BCF project outlines and ACTION PLAN

Service Area / Condition	Project Outline	Project Impact	Project Timescales	Responsible Body
Protection for social care services (rather than spending) with the definition determined locally	**ADVANCED DEMENTIA DAY CARE PROVISION:** Raglan and Netherwood are two day support services for people with advanced dementia. These are currently commissioned to support 50 people per day across two centres. The long term plan is to put these services out to tender and to move to an activity driven model rather than a block contract. The tendering process is due to commence during 2014/2015 and future proposals will be informed by the emerging Day Opportunities Strategy.	• Reduction in admissions to residential and nursing care home • Prevention of avoidable hospital attendance • Improved customer mental, emotional and social wellbeing	**EXISTING** **To be determined**	LA
	REABLEMENT : The reablement strategy aims to increase the amount of intensive social care reablement packages offered to reduce the reliance on care in the following ways : 1) Increasing the amount of intensive social care reablement packages by offering two types of overnight reablement care to support people to live at home and prevent avoidable admission to hospital and	• Reablement care packages • DTOCs 99% • Reduction of avoidable admissions • Reduction of admission to nursing or residential care	**EXISTING**	LA

	nursing or residential care through: • Waking night care service whereby the carer has designated jobs to undertake during the evening for the individual at regular intervals and is significant enough to require the carer to be in attendance. • Sleeping night care service this is where it is advisable to have another person present in the home either for reassurance and to deal with situations when/if they arise. This service is targeted predominately (although not exclusively) to those customers who have been assessed within the hospital setting as requiring night care to facilitate a safe discharge or prevent a hospital admission. This service can provided to all adults including older adults with dementia and all age disabilities including Learning Disabilities. Social work teams within the two acute trusts will identify customers who have a high level of care needs with an aspect of care required to prevent falls and encourage the individual to learn techniques to mitigate risks. 2) An increase in the number of reablement beds that can be accessed in the community to prevent hospital admission and deteriorate a safe discharge. These are –			

	• 4 single beds and 1 double bed at Henderson Court a sheltered accommodation unit. • 10 single beds within Roseberry Mansions an Extra Sheltered Unit 3) Reablement service are currently been developed, and due to be operational within 2014, through a range of initiatives to enable people to live at home longer and increase independence and confidence these include; • Developing Integration opportunities to work with Community Health thorough early reablement intervention to avoid hospital admissions. • Developing a reablement service that meets the needs and requirements for those people with a learning disability • Developing an approach to reablement that helps to tackle social isolation and reintroducing people back into their local communities – provide a focus to reablement that is within community settings as well has home environments. • Developing the Mental Health Outreach Reablement Service to work with people in reablement accommodation and look to offer this resource to people with a mental health condition and / or dementia.		**May 2014** **December 2014**	

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	Care packages (existing): Assessment and Care Management Service assessing customer need and implementing a combination of services to meet customer need. Providing early identification, proactive support and access to prevention and reablement services to remove, minimise or delay individuals' and carers 'need for care and support. Social care practitioners defining eligibility of care through the Fair Access to Care Services (FACS) A flexible, robust and responsive approach to the provision of services through a Central Allocation Panel (CAP)	• Prevent admission to residential or care home • Prevent hospital admission through the implementation of care provision • Delayed Transfers of Care • Person centred assessments undertaken to improve customer experience and outcomes • Providing carer support to prevent carer breakdown and improve quality of life	**EXISTING – ONGOING**	**LA**
	Care Plan demographics and care bill: Enhancement of existing care package funding to support the changes in demographics and changes within the care bill	• Enhancement of existing care package funding to support the changes in Camden's demographics and changes within the Care Bill	**April 2015**	**LA**

		• Health and social care partners working together to implement the changes within the care bill		
	Preparation for the Care Bill: Health and social care partners working together to implement changes within the social care bill including: Considering the impact of the proposed changes on adult social care in Camden for Responding to consultation documents on specific aspects of the Bill Anticipating and developing some early plans to implement the potential requirements Responding to further direction/guidance as it becomes available, Highlighting the need for any future policy changes and financial implications. Work streams and workgroups identified take forward key areas e.g. prevention, prior to full implementation of the bill	• Considering the impact of the proposed changes on adult social care in Camden • Responding to consultation and specific aspects of the Care Bill • Anticipating and developing some early plans to implement the potential requirements • Responding to further direction / guidance as it becomes available • Highlighting the need for any future policy changes and financial implications	**July 2014 – April 2014**	**LA**

Seven day working in social care to support patients being discharged and prevent unnecessary admissions at weekends	**SOCIAL CARE IN GP PRACTICES:** 18 month pilot for a 'test bed' project with an action learning approach with a social care team made up of 1 Operational Manager, 5 Social Workers, 1 Occupational Therapists based within GP practices throughout Camden. Social Care team to be deployed across a number of surgeries across Camden and receiving referrals directly from GP and community nurses. Development of 'hub' sites in general practice to allow for clinical and MDT meetings Provides opportunity to test new ways of working and develop a full service specification based on collaborative integrated care working. Facilitating joint working with a particular emphasis on: hospital avoidance, prevention, long term conditions and complex care for those frail and elderly customers and all age disabilities including Learning Disabilities This is a combined initiatives with the mental health services with psychologist, psychiatrist and mental health nurse. The aim of the project to; • Increase the QoF register of patients with Depression / anxiety and mental health • Develop a register of patients with Personality Disorder • Increased care management with an	• Increase the number of joined up health, mental health and social care assessments and care plans to improve care co-ordination and individual outcomes • Developing joined up working arrangements between health and social care to reduce lengths of stay and prevent avoidable hospital attendance and delayed transfers of care • Co-ordinated care between health, mental health and social care preventing duplication and improve communication and customer experience • Positive risk taking and joined care management supporting people to remain at home	**June 2014 – December 2015**	**LA**

	emphasis on holistic assessments • Establishing clear pathways, training and support to increase the effectiveness of the health and social care system			
	Enhanced social work discharge team : ***EXISTING** Additional resources have been deployed to enhance existing social work teams across the two acute hospitals with a particular focus on avoidable admissions and DtoC through the implementation of a reablement care package the ability for someone to remain at home. This has enabled practitioners to maximise opportunity in identifying those customers who will benefit from reablement and implement care at the right time. Facilitating a streamline services to ensure continuity and a named contact to prevent re-admission through well-co-ordinated and targeted care Ensuring reviews are timely and undertaken by original assessor to help benchmark whether goals have been met and determine longer term care requirements	• Enabling individuals to reach their potential by implementing reablement, achieving greater integration and prevent hospital admission and facilitate safe discharge • Prevention of long term admission to long term care by maximising opportunities for greater independence • Reduce handoffs and providing consistency of care, timely reviews and improved individual experience • Facilitating timely discharges through dedicated reablement workforce	**EXISTING**	**LA**

	SOCIAL WORK WEEKEND WORKING: Since March 2014 ASC have been providing a 7 day week service within the acute hospital. Based within the A&E department the core focus of the work has been through: : • **A&E** – facilitating discharge for those who present to hospital and do not require medical admission but require social care input to support an avoidable admission. • **AMU** – assessment for those on the medical assessment units facilitating a speedy discharge when longer term admission to hospital is not required • **Reducing lengths of stay** – early assessment for those patients who have been admitted to hospital and helping to facilitate their discharge more speedily The Social worker has worked alongside health care professionals with in the Accident and Emergency department and be the first line of contact for those patients who present and have social care needs. This pilot has provided the opportunity to understand how social work could be implemented at the weekend post pilot as well as assessing the benefits and risks to such arrangements. The infrastructure required to help support social work weekend working has	• To reduce lengths of stay and Delayed Transfers of Care by facilitating safe discharges across a 7 day week for those who require social care input • To prevent avoidable admissions at the weekend by providing social care input within A & E • To provide advice and support within the acute setting over the weekend to facilitate informed decision making and discharge • To help influence organisational cultural change and identify the infrastructure required to support a robust 7 day week health and social care system	**March 2014** **June 2014**	LA

	been developed since the pilot and includes changes to: extension of the 'care link' service, care of the elderly consultant access and referrals to therapy services. A further development has been through the implementation of the social care GP project which covers a 7 day working week as well as extended hours from 8am to 6.30pm. As from June 2014 a social worker has been based within the weekend RAPIDS service providing a same day nursing, therapy and social work intervention for those people at risk of admission to hospital.			
	<u>CASE MANAGEMENT PROJECT:</u> The overall aim of the two year case management project is to anticipate, co-ordinate and join up health and social care for patients at a high risk of unplanned admissions to hospital through the provision of three band 7 Case Managers to work across the three localities to: a) provide in-depth case management for up to 12 weeks for 300 people registered with practices in Camden who are at highest risk of hospital admission and have highly complex health and social care needs b) Provide training, development and supervision to the CNWL integrated primary	• Increase the numbers of people on practice frailty registers who are proactively case managed preventing further deterioration in their condition (700 people by March 2014) • Very complex patients to be intensively case managed for up to 12 weeks (From 75 to 300 by March 2014) • Secondary care Track impact on secondary care use of patients case managed and care	**July 2014**	**CCG**

	care service, GP practice teams and ensure that multidisciplinary working with practices is embedded at practice level including the regular attendance at practice MDTs of complex case management (frailty) leads. c) develop joint working arrangements with acute hospitals, social care, community geriatricians and the rapids team d) Ensure regular feedback from patients who are being case managed and their carer's and family on the experience of being case managed, identifying opportunities for improving the existing service.	planned • Track impact on social care input on patients intensively case managed		
Creativity Innovation and Learning from others	**INNOVATION:** It is envisaged as the projects from the Better Care Fund rolls out and lessons from Pioneers are rolled out there will be projects we could wish to consider for further funding	• As the projects from the Better Care Fund are implemented and lessons from the Pioneers are rolled out there will be further projects that could be considered for further funding	**To be determined**	**Joint**
Better data sharing between health and social care, based on the NHS Number	**SHARED DATABASE:** ***EXISTING** Camden Integrated Digital Records (CiDR) – is a newly developed IT interface system which has been commissioned with the purpose of providing a consolidated dashboard of data	• No financial investment required through the Better Care Fund – initiatives support the targets and conditions of the Better Care Fund	**EXISTING**	**Joint**

	from health and social care systems. The system is live with information portals across all key health and social care sectors e.g. acute trusts, primary care, community nursing and adult social care.			
	CROSS BOUNDARY: Cross Boundary Patients – 10% of Camden residents with a Camden GP live within another borough which presents complexities when integrating health and social care assessments data sharing arrangements to be developed through local data sharing projects. Work is being developed to help tackle this issue. Adult community nursing contract now reflects that Camden residents with a Westminster GP can be assessed and due to be rolled out to Brent late 2014. We are awaiting further guidance on LA cross boundary working from ADASS	• No financial investment required through the Better Care Fund – initiatives support the targets and conditions of the Better Care Fund	**EXISTING**	**Joint**
Plans and targets for reducing A&E attendances and emergency admissions	**URGENT CARE REVIEW PARTNERSHIP:** A multi-agency board has been implemented to address the whole system approach that is required to review local urgent care services. Key solutions have been identified through the development of new urgent care model including components of ; extended GP hours, Multidisciplinary Teams, Community teams, urgent care centres and specialist care teams.	• No financial investment required through the Better Care Fund – initiatives support the targets and conditions of the Better Care Fund with particular emphasis on avoidable emergency admissions	**EXISTING**	**Joint**

	CAMDEN RAPID INTERMEDIATE CARE SERVICE: The Rapid Response service caters for individuals who have an immediate health and/or functional need necessitating advanced nursing care and/or urgent Occupational therapy on the same day as referral to prevent an inappropriate admission to hospital. Immediate, short-term social care needs can also be met for These clients. The service has been expanded to include 7 day week working - Team comprising nursing, occupational health, Physio therapy, health care assistant and Care Link. Providing 7 day a week out of hour's community nursing and therapist service. Carelink operating Monday to Friday 9am – 8pm and Saturday and Sunday 9am to 3pm Working with people for up to 6 weeks then transferring for longer term community nursing or social care if required. Provides a rapid service to those vulnerable people who will benefit with their health needs been met within their own home environment instead of admission to A&E. Promoting service within nursing and residential homes Learning Disability Services – encouraging providers to contact rapid	• Prevention of admission of older people to residential and care home by providing community support to regain a higher level of functioning, leading to reduction in care packages and hospital admissions • Early discharge intervention to increase patient level of functioning and reduce risk of readmission and enable patients to remain at home for longer • Admission avoidance as service acts as alternative to hospital admission including referrals from Self /NOK (target for average of 20 admission avoidance referrals weekly, full year effect over 750 admissions avoided)	**October 2013**	**CCG**

	service instead of 999.People seen day of referral or access visit arranged the following day if person is safe Comprising a falls pathway due to high number of patients who suffer with falls	• Better co-ordinated care through integration, community intermediate care team, therapists and specialist support and expertise including complex neurological conditions		
	<u>CAMDEN INTEGRATED CARE SERVICE</u>: ***EXISTING** CICS –This project has been in situ since April 2012. Through weekly borough wide Multi-disciplinary meetings providing intensive case management to people with complex health and social care needs including all adults with disabilites outside of the acute setting whenever possible. Weekly MDT's includes, GP, psychiatry, psychologist, social work, occupational therapy, physiotherapy, Community psychiatric nurses, pharmacist and third sector organisations. Case presented for those patients who have been placed on the frailty register (1120 patients have been on the register) where there are unresolved complex issues that require multi-disciplinary solutions. Once presented if required a joint home visit is co-ordinated and services and support implemented. All cases are reviewed and re-presented if required and	• Improve the experience of individuals by providing a more responsive service able to provide the right level of support at the right time for each individual and in doing so improve their quality of life • Co-ordinated care and joined care planning to prevent inappropriate admissions to hospital, reduced number of frail and elderly individuals being admitted to residential and nursing care and short stay assessment beds, • Reduction in care breakdown and the	**November 2012**	**CCG**

	beneficial. The vision for this service over the next two years is to work with all partners to deliver further transformational change and to progress towards commissioning a new service model of integrated care for the frail and elderly from 2016. The overall vision of the programme is to improve the outcomes and quality of life for frail and elderly patients and their carer's in Camden.	necessity for crisis interventions.		
	OCCUPATIONAL THERAPY LED PROJECTS: 1.) Manual handling project – To reviewing all manual handling cases for customers who are in receipt of care whether their care is commissioned by Adult Social Care or whether they are in receipt of Direct Payments and oversee their own care arrangements. It is anticipated that with a primary focus on those customers who require double handed care that with a full review of their manual handling requirements there will be changes and adjustments that can be made that will result in significant savings. This will be achieved through full re-assessment and consideration of the customer's	• focussed on keeping customers within their homes and therefore reducing hospital admissions and residential transfers • focus on maintaining the clients medical health therefore avoiding hospital admissions • Assisting in safeguarding investigation with clear and reportable conclusions • Delivery of 120 scheduled reviews to meet organisational		**LA**

	equipment and adaptations and additional solutions identified to better manage their ongoing care needs. This will not only reduce cost to Adult Social Care but improve safety comfort and independence to the customer and reduce the risk of further deterioration e.g. pressure sore issues. This project will also focus on training care agency providers in manual handling when providing are to ensure that risk and injury is reduced to both customer and carer, including those individuals who are providing services via a Direct Payment. A further component is to provide on-going consultancy support as the needs of the customer change and issues arise. Although this project initially focuses on customers who are living in their own home there is the potential to expand this to include day care provision and care homes. This project is for 12 months and an evaluation Programme will be implanted as part of the process. The learning and findings from the evaluation will help influence main stream occupational therapy practice within the wider Assessment and Care Management Service 2.) – Seating project: Focusing on two care homes e.g.	targets • All projects are proposed to deliver improved customer experience. • Each of the projects considers user engagement as part of the core evaluation. Each will also use this feedback to develop models of future best practice • All projects deliver on the agenda outlined in the ASC framework. I.e. quality of life for people with long term conditions /social care related quality of life. This is achieved by maintaining people within their own homes and providing a higher quality personalised experience which is one of the complimentary indicators.	**November 2014**	

	Maitland Park and St. John's Wood care home all seating options will be reviewed for residents. In undertaking this review improved options for seating will be identified and implemented. This will help promote best practice and improved quality of life. the following principles: 3.) - Review of Equipment and Adaptations Project: Undertake reviews on 100 customers who have received equipment and major adaptations form Assessment and Care management Service. Complete focused reviews will help identify customer's current and on-going needs and implement appropriate aids and support. This will achieve statutory review returns whilst care savings are also expected. Reviewed undertaken over a 65 week period including full liaison with multi-disciplinary teams, when appropriate			

	INTEGRATED HUB SERVICE: To implement a two-year 'proof of concept' pilot for the development of a pioneering integrated hub service aimed at improving the outcomes and wellbeing for the frail elderly and those with LTCs through the provision of personalised and co-ordinated care and support across a network of providers focused on improving self-management and preventing avoidable primary/secondary activity Pathway navigators will - Provide support to navigate the system Provide 'live' feedback on service to GP Role supported by mentoring and education package – quality and consistency	• Delivery of the Service to a minimum total of 2,500 referrals over the course of two year pilot, with Provider(s) developing and implementing a phased approach to increasing the referral capacity of the Service during Year 1. (800 referrals 2014/15)(1,700 referrals 2015/16)	**October 2014**	**CCG**
	ASSISTIVE TECHNOLOGY: In 2012/13, 527 people were supported with Telecare sensors and 7 people in receipt of Tele-health monitors. There are ambitious targets to increase this service take-up in coming years. In 2013/14 anticipated numbers of people supported with Telecare will increase to 737 and Tele-health 32 (and an annual increase of 100 users per annum thereafter) Camden are committed to the development and implementation of a range of assistive technology options to help support people to live as independent live as possible within their own how. The two work streams include:	• At least 100 telehealth units to be provided to clients by March 2015, increasing to 170 units a year by 2017/18.(2014/15 minimum 100 new clients) (2015/6 minimum 150 new clients) • To increase the number of people with telecare sensors by 20% by April 2014. This means 659 Camden residents with telecare sensors and Careline Telecare alarm		**LA**

	Telecare: Work began in July to update the prescriber's catalogue, referral form, website and a telecare unit is to be set up again to train referrers possibly in Sept/Oct 2014. The electronic medication dispenser project is also underway- defining referral, assessment prescription, and review processes as well as setting up a system with community pharmacists for refilling the dispensers. **Telehealth:** To mainstream, roll out and rationalise telehealth service between health and social care. – 25 units will be leased for a one year period from the go live date of 14th July 2014. The units will initially be prescribed to patients with COPD and/or heart failure. The units will be monitored by a clinical triage team within CNWL. An awareness session/launch event was held in July 2014. The focus is to increase Telecare uptake by older people, people with disabilities and dementia. Telehealth –care is a central part of the strategic re-orientation of Camden's social and health care towards greater preventative approaches for people to stay active, healthy and as independent for as long as possible in their home and community of choice. The services will help promote peoples wellbeing and independence instead of waiting for people to reach a crisis point. Camden is developing a Telehealth-Care Strategy which will be finalised	buttons. A further 25% a year from 2014/15 onwards. This will mean that the number of customers will increase from 949 to 1,608 by April 2018. • Increased user awareness, self-care management and experience of care At least 80% clients report telehealth has helped understand how to manage their long term condition better • At least 80% clients report telecare has helped them retain their independence • Reductions in permanent admissions of older people (aged 65 and over) to residential and nursing care homes Baseline and target to be agreed by steering group in April 2014. • Increased proportion of older people (65 and over) who were still at home at 91 days after discharge from hospital	**EXISTING**	

	in 2014.	into reablement/rehabilitation services Baseline and target to be agreed by steering group in April 2014.		
	ENHANCED HOMECARE PROJECT: Community Based Support – merging all or part of our domiciliary contracts with community nursing to develop an integrated home based care solution - for non-essential clinical services e.g. eye and ear drops, medication administration and basic wound care. This project will provide the opportunity to foster a collaborative approach between district nursing and homecare and 'test bed' a system that best utilises the resources and skills within community nursing and domiciliary home care provision whilst putting the customer in the centre of the process. In undertaking this initiative it is anticipated that care will be less fragmented with the necessity for multiple carers to be involved at any one time. Additionally this should help foster closing working relationships between health and social care through combined care and support packages. This project will be initially pilot within two community nursing services for 6 months with a view to full scale role out post pilot depending	• Reduction in number of people admitted to short term and long term care due to more co-ordinated and joined up care packages supporting health and social care needs • Reduction in avoidable attendance at A & E and admission to hospital as a result of more joined up care and consistency with formal carers with a holistic view of the customers health and social care needs • Reduction in lengths of stay and DtoC as care and support will be arranged in an well-co-ordinated and effective way facilitating speedy	**September 2014**	**CCG**

	on the learning from the pilot.	discharge from hospital • Improved communication and co-ordination of carers resulting in improved patient / customer experience • Improved experience as customers receive the right support from the right person		
	PATIENT DISCHARGE IMPROVEMENT PROGRAMME: A short term project looking at discharge pathways from acute to community setting the prime aim is to inform commissioning intentions for community/rehabilitation services to prevent avoidable admissions to hospital. The programme work streams include the following: 1. Delayed discharge policy review 2. Section 2 and Section 5 hospital Audit 3. Community Rehabilitation Access Criteria Review 4. Family interventions hospital discharge programme 5. Mental Health discharge pathway	• Provides additional service information in order to identify future commissioning intentions as well as improve existing data collection and monitoring arrangements for both performance target setting and service outcome frame works. • Any improvement of the hospital discharge pathway only serves to encourage a reduction in residential and nursing care home placements. This	**EXISTING**	**Joint**

	review 6. Discharge pathway Maitland Park 7. Mediquip Hospital pathway 8. Evaluation of step down beds 9. Establish multi-agency IT systems 10. Evaluation of short stay provision for hospital avoidance 11. Acute hospital trusts – Continuing Health Care 12. Extension of Camden Carers 13. District Nurse – continuing health CQUIN 14. Trusted assessors for short stay beds and S.t Pancras This programme of work is being incorporated into the integrated delivery plan	includes improved access to community and Primary care services. • An improved hospital discharge pathway will ensure timely and appropriately resourced transition of care between acute and Community reablement / rehabilitation services. • By improving the continuing healthcare assessment rates of district nurses will help identify earlier community resources • Improved mental health pathways improve earlier community intervention • Earlier involvement of family, carer and advocate agencies on admission will reduce patient choice DTOC issues and help manage overall patient and carer expectations better.		

	WORKFORCE DEVELOPMENT: Implement training programme for the whole of the health and social care workforce including opportunities for all disciplines. Key training to be delivered on areas such as:- • Mental Capacity Act • Safeguarding Adults • Patient Self – Management • Positive Risk Taking • Case Management • Motivation and self-development • Housing Legislation Developing opportunities for cross virtual health and social care workforce for y training on key issues e.g. Social Care Bill, integration between health and social care, new ways of working and cultural opportunities / challenges to implement collaborative working.	• Increase in skill, knowledge and confidence throughout the workforce. • Reduced complications, errors and waste. • Slow disease progression, reduce complications. • Improve coordination and efficiency between health and social care. • Streamlined communication and improve productivity. • Improved compliance best practice models • Improved rates of retention and employee satisfaction.	**September 2014**	**LA**

	Integrated Community Equipment Service (ICES): Through this arrangement the CCG will be able to take advantage of the procurement arrangements of the West London Consortium via London Borough of Camden as the Transforming Community Equipment Scheme (TCES) provides bulk purchase and economies of scale. Equipment can be bought or rented at significantly lower rates than the current contract price. Utilising TCES to provide equipment delivers a more cost efficient service which is intended to provide additional equipment capacity to meet an increase in demand that is generated through improved hospital discharge pathways and increasing numbers of people cared for in their own homes and community settings.	• A rapid response nurse therapy team aims to respond within one hour to calls for urgent Nursing/Therapy assessments that may avoid a patient having to attend A&E or hospital. (2014/15 100% response to urgent nursing/therapy assessments within 1 hour (2015/16100% response to urgent nursing/therapy assessments within 1 hour) • The % of all items delivered within 5 working days (2014/15 95%) (2015/16 95%)	**EXISTING**	**LA**

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