Appendix 3 - Lambeth BCF Plan September 2014

This document includes the detailed scheme descriptions for the following services that are included in Lambeth's Better Care Fund

Ref no.	Scheme
BCF01	**Reablement** **I**mproves independence through reablement and reduces the need for on-going home care packages, delays the need for residential and nursing homes, and avoids visits to hospital A&E or in-patient beds.
BCF02	**@home** Offers more intensive medical support for a shorter period of time in a patient's home. This service enables patients either to avoid coming into hospital at all, or to help them return home sooner with extra support.
BCF03	**Enhanced Rapid Response** Facilitates discharge from hospital and provides home based rehabilitation and support targeted at adults and older people with a physical or sensory disability, with the aim of them regaining or maintaining independent living within the community and preventing unnecessary hospital admission.
BCF04	**Intermediate Care** Provides a step down service on discharge from hospital to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital, reduce delayed transfers of care, and maximise independent living.
BCF05	**Support for Carers** Provides carers access to independent advice, advocacy, information, assessment and helpful resources to support them in their role, as well as emotional and physical support, training and access to services that support wellbeing, and promote independence. Provides a base for and coordination of local information and activities that are likely to support carers, as well as access to a range of specialist groups, courses, advice sessions and activities. Provides respite from their caring role.
BCF06	**Care Homes** Supports care homes with dedicated GP support and access to a specialist team, including a geriatrician. The scheme improves working between acute hospital and care homes for better transition at discharge and support care homes in early identification of infections and other health issues that, with deterioration, are likely to require an emergency admission. The scheme also identifies care home staff training and education needs.

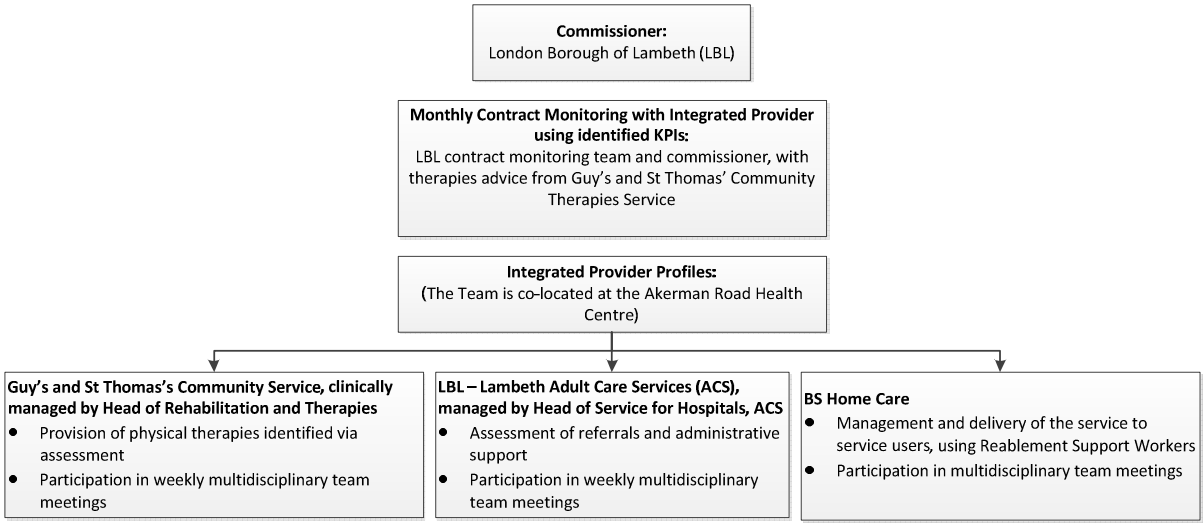
Scheme ref no.
BCF01
Scheme name
Lambeth Integrated Reablement Service
What is the strategic objective of this scheme?
To improve the health, wellbeing and independence of service users. Overall, the service: • reduces the need for ongoing home care packages • reduces the hours required • delays the need for residential/nursing care • avoids visits to hospital A&E or in-patient beds
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Lambeth Integrated Reablement service provides health and social care support by a single, dedicated assessment team, co-located with a commissioned private sector specialist provider. The Assessment Team comprises of Occupational Therapists, Physiotherapists and Social Care Assessors. The aim is to help service users re-learn lost skills, or acquire new ones following a period of illness or debilitation, helping them to manage their own care more independently, usually in their own homes. The service is set up in negotiation with the service user, and their carer(s) to set realistic goals. The approach is person centred, and based on service users' aspirations, abilities and motivation. In particular, the emphasis is on service users learning to care for themselves rather than being cared for. The service is time limited; on average service users receive input for around 4 weeks. Referrals come from Hospitals, Therapists, Health Professionals and from the local Adult Social Care Community Teams. The service takes an enabling approach to a variety of daily living tasks, including management of medication, and self care such as: • Washing, dressing, continence promotion, getting in and out of bed • Cooking, preparing meals, eating • Building confidence • Shopping, pension collection, laundry and other household tasks • Coping with poor memory • Social and leisure activities • Indoor and outdoor mobility • Establishing and maintaining links with family, friends and the wider community. Signposting to other community services and activities, as well as observing a service user's overall health and wellbeing both emotionally and socially are important elements of the service. An early alert system is in place to help prevent illness or a deterioration in health. The Service provides on-going observation to inform continuous assessment of service users at weekly Multi Disciplinary Team meetings, and individual support plans are reviewed and adjusted on a regular (sometimes daily) basis to reflect each service user's progress and abilities.

The service is available to adults who have a social care or health care need and are assessed as able to benefit from the service. It is seen as a responsive, individually tailored and preventative service. Most Reablement is carried out within a service user's home, although can be delivered in other settings, i.e. residential care.

We anticipate approximately around 1,300 service users will benefit from the Reablement service per annum. This has been analysed from the use of historical data, then projecting this forward. The annual breakdown is 780 via hospital discharges and 520 from community social care teams.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1. A Strategy Group comprising of Stakeholders from health and social care has met monthly to consider the selection, design and outcomes of Reablement.
2. A series of meetings took place to model and scope out requirements. At those meetings presentations of benchmarking across London and other parts of the country, particularly London, were debated. This involved talking to other Local Authorities, including our neighbours in Southwark, Croydon, and Wandsworth, viewing websites, and considering how this intelligence might fit with Lambeth's needs.
   - Model elements included: choice of a selection model to target the service on those most likely to re-present to health or social care
   - Design of the appropriate proportion of assessment to therapy staff within the team, (two studies took place to look at referrals, response and keyworkers)
   - The impact of Reablement on re-admissions to hospital as well as reduction to the Domiciliary Care budget.
3. The original Reablement service was launched in 2009, but within 2 years it was clear that the provider was unable to deliver a service to the quality and quantity required, Lessons were learned from the experience, which influenced the current

model. Examples include:

4. The co-location of all Reablement staff within one open plan Office
5. Safeguarding such as missed calls by the provider was highlighted as an issue, and as a consequence the building in of an Electronic Call Monitoring system has been incorporated into the current model.
6. A robust costing of options including an in-house service managed by either the NHS or Adult Social Care were considered, but rejected in favour of commissioning a bespoke, experienced private provider following a thorough risk assessment and procurement process.
7. A study of likely demand following hospital discharges and new Adult Social Care cases was used to anticipate service numbers and hours required. Reablement is now the default position for all new service users.
8. KPIs were established by viewing historical data from our previous provider, (82% exited or resulted in reduced hours between 2009-2011). We also viewed the success ratings of our neighbouring authorities, and Department of Health/CSED data. This was followed by viewing more recent outcomes without a bespoke Reablement provider, (30% exited with no service, and 19% with a decreased service) and the desire to make targets aspirational and in our opinion, achievable.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

1 The Adult Social Care database system is set up to pick up outcomes, for example, number of people who enter the service requiring double handed support, and exit with single handed, or no service.
2 Service user feedback on their experience is collated on service exit.
3 The 91 day Review identifies outcomes post service.
4 The Strategy Group's emphasis has changed so that Reablement is considered as an integral part of the unified and integrated care provided within Lambeth.
5 Close contract monitoring of BS Homecare and the achievement of KPIs ensures quality standards in terms of increased independence and reduced dependence on health and social care services. In turn, where issues arise, these can be dealt with effectively, as opposed to affecting outcomes.
6 Shared discussion of aspirations and outcomes with all Stakeholders, including problem solving and risk assessment.
7. The KPIs are:
   - 60% of service users completing Reablement, and exiting with no ongoing care
   - 35% of service users completing Reablement and exiting the service with decreased hours (compared to start of service)
   - 50% of double handed service users reducing to single handed care

Savings outlined in the Planning Template are based on these KPIs.

Key success factors for implementation of this scheme?

1. Achievement of KPIs
2. Service users' satisfaction, including feedback on feeling safer at home, exercising choice and control, and experiencing service flexibility
3. Service users' increased independence
4. Reduction of ongoing care packages and subsequent costs
5. Good, effective working relationships across health, social care and the bespoke provider
6. Reduction in the need for hospital re-admissions and more expensive health interventions

7. Value for money service
8. Health and social care staff have continued to work closely on the development of Reablement in Lambeth, and the procurement process was a joint exercise. The outcome is shared confidence in the service provision.
9. Assessment team staffing levels constantly under review and reconfigured as needed.
10. Service outcomes and how Reablement fits into the whole integrated care within Lambeth continues to be monitored from a strategic perspective by all Stakeholders

Scheme ref no.

BCF02

Scheme name

@home

@home is a new service developed by Guy's and St Thomas' NHS Foundation Trust in collaboration with King's College Hospital operating within Lambeth and Southwark. It is different to the home care provided by district nurses and carers because it is designed to offer more intensive medical support for a shorter period of time (usually two to seven days). This service enables patients either to avoid coming into hospital at all, or to help them return home sooner with extra support.

The strategic objective of this scheme?

The **@home** service is an important part of the admission avoidance strategy in the Boroughs of Lambeth and Southwark. Avoiding an admission or the early discharge from a hospital admission contributes to releasing capacity in acute beds to support elective and necessary admissions

@home Strategic objectives

a) To develop an innovative service that provides integrated, acute, complex and intensive clinical care at home, with optimum safeguarding for people who access this service.
b) To provide an equitable and responsive service on a scale that meets local need, maximises service outcomes and improves the patient experience.
c) To improve clinical outcomes and patient satisfaction.
d) To develop a service that gives confidence to GPs, hospital consultants and other acute partners in referring, and confidence to staff, patients and carers for timely discharge and admission avoidance decisions.
e) To create a major building block, in the redesign of community nursing and other community services. To increase community nursing's confidence in offering acute care and to up-skill clinical staff in the community.
f) To relieve pressure on acute services, reduce patient length of stay, and facilitate better use of inpatient beds for elective and other patients.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The **@home** service provides acute clinical care at home that would otherwise be carried out in hospital. Interventions are delivered in the usual place of residence in order to provide the best possible patient experience and outcome, and enable the patient to benefit from holistic integrated care.

Such services have already been introduced successfully in several parts of the UK. The concept of providing healthcare **@home** means that instead of patients being admitted to hospital, a multi-disciplinary team works collaboratively with GPs, hospital staff and other organisations to deliver safe, quality healthcare within the patient's own home. This care also supports advanced discharge from hospital so that people can complete their episode of treatment at home. The @home team includes Nurses, Practice Development Nurses, Therapists, Pharmacists and Social Workers, who are all involved in visiting patients in their own home and administering the care

required.

The service has three main aims:

- Identifying people at risk of a hospital admission and providing care which prevents their condition getting worse.
- Allowing people to be given a high level of care in their own homes instead of being admitted unnecessarily to hospital.
- Allowing for advanced discharge out of hospital, so patients can recuperate in the comfort of their home while receiving high quality care.

Referrals can be made between 08:00 – 23:00hrs (by 19:00hrs for same day admission) 7 days per week.

Patients must reside in Lambeth or Southwark and be registered with one of the Boroughs' GP practices.

How does the @home service work?

Once a referral has been made, a member of the **@home** team will visit the patient at home for an initial assessment and explain the care that will be given. An **@home** clinician will be appointed and they are responsible for making sure the right care is given by the right professional in the team at the right time. Patients will be discharged from the **@home** team once their course of care is complete.

Referral Criteria:

Patients aged 18 or above with acute episodes of medical illness who would otherwise require hospitalisation for stabilisation and management. Who require the following interventions:

Intensive support and monitoring by highly train clinicians for an acute episode of illness

IV Therapy including PICC & Hickman Lines

Complex Wound Management including VAC Dressing

Blood Monitoring and Anticoagulation Therapy in an acute episode of illness

Clinical support and monitoring for an acute exacerbation of Chronic condition such as LVF, COPD

Clinical support and monitoring to facilitate early discharge i.e post operatively, A&E, MAU in order to reduce hospital stay

Who Can Refer:

GPs, SELDO, London Ambulance Service, Hospital Consultants and Other Health Professional.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lambeth and Southwark CCG both commission GSTT to provide the **@home** service.

See attached **@home** professional leadership structure.

A Deputy Head of Nursing/Clinical Lead has operational line management of four **@home** Matrons who lead the multidisciplinary teams, and two Clinical Nurse Practitioners liaising with acute colleagues and case finding within the hospitals. This

operational manager is a dedicated leadership and development role reporting to the Head of Community Nursing and Nursing Practice

There are close working relationships with acute medical colleagues, Enhanced Rapid Response and Supported Discharge Team, GPs and social care

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Pilot

A pilot 'Home Ward' service was initiated in January 2012 by a joint commissioner, provider and social care programme board (the Admission Avoidance Programme Board).

The pilot led to a compelling strategic, clinical and financial case for the full implementation of an **@home** service across Lambeth and Southwark. Wide stakeholder consultation and service observation took place in preparing the business case, achieving significant engagement across GSTT, KHP (Kings Health Partnership) and primary care, to support the expansion of the scheme. Those who had referred patients to Home Ward - GPs, hospital Consultants, District Nurses etc - expressed appreciation of the service and were keen that it should continue and expand. They were eager for it to be available across both boroughs.

The business case built on a number of previous analyses and evaluations of Home Ward (HW) and related developments, notably:

- an external evaluation of the Home Ward pilot by Virginia Morley Associates in September 2012 including user feedback;
- the original business case for the Home Ward Pilot as part of the transformation of community services;
- the new older people's pathway developed by Southwark and Lambeth Integrated Care (SLIC);
- scoping work on the future of Home Ward in November 2012;
- work on the Intermediate Care Pathway;
- the operational policy and medical model options papers;
- patient and referrer feedback

The business case also incorporated a review of other NHS and commercial models of acute home-based provision including Medihome, Hospital at Home Ltd, Orla, other NHS models and contact with virtual ward related services in three other trusts in addition to Virtual Wards visited in the original Pilot start-up and awareness of PACE (Post Acute Care Enablement Service) provided by Bromley Health Care (a social enterprise).

Early evaluation conclusions by Virginia Morley Associates included

- Patient feedback about the service was overwhelmingly positive.
- The scheme experienced a number of initial teething problems, but most had been overcome by the five month mark.
- A preliminary internal analysis of costs at month five suggested that the Home Ward scheme was no less costly than acute care, but this reflected that the scheme had not been working at full capacity (the pilot had suffered from a lack of GP endorsement and a

small catchment area), which pushed up bed costs and length of stay.

The evaluators summarised feedback and operational problems that were highlighted during the qualitative interviews with clinicians and others involved in the programme. This provided the community services management team with an opportunity to resolve outstanding problems where possible. In light of the above, it is evident that the admission avoidance programme should be viewed as a longer term strategic piece of work that is developed and implemented over a 3 to 5 year period of time, aligned with the integrated care programme. This is expected to give the service a chance to learn from the set up, improve any operational difficulties, provide an opportunity to adjust and change referral patterns if required and for more robust quantitative and qualitative evaluation to be completed as part of larger externally commissioned evaluation of integrated care. Lambeth and Southwark commissioners believe that the schemes that have been funded can make inroads into acute pressures but that they need to be given time to achieve this.

Patient choice
In addition to the high cost associated with hospital admission, prolonged length of stay - especially in the frail elderly and those with long term conditions - can lead to a higher risk of acquired infection and other complications, loss of confidence, function and social networks. Increasingly, given the choice, patients and their carers show a preference for receiving care at home, when they have confidence that it will be provided by skilled practitioners offering continuity of care and working collaboratively.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Integrated metrics are reported monthly which track referrals/ impact on length of stay and admission avoidance across primary, community and acute.

Evaluation commissioned that will include:
Patient satisfaction
Impact on family/informal carers
Impact on other community and social services
Bed occupancy on the **@home** wards
Length of stay
Number of unplanned admissions to hospital
Incidences of cognate clinical complications (health care related infection, pressure sores, other condition specific complications)
Staff satisfaction in terms of readiness for working on the **@home** wards and rotational opportunities and sharing of skills between nurses and therapists.

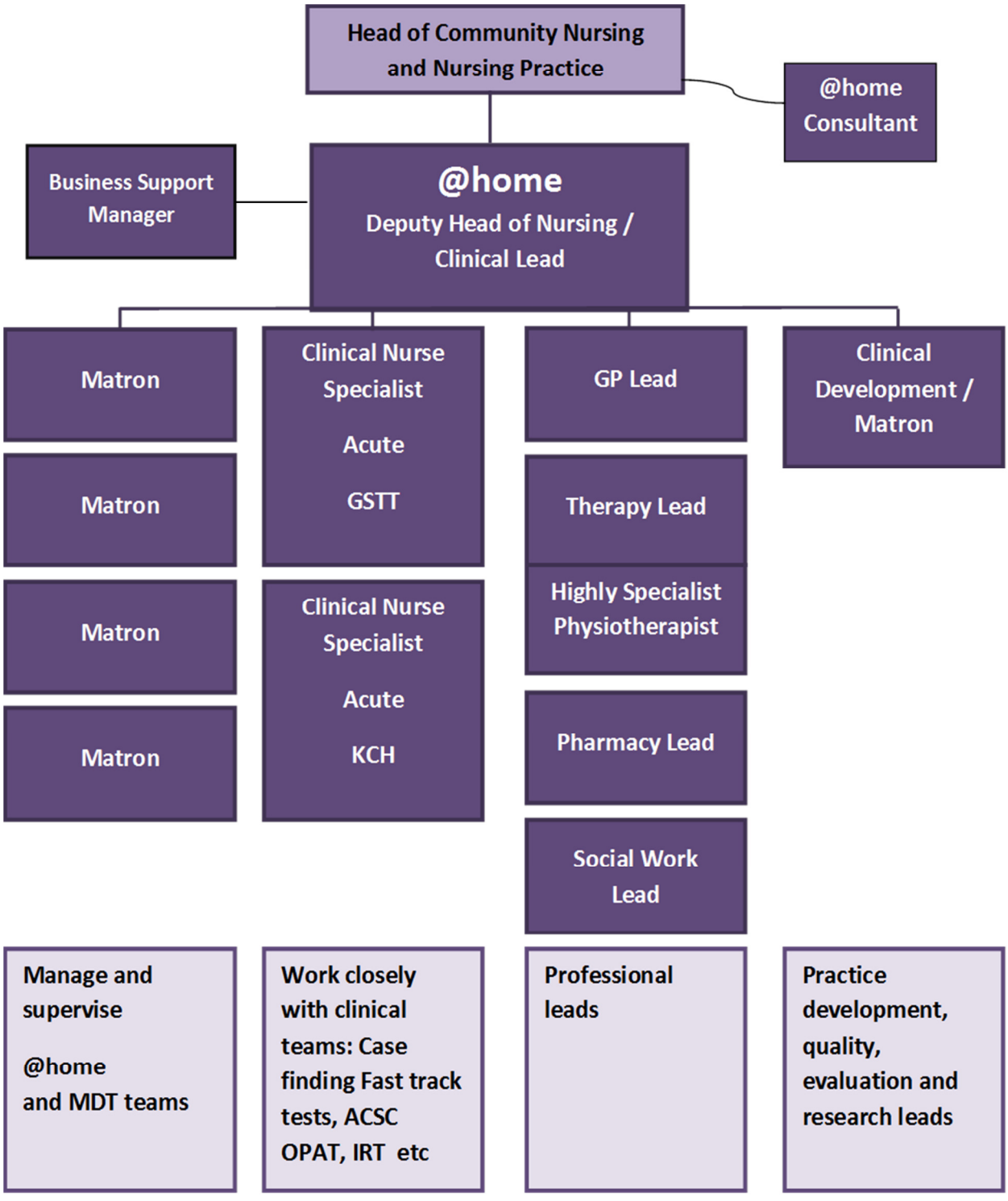
Key success factors for implementation of this scheme?

Conditions for success
Based on the evaluation of the 'Home Ward' Pilot, experience of services elsewhere and stakeholder consultation, the following conditions for successful expansion of the service were identified and incorporated into the service design and implementation of **@home** during 2013/14:

1) Reduction in emergency admissions/ admission avoidance and reduced length of stay.
2) Strong dedicated developmental and operational **leadership**, with effective business

support.

3) @home serving **all GP practices** in Lambeth and Southwark, who have regular contact with representatives of the service.
4) An integrated **IT and telecommunications** system that is fit for purpose in a mobile, rapid, geographically distributed service, including teleconferencing capability for MDTs, and a business continuity plan to overcome any interruption to critical IT information.
5) A **scalable model** of service delivery providing for a minimum 80 o 100 beds, sustaining occupancy levels that demonstrate cost effectiveness and relief of pressure on in-patient beds.
6) Clear **patient pathways** for referral and expectations for length of stay in Home Ward, with timescales for discharge regularly monitored.
7) A **single point of access**, with a streamlined and integrated referral process for Home Ward and Enhanced Rapid Response (ERR), i.e. a single phone number and a single route for e-referral, including 'out of hours' cover.
8) Excellent **clinical nursing** care combining best practice of acute and community nursing, with confidence to treat more patients traditionally cared for in acute settings.
9) Integrated multi-disciplinary and **inter-disciplinary working**, with clarity about **medical responsibility**.
10) A consistent service presence in local acute hospitals (**Guy's and St Thomas' and King's College Hospital)** at the right level and background, working with hospital teams, MDTs etc. This will be crucial to the visibility and effective take-up of Home Ward as an alternative to in-patient care.
11) Clear protocols for case managed patients, with **Community Matrons** included in Home Ward multi-disciplinary team meetings.
12) A 'ready use' **equipment store**, with a small number of key items e.g. portable bladder scanner, home ADL and mobility equipment, IV stands, for short term loan when existing equipment arrangements cannot meet service needs.
13) A new **career pathway** for community nursing, supported by tailored class-leading HW training, to develop senior community practitioners with advanced clinical reasoning, practice and decision-making skills.


Head of Community Nursing and Nursing Practice
@home Consultant
Business Support Manager
@home
Deputy Head of Nursing / Clinical Lead
Matron
Matron
Matron
Matron
Clinical Nurse Specialist
Acute
GSTT
Clinical Nurse Specialist
Acute
KCH
GP Lead
Therapy Lead
Highly Specialist Physiotherapist
Pharmacy Lead
Social Work Lead
Clinical Development / Matron
Manage and supervise
@home and MDT teams
Work closely with clinical teams: Case finding Fast track tests, ACSC OPAT, IRT etc
Professional leads
Practice development, quality, evaluation and research leads

Scheme ref no.
BCF03
Scheme name
Enhanced Rapid Response (ERR)
The strategic objective of this scheme?
Overall the service will: • Promote independence and, where possible, enable older people and adults to continue to live in their own homes • Prevent unnecessary admissions to acute care • Facilitate discharge for patients whose hospital admission is less than 48 hours (has been extended to 72 hours if referral is received within 48 hours) • Provide a specialist intermediate care assessment of the adult/older person (and their carer) in an appropriate environment, ideally in their own home.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
ERR provides home based rehabilitation and support targeted at adults and older people with a physical or sensory disability, with the aim of them regaining or maintaining independent living within the community and preventing unnecessary hospital admission. The service is able to respond rapidly (within two hours if needed) to carry out a holistic assessment of needs and put support in place to prevent unnecessary hospital admission. Referrals are accepted from a range of areas including GPs, Community Matrons, District Nurses, community therapists, London Ambulance Service, A&E and other acute wards and acute assessment units where the patient's length of stay is under 48-72 hours. Any referrals for patients whose length of stay is greater than 48 hours (or 72 hours if the referral is received within 48 hours), should be referred to the Supported Discharge Team or Reablement Team as appropriate. The service provides short term; outcome focused interventions in patient's homes, through multidisciplinary assessment and interventions co-ordinated by a nurse, physiotherapist or occupational therapist, and delivered by Rehabilitation Support Workers (RSW's). The service can implement care, support, therapy or assistive equipment to: • Increase independence/safety with activities of daily living (ADL) such as washing, dressing and meal preparation • Improving independence and safety with transfers, mobility and stairs • Assess and take action to reduce the risk of falls including provision of home exercise plans • Improve community access such as shopping and attending GP clinics • Basic nursing interventions such as medication management, monitoring skin integrity, simple dressings, self-management/education, continence assessment and support • Assess for and prescribe adaptive equipment to improve safety with mobility and activities

daily living such as walking aids, bedside commodes, and chair raisers.

Patients may require and receive support from a single clinician or two or more clinicians working together, depending on their needs.

A specialist medical consultant is aligned to the service to provide medical support and advice; however the medical responsibility for the patient remains with their GP.

The maximum anticipated episode of care is usually six weeks, with many patients needing only one to two weeks to achieve their goals.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lambeth and Southwark CCG both commission GSTT to provide the ERR service.

The Clinical Lead, who is also the operational manager, has line management responsibility of the Therapy Leads. The operational manager is a dedicated leadership and development role that reports into the Head of Rehabilitation and Therapy.

There are close working relationships with social care, GPs, acute medical colleagues, @home, Reablement and the Supported Discharge Team.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Department of Health Policy documents:
- Transforming Community Services
- High Quality Care for All
- Care Quality Commission (CQC) Regulations
- National Service Frameworks (NSFs, including for Older People, Long Term Conditions)
- Our Health, Our Care, Our Say
- Intermediate Care – Halfway Home
- End of Life Care Strategy

Regulatory Documents:
- CQC regulations
- Health and Care Professions Council (HCPC) Regulations/Standards
- Nursing & Midwifery Council Regulations/Standards
- Professional Standards (College of Occupational Therapy, Chartered Society of Physiotherapy, Nursing and Midwifery Council)
- All nationally unregulated staff within the team work to organisational and local policies, procedures and competency frameworks

National Guidance:
- National Institute of Clinical Excellence e.g. Falls, Osteoarthritis, Parkinson's Disease.

Local drivers:
- Joint Health & Social Care Strategy for Older People
- Urgent and unscheduled care network

- GSTT Adult Community Business Plan
- Southwark and Lambeth Integrated Care (SLIC)
- GSTT Local Services Programme
- Winter planning and pressure surge management.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following approach is being taken:

- Bi-monthly Clinical Governance Meetings
- Bi-monthly Leadership Operational Meetings
- Monthly staff meetings
- Timely review/investigation (and escalation as appropriate) of Datix incident reports
- Participation in National Audit of Intermediate Care (NAIC) and review of results
- Action plans implemented based on results of Trust Patient Survey
- Patient satisfaction feedback sought and analysed
- Exit interviews for leavers
- Monthly 1-1 supervision sessions and appraisal
- In-service training programme
- Yearly service audit

The key success factors for implementation of this scheme?

- The provision of rapid delivery of assessment, goal setting and interventions within specified timelines of referral request, typically same day or next day.

- Each patient will have achievable, measurable and person centred goals which will be reviewed regularly and at discharge.

- Patients will have increased or maintained their level of independence at the end of the period of intervention.

- Patients will remain living in their own home at discharge from the service.

- Patients will have a care plan that addresses a range of needs and domains including physical, psychological and social.

- Liaison, collaboration and signposting with and to other services will be co-ordinated as part of the service episode.

Scheme ref no.

BCF04

Scheme name

Redesign of intermediate care

The strategic objective of this scheme?

The objectives of this scheme are:

- To improve the health, wellbeing and independence of patients requiring intermediate care via time-limited interventions with goals agreed with the patient.
- To ensure a quality service that provides value for money.
- To ensure further integration of intermediate care services centred around the patient.
- To reduce avoidable emergency admissions.
- To reduce length of stay in hospital.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Intermediate care in Lambeth is provided to patients requiring a step down service on discharge from hospital. The service supports patients aged 18 and over, and is designed to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital, reduce delayed transfers of care, and maximise independent living.

The current service consists of:

- Stand alone unit of 20 intermediate care nursing beds (Lambeth only)
- Supported Discharge Team for home-based intermediate care (Lambeth and Southwark)

An initial review in July 2014 of the 20 bedded intermediate care unit was carried out.

1. Analysis of the 20 intermediate care beds indicates underutilisation:

Intermediate care – occupied bed days (specified 95% occupancy)			
Year	Total capacity available at 95% occupancy	OBDs	% of total capacity
2011/12	6,954	5,333	77%
2012/13	6,935	4,833	70%
2013/14	6,926	4,370	63%

2. Delays in admissions (6 days on average with the longest wait of 16 days) due to single sex accommodation – unavailable male beds, as most of the beds are in bays instead of single rooms.
3. A higher than expected readmission rate of 24%.

Service redesign in 2014/15 will:

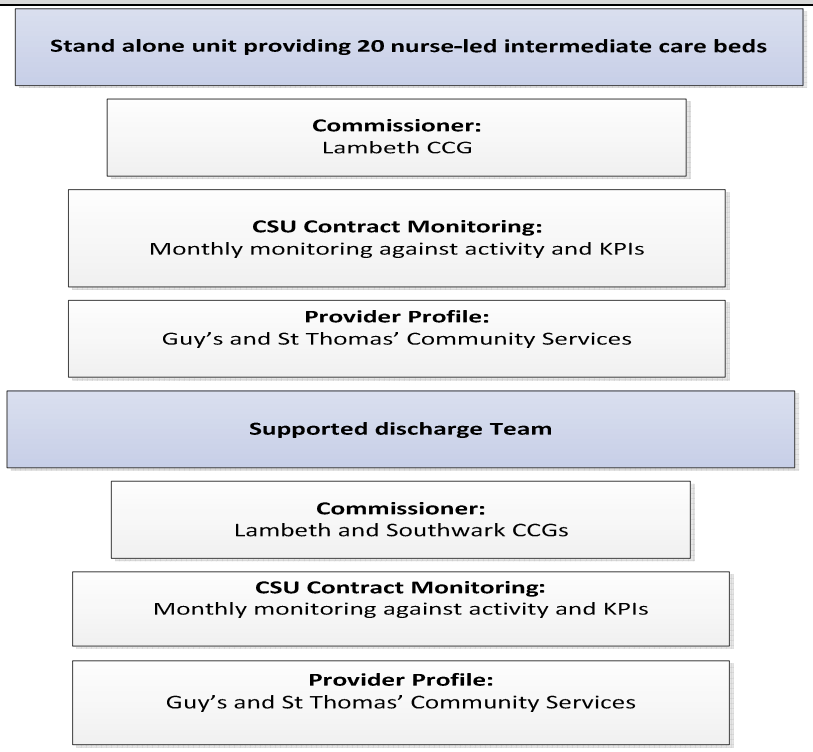
- Engage with HealthWatch and interested citizens regarding the redesign of intermediate care

Service redesign and commissioning in 2015/16 will:

- Establish a single point of access for all intermediate care referrals

- Develop business case for redesign of service
- Further integration of health and social care intermediate care services for patient centred care and value for money, specifically the Reablement Service, Enhanced Rapid Response Team and @Home Team
- Establishing mixed provision of intermediate care beds based on need and to enable more patients to return to their home at discharge with an intermediate care package, and remain at home with appropriate support
- Adjust the provider market for intermediate care beds based on need
- Informed joint commissioning of intermediate care with adjacent borough (Southwark)

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved



The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The proposed service redesign is based on Developing Intermediate Care, Kings Fund 2009; and
Department of Health: Intermediate Care – Halfway Home, Department of Health, July 2009

Evidence recommendations
Active enablement, which is likely to require any one of a range of therapeutic skills, including support for the social and environmental adjustments that users and their carers may need to make in response to reduced functional capacity.

A single point of referral with an holistic needs assessment that is used throughout the intermediate care episode.

Regular integrated, multidisciplinary review of patient need and response throughout intermediate care episode to ensure patient centred care and clear process for discharge.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Following a prospective audit of intermediate care activity and engagement with Healthwatch and interested citizens, a business case will be developed for the redesign of intermediate care. Working with current providers and using a single point of access, it is envisaged that redesign and integration of intermediate care will occur during 2015/16 for benefits realisation in 2016/17.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Regular monitoring of current contracts is established, based on agreed activity and outcomes reporting, as per the delivery chain.
The key success factors for implementation of this scheme?
It is envisaged that redesign of services during 2015/16 will provide an integrated, efficient and responsive intermediate care service.

Scheme ref no.
BCF05
Scheme name
Support for Carers
The strategic objective of this scheme?
To ensure carers have access to independent advice, advocacy, information, assessment and helpful resources to support them in their role. To provide carers with emotional and physical support, training and access to services that support wellbeing, and promote independence. To provide a base for and coordination of local information and activities that are likely to support carers. To provide a base for carer groups, activities and events, as well as access to a range of specialist groups, courses, advice sessions and activities. To support respite for those caring for people with learning disabilities. To implement the Carers Act.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Carer services are available to any person that has a caring role, categorised as: Adult carers – an adult carers for another adult such as spouse, partner, children, relative or friend Parent carers – of children with disabilities Young carers – those under 18 years who are in some way affected by the need to take physical, practical and/or emotional responsibility for the care of another person The Scheme consists of: **The Carers' Hub** is a consortium led by South Thames Crossroads, and includes Disability Advice and Support Lambeth (DASL) and Age UK Lambeth. The service offer includes a provision for Information, Advice and Advocacy (IA&A) for carers and work towards a number of outcomes including maintaining the carers' and the cared-for person's health and wellbeing and helping carers to be socially included. **The Carers' Breaks Service** is operated by Certitude and supports adults with learning disabilities (ALD) service users and carers to take short breaks to give the carer a break from their caring duties. They also offer sessions during the week where carers can partake in activities and enjoy the opportunity to socialise with other carers. They work towards a number of outcomes, including making sure that both the carers and cared for people have access to quality breaks, and carers feel supported in their role and are not socially excluded. **Fix Yourself a Break** is an eligibility based grant per annum for carers.

Direct Payments supports people and their carers to decide how they want to manage their direct payments, for example recruiting and managing a Personal Assistant, devising a support plan etc.

Respite for Carers offers specific respite based on assessment of eligibility and need. The amount is agreed on a case-by-case basis and is used to fund accommodation in an appropriate home for the cared for person.

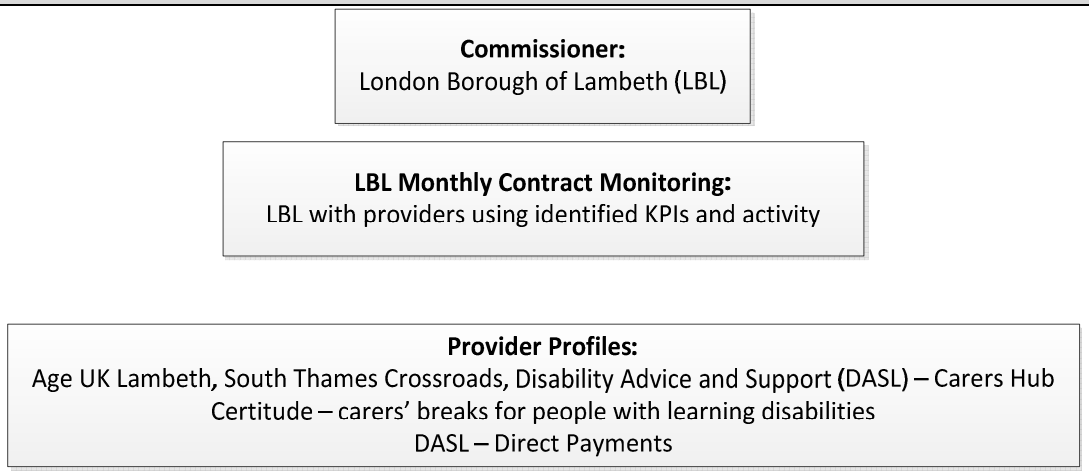
The intention of the Carers Scheme is to bring together the services outlined above into one Social Care Hub. This will be a 'one stop shop', offering services for Older People, ALD and Physical Disabilities service users, as well as adult and young carers.

A new Social Care Hub is being devised for 2015/16 that will incorporate information, advice, advocacy and carers' services, as well as elements from the other contracts. The specification, including the outcomes and activities, will be coproduced with service users, carers, providers and other internal and external stakeholders. This ensures a service model which provides a resource that is effective, and delivers according to the wants and needs of those who use it.

By pulling together these contracts, officers from different teams will be joining together services which up until now have been largely disparate. They have been working to similar outcomes, the service user groups they work with crossover, but quite often there is little or no connection made between the services, which can lead to large inequalities in level of service between recipients. It can also lead to service users being unsure as to where to go to receive the right service.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Care Bill 2013 creates new duties for local authorities to provide information and advice for adults and carers as set out in the white paper 'Caring for our future: reforming care and support' (July 2012).

The ambition of the Bill is to have a social care system that promotes people's well-being by enabling them to prevent and postpone the need for care and support and to pursue education, employment and other opportunities to realise their potential. The core principle of the Bill is that the individual well-being should be the driving force behind care and support arrangements.

National Carers Strategy
Carers' Strategy (England) 2008-2018, refreshed 2010 has the following priorities:

- Recognised and supported as an expert care partner
- Enjoying a life outside caring
- Not financially disadvantaged
- Mentally and physically well; treated with dignity
- Children will be thriving, protected from inappropriate caring roles.
- Supporting early self-identification and involvement in local care planning and individual care planning
- Enabling carers to 20ulfil their educational and employment potential
- Personalised support for carers and those receiving care
- Support carers to remain healthy

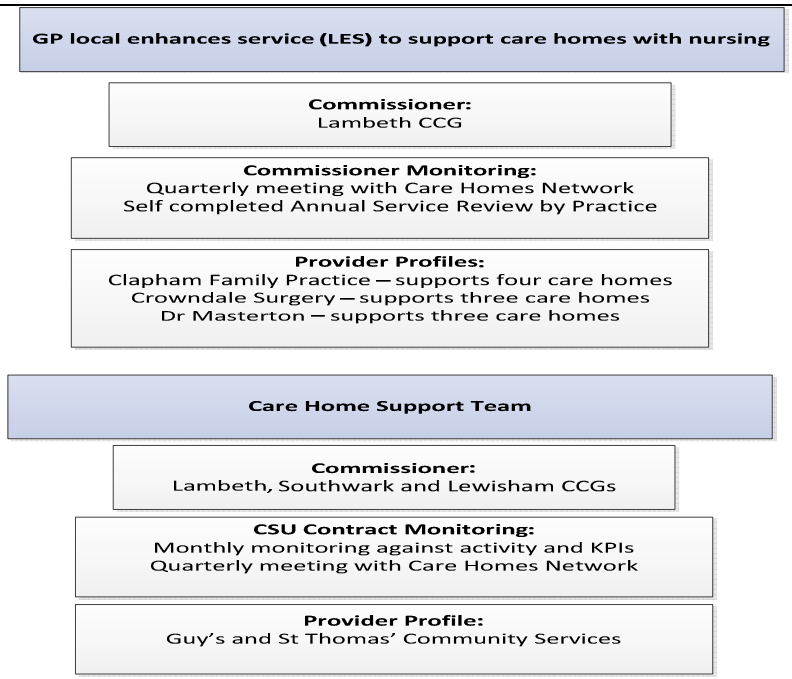
Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Regular monitoring of contracts is established, based on agreed activity and outcomes reporting, as per the delivery chain.

The key success factors for implementation of this scheme?

Carers feel supported and have access to advice and signposting to services that enable them to continue in their caring role.

Scheme ref no.
BCF06
Scheme name
Care homes (with nursing)
The strategic objective of this scheme?
The main drivers for this scheme are to: • Improve the quality of life for patients in care homes • Support improved working between acute hospital and care homes for better transition at discharge • Support care homes in early identification of infections and other health issues that, with deterioration, are likely to require an emergency admission • Identify care home staff training and education needs
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are 10 care homes with nursing in Lambeth offering a total of 624 beds. Two of the homes provide specialist support, one for neurological conditions and the other providing high level nursing need e.g. ventilation. The scheme focuses on people 65 years and older, resident in a care home with nursing, but does not exclude the two homes providing specialist support, who will have a younger patient cohort. There are three components of the scheme: **GP support to care homes** Includes regular weekly sessions in the home, telephone support, care planning, physical and medicines reviews. **Care Home Support Team (CHST) consisting of a geriatrician, specialist nurses and medicines advice** Provides full assessment of patients for continuing care, advice and support, including access to tissue viability nurses, medicines expertise, geriatrician telephone advice and support. **Care Homes Network** Quarterly meeting of Lambeth and Southwark care homes with nursing, the GPs that support the care homes, representatives from local acute hospitals (Guy's and St Thomas' and King's College Hospital NHS Trusts), Care home Support Team, commissioners from both CCG and Council. The meetings are already improving practice, collaborative working, and a better understanding of care centred around patients.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

My Home Life, Help the Aged in partnership with the National Care Forum and the National Care Homes Research and Development Forum, 2006 recommends:

- Good transition to nursing home from hospital is critical
- An holistic view of patient need is required

Delivering Dignity, February 2012, Commission on Dignity in Care for Older People

Recommendations include:

- Hospitals and care homes need to assess older people when they are admitted, so a co-ordinated and holistic care plan can be developed.
- Families, friends, carers and advocates should be seen as partners in care, where the older person wishes it, not as a nuisance or interference.
- Hospitals should carry out a comprehensive assessment of an older person's health and care needs before they are discharged. The outcome of the assessment must be discussed with the person themselves, their family, carers and others (such as the GP, the care home manager and social workers), to ensure that the right support is in place when they leave hospital.

British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes, 2011

Recommends:

Working in partnership with the care homes sector and care homes staff is critical in providing effective healthcare support to older people in care homes. Many care home staff have relationships and knowledge about the people for whom they care, and the care homes sector has developed considerable expertise in managing the care (including end of life care) of frail older people.

The report also evidenced the impact of GP support to care homes including:

In Sheffield, a locally enhanced service (LES) evaluation of the Sheffield PCT scheme

demonstrated that the overall care planning process is carried out well and there is widespread evidence of good relationships developing between practices and homes. Although the pilot in Sheffield has only been running for a short time, evidence of the benefits of the scheme is beginning to emerge. In year one of the scheme, there was a reverse in the trend of rising emergency visits from care homes in the area, with a reduction in emergency admissions by six per 100 care home beds (approximately 9%) compared with the previous year. This translated into a gross savings of £145,000 in a single year for the 500 care home beds taking part in this small-scale pilot. The number of A&E attendances fell by three per 100 care home beds (approximately 10%) at a time when A&E attendances were rising in other areas. The use of emergency care practitioners (ECP) following 999 calls also fell by approximately one third.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly reporting of A&E data per care home shared with GPs supporting the care home. Use of Care Homes Network to facilitate discussion and learning regarding admission avoidance.

The key success factors for implementation of this scheme?

- Continued collaborative working across stakeholder organisations
- Effective collaborative approach to decision making regarding patient care, including interested family/carers
- Patient-centred care in care homes
- Reduction in A&E admissions