NEWHAM AGEING WELL STRATEGIC ACTION PLAN

PRIORITY 5: PLANNING AND PREPARING FOR LATER LIFE

www.newham.gov.uk/ageingwell

WE ARE NEWHAM.

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I am able to plan for my future care and after my death – ensuring my wishes are known and respected. I receive safe, high-quality Health and Social Care as needed.

ACTION PLAN

	TASKS	YEAR TEAM BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.1 Advanced planning					
LEAD: Assistant Director of Commissioning - Adults and Health (Council – Adults and Health)					
5.1a	Produce an online and paper-based resource on the main Advanced Planning documents; and Life Insurance and Funeral Plan options.	2022/23 Adults and Health Commissioning Existing	• Online resource refreshed. • Paper-based resource agreed and distributed.	Residents are able to plan for their future care and after their death - ensuring their wishes are known and respected.	**Increase in the number of 'End of Life Care' residents who die in their preferred place of care and death.**
5.1b	Map the observation days the Council celebrates / observes where it would be appropriate to promote Advanced Planning (e.g. Carers Week, Dementia Awareness Week, etc). Ensure each of these include Advanced Planning information / stall / session, as appropriate.	2022/23 Adults and Health Commissioning Existing	• Observation days mapped. • Number of residents reached; broken down by their protected characteristics.		
5.1c	Identify resident cohorts (defined by one or more of their protected characteristics) with low-levels of Advanced Planning who die in hospital and co-design an awareness / support programme.	2022/23 Adults and Health Commissioning Existing	Number of residents with a My Wishes account.	Residents consider their digital assets and legacy when Advanced Planning.	

<table>
<tr><th colspan="2">TASKS</th><th>YEAR
TEAM
BUDGET</th><th>SERVICE OUTPUTS</th><th>INTERMEDIATE OUTCOMES</th><th>STRATEGIC OUTCOMES</th></tr>
<tr><td colspan="6">5.2 Integrated care</td></tr>
<tr><td colspan="6">LEAD: Primary Care Clinical Lead (Primary Care)/ Director of Delivery (Newham Health and Care Partnership)</td></tr>
<tr><td>5.2a</td><td>Improve GP access.

Within this, consideration to be taken on how frail / vulnerable residents can ensure access when required; and support to those with Learning Disabilities and / or a sensory impairment.

Access should not be dependent on digital access.</td><td>2022/23
Primary Care Clinical Lead
Existing</td><td>Number of GP appointments allocated to residents aged 50+; broken down by their protected characteristics.</td><td>Resident self-reported improved access to GP appointments.</td><td rowspan="5">Improved early identification of long-term conditions or disability, including frailty; and appropriate treatment / support provided to prevent, delay or minimise impact.

Improved patient experience.</td></tr>
<tr><td>5.2b</td><td>Encourage take-up of Health Checks for all eligible registered residents aged 50+.</td><td>2022/23
Primary Care Clinical Lead
Existing</td><td>Number of eligible residents attending their Health Checks; broken down by their protected characteristics.</td><td>Increase in completed Health Checks.</td></tr>
<tr><td>5.2c</td><td>Establish a Geriatric Health Visitor Team who would make annual calls to residents aged 75+ to check in on them / their health and wellbeing. Secondary care will also be a part of this action.</td><td>2022/23
CCG / Primary Care Clinical Lead
TBA</td><td>Number of eligible residents reached; broken down by their protected characteristics.</td><td rowspan="3">Frail residents are identified when their health and wellbeing deteriorates and they begin to lose their independence; and are appropriately and systematically supported to prevent further deterioration (where possible).</td></tr>
<tr><td>5.2d</td><td>Review Social Prescriber training programme and refresh in order to upskill around common themes.

Links to www.longtermplan.nhs.uk/areas-of-work/ageing-well</td><td>2023/24
Public Health / Training Hub
Existing</td><td>• Training programme reviewed.
• Number of sessions held.
• Number of Social Prescribers attended; broken down by Team.</td></tr>
<tr><td>5.2e</td><td>Pilot a frailty and anticipatory care project to develop integrated multi-agency way of identifying and supporting residents with frailty.

Links to www.longtermplan.nhs.uk/areas-of-work/ageing-well</td><td>2022/23
Newham Integrated Community Care Borough Transformation Lead
Existing</td><td>• Pilot completed and evaluated.
• Number of residents reached; broken down by their protected characteristics and intervention impact.</td></tr>
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	TASKS	YEAR TEAM BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.2f	Review the Rapid Response Service - ensuring a two-hour crisis response at home service operating 8am-8pm, seven days a week - accepting referrals directly from all key sources (inc. 999, 111, Primary Care, Social Care (inc. Care Homes and Domiciliary Care), etc). Links to **www.longtermplan.nhs.uk/areas-of-work/ageing-well**	2022/23 CCG / East London Foundation Trust Existing	• Service reviewed and promoted. • Number of residents supported; broken down by their protected characteristics and referral source.	Reduction in unplanned hospital attendance and admission.	
5.2g	Review the Falls Prevention Service to be able to provide support pre-fall; and offer home visits.	2022/23 CCG / East London Foundation Trust Existing	• Service reviewed and promoted. • Number of residents supported; broken down by their protected characteristics. • Number of unplanned hospital attendances and admissions in relation to falls; broken down by their protected characteristics.		
5.2h	Explore how to better integrate Teams that support either physical or mental health (e.g. Rapid Response, Frailty Clinic, etc).	2022/23 CCG / East London Foundation Trust TBA	• Tower Hamlets model reviewed and feasibility for Newham explored. • Actions added to this Action Plan for Year 2.	Residents mental health and physical health needs are looked at holistically.	**Improved patient experience.**
5.2i	Review Urgent Care to assess the reason for attendance and subsequent treatment; and unmet need with a view to better address these (e.g. an on-site Pharmacy, on-site Social Prescriber, etc).	2023/24 CCG / Barts NHS Health Trust TBA	• Review completed. • Actions added to this Action Plan for Year 2.	Minor and social reasons for attending Urgent Care addressed at the front-door.	

	TASKS	YEAR / TEAM / BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.2j	Implement Virtual Wards. Links to **www.longtermplan.nhs.uk/areas-of-work/ageing-well**	2023/24 CCG / Barts NHS Health Trust TBA	• Virtual Wards implemented. • Number of residents reached broken down by their protected characteristics, condition and intervention/s.	Residents get the care they need at home safely and conveniently rather than being in hospital.	**Improved management of Long Term Conditions leading to an improved sense of wellbeing.**
5.2k	Commission Pain Management courses for residents and their families.	2022/23 CCG / ELFT TBA	• Pain Management course commissioned. • Number of sessions. • Numbers of residents reached broken down by their protected characteristics.	Residents are better able to control pain which may improve how they feel and function.	
5.2l	Develop better understanding of Long Covid with a focus on its exacerbation of frailty. Within this, explore implementation of a multi-disciplinary Long Covid Team.	2022/23 Primary Care / Barts NHS Health Trust / ELFT Existing	Task and Finish Group established to explore effects of Long Covid.	Better understanding of Long Covid by Health and Social Care professionals. Residents with Long-Covid identified and supported.	
5.3 Adult social care					
LEAD: Corporate Director of Adults and Health (Council – Adults and Health)					
5.3a	Co-design and implement a Significant 7+[1] education programme for residents, commissioned Adult Social Care Providers, Housing partners and the community, faith and voluntary sector.	2022/23 Adults and Health Workforce Development Existing	• Number of sessions held. • Number of residents reached; broken down by their protected characteristics. • Awareness video produced and promoted. • Number of video views.	Residents and those who support them are aware of the softer signs of deterioration and understand how to address them.	**Reduction in number of residents with an unplanned attendance / admittance to hospital following a fall or Urinary Tract Infection**

1. Significant 7+ provides the tools to identify the first signs of deterioration across the areas of confusion, mood, pain, hydration and nutrition, skin, breathing, toileting and

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5.3b	Promote Ask SARA, an online information and self-assessment tool providing expert advice on a wide range of Assistive Technology and Community Equipment products to support residents to remain safe, secure and independent in and around their home.	2022/23 Adults and Health Commissioning Existing	Number of residents who use Ask SARA and purchase recommended apps / products.	Decrease in the number of residents requiring an Occupational Therapy Assessment for low-level needs.	**Ensure residents who require Adult Social Care are able to access the right support at the right time. Residents will have choice and control over the care and support they receive and will have access to person-centred, high quality, joined-up and safe services which deliver value for money close to where they live.**

mobility.

	TASKS	YEAR / TEAM / BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.3c	Review the Demonstration Area Service with a view to expand the range of apps / products on-site (with a focus on what is available universally) and resident usage.	2024/25 Adults and Health Commissioning Existing	Fit-for-purpose Demonstration Area accessed regularly by residents who are interested in finding out more about universal and specialist apps and products that can meet their Health and Social Care needs now or in future.		
5.3d	Review and document the Adult Social Care Operating Model to a) prepare for the **Build Back Better - Our Plan for Health and Social Care reform**; and b) focus on Strength-Based[2] Assessment and support.	2022/23 Adults and Health Improvement, Change and Control Existing	Operating model reviewed and agreed changes implemented.	Refreshed Operating Model in place that focusses on Strength-Based Assessment and support and meets the Social Care Reform requirements.	
5.3e	Review the Reablement Service[3] with a view to increase the number of eligible residents to receive it.	2022/23 Adults and Health Operations Existing	• Reduction in the number of residents who need long-term support. • Increase in number of people who remain independent 91 days after hospital discharge (who use Reablement)	Fit-for-purpose Reablement Service delivered to all eligible residents.	

2. A strength-based approach identifies what a person is able to do and encourages them to talk about what they find difficult to manage and what would help them the most / outcomes that matter to them - focussing on what motivates and enthuses them.
3. Enablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury. The purpose of enablement is to help people to relearn the skills and regain the confidence to perform the essential activities of daily living - to maintain and improve, where possible, their health and autonomy and to live as full a life as possible: safe and independent at home. Through achieving this, the Service seeks to prevent avoidable and inappropriate hospital re/admissions and delay or reduce the need for long-term support.

	TASKS	YEAR TEAM BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.3f	Review the Direct Payment process, as the current process takes too long, is complex and rigid.	2022/23 Adults and Health Improvement, Change and Control Existing	Accessible and simplified Direct Payment process in place.	Increase in the number of Care Act eligible residents accessing agreed care and support via a Direct Payment.	
5.3g	Embed and expand the ILSS Trusted Assessor role to support the wider system to be more responsive for those in receipt of Domiciliary Care.	2022/23 Adults and Health Commissioning Existing	• ILSS Trusted Assessor role is embedded. • Number of ILSS Trusted Assessors broken down by Provider. • Number of residents supported by a Trusted Assessor broken down by type of support and level of need.	Embed and develop the Trusted Assessor model.	

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<tr><td colspan="6">5.4 Living well with dementia</td></tr>
<tr><td colspan="6">LEAD: Director of Integrated Care</td></tr>
<tr><td>5.4a</td><td>Use routine Health appointments to identify residents at risk of Dementia and give advice on how to minimise risks.</td><td>2022/23
Adults and Health Commissioning
Existing</td><td>Dementia prevention incorporated into routine appointments.</td><td rowspan="2">Raise awareness, greater understanding and empathy for residents with Dementia.

Residents with Dementia have information and practi-cal advice to support them to better manage independent-ly or obtain support - thus improving wellbeing and quality of lifeResidents are aware what Dementia is, its causes and how it may be prevented.</td><td rowspan="2">Preventing Well: Risk of residents developing Dementia is minimised.</td></tr>
<tr><td>5.4b</td><td>Incorporate the provision of Dementia prevention advice and support into Health Checks from age 50.</td><td>2022/23
Adults and Health Commissioning
Existing</td><td>• Dementia prevention incorporated into Health Checks.</td></tr>
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	TASKS	YEAR / TEAM / BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.4c	Complete a training audit (i.e. what training is in place across Health and Social Care - content and frequency; obtain feedback on effectiveness; identify duplication and gaps; develop a training programme).	2022/23 Existing	• Audit completed. • Actions added to this Action Plan for Year 2.	Health and Social Care professionals are aware of Dementia, it causes and impact and how to best support those with Dementia. The community, faith and voluntary sector are aware of Dementia, its causes and impact and how to refer / support residents pre and post diagnosis for advice and support.	
5.4d	Implement a three-year rolling training programme based on the audit findings. Within this will be awareness training for the community, faith and voluntary sector.	2022/23 Adults and Health Commissioning Existing	• Number of training sessions delivered. • Number of attendees, broken down by Team / organisation.		
5.4e	67% (pre-pandemic level and national target) Primary Care participation in the national Dementia Enhanced Service (DES).	2022/23 Adults and Health Commissioning Existing	Number of residents identified and supported broken down by their protected characteristics.	Increase in early diagnosis.	**Diagnosing Well: Timely, accurate diagnosis, care plan and review within the first year.**
5.4f	Ensure the DES screening tool is used appropriately with residents with additional needs, including Learning Disabilities and sensory impairments.	2022/23 Adults and Health Commissioning Existing	Number of residents identified and supported broken down by their protected characteristics.	Increase in diagnosis rate of residents with Learning Disabilities. Increase in diagnosis rate of residents with a sensory impairment.	
5.4g	Increased Primary Care participation to use the validated Alcohol Screening Tools to identify (and prevent where possible) residents at risk of the developing alcohol / substance misuse related Dementia.	2022/23 Public Health Commissioning Existing	Number of residents identified and supported broken down by their protected characteristics.	Increase in diagnosis rate of residents with a alcohol / substance-misuse related Dementia.	

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5.4h	Re-commission the **Dementia Support Service**. The current Contract expires on the 31.12.2023 (with the option to extend for a further year).	2024/25 Adults and Health Commissioning Existing	Dementia Support Service re-procured.	Specialist support Service in place.	**Living Well: Residents with Dementia can live normally in safe and accepting communities.**
5.4i	Increase the number of Dementia Friends[4] in each Neighbourhood of the borough. This includes the Community Neighbourhood Link Workers and the ILSS Trusted Assessors.	2022/23 Adults and Health Commissioning Existing	Raise awareness, greater understanding and empathy for residents with Dementia.	Newham to obtain Dementia Friendly Community status.	
5.4j	Identify the Neighbourhood area with the highest number of residents with a Dementia diagnosis and work within this area to reach Dementia Friendly Community[5] status.	2022/23 Adults and Health Commissioning Existing	• Raise awareness, greater understanding and empathy for residents with Dementia. • Residents with Dementia feel safe and supported by and within their local community.		
5.4k	Produce an online and paper-based resource on Living Well With Dementia. Within this explore different mediums and language needs (including British Sign Language).	2022/23 Adults and Health Commissioning Existing	Residents with Dementia have information and practical advice to support them to better manage independently or obtain support - thus improving wellbeing and quality of life.	Residents with Dementia have access to activities that support their wellbeing.	

4. www.dementiafriends.org.uk/WEBArticle?page=become-dementia-friend
5. www.alzheimers.org.uk/get-involved/dementia-friendly-communities/how-to-become-dementia-friendly-community

	TASKS	YEAR TEAM BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.4l	Develop and promote a range of evidence-based, post-diagnostic support interventions for residents with Dementia to maintain their mental and physical health and wellbeing. Within this work closely with the Dementia Support Service, Community Neighbourhood Link Workers and Social Prescribers to ensure residents with Dementia and their Carers are encouraged and supported to continue to take part in the activities they enjoy, and to develop new interests.	2022/23 Adults and Health Commissioning Existing	• Number of interventions broken down by nature. • Number of residents reached broken down by their protected characteristics, where feasible.		
5.4m	Promote Dementia friendly events and activities to encourage residents with Dementia and their Carers to continue to engage in a range of interests, hobbies and activities. Within this, continue to offer and promote a range of arts and cultural opportunities (e.g. access to singing, music, arts, and crafts activities).	2022/23 Adults and Health Commissioning Existing	• Number of events broken down by nature. • Number of residents reached broken down by their protected characteristics, where feasible.		
5.4n	Map the End of Life Care journey for residents with Dementia to identify the challenges and opportunities to address the disparity in the care and support received.	2022/23 Newham Dementia Board Existing	• Journey mapped against relevant NICE Guidance and Quality Standards. • Discrepancies between journey and the NICE Guidance and Quality Standards identified. • Actions to resolve the discrepancies added to this Action Plan for Year 2.	Increase in number of ‘End of Life Care’ residents with Dementia who are able to plan for their future care and after their death - ensuring their wishes are known and respected.	**Dying Well: Residents with Dementia die with dignity in a place of their choosing.**

	TASKS	YEAR / TEAM / BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.5 End of life care (EoLC)					
LEAD: Newham End of Life Care Board, Director of Nursing - Integrated Care (East London Foundation Trust)					
5.5a	Develop, document and implement an EoLC journey for the three illness trajectories: Cancer, organ-failure and Dementia / frailty. Within this is an emphasis on early identification of individuals through pro-active case finding in order to maximise the opportunities to plan care in advance and ahead of a crisis.	2022/23 Newham End of Life Care Board Existing	• Illness trajectories mapped against relevant NICE Guidance and Quality Standards. • Discrepancies between each journey and the NICE Guidance and Quality Standards identified. • Actions to resolve the discrepancies added to this Action Plan for Year 2.	Clear, well-communicated and equitable EoLC journey in place for the three illness trajectories.	**Better enable residents approaching the end of their life, their families and professionals to recognise, prepare for and manage the end of life process. This will enable residents to be cared for and die in their place of choice.**
5.5b	Undertake an audit of those who died in hospital who had no Advanced Care Plan / their Plan specified an alternative place of care and death - to identify and address the issues / obstacles.	2022/23 Newham End of Life Care Board TBA	• Audit completed. • Actions to address issues / obstacles added to this Action Plan for Year 2.	Reduction in number of ‘End of Life Care’ residents who die in hospital.	

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5.5c	Explore Teams / Services where advanced planning tools should be discussed by practitioners as part of their care and support (e.g. upon Dementia diagnosis at the Memory Clinic, when completing a Decision Support Tool, when implanting a cardioverter-defibrillator, etc).	2022/23 Newham End of Life Care Board Existing	• Teams / Services identified. • Number of training sessions held. • Number of practitioners reached; broken down by Team / Service.	Practitioners discuss advanced planning as part of a patient's diagnosis / treatment.	
5.5d	Adult Social Care practitioners discuss advanced planning tools at every contact. AzeusCare amended to prompt and record relevant information about advanced planning.	2022/23 Improvement Change and Control / Operations Existing	• AzeusCare refreshed. • Number of training sessions held. • Number of practitioners reached; broken down by Team / Service.	Assessments and Reviews are audited for evidence that patients are being asked about advanced planning and priorities for care; and supported to implement them as appropriate. Practitioners share information with Providers as part of care planning and review - with patient's consent.	
5.5e	In partnership with ELHCP, agree a list of EoLC medication and commission one Pharmacy per borough to stock and dispense, as required, 24/7.	2022/23 Clinical Commissioning Group / Local Pharmaceutical Committee Existing	Pain medication is available 24/7 for 'End of Life Care' residents in the community, as required and prescribed by a GP.	improving 24/7 availability and knowledge of EoL pain medication in the community;	

	TASKS	YEAR / TEAM / BUDGET	SERVICE OUTPUTS	INTERMEDIATE OUTCOMES	STRATEGIC OUTCOMES
5.5f	Identify patients who are approaching the end of their life and present at the Urgent Care Centre / A&E to redirect home via the Virtual Ward with appropriate treatment and support rather than admission. Identification to be completed via Frailty scores / IPOS / AKPS scores and number of admissions.	2022/23 Barts NHS Health Trust (Newham Hospital) Existing	Number of patients supported broken down by their protected characteristics, reason for attendance and illness trajectory.		
5.5g	Explore implementing an EoLC Coordination Hub: single point of access for proactive case management for individuals approaching the end of their life; and support to Health and Social Care professionals.	2022/23 Clinical Commissioning Group / Primary Care / ELFT Existing	• Exploration complete. • Actions identified to be added to Year 2.	Reduction in hospital admission in the last 90 Days of life.	
5.5h	Review Community Nursing Service to identify any gaps with provision in relation to EoLC.	2022/23 Clinical Commissioning Group / ELFT Existing	• Community Nursing Service reviewed. • Actions identified to be added to Year 2.		
5.5i	Develop a joint approach to and programme of training for Health and Social Care staff and independent Providers (including Carers Support Service, Care Homes, Extra Care and ILSS). This is to include: • Advanced Planning; • Dementia Awareness; • Caring for Lily; • Care of the Dying; in line with the Core Skills Education and Training Framework for EoLC. Within this establish and deliver a rolling training programme for Health and Social Care professionals on EoLC resources (e.g. Marie Curie, St Joseph's helpline, welfare benefits, etc) Links to: The TNW end of life care programme	2022/23 CCG / Newham End of Life Care Board Existing	• Number of sessions broken down by nature and type. • Number of attendees broken down by Team / organisation.	Training is effective; and resources are shared and as such more efficient (avoiding duplication and cost).	

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5.5j	Produce online and paper-based material on End of Life Care Services that enables residents approaching the end of their life to die at home (or preferred place of care and death).	2022/23 Adults and Health Commissioning Existing	• Online resource agreed and promoted. • Paper-based resource agreed and distributed.	Improve residents understanding of EoLC and how to obtain support.	
5.5k	Co-design and deliver a rolling training programme for Carers on EoLC roles and responsibilities, journey and resources.	2023/24 Adults and Health Commissioning Existing	• Training programme designed. • Number of sessions held. • Number of Carers reached; broken down by their protected characteristics and the cared for person's primary need.	Improve Carers understanding of EoLC and how to obtain support for the cared for person approaching the end of their life.	
5.5l	Co-design and deliver a rolling training programme on the last days of life (inc: process of death) for Carers. Links to **www.newham.gov.uk/health-adult-social-care/carer-2/4**	2023/24 Adults and Health Commissioning Existing	• Training programme designed. • Number of sessions held. • Number of Carers reached; broken down by their protected characteristics and the cared for person's primary need.		

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5.5m	Explore existing EoLC journey and support for residents with Autism and / or a Learning Disability.	2023/24 Newham End of Life Care Board Existing	• Journey mapped against relevant NICE Guidance and Quality Standards. • Discrepancies between journey and the NICE Guidance and Quality Standards identified. • Actions to resolve the discrepancies added to this Action Plan for Year 3.	Increase in number of 'End of Life Care' residents with Autism and / or a Learning Dis-ability who are able to plan for their future care and af-ter their death - ensuring their wishes are known and respected.	
5.5n	Explore existing EoLC journey and support for residents with forensic Mental Health needs.	2023/24 Newham End of Life Care Board Existing	• Journey mapped against relevant NICE Guidance and Quality Standards. • Discrepancies between journey and the NICE Guid-ance and Quality Standards identified. • Actions to resolve the discrepancies added to this Action Plan for Year 3.	Increase in number of 'End of Life Care' residents with forensic Mental Health needs who are able to plan for their future care and after their death - ensuring their wishes are known and respected.	
5.5o	Refresh the online and paper-based material on Bereavement. Make this available via the Registrar.	2022/23 Adults and Health Commissioning / Registrar Existing	• Bereavement resources reviewed and refreshed. • Resources promoted to bereaved residents via the Registrar.	Bereaved residents have access to advice and support as required.	**Appropriate and timely bereavement care is available for residents affected by the death of a loved one/s.**
5.5p	Re-commission / extend the **Community Bereavement Service**. The current Contract expires on the 30.09.2026 (with the option to extend for a further two years).	2024/25 Adults and Health Commissioning Existing	• Community Bereavement Service reprocured. • Number of residents to receive the Service; broken down by their protected characteristics. • Resident satisfaction.	Fit-for-purpose, well-promoted Community Bereavement Service.	

INDICATORS AND BASELINE DATA

OUTCOME	INDICATOR	DATA SOURCE	COLLECTED	BASELINE
Improved early identification of long-term conditions or disability, including frailty; and appropriate treatment / support provided to prevent, delay or minimise impact.	Percentage of the eligible population aged 50 - 74 who receive an NHS Health Check.	Fingertips	Annually	65.3% 2016 - 21
	Number of residents diagnosed with frailty at a severe stage.	Public Health	Annually	
Improved patient experience.	Patient experience of GP Services.	NHSE Outcomes Frame-work	Annually	73.5% 2022
Improved management of Long-Term Conditions leading to an improved sense of wellbeing.	Proportion of people feeling supported to manage their condition.	NHSE Outcomes Frame-work	Annually	47.5 2022
	Health-related quality of life for people with long terms conditions.	NHSE Outcomes Frame-work	Annually	0.783 2022
Reduction in number of residents with an unplanned attendance / admittance to hospital following a fall or Urinary Tract Infection.	Unplanned hospitalisation for chronic ambulatory care conditions.	NHSE Outcomes Frame-work	Annually	868.1 2022
	The proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.	ASCOF	Annually	94.1% 2021
Ensure residents who require Adult Social Care are able to access the right support at the right time. Residents will have choice and control over the care and support they receive and will have access to person-centred, high quality, joined-up and safe services which deliver value for money close to where they live.	New requests for support by age band: 65+.	ASCOF	Annually	3.4K 2021
	Clients accessing long term support: 65+.	ASCOF	Annually	2.7K 2021
	The outcome of short-term services sequel to service.	ASCOF	Annually	93.8% 2021
	Clients' quality of life score (out of 24) 65+.	ASCOF	Annually	**NEW**

OUTCOME	INDICATOR	DATA SOURCE	COLLECTED	BASELINE
Preventing Well: Risk of residents developing dementia is minimised.	Estimated dementia diagnosis rate (aged 65 and over)	Fingertips	Annually	59.5% 2020/21
Diagnosing Well: Timely, accurate dementia diagnosis, care plan and review within the first year.*	% of patients seen within 6 weeks (Referral to Treatment)	Rio (ELFT)	Annually	19% March 2022
	% of patients diagnosed within 18 weeks (Referral – Diagnosis)			40% March 2022
Dying Well: Residents with dementia dying in hospitals	Number of dementia deaths at Bart's	EOL Report	Annually	8 March 2022
Better enable residents approaching the end of their life, their families and professionals to recognise, prepare for and manage the end of life process. This will enable residents to be cared for and die in their place of choice.	Number of patients on the Palliative Care Register.	EMIS, GP sys-tems & System One	Quarterly	3789 Jan-June 2022
	Reduction in number of hospital attendances and admissions for 'End of Life Care' residents in the last 91 days of life.	EMIS	Quarterly	Non-Elective EOL Attendances: 96Nov 2021
				Non-Elective EOL Admissions: 85 Nov 2021
Increase in the number of 'End of Life Care' residents who die in their preferred place of care and death.	Number of 'End of Life Care' residents who die in their preferred place of care and death.	EMIS	Quarterly	No. of patients with CMC who did in their PPD: 6 Nov 2021
Appropriate and timely bereavement care is available for residents affected by the death of a loved one/s.	Number of residents given the Bereavement leaflet when registering a death.	Registrar	Quarterly	**NEW**
	Number of hits on the Council's Bereavement webpage.	Adults and Health	Quarterly	25 May 2022

OUTCOME	INDICATOR	DATA SOURCE	COLLECTED	BASELINE
	Number of residents accessing the Community Bereavement Service.	Bereavement Service Provider	Quarterly	165 2019-2020 185 2020-2021 329* 2021-2022

* (contract increased from October 2021 hence the uplift in clients supported)

Contact

To find out more about the strategy or how you can take part, get in touch via: **AgeingWell@newham.gov.uk** or 020 3373 0731 (9am - 5pm Monday to Friday).

www.newham.gov.uk/ageingwell