APPENDIX A

Integration of **Health & Social Care** in Barking & Dagenham

Our Journey So Far; our current position

A short narrative history and some notes on current and future plans, developed to aid thinking on health and social care integration in Barking & Dagenham.

DRAFT VERSION 1

Introduction

It is too easy to see 'integration' as the new, fashionable answer to the sustainability problems of the health and social care system. As anyone working in health and social care will readily certify, it has been a long-standing policy theme. The immediacy of the current financial pressures is shining an uncompromising spotlight on the level of complexity involved in further integration of health and social care, particularly across changing geographies. To give a useful context to some of that complexity it is essential that we understand the history of integration, and can build on the achievements of colleagues past and present.

For a number of years, Barking & Dagenham has pursued various integration options for health and social care, both for adults and for children. There have been varying degrees of success and longevity across these different activities, but the approaches taken clearly evidence a willingness to share responsibility for outcomes, to share control over resources, and to consider new structural and managerial opportunities. This short paper gives an overview of the journey so far, and at the end will consider the implications for the way forward into 2017/18 and beyond.

Part 1
Looking back

Early steps

In November 2000, Barking & Dagenham Council and the local NHS took a very substantial step towards integrating service management and delivery. The decision was taken by the then-Council Executive to have the Director of Social Services appointed to the post of Chief Executive of the Primary Care Trust, thereby initiating the management of both social care and health functions under a common structure[1]. This was to have taken effect, more or less, from the inception of the Primary Care Trust on 1 April 2001, which had been created in the third wave of PCTs to emerge nationally under the NHS Plan 2000[2], out of the 481 Primary Care Groups that had previously existed.

A report to Cabinet in September 2003 ended this arrangement[3], the minutes noting that "*joint management arrangements between the Primary Care Trust and Social Services [have] been terminated*", with the Director of Social Services returned to her substantive Council post. The termination of the arrangements, which had been described by the Guardian[4] as "*pioneering*", came as a surprise nationally. The then-President of ADASS observed that it served as "*a powerful reminder of the need for organisations to attend to the core need of meeting the needs of local people above structural reform*".

In a theme that will recur through the narrative of integration attempts in Barking & Dagenham, causes cited included pressure on resources (the PCT was significantly below target capitation at the time) and changing relationships with more central NHS bodies, in this case the new North East London Strategic Health Authority.

Bloodied but not beaten

Bruising as it was to have dissolved the integrated PCT management arrangements so publicly, it is crucial to maintain a wider view of the joint work that continued in health and social care. The report that re-established Council management arrangements following the ending of formal integration set out in the first lines to reaffirm the Council's commitment to continue integration of services for the public benefit[5]. The report observed

[1] http://modgov/documents/s656/Main%20Report.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC32310/ and http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/The_legacy_of_PCTs.pdf
[3] http://modgov/ieListDocuments.aspx?CId=180&MID=1547#AI6101
[4] https://www.theguardian.com/society/2003/sep/03/guardiansocietysupplement.politics3
[5] http://modgov/documents/s4327/Health%20and%20Social%20Care%20Management%20Arrangements.pdf

that it was not expected that there would be any services "*where existing integrated working arrangements will discontinue*". Once again, a theme for the future is indicated: that the pragmatic approach to establishing joint delivery takes precedence over grander, high-level integrated management arrangements.

Amongst these arrangements, in January 2002, the Council had agreed[6] to proceed with integrated personal, social and healthcare services for people with a learning disability, under a Partnership Arrangement with pooled budgets. In December 2003, the Council proceeded with building Grays Court[7] for the provision of intermediate care for speeding up hospital discharge, the facility to be rented by the PCT for these purposes.

Whilst various of these specific shared arrangements continued, the next significant milestone came in 2008 with the completion of a report by consultancy *ChangeFX*, received by the Cabinet in late 2008[8], on integration and joint working. The report, firmly anchored in the context of the Comprehensive Area Assessment being introduced by the Audit Commission, drew on learning from the 2001-2003 experience. It summarised that learning as being about:

- *Excessive pace in the face of significant complexity;*
- *Lack of a clearly agreed common purpose, rooted in community outcomes;*
- *Lack of genuinely shared sense of ownership (since the new PCT had not had time to form properly);*
- *Lack of common culture, and the clashes that resulted in the face of a lack of clarity about what was a joint activity and what was any one agency's.*

These are the sorts of conclusions that will resonate with any setting where integration is pursued. Nonetheless, the next steps recommended for Barking & Dagenham were rooted in the challenges to be delivered jointly under the Local Area Agreement. It was observed that the commissioning of services across the four Outer North East London PCTs needed strengthening as they disaggregated commissioning from direct provision under national directives. Moves were made to form a steering group, appoint a joint Programme Director, and established a shared vision.

Following acceptance of the ChangeFX recommendations, the borough began work on a new Health & Wellbeing Strategy which was eventually agreed to run from 2010 to 2012/13. In the months following this refresh of the

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[6] http://modgov/documents/s599/Learning%20Disablities%20report.pdf
[77] http://modgov/ieListDocuments.aspx?CId=180&MID=1755#AI7109
[8] http://modgov/documents/s20220/Anne%20BristowExecutive%20Report%20-%20improving%20partnership%20working.pdf

direction, national policy developments began to build towards the Health & Social Care Act 2012, which would establish Health & Wellbeing Boards in the form that they currently exist. However, under the Local Strategic Partnership a fledgling Health & Wellbeing forum was introduced in 2008/09, such that it was ready to take on 'Shadow Health & Wellbeing Board' status, and begin to test out the new national proposals, from its 23 November 2010 meeting[9]. The borough partnership was therefore already well set-up for the introduction of the Act and its new governance requirements from 1 April 2013.

Service integration continues

In the meantime, the partners continued to operate integrated arrangements for the delivery of learning disability services and support for people with mental health problems. By 2005 NELFT and the Council were operating joint learning disability services[10]. It was not until 2011 that formal agreements under Section 75 of the NHS Act 2006 covered the operation of integrated mental health services[11], though they had been operating jointly for some time. The operational director for NELFT attended the Council's Adult & Community Services Departmental Management Team as a joint appointment, and by this means the effective integrated oversight was maintained.

Integration from the bottom up

In 2008, the Unique Care pilot was introduced, with the PCT and Council bringing together resources for primary and social care services to pilot joint working to improve hospital discharge and prevention of admissions. Relatively quickly, this pilot was recognised as having significant potential to improve services and, from 2011, the model was rolled out as an operational mechanism for health and social care. The six resulting 'clusters' of primary, community and social care services were established as the fundamental basis for integrated health and social care delivery. There is relatively little formal discussion of the model in the Council governance, and for reasons which, with hindsight, are positive: the development was achieved with relatively little fanfare, and with the emphasis on practical, ground-up moves to integrate. Space was created to support co-location, the regular multi-disciplinary case management discussions were established, and together

[9] http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=477&MID=5306#AI34857
[10] http://moderngov.barking-dagenham.gov.uk/documents/s11232/Action%20Plan%20to%20Achieve%20Full%20Compliance.pdf
[11] http://moderngov.barking-dagenham.gov.uk/documents/s37378/Mental%20Health%20Section%2075%20report.pdf

with the use of Health Analytics to bring a data-driven 'integrated overview' of the service users at greatest risk of hospitalisation, the model was largely formed. Greater governance began to be set in place over time, including ensuring that the model became the core of the Better Care Fund plan when first introduced.

In 2012, the partnership was able to take the model for Integrated Care Clusters to the National Children & Adults' Social Care Conference[12] and present it as pioneering practice, answering a topical debating point about how to achieve integration. A packed audience for the policy session received the presentation well, and left with a suite of supporting documents and information. Key to the presentation and the interest that it generated was that integration could be a pragmatic, staff-led activity, rather than part of a high-level top-down strategic plan.

Joint Assessment & Discharge Team

The next major operational development is the integration of hospital discharge services with neighbouring London Borough of Havering and the CCGs and health trusts for Barking & Dagenham, Havering and Redbridge. The Health & Wellbeing Board agreed the proposal in June 2013, and Barking & Dagenham would become the initial host organisation for the service. It has since been widely credited with being responsible for such strong performance on delayed transfers of care, and has set a strong direction for joint work on the hospital discharge pathways.

Adapting to the new NHS

With the implementation of the Health & Social Care Act 2012, the relative roles of both the NHS and local government changed radically. Public Health transferring to the Council, the establishment of the Health & Wellbeing Board, and commissioning of Healthwatch were the Council's major new responsibilities. As significantly for the integration journey, perhaps, was the creation of the Clinical Commissioning Group in place of the Primary Care Trust. Central government imposed severe resourcing limits on CCGs and their support costs, and new shared arrangements were developed in order to defray the costs. For some time, the PCTs or Outer North East London had increasingly merged their day-to-day activities, and this had had an impact on strategic relationships in Barking & Dagenham. Now, with the creation of Commissioning Support Units and small teams at borough level to support the CCG clinical directors, there were strong local relationships with long-standing trusted partners, but an increasing difficulty in accessing information

[12] http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=477&MID=6315#AI41718

and a frustration from the Council's perspective that the operational power of the Commissioning Support Unit (for north east London) was driving the strategy rather than the locally accountable CCG Governing Body.

Nonetheless, the Council had been an early adopter of the Health & Wellbeing Board, with its pre-existing shadow Board standing it in good stead. Membership was wide and inclusive, and the borough was at the forefront of advocating for providers to be part of the core Board membership so that it had a genuine system leadership role, rather than a more restricted commissioning focus.

On 1 April 2013, the Health & Wellbeing Board formally took on its statutory role as the borough-based system leadership forum, promoting integration and being the checkpoint for consistency of decision-making with the Health & Wellbeing Strategy and the Joint Strategic Needs Assessment. This built on the steady development of good relationships over the preceding 18 months.

Campaigning: Health for North East London

All of these developments came at a time of some strong campaigning from local people and councillors across the three boroughs of Barking & Dagenham, Havering and Redbridge, related to proposals to downgrade the A&E department at King George Hospital and centre activity on the A&E at Queen's Hospital[13]. Local members were vocal in opposition to the proposals, centring around poor consideration of access to Queen's Hospital for residents of Barking & Dagenham, and the poor performance of the over-stretched A&E at Queen's. Referral to the Secretary of State, including by Barking & Dagenham Council, led to intervention by the Independent Review Panel in 2011, and ultimately the Secretary of State accepted the proposals, but with caveats around improvements in performance at Queen's Hospital before services could be considered to be safe to transfer. The discussions on these matters coincided with the issuing of a poor inspection judgment by the Care Quality Commission on the emergency department at Queen's Hospital, which ultimately contributed to the 'special measures' rating for Barking, Havering & Redbridge University Hospitals NHS Trust. The move remains to be fully enacted, though there have been gradual and partial shifts of 'blue light' activity from King George to Queen's Hospital. Through its positive engagement in the work of the Integrated Care Coalition, the Council has shifted its policy position to broadly accept the clinical case for relocation of services, but continues to raise concern about the readiness of Queen's Hospital, and further questions the changing demographics of the area that raises the need for more emergency care options.

[13] http://webarchive.nationalarchives.gov.uk/tna_la_nhs/20120831162929/http://www.health4nel.nhs.uk/

Throughout, however, integrated work continued with Barking & Dagenham an active participant. The scrutiny call-ins and heated discussions in partnership forums may have been tough and uncompromising, but they did not fundamentally challenge the position that Barking & Dagenham Council wanted to collaborate for better health and care for the residents of the borough. Disagreement was real and strongly felt, but it was not a disagreement about the basic outcome of better and more accessible health and care services, it was a disagreement on one important aspect of 'how'.

Better Care Fund

From its first announcement as the Integration & Transformation Fund, Barking & Dagenham's position was to use this national process to support our local priorities to the greatest extent possible. It was received proactively, and an agreed plan was quickly developed[14]. The funding that was included in what came to be known as the Better Care Fund was existing funding, and came with commitments already made. Barking & Dagenham Council readily agreed to pool more than the minimum amount, including substantial preventive elements of the Public Health Grant. The plan was signed off in September 2014, with a total Barking & Dagenham pooled fund was £21.6m in 2015/16.

Progress from then onwards has been mixed. The experience of operating a risk share arrangement, as required in the guidance, was not a positive one. The target which formed the basis of the risk share – emergency admissions – was volatile and continued to rise over the year, whilst performance remained good on hospital discharge. Major schemes in the BCF – integrated care cluster arrangements, intermediate care, and the Joint Assessment & Discharge Service – continued to perform well. Developmental strands suffered for two reasons: a need for greater flexibility in redistributing resources beyond the small allocations initially made, and the commissioning and leadership resources to see change through, to scope the benefits and to sustain the implementation. All flexible monies were in the local authority funds in the pool, with CCG money tied up in NELFT contract and therefore inflexible. Reflecting on the Better Care Fund, it has not really deepened the partnership relationships since its first agreement, and the administration process has become more of a distraction than a help, given the otherwise strong context of partnership working in Barking & Dagenham.

Emerging cross-borough working

Part of the difficulty for the Better Care Fund was that, broadly in parallel, financial constraints on the management costs of the new CCGs required that

[14] http://modgov/documents/s74173/Integration%20Transformation%20Fund%20201516.pdf

they pool some of their activity. Thus, a relatively small borough-based team supported the CCG Governing Body, with the bulk of the support resource being provided through the Commissioning Support Unit, which grew to support 13 north east London boroughs, as mentioned above. The joint arrangement of Outer North East London PCTs had already seen relationships more strained between Barking & Dagenham Council and commissioning health partners. In November 2010, Cabinet received[15] a report on the White Paper *Equity & Excellence: Liberating the NHS* which detailed a number of steps being taken to prepare for the proposed health reforms and a new role for the Council. As well as establishing the 'shadow' Health & Wellbeing Board, the paper sought approval to enter into an agreement under Section 75 of the NHS Act 2006 to ensure that a range of existing integrated services "are not destabilised by debates about the terms of the agreements during the forthcoming period of transition".

In January 2012, Chief Executives and senior leaders from commissioning and provider organisations across the health and social care sectors in Barking & Dagenham, Havering and Redbridge met to explore their vision and ambitions for collaborative working to deliver more effective integrated care for people in North East London[16]. As a result, a new guiding partnership was established to focus on system integration and to oversee the development of a joint Integrated Care Strategy, to be called the Integrated Care Coalition. This would be a strong focus for integrated planning between health and social care in Barking & Dagenham, Havering and Redbridge (BHR). It is under this banner that the Joint Assessment & Discharge Service would be developed, and the principles of Barking & Dagenham's integrated care cluster arrangements would be shared with partners in other boroughs who were thinking along similar lines. Eventually, the Integrated Care Coalition would be the vehicle for the major project to shape devolution of health and social care to BHR and London.

Transforming Care for people with learning disabilities and behaviours that challenge services

Following the Winterbourne View scandal there were attempts nationally to deliver community-based placements for NHS patients that had been in long-term care in Assessment & Treatment Units. When concerns were raised at the pace of delivery of this work, NHS England launched Transforming Care[17], to drive 'system-wide change' in services for this cohort of people. Barking & Dagenham has engaged in this programme proactively, notwithstanding the potential of the required work to skew activity towards this small cohort and away from the wider needs of the community of people with a learning

[15] http://modgov/documents/s27237/NHS%20White%20Paper%20Report.pdf
[16] http://modgov/documents/s60766/20120619%20Integrated%20Care%20Report.pdf
[17] https://www.england.nhs.uk/learning-disabilities/care/

disability. The presence of a joint commissioner post has been helpful in focusing this work but, for example, the rates of people with learning disability receiving an annual healthcheck has continued to be a concern, and the activity needed to drive improvement is lost to the need to deliver the NHS England targets on TCP.

Integrated Care Partnership

The common theme from the three pieces of work described above (Transforming Care, the BCF and the cross-borough CCG structures) has been to disrupt shared expectations around the outcomes desired for local residents, and the relationships in place through which they can be delivered. Barking & Dagenham has generally been vocal in advocating for a strong focus on the needs of the borough's population, with some scepticism about top-down imposition of programme and commissioning arrangements, whether from NHS England or from a multi-borough NHS commissioner arrangement. Where outcomes have been compromised by the lack of local commissioning focus or proactive NHS leadership, such as healthchecks which are commissioned from GPs by the local authority, this debate has resurfaced.

More positively, however, in September 2015 there was an agreement to pursue an ambitious proposal to develop a business case which would scope a potential future Accountable Care Organisation. The ambition at the outset was one that had a strong political backing Barking & Dagenham, with a single organisation to take responsibility for health and social care, under joint political and clinical leadership. The subsequent failure to secure a vision as ambitious as this was in part related to failing to marry up the strategic ambition with the priorities at a more operational level, particularly amongst wider primary care. Therefore, unlike B&D's earlier cluster integration work, those at the frontline had not been convinced of the potential for transforming their working practices and environment, and the case for such major transformation was therefore harder to make.

What has past integration activity taught us?

Learning from the history of integration can be summarised as the following key points, and they are worth keeping in mind whilst considering the current position with respect to integration activity:

1 The win-win

It is vital that any integration is approached as a win-win, serving both parties well. This should be reflected in balanced and mutually agreed outcomes, and an equal sense of ownership.

2 Resources

Integration needs to be resourced appropriately, with clarity about what resources each partner are contributing for what outcomes. Equally, it needs to have the investment in co-ordination and leadership if it is to work effectively.

3 Aligning strategy and operations

To succeed, any integration approach needs to inspire commitment in both spheres of operations and high-level strategy. This takes time to develop.

4 Continuous leadership

Integration needs on-going management oversight – it isn't something that just 'coasts along', but requires continuous input and direction.

5 Willingness to rethink

Partners to integration work need to be brave enough to change it when it's not working – and to see the longer horizon, so that a big decision to stop or change something isn't a fundamental rejection of working together, it just recognises that another way needs to be found.

6 A focus on Barking & Dagenham

Finally, it is of vital importance that the reasons for integrating services are absolutely grounded in delivering for the needs of

Barking & Dagenham residents. To command local engagement and political leadership, any multi-borough arrangements need to be carefully nuanced to ensure their required tailoring for individual borough needs.

Part 2
Current activity

The Integrated Care Partnership for Barking & Dagenham, Havering and Redbridge

Despite not achieving the level of ambition originally intended, the Council remains committed to the development of greater integrated arrangements across Barking & Dagenham, Havering and Redbridge for the delivery of health and social care. Not only does this bring a sustainable health and social care system, but it will deliver a better service to residents. The commitment to a leading role is exemplified by Councillor Maureen Worby taking on the chairing of the Integrated Care Partnership Board.

As part of that programme, the work on localities is being taken forward by Barking & Dagenham, and the six clusters have been relatively quickly reorganised into three localities. This is felt to be a good move, and aligns with the new Target Operating Model for adults care and support, children's care and support, and the Disability Services. However, Barking & Dagenham continues to push the case that this is only one small part of the picture of transformed integrated services for BHR. There is widespread agreement on this point, but there are also differing views about the pace, scope and complexity. With the Joint Commissioning Board recently established, there needs to be some impact quite quickly from both this new forum and the provider collaboration arrangements led through the System Performance & Delivery Board.

In particular, joint commissioning must have real teeth, and involve a handover of real control of budgets and outcomes from constituent and partner agencies. This can initially be in relatively defined areas of spend and outcomes, such as learning disability, or a pathway such as hospital discharge, but there should be a real plan to expand and develop the remit, keeping in view the need to ensure that all partners can see benefit. In particular, the local authorities all have financial challenges and, notwithstanding the additional cash investment from central Government, they remain under severe pressure on adults' and children's social care. It is important that the integration arrangements deliver financial efficiencies and benefits for the local government sector as well as the NHS. In time, if this is starting to become a reality, Barking & Dagenham has expressed an interest in scoping an arrangement whereby the Integrated Care Partnership would become a new, joint Health & Wellbeing Board for the BHR area, cementing shared statutory responsibilities at that level.

The System Performance & Delivery Board has initially focused on the need to ensure that the financial gap in the NHS is planned for closure as required by NHS England. However, Barking & Dagenham is quite keen that the group quickly refocuses its activity to the original scope set out in the business case for the ACO, where the finances of local government were built into the

modelling. For this, it is essential that across the partnership the equivalence between clinical ("health") and professional ("social care") leadership are recognised, as well as the role of social care being wider than the propping up of the hospital system. Barking & Dagenham's degree of proactivity in its commitment to the partnership overall is to an extent dependent on maintaining all partners' financial and delivery requirements firmly in view.

Devolution

Currently still awaited, the final devolution settlement for London will hold some interest for Barking & Dagenham, the health elements having been significantly shaped by the BHR partnership work. The extent to which any devolution measures (such as retention of NHS capital receipts for local investment) is yet to be seen, with both the London and North East London Sustainability & Transformation Plan 'levels' playing a significant role which is yet to be fully clarified. The BHR partnership has, however, been clear that most of what was asked for can, in practical terms, already be done within existing legal frameworks. The devolution settlement should, however, provide a framework within which to 'push back' on excessive regulatory control, if BHR can ensure that the right arrangements are in place to manage the programme well, and deliver the outcomes for residents.

Sustainability and Transformation Plan

In October 2016, a plan for heath service transformation in North East London was submitted to NHS England for review. It had been developed over a very short timescale, and was a first draft. The Sustainability & Transformation Plan is one of 44 such plans nationally. Subsequently refined, the plan and its partnership arrangements are increasingly the main focus for all health service planning activity and, crucially, for the discussion on devolution. North East London STP takes in three health 'systems': the BHR system (based loosely around Queen's Hospital); Waltham Forest and East London (WEL, based around Barts Health NHS Trust sites); and City & Hackney (with the Homerton Hospital as its focus).

Bearing in mind the work that had been undertaken to build a strong, democratically led partnership for the transformation of health and care services in Barking & Dagenham, Havering and Redbridge, the top-down imposition of this planning framework was not welcomed, in Barking & Dagenham or across any other local authority. In principle, the actual ambitions and transformation proposals for the STP were as contained in the BHR devolution business case, with common themes around care closer to home, localities, and transformation of key pathways in planned and urgent and emergency care. What the STP still omits, which is more strongly threaded through the BHR work is the inclusion of social care in the

transformation planning. Certainly, in terms of financial gap, the STP is focused entirely on NHS finances, whilst the BHR proposals started from the outside on the principle of including local government and NHS financials.

The principle of subsidiarity was pushed strongly by all local government partners, which was similarly agreed through the BHR work as well so that only things that were genuinely more valuable to be done at BHR level were planned at that level. However, the tenor of discussions since then has been to establish a cross-STP governance, including forums for Members, voluntary sector and officer groups such as DASS/DCS/DPH. There has been a significant level of discussion about how the 'top-level' STP Board is composed, whether with representatives from every sector and every borough (i.e. a councillor from each borough, or a couple of councillors to represent the sector). BHR favoured a focus on the systems putting forward their representatives, with the BHR Integrated Care Partnership providing their mandate and the forum for them to bring back issues and establish policy positions. This remains to be fully resolved and a Memorandum of Understanding was in development to shape the governance and focus agreement of partners. This approach has also led to a number of discussions about what can be usefully done at STP level, which seems to push against subsidiarity by seeking to abstract issues up to STP level rather than waiting for such issues to emerge where they cannot be 'cracked' at system (i.e. BHR) level.

Having raised a number of these issues through the appropriate discussions, sharing them with BHR partners, Barking & Dagenham's position is to contribute to the STP as far as it is possible to resource such contributions, but to focus most energies on the BHR collaboration and in-borough transformation activity. The Council continues to observe the development of the STP and monitor its impact on the programmes which have been agreed through BHR and partners. To this end, we have not yet agreed to sign the Memorandum of Understanding that has been proposed to bind the partnership together in the STP; we are not alone across local authorities in north east London.

Prevention

The theme of prevention of ill-health features strongly in both the STP and the BHR programmes. Barking & Dagenham has taken a robust approach with the transfer of public health responsibilities to the Council, and in the deployment of the Public Health Grant. It currently funds a wide-ranging programme, including early years health improvement provision, Active Age interventions, healthchecks, general population health improvement and services to address domestic violence and substance misuse.

The theme of the coming years is to rationalise and focus this investment so as to achieve maximum value and impact. Reviews are underway of all programmes, with the Council's wider transformation and the health and social care partnership arrangements in mind.

With the Public Health responsibilities comes a requirement to commission healthchecks for the population, as well as screening for cancers. Performance on this has been variable to date, being heavily dependent on the primary care sector to offer them to the eligible population and manage take-up (for which they are remunerated). This is an area where the Council will be seeking to exert greater influence in future to give reality to the prevention ambitions that the partnership has set itself. It is a critical element of the prevention programme and the low rates of uptake mean that the basic opportunities to address behaviours and provide earlier intervention are being missed. The Cabinet Member and Deputy Chief Executive have met with the Chair and Accountable Officer of the CCG to put their concerns about the poor performance of the primary care sector in this area.

Children's services

Since its inception, there has been a subgroup of the Health & Wellbeing Board, with joint reporting to the Children's Trust, to co-ordinate between commissioners and providers of health and care services for children and young people. A newly formed Children's Partnership will now bring greater weight and breadth to this collaboration, to strengthen our partnership oversight of the children's agenda under the Health & Wellbeing Board. Barking and Dagenham's Health and Wellbeing Strategy, Joint Area Needs Assessment, Corporate Parenting Strategy, Education Strategy and Early Help Strategy provide an overarching summary of the borough's vision for its community, with NHS and Council influence over, and sign-up to, the strategic objectives, partnership working and accountability structure. This solid collaboration was well-evidenced in the recent joint inspection of the local area's arrangements for meeting the needs of children and young people with special educational needs and disabilities. Formalisation of joint commissioning arrangements was highlighted as an area that would benefit from further development. Working together with schools, the Council has been lobbying for some time for investment in therapy services for children, which the Clinical Commissioning Group has now been able to factor into its commissioning intentions for the coming year.

One area that will be seeing significant development over the coming year is in the redesign of a more comprehensive 0-19 offer. The Council's new responsibilities for commissioning health visiting services has been the starting point for this development, but linking the offer more broadly into

the new Community Solutions, Children's Care & Support and other preventive interventions is seen as a high priority.

Mental Health

After a number of years of operating integrated arrangements for delivery of mental health social care services, Barking & Dagenham Council commissioned a review of its Mental Health Social Care Services. This followed correspondence from the Chief Social Worker for Adults, Lyn Romeo, seeking assurances from statutory Directors of Adult Social Services that the appropriate statutory duties around adult mental health services were being satisfactorily discharged. The review report was completed in February 2017 and was received by the Deputy Chief Executive in March 2017.

The Report recognised a number of areas of good practice in place in Barking and Dagenham's mental health services. However, alongside this, it raised some immediate concerns around compliance with safeguarding procedures, the stability of the workforce (the Approved Mental Health Professional Service in particular), and some limitations with the Care Act compliance of the service. In overall summary, it was indicated that the distinctive value of social work did not have the opportunity to have the impact that it might within the current integrated arrangements for delivery of mental health services overall. This becomes particularly relevant, considering the changing ways in which the NHS and local authority deliver and commission mental health and related support.

It was also recognised that the way in which the Council and its health partners approached integrated services had changed, with a more comprehensive locality-based approach is being developed under the BHR Integrated Care Partnership. Alongside this, the Council has initiated its new Community Solutions service for initial access to social care services alongside welfare, employment and housing advice. Finally, work is underway to rethink the future of employment and vocational support for this service user group. It was recognised that this was an opportunity to re-evaluate the place of mental health social care services in this new landscape.

In her role as statutory Director of Adult Social Services, therefore, the Deputy Chief Executive took the decision to reinstate a direct management relationship with Mental Health Social Care Services. A temporary six month extension to the Section 75 arrangement with NELFT is being negotiated to maintain the service for the delivery of the integrated service. With a date effective from 1 October 2017, a refocussed Mental Health Social Care Service will be in place, continuing to deliver under Council management, and within a strong partnership with NELFT.

Currently, there are no clear plans for integrated commissioning arrangements for mental health, although a BHR programme on mental health service transformation, and the emergence of the BHR joint commissioning board, may bring opportunities to revisit this issue.

Learning Disability

Learning disability continues to be managed (by the Council) as an integrated service. With the new Disability Service about to launch, integration across age as well as across service structures and organisations will be an emerging theme. It will be important to maintain the shared focus on service user experience through these changes, with expected improvements in transition planning, but also as continued pressure is exerted on budgets (especially high cost placements) and support planning is reviewed.

Alongside work more broadly on learning disability services, the Transforming Care Programme continues to be a major centrally-mandated focus for partnership work with health. Barking & Dagenham commits significant resource to this, above and beyond the one-day-per-week of joint commissioner time that the NHS currently pays for. However, the demands for reporting and for case managing a small number of high-need individuals continues to outstrip available resources. In addition, the "dowry" system promised for those patients who had been in Assessment & Treatment Units the longest continues to fall short of the resourcing needed for the health and social care packages in the community. This represents a significant resource challenge for the Council, and whilst it is an important principle not to hold up care placement on the basis of funding disagreements, such decisions are exercised with due caution to ensure that funding responsibility is clear and proportionate.

There has been some greater progress in joint commissioning for learning disability than for mental health services. A joint commissioner post has been established for some time, with CCG contributing one day per week and the Council bearing the remainder of the cost. This was a pragmatic decision to enable the proposal to create the post to go ahead when the CCG was under significant scrutiny for its management overhead. In the new BHR joint commissioning arrangements, it is likely this will be revisited to get a more robust set of resources in place to support this work. The Council, as lead commissioner for learning disability services, continues to express concern that a disproportionate focus of the Clinical Commissioning Group is on responding to NHS England's pressure on delivering the Transforming Care Programme, and not the improvement of services and wellbeing for the wider cohort of people with a learning disability.

Continuing Healthcare and Section 117 Aftercare

Joint funding decisions on significant spend for individual packages tend to focus around Continuing Healthcare and Section 117 Aftercare. The former is the regime under which those with severe and long-term healthcare needs can have their needs met by the NHS rather than the social care system, which is, of course, means-tested rather than provided free at point of use. Section 117 of the Mental Health Act prescribes that those leaving a stay in detention under the Act must be provided with no-cost aftercare support for a period of rehabilitation, which can be joint health and social care funded, or down to either partner solely.

As part of attempts to manage spend, the CCGs for BHR announced a programme of proactive review of CHC, which at various points has had savings targets attached of the region of £1m per borough. The implication is to shift the cost to the local authority social care budget where eligibility is reviewed and CHC is withdrawn. The Council continues to engage in establishing the a workable, compliant, policy framework for this, and ensuring that dispute procedures are in place and are used proactively. There are forums established for taking forward discussions about difficult-to-resolve cases, including where we have identified a case that might now be eligible for CHC or for other joint NHS funding. This remains an area where there will be dispute over due process.

Integrated Care

The direction of travel on integrated care more generally, albeit with an initial focus around frailty and long-term conditions, is set out above. Barking & Dagenham has moved from its six clusters to three localities for the collaboration between community health, primary care and adult social care. With the addition of children's social care, and with the introduction of the Disability Service and Community Solutions, the Council's transformation programme will add greater strength and depth to the locality model in Barking & Dagenham. NELFT and the CCG are also working on the final stages of moving to the model, and this will be the bedrock of health and social care delivery not only in Barking & Dagenham, but also in neighbouring Havering and Redbridge. It will therefore be the expectation that any activity by the new joint commissioning board will be firmly rooted in supporting delivery as far as possible at this locality level.

In this vein, the Council continues to take a proactive position on minimising hospital discharge, yielding a performance on acute hospital discharge that is one of the best in the country. Minimal delays are caused by social care, though there is a level of shared and NHS-only discharge delays that continue to merit partnership scrutiny. This has not come without cost, and we have had to take steps to contain pressures in the crisis intervention budget. We

are in discussions with neighbouring boroughs about the future of the interventions that support this positive success, including the Joint Assessment and Discharge Service, which will be included in the Better Care Fund plan once again and will therefore, in time, potentially be a more formally jointly commissioned intervention. Further requirements of the Better Care Fund that seek to minimise hospital delays, such as Discharge to Assess (where the patient is discharged to a community setting or back home before being assessed for longer term care), would need careful scrutiny to ensure that costs are appropriately met by the system, rather than the Council incurring significant additional cost to the benefit of the hospital.

The 'improved' Better Care Fund

Over the coming three years, the Council is expecting to receive enhancements to the Better Care Fund pool of around £1m, £5m and £8m respectively. These allocations have been announced for some time, responding to the national growing pressure on the adult social care system. The aims of the BCF remain broadly the same, as outlined in the recently-issued guidance, namely to avoid hospital or care home admission and to improve hospital discharge. It is therefore largely focused on older, frail people or those with long-term conditions. One condition strengthened in the new BCF is the protection/stabilisation of adult social care, and the Council will engage with partners on this basis, noting the increasing pressure in the market and the budget gap that the Council is currently still forecasting.

There have also been moves to seek to improve the flexibility of the CCG allocations into the BCF pool, by opening up more information to commissioners on the NELFT contract and its service-level cost breakdown. This is welcomed by the Council, and the one-sided approach to freeing up re-investment opportunities only in Council resources should be improved if this can be achieved. To that end, in addition, the Council is proposing to reduce its investment in the BCF pool, from the enhanced allocations it has made in the past down to the prescribed minimum. This is to remove some Public Health and General Fund spend and to maximise the flexibility the Council has to reallocate in order to manage the pressures ahead.

Discussions are well advanced about placing the BCF into the context of the three-borough arrangements so that the Joint Commissioning Board may be able achieve greater efficiencies by fostering collaboration with neighbouring boroughs on schemes such as, for example, reablement and Discharge to Assess. This is to be a staged process, and currently boroughs are working on aligning the BCF plans, with a view to setting out the intention of a single plan for the second year (18/19) for areas where this makes shared sense.

Guidance has been issued late in the year, delayed by the General Election, and the two-year plan will be submitted in mid-September.

Financial pressures: NHS and adult social care

Both sectors are currently under significant financial pressure. Barking & Dagenham CCG has to save £15m from its ca. £400m budget, part of a plan across BHR that needs to remove £55m of cost from the system, which the System Performance and Delivery Board has been tasked with co-ordinating. A number of savings proposals are now emerging for consultation, some of which are likely to be controversial (reduction in IVF cycles, cosmetic procedures) and some which have the potential to cut across partnership priorities (cessation of funding for children's Portage services).

For the Council, there is still a significant budget gap, some of which will have to be met by further savings in adult social care. The new investment of resources falls into four main headings: the social care precept, the original adult social grant from the Autumn Statement, the expected Better Care Fund investments, and now the recent further investment from the Spring Budget. These funds will need to stabilise local social care markets, support further transformation in future years (including some digital options, for example), meet escalating costs, and simply contain existing budgets. The new additional investment comes through the Better Care Fund and will need to be signed off as a joint plan with the CCG, albeit that there is clarity in the guidance of the focus on stabilising adult social care. The Council therefore will need to enter these negotiations with a clear emphasis on the need to support social care spend before any further joint investments can be considered.

Part 3
Policy positions

Based on the history outlined above, and the overview of current work and priorities, the policy positions that follow are proposed as both a statement of the Council's intent, but one which partners should be able to agree to in principle through the Health & Wellbeing Board.

1 Our focus is on Barking & Dagenham

Joint arrangements both within the partners of the Health & Wellbeing Board, and our neighbouring boroughs, must deliver outcomes for the residents of Barking and Dagenham.

2 We are shaping our own destiny

Our mission is to deliver its shared vision, articulated through the Borough Manifesto, and the Health and Wellbeing Strategy. All other activity must be otherwise resourced.

3 BHR is our major focus for cross-borough work

We look to the BHR Integrated Care Partnership to be the main focus for its collaboration across boundaries in health and social care. It will support the STP where it can, but it will always critically evaluate proposals from the STP to ensure that there is not a more local level at which they can be more effectively led, shaped and delivered.

4 Everything should strengthen localities, where feasible

We are strongly committed to locality work, and will influence all partners to consider the opportunities for strengthening the local partnership delivery around a common locality structure.

5 We are committed to integrated delivery

For specific care groups (children with special educational needs and disabilities, learning disabled adults, those with mental health conditions), We understand the potential of integrated commissioning, both within Barking and Dagenham and with partners from neighbouring boroughs. However, all partners will continue to receive assurance that statutory duties are being discharged effectively.

6 Partnership can and should encompass robust challenge

We believe that the key to successful partnership is the ability to robustly challenge one another. We will encourage all partners to do so where decisions do not appear to be in the interest of local residents, or which are in contradiction with shared priorities.

7 We want to strengthen democratic leadership of health

Real democratic accountability – not just consultative forums – should be a part of all integrated governance arrangements, ensuring the leadership of all integrated arrangements are truly accountable to the residents they serve.

8 We work at our own pace

While the crisis facing the health and social care sectors is severe, effective integration takes time to devise and implement. We will not rush into arrangements without first properly considering the consequences; we will value quality over speed.

9 We will work sustainably

Our population is growing and changing. To be able to continue to offer residents the excellent health and care services they need and deserve, sustainability must be a critical consideration in all future work and arrangements.

10 Innovation is key

Lastly, we will endeavour to make Barking and Dagenham a centre for health and social care innovation, and the test-bed in which our current challenges are met. We will do this because we owe it not only to partners across the country who face similar pressures, but also – more importantly – we owe it to our residents.