



Integration and Better Care Fund 2017-19

Joint Narrative Plan

Area	London
Constituent Health and Wellbeing Boards	London Borough of Barking & Dagenham London Borough of Havering London Borough of Redbridge
Constituent CCGs	NHS Barking & Dagenham CCG NHS Havering CCG NHS Redbridge CCG



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Foreword

Our vision for Health and Social Care is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services.

To the individual, the system will feel seamless and responsive to their needs. There will be clear information and advice about how to access services and ensure that they receive the right care, in the right place, all of the time. Those working in health and wellbeing, including other critical support services such as local authorities, community care, public health and the voluntary sector will be members of a community of care driven by a shared vision.

This Better Care Fund plan allows us to set out greater level of detail about how this vision will be delivered. For the first time, the three borough's plans will join together to create a clear, unified approach with a series of common aims, while also retaining the local differences that reflect the differing nature, demography and demand that our areas dictate. This joint approach is the practical first step towards the planned move towards the plans set out in our Strategic Outline Case in November 2016 for an Accountable Care System for this area.

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1. Introduction

1.1 Overview

This Integration and Better Care Fund (iBCF) narrative reflects our strong collaborative working across the three London Boroughs of Barking & Dagenham, Havering and Redbridge (BHR) within which system wide issues and opportunities are addressed, alongside a strong focus upon variations and local priorities across the three boroughs. Health and Care Partners, through the BHR Integrated Care Partnership, are exploring the benefits of closer integration of both commissioning and service delivery to make best use of the resources available to us, and improve outcomes for local people. The iBCF presents us with the opportunity to test integrated commissioning and as a system BHR partners are supportive of being ambitious around our approach to iBCF over the next two years to take us to a position of potentially developing a shadow joint commissioning budget to support providers to come together to deliver integrated care in the context of an Accountable Care System.

We are therefore seeking to build upon previous years of BCF planning, reflection of outcomes, alongside our work as a system, to develop our proposals for an Accountable Care System, Sustainability & Transformation Partnership (East London Health Care Partnership) alongside key high-level local strategies (Health and Wellbeing Strategies) and direction provided by our respective Health and Wellbeing Boards and engagement with key stakeholders who have confirmed what their priorities for success will be.

Our plan recognises both national and local challenges, including affordability challenges for social care and health. It includes consideration of both iBCF finance and that provided through the Social Care Grant to local authorities (LA's) with associated conditions to be met - including stabilisation of the home care and residential care markets, improving discharge arrangements and supporting the structural deficit in social care funding which would otherwise make such steps unsustainable.

Key to our plan is the deepening of integration across the life of this iBCF period, using iBCF as an enabler towards the bigger prize of a new model of care, delivered through a Locality model supported by the development of a provider alliance within an Accountable Care System (ACS).

1.2 Protecting Social Care

The guidance gives weight to the Protection of Social Care. Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings when necessary. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

This protection is against a backdrop of substantial reductions in social care budgets within the local authority's austerity response and funding formula changes. This plan describes the approach we will take to ensure the most effective protection of services. Some iBCF funding will be applied into the Councils' base budgets which will better protect against services being stopped or reduced. For Councils, the recent context has been one of a sustained reduction in available resources at a time of demand growth. The extent to which core social care services underpin the effective working of the

health and care system is in little doubt; the consequence of not supporting base budgets in this way is a risk that there will be a reduction of key elements of social care, which in turn would significantly impact on the health system locally resulting in a health and care system where capacity and resources are outstripped by demand. Investment in social care supports whole system flow and while it may not be so visibly linked to the immediate needs of the acute sector and Delayed Transfers of Care (DToC) specifically, the effect of the absence of good social care is quickly evident. Social care services offer good value for investment and in some cases, can offer a viable alternative to health managed and delivered services.

The LA's note that transfer delays due to social care in BHR have been successfully managed down to very low levels in comparison to those nationally, as social care continues to support getting people out of hospital and address delayed transfers. This approach however of investing to support discharge has led at times to localised market capacity issues and budget pressure (overspends). Greater use of residential care and residential with nursing care places across the boroughs might destabilise those markets locally or push prices up for Local Authorities but there is opportunity to work together to minimise any impact.

1.3 System Change

The BHR health and social care system is facing significant financial challenges. The Barking and Dagenham, Havering and Redbridge Strategic Outline Case for an Accountable Care Organisation (January 2017) reported that in order to continue providing services consistently, and if the system were to deliver care in the same way that it does today without achieving any efficiencies, expenditure in 2020/21 is forecast to exceed income by £614 million.

The financial challenges facing the BHR health system, following agreement of 2017-19 NHS contract values, became very significant at £55m (5.6%) for 2017-18 requiring a step change in cost removal. NHSE requires the BHR CCGs to achieve 'in-year breakeven' in 2017/18. This is clearly a very challenging requirement, given the stated financial position.

Local Authorities have been embarking on transformational plans to deliver budget savings over several years and have significant challenges over the coming three years to balance their budgets.

To respond to the system challenge, the Integrated Care Partnership Board (ICPB) established a BHR System Delivery and Performance Board in (SDPB) January 2017. The SDPB is a partnership group responsible for BHR system level delivery planning and implementation. Partners on the Board are both accountable to their respective organisations and are collectively accountable to the ICPB as the programme board for the development, agreement, implementation and monitoring of the BHR System Delivery Plan and the financial and performance health of the integrated system. The role of the SDPB is distinct from and complementary to that of the Joint Commissioning Board which is similarly accountable to the ICPB. Whilst the initial focus of the SDPB has been to develop a System Wide Delivery Plan for in year achievement in 2017/18 of savings of £55m within NHS partners, the Board is also responsible for the development of an outline transformational change support plan on which the system can build as it develops clinical and system change capacity and capability.

In light of the BHR ICPB vision and direction of travel, a staged approach is to be adopted which will allow the detail of our joint plan to evolve and develop through 2017/18 and be implemented in 2018/19.

1.4 Plan for 2017-2019

The plan's structure allows for the flexibilities of each Borough to ensure that the 'protection of social care' element is fulfilled directly, with the remaining pool used to support a more integrated plan. Moreover, the protection of social care allocation within the iBCF will be visible and protected for social care purposes (that do of course positively impact on the whole system). The governance focus within the joint management forums will drive local innovation opportunities which can take into account local operating conditions/variations in need and demand. Without such a focus it is unlikely that marked progress can be made.

In the first year of this iBCF plan, we start to move to revised governance arrangements: Tier 1 consisting of four BHR wide themes within which schemes and activity are planned across all three boroughs, coordinated where appropriate, increasingly overseen by the BHR Joint Commissioning Board; supported by Tier 2 schemes through local joint management arrangements providing both BHR wide and a local area focus.

This plan is set out as a common narrative to reflect the journey that BHR is on towards increasing integration; for the purposes of metric and financial planning, the plan is accompanied by three separate Borough based template submissions, setting out the respective targets and financial breakdown. These three plans, for year one, will be governed through three separate Section 75 Agreements. For year two, we aim to bring these pooled funds together under a common governance arrangement. Depending on the approach taken at an ACS level, this might either be a single Section 75 agreement, or an ACS approach, perhaps capitated budgets.

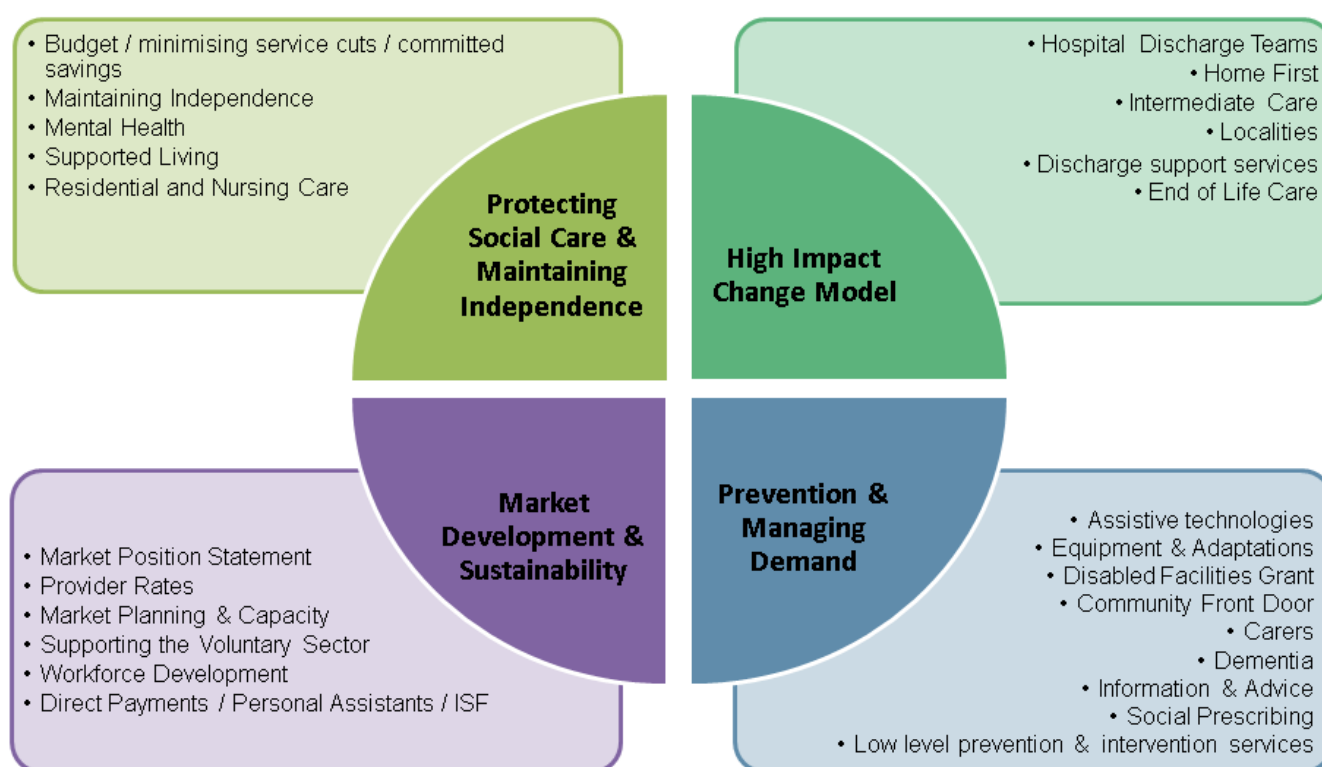
It is recognised that Councils are largely bearing the costs of iBCF administration and with four separate commissioning teams involved (three LA and one CCG lead) there are overheads to the creation of this joint plan. One way of mitigating the impact of supporting iBCF is for activity to be shared through a move to Lead Commissioning arrangements and greater freedom to invest in change and innovation. We will be reviewing our S75 arrangements to clarify lead commissioning and accountability arrangements.

It is clear that Councils face a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures, which would in themselves require utilisation of grant monies which are clearly expressed within the accompanying grant conditions. Taking steps to improve market sustainability would ordinarily introduce costs which would be unsustainable to Councils and prevent building for medium term benefit.

Our plans and the local schemes – set out below - within each HWB area reflect a clear need as part of seeking improved sustainability, for further improvements in our management of demand and that preventative opportunities are maximised. As important as this is, for social care and health services and in the best use of available resources, we are seeking, for individuals, to support improved levels of independence, choice over how their care and support needs are best met, improved self-care and levels of wellbeing for our local populations. Such a focus will seek, as far as possible, to banish reactive responses by services and escalating needs to one of early intervention, ensuring that the right support is available in both the place of choice, is timely and along any pathway and within services themselves, that these principles are fully embedded.

2. Executive Summary

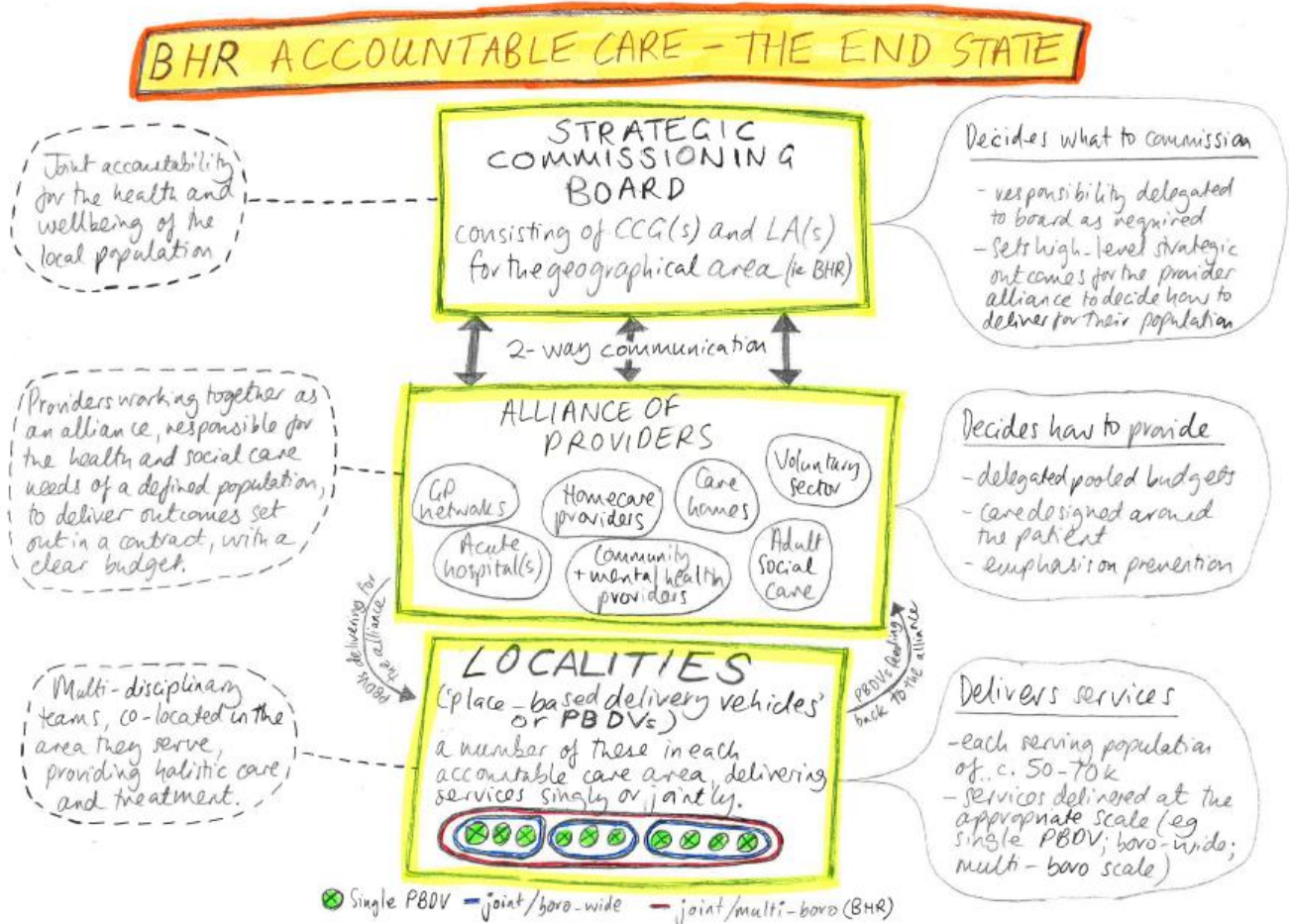
Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services. This plan sets out a clear determination that the BHR area will move increasingly towards that vision with a new model of care, building upon the history and experience we have together to meet the challenges of increasing demand, demographic change and financial constraint. We have defined, and agreed, a series of themes. Each of them is important to the BHR health & care system and all are central to the Better Care Fund. The plan overall is expected to deliver against the key requirements as set out in the National Guidance and Policy Framework, including the eight elements of the High Impact Change Model, market capacity and sustainability, supporting the acute hospitals' 'flow' and ensuring that social care services are protected wherever possible, which in turn supports the whole health and care system.



Having invested in the development of our locality models over the past couple of years, bringing greater levels of integration and co-location of teams, we are developing this further, as a part of our ambition for Accountable Care. Localities will become the default mode of operation – for both commissioning and provision and increasingly this will draw in the wider range of services than our current community models deliver, such as housing, general practice, voluntary sector services and so on.

Within this plan, we look both at the immediate progress to be made and towards the bigger picture for our health and care system. The Accountable Care System work is gathering pace as it becomes clearer as to how it will work, what is involved and the changes that will be required. We believe this iBCF plan gives significant grounding to that work; building our partnership to practically learn with each other and to support each other as partners while recognising the pressures within our individual organisations.

The following diagram illustrates the 'Accountable Care System' element of this in more detail and is the broadly agreed vision that BHR partners, through the Integrated Care Partnership, are working towards.



We have provided a single narrative plan to cover the BHR area; alongside this we have prepared separate Finance and Metric template submissions for each Borough. As the plan progresses, we expect to be able to bring this template together for the second year, alongside a Section 75 agreement that reflects the joint arrangements.

The BHR system is in the process of developing a single plan (the 'Winter Plan') for urgent and emergency care in order to better coordinate the delivery and outcomes across our geography. The Plan is divided into four sections which focus on: (1) Pre-A&E front door; (2) Inflow to the hospital; (3) Through flow in the hospital; (4) Outflow from the hospital. The plans within the BCF are integral to this and demonstrate the join up for delivery across health and social care. The BCF plans will specifically support pre-A&E front door and outflow and are essential in terms of best management of demand.

The plan will be completed as a full draft by 8th September 2017 but will be a living document as delivery against each of the schemes will be updated weekly. Performance will be monitored through the A&E Delivery Board, which all partners in the system are part of, and the reporting route for this is reflected in the organisation chart in section 9 on page 54.

BHR Joint Funding Position - Source of Funding - 2017/18 and 2018/19									
	2017/18 Expenditure (£'000)				Total 2017/18 Expenditure (£'000)	2018/19 Expenditure (£'000)			Total 2018/19 Expenditure (£'000)
	CCG Minimum Contribution	Improved Better Care Fund	Local Authority Contribution			CCG Minimum Contribution	Improved Better Care Fund	Local Authority Contribution	
High Impact Change Model	31,385	1,920	802		34,107	31,942	2,011	802	34,755
Prevention & Managing Demand	7,309	1,039	5,517		13,865	6,420	1,135	5,932	13,487
Market Development & Sustainability	-	5,732	-		5,732	-	6,942	-	6,942
Protecting Social Care & Maintaining Independence	8,292	5,740	672		14,705	9,517	9,320	672	19,509
Grand Total	46,986	14,432	6,991		68,408	47,878	19,409	7,406	74,693

BHR Joint Funding Position - 2017/18 and 2018/19									
	2017/18 Expenditure (£'000)				Total 2017/18 Expenditure (£'000)	2018/19 Expenditure (£'000)			Total 2018/19 Expenditure (£'000)
	Barking & Dagenham	Havering	Redbridge			Barking & Dagenham	Havering	Redbridge	
High Impact Change Model	10,583	13,043	10,481		34,107	11,191	12,983	10,582	34,755
Prevention & Managing Demand	3,174	4,462	6,229		13,865	3,375	3,483	6,629	13,487
Market Development & Sustainability	1,592	1,731	2,409		5,732	2,150	1,792	3,000	6,942
Independence	6,409	3,424	4,871		14,705	7,521	5,907	6,082	19,509
Grand Total	21,759	22,660	23,990		68,408	24,237	24,165	26,292	74,693

3. Setting the Scene - Background and context to the plan

Barking & Dagenham, Havering and Redbridge are adjacent boroughs in outer north east London. We share a single major acute provider, Barking Havering and Redbridge University Trust, and a large community and mental health Trust, NELFT NHS Foundation Trust. This creates a natural alignment for health and local authority partners to work together to achieve the best outcomes for the whole population.

The three boroughs have distinctive populations: Barking and Dagenham has a younger and ethnically diverse population which is the third most deprived in the country; Havering an older, largely white population; and Redbridge an ethnically diverse, majority Asian, median income population. The variation between the three boroughs means that through working on a combined footprint, there is an opportunity to pool resources and redirect additional support to places where they are needed most.

Demographic change is an important driver of demand for health and wellbeing services. BHR's population has been increasing rapidly and is projected to rise for the next two decades. The current system will struggle to respond to the overall projected increase of 19 to 28% by 2031.

Our acute providers have both had period of being under Special Measures - Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) - was placed in special measures in 2014. Since then, it has seen significant improvement in emergency flow, staff engagement and financial performance which saw it come out of Special Measures in 2017. However, broader system wide partnership is needed to address longstanding access issues including increasing A&E attendances, acute admissions and reducing waiting times for elective care. Primary care also faces significant challenges with a large proportion of GPs nearing retirement age, difficulty in attracting new talent, and increasing demand. All of this has contributed to a significant financial challenge - in order to continue providing services consistently and if the system were to deliver care in the same way that it does today without achieving any efficiencies, expenditure in 2020/21 is forecast to exceed income by a significant margin.

While Barking & Dagenham and Havering have BHRUT as the one main acute provider, Redbridge also has Barts Health NHS Trust (Barts) in addition to BHRUT through Whipps Cross University Hospital, situated in the north west of Redbridge serving approximately one third of the population and is the provider of choice for a number of residents due to access with Redbridge CCG commissioning services with Barts. Barts sits within the borough of Waltham Forest, a partner borough within the East London Health Partnership (previously north east London STP) footprint.

3.1 Summary of previous BCF Progress

Health and Care partners across BHR have a history of strong collaborative working. With the conception of the Integrated Care Coalition in 2011, evolving into the Integrated Care Partnership Group in 2016, BHR Partners have worked within a formal partnership governance framework to deliver successful initiatives, supported by the Better Care Fund.

3.1.1 Improvements in Governance

The Better Care Fund planning process and delivery has brought together commissioners from the local authorities and clinical commissioning groups through shared joint governance arrangements, determining necessary steps to both manage the resources within the agreed pooled fund, take a

shared view on performance and necessary steps for improvement along with improved consistency and clarity for providers in required outcomes. Such focus provided through Better Care Plans, focus provided through joint management arrangements, has supported sustained improvements in key performance areas, both by HWBB areas, but also through how working together, across a broader system, can deliver further improvements. This has helped to balance what can be affected locally with what needs a BHR wide focus. Whilst comparative performance is very strong, we maintain an on-going focus on further improvement, for both individuals, their outcomes and for the broader system.

Health and Wellbeing Boards have benefitted from oversight of the BCF and have helped to shape the plan focus and delivery, receiving regular updates in our shared progress. Governance and agreed levels of delegation have meant that Boards have been freed from minutia but have been able to consider key decisions, their impact and alignment with broader strategies, including activity sitting outside of BCF. Boards also provide a further opportunity to bring together commissioners with key service providers.

3.1.2 Joint Assessment and Discharge Services

The Joint Assessment and Discharge service became fully operational in 2014, bringing together disparate staff (from LBBD, LBH and BHRUT) involved in supporting discharges from hospital, under a single line manager, supported by a steering group comprising the partners with a S.75 agreement. With successful implementation the steering group was dissolved and hosting of the service moved to LB Havering. The JAD helped partners to achieve a greater focus upon positive early identification and planning for discharges closer to the point of admission and away from a former level of conflict and attribution of blame and responsibility, sharing processes, systems and delivering on key themes such as 'trusted assessor' and shared accountability.

Redbridge has dedicated Hospital Social Work teams based in both Kings George Hospital (part of BHRUT acute provider) and Whipps Cross Hospital (parts of Barts Trust acute provider). These teams support the discharge of people with social care needs by providing a positive and quality experience for people leaving hospital who are in need of social care by preventing ill health through accessing preventative and reablement services, and where appropriate care packages. The Team ensure that the person, their carer, and family are involved in care planning and manage the complex interface between social care and the NHS.

3.1.3 Help Not Hospital & Escorted Hospital Discharge Service

Havering and Barking & Dagenham have commissioned the British Red Cross to deliver a 'Help Not Hospital' service, providing people leaving hospital or having presented at hospital, a supported return home. The target group are primarily people who may fall outside of, or just below, existing eligibility or access criteria of mainstream services. The Red Cross are delivering the service using a successful mix of paid and volunteer staff and are currently supporting 70 people per month. Partners are currently exploring the option of a transport service as an additional element to the service and are extending trusted assessor roles to service co-ordinators to enable direct access to assistive technology and digital solutions.

Outcomes have included:

- Referral to befriending services to address loneliness and isolation
- Support to access outpatient and follow up appointments and medication reviews
- Practical support to resolve domestic and environmental hazards

- Support to access services such as falls prevention
- Contributions to the completion of Home First discharge assessments

Redbridge commissions Age UK to provide an 'Escorted Hospital Discharge Service'. Funded by both the CCG and local authority the service supports around 280 people a year. It aims to:

- Increase health and social care cost efficiency by reducing the need for hospital admission or costly intensive / long term care;
- Improve capacity to maintain independent living following an episode of treatment or support
- Provide better outcomes for local people

The Escorted Discharge Service in Redbridge ensures that older people living alone who are discharged home from hospital have dedicated support to ensure that they travel in comfort, are settled back home and have adequate food, heat and support to meet their individual needs as appropriate upon discharge from hospital. This also includes transfer home and settling in at home, or settling in only, if the older person requires an ambulance for the journey home. Other key functions include:

- Meeting with the older person prior to the day of discharge
- Practical services such as: location of house keys, availability of mobility aids, sufficient food and drink and shopping for any essentials, ensuring that the utilities are working
- Ensuring that the older person is able to take their prescribed medication
- Making a home hazard check in accordance with falls prevention and fire brigade advice
- Notifying friends and relatives that the older person is at home and preparing meals / sandwiches and drinks for the first day home

This is followed up by home visits and referrals to other services if needed including information and advice.

3.1.4 Redbridge localities

Redbridge Community Health and Social Care Services (CHSCS) model was the product of BCF funding and support in previous years, now a fully implemented model of locality working CHSCS. See section 4.6 for further details.

3.1.5 Havering Integrated Reablement and Rehabilitation Service

An Integrated model of reablement and rehabilitation has been commissioned in Havering as a first step towards a wider intermediate care tier across BHR. The contract is currently held with NELFT on a 12 month basis, and is due to expire on the 17th April 2018. The contract was awarded for an initial 12 month period to allow Havering to explore a design for the wider intermediate care service model across Barking, Havering and Redbridge.

The principles of the integrated model included a joint access point for referrals, joint assessment process, single care planning and review process and weekly MDTs to discuss joint cases. Whilst the integrated approach has started to demonstrate some positive outcomes, more work is required to further integrate other services to develop a single, streamlined intermediate care tier across BHR.

3.1.6 Community Treatment Team

Although initially not strictly a BCF programme, the Community Treatment Team, developed as part of a wider programme of improvement to the Intermediate Care Tier of services in BHR, has been successful. Following public engagement and consultation, BHR partners were able to centralise and

reduce the number of rehabilitation beds across the system, creating a significantly more streamlined pathway for service users, and increasing intermediate care capacity eight fold with the creation of the Intensive Rehab Service and Community Treatment Team service delivering rehab and rapid response care respectively to people at home. The service was shortlisted for an HSJ award, supports people to stay well at home (avoiding inappropriate acute admissions), and receives consistently high service user satisfaction scores. We intend to further integrate and improve the intermediate care tier of services over the next two years through the iBCF as described in 3.1.15 above

3.2 Case Studies illustrating changes in the system:

3.2.1 Case Study 1: Home First

Ms S presented at A&E with an infection and confusion and was admitted to hospital. Ms S was successfully treated but staff were concerned about her ability to cope at home. Ms S lived alone and there was some concern that she had not taken as much care of herself since the death of her partner. Mrs S has a daughter who lives a long way away who was very concerned about her mother and the limitations on the support she was able to provide, this appeared to add to Ms S' concerns. Staff identified the need for further assessment and it was proposed that this would take place within the hospital setting, but Ms S was keen to return home and was becoming increasingly anxious. Recognising Mrs S wishes to return home, she was supported home with Crisis Intervention (support at Home) and assistive technology which were able to provide information that aided the completion of the assessment in the place and context of choice. Ms S was supported through referral to befriending services which helped to address her loneliness and isolation and through the short term intervention provided. Ms S was also referred for practical changes to her bathroom allowing her to safely use her shower and also for a medication review with her GP. Ms S is also able to skype her daughter which both better maintains contact but also provides reassurance to daughter as she can see her mother as they speak.

3.2.2 Case study 2: – voluntary sector partner – Help Not Hospital Service

Mrs B had a history of admissions to hospital and was described as being 'self-neglectful'. She was clear that she didn't want to stay in hospital and wanted to return home. Staff were concerned about her ability to cope at home and wanted to refer her for further assessments which she was unwilling to accept, worrying that this would delay her going home and fearing that she might not return home at all. She agreed to a referral to a recognised and trusted partner service such as that provided by the Red Crosses Help Not Hospital service / or Age UKs Escorted Hospital Discharge Service and the co-ordinator met with her and talked through their service and how it could help support her home. Mrs B was willing to accept their support, recognising that the organisations such as Red Cross /Age UK are well known and trusted, giving her confidence that she could be supported to go home straightaway. The offer provided assurance that she would be supported to return home and issues leading to previous admissions might be addressed and provided at a nil charge. Mrs B was escorted home where the service helped her access:

- Settle in - ensuring she was safe and she had basic provisions at home
- Medication review with her GP where her medication was changed to a more appropriate mix
- Referral to handy person scheme to address some of the environmental risks at home
- Referral to befriending service to address loneliness and isolation
- The service supported Mrs B for 2 weeks during which a positive relationship was built and she accepted a referral for a social care assessment which resulted in her receiving support with her personal care, support with her medication and meals. The assessment was completed within Mrs B's home environment.

3.2.3 Case study 3:

Ms Y was admitted to the hospital's short stay ward following a fall which required investigation; this fortunately revealed that no injury had occurred but her history indicated that she had had a number of falls previously. Whilst in hospital it was identified that she had Type 1 diabetes which wasn't being managed well with erratic medication consumption and poor diet contributing to this. Staff wanted Mrs Y to remain in hospital in order to stabilise her diabetes and for her to participate in the hospital's falls prevention service. This would have delayed her return home and Mrs Y was keen to get back home. Mrs Y was identified for Home First, reflecting both her wishes and the opportunity for identified needs to be explored and addressed within her home environment. Completion of the assessment identified that MS S's house contained a number of trip hazards which may have contributed to her previous falls. With Mrs Y's agreement a referral was made to the handy person scheme which was able to take a number of practical steps to reduce risks. Mrs Y was also referred for a medication review with her GP and to a dietician alongside accessing an exercise group aimed at older people with a focus on strengthening exercises to improve coordination and stamina. Mrs Y was also able to access a free eye test as she was concerned that her eyesight had deteriorated and was a factor in her falling.

3.3 Integrated Locality Working

In the context of constrained finances and rising demand, the Locality model of place based care offers our providers the opportunity to work, and utilise resources, differently. The way in which organisations work currently lends itself to duplication in the system, and can create artificial barriers to the delivery of health and care which can be frustrating to both those on the receiving end, and those delivering the care.

The locality model of care offers our providers the opportunity to work together to deliver a single set of clear outcomes for our population, utilising scarce resources (including practitioner and service user time) more efficiently. It also gives us the opportunity for integrated learning, expanding the knowledge base and skills of those on the ground and delivering a service that feels seamless and joined up to the end user. Research, at both a National and International level, corroborates that this is the best way to deliver high quality seamless care and improve outcomes for local people, whilst ensuring system sustainability.

To date, integrated locality models in BHR have centred mainly on variations of model around co-location of community health and social care teams. Section 4.3 sets out more detail about the BHR model and the progress being made towards the locality model.

3.4 What are our Challenges?

From our Joint Strategic Needs Assessments (JSNA) and detailed work set out in the BHR Accountable Care Strategic Outline Case, Jan 2017,, the following are a range of the key challenges facing the BHR system:

- Our rapidly increasing and changing population profile means we need a new approach to preventing ill health, targeting people who are more likely to require health and social care in the future.
- Resources required per head increase with age therefore any new service model and resource allocation must be appropriately designed to address these challenges given that Havering has one of the oldest populations in the country

- The BHR system has significant challenges to tackle including poor health and inequalities, care and quality and financial sustainability. We have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs and in some cases poor health outcomes. Demand is expected to be highest in more deprived localities.
- Barking and Dagenham is the 3rd most deprived area nationally with both a prevalence of long term conditions, below average life expectancy alongside an increasing population specific and marked increases in key groups; an example is a projected 56% increase in Older People over the next 20 years.
- Redbridge has an increasing prevalence of long term conditions in an ageing population and the combined effect of this and demographic is projected to result in an increased demand for hospital care of 65% more elective admissions and 54% more emergency admissions, and a 32% increase in demand for long term social care by 2030 if the model of care does not change
- Havering has the oldest resident population in London, yet also had the largest inflow of children in a six year period. It is estimated to have one of the highest rates of serious physical disabilities among London boroughs and one of the largest proportions of the population in the country with dementia and it is estimated that around half of people living with dementia are as yet undiagnosed. The proportion of children (aged 4-5 years) classified as overweight or obese (25.8%) is significantly higher than the averages of London (23.1%) and England (22.5%). The ethnic diversity of the population is fast changing too, having had a predominantly white, older population until very recently.
- Healthy life expectancy in Redbridge (63.1 years for women and 62.8 years for men) is below national and regional average, whereas Havering is above (64.8 years for women and 65.8 years for men). Barking and Dagenham (58.5 years for women, 59.8 years for men) is significantly below comparable figures in London (64.1 years for both men and women) and nationally (64.1 years for women and 63.4 years for men) in 2013-15.
- Patients have often found it challenging to access the right service, in the right place, at the right time. Our acute provider has seen significant improvement (it was placed in special measures back in 2014, but has since been moved out of special measures) in emergency flow, staff engagement and financial performance, however, broader system wide partnership is needed to address longstanding access issues, including increasing A & E attendances, admissions and waiting times for elective care.
- Primary care also faces significant challenges with a large proportion of GPs nearing retirement age, difficulty in attracting new talent and increasing demand.
- All this together has added to an already significant financial challenge – in order to continue providing services consistently and if the system were to deliver care in the same way that it does today without achieving change/efficiencies, expenditure in 2020/21 is forecast to exceed income by significant margin..
- Health Commissioners in BHR are facing a deficit of £55 million in 2017/18 which they are working to address, in addition to this Health providers (BHRUT and NELFT) are required to deliver their own Cost Improvement Programmes totalling circa £40m in 2017/18. This is in the context of a growing population with increasing Long Term Conditions and co-morbidities, and a sustained increase in the utilisation locally of urgent and emergency care. Recruitment of clinicians to the area, although being addressed through partnership working, will take a number of years to address, and BHR is running services with a number of vacancies and are faced with a large proportion of GPs approaching retirement age. Health outcomes for those living in BHR are

variable, with those living in Redbridge and Havering experiencing significantly better outcomes than those living in B&D. The infographic at Appendix 1 sets these challenges out in further detail.

Further detail supporting the background and context is provided within Appendix 2. This covers:

- Population profile and growth
- Health and wellbeing economy

3.5 The Future of Commissioning across BHR

As a result of Devolution opportunities and development of a Strategic Outline Case for BHR (to test the merits of the establishment of an Accountable Care System in BHR) we have a much clearer picture of what we can do together to address our challenges; we intend to explore the development of an Accountable Care System through integrated commissioning, and integrated provider delivery.

Commissioners will come together under a Joint Commissioning Board to test how we can be more strategic and joined up in the way that we purchase services. This will be a key enabler to support providers to integrate their delivery of services, and help the BHR system achieve financial sustainability. Partners are working on a high level timeline for this and have agreed that the iBCF plans will be a key enabler for testing joint commissioning going forward. The proposed high level timeline for this joint commissioning approach includes:

- October 2017 – agree a new service/model and pooled budget for integrated delivery
- October 2017 – March 2018 – work with BHR provider alliance to redesign service, agree outcomes, assure readiness and contract for delivery
- April 2018 - to mobilise new service
- For 2018/19, if this approach proves successful, we intend to expand the pooled budget to a full capitated budget; a set amount of money to deliver the health and care needs for a defined population, based on delivery of positive outcomes
- A robust gateway process for providers will be developed to support this process

It is anticipated that providers will respond to this by reviewing options for formal collaboration and agreeing how to deliver more integrated care, the structure this will take (e.g. Provider Alliance) and the supporting governance around the provider collaboration.

Commissioners have identified intermediate care as the priority scheme within the BCF plan for delivering the high impact change model and are proposing a joint commissioning approach to enable service redesign and contract delivery. This would be subject to the legal frameworks that underpin our respective commissioning duties.

BHR Partners have established a Joint Commissioning Board and are currently reviewing the potential extent to which all Health, Social Care and Public Health commissioning may be carried out jointly. The form and function of that activity is still to be agreed and designed, and, as set out in this plan, partners intend to test this through the iBCF.

The overarching vision for BHR is to:

‘Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services.’

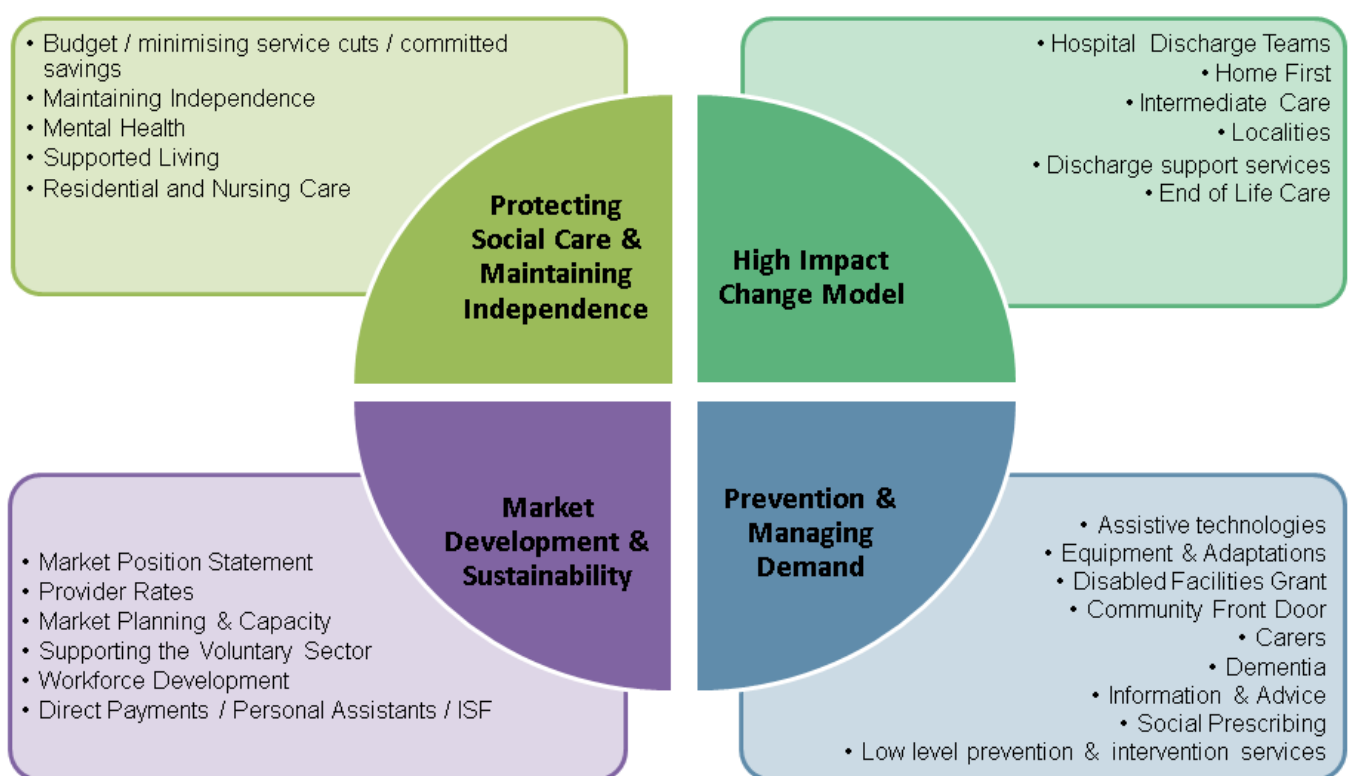
- **Create an environment that encourages and facilitates healthy and independent lifestyles** by enabling and empowering people to live healthily, to access preventive care, to feel part of their

local community, to live independently for as long as possible and to manage their own health and wellbeing

- **Organise care around the individual's needs**, involving and empowering them, integrating across agencies, with a single point of access, and providing locally where possible. It will meet best practice quality standards and provide value for money.
- **Ensure organisations work collaboratively**, sharing data where appropriate, and maximise effective use of scarce/specialist resources (e.g. economies of scale).
- **Remove artificial barriers that impede the seamless delivery of care**, bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.

3.6 Schemes

Our four thematic collections of schemes to move forward our vision and support integration are illustrated as follows:



Section 6 sets out further details of our plan and Appendix 3 provides the detail of the local schemes that make up the activity underlying the finance and metric submissions.

4. Local vision and approach for Health & Social Care Integration

Our vision for Health and Social Care was set out in our BHR Accountable Care Organisation Strategic Outline Case which tested the benefits of establishing an ACO / Accountable Care System in BHR, and potential additional powers required via Devolution to achieve this

Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services. These will be delivered by a system with the following aims:

- Enable and empower people to live a healthy lifestyle, access to preventative care, to feel part of their local community, to live independently for as long as possible, to manage their own health and wellbeing, which creates an environment that encourages and facilitates health and independent lifestyles.
- Where care and support is organised around the individual's needs, involves and empowers the service user, is integrated between agencies, with a single point of access, is provided locally where possible, meets best practice quality standards and provides value for money.
- In which organisations share data where appropriate, work collaboratively with other agencies and make more effective use of scarce resources (e.g. economies of scale).
- Where organisational barriers that impede the seamless delivery of care are removed, bringing together not only health but social care, but a range of other services that are critical to supporting our population to live healthy lives.

This vision was developed in response to the NHS Five Year Forward View, published in October 2014, which made clear the scale of the current challenges facing the local health and care economies, and the need to move forward collaboratively through new models of care. The Five Year Forward View set out the need for a step change in prevention, and suggested the types of new models of care through which local health and care providers could come together to deliver care closer to home, including Multi-specialty Community Providers, and urgent and emergency care networks etc. Exploration of the benefits of the establishment of an Accountable Care Organisation/System in Barking and Dagenham, Havering and Redbridge is a direct response to the challenges set out in the Five Year Forward View.

From an individual's point of view:

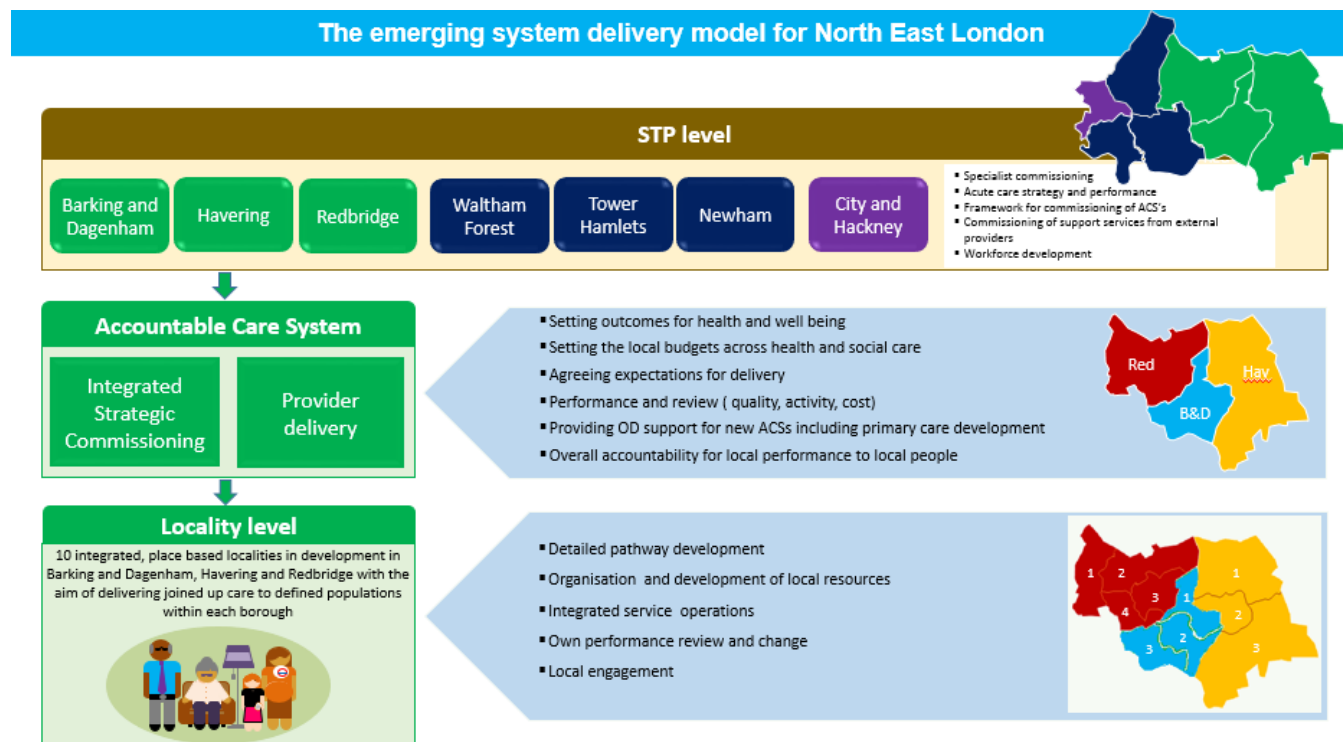
- The system will feel seamless and responsive to their needs. There will be clear information and advice about how to access services and ensure that they receive the right place, all of the time. Those working in health and wellbeing, including other critical support services such as local authorities, community care, public health and the voluntary sector will be members of a community of care driven by a shared vision.

This is a two year plan, but as set out across this document, the BHR Health and Care system is far more focussed on the bigger picture for integration. Within the plans, there are clear threads to the delivery of an Accountable Care system and the connected changes in ways of working, workforce, governance and financial management.

Each of the borough's HWB Strategies incorporates clear plans around managing demand, especially though the increase in self-management, healthy lifestyles and the links to some of the wider determinants of health – such as housing, children and families, education and skills. These are central both to this BCF plan to our Accountable Care ambitions.

4.1 What does this mean?

The following diagram illustrates the locality model, Accountable Care System, and Sustainability and Transformation Partnership in context, detailing some high level activities at each level.



It is acknowledged that certain services are only viable on a large scale, while others may be driven much more effectively at a local community level. Work is underway in each Borough to determine the appropriate layers for a range of community services – i.e. locality, borough, BHR, STP.

4.2 New model of service delivery

We are proposing to build a locality based model of care based upon the key principle of organisations working together to manage common resources to improve the health and wellbeing of a geographically defined population of circa 80,000 (as per the evidence set out by the King's Fund in *Place-based systems of care; A way forward for the NHS in England, Chris Ham Et al, November 2015*). This model builds on our local experience with Health 1000.

The proposed locality delivery model of care is designed to radically alter the way that residents access health and wellbeing services across BHR. Prevention will be the bedrock of the model, with a focus on early intervention and support at the point where it is the most beneficial to individual, family or community.

The Havering Adults design builds upon the Intermediate Care model. This model draws together Reablement, Rehabilitation, Community Treatment Team, Voluntary Sector services to build a connected, single approach to support people in their own homes, to reduce unnecessary admissions to hospital and accelerate discharge if admission was necessary. The Locality model widens the interaction and connectedness of agencies such as Housing, General Practice, Education and Skills, Benefits and the Voluntary Sector to recognise the impact on some of the wider determinants of health.

Each of the three BHR boroughs is integrating its health and social care services at a local level. Redbridge launched their integrated model on 1st April 2017, while Havering and Barking & Dagenham are in the process of integration.

In implementing the various integrated locality systems, each borough will share the opportunities for identifying good practice; lessons learnt and how further integration across services may be identified both with their own areas and across the BHR wider footprint.

Within its model Redbridge has already begun to identify and recognise the health profiles in each locality. Recognising that localities have distinct population profiles, with significant variation in age, ethnicity and deprivation driving the need for services, these enable a better understanding of needs, population projection and potential demand and planning for future services. However, further detailed work and analysis of how this will impact upon commissioning for services based on need; care quality, and resources variation across localities, is yet to be fully explored. Early identification of health and care needs at the beginning can reduce the inappropriate use of medical services and reduce need for or reliance on social care services.

With current models of care not sustainable given the current and projected increases in population and the increase in demand this places on the system, examining other models of care is forming part of a number of transformational activities for each borough. Integrated care pathways with more locally based services would potentially better serve the needs of the population.

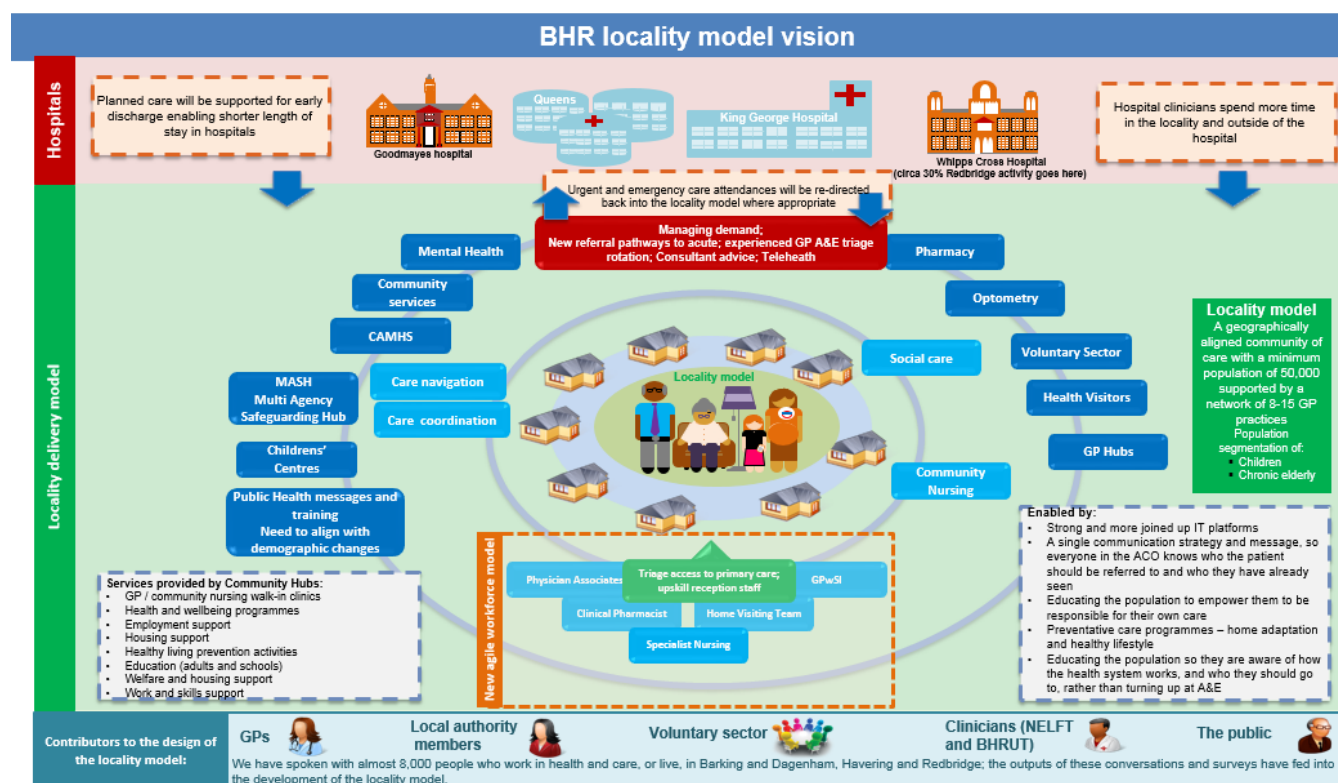
Key aspects of an aspirational integrated locality model could include:

- GP's working in a more integrated way with community, social care, pharmacy, dental and optician providers and professionals, the voluntary sector and local authority services to address the wider determinants of health such as housing and employment forming multi-disciplinary, teams, providing local people with the majority of their care, closer to home.
- Primary care will be proactive, accessible and co-ordinated with a stronger focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions.
- A universal health and wellbeing offer that focuses on self-care, prevention and integrated local services and a single point of access to assessment, support and treatment.
- A locality model gives the opportunity to target the specific needs of the locality communities.
- Further integration could lead to a reduction in the demand for acute care services and empower our population to be more responsible for their own health and wellbeing.

4.3 Key features of the locality delivery model

We are acutely aware of the need to be more strategic in how we react to growing demand for health and care services. The key elements of the new model listed below illustrate how our approach to work as a system will enable us to be more tactical, efficient and responsive to the health and wellbeing needs of our residents, delivering better outcomes for locality people and greater value for money.

For all of the reasons set out above, we believe that the locality model of care, supported by strategic commissioning across BHR is the best way forward to deliver quality services to local people, within the context of constrained finances.



4.3.1 Ambition:

- Universal health and wellbeing offer across BHR that focuses on self-care, prevention and integrated local services to improve local residents lives

4.3.2 Principles:

Remove where possible, or reduce organisational boundaries to support organisations to collectively treat a person, enabling better coordinated care; greater focus on early intervention and prevention activities; promoting individual empowerment and self-care

4.3.3 Scope:

Covering population of circa 80,000, providing primary, community and social care and local authority services that address the wider determinants of health such as housing, employment, diet and lifestyle, working together to form a highly effective extended team, providing local people with the majority of their care closer to home.

4.3.4 Design features:

- Multidisciplinary teams, involving clinicians and professionals from every part of the system collocated and working together to provide holistic treatment of a person as a whole, rather than a focus on specific disease pathways
- Tailored and flexible in terms of staff levels and principles to respond to specific population needs
- Centred on delivering primary care at scale (through GP Networks – highly productive GP practices working collaboratively to deliver primary care at scale)
- Coordinated care through collocation of services where possible in community hubs (making best use of existing community spaces), creating a single point of access to assessment, support and treatment, supporting our population to feel confident when managing their own care, and to be clear where to go when they require support

- Targeted and coordinated care through the use of population segmentation/stratification tools (moving away from current system which is organised around services and conditions, to one that focuses on population need and risk, identifying people who are likely to avoid serious health problems if early support is offered).
- Delivery of effective preventative interventions (screening, immunisation, proactive care, behaviour change support) at sufficient quality and scale to make a demonstrable contribution to improved outcomes and reduce demand amongst local people in that community
- Fully utilising a single care plan developed with people and their carers and enabled through common protocols and shared information platforms
- Implementing best practice, prioritising service change in pathways identified as requiring change to close BHR system gaps
- Use of existing and emerging evidence in decision making and service delivery including regular change reviews, updates and additions to the evidence base, and the creation of a mechanism for fast adoption of these findings into the transformation of care
- Empowering front line staff to effect changes and supporting PDSA (Plan, Do, Study, Act) approaches to transformation

The following sections set out the progress made so far with our integrated locality models and co-location of community teams.

4.4 Barking & Dagenham

Barking and Dagenham's locality arrangements between Social Care and NELFT are a key part of our integrated care services bringing together practitioners and staff clustered around GP practices. Our model continues to develop with new arrangements successfully implemented from April 2017, 6 clusters becoming 3 with a 4th to be implemented alongside the development of Riverside. We have introduced changes to the role of social workers and introduced the new role of Care Navigators. Critically development provides a tie in with our work to shift the completion of out of hospital assessment (Home First) to the community and in peoples own homes. For some time now there has been an ability to undertake joint assessments, particularly in cases where an individual's needs may be challenging and complex. It is also here that we will further improve the promotion of early intervention and identification of factors which lead to poorer health and dependency that may lead to hospital or bed based admissions and work collaboratively with colleagues and individuals to improve avoidable admissions to acute care. In any complex system it is helpful to provide capacity to both navigate through the system (ensuring that services can be accessed at the right time) but also to improve our intelligence about market gaps and opportunities, improving our engagement and local service development with the voluntary sector and others.

The further development of Barking and Dagenham's locality model is supported by the development of a Commissioning model which will ensure and shape alignment with key outcomes from both a social and whole system perspective, critically enabling each professional to understand their role and contribution to achievement, supported by new job descriptions delivered through consultation and restructuring. The Commissioning Mandate sets a number of key deliverables which include those of Care Act implementation and compliance, prevention and maximising self-care – improved management of demand, with enhanced wellbeing and specific contributions to local schemes such as those of End of Life Care and the utilisation of commissioning intelligence through work with individuals to inform commissioning intelligence and specifically the development of our Market Development scheme.

Our locality teams are currently working with 1900 people within the Borough, of these 318 are receiving bed based support with the remaining majority being supported in their own homes through a range of community based services. Our investment in Crisis Intervention as part of our Home First mix supports 200 people at any one time, alongside the provision of on-going support, 90 new assessments are completed on average each month.

As might be expected there is also a focus upon sustained improvement within existing metrics for social care which are:

- Social care-related quality of life
- Proportion of people who use services who have control over their daily life
- Proportion of people using social care who receive self-directed support
- Proportion of people using social care who receive direct payments
- Proportion of people using social care receiving self-directed support
- Proportion of carers receiving self-directed support
- Carer-reported quality of life
- Proportion of people who use services who reported that they have as much social contact as they would like
- Proportion of carers who reported that they have as much social contact as they would like
- Permanent admissions to residential and nursing care homes for younger adults (per 100,000 population)
- Permanent admissions to residential and nursing care homes for older adults (per 100,000 population)
- Delayed Transfers of Care
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

4.5 Havering Community Health & Social Care Service for Adults

The BCF Integrated Localities scheme in 2016-17 developed the design for co-located teams across Community Health and Social Care.

Phase 1 of the project (Co-location) is now complete with 41 adult social care staff now located across the 4 localities – Cranham, Elm Park, Romford and Harold Hill. Feedback from staff is generally very positive; good working relationships have formed in the teams and there has been improved communication and information sharing.

The focus for Phase 2 of the project is to move from co-location to fully integrated teams. There has been further review of current operational processes for both health and social care and identifying areas that can be joined up to support integrated working. Some of the key areas that are being developed are:

- Joint consent process
- Joint assessment process
- Joint care planning process
- Referral pathways between teams
- Review of community OT function across health and social care

Some of the workforce development that was planned for early 2017 has been postponed due to the development of the Adults Localities Model for Havering. This is a significant system wide programme of work which will expand on the current locality model to include other key services such as housing, pharmacy, voluntary sector, employment and welfare presenting a more joined up service with stronger inter professional relationships. The initial design of the locality model resulted in the locality boundaries being changed from 4 to 3; North, Central and South. The detailed design of these localities is currently underway and will inform any physical movement of staff required to meet the service demand in the new localities. The design will also inform further work required in terms of the integration of operational community teams.

4.6 Redbridge Community Health & Social Care Service for Adults

In April 2016 Redbridge Council in partnership with NELFT (North East London Foundation Trust) under a Section 75 agreement, launched its locality based integrated multidisciplinary 'Community Health & Social Care Service for Adults'. Based on four locality areas aligned to that of the GP areas of Wanstead, Fairlop, Seven Kings and Cranbrook and Loxford it has multi-disciplinary teams, which include:

- Adult Social Services and staff including Social Workers, Occupational Therapists and Support staff with internal provider services including Day Opportunities, Extra Care etc.
- NELFT services for adults Memory Clinic, Palliative Care, Tissue Viability, Continence, Nursing Services etc.

The service focuses on early intervention and prevention to support people who are over the age of 18 and are vulnerable older people; have a learning disability and/or on the autistic spectrum; have a physical and/ or sensory disability or a mental health issue. It utilises this through an enhanced 'front door' with a single point of access providing:

- Comprehensive advice and signposting informed by good local knowledge
- Crisis and quick intervention where necessary
- Greater focus on early intervention prevention through appropriate sign posting
- Initial well-being assessment delivered by skilled Wellbeing Officers
- Proportionate response with timely and appropriate referral handling

This approach ensures:

- A clear pathway developed with stakeholders including people who use the service
- There is a focus on person centred holistic support planning to maintain independence by promoting health and wellbeing
- That team responsibility for delivering a service based is based on where a person lives not presenting needs
- A joint assessment approach, which covers both health and social care needs
- A care coordination approach, which provides a single point of contact for people and their carers

Our vision for integrating our Health and Adult Social Services was to:

'Develop an integrated health and adult social care services delivery model which are person-centred; with increased focus on prevention and early intervention to improve outcomes and manage demand.'

A key difference between this integration work and other health and social care integration initiatives is that it is a provider-led process rather than a commissioning-led process, which means that our integration approach has enabled the focus to be on changes to the experience of people using the services. The integration re-organisation had two parts consisting of the of non-service user facing

adult social services and public health becoming a 'Hub' bringing together a range of strategic and operational functions that support integrated strategy and commissioning, contracts and procurements, resources, safeguarding and operational business requirements and the front line service user facing integration localities.

Integrating Adult Social Care Services and Public Health functions has enabled public health skills and expertise in population health to be directly applied to a wider range of service areas, including adult social care. The Hub would also work with children's services, and with the Redbridge CCG; and, across a range of other partnerships to improve health and wellbeing and tackle health inequalities. In addition, it would build on Care Act requirements by focussing on information and advice provided to people to improve their health and manage their own care.

The focus of the Hub is to:

- Provide leadership for social care, health and wellbeing
- Collaborate with partners around health and wellbeing improvements and reduce health inequalities
- Use evidence and intelligence for policy and strategy development
- Design and commission services and monitor service quality and outcomes
- Safeguard vulnerable adults and communities
- Focus on prevention and early intervention
- Support systems and processes to support the work of the CHSCS

The development of the integrated public health, adult care, community health and wellbeing service built on three existing Section 75 Partnerships between LBR and NELFT (and Redbridge CCG), which enabled teams to work together across NHS and Local Authority organisational boundaries. Prior to the restructure, NELFT IRS and CTT services complimented community health and social care services which were multi-disciplinary community teams providing learning disability and mental health support through a locality model. These formed the core of our new model of integrated care.

And given changes through the Health & Social Care Act 2012 and the Care Act 2014, that facilitated Public Health becoming part of Local Authorities and major changes to social care legislation, the governments vision for health and social care integration by 2020, plus programmes such as the Better Care Fund, our new model was influenced by both a national and local context, as well as built on existing partnerships, and therefore was aligned with this national move towards greater integration. It also increased national and local emphasis on place-based and person-centred care.

Furthermore, in line with national trends, we are developing and 'asset-based approach' to health and social prescribing initiatives to promote strengths based services and self-management. It was also anticipated that the locality clusters would link with local place based assets in the community; for example, health improvement services like smoking cessation, healthy weight support or local leisure, culture or volunteering opportunities.

We also developed a number of ['I' Statements](#) to monitor and check how the new service is making life better for residents using services. The key headings cover:

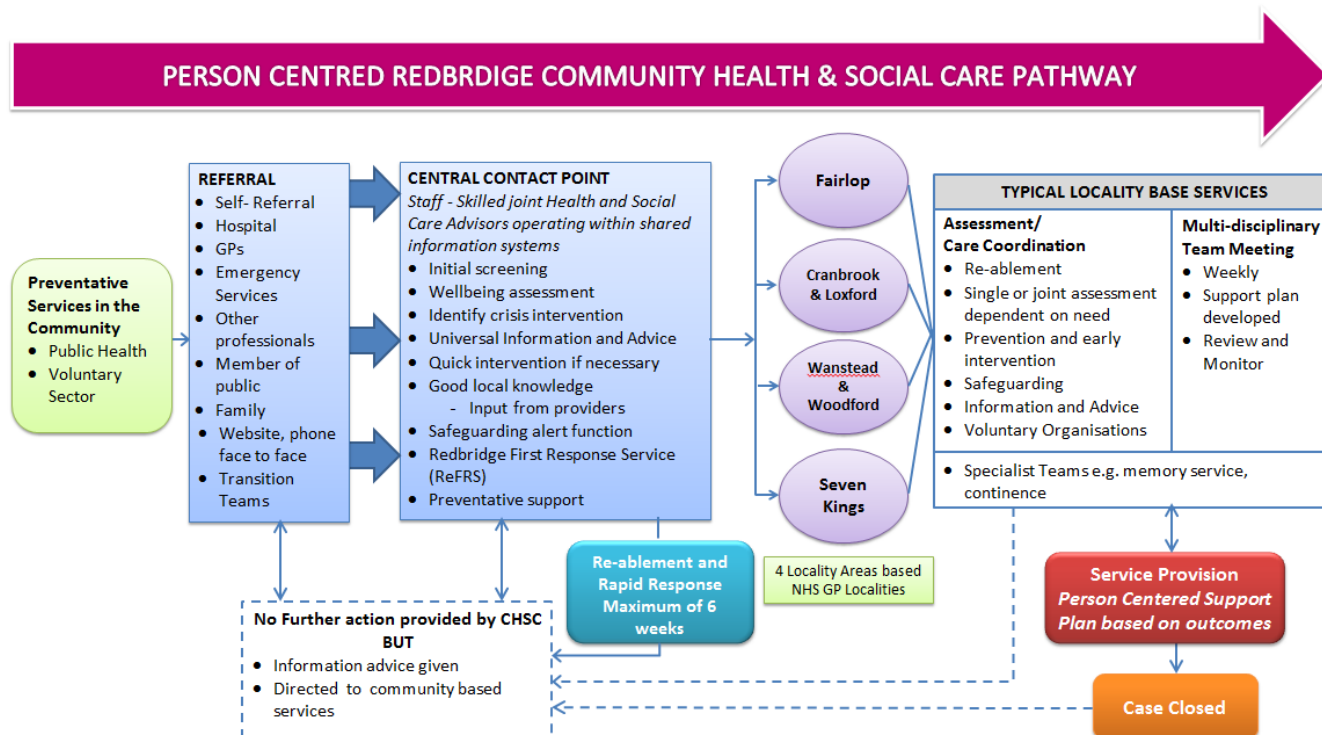
I get support that is right for me to make sure:

- I can access the support I need
- I know how to get good advice and information
- I know how to get good advice and information

- I know who my details will be shared with and what will happen next because staff talk to me and each other
- I know what to expect from services I am getting
- I can have a say in planning and monitoring future services

4.6.1 The Referral Process:

Individuals are to access the service through a number of routes, including self-referral, referral by family members, other members of public, health professionals and emergency services.



If further community health and/or social care support is required, individuals assessed by the First Contact Team (FCT) are assigned to one of the four areas depending on their postcode of residence (place-based care) for a single or joint assessment.

Aligning the locality bases with the GP Clusters was designed to fit with ongoing developments including Transforming Primary Care, the Urgent Care Vanguard and other activities designed to promote further integration across health and social care. This locality model reduces the opportunities for people to be passed around the system, removing ambiguity and identifying the responsible team based upon where the individual lives. This was identified as particularly important for individuals with multiple health and social care needs and where there ambiguity/debate about which service will take responsibility for their care and support, which can result in multiple care plans and assessments.

4.6.2 Key Achievements

As of March 2017, our new integrated teams had:

- Assisted 12,955 people with relevant information and advice about the care and support available
- Helped 1,020 people over 65 recover following hospital admission, living independently at home 3 months after
- 550 people who pay for their own services were supported to access suitable care services
- Supported 4,402 people to maintain their independent living arrangements in their own accommodation

- Helped 682 vulnerable people who were harmed by others in some way or at risk of being harmed
- Supported 2,443 people caring for relatives or friends
- Undertook 8,214 assessments or reviews
- Provided 6,795 people with care services such as personal home care, residential care and end of life care

Key achievements

- **More efficient working:** Leading to less duplication, easier communication, easier data sharing and data management, and facilitation of autonomous decision-making. And for service users, more streamlined and timelier referrals, reduced waiting lists, and improved information and advice.
- **Relationship building:** Working with colleagues from other disciplines in better understanding each other's roles, and developing shared goals.
- **Lesson learnt and good practice:** Providing valuable learning, building on previous work, to take forward to future integration efforts. Integration was felt to have led to an increased use of local data to inform strategy and commissioning, and to have provided opportunities for learning new skills outside of their discipline.
- **Improved care:** Lastly, integration to date was perceived to have influenced improved care for all three stakeholders, including the development of joint assessments. For service users, clearer care pathways, reduced bounce-back (each service user is everyone's responsibility), more patient centred approaches, and more holistic approaches to care and improved care was evidenced by fewer patients being passed around the system, more holistic awareness of patient needs and better health and social care outcomes.

4.6.3 The Future

Following our successful locality model development and implementation - future areas for progression would see a focus on improved communication, IT and further training opportunities. In addition, there is a need to increase efficiency through streamlining processes and procedures; increase the level and scope of integration including non-statutory services and GPs; exploring different models of service delivery with freedom for creativity; and, an increasing focus on prevention, preventing or delaying need for formal services.

4.7 How it will feel different:

The following material was developed in partnership with Healthwatch and tested with their volunteers and is intended to illustrate what tangible changes different groups will notice based on the proposals in BHR to develop more integrated commissioning and provider delivery to which the proposals set out in the BHR iBCF are a key enabler.

What will the proposed changes mean for me?


We have set out below what we think the proposed changes will mean to the people who live in BHR and the health and care staff who work here

Adult patient/service user



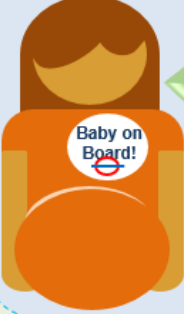
If you need support you will know where to get the information that you need. The service that you receive will be easy to access. You will have faith in the person that you speak to and will won't feel the need to go to hospital unless it is a true emergency. You will feel more supported and informed and will enjoy better experiences of health and care services and will find that the services or information and support that you receive meets your needs and improves your wellbeing.

Child patient/service user



If you need support or advice, you will know how and where to get this. You will have faith in the person that you speak to and will feel that your needs and opinion are being taken into account. You will find services simple to access and the information that you receive easy to understand and follow.

Families




Our families will be supported as a whole where a family member is experiencing issues. Health and care staff will have the freedom to seek to support you to resolve issues that may be the root cause of problems that you are experiencing e.g. You may be feeling anxious/depressed about mounting debt and worried about losing your home. This in turn could be affecting the behaviour of your family. We will look to support you to truly resolve your issues and put you in touch with the right people who can give you the information and support that you need.

Local people



You will understand where to access support and information when you need it and will be directed to the right information/services first time, so that you don't have to speak to lots of people before you get the right help. The support available to you will be easy to access and quick to respond and you will be supported to live as long, independently, and healthily as possible.

Paid carers



You will benefit from greater opportunities in the system as enhanced caring roles are created to ensure that the needs of our communities are met. You will benefit from training programmes alongside other roles e.g. social workers, and a greater understanding of your important role within the system. You will be aware of where to access support and advice that you need so that you can support those that you care for to remain in their chosen place of care for as long as possible, with fewer unnecessary visits to hospital.

Unpaid carers



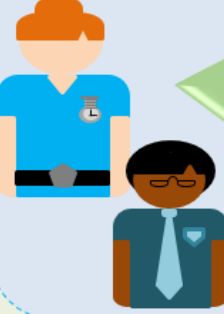
You will have more access to advice and information including the support that is out there to help both you and the person that you care for. Your health matters, and your needs will be taken into account. Your opinion will be considered when providing services to the person that you care for and you will feel confident to support your loved one/friend at home for longer and will be supported to feel as healthy and happy as possible.

General Practitioner (GP)



You will work closely with community teams and the front door of the hospital, with more influence over who is supported back home sooner. Information sharing between services will be more robust and you will be supported to address the wider determinants of health that may be the root cause of your patients issues e.g. housing/employment/loneliness etc.

Community clinicians, emotional health, Social Care & support staff and Pharmacists



We will work together more intelligently to increase the proportion of clinical time that you have with patients/service users. Different ways of working will give you the freedom and information that you need to fully support your service users and make each contact with them as impactful as possible, providing better and longer lasting outcomes. Barriers between services which you may find currently affect your ability to support people will be reduced where possible. The key role of community pharmacy will be utilised to it's fullest.

What will the proposed changes mean for me?

We have set out below what we think the proposed changes will mean to the people who live in BHR and the health and care staff who work here

Hospital Clinicians & support staff



You will be supported to provide a trusted, quality service which will help our residents to use emergency services only in an emergency, reducing the current demand seen at your local hospitals. New ways of working will build stronger relationships between different staff, regardless of who employs them, and will support an understanding of each others challenges so that these can be addressed.

Community & Voluntary Sector



You will be able to work more closely with health and social care to provide better outcomes for our communities. You will have more opportunity to influence the design of local services, and as the different organisations in the system work together more seamlessly with a focus on responding to identified 'need', you will be given the opportunity to work more closely together to deliver services that respond to this need and make best use of our resources to support people to self care and maintain their independence.

London Ambulance Service



Our new ways of working will provide you with a clear and trusted service so that you are empowered to make the right decisions for patients and can transfer or direct more people to community services (where appropriate) without the need for a transfer to Accident and Emergency.

A person who is struggling but doesn't currently meet service threshold criteria



If you are beginning to struggle, e.g. you may have recently lost your home due to falling behind on rent payments and may be relying on friends and family for support and to provide somewhere for you to sleep, we will provide services that meet your needs and can help you before your situation gets worse. Our aim is to support as things start to go wrong, before they get worse and have a lasting impact on your health and wellbeing.

4.8 High Impact Change Model

Work to deliver against the required elements of the High Impact Change Model is in progress; the work items have been managed by the Discharge Improvement Working Group on behalf of the A&E Delivery Board across BHR. A summary of the current status is provided in section 7.4.

5. Evidence base and local priorities to support plan for integration

5.1 Equalities

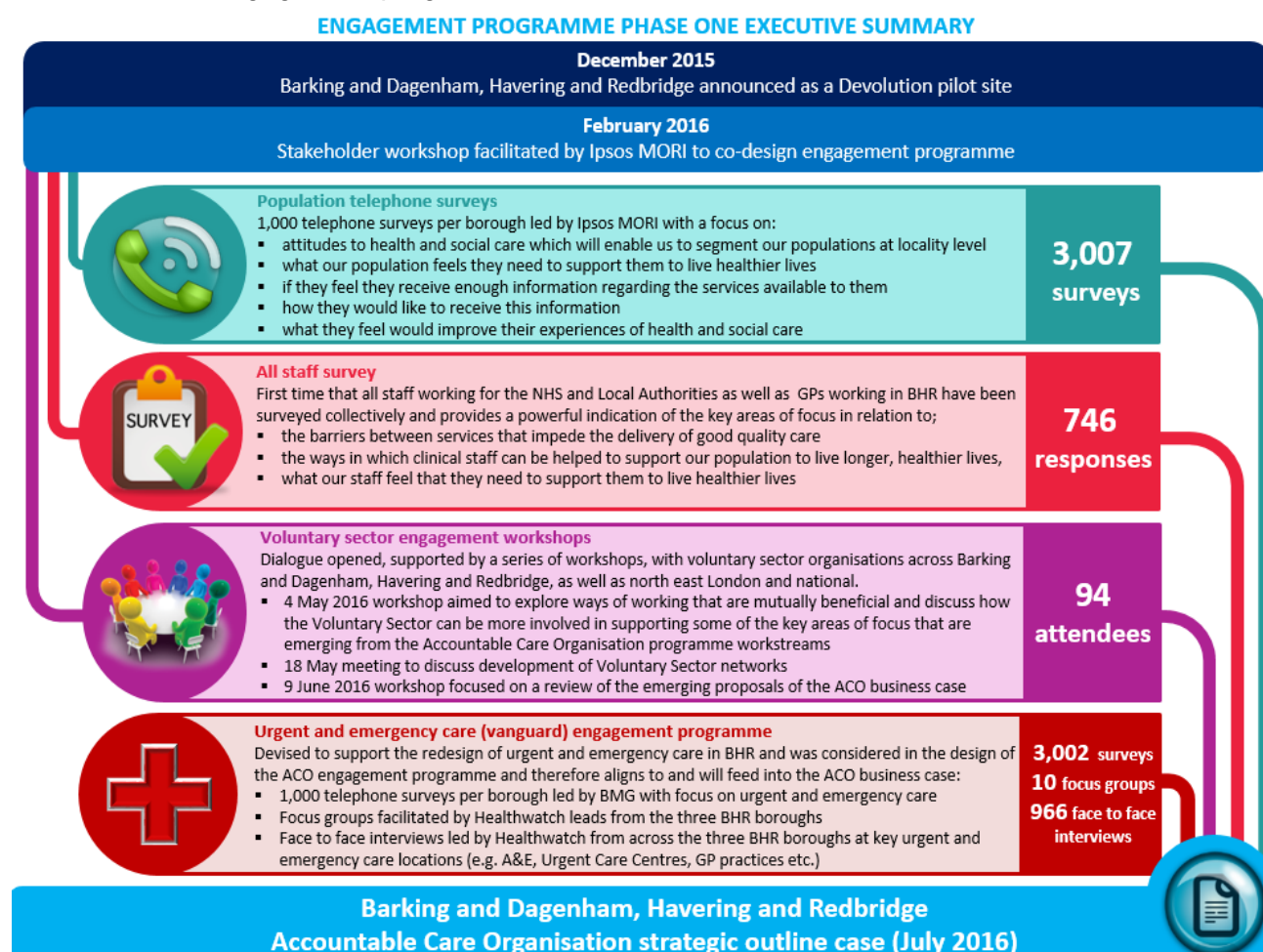
Our iBCF draws together a range of strategies and policies which have, in their development been subject to an assessment of their impact upon key groups within our population. In addition the iBCF is driven by national policy, designed to positively impact upon both the health and social care system and importantly, upon individuals improved health, self-care and wellbeing, seeking to address inequalities and improve outcomes informed by our Joint Strategic Needs Assessments.

In considering the development of our aligned plan across BHR, it is recognised that it is both complex and multi-faceted and, it is for this reason, that Equalities Impact Assessments are managed at a scheme level. Each scheme or project has its own EIA related to a particular strategy and policy. In principle, there are no expected implications for any one section of the community, but inevitably when any process or access route to services changes, there may be an impact that is unintended. Therefore, all changes will be subject to ongoing review to consider the EIA implications.

As a collection of initiatives, there will also be a review to ensure that the cumulative effect of changes has not or does not unduly affect any one cohort of people.

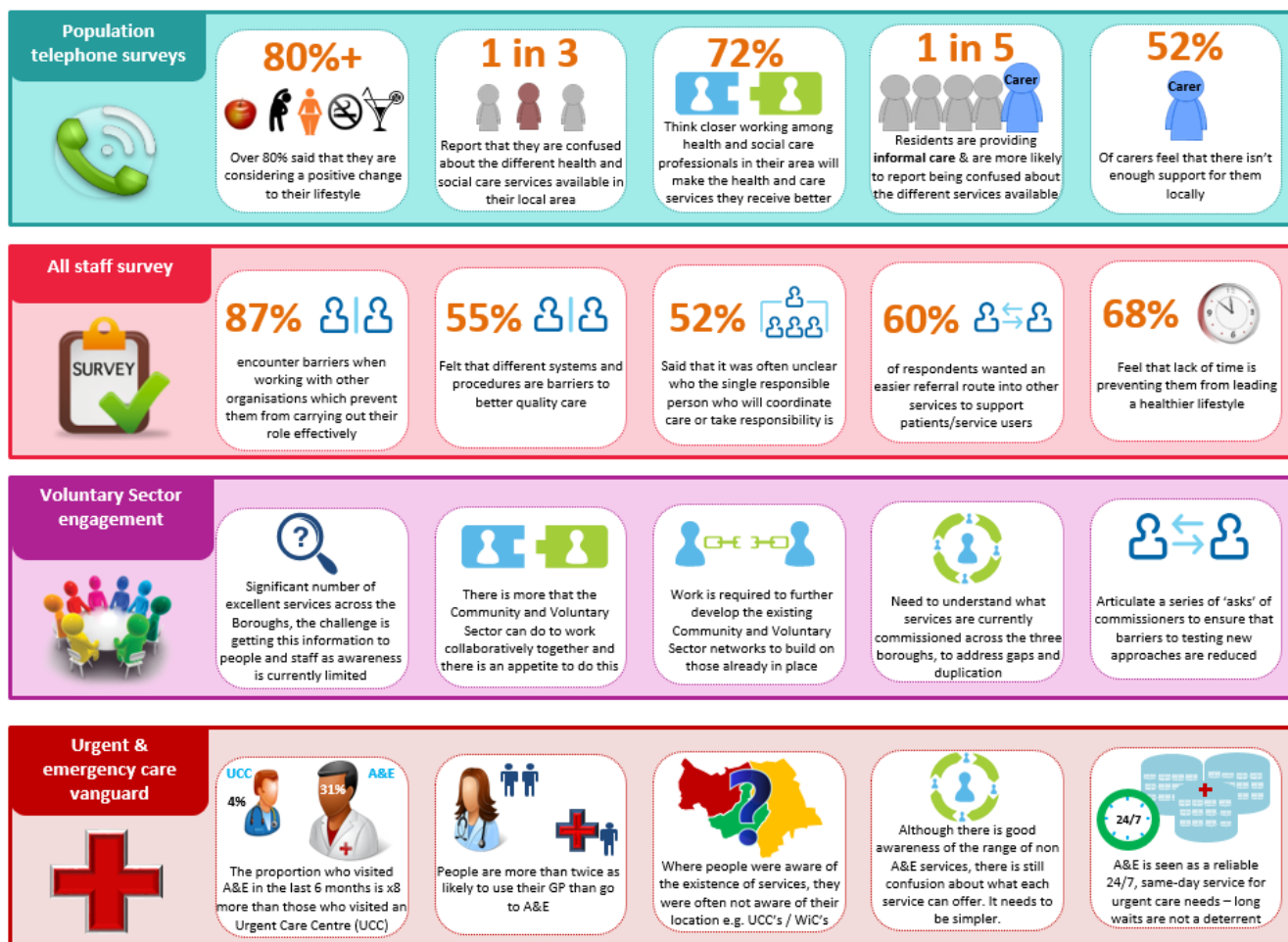
5.2 Consultation and Engagement

As part of the process to develop an ACO Strategic Outline Case, BHR partners embarked on a system wide programme of engagement with local people, service users, health and social care staff and wider partners including the community and voluntary sector (circa 8,000 individuals). A summary of key activities of this engagement programme is set out below:



5.3 Key findings:

ENGAGEMENT PROGRAMME PHASE ONE EXECUTIVE SUMMARY – KEY HEADLINES



Further recent engagement and consultation exercises undertaken by BHR partners include:

- Engagement around the **Sustainability and Transformation Plan** at a north east London level
- Engagement with over 3000 people are part of the **urgent and emergency care** improvement programme (detailed in the summary above)
- **Intermediate Care**: A formal public consultation on the future model of intermediate care services in Barking and Dagenham, Havering and Redbridge took place from 9 July 2014 to 15 October 2014 (14 weeks). 438 responses to the consultation were received: 413 questionnaires and 25 letters/emails. 50% of responses were from Redbridge, 21% from Barking and Dagenham, and 19% from Havering. The remaining 10% did not identify a Borough on the monitoring form. There was support overall and in each borough for the preferred option: home-based services where possible and one community rehabilitation unit on the King George Hospital site. There was strong support overall and in each borough for permanently establishing the new home-based services. Respondents generally thought people preferred to receive care at home, where possible, and agreed that this helps people to recover more quickly. They were keen to ensure that services were integrated and individualised. Respondents did not want NHS resources to be wasted on beds that were not used.
- **HWB**: Joint HWB Strategies are routinely consulted on and the work when published and reviewed.

5.4 Proposed changes in delivery model and commissioning arrangements

All of the challenges and evidence outlined so far (including engagement work) have informed and shaped proposed plans for a new service design and delivery model.

It is clear from the evidence outlined above that our existing model of commissioning and providing prevention and care is struggling to meet the current levels of demand. With future pressure from rapid demographic changes including population growth, rising levels of long term conditions and variable levels of deprivation, the BHR ACO SOC recommends a new model of service delivery supported by more effective joint strategic commissioning arrangements.

This approach is recommended following an extensive period of consideration of potential business and service models (including an Accountable Care Organisation). At this stage leaders have taken the view that form must follow function. The process of considering the ACO option has created a desire to further develop the system but in a phased and measured way. Going forward the programme is being framed in the context of an Accountable Care System rather than organisation, focusing on the changes set out below.

The three major drivers for joint commissioning

1: ACCOUNTABILITY

Cementing moves over the recent 18 months to bring both democratic and clinical leadership to health and social care planning.

3: SYSTEM LEADERSHIP

To make an Accountable Care System work effectively, commissioners must act in harmony and provide, as far as possible, a single voice to ACS partners. Most of all, conflicts of direction must be avoided if the ACS is to deliver for residents.



2: FINANCE

It is not expected that savings in joint commissioning alone are significant: care markets in particular are already under significant pressure.

Joint Commissioning of an ACS model must drive out the inherent financial perverse incentives of separate organisational interests

6. Our Better Care Fund Plan

6.1 Theme Summaries

Cross system schemes:

- **Intermediate Care** – joint commissioning of a new Intermediate Care tier, bringing together health and social care models and aligning commissioning interests around an outcome based model. Brings together community health, reablement/crisis intervention and voluntary sector. Rolling out deeper forms of trusted assessor within the model.
- **Home First** – delivering cross system changes required to ensure that discharges are timely and meeting the key principles as set out by NHS E. All boroughs participating.
- For LBBD and LBH, the hospital based, multi-discipline **Joint Assessment & Discharge** team continues to be supported, in LBR, the hospital discharge teams also continue to support BHRUT and Barts

Local schemes:

- LBBD:** MH, Localities
- LBH:** Community Front Door and Integrated Localities (both as part of the ACS Localities programme)
- LBR:** Supporting Hospital Discharge & Reablement, Localities, End of Life Care

High Impact Change Model

- Hospital Discharge Teams
- Home First
- Intermediate Care
- Community Front Door
- Integrated Localities
- Discharge support services
- End of Life Care

High Impact Change Model £'000	2017/18 Expenditure	2018/19 Expenditure
Barking & Dagenham	10,583	11,191
Discharge Team	651	651
Enablers for integration	1,117	1,481
Intermediate care	7,888	8,130
Mental Health	928	928
Havering	13,043	12,983
Discharge Team	849	600
Home First	433	350
Intermediate care	6,124	6,278
Locality Teams	5,636	5,756
Redbridge	10,481	10,582
Discharge Team	958	916
Intermediate care	5,706	4,454
Locality Teams	3,599	4,991
Mental Health	217	221
	34,107	34,755

Cross system schemes:

- Higher levels of DFG allocation (reflecting the removal of the Social Care capital grants in 2015/16) gives an opportunity to review the grants process and allocation.
- Support for Dementia continues in LBR/LBH
- Focus on Assistive Technology and equipment, including the work to integrate equipment services across BHR
- Information and Advice, including self-help

Local schemes:

- LBBD:** Prevention, Equipment, Assistive Technology and Digital solutions
- LBH:** Prevention, Integrated Locality Working, Integrated Community Front Door, DFG
- LBR:** Equipment, Assistive Technology, DFG and Falls Prevention, Dementia and Carers

Prevention & Managing Demand

- Assistive technologies
- Equipment & Adaptations
- Disabled Facilities Grant
 - Carers
 - Dementia
- Information & Advice
- Single Front Door Team
 - Social Prescribing
- Low level prevention & intervention services

Prevention & Managing Demand £'000	2017/18 Expenditure	2018/19 Expenditure
Barking & Dagenham	3,174	3,375
Assistive Technologies	470	470
Carers	777	777
DFG	1,391	1,517
Equipment	537	612
Havering	4,462	3,483
Assistive Technologies	158	50
Carers	130	130
Demand Management	2,621	1,623
DFG	1,553	1,680
Redbridge	6,229	6,629
Care Act	360	460
Community Front Door	3,406	3,531
DFG	1,822	1,984
Enablers for integration	641	653
	13,865	13,487

Market Development & Sustainability

- Market Position Statement
- Provider Rates
- Market Planning & Capacity
- Supporting the Voluntary Sector
- Workforce Development
- Direct Payments / Personal Assistants / ISF etc

All boroughs are facing both demographic and financial pressures on current and future services. Significant effort will be required to ensure that our health and social care services deliver better outcomes for our residents and minimise the impact of reduced funding levels.

Cross system schemes:

- **Market Position Statement** – for the first time, a single, cross borough MPS will be developed, enabling a joined up, cohesive statement of provider need, market development,

- **Workforce Development.**

- **Market development work**, including ensuring sustainability

Local schemes:

- LBBD:** Market development
- LBH:** Market review and development, Voluntary Sector Framework.
- LBR:** Market Development & Sustainability

Market Development & Sustainability £'000	2017/18 Expenditure (£'000)	2018/19 Expenditure (£'000)
Barking & Dagenham	1,592	2,150
Provider Rate Reviews	1,592	2,150
Havering	1,731	1,792
Placement Pressures	751	1,292
Provider Rate Reviews	980	500
Redbridge	2,409	3,000
Provider Rate Reviews	2,409	3,000
	5,732	6,942

- Maintaining Independence
- Budget / Avoiding Cuts / Committed Savings
- Mental Health
- Supported Living
- Residential and Nursing Care

Protecting Social Care & Maintaining Independence

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings when necessary. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

This protection of social care is against a backdrop of substantial reductions in social care budgets within the local authority's austerity response and funding formula changes.

Local schemes:

- LBBD:** Prevention and End of Life Care
- LBH:** Base budget protection
- LBR:** Maintaining Independence, Mental Health

Protecting Social Care & Maintaining Independence	2017/18 Expenditure	2018/19 Expenditure
Barking & Dagenham	6,409	7,521
Budget Protection	1,970	3,070
Care Act	628	640
End Of Life	105	105
Locality Teams	672	672
Packages of Care	3,034	3,034
Havering	3,424	5,907
Budget Protection	2,620	5,091
Care Act	632	644
Supported Living	172	172
Redbridge	4,871	6,082
Carers	130	130
Packages of Care	4,741	5,952
	14,705	19,509

Further details in relation to Borough schemes on activity and finance are contained in Appendix 3.

6.2 Disabled Facilities Grant

Statutory Disabled Facility Grants (DFG) will continue to be delivered via the Better Care Fund which significantly contributes towards helping older and vulnerable homeowners remain in their properties;

this meets one of the key aims of the BCF to prevent people from being admitted into hospital or residential care.

The boroughs have a significant population of elderly residents (over 65), particularly Havering, and as such have seen a steady increase in the demand for disabled facility grants. As a system there has been an increasingly joined up approach across health, social care and housing to help deliver adaptations to support people remaining in their own homes.

Traditionally disabled facility grants pay for a range of adaptations to people homes, including Level Access Showers, Ramps, Stairlifts and extensions to provide ground floor bedrooms and bathrooms. However we are aware that the incorporation of the DFG within the Better Care Fund is to encourage the Council and CCG to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes.

The funding increases for DFG will allow the Boroughs to adopt a higher profile for their provision of grants.

Greater use of discretionary funding, subject to changes in policy and further work required will lead to increased spend against this fund; it is recognised that there have been difficulties with allocating the full fund in previous years due in part to the lengthy nature of the means test, low take up and because the increase in the size of the DFG allocation in 16/17 when the Social Care capital funding was incorporated has taken some time to work through the system to support new developments of the scheme.

The Integration and Better Care Fund Policy Framework 2017-19 states that the national funding and allocation for Disabled Facilities Grant will be:

	National	Barking & Dagenham	Havering	Redbridge
2017 / 18	£1.115bn	£1.391m	£1.553m	£1.822m
2018 / 19	£1.499bn	£1.577m	£1.680m	£1.984m

6.2.1 Barking & Dagenham

Alongside a range of delivered solutions and innovations, Barking and Dagenham will deploy additional DFG resources to staffing to accelerate access to assessment to further improve the timeliness in our out of hospital solutions. This will further contribute towards Home First and HICM. The balance of resources is 88% individual applications with 12% total staffing contribution.

Home adaptations and assisted living enable disabled, vulnerable and older people to maintain their quality of life and improve their ability for independent living and self-care in their home. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs. Adaptations are carried out using the BCF funded Disabled Facilities Grant (DFG) in a variety of ways.

As well as the Mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Barking and Dagenham offers a discretionary DFG to 'top up' mandatory works where the cost exceeds the maximum mandatory allowance. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus avoiding the need for bed based stays.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System) and will recommend other works to reduce hazards like cold homes, and trips and falls. These works are then carried out using other funding set aside for Home Repairs Grants. Alternatively a referral may be made to Barking and Dagenham's Handyperson Scheme for minor repairs and improvements

While the Handyperson Scheme is funded from another budget, we are looking at options to expand on this service using DFG funding through the BCF. Priority is already given to residents about to be discharged from acute care.

6.2.2 Havering

Havering is reviewing how it manages its Disabled Facilities Grants to maximise the benefit of future increases in the Better Care Fund resource and intends to update its policy around the use of Discretionary Grants, to supplement the mandatory scheme and improve the options and support available to people with disabilities for essential adaptations to give disabled people better freedom of movement into and around their homes, and to give access to facilities within the home. See Scheme H5 in Appendix 3 for more detail.

6.2.3 Redbridge

Home adaptations and assisted living enable disabled and vulnerable people to maintain their quality of life and continue independent living in their home environment. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs. In Redbridge adaptations are carried out using the BCF funded Disabled Facilities Grant (DFG) in a variety of ways.

As well as the Mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Redbridge offers a discretionary DFG to top up mandatory works where the cost exceeds the maximum mandatory allowance of £30k. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus reducing the need for hospital stays and residential care. The discretionary DFG is particularly relevant for children's cases as adaptations need to be designed to meet the ongoing complex needs of a growing child and their family.

In some cases it is not possible to adapt the current home of a disabled resident. This could be because of the size, layout or planning restrictions in place. In such instances Redbridge also offers a Relocation Grant to assist with the cost of moving to a more suitable property.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System) and will recommend other works to reduce hazards like cold homes, and trips and falls. These works are then carried out using other funding set aside for Home Repairs Grants. Alternatively a referral may be made to the Redbridge Handyperson Scheme for minor repairs.

While the Handyperson Scheme is funded from another budget, we are looking at options to expand on this service using DFG funding through the BCF. Priority is already given to residents about to be discharged from hospital where they need help with moving furniture, fitting of key safes, home security and minor adaptations. Discussions are also taking place with our current provider to expand this service to include things like a home from hospital service which would further contribute to quicker hospital discharge. To support this DFG funding has been used in to part fund our Lifeline and Telecare systems (assistive technology) which allow vulnerable residents to remain independent in their own homes.

While continuing to offer the services outlined above, Redbridge is currently developing a new comprehensive Private Sector Housing Renewals Policy which includes major reviews of the provision of adaptations and repairs for vulnerable residents. This policy is part of a wider service review which will reduce processing times for DFGs. The following key policy changes are under consideration:

- An increase in the available top-up grant for Mandatory adaptations in excess of £30,000.
- An alternative disabled facilities grant to the current mandatory grant.
- A simplified means test and application process to enable speedier processing.
- An increase in the available Relocation Grant to reflect the increased costs of moving in London.
- A minor works grant to supplement social care equipment budgets with minor adaptations that cannot be covered by those budgets.
- Partnership working with neighbouring authorities in the Healthcare Trust to develop lists of competent contractors to work with us to provide quicker adaptations under a framework agreement.
- Partnership arrangements to enable rapid 'off the shelf' adaptations from stock.

6.3 Key Plan Milestones

Key Actions and Milestones

KEY ACTIONS / MILESTONES			BY WHEN	
			2017-18	2018-19
1	PLAN SUBMISSION			
1a	BCF Plan Approval	BCF Plan and Expenditure approved by local Executive Management arrangements and HWBs	8 Sep 17	
		2018-19 Plan revisions - Subject to guidance		Expected late 2017 / early 2018
1b	Submission of agreed narrative and expenditure Plans	Final submission to NHS England	11 Sep 17	
		2018-19 Revision submission		TBC
1c (i)	Plan Assurance	Outcome of assurance and plan approval	w/c 9 Oct 17	
		2018-19 Revision assurance		TBC

1c (ii)	Re-submission (If relevant)	If not fully approved, deadline for areas with plans rated approved with conditions to submit updated plans	31 Oct 17	
		2018-19 Revision re-submission		TBC
2	GOVERNANCE			
2a	Current BCF Section 75 agreements	Section 75 agreements to be in place <ul style="list-style-type: none"> Redbridge: Current s75 extension already agreed until March 2019 Barking & Dagenham: new s75 will be required for 2018/19 Havering: Deed of Variation to cover 2017/18 to be in place as soon as possible 	30 Nov 17	
2b	Joint BHR BCF Section 75 agreement	Proposal of joint BHR BCF Section 75 development	Oct-Dec18	
		Agreement to proceed with joint BHR BCF Section 75	Jan 18	
		Joint BHR BCF Section 75 to commence		April 18
2c	Local BCF Governance arrangements	Local joint Executive Management groups continue and ensure BCF implementation	Continue until Mar 2018	
		Local executive group arrangements for BCF governance move to Joint Commissioning Board (JCB) as part of ACS plans		April 18
2d	Scheme Implementation	Schemes continue implementation and delivery through Executive Management arrangements and HWBs	Until 2018	
		Potential Scheme Revision for 2018-19		TBC
		Schemes continue implementation and delivery now overseen by JCB and HWBs		April 18

2e	Theme / Schemes	<p>See section 7.4 for HICM milestone dates</p> <p>Although the themed schemes (see Appendix 3) are planned over 2 years, they will be reviewed at the end of each financial year to monitor the work being undertaken and delivered, continues to reflect the BCF ambitions and our vision for integration.</p> <ul style="list-style-type: none"> • HICM • Prevention & Managing Demand • Market Development & Sustainability • Protecting Social Care & Maintaining Independence 		
3	METRICS & SCHEMES			
3a	iBCF Quarterly Reporting	Submission of Quarterly Reporting templates	<p>Q1 - 21 Jul 17 (Completed)</p> <p>Q2 - 20 Oct 17</p> <p>Q3 - 20 Jan 18</p> <p>Q4 - 21 Apr 18</p>	TBC
3b	Review of iBCF Grant allocations for DToC metric	Government will consider a review of 2018-19 allocations of the iBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care.	Nov 2017	

7. National Conditions

7.1 National Condition 1: Jointly Agreed Plan

Our Better Care Fund Plan builds upon the work previously undertaken to develop our application for Accountable Care system which was subject to a significant level of consultation and engagement, details are provided within Appendix 2. The emphasis of the business case development process was on a coherent strategic direction for the health and social care system across BHR, so that if an Accountable Care organisation was not deliverable, there will still be strong strategic direction articulated for the long term integration of services. This includes how to deliver the best outcomes for local people, ensure future capacity, plan workforce requirements and scoping of the implications for both local providers and the regulation of services, as part of a potential set of devolution 'asks'.

The plan is also grounded within respective HWB strategies, the CCGs operating plan and the East London Health and Care Partnership sustainability and transformation plan.

We have also sought to take a three borough joint approach cementing an alignment of our plans across BHR HWBs, with our intention that this year provides a basis upon which steps towards increased integration be delivered within year two. Such steps and options will necessarily involve all our key stakeholders and scrutiny through governance of Boards, and clearly will represent a marked shift in operational delivery across BHR. This will include collective analysis of our respective communities in terms of the health and social care footprint, so that we target resources to build resilience and address social inequality.

To expedite the plan within the timescale provided, recognising the potential lack of alignment with scheduled HWB meetings, we have previously secured delegated authority to the HWB chairs to sign off 2017/19 plans, however advanced drafts have been presented at the respective HWBs meetings in August/September with final drafts been circulated to Board members for comments prior to delegated authority sign off, therefore, ensuring the opportunity for all Board members to engage.

We have also acknowledged that with the inclusion of the new social care grant monies into the BCF and key grant conditions, such as stabilisation of and development of the market, this is an iterative process through which on-going engagement with providers and others will be key, and addressed within our shared Market Development scheme. We have collectively reviewed progress over the last year, which has shaped our thinking in terms of ensuring synergy across the wider geographical footprint. We agree that by joining up market shaping strategy we will be able to demonstrate increased transparency and sustainability, through both better economies of scale and more informed commissioning. We recognise the importance of ensuring that 'wrap around' community support is available at the right place at the right time, to enable safe and effective discharge from acute settings, and feel this is best achieved collectively, in line with our Integrated Care Partnership vision.

In addition key partners have steered our work in the development of Intermediate Care – a clear example being through the form of the new developed Joint Commissioning Board and grounding our implementation of key principles relating to Home First through the A & E Delivery Board.

The BCF plan has involved and engaged the signatories.

7.2 National Condition 2: Social Care Maintenance

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with where required, very occasional admissions to acute hospital settings. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local Health system would quickly become unsustainable.

The partners recognise that adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, at the right time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

This protection of social care is against a backdrop of substantial reduction in social care budgets within the local authority's austerity response and funding formula changes. The guidance gives weight to the Protection of Social Care. This plan describes the approach we will take to ensure the most effective protection of services.

BCF funding will be applied into the Councils' base budget which will better protect against services being stopped or reduced and with Social Care Grant monies, support our shared Market Development Scheme across BHR which will critically look at the broader market for care and support. For Councils, the recent context has been one of a sustained reduction in available resources at a time of demand growth. All steps here are supported through our focus within the BCF of improving our management of social care demand which would otherwise have seen sustained growth outstripping available resources.

The extent to which core social care services underpin the effective working of the health & care system is in little doubt; the consequence of not supporting base budgets in this way is a risk that there will be a collapse of key elements of social care, which in turn would collapse the health system locally. Investment in social care supports whole system flow and while it may not be so visibly linked to the immediate needs of the acute sector and DToC specifically, the effect of the absence of good social care is quickly evident. Social care services are cost effective and in some cases, can offer a viable alternative to health managed and delivered services.

The Local Authorities are keen to ensure that additional funding from Government is used to deal first and foremost with structural social care deficits within their budgets – examples of particular areas of pressure are in reablement and Crisis Response spend all of which have a particular and clear health benefit; and linked to this therefore, targeting improved market stability in the home care and residential care markets. The LAs noted that delayed transfers due to social care remain at negligible levels, as social care continues to support getting people out of hospital and address delayed transfers, leading to localised market capacity issues and budget pressure (overspends). Greater use of residential care and residential with nursing care places across the boroughs might destabilise those markets locally or push prices up for Local Authorities but there is opportunity to work together to minimise any impact and we are seeking the development, through our Market Development Scheme of a shared market development approach.

The CCG contribution for 2016/17 and 2018/19 are included within the planning template for each HWB and reflect the required increases (inflation). No additional funding increases have been agreed.

7.3 National Condition 3: NHS Commissioned Out-of-hospital Services

The Five Year Forward View has a significant focus on out of hospital services and their key importance in ensuring that services are designed around and respond to, the needs of local people, delivering care in community settings where possible to ensure future sustainability. BHR partners, through the Integrated Care Partnership, have been working together to develop out of hospital services that are integrated and responsive. Part of this model involves locality development; health, care and third party organisations coming together to deliver care to local populations of circa 80,000 people, and there has also been a strong focus on developing the 'intermediate care' tier of services in BHR, with the establishment of services such as the Intensive Rehab Service and Community Treatment Team, delivering rehabilitation in people's homes and a rapid response service respectively, designed to support people to stay at home without the need for an acute admission.

BHR Partners have made clear throughout this plan their intention to further integrate and support the intermediate care tier of services, alongside locality development, both of which are fundamental enablers on the BHR system's journey towards becoming an Accountable Care System. These proposals include both health and care.

The BHR CCGs reviewed the model of intermediate care in 2014 and agreed a new model that permanently established community treatment teams and an intensive rehabilitation service across the three boroughs. Investment was made in community based services that enabled a reduction in community rehabilitation beds and their co-location on the King George Hospital site.

New referrals into these community services are reported below:

	Q1 (16/17)	Q2 (16/17)	Q3 (16/17)	Q4 (16/17)	Q1 (17/18)
CTT	3,128	2,993	2,705	3,461	3,109
IRS	527	463	381	374	334

Transfer rates from acute to community rehabilitation beds are good with an average transfer rate in quarter 1 2017/18 of 1.79 days across the BHR CCGs which is below contractual KPI target of 3 days (72 hours).

These services are commissioned under an NHS standard contract for community health services and are part of a block contract. The service line budgets reported are indicative and based on un-validated information from the provider. Confirmation of service line budgets is being taken forward through the CCG contract management process.

Intermediate care is one of the high impact schemes that the partnership has prioritised in the BCF plan. A need to develop a more integrated and flexible model has been identified through the A&E Delivery Board, recognising that it will form the delivery model for Home First.

The CCGs and Local Authority commissioners will be taking this forward through the development of joint commissioning intentions for 18/19.

7.4 National Condition 4: Managing Transfers of Care

Fundamentally, our BCF Plan is aimed at ensuring that a new BHR model of care is delivered, building on the improvements across the BHR health and care system over the past couple of years and using the momentum of the Integrated Care Partnership Board's aim to create an Accountable Care System to deliver substantive shift in all aspects of health and care pathways.

The improvement work undertaken in the BHRUT and Barts acute hospitals to improve patient flow could not be as successful as it has without the support of clear discharge pathways, home care provider markets, community health services and social care assessment and provision.

The introduction of the Joint Assessment & Discharge Team for LBBB & LBH, alongside the LBR Hospital Discharge Team has enabled BHR's performance on delayed discharges to be among the best in London and in England. Delays due to Social Care are minimal; delays due to NHS are largely due to high volume of complex cases – often awaiting resolution of the Continuing Health Care funding process.

Through our A&E Delivery Board we have agreed a programme of work to improve early discharge and reduce DToCs. We address these through our Discharge Improvement Working Group that looks at discharges across the pathway from acute to local councils. This includes simple and early discharges from the Trust through to complex patients involving Continuing Health Care and Specialised services. It is worth noting that BHRUT has agreed to underwrite the setting up of the discharge improvement plan with £400k. This recognises that as discharge to assess and other initiatives are embedded there can be cost pressures building in the system. For example care packages may require an initial higher value to discharge a complex patient but with intensive review this will reduce in the medium term. This would put undue pressure on social care budgets and therefore the underwriting is helpful to ensure this is mitigated.

We are not complacent about the challenge, and continuous improvement of processes and pathways is expected to be delivered through BCF activity in this plan. For example Havering and Barking & Dagenham have already jointly commissioned a Help Not Hospital service with the British Red Cross (while Redbridge commissions Age UK), to facilitate smooth accompanied transfers' home from hospital, making links to wider support in the community for those that need it. Integrated Locality arrangements as described above are ensuring greater connection between community based services, and these are set to improve still further with the development of the Localities model.

In Havering, the newly commissioned Integrated Reablement & Rehabilitation service has delivered faster discharges, with reduced assessment and paperwork, with a higher proportion of patients being discharged within 24 hours of being declared medically fit, often much quicker. The model of working is now also being tested with LBBB's Crisis Intervention providers, also removing assessment steps wherever possible. The principles of Home First and Discharge to Assess are embedded in both of these services.

7.4.1 Simple Discharges

Our programme is based on the implementation of the Red / Green SAFER bundle as recommended by ECIP. This includes wards restarting packages of care to avoid delays, therapists referring directly into reablement, streamlining assessments and paperwork between the different teams. This has significantly improved the admitted flow and early discharge at the hospital. SAFER is to be rolled out to all hospital wards from September 17. The stranded patient metric (those with a LoS over 6 days) is being used to monitor flow. Where the LoS metric triggers advance warning of flow and discharge being an issue (and in advance of bank holidays and other holiday periods), the system comes together through mini-MADEs (multi agency discharge event) where all partners review patients to ensure that any clinical / managerial delays are challenged. This addresses risk averse behaviour within the Trust in discharging some patients back into the community.

7.4.2 Complex Discharges

The health DTOCs are relatively low across BHR and there is joint work in place through the system - wide Discharge Improvement Working Group to ensure that the numbers meet the trajectory. The programme to manage health delays has been agreed through this group and we have nominated key domiciliary providers who we are trialling the discharge to assess arrangements. The CCGs are appointing a CHC Clinician Home First Lead who will work on discharge protocols with the Joint Assessment and Discharge team. We will be working with home monitoring systems for complex discharges at home to demonstrate nursing home requirements. An interim discharge to assess arrangement is in place, with 10 commissioned beds that the Acute hospital are using. The plan is to implement a full programme to deliver 80% of CHC assessments outside hospital (May performance was 44%).

7.4.3 Mental health delayed transfers of care

Mental Health DToCs performance for Q1 2017/18 is summarised below:

CCG	Requirement	Threshold		Apr	May	Jun	Jul
B&D	Delayed Transfer of Care	< 7.5%	Adults	0.0%	4.8%	0.0%	0.0%
			Older Adults	0.0%	0.0%	0.0%	0.0%
HAV	Delayed Transfer of Care	< 7.5%	Adults	0.0%	4.8%	0.0%	0.2%
			Older Adults	15.5%	13.6%	*13.0%	10.7%
RED	Delayed Transfer of Care	< 7.5%	Adults	3.41%	3.30%	6.60%	5.80%
			Older Adults	0.00%	0.00%	0.00%	0.00%

***NOTE:** This relate to two complex patients which are very challenging to place. One is subject to court proceedings

Generally MH DToCs are managed well, with 0 DToCs reported consistently for older adults in B&D and Redbridge in Q1, and 0 DToCs for adults in B&D and Havering in 3 of the 4 months of this first quarter. Where DToCs occur, as with the Havering older adults DToCs highlighted above, this can be due to particularly complex patients.

Mental health inpatient services are provided for BHR by NELFT as part of an integrated acute pathway. The model of service (identified as an exemplar of good practice for acute care) is of a low bed base and enhanced community provision. This model is based on a continued focus of average length of stays, readmission rates and delayed transfer of care to ensure optimum throughout is achieved and maintained. DToCs are managed by the provider through weekly bed management meetings with Local Authority input.

We have undertaken an initial assessment of local DToC performance and drivers for DToC as requested by NHSE in January 2017. The drivers identified are: access to accommodation particularly where supported accommodation or complex residential /nursing care is needed. This would also include patients who have no settled accommodation, or are homeless, who do not need specialist facilities; delays in agreeing funding for patients where 117 aftercare applies; and Community Recovery team Care Co-coordinator capacity to arrange post discharge packages of care for admitted patients within optimum timescale. We are working with our Local Authorities to produce and deliver a local

mental health DToC action plan which will address these issues in addition to escalating and jointly managing the particularly complex cases associated with some lengthy DToCs.

The key components of our action plan are:

- Developing common and borough-specific actions to agree a trajectory to achieving the London standard of 2.5%
- Agree joint LA/CCG 117 funding apportionment methodology and to review and refine process for funding decisions
- Consider how to increase Community Recovery Team capacity

Progress on actions is as follows:

- We have undertaken a series of workshops to develop a pan-BHR s117 policy and have made good progress towards this goal
- We have further work planned with local authorities to agree detailed borough-based actions on access to accommodation.
- Commissioners are considering options for increasing CRT capacity with our provider.

Whilst we have seen improvement in Older People with MH delays, Barking and Dagenham is making additional investment in Mental Health over the next three years or £500k each year across 2017/18, 2018/19 and 2019/20. This level of investment, is in part supported by monies provided within the new social care grant with 50% each year specifically allocated to improving discharges and (DToC) with the remainder providing recurrent investment to base budgets. This investment will see the delivery of independent living beds and floating support services providing a step-down model which will not only positively impact upon discharge and improving system flow, but also work to avoid where possible admissions to bed based or acute services. Tender is pending completion which will strengthen our personalised, community offer across care and support settings. Such innovations will be complemented by broader changes such as the implementation of 9 new Care Navigator roles and the advent of our community solutions service in the autumn. Based upon our analysis we conservatively expect this to positively impact upon delayed bed days by at least 90 beds days a quarter.

In Havering, the majority of Social Care related delays are related to non-acute beds; they are Mental Health related beds with a small number of patients for whom highly complex placements or care packages are needed but extremely difficult to source. Work is being started to review these patients in Havering to determine whether additional commissioning is required; this may be done on a BHR footprint if required to deal with similar cases in B&D or Redbridge.

Within Redbridge we are about to embark on a review of our supported living accommodation. We are reviewing the requirements for this type of accommodation and are considering options both related to the accommodation itself and the support itself that is provided. We are also commencing discussion with housing colleagues about how we can best move people on from supported accommodation to general needs housing. We are considering how housing and social care can improve working more closely together to improve accommodation outcomes for people with mental health problems. Currently there is a bottle neck to move people on from supported living, given the challenges in regards to accommodation being available within Redbridge generally. The discussions with housing will focus on improving the move on process from supported accommodation and how best people can be supported within general needs housing.

7.4.4 High Impact Change Model

The BHR system's assessment of readiness against the High Impact Change Model framework is set out below.

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Early discharge planning	Plans are in place	Rollout Red to Green EDDs set in a timely manner Set expectation on admission	TBC	LOS will reduce Improved patient flow Patients informed regarding plans/ treatment options Increased No. of green days
Systems to monitor patient flow	Plans are in place	Consistent systems within Trust that provide accurate info/ patient status in real time	TBC	Easy identification of barriers to discharge
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Establish/ mature	Increase CHC assessments outside of hospital Full implementation of home first approach	October 2017	Improved patient flow and experience Increase of patients returning home Reduction in placements
Home First Discharge to Assess	Plans are in place	Improve internal discharge processes ie. TTA's, transport	October 2017	Improved patient flow and experience Increase of patients returning home Reduction in placements
Seven-day services	Mature – Social Care Plans in place - Hospital	Whole system to operate at this level Clinical cover/ decision making over weekends for discharge	Social care already provides seven day service TBC - Hospital	Consistent discharge picture through the week
Trusted assessors	Plans are in place	Primarily using Therapy reports to commission home care services	October 2017	Minimise duplication Improved patient flow and experience Reduce DTOCs
Focus on choice	Plans are in place	Protocol and processes in place to be understood and followed	October 2017	Choice issued at correct time Reduction of choice delays Patients aware of discharge expectation on admission
Enhancing health in care homes	Plans are in place	Care home staff and primary care to manage patients in community	TBC	Reduction in admission from care homes

Through the A&E Delivery Board, the BHR system is developing a single urgent and emergency care delivery plan which will incorporate actions for delivering the high impact change model. The development of a single plan reflects the need to manage care across the urgent and emergency care pathway from admission avoidance through to discharge. The plan is due to be signed off by all partners by the end of September 2017.

7.5 Home First

We have embarked on plans for the implementation of a Home First / Discharge to Assess model and to move towards a Trusted Assessor operational delivery approach. Delays attributable to social care are low with BHR performance within the top quartile. Across the partners there is work underway to on discharge pathways, therapy services, patient flow and within Havering first steps have been made towards integrated reablement services, with alternative models applied in Barking and Dagenham and Redbridge.

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 is for a phased approach, building on existing first steps such as the new integrated Reablement and Rehabilitation service, revised Acute Therapy pathways and work starting now on the CHC discharge process.

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.

Work currently underway is aimed towards implementation of a 'Home First' model by the end of September 2017.

7.5.1 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

7.5.2 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

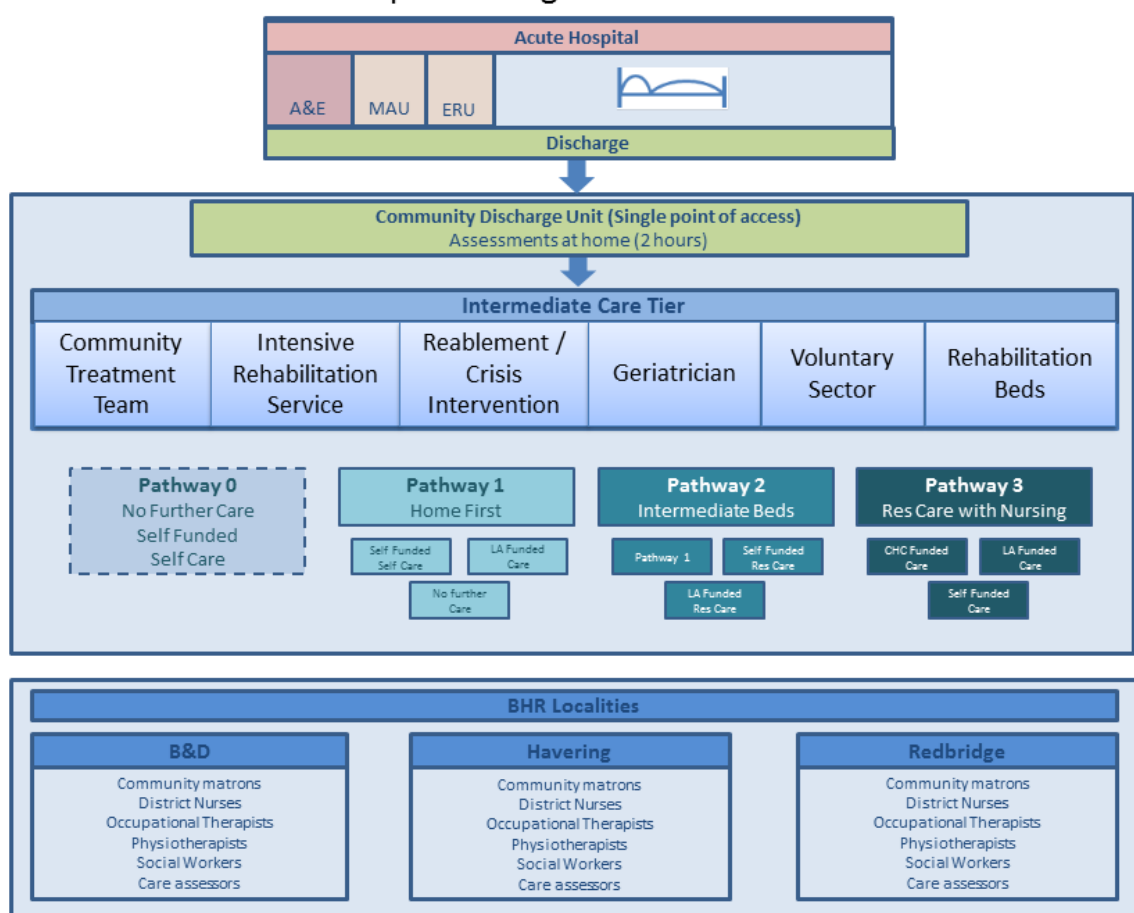
This principle around ‘Home First: getting you home’ will require health and social care partners to challenge current practice and change mind-sets and through collaboration ensure sufficient quality of service, demonstrable change and agreement on how best to allocate resources and funds and share 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.

For operational reasons, Havering has pressed ahead with the implementation of a new model of integrated Reablement and Rehabilitation. Any ‘Home First’ model will need reflect the current work in Havering to develop an Intermediate Care Tier built upon the this service.

7.6 Intermediate Care Tier – conceptual model:

The high level model, illustrated below, describes in concept to be developed through joint

Intermediate Care Tier – Conceptual Design



commissioning of a new Intermediate Care Tier. This will build on from the successes of the Joint Assessment and Discharge Team, bringing a multi-organisation, multi-disciplinary team together to triage and manage the appropriate pathway response for each case. This also leads us towards the trusted assessor model. This pathway might include voluntary sector services, support for self-funders and information and advice.

It was initially thought that a three-borough intermediate care service would be best achieved by a joint recommissioning of the service across BHR CCGs and the three Local Authorities, however in light of the developing ACS model the preferred option now is to develop the intermediate care service as a pathway within the ACS. This option requires a significant level of engagement with the system to ensure all partners are fully committed to the model. There will be a programme of work of develop a budget understanding and a set of outcomes prior to working with providers to develop the practicalities of a joint service to be in place from March 2019.

For LBH to align with system partners in developing the ACS model, a 12 month contract extension will be required on the current reablement contract. This will enable a full design process to take place as part of the ACS model and will also allow further learning to be drawn from the current integration of the rehab and reablement services.

8. Overview of Funding Contributions

8.1 Summary of Financial Allocations

8.1.1 2017/18

2017/18	DFG	CCG Revenue (RNF)	CCG Revenue (Non RNF)	Additional contributions		iBCF (2017)	BCF Total	Additional Budget Allocation	Total
				LA	CCG				
Barking & Dagenham	1,391	4,333	9,082	1,524	0	1,044	17,374	4,385	21,759
Havering	1,553	4,773	11,872	702	0	-	18,900	3,761	22,661
Redbridge	1,822	5,296	11,630	0	0	360	19,107	4,882	23,990
Total	4,765	14,402	32,584	2,226	0	1,404	55,381	13,028	68,409

8.1.2 2018/19

2018/19	DFG	CCG Revenue (RNF)	CCG Revenue (Non RNF)	Additional contributions		iBCF (2017)	BCF Total	Additional Budget Allocation	Total
				LA	CCG				
Barking & Dagenham	1,517	4,416	9,254	1,524	0	4,910	21,620	2,616	24,236
Havering	1,680	4,864	12,097	702	0	1,978	21,321	2,844	24,165
Redbridge	1,984	5,397	11,851	-	0	3,886	23,118	3,175	26,293
Total	5,181	14,676	33,202	2,226	0	10,774	66,058	8,635	74,693

Key:

DFG = Disabled Facilities Grant

RNF = 'Relative Needs Formula' based allocation of funding

8.2 Health Spend

A significant proportion of the health services commissioned through the BCF are provided by NELFT NHS Foundation Trust through their contract with the BHR CCGs. They provide all of the community nursing/ therapy services and mental health services, along with a host of others, for the residents of BHR and have been key in the development and support to the establishment of integrated locality teams.

In order to best support the service plans outlined in the BCF, as well as those in the wider urgent and emergency care plan, the CCGs have formally requested a service line breakdown from NELFT to ensure that we have the correct staffing and budget alignment. Once this review is complete then we can ensure that we have a joint understanding of the health resource that is available to support further development of the integrated locality teams, delivery of the high impact changes and reablement

8.3 BHR Joint Spending Position / Source of Funding - 2017/18 and 2018/19

Further details regarding scheme funding is included in the BCF Planning template for each HWB area.

	CCG	Improved	Local	Grand Total	CCG	Improved	Local	Grand Total
	Minimum	Better Care	Authority		Minimum	Better Care	Authority	
	Contribution	Fund	Contribution		Contribution	Fund	Contribution	
	2017/18 Expenditure (£'000)				2018/19 Expenditure (£'000)			
High Impact Change Model	31,385	1,920	802	34,107	31,942	2,011	802	34,755
Discharge Team	2,209	249		2,458	2,166	-		2,166
Enablers for integration		1,117		1,117		1,481		1,481
Home First		433		433		350		350
Intermediate care	18,895	121	702	19,718	17,980	180	702	18,862
Locality Teams	9,236			9,236	10,747			10,747
Mental Health	1,045		100	1,145	1,049		100	1,149
Market Development & Sustainability		5,732		5,732		6,942		6,942
Placement Pressures		751		751		1,292		1,292
Provider Rate Reviews		4,981		4,981		5,650		5,650
Prevention & Managing Demand	7,309	1,039	5,517	13,865	6,420	1,135	5,932	13,487
Assistive Technologies		158	470	628		50	470	520
Care Act		360		360		460		460
Carers	625		282	907	625		282	907
Community Front Door	3,406			3,406	3,531			3,531
Demand Management	2,450	171		2,621	1,423	200		1,623
DFG			4,765	4,765			5,181	5,181
Enablers for integration	641			641	653			653
Equipment	187	350		537	187	425		612
Protecting Social Care & Maintaining Independence	8,292	5,740	672	14,705	9,517	9,320	672	19,509
Budget Protection	1,723	2,868		4,591	2,841	5,320		8,161
Care Act	1,260			1,260	1,284			1,284
Carers	130			130	130			130
End Of Life	105			105	105			105
Locality Teams			672	672			672	672
Packages of Care	4,902	2,873		7,775	4,985	4,000		8,985
Supported Living	172			172	172			172
Grand Total	46,986	14,432	6,991	68,408	47,878	19,409	7,406	74,693

8.4 BHR Spending Position by Borough - 2017/18 and 2018/19

	2017/18 Expenditure (£'000)			Total 2017/18 Expenditure (£'000)	2018/19 Expenditure (£'000)			Total 2018/19 Expenditure (£'000)
	Barking & Dagenham	Havering	Redbridge		Barking & Dagenham	Havering	Redbridge	
High Impact Change Model	10,583	13,043	10,481	34,107	11,191	12,983	10,582	34,755
Discharge Team	651	849	958	2,458	651	600	916	2,166
Enablers for integration	1,117			1,117	1,481			1,481
Home First		433		433		350		350
Intermediate care	7,888	6,124	5,706	19,718	8,130	6,278	4,454	18,862
Locality Teams		5,636	3,599	9,236		5,756	4,991	10,747
Mental Health	928		217	1,145	928		221	1,149
Market Development & Sustainability	1,592	1,731	2,409	5,732	2,150	1,792	3,000	6,942
Placement Pressures		751		751		1,292		1,292
Provider Rate Reviews	1,592	980	2,409	4,981	2,150	500	3,000	5,650
Prevention & Managing Demand	3,174	4,462	6,229	13,865	3,375	3,483	6,629	13,487
Assistive Technologies	470	158		628	470	50		520
Care Act			360	360			460	460
Carers	777	130		907	777	130		907
Community Front Door			3,406	3,406			3,531	3,531
Demand Management		2,621		2,621		1,623		1,623
DFG	1,391	1,553	1,822	4,765	1,517	1,680	1,984	5,181
Enablers for integration			641	641			653	653
Equipment	537			537	612			612
Protecting Social Care & Maintaining Independence	6,409	3,424	4,871	14,705	7,521	5,907	6,082	19,509
Budget Protection	1,970	2,620		4,591	3,070	5,091		8,161
Care Act	628	632		1,260	640	644		1,284
Carers			130	130			130	130
End Of Life	105			105	105			105
Locality Teams	672			672	672			672
Packages of Care	3,034		4,741	7,775	3,034		5,952	8,985
Supported Living		172		172		172		172
Grand Total	21,759	22,660	23,990	68,408	24,237	24,165	26,292	74,693

8.5 Allocations and spending at required levels

The above allocations are confirmed to meet the minimum CCG allocations, including uplifts for inflation as specified.

8.5.1 Out of Hospital Commissioned Services spend

The level of funding applied to commissioning of Out of Hospital services exceeds the required minimum level. The required minimum allocations and the actual levels are set out as follows:

	2017/18		2018/19	
	Minimum £	Actual £	Minimum £	Actual £
Barking and Dagenham	3,812,152	8,244,390	3,884,583	8,416,940
Havering	4,729,895	10,374,057	4,819,763	10,571,163
Redbridge	4,809,912	10,150,985	4,901,300	10,346,234
	13,351,958	28,769,432	13,605,646	29,334,337

8.5.2 Protection of Social Care

The level of funding applied to the protection of social care meets the minimum required.

	2017/18		2018/19	
	Minimum £	Actual £	Minimum £	Actual £
Barking and Dagenham	4,970,629	4,970,629	5,065,072	5,065,072
Havering	6,270,264	6,270,264	6,389,399	6,389,399
Redbridge	6,644,851	6,645,094	6,771,103	6,771,351
	17,885,744	17,885,987	18,225,574	18,225,822

8.5.3 Section 256 Monies

The original Section 256 Monies, covering Carers Breaks, Reablement and the Care Act funding, are dealt with variously by each borough. While not necessarily overtly managed in these headline tables, the full value of the funding is being applied as required within core budgets to activity that is not necessarily 'new' but mostly builds upon the work delivered under previous BCF plans. As set out in previous sections above, this approach enables core spending levels to be maintained to support the whole health and care system. This includes the application of Care Act monies to assessment budgets, including carer's assessments, and to provide some carers' provisions.

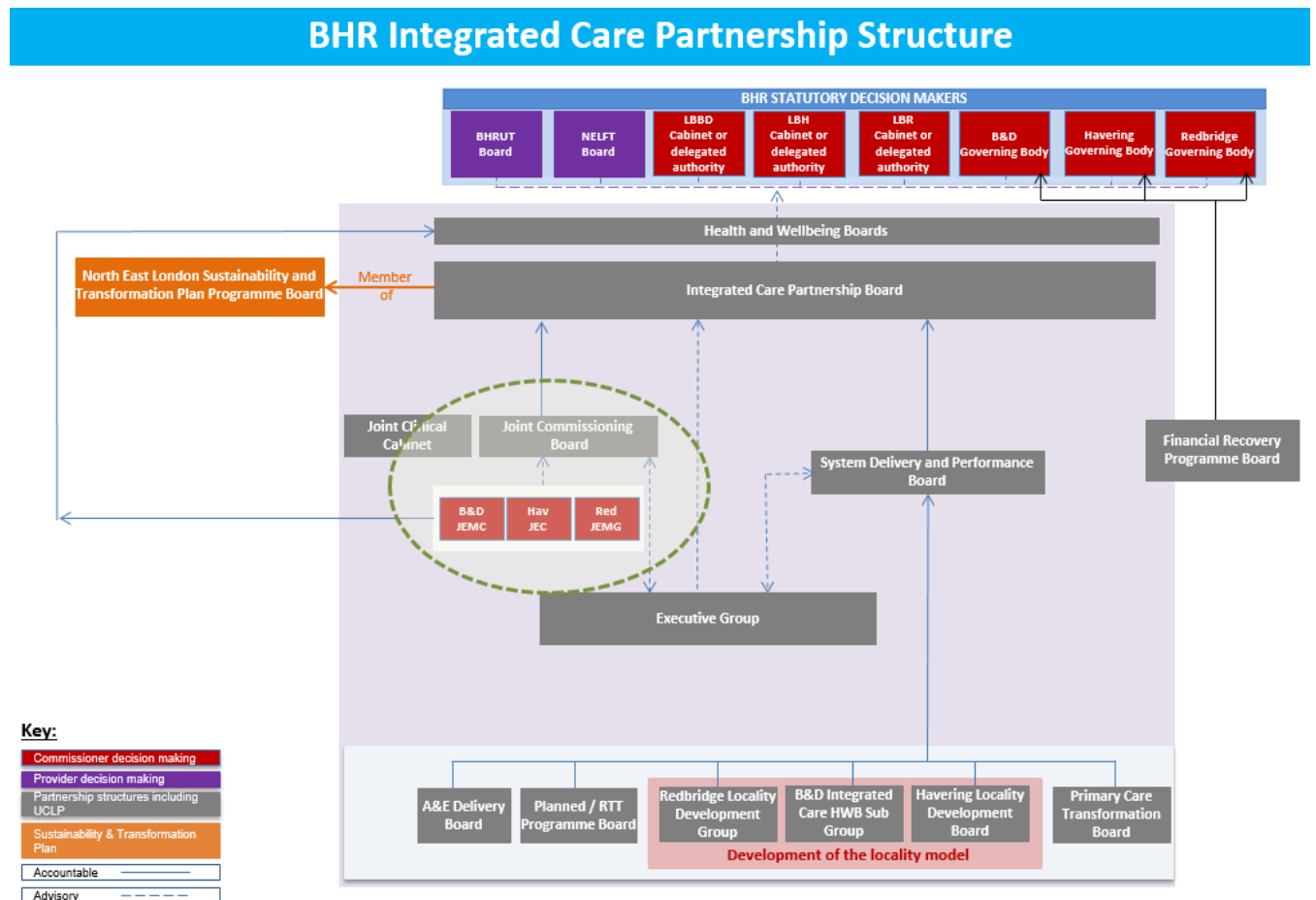
9. BHR BCF Programme Governance

9.1 Year 1: 2017/18 Governance & Section 75 Arrangements

Delivery of year one of our BHR BCF plan will be governed by the arrangements that have been set out in borough Section 75 agreements, with the Joint Commissioning Board taking an increasing role in the oversight of BHR wide schemes (tier 1 schemes). Tier 2 schemes (local schemes) will be managed through local joint executive management arrangements (listed below).

- Barking & Dagenham: Joint Executive Management Committee
- Havering: Joint Management and Commissioning Forum
- Redbridge: Joint Executive Management Group

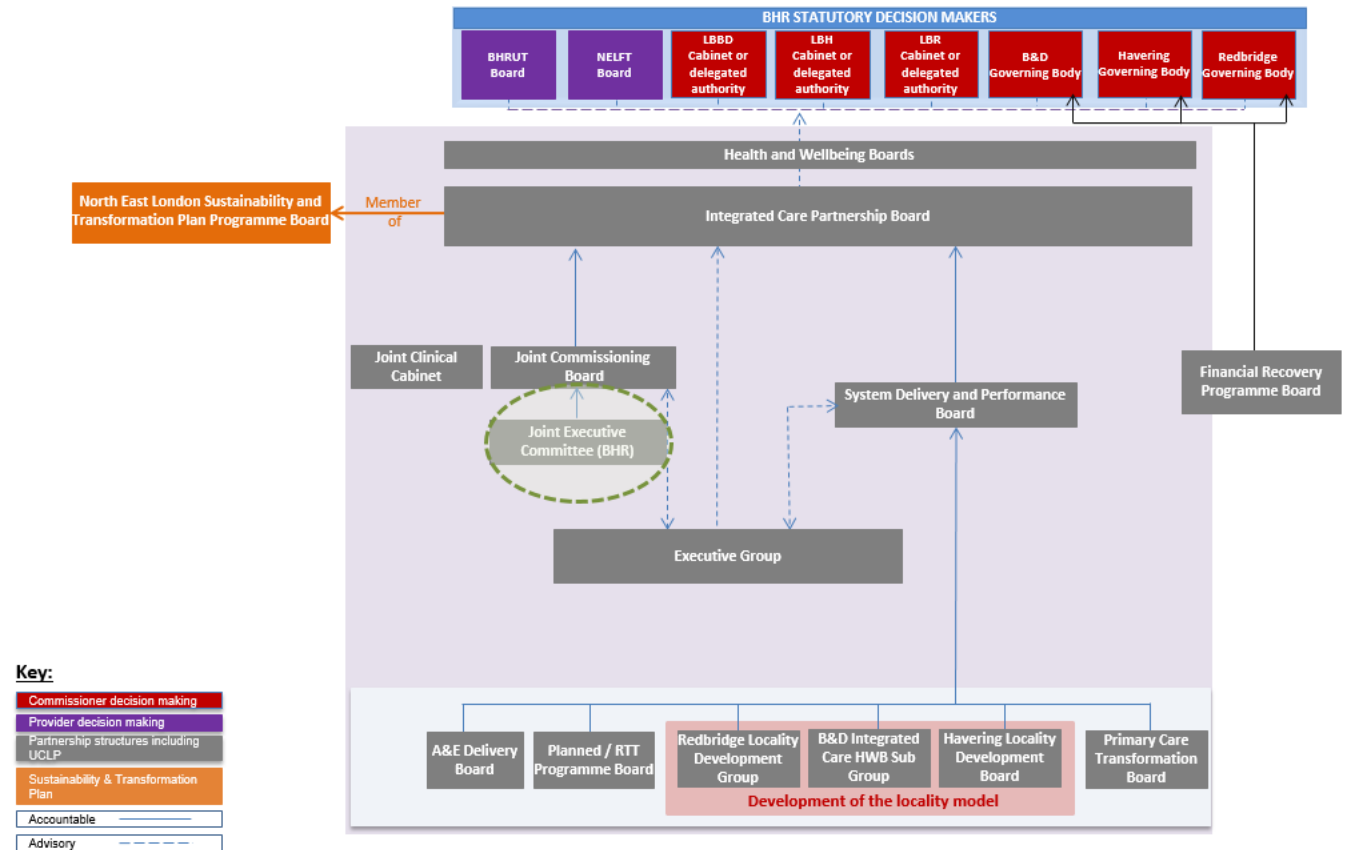
It is expected that there will be a review of governance arrangements in year 1 to enable a staged process of moving away from the local area executive management arrangements to full ownership by the BHR wide JCB. Individual local area section 75 agreements will remain in place throughout year one.



9.2 Year 2: 2018/19 Governance & Section 75 Arrangements

It is expected that by year 2 of our BCF plan, the JCB will be the executive management body responsible for the BCF. This will then lead itself to an opportunity to explore an overarching pool for such monies - drawn from the respective local areas, with a joint section 75 proposed across the BHR area for BCF.

BHR Integrated Care Partnership Structure



*LBBD = HWB with delegated authority.

9.3 Programme Overview

The nature of this multi borough plan, including the use of some of the funding to support core budgets means that it is not possible to treat the activity in all cases as a conventional programme plan or to manage it as such.

The BHR A&E Delivery Board will be responsible for monitoring the delivery of actions in the urgent and emergency care delivery plan which will provide assurance to commissioners on delivery of the BHR high impact change model initiatives. The A&E Delivery Board reports to the BHR System and Performance Board which is a partnership group responsible for BHR system level delivery planning and implementation. Partners on the Board are both accountable to their respective organisations and are collectively accountable to the ICPB as

the programme board for the development, agreement, implementation and monitoring of the BHR System Delivery Plan and the financial and performance health of the integrated system.

Joint Commissioning Board (JCB), as it develops over the coming months, will increasingly take an overview position on behalf of the Integrated Care Partnership Board for the delivery of the BCF plan and the associated changes to the services and processes.

9.4 Benefit Realisation

This plan is not predicated on the definable single focussed delivery of change activity normally associated with clear benefit realisation planning. However, the direction of travel for this BHR system is towards the NHS England vision for our services set out in the Five Year Forward View; by setting ourselves towards the creation of an Accountable Care System, and using the BCF as a joined up approach to integrated care planning, the major benefits will be in how the local system will learn and develop further through joint commissioning and collaborative provider approaches.

The Accountable Care System work programme will include the development of overall funding and risk/benefit share arrangements, possibly such mechanisms as capitated budgets and/or locality based budgets. Such approaches will in themselves deliver a benefits realisation process, along with oversight and monitoring arrangements. Therefore, discrete local arrangements to support the BCF plan are not intended to be put into place.

9.5 Measurement

Aside from the normal BCF metrics submitted as part of this plan, JCB will be able to use any of the standard reporting – QOF, ASCOF, PHOF etc., and the normal reporting packs used by system wide Boards such as the A&E Delivery Board, Health & Wellbeing Boards and so on – to monitor the effects on the system of these and other change activity.

9.6 Outcomes and Achievement

There is a need for flexibility in the plan to allow targeted resolution of issues that emerge over time. While this plan might set out to cover two years, it is clear that there it cannot be completely fixed or static; the system leaders at ICPB and JCB must retain the flexibility to add, remove or change activity to reflect emerging issues or to respond to changes in demand profiles, and to respond where change activity is seen not to be effective or indeed to invest more where it is so effective that to do so would bring greater benefit.

10. Risk Management

10.1 Risks

Risk management is essential to ensure the effective implementation and delivery of the BCF plan and schemes.

There remain two fundamental risks:

1. The continued downward pressure on the LA budgets, which is only partly mitigated by the additional grant monies and precept. There continues to be demand and demographic growth shifts in the area that out-strip the rest of London and these significantly impact on ASC despite the level of cash releasing savings already achieved together with successful cost avoidance implementation. The impact of the Care Act funding reform has been deferred until 2020, but cost pressures remain in the form of support for carers and infrastructure costs.
2. A reshaping of the acute system across the BHR CCGs footprint, dealing with the well documented issues of quality, finance and performance. The pace of that change together with the development of alternative community based services, both integrated and affordable, will be challenging in its depth and breadth. The pace will require careful management and flexibility in timing to maintain public confidence.

Partners remain totally committed to the challenges represented in this plan and have implemented strong governance through which both the policy, financial and performance risks have been and will be managed effectively. Through the HWB's and other forums (such as client partnership boards, voluntary and community sector forum), risks have been identified with mitigation proposed.

BHR overarching risks will owned by all three area management groups and raised at the JCB, and local joint executive management arrangements, and where necessary raised at the A & E Delivery Board. Local area risks will be managed by the respective borough BCF Joint Management arrangements.

10.2 BHR Risk Log

Risk No.	Identified Risk	Risk Mitigation	Likelihood Without mitigation	Impact Without Mitigation	Risk Score	RAG With Mitigation
BHR 1	Demographic demand - increasing numbers of Older People (over 85s and over 65s), people with long term conditions, low number of healthy life years, deprivation etc. raise specific challenges.	Investment in prevention and managing demand and use of the social care grant to support and protect social care, pending solutions to longer term funding solutions to social care funding.	4	4	16	AMBER

Risk No.	Identified Risk	Risk Mitigation	Likelihood Without mitigation	Impact Without Mitigation	Risk Score	RAG With Mitigation
	These budget pressures sit alongside corporate financial pressures faced by the partners	Best use of existing community capital and signposting. Use of CT Precept to invest Encouragement of population to take responsibility for their own health, self-management Upstream preventative / early intervention investment				
BHR 2	Transformation and leadership, including that within new governance arrangements proposed are insufficient to deliver the changes proposed, and benefits are not measured or realised.	Iterative approach that seeks to manage the level of change. Ensuring active linkage with existing strategies and test capacity for delivery. Targeting resources to where they are most effective. Integrated Care Partnership is responsible for ensuring these tensions are understood and managed	2	4	8	GREEN
BHR 3	Transformation requirement in each organisation might impact upon the ability to deliver within the wider partnership and the Better Care Fund Plan	Integrated Care Partnership is responsible for ensuring these tensions are understood and managed	2	4	8	GREEN
BHR 4	Costs and benefits fall unevenly across the system and inequitably to the investing partner for areas of change such as Discharge to Assess.	<ul style="list-style-type: none"> Review and transparency of impact and outcomes achieved. Affordability to be a determinant of further steps. Risk share remains an option for consideration. 	4	3	12	AMBER

Risk No.	Identified Risk	Risk Mitigation	Likelihood Without mitigation	Impact Without Mitigation	Risk Score	RAG With Mitigation
		<ul style="list-style-type: none"> Protection of social care services and consideration of pooled budgets. Ongoing monitoring of impacts. 				
BHR 5	Short term funding, such as that provided within the social care grant, helps mitigate the capacity and provider rate issues but does not solve the underlying issues,	Transformation activity planned Working with providers Market development workstream, as a part of iBCF delivery Whole system approach and careful management of resources.	4	3	12	AMBER
BHR 6	Resources locked into current contracts/ activity cannot be effectively unlocked to support activity where positive evidence of improved outcomes are drawn.	Engagement across commissioners and providers with service contracts having sufficient flexibility to allow for adjustments, contract review schedules are considered through governance alongside iBCF activity. Effective contract management and the right level of governance.	4	2	8	AMBER
BHR 7	System changes that impact upon onward service providers are inhibited through the inability of these services to respond to new requirements.	We will seek to mitigate through our shared market development scheme across BHR.	4	2	8	GREEN
BHR 8	Three borough complexity slows progress because of differing democratic leadership, priorities and indeed financial values into specific /shared schemes.	We have mitigated the challenge posed by taking an iterative approach to our deepening the reach of the BCF plan over the two year period. Integrated Care Partnership is	4	3	12	AMBER

Risk No.	Identified Risk	Risk Mitigation	Likelihood Without mitigation	Impact Without Mitigation	Risk Score	RAG With Mitigation
		responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points.				
BHR 9	Elections at both a local and national level result in changes to administration(s) and policy direction.	“Watching brief” on policy and guidance changes	4	1	4	GREEN
BHR 10	Clear risk that our intention/direction may be subverted by national BCF changes implemented ahead of year 2.	This remains a risk and will be monitored through the BCF governance mechanisms.	3	3	9	RED
BHR 11	Any review in November of DToC performance gives a risk that funding is withdrawn without consultation or recognition of the impact of money and resources already committed	Home First project in place – covering CHC and mainstream discharges JAD and Hospital Discharge Teams supporting discharges Intermediate Care re-commissioning will strengthen community response capacity Constant monitoring and management oversight of the outcomes	4	3	12	RED
BHR 12	The Councils structural budgetary deficit and transformation needs.	In part mitigated by the delivery of the social care grant but the longer term remains a concern.	4	4	16	RED
BHR 13	Commissioning capacity and staffing resources.	Improving joint and or lead commissioning across BHR will seek to reduce the burden of individual organisational activity, alongside our intention through the	3	2	6	AMBER

Risk No.	Identified Risk	Risk Mitigation	Likelihood Without mitigation	Impact Without Mitigation	Risk Score	RAG With Mitigation
		BCF plan to achieve a greater level of integration and available resource utilisation.				
BHR 14	Service demand continues to increase for social care.	Implementation of our new community solutions team, providing earlier intervention, passporting to alternative, community and universal services is expected to improve management of demand.	3	3	9	AMBER
BHR 15	Increasing costs faced by service providers, rates available to Personal Assistants unsustainable.	The Social Care Grant provides some capacity to stabilise the current market, adjusting rates available and improving access to services. However the sustainable funding of social care remains an issue.	3	2	6	AMBER
BHR 16	Community health services are commissioned under a block contract – lack of transparency regarding service line budgets limits the joint commissioning opportunities.	BHR CCGs and NELFT have escalated this for formal resolution through the contractual process.	4	3	12	GREEN

10.3 Risk Share Arrangements

As required under the guidance, the CCG and Local Authorities have considered risk share and contingency arrangements taking into account the experience of 2015/16 and in light of the decision not to strive for additional Non Elective Admissions targets over and above the CCG operating plan levels..

Financial Risk

- It is noted that all partners are facing great financial pressures in the life of this plan and are developing transformative approaches to addressing ongoing sustainability. It is also noted that any risk share for 17-19 is likely to be counterproductive to the development of an ACS and that the development of the ACS represents the main mechanism through which rising activity/acuity risks may ultimately be mitigated.
- In light of the above and in the spirit of strong partnership working on transformation, it is proposed that no risk share arrangement will be put into place.
- Although partners will not have a risk share for 17-19, it is proposed that the following measures are in place to meet shared targets, particularly around admissions and DTOCs - and to manage risks.
 - Partners to continue to be responsible for overspends on their respective budgets within the BCF.
 - Partners to consider using underspend/uncommitted funds for 2017-19 within the BCF against key risks against meeting shared BCF targets – in particular around mental health and DTOCs and non-electives.
 - Partner's ongoing commitment to impacting non-elective admissions in line with reductions set out in the CCG operating Plan.

The CCGs holds the 0.5% contingency as per business rules, which is greater than the BCF risk.

11. National Metrics

11.1 National Metrics

- Non-elective admission (general and acute)
- Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)

11.2 Summary of Performance 2016-17

Non Elective Admissions by CCG, Year and Trust							
CCG_Name	Barking, Havering and Redbridge University Hospitals NHS Trust		Barts Health NHS Trust		Total		Variance
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	
NHS Barking and Dagenham CCG	14,620	13,678	2,337	2,469	16,957	16,147	-810
NHS Havering CCG	22,068	21,659	916	937	22,984	22,596	-388
NHS Redbridge CCG	13,727	12,756	7,060	6,953	20,787	19,709	-1,078
Total Sum of Activity	50,415	48,093	10,313	10,359	60,728	58,452	-2,276

Metric	Barking & Dagenham	Havering	Redbridge
Non-elective Admissions (all Ages)	Against our target of 19,880 admissions, we achieved -206 fewer admissions at 19,674	Against our target of 26,109 admissions, we missed the target with +259 more admissions at 26,368	16/17 saw 23,493 admissions against a plan of 26,493 and a rate of 7,678 per 100,000 which is an improvement of 10%
Admission to residential (aged 65+)	Against our target of 170 admissions, we achieved -25 fewer admissions at 145	Against our target of 272 admissions, we missed the target with +49 more admissions at 321	Against our target of 170 admissions, we achieved -22 fewer admissions at 148.
Reablement/ Rehabilitation (aged 65+)	Against our target of 80% we achieved 88.6%	Against our target of 87.0% we achieved 87.7%	Against our target of 85.7% we achieved 91.7%
Delayed Transfers of Care per 100,000 Population	BCF target was an average of 286 days and we ended slightly above target with average through year of 291. This was adversely affected by a single CHC case in October.	Against our target of 2,792 delayed days we achieved 2,337 days, a reduction of 448	Delayed transfers of care performed at 3% over plan at 1,712 per 100,000 against a plan of 1,669. This equates to 99 days above plan.

11.3 Barking & Dagenham Summary of performance 16-17

11.3.1 Non-Elective Admissions

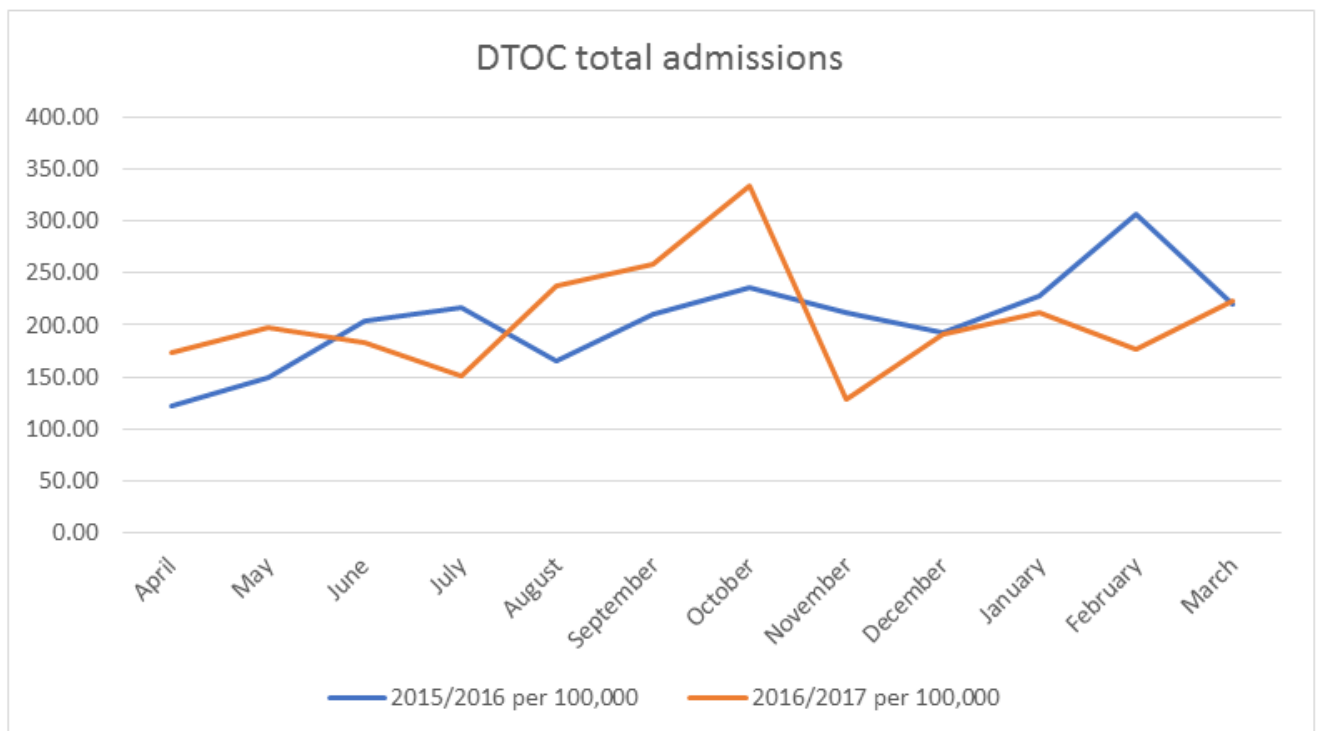
The work across health and social care led to a reduction in non-elective admissions to hospital when comparing 2016/17 activity to that seen in 2015/16. This has been seen across the contract portfolio and specifically for our two main local providers – Barking, Havering and Redbridge Hospitals NHS Trust and Barts Health for which the reduction was 810 patients. This is an achievement against a growing rate of attendances in A&E and has been achieved through joint work and pathway development in the hospitals.

11.3.2 Delayed Transfers of Care (total delayed days)

LBB and its NHS partners performed well against the target of 201.15 per 100,000 proposed by the BCF, finishing slightly above target with an average throughout the year of 205.80. The figure is slightly higher than the previous year's average (205.25 per 100,000 or an average of 293 days). From analysing the data from the NHS we can see a spike in October 2016 where the total days were 473. This was due to a CHC case awaiting a placement in a nursing home (127 days) and a CHC case awaiting assessment. The highest proportion of days attributable to Social Care only for the same period was 30 days, due to arrangement of nursing home placement). There were also 31 days recorded that were attributed to both the NHS and Social Care (due to issues relating to public funding). The largest proportion of delayed days for the previous year was 438 (February 2016).

The point at which the fewest total days were recorded was in November 2016, where 182 days were recorded. This was a reduction compared to the previous month of 61%, and the largest reduction between two months for the whole year.

Overall the performance of the council, when compared nationally, was within target with the national average being 434.82. We can see in the chart below that the trend for 16/17 evens out throughout the 12 months of the year, whereas the previous year shows a steady climb throughout the 12 months, peaking similarly in one month (February 16) and dropping back down again.



11.3.3 Delayed Transfers of Care

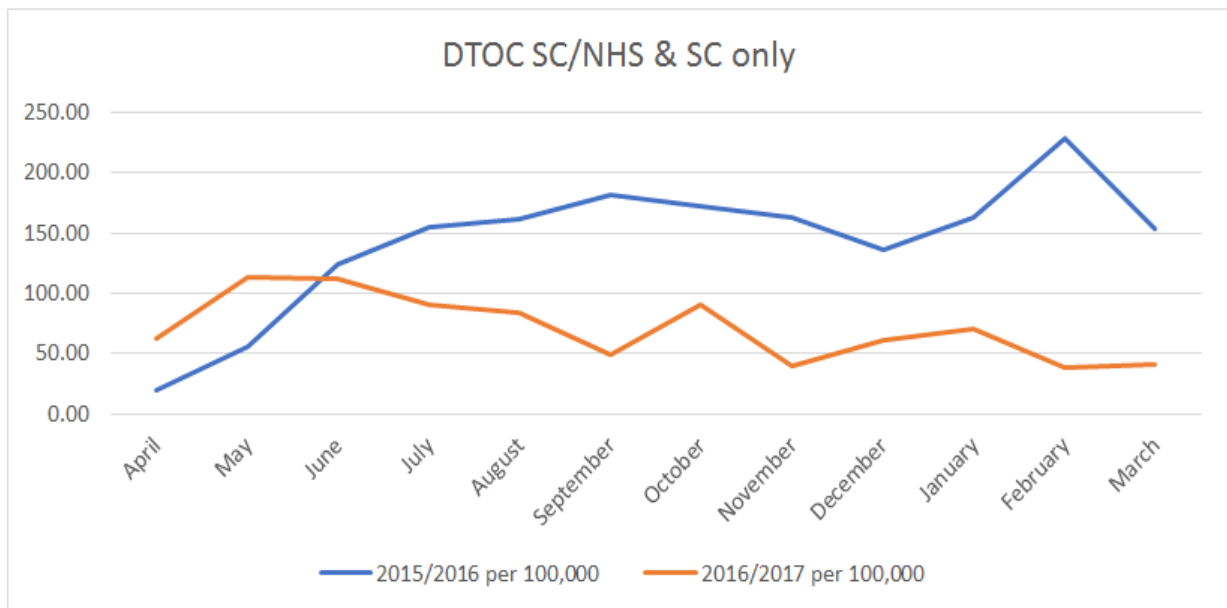
Performance for social care only during 2016/17 was within target, finishing with an average of 70.95 per 100,000 population (a 29% decrease on the target of 100.00 per 100,000 set by the BCF). This is also a lower figure when compared with the previous year’s average of 142.65 (a 50.2% decrease). The same trend can be seen in the figures for both NHS and Social Care attributable delayed days and Social Care only attributable days as above, with the data peaking in October and falling sharply in November.

The largest proportion of delayed days for 2016/17 was May, where 161 days were recorded (89 days due to issues relating to public funding, 39 days due to completion of assessment and 26 days due to patient/family choice).

The smallest proportion of delayed days for 2016/17 was February 2017, where 55 days were recorded (a reduction of 174 days or 75%).

As shown in the graph below, performance was gradually maintained throughout the year, concluding at a lower figure than the start of the year.

A Discharge Improvement Working Group was established across the BHR system during 2016/17 as a result of joint work with ECIP. The meeting has representation across Health and Social Care and has been instrumental in the improvement in the position.



There was no variation in the number of DTC patients between 2015/16 and 2016/17. There was however a small increase in the number of bed days for DTCs – the variance was 32 (1%) bed day more than 2015/16. Most months were lower than the previous year but there were particularly high numbers in September and October when compared to 2015/16.

11.3.4 Reablement

We have seen sustained improvement against this indicator, relating to the % of people remaining at home for 91 days following discharge from acute care. This sustained improvement has enabled us to increase our plan target from 80% to 84.3% from 16/17 to 17/18 with final quarter performance in the last year of 86%. However, we are seeking further improvement and to this end are undertaking further work with our commissioned service providers to look at the necessary ingredients and support, which will deliver further improvements in outcomes. Such a focus is not just considering the ability to remain at home, but also the extent to which further gains can be made in independence, reductions in dependency and in an improved ability for self-care, contributing towards improved wellbeing. Current services are readily accessed and are not in themselves a cause of delay, but we are keen to further extend service providers roles as 'trusted assessors' for a range of service solutions which might emerge or be identified along the care and support pathway.

11.3.5 Admissions to residential care homes

- During 2016/17, 10.0 per 100,000 of the 18-64 populations long term needs were met by being admitted to residential and nursing care, the figure decreasing from the previous year's performance of 14.2 per 100,000.
- During 2016/17, 686.0 per 100,000 of the 65+ populations long term needs were met by being admitted to residential and nursing care. This is a large decrease from the previous year's performance, where the figure was 910.7 despite unprecedented levels of demand.

As a result, we have seen an increase over the previous year of people accessing care and support via direct payments and managed budgets, decreasing the number of clients in permanent care while ensuring they are receiving the necessary level of care and their needs are being met. From this information, we can ascertain that more service users are having their needs met by community based services rather than permanent admissions. From the above, we can also see an improvement in our reablement services, with 61.3% clients receiving ST-MAX (crisis intervention) services going on to have a low level of service (equipment) or no service at all. We performed well against this figure for 2016/17 and that trend has continued to show.

11.4 Havering Summary of Performance 2016-17

11.4.1 Non Elective Admissions

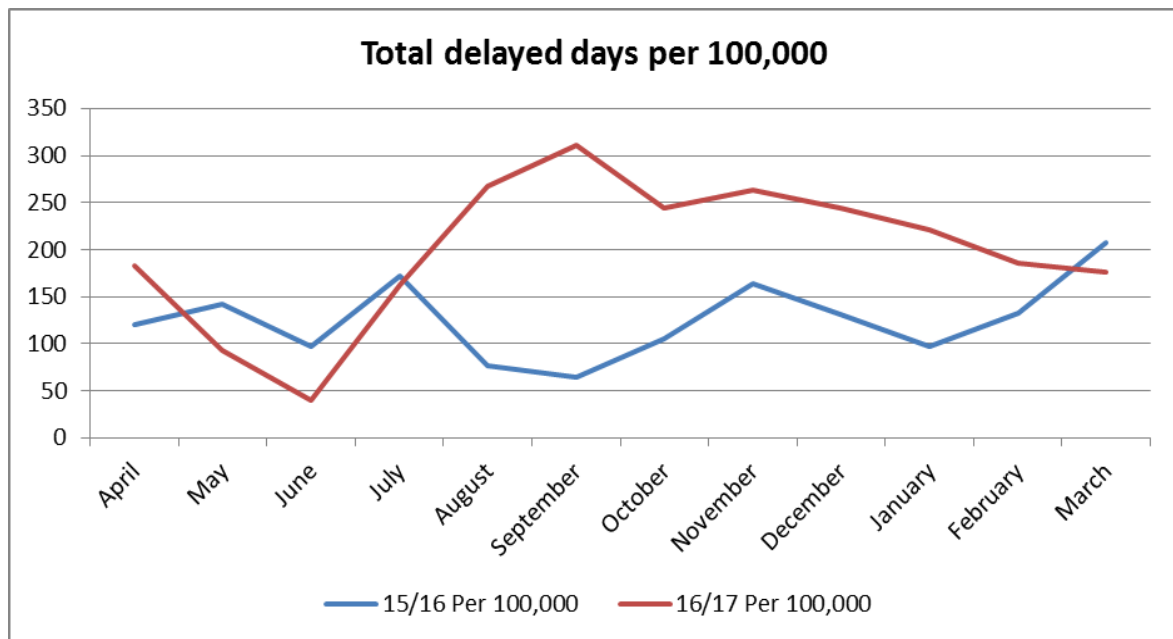
The work across health and social care led to a reduction in non-elective admissions to hospital when comparing 2016/17 activity to that seen in 2015/16. This has been seen across the contract portfolio and specifically for our two main local providers – Barking, Havering and Redbridge Hospitals NHS Trust and Barts Health for which the reduction was 388 patients. This is an achievement against a growing rate of attendances in A&E and has been achieved through joint work and pathway development in the hospitals

11.4.2 Delayed Transfers of Care (total delayed days)

Health and Social Care services in Havering performed well against the target of 233.3 per 100,000 proposed in the BCF, finishing better than target with an average throughout the year of 199.3. The figure is slightly higher than the previous year’s average (126 per 100,000 or an average of 244 days). From analysing the data from Unify we can see a spike in September 2016 where the total days delayed were 611. More than half of the delays for this period were due to either placement into Nursing/Residential Care or awaiting an assessment from health staff. The highest proportion of days attributable to Social Care only for the same period was 21 days, due to arrangement of nursing home placement). There were also 21 days recorded that were attributed to both the NHS and Social Care (this was due to issues relating to assessment). The largest proportion of delayed days for the previous year was 403 (March 2016).

The point at which the fewest total days were recorded was in June 2016, where 78 days were recorded. This was a reduction compared to the previous month of 57%, and the largest percentage reduction between two months for the whole year.

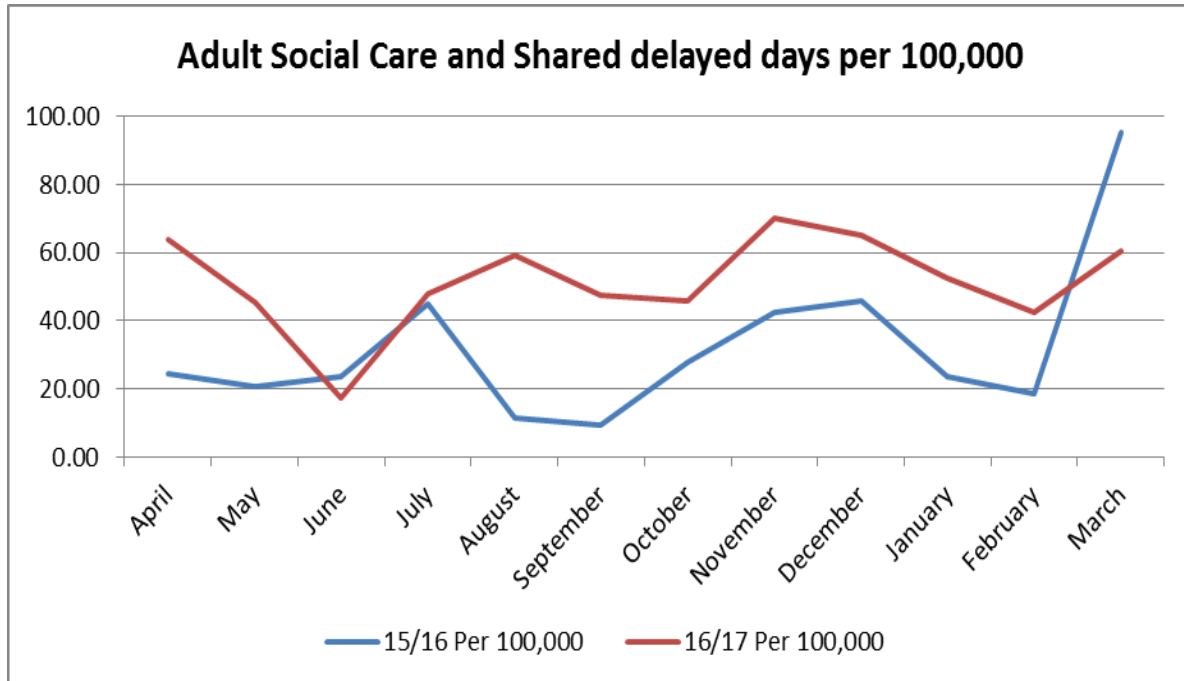
Overall the performance of the council when compared nationally was better than the average (434.82). Havering also performed within the top 10 of all London Boroughs



There has been a significant variation in both the number of patients and bed days attributed to DTOCs when comparing 2015/16 to 2016/17. The number of patients increased by 68 (75%) and every month was higher than the previous year with the exception of March. The number of beds associated with DTOCs also increased by 1771 (61%) between years.

11.4.3 Delayed Transfers of Care (delays to social care and shared)

- Performance for social care and shared delays performed well during 2016/17, finishing with an average of 51.42 per 100,000 population, this was shared relatively equally with acute and non-acute delays.



The largest proportion of delayed days for 2016/17 was November, where 138 days were recorded (66 days due to awaiting placement in either nursing or residential care, 24 days due to completion of assessment and the rest due to a variety of issues).

- The smallest proportion of delayed days for 2016/17 was June 2016, where 34 days were recorded (a reduction 66% of the average days delayed for the year).
- As shown in the graph below, performance was similar to that of the previous year, concluding at a lower figure than the start of the year.
- A Discharge Improvement Working Group was established across the BHR system during 2016/17 as a result of joint work with ECIP. The meeting has representation across Health and Social Care and has been instrumental in the improvement in the position. This group importantly included input from Continuing Health Care and alignment of processes and effect between health and social care is demonstrating benefits.

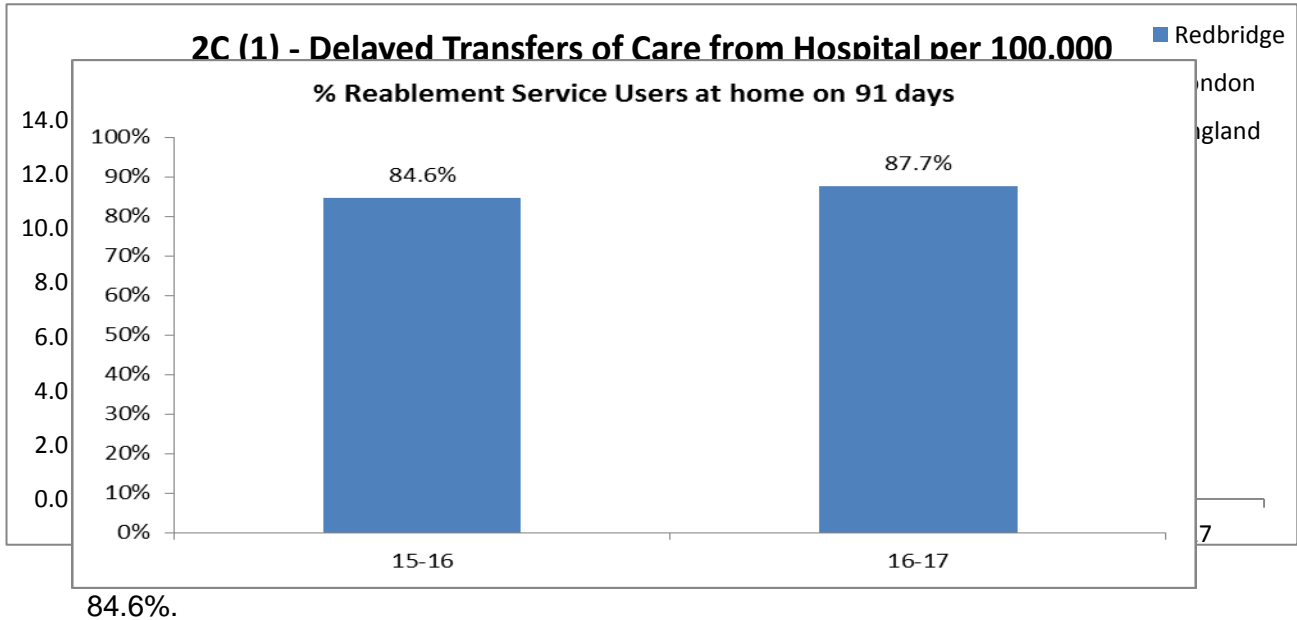
11.4.4 Admissions to residential care homes.

- During 2016/17, 8.7 (13 admissions) per 100,000 of the 18-64 populations long term needs were met by being admitted to residential and nursing care, the figure decreasing from the previous year's performance of 10.2(15 admissions) per 100,000.
- During 2016/17, 689.0 (321 admissions) per 100,000 of the 65+ populations long term needs were met by being admitted to residential and nursing care. This is an increase from the previous year's performance, where the figure was 583.8 (271 admissions).
- It is also worth noting that the average age of service users who are admitted into permanent long term placement is 85.
- Whilst the number of service users who receive long term community services has stayed relatively static, the average cost of these has risen; this shows that the needs of the individuals are rising. We have also see an improvement in our reablement services, with 62.5% clients receiving ST-MAX (crisis intervention) services going on to have a low

level of service (equipment) or no service at all in 16-17, this was compared to 58.6% in 15-16.

11.4.5 Reablement at home after 91 days.

- During 2016/17, 87.7% of service users who were discharged from hospital in reablement services (during the monitoring period of Oct 16 – Dec 16) were still at home on the 91st day, this is an increase against the previous year when the outturn was



11.5 Redbridge Summary of performance 16-17

11.5.1 Non Elective Admissions

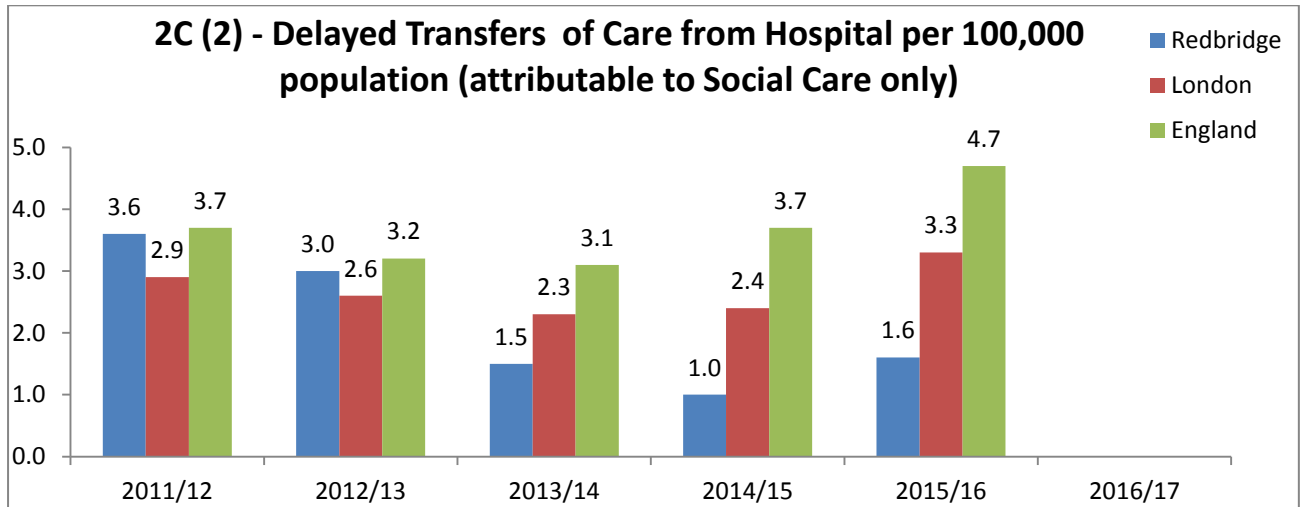
The work across health and social care led to a reduction in non-elective admissions to hospital when comparing 2016/17 activity to that seen in 2015/16. This has been seen across the contract portfolio and specifically for our two main local providers – Barking, Havering and Redbridge Hospitals NHS Trust and Barts Health for which the reduction was 1078 patients. This is an achievement against a growing rate of attendances in A&E and has been achieved through joint work and pathway development in the hospitals.

The plan for NEL admissions was a reduction of 528 compared to 2015/16. Admissions were lower than plan for every month of the year and the final position was 1810 admissions less than plan which is a 7% variation against baseline.

11.5.2 Delayed Transfers of Care

The chart below demonstrates that the London Borough of Redbridge and NHS Partners, including NELFT, Barts Health, BHRUT and the CCGs, continue to work jointly and have been successful in driving down delayed transfers of care from hospital. It also shows that as a health and social care economy we regularly outperform the national average and also since 2013/14 the regional average. In relation to our whole health and social care economy we perform well in comparison to other outer London boroughs being ranked 3rd amongst our nearest neighbours for our ASCOF measures.

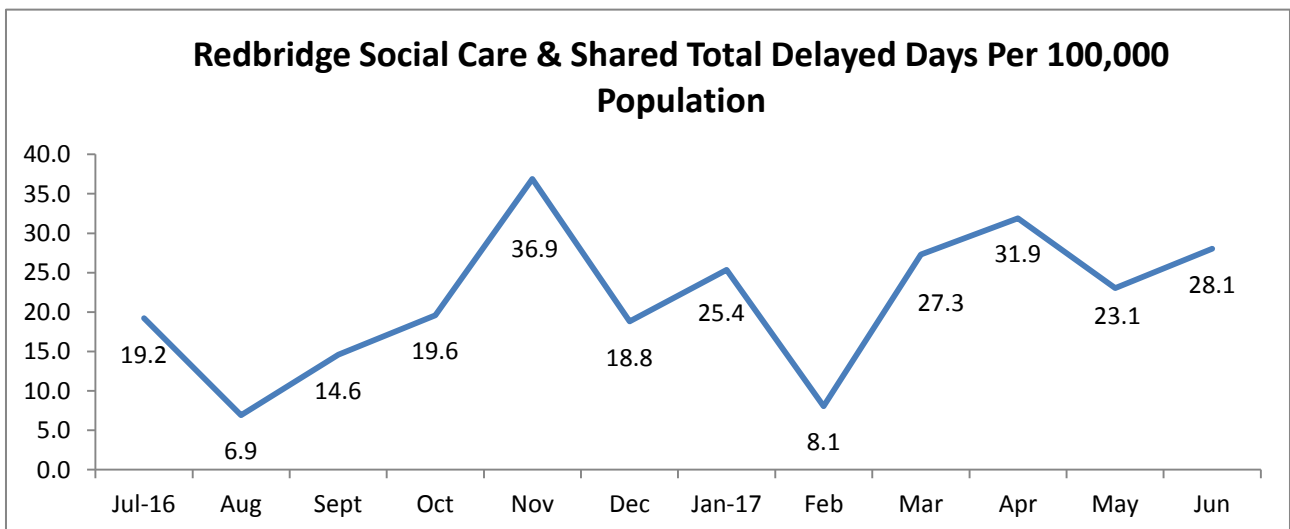
The following chart demonstrates that the London Borough of Redbridge has been successful at reducing and sustaining the level of delayed transfers of care from hospital.

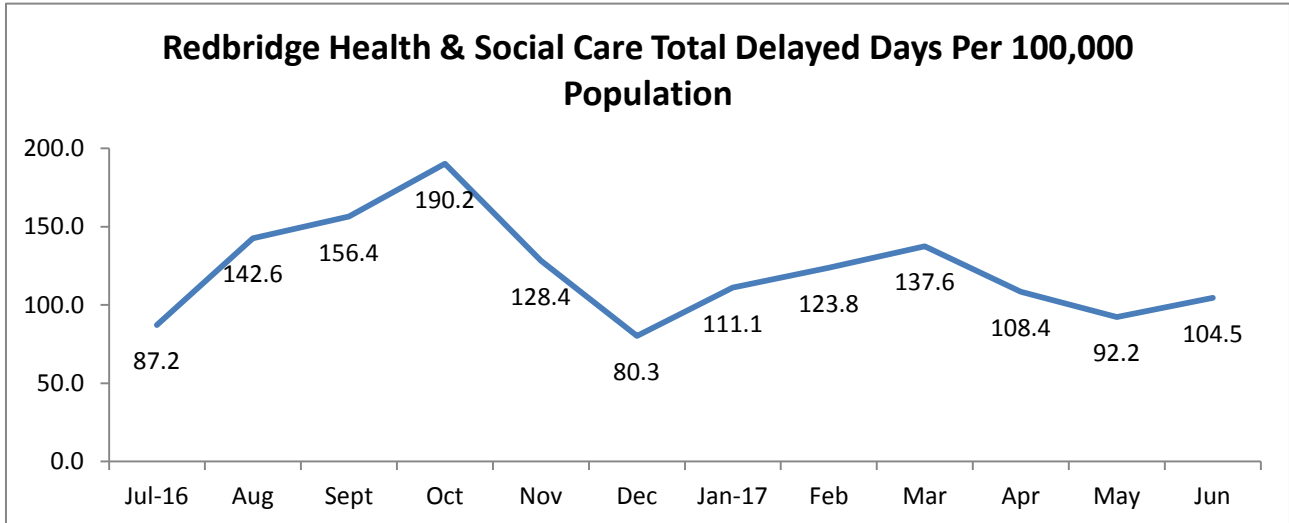


In respect of delayed transfers of care the Redbridge health and social care economy outperformed its 2016/17 target of 495 every month.

Bed days associated with DTOC have increased between 2015/16 and 2016/17. The number of bed days increased by 121, when comparing the years, and the increases occurred during September to November with a further spike in February. Against this the number of DTOC patients actually reduced between the years by 4 patients (-3%).

In relation to the new BCF metric on delayed days it is clear that the London Borough of Redbridge are at a disadvantage as the snapshot for February shows that this was a positive outlier of our performance. Agreement has been reached for the London Borough of Redbridge to sustain performance rather than require improvement within the social care economy. Our NHS colleagues have targeted to improve their own performance in relation to our joint working.

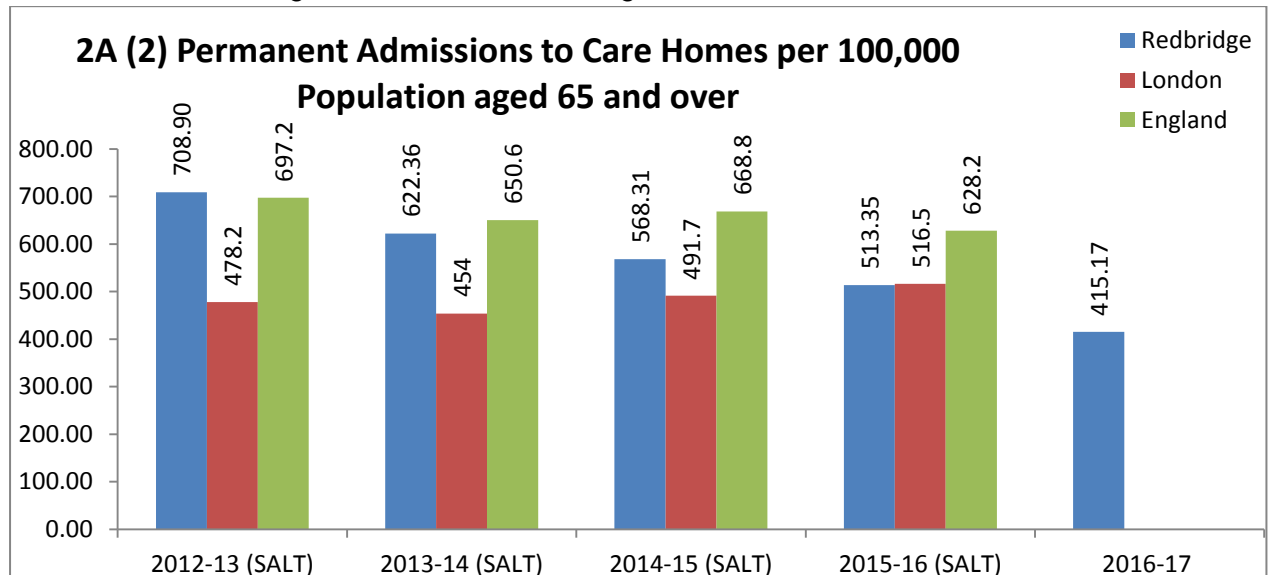




The largest number of delayed bed days for Redbridge in the last year came in October 2016 with 190.2 per 100,000 adult population and the lowest number came in December 2016.

11.5.3 Admissions to residential care homes

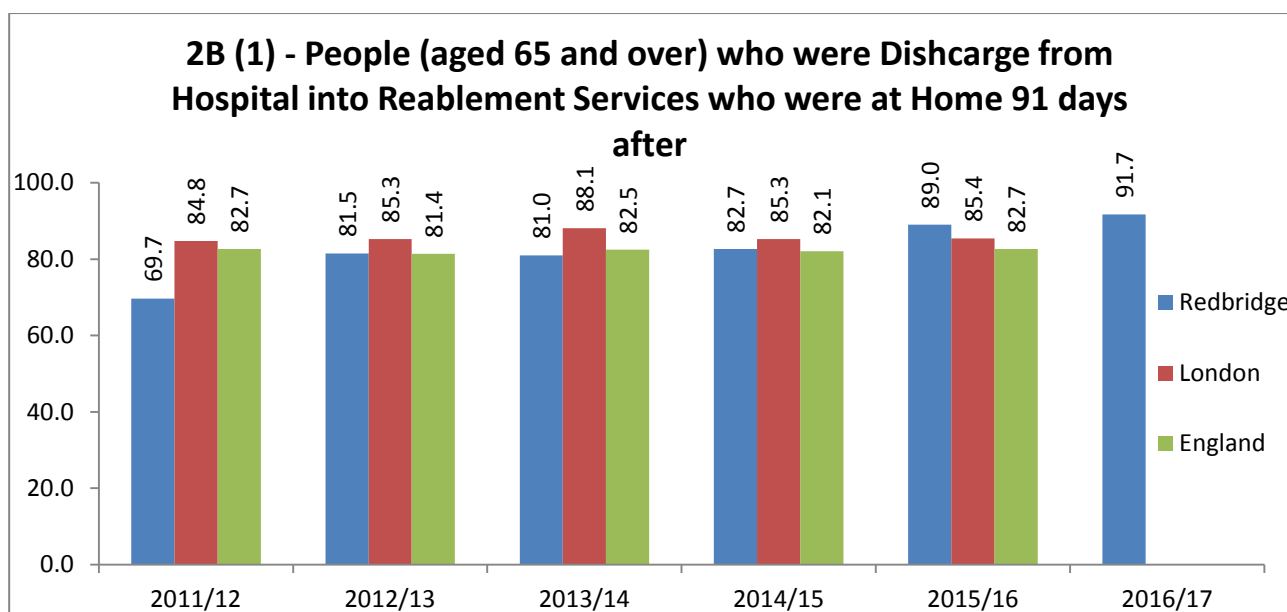
The charts below demonstrates that the London Borough of Redbridge have been performing well and improving year on year in relation to permanent admissions to residential and nursing care homes for adults aged 65 or over.



We outperformed our BCF target of 460.9 for 2016/17. As a result we have targeted to maintain this level of performance for 2017/18 and 2018/19 due to our increasing older population. This will still achieve improvement.

11.5.4 Reablement

The London Borough of Redbridge have seen virtual year on year improvement in the number of older people who remain living in the community following hospital discharge and effective reablement.



Our BCF target for 2016/17 was 85.7% which we have outperformed with our final annual figure being 91.7%. For 2017/18 we have targeted to maintain our 2016/17 performance given the level of improvement within that year and push for further improvement in 2018/17.

11.5.5 Summary

All Redbridge BCF performance metric targets were met for 2016/17.

11.6 Annual Performance Targets for 2017-18*

Metric	Barking & Dagenham	Havering	Redbridge
Non-elective Admissions (all Ages)	19,746	25,301	24,929
Admission to residential (aged 65+)	160	660.3	150
Reablement/ Rehabilitation (aged 65+)	84.3%	88%	89.4%
Delayed Transfers of Care per 100,000 Population	2,322.6	2,206.6	1,396.5

11.7 Annual Performance Targets for 2018-19*

Metric	Barking & Dagenham	Havering	Redbridge
Non-elective Admissions (all Ages)	20,138	25,794	25,409
Admission to residential (aged 65+)	160	640.8	148
Reablement/ Rehabilitation (aged 65+)	84.3%	88.4%	92.1%
Delayed Transfers of Care per 100,000 Population	2,322.6	2,168.4	1,376.4

*This information is also contained within Tab 4 of the Planning Template for each HWB area only and collated here to show the whole BHR area.

11.8 BHR Target Variation Narrative

11.8.1 Barking & Dagenham

Barking and Dagenham has strong performance on delayed transfers of care, maintained and improved over a long period. We have already implemented, or have developed plans, for the good practice interventions identified. In the required July return, where targets were set by NHS E, we were asked to reduce DToCs attributable to social care to 30 days. The policy position was understood to have been that 'maintenance' would be the requirement. Such a reduction, on already good social care performance, is very challenging. We advised NHS England, in our return, that we do not believe that it is possible to reduce delays to the projected figures and maintain safe discharge. The projection and target set for us was based on the period Feb-May 2017, which was an exceptionally low outturn for us. Our position is that a more realistic target, therefore, would be ca. 40-44, which is consistent with the earlier direction on 'maintenance' rather than significant further numerical improvement for good performing authorities such as Barking & Dagenham and we have indicated that this will form the basis of our BCF target, although this will, of course, be subject to plan assurance once submitted from 11th September. We have a key duty which must be, at all times, to ensure safe discharge, not merely fast discharge, and we are currently working on the outcomes of Safeguarding Adults Reviews which have looked into these issues. However, the trajectory provided delivers an improvement in target of approximately 1.1%.

Notwithstanding this, and recognising in year gains in reducing delays for people with Mental Health needs (notably Older People) we have clear steps for additional investment in Mental Health (all age), which from our situational analysis, represents a further opportunity to positively impact upon delayed days. This additional investment, supported through monies within the new Social Care Grant, comprises £500k recurrent investment in each year for 17/18, 18/19, 19/20. Alongside the provision of step down beds and outreach services £250k in each year is specifically allocated for improving discharges and delayed days. Indeed, a conservative estimate indicates, alongside a range of positive outcomes, a reduction of at least 90 bed days per quarter. We want to complete our work here, and complete our current service tender and test impact in relation to any revision to target.

11.8.2 Havering

The July Provisional DTOC submission template set out a flat “delayed days per day” monthly format for metric setting which does not take into account seasonality of the metric or indeed the Q1 actual results. Havering therefore has re-profiled the monthly targets to match previous year’s seasonality and has also included the Q1 out-turn to set its targets for this revised submission. As demonstrated below, the overall level remains the same for the year.

"Flat Projection" per July DTOC template	17-18 plans												Total
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	
NHS attributed delayed days	271.8	280.4	271.8	280.8	280.8	271.8	280.8	271.8	280.8	280.8	253.6	280.8	3306.0
Social Care attributed delayed days	84.6	87.4	84.6	87.5	87.5	84.6	87.5	84.6	87.5	87.5	79.0	87.5	1,029.7
Jointly attributed delayed days	4.2	4.3	4.2	4.4	4.4	4.3	4.4	4.3	4.4	4.4	4.0	4.4	51.8
Total Delayed Days	360.6	372.1	360.6	372.7	372.7	360.7	372.7	360.7	372.7	372.7	336.6	372.7	4387.5
Population Projection (SNPP 2014)	198,408	198,408	198,408	198,408	198,408	198,408	198,408	198,408	198,408	200,246	200,246	200,246	198,867
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	181.7	187.5	181.7	187.8	187.8	181.8	187.8	181.8	187.8	186.1	168.1	186.1	2206.3
Quarterly			1093.3			1106.1			1106.1			1082.0	
Seasonally Adjusted	17-18 plans												Total
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	
NHS attributed delayed days	235.0	234.0	268.0	301.0	301.0	291.6	311.6	301.5	312.6	280.8	253.6	280.8	3371.6
Social Care attributed delayed days	60.0	54.0	39.0	94.0	94.0	90.9	97.3	97.3	94.2	87.5	79.0	87.5	974.6
Jointly attributed delayed days	0.0	0.0	0.0	4.7	4.7	4.5	5.0	5.0	4.8	4.4	4.0	4.4	41.6
Total Delayed Days	295.0	288.0	307.0	399.7	399.7	387.0	413.9	403.8	411.6	372.7	336.6	372.7	4387.7
Population Projection (SNPP 2014)	198,408	198,408	198,408	198,408	198,408	198,408	198,408	198,408	198,408	200,246	200,246	200,246	198,867
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	148.7	145.2	154.7	201.5	201.5	195.1	208.6	203.5	207.5	186.1	168.1	186.1	2206.4
Quarterly			890.0			1186.4			1229.3			1082.0	

11.9 Scheme Contributions to Metrics

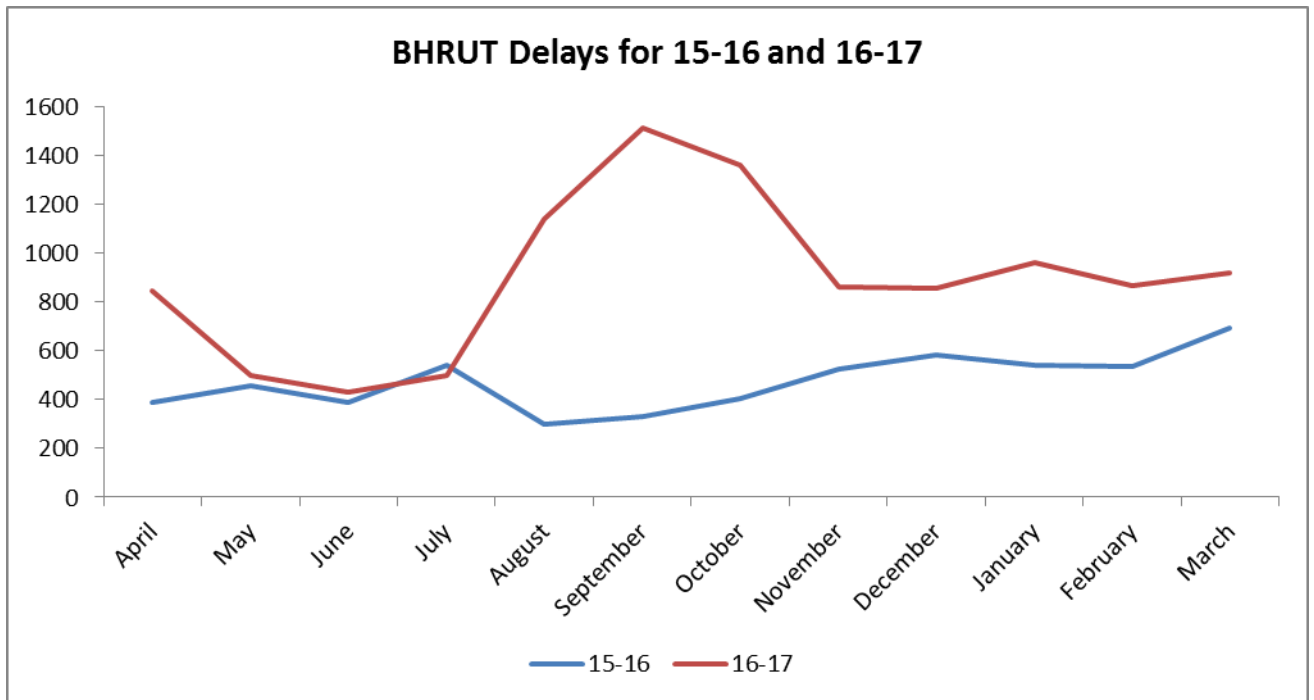
Metric	Schemes	HWBB	Commentary
Non Elective Admissions	<ul style="list-style-type: none"> ➤ Prevention ➤ Localities ➤ Dementia and End of Life Care ➤ Carers ➤ Equipment, Assistive Technologies and Digital solutions 	<p>B&D,R, H B&D,R, H</p> <p>B & D B&D, R B&D, R</p>	Local Scheme design and focus has built upon our situational analysis, feedback and experience from last years BCF, and the positive progress achieved, and with iterative development through our BCF governance to further shape and maximise impact.
Delayed Transfers of Care	<ul style="list-style-type: none"> ➤ Market Development ➤ Intermediate Care ➤ Mental Health ➤ Localities ➤ Dementia and End of Life Care ➤ Equipment, Assistive Technologies and Digital Solutions ➤ DFG 	<p>B&D,R,H B&D,R,H B&D B&D,R,H B&D</p> <p>B&D,H, R</p> <p>B&D,R, H</p>	<p>Key consideration in the shaping of our local schemes is their contribution towards HICM, clear examples here are capacity to complete assessments in the community, further delivery of trusted assessors and improved access to timely services, in the right place.</p> <p>BHR's performance in DToC is within the top quartile but we continue to seek further improvements.</p>
Permanent admissions to residential care	<ul style="list-style-type: none"> ➤ Prevention and managing demand ➤ Equipment, Assistive Technologies and Digital Solutions ➤ Market Development ➤ Mental Health ➤ Dementia and End of Life Care ➤ Carers ➤ DFG 	<p>B&D,R,H</p> <p>B&D, R</p> <p>B&D,R,H B&D</p> <p>B&D, R B&D, R B&D,R,H</p>	We have carefully considered steps previously applied, progress and key points of pressure which have informed our local approaches to deliver the targets set to which identified schemes will contribute towards the required outcomes, alongside activity currently sitting outside of our BCF plan.
Reablement	<ul style="list-style-type: none"> ➤ Intermediate Care ➤ Market Development ➤ Integrated Community front door ➤ Localities ➤ Equipment, Assistive Technologies and Digital Solutions 	<p>B&D,R,H B&D,R,H H,R</p> <p>B&D,R,H B&D, R</p>	Our shared further development of the model for intermediate care is a key enabler of further progress, alongside local applications which currently include commissioned solutions such Crisis Intervention and our shared market development plans which will further embed re-abling approaches.

12. Delayed transfers of care (DTOC) plan

We have defined our plans for reducing Delayed Transfers of Care above in section 7.5.

12.1 Case for Change

A number of people remain in acute hospital beds when their condition has been medically optimised and they do not require an acute hospital bed. This leads to delayed transfers of care (DTOC) and a poor patient experience.



Current intermediate care services, partly due to the constraints of the contracts in place, are somewhat duplicative and fragmented, particularly if a patient is referred for both community rehabilitation and social care as part of a hospital discharge process. Havering council has commissioned a new reablement service, delivered by NELFT that will be integrated as far as possible with their rehabilitation service, in order to reduce this duplication and fragmentation, but this will have limited effect without further changes to the other intermediate care services and of course this is only in place in one borough.

Implementing a full Intermediate Care Tier enables the delivery of Home First. Intermediate Care covers all health and social care commissioned and provided services that support people to be discharged early from hospital, enable support and reablement prior to any community assessment.

Once the patient is home and stable, they will need an assessment that allows the right decisions to be made about the level of intermediate care and if required, on-going care people require to help them to become, or remain, independent in their own home.

There is work underway to:

- Review and refine our discharge pathways,
- Review the various therapy services across all BHR organisations,
- Improve patient flow through our acute hospitals; and,

- To deliver an integrated reablement and rehabilitation service in Havering initially that supports our vision of supported community living.

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).

12.2 Background / Introduction

Evaluation of a 'Discharge to Assess' pilot in 2016 in the BHR system concluded that services such as CTT and IRS, including the in-reach services, are already having a positive and measurable impact on the reduction of admissions and Length of Stay but showed that inserting new service process piecemeal into the existing array of services will not work. This is partly to do with the complexity of the service array, and partly due to the complexities of the contracts in place that are a disincentive to providers to adapt their services.

Early discussions with Local Authority colleagues in Barking & Dagenham, Havering and Redbridge indicate that there is interest in widening the scope of the new model to include a single or shared reablement / rehab pathway which would provide an equality of access / outcome for service users being discharged from BHRUT. It is worth acknowledging that there are currently differing arrangements in each of the boroughs and the positive attributes of each model should be brought to the scoping of a new design; the final model design will cater for such operational differences.

The Discharge Improvement Working Group (DIWG) has been leading the various streams of work underway surrounding discharge, introduction of the SAFER bundle and the well-known issues with CHC / FNC, including delivery against the High Impact Change Model.

12.3 Performance and activity impact by month

Setting targets for this process before it is designed and fully understood is inappropriate; it is proposed that the service is designed and run over a period of 6 months. After this time, we will be in a position to assess its impact and then set appropriate performance and financial trajectory on that basis.

During the initiation period, the suite of key performance indicators and associated historical activity levels will be prepared.

12.4 Principles

The programme delivery team will adopt the following principles (which the System Delivery Programme Board have adopted and are consistent with the North East London Sustainable Transformation Plan), which means that it will:

- Have a joint and robust process that is clinically led;
- Not remove costs from the BHR system and not transfer costs between parties unless there is explicitly agreed mitigation for the transfer;
- Operate an open book approach to sharing operating costs and risks at a level of detail sufficient to assure all partners on the true impact of cost removal from the BHR system, of any scheme;
- Take high quality care and healthcare well evidenced and as defined by health and care professionals, patients and users as its starting point for redesigning services;



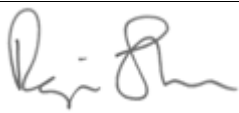
- Take an open and transparent approach to evaluating, consulting upon and agreeing the plans that will enable the system to return to financial balance supported by a robust communications and engagement process;
- Redesign care and healthcare in ways which minimise waste and handoffs, optimise the use of new technologies and modes of care, concord with the best available evidence of effectiveness and optimise the use of scarce professional time – retaining the most highly skilled and trained staff for the most complex interventions patients and individuals require;
- Remove any potential barriers via a contracting mechanism so that changes can be made quickly and flexibly.




12.5 Dependencies


The following key dependencies, not in the remit or scope of this programme, must be resolved or completed in order to successfully deliver this plan:

- Delivery of the actions detailed for Pathway 3 - CHC pathway will be managed as part of the CCG Financial Recovery Plan;
- Agreement of the Intermediate Care Tier approach to deliver Home First;
- Agreement that rapid "PDSA" style development of small incremental steps is 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;
- Agreement of existing provider services to participate in the design process, to provide a range of data on services including potentially information beyond that which is required by contract performance management. Up to date financial information on the value of services will also be required. Implicitly, this includes the agreement to the provision of Service Line Reporting.
- Agreement of multi-agency risk share agreement across health and social care partners;
- Delivery of the outputs of the Connected Data workstream;
- Development of understanding of the workforce implications



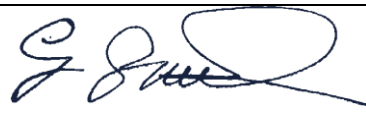
13. Plan Approval & Sign off

Barking & Dagenham		
Chair of the Health & Wellbeing Board	Cllr Maureen Worby Cabinet Member for Social Care & Health Integration	
DASS	Mark Tyson Commissioning Director, Adults' Care & Support	
CCG	Gina Shakespeare Acting Chief Officer	
Date of Health & Wellbeing Board Agreement		6 September 2017

Havering		
Chair of the Health & Wellbeing Board	Cllr Wendy Brice-Thompson Cabinet Member for Adult Social Services & Health	
DASS	Barbara Nicholls Director Adult Social Care & Health	
CCG	Gina Shakespeare Acting Chief Officer	
Date of Health & Wellbeing Board Agreement		Approval of Approach 17 July 2017 Signed under Delegated Authority Full plan to be agreed on 20 September 2017

Redbridge		
Chair of the Health & Wellbeing Board	Cllr Mark Santos Cabinet Member for Health & Social Care	
DASS	Adrian Loades Corporate Director of People	
CCG	Gina Shakespeare Acting Chief Officer	
Date of Health & Wellbeing Board Agreement		4 September 2017

In accordance with the stipulation by the Department of Communities and Local Government, Section 151 officers for the three Local Authorities hereby certify that spending of the additional money provided at the 2017 Spring Budget will be additional to previous plans for adult social care spending. The IBCF is allocated over three years (until 2019-20) and is intended to support sustainable approaches to stabilising the social care market and relieving pressure on the NHS.

Section 151 Officer and Finance Director Sign-Off		
Barking and Dagenham	Claire Symonds Chief Operating Officer	
Havering	Debbie Middleton Section 151 Officer (Interim)	
Redbridge		
NHS Clinical Commissioning Group	Tom Travers Director of Finance	

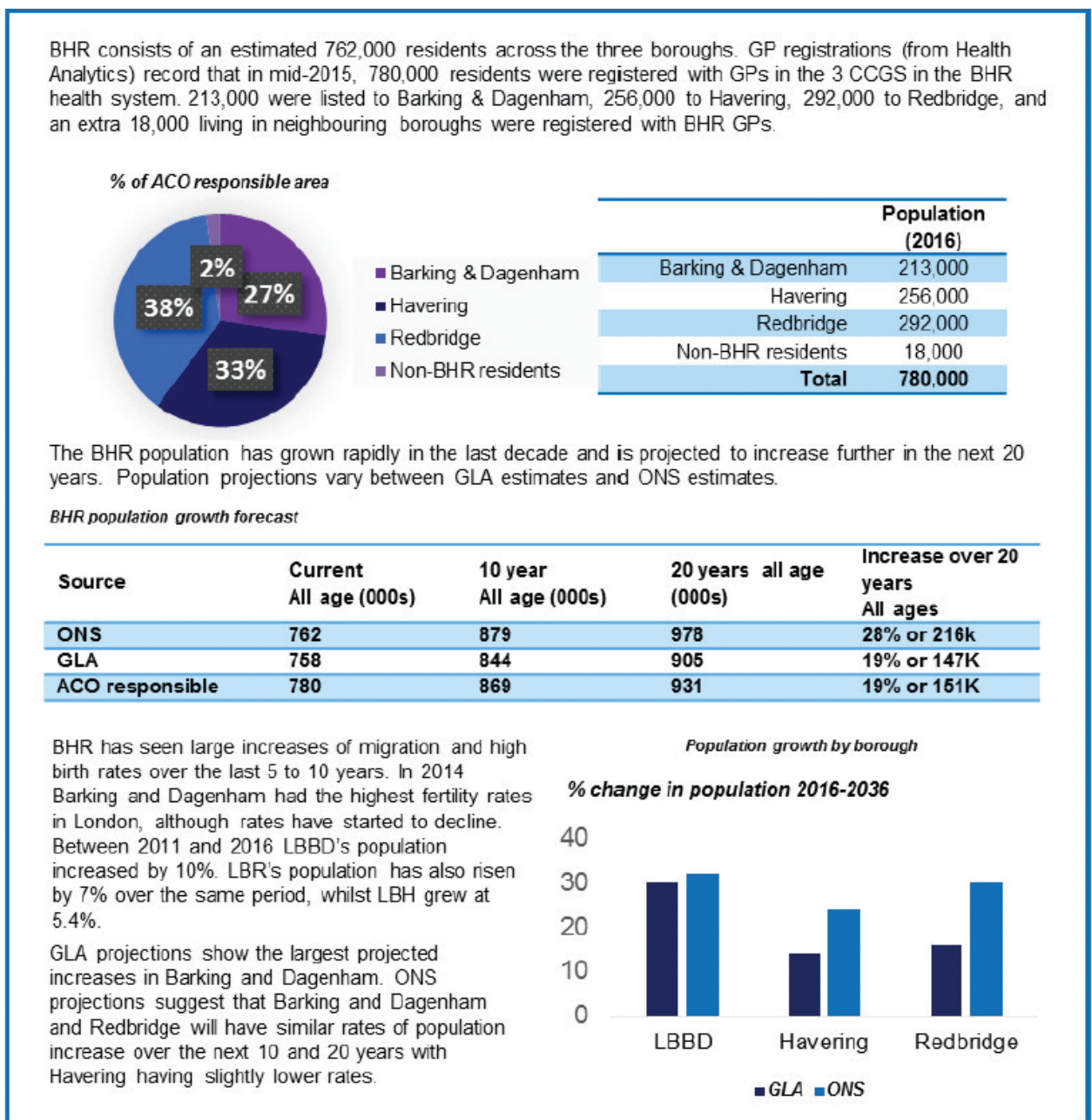
Appendix 1 – Background & Context Detail

Population growth will result in considerable increased demand for both health and social care. Adapting our service delivery model must be a priority, to ensure resources are directed to BHR residents in the most efficient way possible

Note: The population information below is taken from the BHR Accountable Care Organisation Strategic Outline Business Case submitted in January 2017.

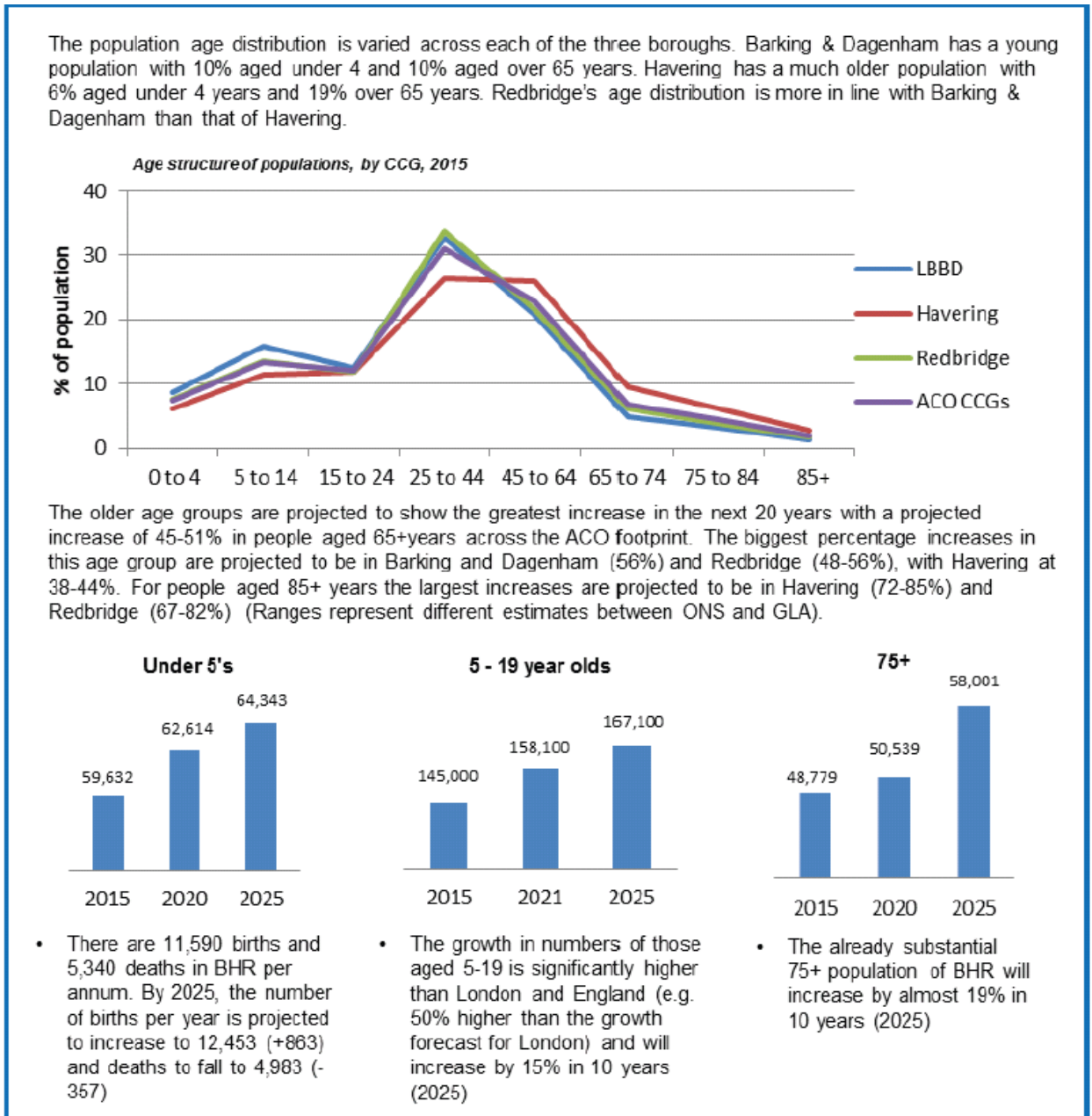
Population Profile and Growth

Figure 1: Population Growth



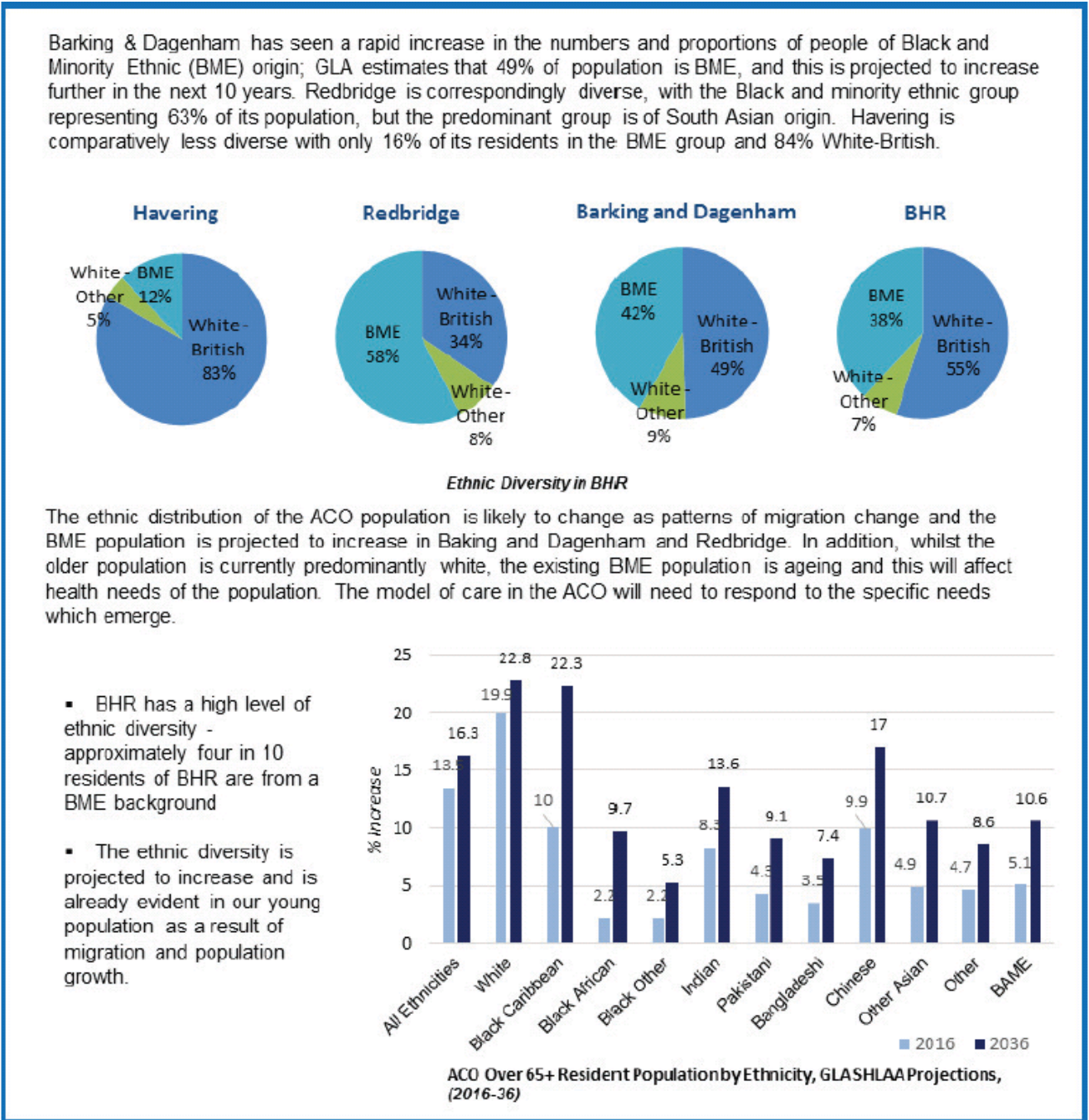
The range of age specific population forecasts means that each borough in BHR has specific healthcare challenges that are associated with their own demographic forecasts. The prevalence of long term illness and demand for care and support increases with age.

Figure 2: Age Distribution



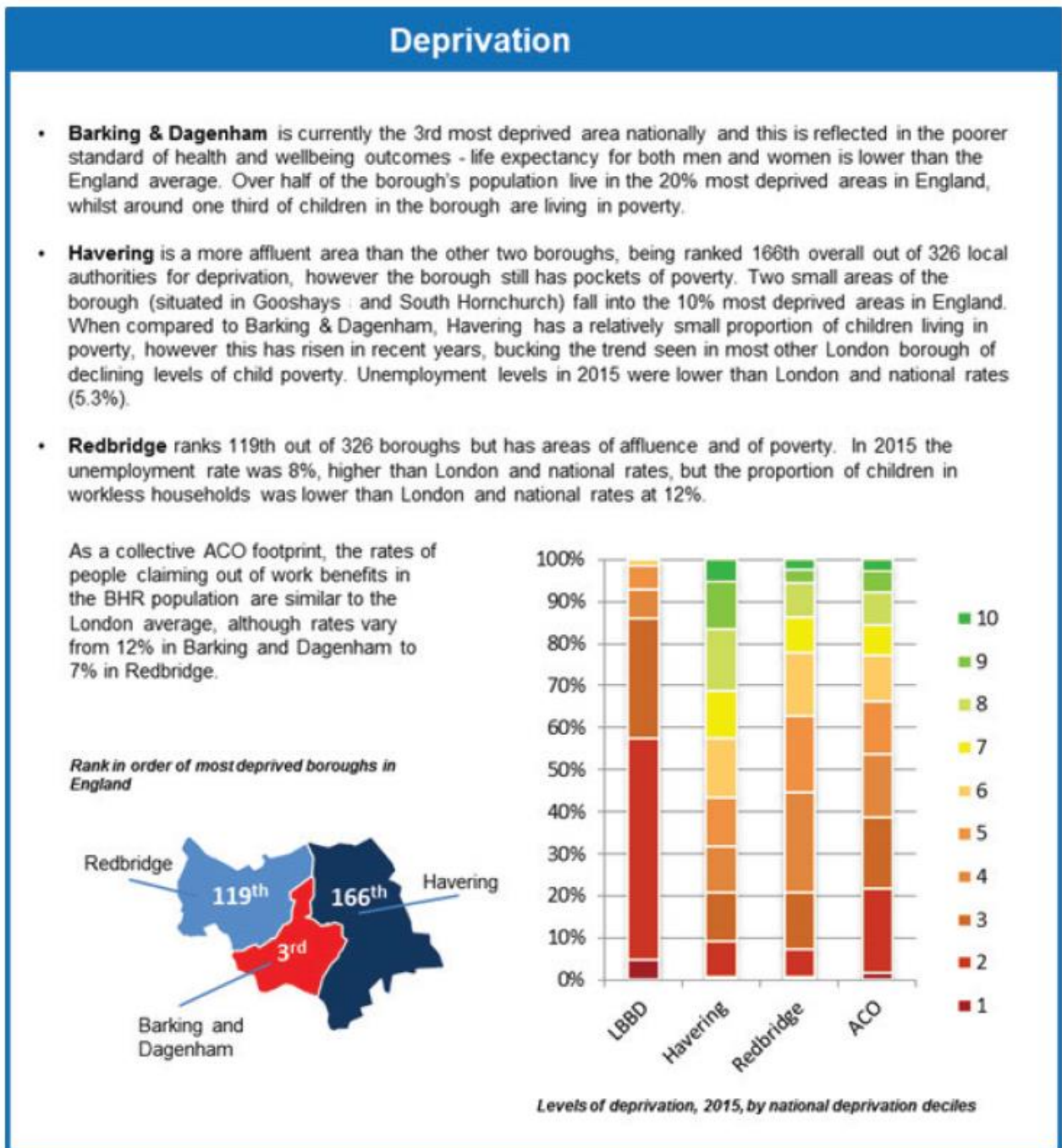
The ethnic diversity of populations can have an effect on the need and demand for health care as some conditions/diseases are more common in some ethnic groups.

Figure 3: Diversity



There is a strong correlation between deprivation, poor outcomes, and the costs of care and support. This represents an opportunity for our service model to better target those who are more likely to require healthcare in the future.

Figure 4: Deprivation



BHR Health and Wellbeing Economy

The BHR health and wellbeing economy is comprised of Barking and Dagenham CCG, London Borough of Barking and Dagenham (LBBB), Havering CCG, London Borough of Havering (LBH), Redbridge CCG, London Borough of Redbridge (LBR), Barking, Havering and Redbridge University Hospitals Trust, North East London Foundation Trust and our academic partners UCLP; who come together to improve outcomes for our diverse

population. The coterminous nature of organisations across the BHR footprint lends itself well to partnership working.

We can identify the key partners across the BHR economy as:

Barking, Havering and Redbridge University Hospitals Trusts (BHRUT)

- Responsible for two hospitals - King Georges Hospital in Redbridge and Queens Hospital in Havering serving a population of around 750,000, employing 6,500 staff and with annual budget of £505m.
- Queens Hospital operates a full A & E service with trauma centre and a hyper-acute stroke unit. It has the largest maternity unit in the country, a renal dialysis unit and a specialist neurosciences centre and a joint cancer centre run with Barts Health Hospital London.
- King George Hospital also provides an A & E department and a chemotherapy day unit.
- Barts health is a provider of specialist services and is the provider of choice for a number of BHR residents due to access, notably from Redbridge.

North East London NHS Foundation Trust (NELFT)

- Provides an extensive range of integrated community health services and employs 6,000, with an annual budget of £330m.
- Provides high quality mental health and memory services.
- It is the principle partner in the Care City innovation Test Bed, addressing barriers to innovation within the NHS and Social Care, and innovation efforts in community services with models such as the community treatment teams.

BHR CCGs

- Responsible for the commissioning of most local health services in Barking and Dagenham, Havering and Redbridge
- Each Clinical Commissioning Group is a legal entity in its own right, but the three CCGs have worked together under a single Accountable Officer since the evolution of CCGs from Primary Care Trusts in 2013 to deliver joined up health commissioning for circa 750,000 people
- All GP Practices in Barking and Dagenham, Havering and Redbridge are part of the CCG

Primary Care

- Barking & Dagenham: 37 GP practices, with all signed up to Together First GP Federation
- Havering: 44 GP practices, with 40 part of the Havering Health GP Federation
- Redbridge: 46 GP practices, with all part of the Healthbridge Direct GP Federation
- Practices have come together to form GP networks within each borough (a total of 10 across BHR) which are coterminous with locality boundaries and which will enable the delivery of primary care at scale

Local authorities (The London Boroughs of Barking & Dagenham, Havering & Redbridge)

- Social care services have statutory responsibilities to safeguard vulnerable children and adults, and to provide a range of services to meet assessed needs in line with the Care Act and Children's Act.
- Councils also provide a range of health and wellbeing services, preventions and interventions, such as re-ablement, and focus on promoting healthy living, preventing illness and supporting patients with long term conditions.
- Responsible for public health services like drug and alcohol treatment and recovery, contraception and sexual health, quit smoking, health visiting and school nursing.

- They have a key role in housing, regeneration, leisure and culture, education, work and benefits system.

Voluntary sector

- Barking & Dagenham and Redbridge voluntary sectors are headed by a CVS in each borough which supports individual organisations to develop and act as a conduit between organisations on the ground and commissioners. Havering has a Concordat which performs a similar function.

Academic Partners

- UCL partners, our academic health science partnership, has over 40 higher education and NHS members, delivering improved health outcomes and wealth through discovery science, innovation into practice and population health.
- UCL partners facilitates the improvement of population outcomes through: Academic Health Science Centre, Academic Health Science Network, Education Lead Provider and aligned with the NIHR Collaboration for Leadership in Applied Health Research and Care and NIHR Clinical Research Network upon Thames. It's the only academic health science partnership in the country to align these NHS and Department of Health designated roles under one umbrella.
- UCL Partners brings links to the academic community and delivery of innovation.

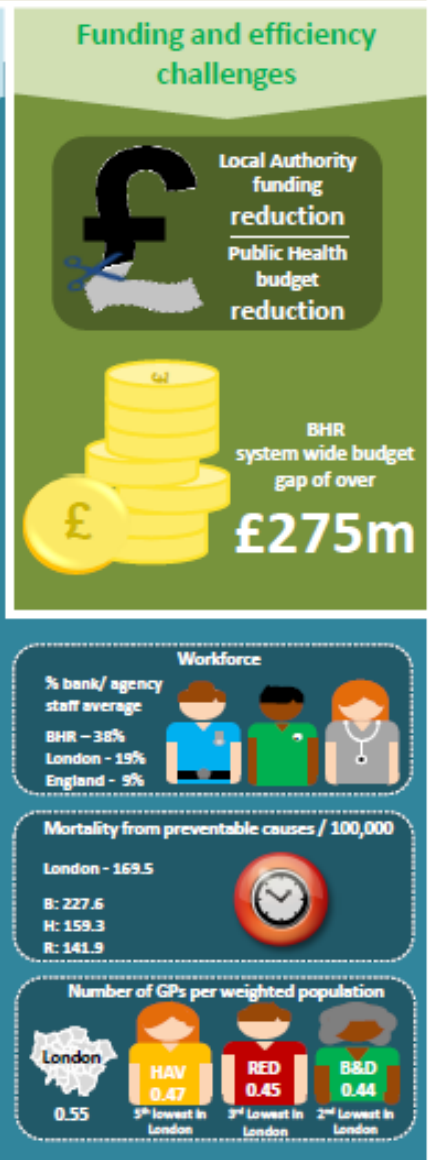
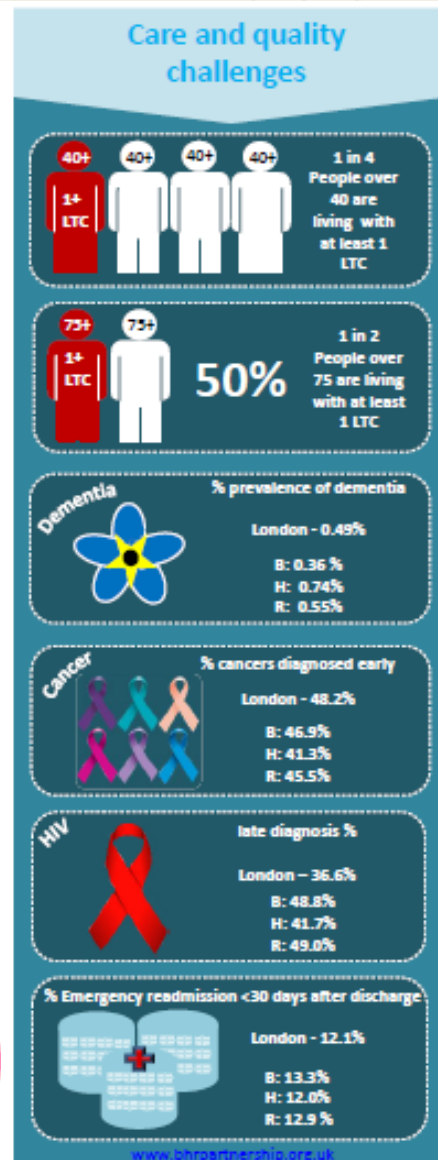
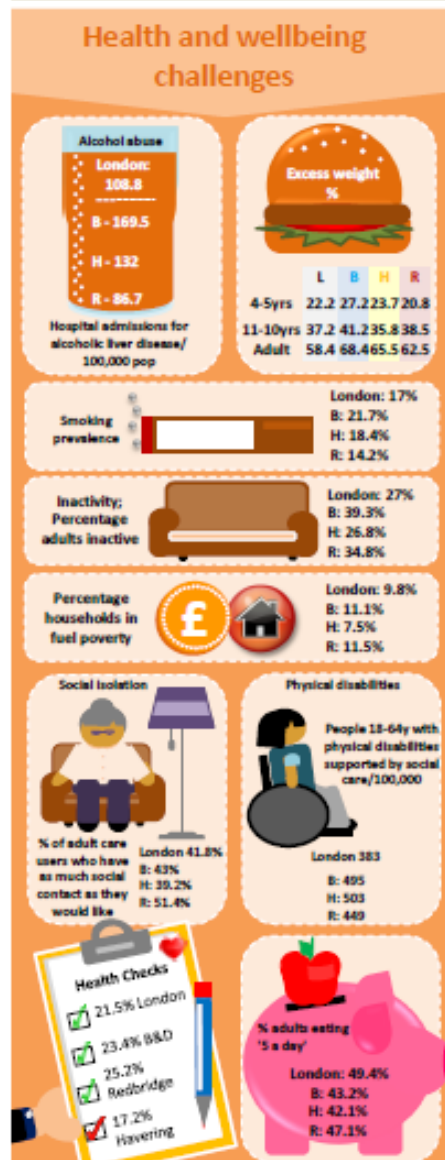
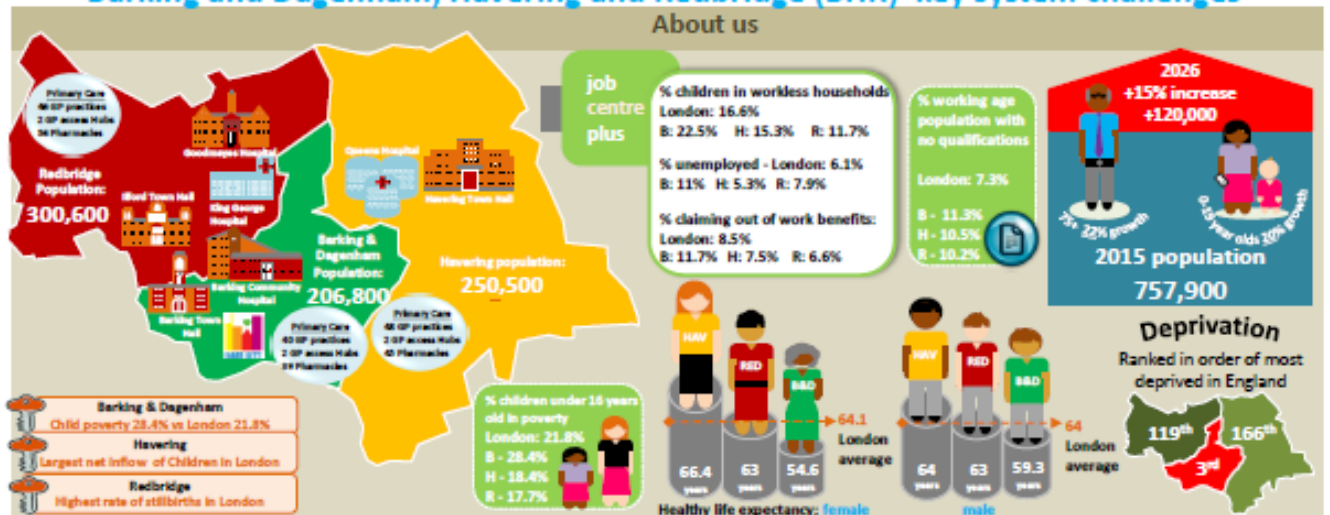
Working Together: A strong history of collaboration

There is a strong history of successful collaboration across health and social care in Barking & Dagenham, Havering and Redbridge, leading to real improvements for our local population.

This is exhibited through the BHR Integrated Care Partnership, formed to provide clinical and democratic leadership for the Accountable Care System work and now leading the joint work to deliver Localities and integrated working through joint commissioning. This builds upon the Integrated Care Coalition (ICC) which was established in May 2012. The ICC brought together the lead organisations in our health and wellbeing economy who are committed to working together in a (guiding) coalition of strategic partners to develop a joint approach to integrated care. This was in response to significant pressure experienced across the system, particularly at BHRUT, resulting in non-delivery of key access targets.

The ICP is a leadership group which makes recommendations to, and works closely with, the local health and wellbeing boards, CCG governing bodies and provider organisation boards.

Barking and Dagenham, Havering and Redbridge (BHR) key system challenges



Appendix 2 – Plan Engagement

BHR Residents Survey

People want a more responsive, joined up system that delivers timely care closer to their homes. There is an appetite for doing things differently:

- Residents recognise the positives of more integrated working
- There is an appetite for services that support healthy living, but better promotion is needed
- Access to and quality of information about services is key (arguably even more so for those in poorer health)
- Carers in particular feel that they need more support to navigate the system and to support their own health and wellbeing
- There is a geographical and demographic dynamic to attitudes, but this exercise means that we understand more about these groups and what drives them to assist with better targeting.

All Staff Survey

Staff working for BHR CCGs, the three local authorities, NELFT, BHRUT, LAs (those in BHR only), Partnership of East London Co-operatives (NHS 111 Services), and the Commissioning Support Unit along with GPs across BHR participated in the survey. This was developed by communication leads from across BHR alongside clinicians in collaboration with a group of operational and back office staff. The purpose was to understand their views on how health and social care services in BHR can be improved and how all of us can be supported to live healthier lifestyles.

This was the first time that all health and social care staff and GPs working in BHR have been surveyed collectively. The key areas of focus were:

- The barriers between services that impede the delivery of good quality care
- The ways in which clinical staff can be helped to support our population to live longer, healthier lives
- What our staff wants from us to support them to live healthier lives.

Survey findings:

- Health and social care staff need to be supported to work more closely together
- There needs to be reduced duplication and more streamlining of services
- There needs to be a shared vision and objectives which reflect the needs and wants of the public supported by organisational cultures that complement each other
- A comprehensive electronic shared records and a single strong IT platform across the system is essential
- There needs to be clear guidance around responsibility for service users/people
- There needs to be work towards a more equitable service provision across the three boroughs
- There must be a focus on outcomes as opposed to finance and activity
- There is an urgent need to address front line staff workloads by ensuring that workforce levels meet current demand
- There are a number of ways in which employers can support staff to live healthier lives and reduce stress.

Voluntary Sector Engagement

We have engaged the thriving voluntary sector to explore ways of working that are mutually beneficial and discuss how they could support some of the key areas of focus that emerged from the programme workstreams. This included the importance of delivering holistic health and social care around key population groups such as those who are frail, complex cases, and a wider programme of prevention to support our population to live longer, healthier lives.

Outputs from workshops and meetings have informed the content and emerging proposals of the ACS business case.

There are a significant number of examples of best practice across the voluntary sector in BHR and these need to be better understood. We need to ensure that best practice is shared in a timely and efficient manner.

There needs to be a single approach to commissioning of voluntary vector services, this should be streamlined, with a clear vision of the needs of the population to ensure that gaps are addressed and that there is no duplication. Services need to be more consistent so that confidence in them can be built.

We all need to work to a single vision and to address a commonly agreed and prioritised set of needs, being clear of our roles within the wider system. This will make best use of limited resources and support people in BHR to live longer, healthier, happier lives.

Clinical Engagement

We have conducted a number of locality delivery model workshops with GPs, health care professionals and members of local authorities to get a collective vision for what the locality delivery model should achieve. The positive engagement with these groups have enabled us to better understand the barriers of working across organisations and the key enablers required for our vision of an integrated system.

- GPs want to work within the locality delivery model structure to develop primary care at scale;
- There should be a defined set of outcomes that the development of the service model can be measured against;
- We need to develop a clear strategy that communicates the benefits of moving to a new model to those who will be affected by it;
- There ideally needs to be a common IT platform, or visibility over other organisation's IT platforms, to enable a single view of the people record.

The results of this engagement work have given a strong insight into the key system challenges as well as some of the behaviours driving this activity and have shaped the initial design of the Locality Delivery model of care. Further engagement with key stakeholders including our population and the community and voluntary sector will continue to ensure that our emerging model is co-designed by all stakeholders.

Appendix 3 – Detailed Local Scheme Information

Themes	Boroughs		
	Barking & Dagenham	Havering	Redbridge
1. High Impact Change Model	<ul style="list-style-type: none"> • Mental Health • Localities • Home First, • Intermediate Care • JAD 	<ul style="list-style-type: none"> • Home First, • Intermediate Care • JAD 	<ul style="list-style-type: none"> • Supporting Hospital Discharge & Reablement • Localities • End of Life Care • Intermediate Care
2. Prevention & Managing Demand	<ul style="list-style-type: none"> • Prevention • Equipment, Assistive & Digital Solutions • Carers • DFG 	<ul style="list-style-type: none"> • Prevention in Havering • Integrated Locality Working • Integrated Community Front Door • DFG 	<ul style="list-style-type: none"> • Prevention and Early Intervention • Equipment, Assistive Technology, DFG • Dementia & Carers
3. Market Development & Sustainability	<ul style="list-style-type: none"> • Market Development 	<ul style="list-style-type: none"> • Market Development 	<ul style="list-style-type: none"> • Market Development & Sustainability
4. Protection Social Care & Maintaining Independence	<ul style="list-style-type: none"> • Dementia & End of life 	<ul style="list-style-type: none"> • Carer / Respite Services • Telecare • Placement Budget support 	<ul style="list-style-type: none"> • Maintaining Independence • Mental Health

1. Barking & Dagenham Schemes

Theme 1: High Impact Change Model

Scheme BD 1: 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:

- 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.
- 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.

Theme 1: High Impact Change Model

Scheme BD4: Localities

Barking and Dagenham have introduced a new locality model which has reorganised locality arrangements from formerly 6 clusters to 3 localities (a 4th to be added with the completion of 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

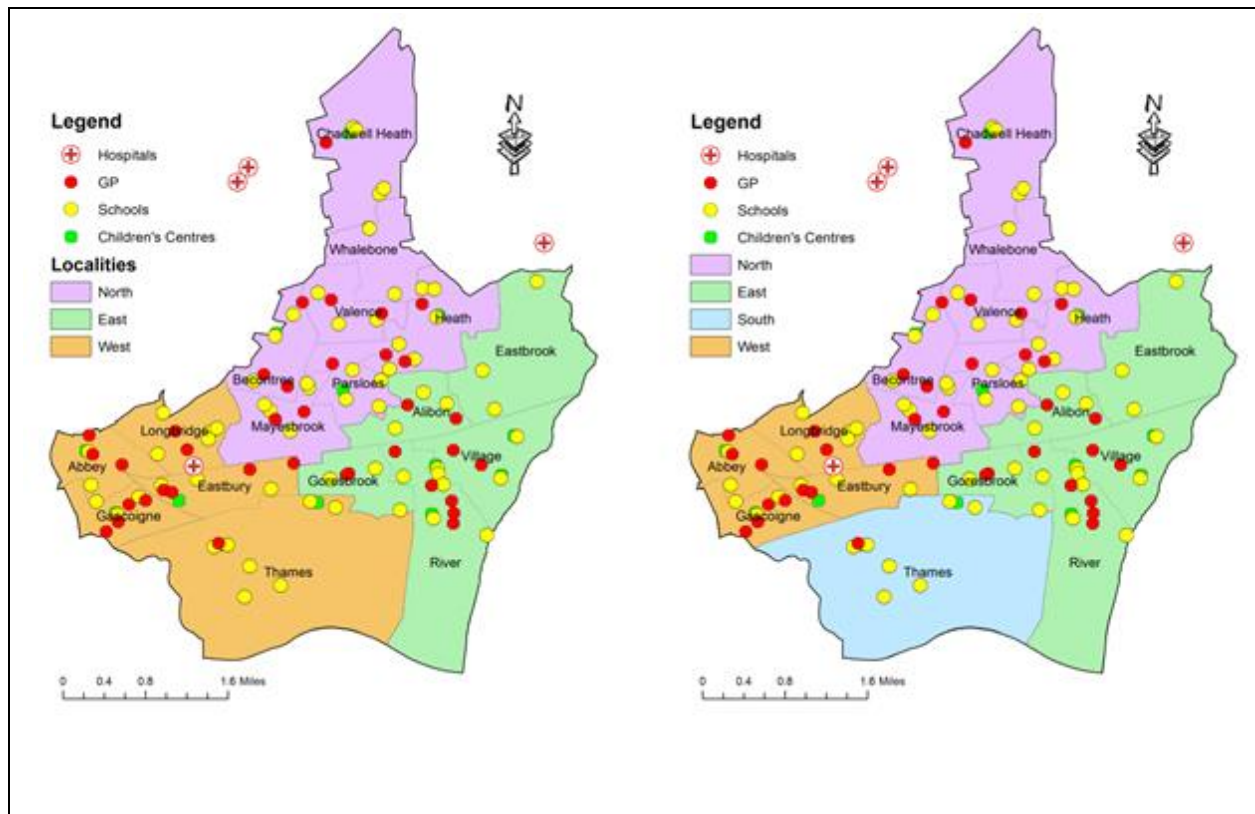
With our partner NELFT we are delivering personalised care and support capitalising upon streamlining of processes, reduction in duplication, and enabling complex tasks to sit with our most skilled and experienced staff. We are also introducing a single Disabilities services to better support whole life 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.

Objectives:

- To continue to embed our locality model and new staff roles and processes
- To seek opportunities to extend impact of localities into early identification and prevention, alongside the delivery of community assessment as a key part of Home First delivery, reviewing the balance of resources with those held within the Joint Assessment and Discharge Service.

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



Theme 3: Market Development & Sustainability

Scheme BD 2 - 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 Market Development scheme 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.

Theme 4: Protecting Social Care & Maintaining Independence

Scheme BD3: 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
- Develop 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.

Theme 2: Prevention & Managing Demand

Scheme BD5: Prevention

Prevention is key to 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.

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

Theme 2: Prevention & Managing Demand

Scheme BD6: Equipment and Assistive Technology

We are eager to optimise the benefits of assistive technologies and digital solutions available within the market to both better optimise improvements for local people in their connectedness to sources of information, support and advice alongside solutions that can enhance levels of independence, self care and improve how risks are managed. With the advent of initiatives such as those of Home First there is an increased emphasis upon timely access to such solutions, their contribution to the completion of assessment and the extension of trusted assessor arrangements.

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
- Implement '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
- 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
- Extend trusted assessor arrangements to key service providers including Crisis intervention service providers and our out of hospital partners of the Red Cross
- 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

Challenges include- access to networks, cultural resistance to alternative forms of support, weakness in evidence based outcomes upon which investment would be based and in some cases a lack of 'connectivity'

Theme 2: Prevention & Managing Demand

Scheme BD7: 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

2. Havering Schemes

Theme 2: Prevention and Managing Demand

Scheme H1 - Prevention in Havering

Utilising all available assets is essential in ensuring that public services continue to support those most vulnerable in our communities. Almost every activity, engagement, communication and discussion between service users and their carers, potential service users and their carers and those who are part of the social care and health system should look to utilise and enhance available assets and abilities as, at least, an implicit aspect of the conversation. The ASC operational service is introducing a model that looks to explore available assets before, as a last conversation, resorting to statutory support. This is not a proxy for leaving people out of a system who need it. It is about empowering and supporting people to use all they have to maintain a healthy and independent life.

Havering has also established a Prevention Programme that will look to maintain and support this approach across a range of commissioned services and at pivotal points for the service user.

The interface between hospital and the community is vitally important in ensuring that, at a point of crisis, preventative measures are put in place to enable a full return to independence where that is possible.

Going into hospital and coming out with a new or on-going need for support demands a quick and effective response, putting in place all the necessary support mechanisms that will reable and rehabilitate the person back to independent living as soon as possible. We are committed to the principles of 'Discharge to Assess', the idea of getting people out of the acute setting as soon as they are medically fit, ideally back home, where prompt assessment of needs leads to support in place quickly, in whatever form necessary, to enhance chances of rehabilitation and independence.

Where commissioned services are part of this they need to be enabled to play their part in contributing to the desired outcome. This needs to be considered in the design of such services, ensuring that integration is designed as an end to end process and not as an individual, segregated service. Commissioners and providers from different organisations need to join up to design across the end to end process. Our design will align with the High Impact Change model; ensuring people get home with all the support necessary to maintain independent lives.

This approach to prevention continues across other commissioned services, including:

- Home Care – Designing the service on outcomes to service users and developing

mechanisms for service user feedback, leading to an outcome based commissioning model. There is no price competition or payment by results, simply an understanding of outcomes and a commitment to continuous improvement.

- Voluntary Sector services – The voluntary and community sector is an important part of the market. Extensive engagement with both commissioned and non-commissioned voluntary sector services co-produced a set of outcomes important in the Havering context. The required outcomes include:
 - High quality information and advice – for adults this is a directly commissioned service, Care point.
 - Ensuring people are supported in their journey from hospital to home; ‘Help not Hospital’ provided by British Red Cross
 - Low level support in the community for vulnerable people that prevents escalation to statutory services; ‘Here to Help’
 - Low level support in the home, providing and installing equipment to support independence; ‘Havering Safe at Home service’.

However the process also identified three other outcomes that are particularly important in the Havering context:

- Social inclusion – informed by the identification of social isolation as a major driver for demand in Havering. Further explored through a social inclusion project, producing recommendations for change that have informed both the need for preventative services but also the idea of social reablement, integrating a social response to work with the support given from the new reablement service for older people.
- Carers, both young and old, supported in their role – informed by the demographic of Havering and the identification in the last census of 25000 carers within the borough. The Carers Strategy identifies more detailed outcomes for the voluntary sector to respond to.
- Development of self-sustaining peer support networks – responding to the need for the community to use all its assets to provide support to people.

A commissioning exercise has been launched for organisations to indicate what service design they propose to best deliver the outcome required. This will go live in 2018.

Once commissioning exercises are complete we will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary.

- Extra Care Housing – We have aligned our 3 Extra Housing schemes and will re-commission the services from 18/19. We will review the offer during 17/18, with a view to improving the service, maximising benefits and applying lessons to any new schemes identified. There is a case for potential increase in provision over coming years and these will be developed in partnership with Housing, using lessons learnt from our current provisions.
- Shared lives – we have introduced a new shared lives service and will develop this, making connections with the community and delivering cost efficiencies.
- Assistive technology – Havering invests considerable amounts in providing Assistive Technology. This supports people to feel safe in their homes, deferring the need for residential care and supporting carers to be more independent when they have the security of such technology.

The financial investment in these services is significant. Pressures on budgets can lead to the immediate cutting of preventative budgets. In the longer term this will have negative impacts on health services and on people within the system. The Better Care Fund is essential in supporting the preventative agenda.

Theme 2: Prevention and Managing Demand

Scheme H 2 - Integrated Locality Working

The BCF Integrated Localities scheme in 16-17 developed the design for co-located teams across Community Health and Social Care.

Phase 1 of the project (Co-location) is now complete with 42 adult social care staff now located across the 4 localities– Cranham, Elm Park, Romford and Harold Hill. Feedback from staff is generally very positive, good working relationships have formed in the teams and there has been improved communication and information sharing.

The focus for Phase 2 of the project is to move from co-location to fully integrated teams. There has been further review of current operational processes for both health and social care and identifying areas that can be joined up to support integrated working across health and social care. Some of the key areas that are being developed are:

- Joint consent process
- Joint assessment process
- Joint care planning process
- Referral pathways between teams
- Review of community OT function across health and social care

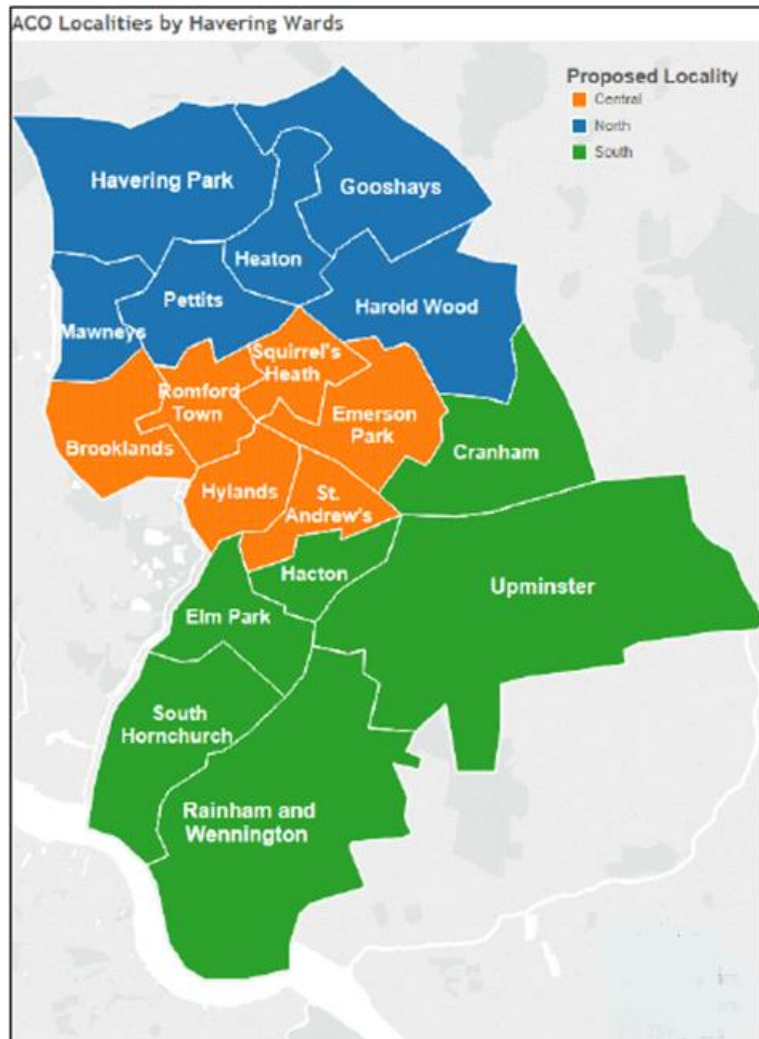
Some of the workforce development that was planned for early 2017 has been postponed due to the development of the Adults Localities Model for Havering. This is a significant system wide programme of work which will expand on the current locality model to include other key services such as housing, pharmacy, voluntary sector, employment and welfare presenting a more joined up service with stronger inter professional relationships.

The initial design phase of the locality model resulted in the locality boundaries being changed from 4 to 3; North, Central and South to align with the GP Networks. The detailed design of the integrated system model is currently underway and a Design Group has been established to drive this work forward. Data from all partner organisations is being analysed to establish the current demand across all service areas to inform the design process ensuring the future model is responsive to need on a locality basis.

A large consultation and engagement exercise is planned with GPs, Forums and Voluntary sector to ensure the design process incorporates views from all key stakeholders.

It is anticipated that staff will find that this model works better for them, presenting a more joined up service that gives them the freedom to address the key issues for their service users and, with stronger inter-professional relationships and understanding and less 'chasing' of other services, affords them more face to face time with their service users. It will simplify the ability for cross-referral between different services, connect services that offer wider understanding of the person's needs such as housing, employment and skills and specialist support such as for domestic violence, substance misuse and voluntary sector advice and support services.

The localities model will deliver a seamless, joined up service which will deliver better outcomes for our service users. It will aim to prevent the need for further, more intensive services later in life and reduce repeated need for outpatient referrals and multiple usage of urgent and emergency care.



Theme 2: Prevention and Managing Demand

Scheme H3 - Integrated Community Front Door

There is a significant programme of work underway to redesign the first point of contact or 'front door' to adult social care. The vision is to develop an integrated health and social care first point of contact which is coordinated and skilled to ensure that people get the right information, advice and support to maximise independence.

The initial phase of the project has focused on the current structure of the team, staffing, and work flows to understand the demand on the front door team and where improvements can be made to promote better outcomes. As part of the design phase, LBH are looking to include the '3 conversations' model as part of the front door redesign which is an innovative approach to needs assessment and care planning. The key focus is on identifying people's strengths and community assets and supports staff to identify this by having 3 distinct conversations. A number of staff engagement workshops have been held to work through the design options, the key design principles at this stage are:

Initial point of contact: Detailed initial contact taken incorporating 'conversation 1' preventing the client having to repeat their information at a later stage. The staff within this team will have access to a wealth of information regarding community assets to enable the provision of

appropriate information and advice and manage independence.

Urgent Response: If, following the initial point of contact, it appears more in depth work is required to support the client, 'conversation 2' will be picked up by a more senior member of the team and if appropriate an immediate response will be provided to manage and stabilise the situation.

Short term intervention: Following the immediate response, the team will manage the case for a short period of time (yet to be defined) focusing on coordinating informal support networks, creative problem solving, reducing current and preventing future risk.

If the client requires further intervention following this, the case will be referred to the appropriate long term team for the planning and management of long term outcomes.

The second phase of the project is to align this model with the Single Point of Access (SPA) model for the community services provided by the North East London Foundation Trust (NELFT) ensuring there is a single access approach across both health and social care. The vision is to have a coordinated response to contacts and where appropriate have a joined up health and social care response to managing crisis situations.

This integrated approach also links into the developing localities model; it is likely the integrated front door will be the access point for the services in the localities to provide a coordinated, seamless approach in the community.

Theme 3: Market Development & Sustainability

Scheme H4 - Market Development

Havering has recognised the pressures on the market. These include financial pressures but also the increasing level of need when people come into the system. For example we have been successful in preventative measures that keep people in their homes for longer but the corollary of this is:

Home care agencies needing to deal with increasing demands in supporting people who are more aged and have more long term conditions

The residential care market receives people with much greater age related needs than was the case when younger cohorts of people routinely entered residential homes.

Awareness of the issues faced by providers can be understood because there has been an investment of time and effort in building relationships with our providers. Listening to their concerns and responding has led to an improved dialogue.

This has led to real change that has been acknowledged by providers and built trust with commissioners. A 10% increase in home care fees in 16/17 was a direct result of listening to the market, but recognising financial pressures is only part of the story. A whole range of changes and innovations have been introduced and are planned to ensure outcomes are delivered and quality improved within a sustainable market. Changes implemented include:

- Development of an Active Homecare Framework, a flexible Dynamic Purchasing System (not based on cost competition or pre-bought IT models) that ensures quality and builds capacity within the market, developing a diverse range of providers. Benefits include the reduction of spot purchasing packages of care from 50% to just 10% of new packages.
- Development of a Training offer coordinated by LBH that was requested by providers
- Ongoing provider forums with a focus on understanding and dealing with issues
- Re-commissioning the reablement provider and looking to integrate with health services

- Significant funding changes to the parts of the residential care market to acknowledge the pressure on the system (7.6% increase to residential care fees)
- The interface between hospital and home is strongly managed with minimal delayed transfers of care

Planned innovations and improvements include:

- Development of Individual Service Funds, giving providers capacity and opportunity to design tailored packages of care with service users
- Review and re-design of the infrastructure for personalisation with the outcome of increased numbers of direct payments
- Review of payment methods for homecare providers
- Proposals to have a council funded officer, appointed by the providers, who assesses people at the point of referral from hospital on behalf of care homes, so they do not have to independently send assessors out from already overburdened services.
- A review in 17/18 of the whole residential market and its funding, with potential for further adjustments to relieve pressures arising from staff recruitment problems and other pressures including minimum wage requirements

This approach to the market has meant some brave decisions on funding and this has put pressure on ASC and Council budgets. There are still more challenges. Providers of learning disability and mental health services are increasingly reporting difficulties in meeting demands. The work we have done with the market needs to be sustained. The Better Care Fund has enabled some of these initiatives and will be used in future to try and maintain and improve the market.

Theme 2: Prevention and Managing Demand

Scheme H5 – Disabled Facilities Grants

The 2016/17 expenditure on Disabled Facilities Grants was £812,000 with over half of these resources being spent on providing 88 wet rooms/level access showers.

Havering is reviewing how it manages its Disabled Facilities Grants to maximise the benefit of future increases in the Better Care Fund resources. This review will include:

- A benchmarking exercise looking at how Disabled Facilities Grants are delivered in other Councils through a Discretionary Grants Policy.
- An examination of the opportunities that will be available to Havering residents if the authority adopts a Renewals Policy enabling the Council to offer discretionary grants instead of means testing.
- A look at the opportunities still available for internal integration, in relation to the range of services provided by the authority, to assist older home owners and clients with disabilities.
- A look at the opportunity available for using the Housing Service procurement frameworks and pool of building surveyors
- A look at the opportunities available for partnership working with Barking and Dagenham and Redbridge Councils
- Review the opportunities that would be available if some of the new services were outsourced
- Continue the dialogue with the voluntary sector regarding the role they hope to play in delivering social care objectives
- Publicity and engagement options, promoting grants with Housing Associations, Registered Providers and Private Landlords to enable the better coordination of work for people with disabilities.

- A review of how we can improve all health and safety issues associated with the delivery of Disabled Facilities Grants.

Havering's Discretionary Grant Policy

The introduction of the Better Care Fund has seen mandatory and discretionary disabled facilities grant play a major role in the delivery of integrated health and social care services, as this form of assistance can contribute to:

- reducing delays in hospital discharges, (through the provision of discretionary funding for stair lifts, ramps, and wet rooms)
- helping older adults and people with disabilities to remain in their homes.
- addressing affordable warmth issues (Energy efficiency measures)
- reducing crime and fear of crime (through home security measures)
- fall prevention work (through funding Handyperson Scheme)
- prevention and hospital avoidance (through telecare and assistive technology)
- provision of advice for self-funders and clients requiring support (through voluntary sector and home improvement agency.)

All assistance provided as part of the Havering Discretionary Grant framework would only be considered having regard to the amount of resources the Authority has at the time.

Early intentions for this new Policy include the following potential discretionary forms of assistance:

Discretionary disabled facilities grants (top up grants)

- The maximum amount of grant available for a mandatory DFG is currently £30,000 the Authority will decide whether through this policy it should provide an additional grant amount of up to £10,000 as a discretionary top-up where the cost of work exceeds £30,000. This grant will be available to cover work that cannot be funded from the available grant and to enable the implementation of the authorities recommended scheme. Also, this grant can be used to cover unforeseen works where the cost of these elements exceeds the mandatory grant limits.

Discretionary Stairlifts scheme (procured via central contract)

- One of the most popular elements of the mandatory disabled facilities grants program is the provision of stairlifts. Currently, this type of work is only approved if supported by a recommendation by an occupational therapist, after which the client is required to complete the mandatory application and means testing forms and find a suitable contractor to provide quotations, before any assistance can be approved and works start on site.
- The introduction of a discretionary stairlifts scheme would mean that the authority would take the responsibility of procuring the appropriate equipment using internal procurement processes. In addition, the associated paperwork will be simplified. In practice, this would mean that we should see quicker and more cost-effective installations of stairlifts across the Borough.
- Consideration will be given to whether the Council should create an ability to remove unwanted stairlifts, and recycling reusable stairlifts by repairing, refurbishing and testing them, as well as using Trusted Assessors to increase the number of health professionals and appropriately qualified individuals who can decide that a client requires a stair lift.

Discretionary wet room scheme (procured via central contract)

- The provision of wet rooms is an increasingly popular adaptation especially for older residents who are unable to get in and out of a bath. Similar to Stairlifts if this work is carried out via a mandatory disabled facilities grant the client is required to find

contractors and organise the building works. It is proposed that using the Authority's procurement framework and adopting standard agreed prices for the building work, should result in a reduction in the time scales associated with the installation of this type of work.

Discretionary telecare and assistive technology scheme (including next Generation technology)

- The installation of the next generation of Tele-care and other assistive technologies could have a major impact in relation to reducing the impact on primary care services by allowing clients to receive more support in their homes. Existing products already have a positive impact in assisting in hospital discharge and allowing people to live longer in their own homes. As a result the Havering believes that the installation of this type of work forms a key pillar in the authority's social care strategy.

Handy person service (fall prevention, minor repairs)

- Many older homeowners find themselves using primary care services due to slips, trips and falls. Other local authorities have demonstrated that there are considerable benefits to funding handyperson services where they specifically target for fall reduction measures. In addition, many older homeowners are prey to unscrupulous builders who overcharge them for minor work that is required to their home and often this work is of poor quality. A handy person service would also undertake minor jobs which could result in a reduction of older people suffering from financial exploitation

Discretionary minor works scheme (energy efficiency, security, ramps etc.)

- It is estimated that over 40,000 older people die of the cold in Britain each year. The provision of discretionary minor works grants would mean that targeted assistance could be provided each year to carry out energy efficiency measures to cold homes. The introduction of discretionary minor works grants would also mean that the issue of crime and fear of crime could be addressed by funding security works for vulnerable households.
- There are a number of other works that could be included as part of this scheme and would address social care issues and have a direct benefit to clients if they could be delivered quickly these include the provision of ramps and energy efficient boilers.

3. Redbridge Schemes

Theme 1: High Impact Change Model

Local Context

Our HICM is described in section 7.4 through to 7.6 in the main narrative as part of the Discharge Improvement Working Group.

We want more people to be supported in the community rather than in acute settings, (unless it is essential). Ensuring the safe and timely discharge of people from hospital will ensure a better use of resources by reducing our reliance on a bed based service for care of frail elders and by providing more community based solutions will enable greater numbers of people to be supported and treated in their own homes, avoid unnecessary admissions to hospital and ensure shorter stays in hospital for people who have needed to be admitted.

With our reablement service free for those who are assessed as being able to benefit from it, it can support essential things including washing and dressing; meal preparation; household

tasks or shopping; getting around or out of the house and getting involved in social and community activities. It will also ensure that we have an increased focus on preventative services ensuring the right support at the right time, the most appropriate level as an enabler of individual health and wellbeing working closely with our partners, community and providers to develop the market.

By March 2017 we had helped 1,020 people over 65 recover following hospital admission, living independently at home 3 months after.

Scheme R1 - Supporting Hospital Discharge & Reablement

Our Hospital Social Work teams based in Kings George's Hospital (under BHRUT) and Whipps Cross Hospital (Barts Trust) support discharge from hospital for people with social care needs from hospital. It provides a positive and quality experience for people leaving hospital who are need of social care in preventing ill health by accessing preventative and reablement services and where appropriate care packages. It ensures the person; their carer and family are involved in care planning and manage the complex interface between social care and the NHS.

This scheme is designed around seven day working and providing social care resources that can support hospital care to maintain the level of discharges across weekends. The objective is to maintain and improve a seamless, integrated service that is standardised across all seven days and which supports patients in being discharged to their homes as quickly and safely as possible. There is reduction in delayed discharges attributable to both health and social care separately and discharge planning coordinated and planned with the individual in a person-centred way.

The Hospital Discharge Scheme commissioned from Age UK Redbridge provides an aligned process from assessment to safe discharge thus avoiding unnecessary readmission soon after discharge. This is a collaborative scheme between health and social care and targets in-patients who need social care input as part of their discharge. It ensures that older people living alone in Redbridge who are discharged home from hospital have dedicated support for assessment from the social work teams. It ensures that they travel in comfort, are settled back home and have adequate food, heat and support to meet their individual needs as appropriate on discharge from hospital (see section 3.1.3 of the main narrative).

The graph shown in section highlights that Redbridge had over 93% of older people (aged 65 and over) continuing to remain in their own home following a stay in hospital and a subsequent short term reablement service. We are continuing to increase the number of older people offered reablement services on leaving hospital either. Reablement referral is assessed through our Hospital Social Work team and also our First Contact team (community front door). It is a key service that offers support and encouragement to residents until they have recovered/convalesced enough to maintain their own independence at home going forward. Reablement outcomes are extremely positive for the individuals in that they remain independent in the community, can prevent unnecessary readmission to hospital and can also prevent reliance on long term health and care services.

During 2016, over 51% of individuals who received a reablement service did not require any other support following their rehabilitation which demonstrates that reablement can be an effective service to support residents and prevent reliance on statutory health and care services.

Outcomes:

- Full implementation of our High Impact Change Model.

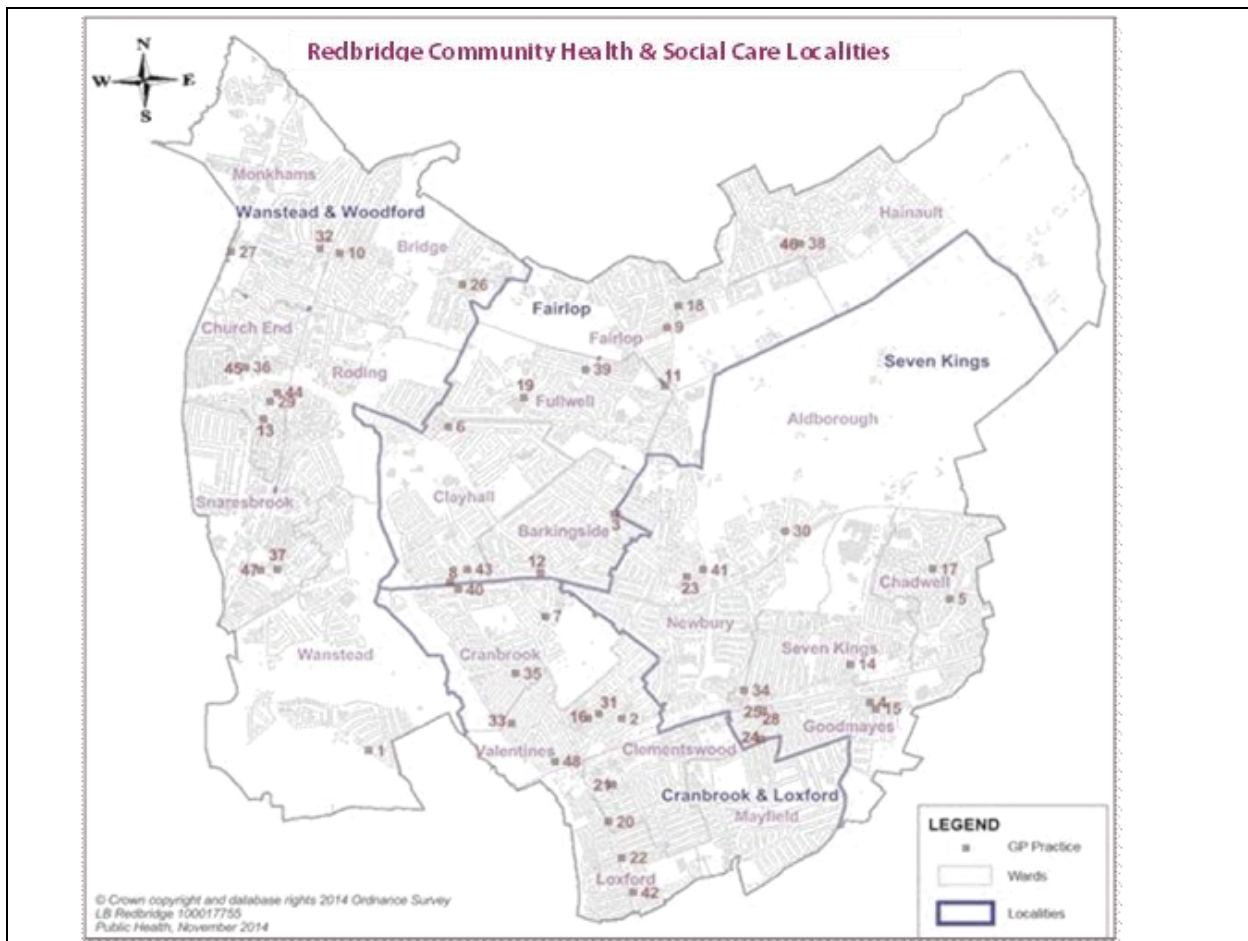
- Focussed safe and timely discharges from hospital facilitating our continued low rate of social care delayed transfers of care out of hospital.
- Strengthened reablement services support the effective discharge from hospital; further reductions in hospital and care home admissions an enabling people to recover and remain independent.

We will:

- Short term recuperation and reablement pathways could be more effective in helping individuals to get better and recover, and reduce the need for long term care and support.
- Work with health partners to develop pathways that support short term recuperation and recovery following an accident, illness or crisis. These will give the individual the opportunity to get fully better without the need for ongoing care or support. This approach is important for those being discharged from hospital to their home, and is not reablement - it acknowledges that recuperation is part of the remedial process before decisions are made about future support needs.
- A pathway to discharge people from hospital in order to assess them is currently being developed across BHR (discharge to assess), and the Council will consider the cost effectiveness and value this offers within the financial resources available, recognising the positive wider impact of prompt hospital discharge.
- Look at our current reablement pathways and services, to focus on rebuilding skills and confidence, and prevention of hospital and care home admission.
- Participate in a review of the intermediate care pathway to facilitate a BHR system wide response to rehabilitation and reablement.

Scheme R2 – Localities

Our Redbridge Community Health & Social Care integrated localities model went live back in April 2017. In partnership with NELFT (North East London Foundation Trust) under a Section 75 agreement, and based on four locality areas aligned to that of the GP areas of Wanstead, Fairlop, Seven Kings and Cranbrook and Loxford it has multi-disciplinary teams, which include social workers, occupational therapists, adults memory clinic, palliative care and nursing services. However, due to the importance of facilitating discharge from hospitals, the social work service in hospitals remained in place. At the same time, a range of public health and adult social care functions were integrated into an adult care, public health and wellbeing hub to support enhanced prevention, demand management and commissioning.



The service focuses on early intervention and prevention to support people who are over the age of 18 and are vulnerable older people; have a learning disability and/or on the autistic spectrum; have a physical and/or sensory disability or a mental health issue. It utilises this through an enhanced 'front door' with a single point of access providing:

- Comprehensive advice and signposting informed by good local knowledge
- Crisis and quick intervention where necessary
- Greater focus on early intervention prevention through appropriate sign posting
- Initial well-being assessment delivered by skilled Wellbeing Officers
- Proportionate response with timely and appropriate referral handling

This approach ensure there is focus on person centred holistic support planning to maintain independence with the team responsible for delivering a service based is based on where a person lives not presenting needs, using a joint assessment approach, which covers both health and social care needs and provides a care coordination approach, through a single point of contact for people and their carers.

Further information on the Redbridge locality model can be found in section 4.6 within the main narrative.

Outcomes:

- Localities are further evolved to provide greater levels of person-centred care with greater GP, voluntary and community sector partner and other key Council service involvement and integration.
- Best practice and sharing of locality development and implementation is embedded into

further integration models.

We will:

- Building on our integrated adult health and social care localities model, the specific needs of communities in each locality will be addressed, with more care delivered in the home or close to home. This will involve shared entry points into services, single or shared assessment processes, and delivery through integrated teams where appropriate. Explore new models of care, focusing on meeting the needs of residents and patients in a sustainable way by working collaboratively and offering support that enables people to gain control within their lives.
- Increasing the level of integration by seeking to involve a wider range of partners (including voluntary and community sector) GPs, health services, and housing for example.
- Focus on prevention services by working with drugs and alcohol services, environmental health, and embedding public health prevention/health promotion initiatives within the locality teams to increase personal self-care and management.
- Work with our BHR partners in progressing further integration models by evaluating lesson learnt from each other, and developing good practice to support and begin the move towards the ambitions of the ACS.

Scheme R3 - End of Life Care

End of Life Care is one of the Ambitions within our new Health and Wellbeing Strategy 2017-120. Our ambition states: *'People who are reaching the end of their life are identified early, and supported with their family or carers to live their end of life as well as possible.'*

In Redbridge, just over 40% of deaths occurred in adults aged 85 and above which is higher than both the London and England average. As a greater proportion of people die during very old age and/ or with an increasing range of complex medical conditions, consideration of quality end of life care for those with complex health and social needs is crucial to ensuring the systems and services are in place to support the service users and their families and carers.

Population based studies indicate that the majority of people would prefer to be able to die at home - wherever people are, we want to enable them to live and die well, with appropriate support available for bereaved carers, family and friends. In addition early support also avoids costly and unnecessary admissions to hospital, and ensuring that residents have the advice, information and support when required to have a choice in where they die is essential.

We want people who are reaching the end of life to be identified early; offered a comprehensive holistic assessment, and supported with their social, practical, emotional and spiritual needs. With care coordinated across settings and services and delivered by a multidisciplinary workforce that supports people to die in accordance with their personalised care plan, for example at home, in a hospice or other appropriate location. Only 20% of deaths in Redbridge occur in the persons own home. This is the lowest in London and eighth lowest nationally.

In addition, more prominence is being given to support at end of life, treating people as individuals with dignity and respect, allowing death to be pain free, in familiar surroundings and with close family and friends.

In supporting delivery of this scheme, we have a Redbridge joint plan for End of Life Services for Adults in Redbridge, 2017-20.

Outcomes:

- An increased number of people who die in settings other than hospital, preferably in a setting of their choice such as home.
- An increase in the number of personal health budgets for people at end of life.
- A reduction in the inequalities of people taking up end of life care services.

We will:

- Effectively plan care and support for people reaching the end of life by involving the individual and carers in the planning process and ensure that services and professionals work together to provide the right help at the right time.
- Raising awareness and empower professionals and local communities regarding the importance of honest, informed and timely conversations about choices for end of life care.
- Enable people at the end of their lives to make choices about where they receive their care.
- Building on existing work, develop a coordinated approach to end of life care by ensuring that the recognised 'building blocks' are in place, which includes an accessible 24/7 advice service and the enhanced community based care including Hospice at Home.
- Establish a coordinated approach across health, social care and the wider community including the development of shared records across health and social care.
- Explore opportunities for information sharing between service providers to assure appropriate actions at times of crisis.
- Identify the needs of isolated older people including those caring for someone with a life limiting or long term condition.

Theme 2: Prevention and Managing Demand**Local Context**

The population of Redbridge is expected to increase by 15% by 2026 with the increases (23%) in the older age groups, have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs and poor health outcomes. Demand is expected to be highest in more deprived localities. Along with the prevalence of long term conditions and survival with complex health and social care needs are increasing with demand for adult social care is projected to increase by 28% by 2030 and demand for hospital care under the current model projected to increase by 64% for elective admissions and 54% for emergency admissions. Identifying health and social care needs and before they become more serious can both prevent major illness, disability and death, and reduce the requirement for expensive treatment.

There is strong evidence that residents will have better health and wellbeing if we focus on preventing and providing support early before health and care problems become complex. This approach has been shown to be cost effective. Without moving our focus towards prevention and early intervention, the health and social care system faces escalating demand for services, and escalating costs to meet complex needs. The relatively good health outcomes most people enjoy in Redbridge will become more difficult to sustain.

This can be achieved through the provision of reliable prevention and early intervention services including promoting access to advice and information, screening, preventative health care and affordable, reliable and practical support in the home, telecare and simple aids to daily living and through the use of personal budgets.

We need to commission person-centred, integrated care and support services to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), in particular locality settings. It will also ensure that we have an increased focus on preventative services ensuring the right support at the right time, the most appropriate level as an enabler of individual health and wellbeing working closely with our partners, community and providers to develop the market.

Good practice will incorporate early intervention and preventative work to reduce the number of hospital admissions, improve hospital discharge arrangements and develop the capacity for more community based support. This includes giving people the skills to better manage their own care, support for family carers, accessible and timely information and support through the provision of equipment, telecare, support at end of life.

In 2017 we:

- Assisted 12,955 people with relevant information and advice about the care and support available
- 550 people who pay for their own services were supported to access suitable care services
- Supported 2,443 people caring for relatives or friends

In supporting and delivering the schemes below, we have a number of local strategies and plans, including:

- Adult Prevention and Early Intervention Strategy
- Carers Strategy (including young carers)
- Dementia Plan
- End of Life Care Strategy

Scheme R4 - Prevention & Early Intervention

Central to our new 'Community Health and Social Care' locality service is our 'First Contact' team, who are a single point of entry for all new health and social care referrals through a single point of entry. This service has both Council and NHS staff working together in one team to make certain that any individual who contacts the service is referred through to the service that is right for them. This team provide comprehensive advice and guidance, 'proportionate' assessments and a well-being assessment where required. For those whose needs did not meet the threshold for formal service provision, they provide universal advice and guidance; and, referral to community and voluntary sector organisations for preventative support. They also arrange support where a minor intervention (such as simple equipment or adaptations) is required. In addition, there is integrated urgent assessment process so that a joint assessment can be carried out within 24-48 hours if someone has immediate needs.

If further community health and/or social care support is required, individuals assessed by the team are assigned to one of the four clusters depending on their postcode of residence for a single or joint assessment.

Our Health and Wellbeing Board includes our local Council of Voluntary Services (CVS) representing the views of the voluntary sector in Redbridge. This provides the opportunity to ensure that our voluntary sector partners, who we work closely with, are engaged alongside other system leaders in health and social care programmes and services across the borough. This close working has been one of the key strengths in the success of our [Redbridge First Response Service \(ReFRS\)](#). The voluntary sector partners have been instrumental in championing the ReFRS model and have experienced the benefits of being able to support people that are seldom heard - particularly those referrals identified by GP's. Many of the voluntary sector organisations are commissioned by LBR are national charities.

ReFRS is a unique and innovative model which offers a whole system approach to keeping people well and independent. It works with key local partners to encourage social inclusion, promote self-care and build resilience within the community and for the individual. The long-term aim of the service is to help postpone and prevent crisis, by improving the health, wellbeing, independence, safety and security of the service user. It acts as a conduit for primary care services to refer people with long term health conditions or social, emotional or practical needs to a range of local, non-clinical/care services, some of which are provided by the voluntary/statutory sector.

It has established a strong partnership across a range of Council departments and has an excellent preventative presence in the community. The current partnership consists of over [50 organisations](#) including LAS, LFB, Met police, Lifeline and telecare, Redbridge Carers and Alzheimer's Society. ReFRS is an example of good practice of early intervention by aiming to improve health and wellbeing, reduce inequalities and demand for health and social care services, through providing people with access to good quality information and advice, in the early stages of their need help to prevent dependency on statutory services.

Building on ReFRS is the development of our pilot social prescribing model 'Health buddies' – again working with our local CVS. This pilot will target those who need extra support to engage in prevention and early intervention services by using a cohort of trained 'buddies' will visit individuals in their own homes to discuss their needs and barriers, and work with them to engage in community services. A co-ordinator has also been appointed, who will act as an interface between the GPs and the service, and will be responsible for managing and directing referrals.

Both in the development of our accountable care system and the north east London STP is the progression of social prescribing services for the health and social care economy to embed early intervention and prevention services. The health impacts and benefits of social prescription have been shown to include:

- Reduced dependency and cost in the long term on health and care services
- Reduced GP's appointments (repeat appointments for non-clinical intervention)
- Reduced attendance at Accident & Emergency through early intervention
- Enables primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services- encouraging a whole system approach to a person's needs
- It empowers people with long term health conditions to promote self-care and remain independent within their homes.

Key to supporting new models of care is managing demand. There is a large amount of research which shows the power of conversations. Evaluations are showing that by introducing the three conversations model, there are improved lives for people, happier staff and a significant reduction in the number of long-term support packages. The first conversation is about connecting people to things that make their lives work better. The second is about working with people in crisis intensively and dynamically to make an immediate and positive difference, sticking to them like glue for short period of time. The third is about ongoing support, but only for those who really need it. Redbridge will begin piloting this model in the Autumn.

Outcomes:

- Residents utilise a range of assets in Redbridge to support their health and wellbeing, and vulnerable adults are supported to access them through ' buddies' and community based organisations.

- Through the provision of high quality prevention and early intervention services through communities (using third sector partners), demand for traditional health and social care services will see a reduction.
- Transformation of our model of social care (such as Three Conversations) leads to a key step change in the way care is assessed and provided, seeing tangible benefits for both service users and the system as a whole.
- The voluntary sector provider market (through the use of social prescribing) is developed to be able to provide and deliver more health and social care services.

We will:

- Continue to strengthen our Redbridge First Response Service (ReFRS) model with GPs and partner organisations in delivering information, advice and intervention for adults who require health and social care support at early stages.
- Deliver our pilot 'Health Buddies' social prescribing model with our third sector partner to improving mental health and wellbeing, promote physical activity, raise awareness and support behaviour change within communities.
- Deliver prevention and early intervention approaches through the First Contact team to manage demand and provide access to a wide range of these services and continue to focus on providing quality and timely information and advice.
- Strengthen the information and advice available on ['MyLife'](#) to make access and navigate, easier and include access to independent financial advice that enables individuals and carers to make informed decisions about how they meet their care and support needs.
- Ensure self-help and promotion of wellbeing is central to all assessment and review processes, through the wellbeing assessment provided by the First Contact team.
- Pilot the 'Three conversations model' to support prevention and demand management and undertake an evaluation to monitor the benefits and lessons learnt. If successful, consider how this could be implemented to support further benefits to service users and system management.

Scheme R5 - Equipment, Assistive Technology & DFG

Supporting people to live at home for as long as they can enables them to maintain independence, choice and control over their lives and retain links to family and community in places where they are familiar results in better outcomes. In turn this helps alleviate unnecessary admissions to hospital, nursing or residential care. However, the increasing numbers of people who require care and support at home will place additional pressures on social care and health resources and while we are successful at keeping residents at home with support; this is at a significant financial cost which is unsustainable. Therefore, we need to ensure that people can access equipment and adaptations through DFG by ensuring that we provide timely assessment, facilitate deferred payments where required and working with housing and planning departments to reduce delays in building and installation.

The Council contracts out virtually all aspects of home care services, with the exception of telecare support and we can do more to help residents make best use of equipment and adaptive technologies, which in some cases provides an alternative to homecare.

Preventing people from falling falls support a reduction in hospitals admissions and ensures people are safe and independent in their own homes. They are a major cause of morbidity, hospital admission and need for social care and as people get older and have more long term illness the risk increases. Redbridge has an increasing population of older people and there is likely to be an increase in the number of falls and admissions if interventions are not strengthened. Financially, falls impose a high cost to both the health and social care services, because of high cost treatment and long term rehabilitation, with several types of costs to

social services as a result of falls ranging from costs of care/residential home following hospital discharge to the cost of equipment, home adaptations and reablement services e.g. personal care for a fall patient.

Outcomes:

- Better utilisation of equipment, assistive technologies and DFG is improved and increased and replaces, and/or reduces (where it can) the demand for more traditional models of homecare.
- New models of home care provide improved contact and purchasing of care arrangements for both the Council and users of the service.

We will:

- Work with BHR partners and the Care City pilots to understand, learn from and take forward the review in relation to assistive technology and digital solutions and how these could be utilised in Redbridge.
- Better utilise and combine the opportunities for equipment, assistive technologies and DFG have to offer as an alternative to traditional homecare packages, reablement and discharge to assess, as a more cost effective way of delivering care.
- Review the way in which we commission our homecare to provide an alternative model of flexibility for the purchasing of care, by gaining more from value from the homecare market in the re-designing and re-procuring of our home care contracts.

Scheme R6 - Dementia and Carers

It is projected that 2,700 people aged over 65 have dementia, which will increase to 3,230 people (13%) by 2025 and 4,350 people (23%) by 2035. This projected increase highlights the need to work in a more integrated way and improving the health and wellbeing of people with dementia and their carers will maximise the extent to which people can continue to remain independent and reduce pressure on long term care services. Early identification of dementia enables treatment and care to be planned for and time for the person and their family/carer to plan for the future. The NHS Health Check Programme will contribute to enabling people to reduce their risk for developing vascular dementia, and identifying early signs of dementia. Our Redbridge Memory Service which is based within NELFT receives referrals from local GPs for an assessment of people experiencing memory problems and can provide outreach services at satellite buildings and in the home. Intensive work has taken place with GPs to increase the number of people being referred for a formal diagnosis and performance in this area has continued to improve.

It is estimated that one in three people will take on a caring role at some point and this can have a practical and emotional impact on their lives and anyone can become a care. Many people with caring responsibilities do not identify themselves as carers and see themselves as spouse, parent, sibling, friend or neighbour and so access to information and advice at the right time is essential. There are around 27,300 people in Redbridge (adult or child) providing care to a partner, family member, or friend; this is nearly one in ten of our population. Carers either receive direct/part payments and/or CASSR managed personal budget/commissioned support. Providing support and improving the health and wellbeing of carers, are significant challenges for health and social care services. Evidence indicates that carers have higher levels of stress and anxiety and poorer physical health than the population generally - given that the number of carers who are being supported is on the increase and national trends project that the number of people aged over 65 who are caring for another individual is also likely to increase year on year.

Outcomes:

- Redbridge is a dementia friendly borough.
- Assistive technology and equipment provides key support to dementia patients safe and re-assures to carers.
- Carers are better supported and empowered through improved pathways, tailored services of advice training and support and Direct Payments.

We will:

- Explore and develop new models of care, to support future health and social care needs, including nursing and mental health of people with dementia.
- Invest in support for carers to keep them well and engaged in caring for their friends or family - build on existing training and support services including advocacy, training and respite provision.
- Develop an effective and seamless pathway that enables people with dementia and their carers to get consistent and timely information and advice about the support available to them and where to access it.
- Ensure more innovative options for the use of Direct Payments is available to improve outcomes for people with dementia and their carers.
- Explore the benefits of using assistive technology including GPS and other specialist equipment for the home that can help prevent people leaving their home when it is unsafe for them, locate people if they are not where expected and provide support and peace of mind for carers.

Theme 3: Market Development & Sustainability

Scheme R 7: Market Development & Sustainability

Redbridge is facing both demographic and financial pressures on its current and future services. We provide efficient high quality satisfaction to our residents, but a growing and changing population changes people's needs. This means that our current model is under increasing pressure and not sustainable in the longer term, we need to consider models which reflect best practice and are sustainable for the future to ensure we are able to meet the needs of our residents, support discharge from hospital and build in prevention by being proactive and responsive to continue the development of our care market.

We need to ensure that our health and social care services deliver better outcomes for our residents and minimise the impact of reduced funding levels, rising needs, and growing demand. To do this we are continuing to rethink the ways in which we provide services and work with service users, carers and partners.

- Support and improve the health and wellbeing of residents
- Respond to the growth, diversity and changing needs of the borough
- Develop services that meet the needs of the most vulnerable
- Increase prevention, early intervention, self-reliance and independence to manage demand
- Achieve efficiencies by extending integrated commissioning and service delivery with partners inside and outside Redbridge
- Engage and co-produce future services by routinely including services users in the design, planning and delivery.
- Build community resilience.

In driving this direction of travel at a local level is our Health and Wellbeing Strategy, a

number of themed strategies and our LBR Commissioning Strategy. In moving towards an outcome-based commissioning approach by expecting service providers to be able to demonstrate their contribution to prevention and demand management, diverting people to alternative care and support where appropriate, and maximising people's independence, health and wellbeing and therefore demonstrating their value in terms of cost, quality and outcomes.

Outcomes:

- A more responsive and sustainable market, able to meet and deliver the area needs.
- Skilled and experienced workforce enabling better recruitment and retention by providers and commissioners.
- High quality services that strengthen care in community settings and in the home to promote independence; meet service user choice and keep people out of acute settings.
- Integrated and coordinated pathways of care supporting fair access and equality of service.
- Support the further integration of health and social care using the BHR BCF through the Joint Commissioning Board for the four schemes.
- Joint and integrated commissioning arrangements should drive better value, quality and outcomes
- Future service design and development with services users was integral to the process.
- The BCF has acted as a key enabler in integrating the vision for health and social care across the BHR area in the design and commissioning providers to support out of hospital commissioned services, protect social care, and maintain independence and in prevention and demand management.

We will:

- Improve our understanding of the provider market and future needs, by an analysis of the current market and where it needs to be in the future. By utilising our business intelligence to provide improved information on current and future needs to efficiently and effectively plan for services, demand management, workforce needs and development, market development of providers (especially the voluntary sector) and ensure market has the capacity for sustainable services.
- Using our evidence base, map resident journeys to identify emerging gaps in current and future provision and to predict service flow through the system and how we develop the market to meet these gaps in provision and improve the journey service users receive. This will focus on discharge from hospital, reablement and homecare.
- As part of the BHR Integrated Care Partnership (Accountable Care System model) work to develop a shared market position statement (while reflecting the uniqueness of the local areas) and shared services with neighbouring councils to offer more choice, facilitate innovation and new market capacity and gain economies of scale.
- Developing a collaborative environment in which we share information, and quality assurance feedback and work through challenges in order to improve outcomes and ensure market sustainability.
- Support the market development and promoting of efficient and effective methods to enable more choice for those service users wanting to use personal budgets and direct payments to buy care and support services for themselves.
- Share commissioning and the Redbridge integration expertise and practice across boroughs through joint commissioning arrangements (in the JCB) and facilitate the development and delivery of lead commission and/or shared services.
- Review our provider rates and provider contracts to support social care services.
- Build upon and strengthen our current work with the voluntary sector in delivering a range of services in the community to support prevention, discharge services and low level intervention services helping to manage demand for social care.

Theme 4: Protecting Social Care & Maintaining Independence

Scheme R8 - Maintaining Independence

Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives, and reduce the need for and dependence on health and social care services. Retaining a level independence supports both psychical and mental health through empowering and maintaining those close community links within a familiar environment.

Supporting people in their own homes is an important part of ensuring that people retain their independence. The retention of links to family and community, in places where they are familiar, results in better health and wellbeing outcomes, as well as reducing the need for costly residential care.

Over 769 people receive Local Authority support in residential or nursing homes across the borough. There are 75 nursing homes in the borough and people will be placed in a particular home according to need and availability. However, people living in residential care are likely to have higher needs for health care which will fall on the local health providers. Neighbouring boroughs have considerably less capacity for residential care than Redbridge so quite a number of people are placed in Redbridge by other boroughs. This will also increase the health need. Conversely 20% of people in residential care are in homes out of borough.

The use of equipment, assistive technologies and DFG enables people to stay in their own homes with a degree of independence. Our Rapid Response Visiting Service directly links with the Telecare monitoring services and provide visiting and response service to support people in their own home who may not require emergency services and therefore reduce unnecessary attendance by emergency services. This includes people who are at risk of falls, have mental health needs including dementia; learning difficulties and those with physical and sensory impairments. The number of people who are issued pieces of equipment to support them with their daily living has increased over the past few years. This allows individuals to live independently in the community and can also prevent support and reliance on home care services, while also reducing the need for home care support as individuals can undertake particular tasks.

Increasing self-directed support through the take up of direct payments and personal budgets and promoting peer support will be a key element of ensuring that service users have more control over the choices they make about the services they use, resulting in better outcomes for people's lives.

We offer a range of specialist accommodation options, including supported living and extra care, and the shared lives programme. Supported living accommodation is commissioned for people assessed as requiring a supported living environment, including people living with or recovering from mental illness or crisis, people with a learning disability, physical disability, at risk of domestic violence, homelessness and for care leavers. Supported living is similar to extra care provision although rather than being based in sheltered housing schemes it tends to be based in shared housing/accommodation. It can also include floating support services where people live independently and receive external support. This housing related support is predominantly provided by registered social landlords that in some cases also provide care to those individuals.

Redbridge already provides an alternative housing offer through its Extra Care services. Oakfield Lodge, George Davies Lodge and Fernways are internal sheltered housing units

where Tenants are able to live their lives independently for as long as possible. People are referred to the units by Hospital Social Workers and Social Workers when they require additional support to remain independent in the community. Our sheltered units aim to prevent people from being admitted to hospital or having to be referred to nursing or residential placements and they do this by ensuring that people are cared for and looked after. The beneficiaries of the services are those who currently reside within these facilities who have a number of health issues including dementia, physical disability, learning disabilities, mental health issues.

Dependent on individual circumstances residents/tenants with significant assessed care needs, including dementia can be supported. Individuals can rent a one bedroom flat, a bedsit or a bungalow and are able to live independently with the knowledge that there is an onsite care team based within their scheme 24/7 and 365 days a year.

The service aims to:

- Prevent social isolation and tailor services to meet the needs of tenants (people who use this service) with social care complex needs
- Ensure that people who use this service are safeguarded and protected from avoidable harm
- Delay and reduce the need for increased levels of care and support

Extra care services provide an alternative approach/model to traditional home care services in people's own homes and to residential and nursing care placements. The transitional service also provides opportunities to individuals who require a higher level of care following hospital discharge to convalesce before returning home when their require level of care improves.

As part of the our Redbridge Adult Social care and Public Health Transformation programme we are looking at places to live, which incorporates provision in residential care homes, sheltered housing, Extra Care and other supported living programmes.

Outcomes:

- Through the use of early intervention and prevention and programmes of providing care in a community setting, there will be a decline in the numbers of people admitted to nursing and care homes especially for longer periods of time. Therefore, the length of stay in an institutional setting should be shorter if support packages can allow the service user and carer the opportunity to stay in or around their own homes.
- Recovery and self-care information and support will allow people to manage their own health condition(s) or disability, utilising technological advances and ensuring people maintain their independence for as long as possible. Reablement, rehabilitation and recovery pathways for people experiencing episodes of poor health will remain focused on helping people achieve their personal goals, independence and wellbeing, reducing long term reliance on statutory services wherever possible.

We will:

- Work with independent service providers to provide the services which effectively support people in the community to stay healthier and independent for longer.
- Improve our systems to increase the option of direct payments.
- Continue to develop services that meet the needs of our most vulnerable residents ensuring they are supported.
- Maximise the strengths of individuals and their families and the use of community assets.
- Develop a range of longer term, wrap around specialist support within local communities in accordance with the wishes of individuals. This might include home support or recruiting and employing a personal assistant.

- Encourage volunteer befriending and mentoring services for people with identified needs, to reduce linked to isolation and loneliness.
- Better utilise and combine the opportunities for equipment, assistive technologies and DFG have to offer as an alternative to traditional homecare packages, reablement and discharge to assess, as a more cost effective way of delivering care and reducing admission to residential care.
- Review and use the opportunity the way in which we commission and re-tender our homecare to provide an alternative model of flexibility for the purchasing of care, by gaining more from value from the homecare market in the re-designing and re-procuring of our home care contracts.
- We remain committed to supporting people in their own home for as long as possible, but continue to rely on residential care when people have reached a crisis in their care needs
- Use our health buddies pilot to reduce social isolation by introducing people to services within their own community.
- Develop a range of informal community initiatives to support people who might have difficulty with social and life skills such as managing budgets, maintaining friendships or arranging trips including befriending and peer support.
- Improve the commissioning of services for people with a learning disability and with complex needs and/or challenging behaviours.
- Continue working closely with the NHS through the Transforming Care Programme, to develop affordable, sustainable services to meet the needs of an increasing number of those with learning disabilities and those in transition with complex needs and/or challenging behaviour within the local area.

Scheme R9 - Mental Health

Mental wellbeing is a fundamental component of good health. We know that people who have poor mental health often have poorer physical health in addition to challenges such as maintaining employment, finding a sustainable home and building a social network. Locally, as well as nationally, there is evidence that mental health needs are increasing.

Poor mental wellbeing is costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities. It has been estimated that poor mental health costs London alone £7.5bn annually - this includes costs to individuals such as days of work lost to poor health and increased health and social care costs. There is strong evidence for a range of interventions in mental health which improve mental wellbeing and are cost effective - these include prevention and early intervention, mental health care for people with physical health conditions and improved services for people with severe mental illness.

An estimated 31,073 adults aged 18-64 in Redbridge have a common mental disorder. The number of people with common mental disorders is projected to increase in Redbridge by 20% to 2035, compared with increases of 14% across the region and 3% across England as a whole. Mental health is one of the six ambitions within our Health and Wellbeing Strategy.

Dementia is an important concern in relation to the health and wellbeing of residents as they age. Our recorded dementia prevalence is just over 4% of the total population and is increasing in line with the regional and national trend, but is lower than England.

Early identification of dementia enables treatment and care to be planned for and provided in a timely manner. Dementia accounts for more expenditure than heart disease and cancer combined, yet a significant proportion of dementia (vascular dementia) is preventable through healthier lifestyles. The NHS Health Check Programme will contribute to enabling people to

reduce their risk for developing vascular dementia, and identifying early signs of dementia.

We support people with mental health problems in a number of ways - through information, advice and advocacy services provided within the home, hospital, community and social settings. Our new pilot Health Buddies social prescribing model aims to reduce social isolation by linking people to local services within their community. (See Prevention & Managing Demand theme). Our User Led service enables service users to voice their concerns and experiences of services through a range of different methods of engagement led involving network meetings, and discussion groups. This allows the views of the service users to inform provider, and commissioners in shaping services to better meet the needs of the local population. Our Mental Health Employment Service for adults with mental health conditions is jointly commissioned by the Council and CCG and is an employment support service to assist people in gaining paid employment or work and or retain employment that they are in.

The Home Treatment Team provides acute home treatment for adults aged 18 to 65 whose mental health crisis is so severe that they would otherwise have been admitted to a hospital. This integrated service is for people with severe and complex mental and behavioural disorders such as schizophrenia, bipolar affective disorder, and severe depressive disorder. The service is usually provided in the person's own home.

Outcomes:


- Local people are supported to maintain good mental health, emotional wellbeing and maximise their resilience to and recovery from adverse situations and events (Health and Wellbeing Strategy Ambition Aim).
- People are supported to people to remain independent and reduce the likelihood of crisis interventions' and hospital admission.
- Good quality community support aids the reduction of DToCs by ensuring services are located where the person lives in familiar surroundings.


We will:

- Identify mental health needs early and ensure timely, evidence based early support.
- Work with local communities, voluntary sector and partner organisations to raise awareness about mental wellbeing and tackle stigma.
- Work with partners (including the local voluntary sector) to tackle factors that make it difficult for people, especially among Redbridge's diverse communities, to maintain good mental wellbeing such as homelessness, substance misuse, domestic violence and social isolation.
- Support people with long term mental health needs to manage their conditions, maintain physical wellbeing, healthy lifestyles, good quality housing, social networks, education or employment.
- Work with partners to identify people who have dementia early, and ensure timely evidence based treatment and care.
- Further develop of Redbridge as a 'Dementia Friendly' borough. This includes a programme of awareness raising for the wider community with the purpose of supporting people living with dementia, enabling them to feel supported and maintain independence for longer. (See Scheme R6 for more on Dementia and Carers).

Appendix 4 – Document Reference List

Related documentation

Document or information title	Synopsis and links
BHR Accountable Care Strategic Outline Case January 2017	<p>Sets out the current key challenges at a BHR system level, including the financial gap, and identifies that the best way to address our system level issues is to explore Joint Commissioning alongside integrated provider delivery to enable the creation of an Accountable Care System.</p> <p> DH reviewed 09.03.2017 BHR SOC</p>
Barking & Dagenham Health & Wellbeing Strategy	<p>Sets out the vision for the people of Havering to live long and healthy lives and to have access to the best possible health and care services. To move towards this vision the Strategy identifies the most critical issues and prioritises the actions.</p> <p>Barking & Dagenham https://www.lbbd.gov.uk/wp-content/uploads/2014/11/JHWS_A4_30-9-15_RF.pdf</p>
Havering Health and Wellbeing Strategy 2015-18	<p>Havering http://democracy.havering.gov.uk/documents/s20440/Item%206-2%20Havering%20Health%20and%20Wellbeing%20Strategy%2015-18%20refresh%20v1%203.pdf</p>
Redbridge Health & Wellbeing Strategy	<p>Redbridge: http://modern.gov.redbridge.gov.uk/documents/s110828/ITEM%207%20FINAL%20VERSION%20TO%20HWB%20%20Sep%202017.pdf</p>
BCF Performance Monitoring Pack	<p>Recent sample BCF reporting pack, setting out the various monthly reporting to BCF Delivery Group and Joint Management & Commissioning Forum</p>
Annual Public Health Report	<p>Redbridge Annual Public Health Report 2015/16: https://www.redbridge.gov.uk/media/1875/annual-public-health-report-15-16.pdf</p>
Joint Strategic Needs Assessments (JSNA)	<p>Joint local authority and CCG assessment of the health needs of the local people and communities to improve the physical, mental health and wellbeing of individual</p>

	<p>communities. A supplementary analysis of critical priorities for action in the integrated commissioning approach has informed this submission.</p> <p>Revised – Published Dec 2015</p> <p>Redbridge JSNA: https://www.redbridge.gov.uk/health-and-wellbeing/public-health-strategies-and-polices/</p>
<p>Market Position Statements</p>	<p>Sets out current analysis of what is in the market, what needs to change and where the gaps are identified. Initiates a dialogue with citizens, carers, providers and service users about future demand, and need and the range of contemporary service design and solutions that will be necessary as responses.</p> <p>Revised – to be published Spring 2016</p>
<p>Accountable Care Engagement Programme Report</p>	<p>Summarises the outputs of extensive engagement with circa 8,000 individuals in BHR, which fed into the Accountable Care Strategic Outline Case</p> <p> ACO engagement programme report_Pf</p>
<p>CCG Delivery Plans 2017/19</p>	<p>The Delivery Plan sets out the CCG's priorities and plans for the next two years, taking into account evidence from the JSNA and robust engagement with partners and stakeholders.</p> <p>[to follow]</p>