Clinic	Target: 400 Actual : 290 to 15/01/16
		Number of those referred to Social Worker (SW) in the Memory Clinic	Target: 150 Actual : 133 to 15/01/16
		Number assessed for Social Care needs	Target: 120 Actual: 98 to 15/01/16
	Carers Assessments offered to carers of those seen by Diagnostic Memory Clinic	Carers advised of their entitlement to a Carers Assessment	Target: 95% of those referred to SW Of those with known carers: 100% offered
		Carers Assessments completed by Social Worker in the Memory Clinic	Target: 30 Actual: 12 to 15/01/2016
	Timely response (within 28 days) for social care assessment whilst under the Memory Clinic *difficulty in capturing this information from electronic system	Contact made with service user to arrange an assessment within 7 days of referral to Social Worker	80 % of those referred to the social worker Actual: 100% from small desktop audit
		Assessment contact completed within 28 days of referral to Social Worker	90% of those referred to the social worker who consent to assessment Actual: 60% from small desktop audit
	Gather Service	Satisfaction survey given	Target:25% response

	user and Carer satisfaction surveys	to all those service users and carers in contact with Memory Clinic Social Worker for an assessment.	rate; 80% positive response rate Actual: 20.4 % response rate to 15/01/16 (20 responses) Nearly 97.5% positive - satisfied or above.

(xv) <u>Strategic Development Schemes: 2015/16</u>

Personalisation

3.67 The Personalisation Programme supports greater person-centred care as part of Tower Hamlets' agenda on delivering Integrated Care. The Programme Board overseeing this work, reports to the CCG's Integrated Care Board. The work streams within the Personalisation Programme have been developed in response to the direction set within NHS Five Year Forward View and Forward View into action: Planning for 2015/16 and enables the delivery of the CCG's new strategic priority on person-centred care.

3.68 The work streams with the programme are as follows:

- Widening the offer of Personal Health Budgets (PHB) beyond Continuing Health Care (CHC)
- Delivering Integrated Personal Commissioning (IPC) in Tower Hamlets and contributing to the national evaluation of this. NHS England has Commissioned RAND Europe to undertake this evaluation.
- Piloting the use of Patient Activation Measure (PAM) in Tower Hamlets
- Self-management, including oversight of the self-management pilots, their evaluation and recommendations on future commissioning plans.

3.69 From October 2014, CCGs were required to offer personal health budgets (PHB) to people with continuing health care needs (CHC/CH). The Forward View into action: Planning for 2015/16 outlines the requirement for CCGs to expand this offer

> *"To give patients more direct control, we expect CCGs to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit. As part of this, by April 2016, we expect that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning difficulties, in line with the Sir Stephen Bubb's review."*

3.70 In addition, the NHS Mandate, 2015, sets the objective that:

- Everyone with long-term conditions, including people with mental health problems, should be offered a personalised care plan that reflects their preferences and agreed decisions;
- Patients who could benefit should have the option to hold their own personal health budget as a way to have even more control over their care.

3.71 As such, the expansion of Personal Health Budgets is a "must do" for CCGs with an ambition for 0.1% - 0.2% of CCG population to have a PHB in the next 3- 5 years. This is equivalent to 300 – 600 PHBs in Tower Hamlets the next 3- 5 years (based on GLA population projections). Tower Hamlets CCG has decided to provide this as part of an integrated personal budget for health and social care, required as part of the Integrated Personal Commissioning (IPC) programme.

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Tower Hamlets Integrated Personal Commissioning (IPC)

3.72 Tower Hamlets is a national demonstrator site for Integrated Personal Commissioning (IPC), which is a three-year programme from April 2015 – March 2018. In Tower Hamlets, it is intended that the expansion of PHB will be introduced as part of integrated personal budgets for people with existing social care packages and complex health needs.

3.73 The goals of IPC are as follows:

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care
- Better integration and quality of care.

3.74 These align closely with the objectives of Tower Hamlets Integrated Care, in particular in its focus on person-centred care planning and moving away from "what's the matter with you" to "what matters to you".

3.75 The IPC financial model also aligns with the capitation model being developed for integrated care. It attempts to shift incentives towards prevention and coordination of care, by testing an integrated capitated payment approach and incentivising providers to proactively understand who is at risk, and take early action to prevent deterioration and coordinate services, which, to be effective, involves working in partnership with people and their carers.

3.76 The four groups of people we will be focusing on are:

- Children with SEND
- Adults with severe and enduring mental health needs
- Adults with learning disabilities
- Adults with multiple LTCs including COPD and on level 2 of Integrated care NIS.

3.77 Early analysis shows approximately 900 adults fall into this cohort. Our original target for 16/17 were 1,275 care plans and 165 budgets. However, based on learning from year one of the programme we will be reviewing these targets. The costing in this business case is based on 100 care packages in 16/17.

3.78 In order to enable this to be delivered the following infrastructure needs to be developed including:

- processes and policies for agreeing and signing off and reviewing care plans and budgets
- determining the services which opened up as part of PHB and the contractual changes needed to enable the funding to be released from these budgets
- agreement around risk management
- set up of brokerage and finance services
- set up advise and support for people undergoing this process

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4. Proposed BCF Programme for 2016-17

4.1 The following table summarises the proposed funding allocations for 2016-17. It can be seen that, to a considerable extent, it is being recommended that the schemes funded in 2015-16 should continue to receive funding in the coming financial year. This is because a number of the schemes presently funded via BCF only commenced in 2015-16, while others are ongoing activity experiencing a high level of demand. In addition, the joint commissioning review between the CCG and LBTH may make recommendations that exceed the scope of current partnership arrangements, and so it is proposed that BCF changes in the interim be minimal, in order to reduce any duplication or additional administrative burden, following the joint commissioning review's report.

	Scheme	15/16 BCF	Changes for 2016/17?	16/17 Allocation
Integrated Teams	Integrated Community Health Team	£7,336,499	Possible changes following mobilisation of CHS contract but not for 1617	£7,336,499
	Primary Care Integrated Care Incentive Scheme	£1,020,746	No material changes, additional CCG contribution to reflect full budget for the NIS	£1,200,000
	Reablement and Rehabilitation Joint Working Pilot	£2,350,000	Potentially based on reablement review. Assume steady state	£2,413,871
	Integrated Health and Social Care CHC	£866,000	Increase due to NI changes	£895,500
	7 day working at the social work team RLH	£1,200,000	Increase due to NI changes	£1,230,800
Mental Health	RAID	£2,106,420	Not in 1617. Evaluation expected soon, maybe changes in 1718	£2,106,420
	Recovery College	£110,000		£110,000
Independence	Independent Living	£646,000	Reduction in line with underspend projection	£649,000
Other	Contribution to PMO	£50,000	No longer required due to TST programme	£0
	Peer researcher	£25,000	No longer required	£0
	Community Geriatrician	£150,000	Incorporated into Integrated Community Health Team	£0

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Mandated	DFG and Capital	£1,629,000		£1,572,542
	Care Act	£733,000		£733,000
	Carers	£697,000		£697,000
	Performance Pool	£1,091,313	Preserve for local incentive scheme of £1m	£1,000,000
New schemes	Autism Service	£330,000	Following LBTH request in December 2015 and new guidance	£330,000
	BME Dementia	£55,000		£55,000
	Dementia Café	£25,000		£25,000
	LBTH Enablers	£176,000		£208,000
	Additional NHS Community Services	£0	Following new guidance	£1,091,000
	Community Equipment Service	£0	7 Day CES Team	£154,985
Other			Additional Tower Hamlets BCF Allocation from DH	£67,000
Total		£20,596,978		£21,875,617

NON RECURRENT	Strategic Development	£852,000	Refreshed following CCG BC process: Personalisation Falls Prevention Mental Health in Primary Care Community Geriatrician	£695,000
Grand Total		£21,448,978		£22,570,617

Governance

4.2 The government makes Better Care Fund resources available to Health and Wellbeing Boards to be spent in accordance with a local Better Care Fund plan. It is proposed that the governance for the BCF remains with the CCG Committee that oversees the delivery of Integrated Care in Tower Hamlets. In 2015/16 this has been the Integrated Care Board. In 2016/17, in line with the refreshed programme structure of the CCG, this will transfer to the Complex Adults Programme Board. ToR and membership will be reviewed in order to accommodate this change

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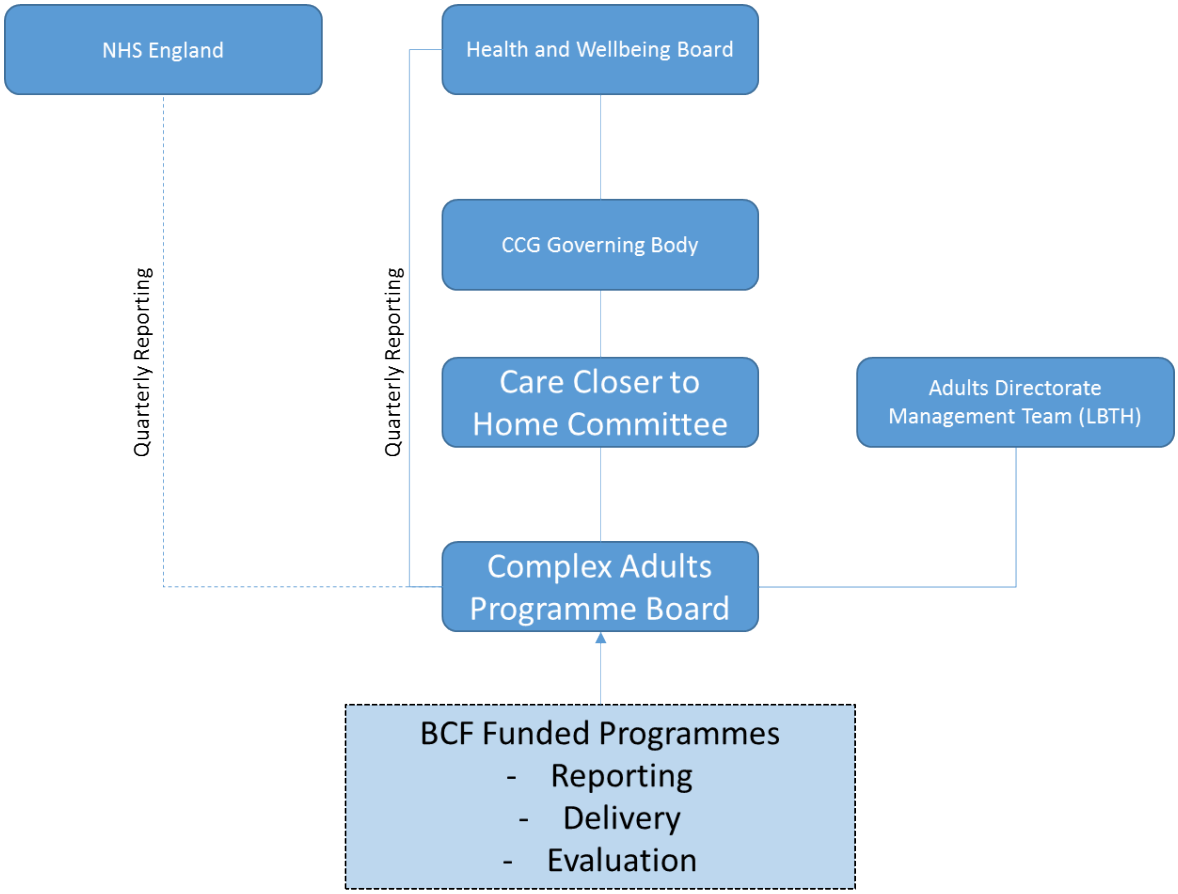

Appendices:

Appendix 1: LBTH paper to the Integrated Care Board requesting re-profiling of schemes

Appendix 2: Proposal for 7 day ICES services