

# HEALTH AND WELLBEING BOARD

6 September 2017

<b>Title:</b>	<b>Better Care Fund: Update and Discussion</b>
<b>Report of the Deputy Chief Executive and Strategic Director for Service Development and Integration</b>	
<b>Open Report</b>	<b>For Information</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> No
<b>Report Author:</b> David Millen – Integrated Care Delivery lead	<b>Contact Details:</b> Tel: 020 8227 2875 E-mail: david.millen@lbbd.gov.uk
<b>Sponsor:</b> Anne Bristow, Deputy Chief Executive and Strategic Director for Service Development and Integration, LBBB.	
<b>Summary:</b> <p>At the last meeting of the Board, members received an update on the development of the Better Care Fund (BCF) Plan 2017-19 for Barking &amp; Dagenham, Havering and Redbridge. The Board delegated authority for approving the final plan to the Deputy Chief Executive and Strategic Director for Service Development and Integration, in consultation with the Cabinet Member for Social Care and Health Integration, the Accountable Officer for the BHR Clinical Commissioning Groups (CCGs), and the Director of Law and Governance. The full planning requirements were published by NHS England (NHSE), the Department for Communities and Local Government (DCLG), and the Department of Health (DH) on 4 July 2017 with clarification on Key Lines of Enquiry (KLOES), which will steer plan assurance, only being available on the 8<sup>th</sup> August which has created a level of challenge in working with colleagues to complete the required plan within the time available and confirming the mix of CCG, local authority and Social Care Grant resources applied across the themes of the plan, as detailed below.</p> <p>Work has continued on the BHR Plan, with our commissioning partners across BHR and reflects our shared ambition for progressing integration and service improvement across BHR. The BHR Plan focuses in Year 1 on aligning plans and governance across BHR. In Year 2 this will allow substantive integration through joint commissioning; creating a truly integrated BHR Plan. This report provides an update for information and discussion on the implications of the full planning requirements, and the development of the Plan and its structure, since the last meeting of the Board.</p> <p>The completed plan must be submitted by 11 September, and details of any feedback from the NHS England assurance process, as well as implementation progress will be provided in regular updates.</p>	
<b>Recommendation(s)</b> <p>The Health and Wellbeing Board is recommended to note and discuss the contents of this report, as well as the Plan summary, and provide comments to inform the final submission on 11 September 2017.</p>	

**Reason(s)**

Each Health and Wellbeing Board is required to guide and approve local BCF Plans. While delegated authority for final approval of the Plan has been given, to support the delivery of the plan within the time available, it is important that the Board be kept abreast, discuss and influence the latest developments.

**1 Introduction and Background**

- 1.1 At the last meeting of the Board, members received an update on the development of the BCF Plan for Barking & Dagenham, being developed in conjunction with Havering and Redbridge. The Board delegated authority for approving the final plan to the Deputy Chief Executive and Strategic Director for Service Development and Integration, in consultation with the Cabinet Member for Social Care and Health Integration, the Accountable Officer for the BHR CCGs, and the Director of Law and Governance.
- 1.2 The local approach to the Plan was outlined. Principally, that it will adopt a staged approach over the next 2 years to ensure that strong and established governance arrangements support meaningful integration and innovation. In Year 2 the plan will see increased integration and opportunities for innovation, supported through joint commissioning within the emerging BHR accountable care system structure. This approach, of working together across BHR, has already received strong support from NHS England.

**2 Planning Requirements**

- 2.1 After some significant delays, the full planning requirements were published by NHS England, DCLG and DH on 4 July 2017. The deadline to submit final Plans to NHS England is 11 September 2017.
- 2.2 Following the publication of the BCF Policy Framework, the more detailed Planning Requirements document contained a number of unexpected inclusions. Primarily, this was an enhanced focus on delayed discharges from hospitals that are attributable to social care, with the apparent assumption that social care delays were the prime national driver for hospital delays. We have also seen the emergence of an apparent threat that councils may face financial penalties if targets regarding delayed transfers of care are not met.
- 2.3 In response to the shift, the LGA withdrew its endorsement for the planning requirements, stating that “the sudden shift in focus, so late in the process, to prioritise delayed transfers of care, and the threat of a review of funding allocations if associated targets are not met, is completely unacceptable to local government”.

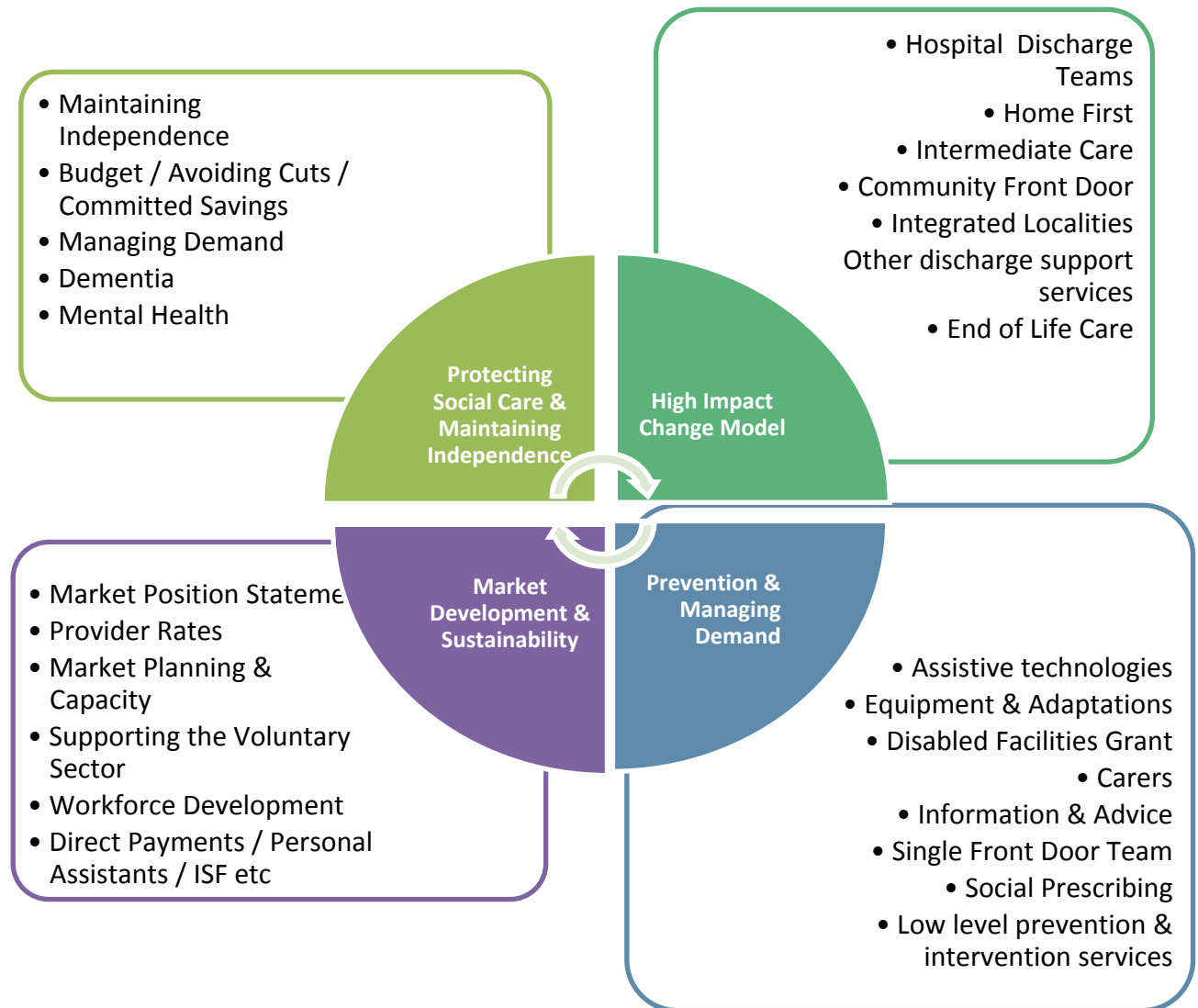
**Development of the BHR Plan**

- 2.4 The development of the BHR plan, and Barking & Dagenham’s contribution to it, should be seen in the context of the developments taking place in the local BHR health economy. Since submitting the Strategic Outline Case for an Accountable Care Organisation to NHS England in November 2016, work has continued to develop both the conditions and the structures for delivery of an accountable care system across the partnership. This has included the development of a Joint

Commissioning Board and a joint provider-led System Delivery & Performance Board. At its meeting on 31 July 2017, the Integrated Care Partnership Board agreed to proceed with developing the structures and processes for a stronger level of integration over the coming three years. Ultimately, the goal remains an accountable care system with capitated budgets and greater provider collaboration to shape services that respond to the needs both of individuals and, on an aggregated level, the localities which are now operating. The locality model brings together social care, community health services, and primary care, with children's services to follow shortly, and will be the principal focus for service delivery and development in future.

- 2.5 The Better Care Fund was agreed in principal to be a significant first step on that journey. In agreeing the BCF plan as a three-borough plan in principal, the Health & Wellbeing Board has backed up its commitment to develop a more coherent framework and deeper integration across the BHR system.
- 2.6 Since July we have taken forward our development of an aligned BCF plan and have set out the use of both BCF resources and the new social care grant monies. This has therefore increased the overall value of the plan.
- 2.7 The current year's plan is based upon the principle that each area, i.e Barking and Dagenham, Havering and Redbridge respectively, will have an aligned plan which balances BHR wide themes with local priorities and contributory services. The overarching narrative draws upon the work formerly completed in relation to the Accountable Care Organisation which sets out our shared vision as well as more local operating conditions and characteristics. We have had close regard to the Better Care Fund Planning requirements for 2017-19 in the drafting of our current approach.
- 2.8 The four shared themes within our BCF plan mirror the national guidance for simplicity, and are:
  - The "High Impact Change Model", which is a set of interventions support by good practice and which the guidance expects to see delivered through BCF investment (the major developments for BHR are the Home First out of hospital schemes);
  - Market Development and sustainability, to respond to concerns about financial pressure and sustainability of the social care provider market;
  - Prevention and Managing Demand, through which we seek to reflect the need to move investment 'up stream', and to both prevent hospital admission and deliver the Care Act vision of preventing, reducing and delaying social care need;
  - Protecting Social Care services, which is a grant condition attached to the new funding and reflects the fact that the Council is facing funding reductions which would otherwise necessitate further cuts in social care services, without some further investment.

## Joint BCF plan common themes



2.9 The detail of the schemes which will contribute to Barking & Dagenham's deliver against this framework is contained in Appendix 1. For each area, we can also summarise the funding sources, in part to demonstrate that we have met requirements around the use of the new social care grant, in particular that it should be used for:

- supporting and protecting social care services (acknowledging the impact of sustained funding reductions over the last 7 years);
- Market stabilisation and development;
- Improving delayed transfers of care, and thereby support the better use of high-cost bed-based services.

2.10 Grant conditions set no specific formula or value to be applied between each condition.

2.11 In addition to the new grant funds, The funding for the next two years allows for inflationary increases of 1.79% and 1.9% respectively against the CCG's allocation

to the pool and a 10% increase in 2017-18 and a 9% increase in 2018-19 against the Disabled Facilities grant (DFG) allocations.”

<b>Integration &amp; BCF funding streams</b>	<b>2017-18</b>	<b>2018-19</b>
<b>Local Authority funding</b>	<b>£'000</b>	<b>£'000</b>
LA Minimum contribution:		
Disabled Facilities grant (DFG):	1,391	1,517
Improved BCF allocation (iBCF):	1,044	4,910
Additional funding for ASC:	4,385	2,616
LA Other contributions:		
Base Budgets:	1,523	1,523
<b>Total LA funding</b>	<b>8,343</b>	<b>10,566</b>
<b>CCG funding</b>		
CCG Minimum contribution:	13,415	13,670
<b>Total BCF pool</b>	<b>21,758</b>	<b>24,236</b>

2.12 Whilst there is a need to submit an agreed BCF plan to NHS England by 11<sup>th</sup> September, we are clear that plan development, engagement and seeking opportunities will continue within the current year ahead of year two, testing the appetite to move ahead in year two for far greater innovation and integration between the partners.

### **Governance**

2.13 The current governance arrangements for the Better Care Fund will continue to oversee the development and management of the Barking & Dagenham BCF plan. There is a Joint Executive Management Committee, formed of three representatives from each of the Council and the Clinical Commissioning Group, whose role is to review performance and sign off spending and changes to allocation of funds. This will continue for the current year, and all three boroughs' JEMCs will provide reports to the BHR Joint Commissioning Board.

2.14 For 2018/19 it is expected that a new structure will be formed to reflect the greater interdependence of the plans as they enter the second year. The JEMC arrangements will be built into the JCB's terms of reference, whether by subgroup or at JCB itself. By making this move, there is real decision-making transferred into the new Integrate Care Partnership Board structures. Further reports to the Health & Wellbeing Board will confirm the detail of those arrangements and seek the appropriate delegation decisions in due course.

### **Performance management**

2.15 The key performance indicators which will apply to monitoring of the Better Care Fund are:

- Non Elective admissions
- Permanent admissions to residential care
- Re-ablement and
- Delayed Transfers of care

- 2.16 Performance will continue to be considered by NHS England and locally on a borough basis, rather than aggregated across the three boroughs that are part of the plan. Whilst there is an option for local areas to set additional local metrics it is recommended that we don't seek to do this within the Better Care Fund plan, given the further reporting and administration burden this would incur.
- 2.17 Barking and Dagenham's end of year position as at 31st March 2017 was that all targets had been positively exceeded.
- 2.18 There are, in addition, a range of national conditions to be met within the plan in order for the plan to be 'assured' by NHS England. These are, in summary:
- Plans to be jointly agreed with a local vision for health and social care;
  - Social care maintenance / protection;
  - NHS contribution to adult social care is maintained in line with inflation;
  - Agreement to invest in NHS commissioned out of hospital services;
  - Implementation of a series of "High Impact Changes", as outlined in guidance, which are expected to contribute to maintaining low delays in the transfer of care out of hospital.
- 2.19 A summary of Barking and Dagenham's contributory scheme activity, within the draft plan, can be found in Appendix 1

#### **Target-setting: Delayed Transfers of Care**

- 2.20 In July, a quarterly return was requested which sought to set out a first view of the targets for delayed transfers of care for the two years of the plan. The national messages were to expect maintenance of current performance where that performance was good. We are consistently one of the high performing councils for London when it comes to social care delays. Delays averaged 44 days total per month for 2016/17 for social care. The later requirement, however, used a benchmark of February to May 2017 as the baseline. This would require a commitment to reduce DToC attributable to social care to around 30 days per month.
- 2.21 In the initial return we followed what was requested, and populated the template with a consistent trajectory based on the months of February-May 2017. However, we have very clearly signalled that we are not at the point of accepting this as a target, and we have set out our rationale. These baseline months were a period of exceptional performance for us, and as a result they set an extremely low target. Since Barking & Dagenham is a strong performer on delayed transfers, it raises a concern that our efforts would be compromised by setting a target that is artificially even lower.
- 2.22 Currently, the extrapolated target is around 30 delayed days per month. A more realistic target would be of the order of 45 days per month. At these tolerances, a more substantive concern is raised, in that we are pursuing a target-setting exercise which will result in unsafe discharges as a result of the lack of any room for flexibility. Barking & Dagenham's Safeguarding Adults Board has received two reports recently relating to failures of safe discharge, and a Regulation 28 report has been issued on a further case by the Coroner. More stringent performance measures raise the possibility of compromises to service user safety for the sake of

a relatively small adjustment in targets against which we have historically performed so well.

- 2.23 None of this is a compromise in our commitment to operate a well-flowing and integrated health and care system, responding promptly to service user need, especially at points of crisis such as hospital admission. With resources stretched so tightly, however, we cannot allow ourselves to be distracted by a strong performance management culture applying to the Better Care Fund on the basis of a wrongly-set target. We are confident in our performance, we remain committed to keeping delays low, and need a pragmatic and locally sensitive approach from 'the centre'. The Board is therefore advised that we will submit the more realistic target as part of our plan, and we will keep the Board informed of any issues that this raises for the acceptance of the Plan.

### **3 Mandatory Implications**

#### **Joint Strategic Needs Assessment**

- 3.1 The BCF plan has been developed being reflective both of the JSNA for Barking and Dagenham and HWBB strategy. The JSNA has formed an underpinning part of our local context and informed the focus of our local schemes and has informed the completion of our local context and delivery conditions

#### **Health and Wellbeing Strategy**

- 3.2 Alongside the required planning guidance from NHS E we have had close regard to both the Health and Wellbeing Strategy for Barking and Dagenham and those for Redbridge and Havering, reflecting the aligned nature of the plan and the local priorities established. The current draft plan includes links to each areas HWBB strategy.

#### **Integration**

- 3.3 Building upon the earlier work to develop a case for an Accountable Care Organisation across BHR and the policy guidance, this BCF, across the two years of the plan is taking integration forward across the commissioning partners. The BCF plan provides a step change in integration which both practically tests the appetite for further practical steps to deepen current levels of integrated care and support delivery across BHR; and delivers now, alignment across key themes such as out of hospital services and the development of intermediate care and localities. Alongside existing governance, the developing role of the Joint Commissioning Board is also recognised in steering further commissioning steps across the partners.

#### **Financial Implications – completed Katherine Heffernan: Group Manager, Service Finance**

- 3.4 The approach for the 2017-19 BCF plan, is to adopt a three-borough approach, aligning Barking & Dagenham's plan with Havering and Redbridge Council's plans. Spend would be reflected against four themes highlighted in section 2.4 of this report. The total pooled fund for Barking and Dagenham for the financial years are £21.758m in 2017-18 and £24.236m in 2018-19 respectively. The BCF template would reflect the financial breakdown for each theme.

- 3.5 For Barking and Dagenham, the Council is currently the host for the pooled BCF funding with the CCG and for 2017-18 spend against the plan for Barking and Dagenham would continue to be reported to the Joint Executive Management Committee monthly. There may be the need at some stage to reflect the progress of the three boroughs but at this stage this arrangement is yet to be confirmed.
- 3.6 As mentioned in an earlier report discussed at the Health and Wellbeing board on the 5<sup>th</sup> of July, the additional grant funding given via the BCF includes conditions so the Local Authority would need to ensure that the grant funds are spent in line with the specific conditions to ensure that the funding is not clawed back and future years funding reduced or suspended.

### **Legal Implications – completed by Derron Jarell: Regeneration Projects Lawyer, Law & Governance**

- 3.7 The director of law and governance notes the contents of this report which recommends that the Health and Wellbeing Board “note and discuss the contents of this report, as well as the Plan summary”.
- 3.8 There are no direct legal implications arising out of this report. The report captures an overview of the iBCF Plan 2017/19.
- 3.9 Options for integrated commissioning include:
- Reaching agreements under section 75 of the NHS Act 2006 to establish lead commissioning, with either the local authority or the BHR CCG taking responsibility as “Host” authority, and pooling the budgets of the organisations;
  - Joint commissioning by the local authority and the CCG;
- 3.10 Under section 195 of the Health and Social Care Act 2012, there is a duty on the Health and Wellbeing Board, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.
- 3.11 The Health and Wellbeing Board must also, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

### **Risk Management**

- 3.12 Our detailed BCF plan includes a comprehensive risk assessment with mitigation steps. This forms part of the plan assurance process managed by NHS England. In current year a key principle is retained that of both financial risks being retained and managed by the commissioning partner and monthly financial reporting of spend-including areas of underspend and overspend to the Joint Executive Management Committee.

### **Patient / Service User Impact**

- 3.13 We have benefited from the extensive engagement undertaken as part of the development of the application for an Accountable Care Organisation. We have also



sought alignment with key strategies upon which earlier consultation has been completed.

- 3.14 Each local scheme as part of its delivery will seek both feedback and engagement with service users and stakeholders which will help to steer further steps.
- 3.15 The development of the plan has also been steered by directions from NHS England and required outcomes designed to impact upon the broader health and social care system alongside improving outcomes for individuals.

**Public Background Papers Used in the Preparation of this Report:**

- Integration and Better Care Fund Planning Requirements for 2017-19; NHS England, Department for Communities and Local Government, Department of Health, July 2017.

**List of Appendices:**

- Appendix 1: Summary Plan
- Appendix 2: Scheme overviews

## Appendix 1 Summary Plan

<b>BHR Scheme</b>	<b>Barking and Dagenham's local schemes / contributing services</b>
High Impact Change Model	<ul style="list-style-type: none"> <li>➤ Contribution to the Joint Assessment and discharge service (hosted by LBH)</li> <li>➤ Crisis Intervention Service spend</li> <li>➤ Social Care Grant (DToC)</li> <li>➤ Intermediate Care</li> <li>➤ Mental Health out of hospital and Employment services</li> <li>➤ End of Life Care</li> </ul>
Prevention and managing demand	<ul style="list-style-type: none"> <li>➤ Prevention</li> <li>➤ Equipment &amp; adaptations</li> <li>➤ Disabled Facilities Grant (DFG)</li> <li>➤ Social care grant (demand management)</li> </ul>
Market Development and Sustainability	<ul style="list-style-type: none"> <li>➤ Market Development</li> <li>➤ Social care grant monies as determined(- placement budget and rates)</li> </ul>
Protecting Social Care and maintaining independence	<ul style="list-style-type: none"> <li>➤ Base care package budgets</li> <li>➤ Social Care Grant Monies (maintaining care and support spend)</li> <li>➤ Dementia Services</li> <li>➤ Localities and integrated care</li> </ul>

### Market Development

The Social Care Market is a key component in the delivery of quality care and support for people in Barking and Dagenham and within our system, achieving timely and cost effective solutions that support the better use of high cost health services and whole system flow – particularly our management of out of hospital and Delayed Transfers of Care.

Many of these services have actively participated in the development of person centred support, improving independence and choice and we have successfully grown the numbers of people accessing individual budgets / direct payments and receiving support via Personal Assistants.

Social Care funding reductions over the last few years have meant that all areas of spend and activity have been subject to savings and funding restrictions which have clearly had an impact. In turn service providers have faced increased costs which have included elements such as pensions, minimum Living Wage increases, and the recent apprenticeship levy.

Social care services represent, from a whole system perspective, a good and cost effective use of resources.

We have particular challenges in areas such as:

- Rates available to people with personal budgets who are seeking to obtain support via a Personal Assistant or from a service provider.
- Although the council undertook a formal tender exercise to establish an approved list of homecare providers with agreed rates for a set period a number of providers have requested increases in the fees paid. These increases have been requested in response to a number of costs incurred by the providers which were not evident at the time of the tender process, for example, increased pension costs and recent Apprentice Levy
- Despite taking steps to increase rates payable to residential care providers by 20% in the last financial year this was from a low base and we are seeing increased price competition into the Borough and challenge from local providers.

The scheme Market Development will be supported by the utilisation of part of the Social Care Grant and properly reflects one of the key grant conditions – ‘Market Stabilisation’

#### Objectives:

- Improved access to sustainable care and support services within the Borough
- Improved sustainability

- Increase choice and diversity and the options from which our integrated locality teams can draw, alongside individuals utilising individual budgets
- Ensure that services can be accessed for local residents that are of sufficient quality and can be accessed in a timely way. Timeliness is a key factor in the effective delivery of Home First (D2A)
- Through BCF governance and specifically that within the JEMC and the Joint Commissioning Board – seek to address shortfalls within the market that improve whole system flow, quality where improved quality could contribute to keeping people healthy and well for longer, with improved wellbeing and self care

**We will:**

- Improve rates available to personal budget holders and in turn to Personal Assistants
- Commission a service which looks at the support available to service users using their personal budgets, particularly in their role as an employer in the Borough and to personal assistants in setting up in the Barking and Dagenham market
- Review rates available to both providers of support at home in the light of identified 'costs of care', helping to protect social care services
- Review rates available to residential care providers in the light of identified 'costs of care'
- Increase collaboration across BHR in the provision of an updated market position statement
- Improve access to person centred support through improving access to personal budgets/ Direct Payments for people currently under represented
- Work with partners in the voluntary sector to support and embed service development and delivery of services improving the range and diversity of local services. This will improve choice within the market.
- Develop proposals for a 'quality premium' that supports our focus upon out of hospital and the achievement of individual outcomes for service users. This will support people remaining in the place of their choice for as long as possible and seek alignment with CCG led practice improvement

## Mental Health

Improving community based support to people with Mental Health needs in the borough is a key priority for the Council and the Clinical Commissioning Group. This scheme is focused upon people of working age and is designed to improve community based support, growing available options, and improving the skills of service providers in supporting improved prevention, resilience and 'self care'.

### Objectives:

- Return Social Workers currently based with North East London Foundation Trust to the Council and improve connections between the remodelled service and other areas of the local authority, particularly innovations in Care and Support and Community Solutions. The inception of new Care Navigator posts with the advent of Community Solutions will support this process and the strengthening and development of our locality model
- To improve the flow of resources in bed based Mental Health services, helping to protect, and improve the sustainability of social care services
- Complete the changes to our contract which supports people with Mental Health needs to remain healthy & well for as long as possible, free of crisis and on the way to gaining employment (access to employment). This will include the introduction of workers focusing on mental health employment into the new Community Solutions service.
- Improve independent living beds and floating support services, providing a 'step down' model to support reductions in Delayed Transfers of Care and to prevent admission to bed based services. Tender to be completed this financial year encompassing a new 'outreach' service strengthening our personalised, community offer across care and support settings.
- Develop the voluntary sector and mental health provider market in order that there is a choice of services and options for individuals with mental health needs to purchase with their personal budget.

## Equipment and Assistive Technology

### Objectives:

- Explore Assistive Technology / Digital solutions that optimise benefits and individual outcomes.
- Improve access and the speed through which solutions can be accessed. Such timeliness is key in our delivery of Home First (D2A) and that delays don't in themselves provide a barrier
- Improve digital access within the borough, improving connectedness in the borough and accessibility to information, advice, and universal services.
- Improve access via 'Home First' discharges, creating AT / Digital champions and ensuring that AT / Digital solutions can readily form part of the interim support solution.

### We will:

- Complete the pilot and review of assistive technology and digital solutions utilisation and other equipment within the borough with our academic partners in Care City/ UCLP. This will determine the effectiveness, efficiencies, and individual outcomes for residents upon which further expansion / roll out might be based
- Implement/extend 'trusted assessor' model to address key points of access whereby there is less dependency upon 'professional assessment'. An example would be new pathways via Community Solutions, voluntary sector – Red Cross, and service providers operating under our Crisis Intervention arrangements reflecting key points in a service user's support journey
- Upskill key staff such as champions and care navigators along with 'health champions' and establish further steps for wider application where these deliver improved outcomes for individuals and demonstrate an effective use of available resources. This will be key in areas such as age related need, as generally, resources required increase with age

## Prevention

Prevention is key in improving health and wellbeing for residents. In our Borough this is particularly significant given the incidence of ill health, lifestyle related conditions and deprivation. This scheme aims to where possible to reduce the incidence of avoidable ill health and reduce demand upon health and social care services. It is also a duty on the council under the Care Act to 'prevent, reduce and delay' social care needs. Board members will recall approving an approach to prevention which captured these requirements, and which this scheme will seek to further embed.

### Objectives:

- Reduce where possible avoidable ill health and dependency that may result in avoidable hospital admissions and intense use of social care. In this way this is a key aspect of protecting social care and health and maintaining existing services as available resources are increasingly effectively applied
- Utilise low cost solutions that provide practical support and solutions
- Enhance service access, including that for people who may fall outside of traditional services access or eligibility criteria widening the net of support solutions
- Seek to embed preventative approaches in core services as a key part of care and support so that individuals are supported to remain independent, healthy and well for as long as possible.
- Further embed prevention within our new locality model, options available and in voluntary sector service delivery, ensuring a shared vision across services.

### We will:

- Maintain the commissioning of the 'Handy Person' scheme and explore the opportunities for its expansion across the BHR area.
- drawing upon evaluation of our recent pilot, re commission an exercise programme,, building stamina and resilience and which supports the wider Ageing Well / Healthy Lifestyles programme (funded by PH) which would address some of the referral challenges from before which limited access.
- Review Public Health activity, particularly projects such as Mental Health First Aid and the Volunteer Drivers scheme with a view to establishing its impact upon iBCF and scheme outcomes
- Maintain our Red Cross Home from Hospital service, helping people to leave hospital more quickly with tailored practical support which is focused upon addressing environmental risks, addressing isolation and loneliness, improving well being and ensuring that follow up appointments with outpatients, GPs and any medication reviews are supported.
- embed understanding and awareness of preventative solutions in our staff and service providers. This will include a key focus upon our new Care Navigators and advent of Community Solutions (First Contact).
- maintain our Care and Support hub, providing health and wellbeing advice and information, ensuring that contents are sufficiently updated and relevant

## Carers

Family and informal carers provide a vital role in our communities, helping people to remain in their own homes for as long as possible. Where admission to acute care has taken place Carers also have a key role in supporting an early return home. Carers often provide considerable levels of support to family members with at times complex and challenging needs. Carers may also be older people themselves and may, in their caring for others, pay less attention to their own health and wellbeing needs, placing them at higher risk. In consultation, carers have told us that they feel that they need support to navigate the 'system' and support their health and well being

We have a joint carers strategy which brings to the forefront of service delivery through innovative solutions and sustainable support that values the experience and knowledge of carers... Previous work including the development of our joint carers strategy and reflection of JSNA and Census data has highlighted that many carers are currently not known to services

### **Objectives:**

- Carers feel better supported in their caring role with access to training and support, a particularly priority for those identified as most at risk within the development of our joint carers strategy; an example would be the delivery of mental health resilience training for carers by our service provider- Carers of Barking and Dagenham
- Eligible (Care Act) carers are able to access individual budgets and that the market is developed to enable carers (and service users) to be able to purchase from a range of different services/solutions that can meet their needs as carers;
- Improve the involvement & inclusion of carers in decision making, this being evident in both individual care and support planning and in broader policy development;
- Promote the role and contribution of family / informal carers;
- Improve access to information, advice, connectedness and to available services through our online carers hub;
- Carers identified as a key part of individual care and support planning, particularly at key points such as discharge from acute care;
- Improve floating support services – particularly for people with Mental Health needs, to impact upon Delayed Transfers of Care and support to family carers;
- Working with our stakeholders and partners, including Carers of Barking and Dagenham to improve commissioning intelligence which will help to ensure market gaps can be addressed, services improved and that a shared vision is promoted across pathways and services.



**We will:**

- Maintain commitment to our carers support contract, continuing both the financial commitment, joint planning and development and evolution of our shared vision across the borough.
- Develop respite provision that is reflective of carers needs and budget requirements
- Maintain and develop further sustainable and quality peer support provision.
- Develop the market to ensure that carers are able to purchase services and interventions that support them in their caring role.
- Via the Carers Strategy Group, work to ensure that the actions within the joint carers strategy and its vision continues to be progressed and areas such as shared vision is promoted across the borough
- Further embed awareness of carers in key teams – including our new locality integrated teams, ensuring both that Care Act requirements are fully met but that, alongside strategic engagement, the centrality of carers is evident in individual decision making and case work.
- funding secured through CEPN enabled the delivery of identifying hidden carers training which produced positive results. This will be revisited as refresher training/ factsheet developed through the carers hub

## Dementia and End of Life Care

Significant steps have been taken locally to improve rates of diagnosis, improved care and support planning etc.. However, there remains much to do if we are to improve service users experience and choices, accessing services that they would wish to that are sufficiently flexible, skilled and experienced, Social care plays a key role in post diagnosis support.

End of Life care encompasses people who need support and care and are expected to die within the year. Whilst diagnosis rates have improved along with the increased use of Advanced Care Plans, within which individual choices and preferences are drawn, too many people don't have the opportunity to die and to be cared for in the place of their choice. This is particularly evident with people with dementia who are often unable to access sufficient support at home to manage perceived risks and level of support, with sufficiently skilled staff, required without entry into a bed based/ institutional setting.

### Objectives:

- Complete a review of current dementia services and pathways to inform future direction, identify market gaps and opportunities for further improvement and improve our shared vision.
- Reduce avoidable admissions into bed based care, enabling individuals to remain in the place of their choice for as long as possible
- Raise awareness with support from our partners including the Alzheimer's Society, including training to equip staff with the necessary skills and support dementia specific support planning and access to personal budgets
- Develop the market for dementia and End of Life Care services improving the range of services that people can spend their personal budget upon, accessing suitably skilled and experienced staff, able to engage in difficult conversations and support.
- Promote dementia friendly communities, determining with our stakeholders the key elements to be included within delivery and resourcing of the necessary steps.
- Improve discharge support, ensuring that people spend as little time in an acute setting as is required, returning to their own homes
- Improve training so that key staff have the necessary skills and experience, competence and confidence to work with people with dementia and or End of Life Care, ensuring that 'difficult' conversations and informed choices can be supported.
- Improve the take up and accessibility of direct payments / individual budgets for people with dementia so that they and their families can access improved personalised support.
- To further strengthen the identification of wishes and preferences within care and support planning, including Advanced Care Plans, DNRs linking with work currently underway to develop a GP End of Life engagement project.

### We will:

- With specialist support from local voluntary sector providers including the Alzheimer's Society, we will review the current process through which

individuals are able to access Direct Payments / Individual Budgets and identify current obstacles to obtaining appropriate support in our local market. This will be fed into the commissioning of the new Direct Payment and Personal Budget Support Service, discussed in the Market Development scheme above.

- Provide training/ information resource for carers supporting an individual at End of Life to increase understanding and also for carers and cared for, to make informed choices and decisions.
- Maintain current care and support arrangements whilst developing a business case for further investment and the 'to be' commissioning model
- Scope review process to support re-provisioning of dementia advisors or (alternatives) with support from Care City and ensure effective engagement with stakeholders
- Commission a training package focused upon dementia and End of Life Care, to improve awareness, skills and competence in staff with a particular focus upon staff at key access points within our social care and health system, training will initially be targeted at key staff and services which will include our integrated locality teams, new care navigators and staff within our Community Solutions service along with Personal Assistants, working with people with their own budgets. We will embed dementia and end of life care as core business with social care and community health care service delivery.
- Within our Assistive Technology and digital solutions scheme we will seek to optimise benefits for this group in order to optimise benefits and improve choice and wellbeing.
- Dementia friendly communities – we will explore steps through which this can be achieved within the Borough with our partners and stakeholders.
- Draw learning from the GP End of Life Engagement Project to inform and shape further steps.

## Localities

Barking and Dagenham have introduced a new locality model which has reorganised locality arrangements from formerly 6 clusters to 3 localities (with a 4<sup>th</sup> to be added with to better support the emerging new communities on the Barking Riverside development). The localities will service populations of 50,000-70,000 people and also strengthening the alignment between children's and over 18 services. We have revised our staffing structure to include the introduction of new Care Navigator roles, 4 senior Social Work posts

With our partner NELFT, and primary care, we are delivering personalised care and support capitalising upon streamlining of processes, reduction in duplication, and enabling complex tasks to sit with our most skilled and experienced staff. We are also introducing a single Disabilities services to better support whole life planning across the life course and implementing a new Community solutions service- strengthening our prevention and early intervention support and providing a seamless holistic experience for the service user.

### **We will:**

- Conclude the implementation of new staff roles and functions
- Plan for the delivery of our fourth locality with the development of Riverside
- Embed our new Disabilities and Community Solutions services

A more substantial localities development plan forms part of the work of the Integrated Care Subgroup of the Health & Wellbeing Board, and it will be connected to the implementation of BCF as we progress.

## Intermediate Care

Intermediate care services are currently subject to particular focus by the Joint Commissioning Board with a view to shaping steps for their further development and direction and how these align with key system requirements such as the delivery of Home First (set out below) For the purposes of this plan Intermediate care encompasses, Intensive rehabilitation and crisis intervention activity.

We are required by NHS England (NHSE) to define our plans for the implementation of Discharge to Assess model and to move towards a Trusted Assessor operational delivery approach. Delays attributable to social care are currently negligible with BHR performance within the top quartile, although maintaining performance is an acknowledged challenge. Across the partners there is work underway to on discharge pathways, therapy services, patient flow.

All of this work is highly interrelated and needs to be managed and coordinated as we need to deliver a fully integrated community based model and it is being managed through the Discharge Improvement Working Group (DIWG). As a first step towards an integrated approach that puts service users at the centre and improves the quality of their care, the system needs to agree that the principles set out in the 'Quick Guide: Discharge to Assess' are adopted, including, and most significantly, that people do not have to make decisions about long term residential or nursing care while they are in crisis, such as a while in hospital

Inserting new service process piecemeal into the existing array of services will not work; the most effective way of achieving substantial change will be to take a more holistic, strategic approach to the design and subsequent commissioning of the right model namely, a redesigned Intermediate Care Tier, across the BHR area to deliver the 'Home First' approach..

The plan and design for the Intermediate Care Tier will also need to ensure that there is strong correlation to the UEC Programme's review of the acute 'front door' services to ensure consistency of approach. As a part of the design process, there will be a review of current commissioned services and the total resources applied to them and a change to the current commissioning and contracting approach across the system, which itself is dependent upon the Service Line Reporting Review with NELFT.

We need to take the opportunity to agree how resources are best applied and moved around the system to follow the patient 1. This must be supported by some form of risk share / gain share agreement to ensure it is clear how resources will be balanced as the service develops and in the event of unforeseen challenges.

The purpose of the shift towards this tier will be to improve outcomes for our residents and patients, reduce the use of services where possible, to ensure the use of high costs services is limited to those that need it, not as a first recourse to those that can find no other support at their time of need. The success of the approach needs to be measured with this in mind.

**Project Aim:** The aim is to implement an integrated discharge 'home first – getting you home' model for people in the BHR system so that where people are medically optimised but may still require care services are provided with short term funded support to be discharged to their own home or another community setting. The aim is to maximise a

person's rehabilitation potential, remove duplicate assessments by using a 'Trusted Assessor mode' and reduce the impact that hospital 'deconditioning' may have on them.

**Discharge Model – The New Approach:** The Discharge Improvement Working Group has agreed to adopt the principle of 'Home First – getting you home' such that regardless of what assessment a patient needs the assessment should be carried out in a non-acute setting, once the patient is medically optimised.

BHR health and social care partners are aspiring to adapt the South West Warwickshire D2A model, to include a fourth pathway:

**Pathway 0:** Patients that leave earlier with no additional support and who, if not returned home within 72 hours, would almost certainly require a placement

**Pathway 1:** Patients who can return home with community support

**Pathway 2:** Patients who cannot be discharged directly but could return after additional rehabilitation support

**Pathway 3:** Complex care/nursing home

This principle around 'Home First: getting you home' will require health and social care partners to challenge current practice and change mind-sets and through collaboration ensure sufficient quality of service, demonstrable change and agreement on how best to allocate resources and funds and share risks. This will require an agreement as to how resources are best applied and moved around the system to follow the patient. This must be supported by a risk and benefits share agreement between health and social care partners to ensure it is clear how resources will be balanced as the service develops.

In the shorter term this will require system leaders approval that more rapid 'PDSA' style development of small incremental steps be adopted immediately to support the design process and improve on current services. This implicitly requires commissioner approval, without contract amendment, for NELFT and BHRUT to work together with the boroughs.

It is assumed that this plan will be cost neutral to the system.

BHR LA's and CCGs would see CHC/Personal Health Budgets as 'in scope', including patients going home and having their CHC assessment undertaken in their home environment. It is recognised that the BHR health and care economy is an outlier for the numbers of people going through the CHC process. The CHC pathway is subject to a separate PID and action plan as part of the CCG Financial Recovery Plan and will be implemented separately.

All partners have recognised that there are numerous challenges that need to be overcome to deliver a discharge to assess model that truly puts the service user at the centre of decision making and their care. One of the most significant challenges is the allocation of financial resource and how all partners trust other partners to make patient centred decisions that involve the allocation of financial resources.

Any re-commissioning or variation of existing contracts to deliver this new Intermediate Care Tier will require flexibilities in contracting arrangements with provider services where appropriate. Contracts with BHRUT, NELFT and potentially a range of Social Care contracts, e.g. voluntary sector, will need to be reviewed.

The model will explicitly seek to meet the essential criteria as set out in the 'Quick Guide: Discharge to Assess'.

This scheme currently includes funding commitments for Joint Assessment and Discharge service and for work force development. Inevitably, as the focus for the completion of assessment shifts to the community, it will be necessary to adjust the resources applied within the hospital setting.