Health and Wellbeing Board

13 November 2019

Title: Better Care Fund 2019/20	
Report of the Cabinet Member for Social Care and Health Integration	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
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Sponsors: Elaine Allegretti; Director of People and Resilience	
Lead Board Member: Councillor Maureen Worby; Cabinet Member for Health and Social Care Integration	

Summary

The Better Care Fund (BCF) is a joint Department of Health, Ministry of Housing, Communities and Local Government, NHS England and Local Government Association (LGA) programme spanning local government and the NHS, which seeks to address mounting budgetary and demand pressures through health and social care integration. Ultimately it aims to promote the kind of service integration that allows people to manage their own health, wellbeing and live independently in their own communities for as long as possible.

In September 2017, the Health and Wellbeing Board signed off the BCF submission for 2017-19, particularly the Joint Narrative Plan which was produced jointly by Barking and Dagenham, Havering and Redbridge local authorities and CCGs and set out our vision for the delivery of the BCF across the three Boroughs, as well as our own locally defined plans. In June 2018 the Board agreed to enter into a Section 75 arrangement with Havering and Redbridge CCGs and local authorities regarding the delivery of a shared Better Care Fund (BCF) programme.

The 2019/20 submission for the Better Care Fund was an extension of the plan set out in 2017-19 and provided an update on the work that has been delivered since 2017. It was submitted before the deadline of 27 September with approval from the Chair and is now going through the NHS England regional and national assurance process with approval expected in mid-November. A summary of the submission is provided in the report below.

Recommendation(s)

Health and Wellbeing Board is asked to:

a) Note the BCF submission for 2019/20.

1. Introduction and Background

1.1 The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

1.2 In September 2017, the Health and Wellbeing Board signed off a Joint Narrative Plan with Havering, Redbridge and BHR CCGs outlining our approach to the BCF and our vision for its delivery 2017 - 2019. The Joint Narrative Plan can be found here: https://modgov.lbbd.gov.uk/internet/documents/s124163/Item%206a.%20BHR%20iBCF%20Final%20Signed%2020170911%20002.pdf

1.3 The narrative sets out our individual Borough schemes under four themes to meet the requirements set out in the Better Care Fund guidance:

1. High Impact Change Model (term set by NHS England, essentially meaning patient flow and discharge from hospital)
2. Prevention and managing demand
3. Market development and sustainability
4. Protecting social care and maintaining independence

1.4 The following schemes operate as part of the Better Care Fund for Barking and Dagenham (more information on the schemes can be found in the link above):

Theme	Scheme
High Impact Change Model	**Mental Health –** Improving community based support to people with Mental Health needs **Localities –** Delivery of the localities model **Home First –** Improve the use of the Home First and Discharge to Assess model, and continue the roll out of Trusted Assessors in care homes model **Intermediate Care –** Delivery of intermediate care services across BHR (NELFT services)

	Joint Assessment and Discharge Service (JAD) – Continued delivery and improvement of the JAD
Prevention and managing demand	**Prevention –** Reduce ill health and dependency that may result in avoidable hospital admissions and intense use of social care **Equipment and Assistive Technology –** Optimise the benefits of assistive technologies and digital solutions for service users/patients, families and staff **Carers –** Delivery of our joint Carers Strategy **Disabled Facilities Grant –** Ensure the most effective use of our Disabled Facilities Grant (DFG) for residents
Market development and sustainability	**Market development –** Ensuring the sustainability of the social care market, including rates, personal budgets, quality, choice and access to person-centred support
Protecting social care and maintaining independence	**Dementia and end of life care –** Improve and enhance the delivery of services and the experience of individuals and their loved ones

1.5 A Section 75 governs the arrangement between Barking and Dagenham, BHR CCGs, Havering and Redbridge and was agreed by the Health and Wellbeing Board in June 2018 for 2018/19 and 2019/20. An executive group steers the development of the BCF across BHR and feeds up into the Joint Commissioning Board (JCB). Members of the executive group have discussed the 2019/20 submission and will resume formal meetings from November 2019 once the 2019/20 submissions have been assured by NHS England. The Section 75 will require updating to reflect the 2019/20 financial arrangements (see below) and to update the membership of the executive group as some staff changes have taken place. Officers will take these changes forward.

2. Better Care Fund 2019/20

2.1 Guidance for this year's BCF was only released in late July and was very similar to the 2017 – 19 planning term. The guidance confirmed that 2019/20 would be a year of minimal change for the BCF and a more comprehensive refresh is expected from 2020/21 onwards following a national review of the BCF. As such, the BCF plans for Barking and Dagenham, Havering and Redbridge have essentially been a continuation of those from 2017 with updates on the progress made in the scheme areas in the narrative sections.

2.2 As previously, the Health and Wellbeing Board must receive and sign-off the BCF plan. As the Board met before the submission was finalised, the plan was agreed by the Chair and the Deputy Chair ahead of the submission deadline on 27 September 2019.

Narrative section

2.3 There have been some welcome changes in the submission expectations. The narrative section has been incorporated into a slightly shorter template and there has been a removal of separate plans for the Winter Pressures grant and for separate iBCF schemes and initiatives. As previously, the DFG is also combined into the planning template. The narrative this year focused around four areas:

- Person-centred outcomes
- Integrating services at a Health and Wellbeing Board level
- Our wider approach to integrating services (e.g. with Housing), including our approach to the DFG
- System level alignment

2.4 Appendix 1 provides the narrative responses submitted as part of the BCF.

Metrics

2.5 The Better Care Fund guidance requires areas to submit targets for four metrics:

(a) Non-elective admissions
(b) Admissions to residential and care homes
(c) Effectiveness of reablement
(d) Delayed transfers of care (DToC) – all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

2.6 The non-elective admissions target is set through the CCG Operating Plans and was not provided in the submission template.

2.7 The DToC target is also set for us by NHS England and has been set at a rate of 5.1 delayed transfers of care per day from hospital (aged 18+). This is a highly ambitious target which was put in place to encourage unrealistic improvement on previous good performance. We have noted on this submission, and all previous submissions, that we are unlikely to meet this

target but have stated that our multi-agency Joint Assessment & Discharge Team has enabled Barking and Dagenham's performance on delayed discharges to be good and routinely better than that of London and England averages.

2.8 We have set our remaining two metric targets for residential admissions and reablement as stretch targets, based on analysis of our previous set targets and statutory returns data. Our admissions to residential and care homes target has been set at 150 (an improvement on the target of 160 in 18/19). Our target for the proportion of older people still at home 91 days after discharge from hospital into reablement has been set at 88.2% (an improvement on the target of 84.3% in 18/19). These is a great deal of confidence that these targets can be met and they will be monitored through performance reporting for the Health and Wellbeing Board.

Financial summary

2.9 The below table is a summary of the pooled budget that will make up the BCF in 19/20. The DFG, iBCF and Winter Pressures Grant are all directly given to the local authority.

Funding Sources	**Income**
DFG	£1,636,536
Minimum CCG Contribution	£14,731,174
iBCF	£9,479,121
Winter Pressures Grant	£913,061
Additional LA Contribution	£0
Additional CCG Contribution	£0
Total	**£26,759,892**

2.10 The CCG are required to give the local authority at least £5,458,324 for Adult Social Care services. In reality, the CCG will be giving the local authority £6,040,406 in total which includes previously agreed monies towards the implementation of the Care Act. The CCG's minimum contribution to social care has increased by £303k since last year. It has been agreed that the majority of this money will be spent on crisis intervention (£257k) with the other money supporting tri-Borough initiatives such as the care home trusted assessor programme, the Home is Best pilot, night sitters and the CCG/local authority contribution to the Reconnections social isolation pilot.

2.11 This year the local authority has decided to only put in its iBCF allocation with no additional LA monies.

3. Next Steps

3.1 The BCF was submitted on 27 September for regional and national assurance. The regional and national NHS England teams will be assuring plans throughout October and approval letters will be sent out by 18 November. Informal discussions with the regional team have shown that there are no problems in our submission, and they will be recommending our submission to the national team to approve.

3.2 Following assurance, the BHR executive group will meet to update the Section 75 and take plans forward for the remainder of 19/20.

4. Better Care Fund 2020/21

4.1 During the Spending Round in September 2019, the Chancellor set out departmental spending plans for 2020-2021. It confirmed that councils will be getting an additional £1 billion grant for adults and children's social care, on top of the continuation of £2.5 billion in existing social care grants in 2020/21. Councils will also have the option to raise up to £0.5 billion, where needed, for social care through additional council tax flexibilities. The Round confirmed that both the Better Care Fund and Improved Better Care Fund will continue in 2020-21 although it is not yet clear how this will operate and whether the additional grant will be given through the BCF mechanisms.

4.2 In the interim, partners will begin to meet to discuss the planning for next year and the increases in grant.

5. Implications

Financial Implications

5.1 Implications completed by: Murad Khan (Group Accountant)

5.2 The BCF is integral to the funding of the Adult Social Care budgets without which the council would not be able to afford to run many of the services this pool funding supports.

5.3 These services improve outcomes and early intervention, implement prevention and safeguarding measures all with the aim of stemming the rise in demand for social care thus minimising the cost of Social Care in the future, without this funding there are significant risks to the social care budgets in the long term above and beyond the pressure we have currently.

5.4 The BCF funds around £15m of budgets within social care and thus the loss of this grant would be detrimental not only to this service but the council as a whole, leaving the council with a large gap that could only be met by further savings and cuts across the council.

6. Public Background Papers Used in the Preparation of this Report

June 2018 Health and Wellbeing Board report '**Authority to enter a Section 75 Agreement to govern the operation of the Better Care Fund 2018/19 and 2019/20**'

September 2017 Health and Wellbeing report '**Better Care Fund: Update and Discussion**'

7. Appendices

Appendix 1 – Narrative answers

Appendix 1 – BCF Narrative Answers

A) Person-centred outcomes

Your approach to integrating care around the person, this may include (but is not limited to):

- Prevention and self-care

- Promoting choice and independence

(1500 words)

In Barking and Dagenham, all partners are working together to enable and empower people to live healthily, access preventive care, feel part of their local community, and manage their own health, care and wellbeing wherever possible. Our joint BCF Plan for 2017-19 sets out this vision and the ambitions for the BHR area. The Barking and Dagenham BCF Plan for 2019-20 continues to build on the four high level schemes of (1) High Impact Change Model; (2) Prevention and managing demand; (3) Market development and sustainability and (4) Protecting social care and maintaining independence. The schemes, in this order, are also reflected in the expenditure tab.

Prevention and self-care in the community:

We have been continuing to seek opportunities to embed preventative approaches and signposting into core and frontline services to enable individuals to stay healthy and well in the community for as long as possible. In the last three years, the local authority has brought together a number of different people-based services into a new 'front door' service called Community Solutions. Teams identify the root cause of an individual's problems and help to resolve these before they escalate to statutory levels. Residents experience a more cohesive service with one point of contact for all issues rather than being passed between different services. Teams also help residents to help themselves, to ensure that they are taking responsibility for their health and care and support needs where possible. Community Solutions has been active in supporting the local community to access community, voluntary and health services/facilities through signposting, social prescribing (see Question Bi), healthy lifestyle programmes, and a volunteer drivers scheme which supports individuals to attend services and appointments.

Community Solutions is also providing a small-scale, fixed package of support to service users on hospital discharge who need relatively low level support and judged unlikely to need long-term care. This short package has seen service users linked up with welfare, community services and other support options. An initial pilot of 10 service users in Autumn 2018 saw 7 requiring no longer term support, providing benefits in terms of personalised outcomes, reduced hospital admissions and diverting spend away from reablement. Since June 2019, the project has been ramped up to work with 5 service users per week.

Additionally, the British Red Cross has been commissioned to provide a 'home from hospital' service for those individuals who do not meet criteria for statutory services. The BRC support individuals to settle at home for a period of up to four weeks following their discharge which has again resulted in improved service user outcomes, reductions in re-admissions and more residents at home after 91 days.

Partners have also continued to commission a local Handyperson Service to reduce trip hazards and the risks of falls, contributing to reductions in hospital admissions.

Older people:

BHR CCGs, the local authority, NHS partners, primary care and the VCS have embarked on a transformation agenda for older people and those who are frail. This spans supporting older people to be healthy well, preventing hospital admission both in the community and at the hospital front door, supporting discharge, preventing people in care homes being hospitalised and enabling a good end of life experience in a persons preferred place of death. Integrating care and streamlining pathways around the person across health and social care is key to supporting the out of hospital agenda.

The BHR Joint Commissioning Board is developing a prevention approach with a single model, promoting a 3-5 year outcome approach and appropriate governance through an agreed action plan across partners and for all ages. For older people, promotion of wellness, prevention and people taking better care of themselves are key enablers through community networks, improving living conditions and supporting the other social determinants of health. Through the transformation work, the Healthy Well work stream is developing a prevention offer for older people. Care Navigation whether social prescribing, VCS navigators or Local Area Co-ordinators will be integral to this offer in the community and supporting discharge from ED to support the reduction in NEA.

The older people's transformation agenda is developing a number of community-based initiatives to promote more choice in health in the community. The work streams include a Place-based Care Model to be configured around Primary Care Networks as an MDT offer from community health services and a range of voluntary sector services commissioned by the local authority and CCG. This will support on-going health conditions enabling people to remain in their preferred place of care and community. Secondly, Home is Best (HIB) will be a new integrated intermediate care service, combining current intensive rehab and nursing services in the community and acute (ED front door), creating a single point of access and linking to the VCS to offer a wrapped package of care for the person to prevent them needing ED or a hospital admission or supporting a more timeous hospital discharge. Geriatricians will oversee the assessment and interventions. Both the above support local authority partners by reducing the need for large care packages or potential care home placements.

Mental health:

Within mental health social work services, the 'Recovery Star' has been implemented with service users to promote self-management, independence and recovery. Mental Health First Aid training has also been commissioned to support

staff following a successful pilot two years ago. Additionally, mental health services within the local authority have recently taken responsibility for all service users with a diagnosis of dementia and will be working over the next 12 months to ensure that preventative approaches are embedded in the care and support model delivered. This is being explored with the local dementia advisor service commissioned and run by the Alzheimer's Society.

Thrive ThamesView is a pilot mental health improvement project that is delivered on ThamesView Estate. The project is supported by Barking and Dagenham Council and the Mental Health Foundation Charity. This project is linked to Thrive LDN- a citywide movement to improve the mental health and wellbeing of all Londoners. The aim of Thrive ThamesView is to co-ordinate a range of peer-support programmes with ThamesView estate residents and local services. The programmes will be aiming to improve people's skills, confidence and relationships and build community cohesion. Peer-support groups will start from June 2019 and be delivered with support from the Mental Health Foundation over a period of six months. The project plans to work with local services and recruit local residents to volunteer to support and take ownership of the project to allow it to continue once the 12month funding has ended. It is hoped that the findings from the work will be used to initiate more groups/activity within the estate and inform wider preventative work across the borough.

Disabilities:

The Borough's Disabilities Service has been reviewed in 19/20 and will be evolving in 19/20 and 20/21, with re-designed and multi-disciplinary working arrangements between health and social care and an improved life planning, transitions and autism pathway. Partners are also looking at the services available in the community to support disabled residents in their everyday life, particularly around activities and employment – see Question B(ii) below.

Social work practice:

Following a 2018 review of the local authority's social work practice model which suggested that practice is overly bureaucratic, jargonistic and too focused on processes and systems, in 2019/20, the local authority will be moving to a relational and strengths-based practice model. This will put servicer user strengths and outcomes at the heart of all social work and will include a re-developed assessment tool (cut down from 30 pages to 3) with a stronger focus on a service user's abilities and assets. This work has already begun with an innovative 'Stories' project in Spring 2019 in which social workers have been telling short stories about their service user's lives and sharing these stories through the mediums of creative writing, songs and art.

Developing the market:

The local authority published its second Market Position Statement for 2019-2021 in March 2019. The MPS identified priority market development areas in mental health, learning disability and carers markets and Commissioners will be working to expand the choice and number of services available within these areas in particular. A Direct Payment support service is also currently being commissioned to support service

users to use their personal budgets creatively, understand their role as an employer and expand the Personal Assistants market. This will be extended to personal health budgets where possible.

We are also extending the capacity and reach of our Shared Lives Service. Through the provision of a Development Worker in a local voluntary sector organisation and promotional activity in 2019/20 we have supported both an increase in carers and supported existing carers to work with younger people with more complex needs. We have also seen improved access to short term placements for younger adults which is providing meaningful alternatives to other forms of care and support. We are working with Havering to expand this provision further.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):

- Joint commissioning arrangements

- Alignment with primary care services (including PCNs (Primary Care Networks))

- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

(800 words)

Joint Commissioning Arrangements:

See answer to Question C regarding the development of our BHR Integrated Care System (ICS) and the Joint Commissioning Board which coordinates the delivery of health and social care projects and supports the drive towards becoming an ICS.

Service developments and pathway redesign in BHR are managed through a number of multi-agency boards. These include an A&E Delivery Board, led by the acute trust. The Discharge Improvement Working Group (DIWG), which is co-chaired by a local authority and NHS community services director, is a sub-committee of the A&E Delivery Board which is responsible for reviewing and managing flow in and out of hospital. The Older People's and Frailty Transformation Board led by the CCG is a clinically and professionally led group which is responsible for co-ordinating transformational change across older people's services to improve quality, patient outcomes and to ensure services are as efficient as possible and integrated around the patient.

As part of long-established BCF schemes, the local authority and BHR CCGs commission employment support for people with mental health needs and a Carers Support Service. The latter service is commissioned from a voluntary sector organisation and delivered in a variety of health and community settings. The service also helps to lead the delivery of the joint health and social care Carers Strategy.

Alignment with primary care service (including PCNs):

With the development of PCNs, the older people and frailty agenda is aligning a Placed Based Care (PBC) model with PCN areas. PBC is a key work stream within the transformation agenda, and is focusing on a whole system solution integrating primary care, community health services, adult social care and the voluntary sector, by developing a proactive model of health and care management. PBC will support and maintain people who are frail to remain in their own home whilst supporting them to manage their health and well-being needs and linking to local community assets. PBC will include enhancing current MDT resources of senior nurses, therapists, social workers, GPs and adding care navigation/social prescribing as part of the PBC offer. As the PCN workforce expands and develops, PBC will also integrate with this new resource to maximise the services offered.

The Borough's locality model continues to work well, bringing together local authority and NELFT community health staff, aligned with GP surgeries. Recent developments have included the introduction of new Care Navigator roles and 4 senior Social Work posts and we are working to ensure better integration with our Community Solutions service. As far as possible, the design of this model will align with the Primary Care Networks.

In April 2019, Community Solutions concluded a 6-month social prescribing pilot with three GP sites. The focus were patients identified as socially isolated, experiencing debt/financial issues, having housing issues, needing support with employment and further education as well as existing healthy lifestyles programmes. This unique model provided GPs with the opportunity to refer into the council's resident facing services, while increasing the likelihood of residents being identified earlier and supported to thrive. From Autumn 2019, the Primary Care Networks (PCNs) in Barking and Dagenham will be developing a holistic and fully integrated Social Prescribing offer across Barking and Dagenham in realisation of the ambitions outlined in the NHS Long Term Plan.

Alignment of services and approach to partnership with the VCS:

BHR CCGs have been developing the role and commissioning of the VCS over the last year. The VCS are now key players in the transformation agendas being key contributors into boards, steering and task and finish groups. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF and the VCS has been key in driving these forward. This includes care home trusted assessors to support patients to be assessed for a care home place in hospital for more rapid discharge, funding additional care navigators to enhance supported discharge and the expansion of Falls prevention classes.

As discussed above, the VCS are commissioned to deliver a number of services including the home from hospital, handypersons and carers support service and Community Solutions are signposting service users to these and other appropriate VCS services and support, such as the CAB and the Independent Living Agency as part of their discharge and social prescribing work.

Independent Age UK have also chosen Barking and Dagenham and Havering as partners for the 'Reconnections' project. This project will address the social isolation of older people in Barking and Dagenham through enabling, preventative and peer

support approaches. The project is jointly funded by the local authority and the CCG, in conjunction with Independent Age and will work in partnership with social care, NHS services and the voluntary and community sector. The project will be in place from October 2019.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:

- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

(800 words)

Barking and Dagenham utilise the DFG for adaptations and social care projects in line with guidance. The majority of the DFG (approx 75%) is spent on adaptations for individuals with disabilities across the life course and the team administering the DFG sits within our all-age Disabilities Service.

In Barking and Dagenham, 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 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.

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 on a case by case basis at management discretion 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 avoiding the need for more costly interventions e.g. high cost packages of care /nursing home accommodation.

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 and refer to other services such as the Handypersons Scheme.

The Council's aim for 2019/20 is to revise our DFG Policy to be more in line with the Better Care Fund metrics, ethos and utilise the flexibility to use the DFG as set in the Regulatory Reform Order 2002. In the last year we have begun to use a small proportion (approx. 25%) of the DFG more flexibly to meet the increasing demands to support people to live independently in their homes for longer, keep individuals safe and decrease levels of falls and reduce hospital admissions. We have begun to finance Housing, Health & Social Care initiatives such as the hoarding and decluttering scheme. This is a pilot provided by the charity MIND and a local voluntary organisation to support individuals who are known to hoard in their properties. The scheme serves to not just support the individual with their mental

health needs but implement a supportive network to clean and maintain their homes sufficiently for their health, identify repairs and any adaptations required to meet their needs and ensure that they are safe to remain in their own homes. The DFG has also been used to finance Assisted Technology services such as Breezie which provides older people with a personalised tablet to be more independent in tasks such as communicating with friends and family and linking in with managing their environment with a touch of a button e.g. adjusting the heating or seeing who is visiting them at the front door.

The local authority has recently commissioned a strategic partner to undertake a pathfinder project around assisted technology to increase digital enablement of residents and to look at technology becoming central to the delivery of care and support to help meet service user outcomes and wider service transformation. The project has seen care and support staff both within the local authority and the hospital trained to identify the need and provision of care technology for service users and new approaches to care technology in supported living and residential care have been piloted. The local authority will be working with BHR CCGs and other partners to learn from the pathfinder and develop a business case for the longer term provision of the service in 19/20.

Mutual Ventures:

Aside from the DFG, Commissioners are working with Mutual Ventures to consider 'spinning out' non statutory services that support people with a Learning Disabilities and/or ASD. We have completed a Demand Analysis for all Learning Disability Services within the borough which found significant unmet demand, particularly in day services and community based social activities. A key advantage of a Mutual would be the ability to engage staff and service users in the ways of working and strategic vision of the service; ensuring that all views are embedded in both of these will be a key to addressing the disconnect between the service's vision and the experience of staff and users. Discussions are ongoing between the local authority and the CCG and an options appraisal will be developed for consideration in Autumn 2019.

C) System level alignment, for example this may include (but is not limited to):

- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans

- A brief description of joint governance arrangements for the BCF plan

(1500 words)

The East London Health Care Partnership (ELHCP), the STP for North East London has a key strategic aim for integration on various levels. This is being planned at a neighboured/network level, borough, multi-borough and STP level. This is to support the management of people with complex needs, who require system wide support to enable them to remain healthy and well.

Within the planning for the STP, BHR are developing an Integrated Care System to deliver high quality, safe, integrated and compassionate care through all

commissioned services, steered by the BHR Integrated Care Programme Board (ICPB). The ICPB is a pan-health and care board who set the pace and tone for the strategic transformation of our local health and care system. The ICPB is the vehicle to ensure pan-BHR leadership alignment and also monitors progress towards becoming an Integrated Care System (ICS).

Integration includes specialist and universal, hospital/community/primary care and local authority and health services. Keys aspects include focusing on health outcomes not organisations, pooling resources (e.g. budgets, facilities, and staff), reducing silos, avoiding duplication and releasing resources to delivery. Key areas for the STP include cancer, frailty (and Aging Well), mental health, urgent and emergency care, medicines optimisation, long term conditions (Respiratory, CVD, Stroke), end of life, primary care, personalisation and prevention. Key enablers include digital technology, workforce, estates and system reform.

BHR has taken a transformation approach using multi-partner boards to develop and support the implementation of a number of agenda's including Older and Frailty, Mental Health, Long Term Conditions, Children and Young People (Maternity), Cancer and Urgent Care that focus on key population groups across the areas of prevention, primary care, planned/unplanned care and integrated care.

The ICPB has established a Joint Commissioning Board (JCB) to coordinate the delivery of Health & Social Care Projects and support the drive toward becoming an Integrated Care System (ICS) through increased levels of planning and joint commissioning across the CCGs and Local Authorities in BHR. The role of the Board is to support and promote the development of effective joint commissioning arrangements within the BHR Integrated Care Partnership; create, develop, support and monitor a work programme of joint commissioning activity and coordinate the development and delivery of the Better Care Fund across the BHR Integrated Care Partnership.

The local authority is a committed member of the Integrated Care Partnership. Our Cabinet Member for Social Care and Health Integration is the Chair of the ICP Board meetings and is a representative on the East London Health and Care Partnership. Our Strategic Director and Director of Public Health also has representation on the governance group which enables strategic conversations designed to develop integrated care across the partnership. There is a commitment to the transformation boards that sit below the higher level governance mechanisms, with some of the workstreams led by the local authority, and this is leading to active delivery of the aspirations of Integrated Care. Further discussions will be taking place in 19/20 regarding the number of boards and working groups that are in place across the system in order that further rationalisation/alignment can take place which promote our joint aspirations as well as our local agendas. The CCG system intentions have been shared with the local authority and these are aligned with the STP/ICS plan. The system intentions have been looked at, challenged and discussed and practical commitments to delivering integrated care developed. There are active plans in place to deliver change. The BCF allows for a range of services to function and underpins the move to integrated services. The transformation boards are prompting the development of opportunities to build on the current programme and look to step up integrated services for residents. The possibility of capitated budgets, whilst not

yet in place or fully committed to, remain on the agenda across the ICP, whilst recognising the significant practical and financial issues in moving to such a model.

The local Health and Wellbeing Board provides system leadership for our health and care economy, including overseeing the implementation of the Barking and Dagenham Health and Wellbeing Strategy including how we work to reduce health inequalities.

As health and care Commissioners we seek to co-produce the design and implementation of our services based on evidence of our local populations need. This is sourced through a range of data including our Director of Public Health reports , JSNA, health and social data from client management systems, as well as performance outcomes frameworks in the design of services. Undertaking Equality Impact Assessments will ensure we are meeting these needs and our duties to reduce health inequalities for those with protected characteristics under the Equality Act.

BCF governance arrangements:

From our BCF 2017-19 plan we developed a joint BHR S75 with the BHR LAs and CCGs, which was completed and signed back in July 2018. This sets out the foundation to strengthen the work across the partners to deliver health and care services across the BHR region using the BCF as a key lever for support integration where this brings efficiencies of quality and sustainability.

The S75 sets out three ‘BCF aligned pooled funds’ for each HWB area, and in addition incorporates the option of utilising a fourth ‘pot’ to facilitate joint pooled commissioning arrangements between partners.

The Better Care Fund schemes are governed through the Joint Commissioning Board, which has three borough CCG and local authority representation. The chair alternates between CCG and local authorities. The Board meets on a monthly basis and oversees delivery of the schemes but also explores opportunities for development of integrated services and joint commissioning. It is also in the process of exploring opportunities for further development of the BCF from 2020 onwards in relation to integrated services and joint commissioning opportunities. Therefore, it is expected that the BCF plans will continue to develop and evolve as the JCB is a forum to which the key commissioning partners can bring forwarded new initiatives to align with local and regional needs and demands.

A Section 75 continues to govern the BCF across the three Boroughs and a steering group of the three Boroughs and the CCGs will continue to drive forward the work of the BCF post assurance and feed up into the JCB.