Barking & Dagenham Place, Havering Place & Redbridge Place

Joint Better Care Fund Plan 2022-23

London Borough of Barking & Dagenham
London Borough of Havering
London Borough of Redbridge
NHS North East London

NHS North East London | London Borough of Redbridge | Havering London Borough | Barking & Dagenham

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North East London NHS London Borough of Redbridge Havering LONDON BOROUGH Barking & Dagenham

BHR Better Care Fund Plan 2022-23

This joint plan (the BHR BCF plan)covers the following Health & Wellbeing Board areas:
- Barking & Dagenham
- Havering
- Redbridge

The following organisations have signed off the plan:
- London Borough of Barking & Dagenham
- London Borough of Havering
- London Borough of Redbridge
- NHS North East London

These organisations are part of the North East London Integrated Care System with our other partners that includes:
- Barking, Havering & Redbridge University Hospital Trust (BHRUT)
- Barts University Hospital Trust (Barts)
- North East London Foundation Trust (NELFT)
- Primary Care Networks
- Emergency Services
- Commissioned services health and social care provider reps
- Patient and Service User reps
- VCS organisations

Summary of National Conditions
Our BHR BCF plan sets out how we will meet these requirements.

	National Conditions	Covered in Sections
1	**Jointly agreed plan between local health and social care commissioners, signed off by the HWBs** - or delegated authority if there is no HWB board. Reports will all go to the respective borough HWBs informing them of the plan. Plans should set out a joined-up approach to integrated, person-centred services across local health, care, housing and wider public services. They should include arrangements for joint commissioning, and an agreed approach for embedding the current discharge policy in relation to how BCF funding will support this.	Sections 1, 2, 3 &4
2	**NHS contribution to adult social care to be maintained in line with the uplift to ICB minimum contribution**	BHR Expenditure Templates
3	**Invest in NHS-commissioned out-of-hospital services** Narrative plans should set out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it. Expenditure plans should show the schemes that are being commissioned from BCF funding sources to support this objective.	BHR Expenditure Templates Sections 2,3,5 & 6
4	**National condition 4: Implementing the BCF policy objectives** National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework: • Enable people to stay well, safe and independent at home for longer.	BHR Expenditure Templates - Metric Tab Section 3

National Conditions		Covered in Sections
	• Provide the right care in the right place at the right time.	

*All detail and data contained within this plan was correct at the time of submission.

Executive Summary

Our Joint Priorities

Across the Barking & Dagenham, Havering and Redbridge Better Care Fund plan for 2022-23, we have agreed the following priorities:

Enable people to stay well, safe and independent at home for longer - Targeted Out-of-Hospital Care

- **To support people with higher care needs to get as great a level of independence as possible**
- **To support people to remain well in the community - maximise their independence and reduce admissions**

Provide the right care in the right place at the right time

- **To support safe and timely discharge from hospital and support a home first approach**

Market Stabilisation

- **To support the stabilisation of the care market and Winter pressures**

These priorities are key to deliver the ambitions of the BCF programme and deliver the standard and quality of health and care services to meet the needs of our residents.

Key Changes to the 21/22 BCF plan

1. The development of a Single Point of Access (SPA). This is now in place and has developed into the *Integrated Discharge Hub* (IDH), combining the Discharge Coordination Unit and the Hospital Discharge Service into a single integrated service. The IDH supports pathways 1-3 for both in-borough and out of borough residents. The service supports the three Places.

2. The *Home First* model of care has been rolled out with senior therapists, rehab assistants and trusted assessors and professional care support working across health and social care. The offer is in all boroughs at varying levels based on need and demand. The service is jointly commissioned with the NHS funding therapy services and the both parties funding reablement care.

3. NHS North East London continue to fund the first four weeks of Discharge to Assess (D2a) Nursing Placements for B&D, Havering and Redbridge places. The system also piloted “Block” D2a nursing beds (28) over three sites with a wraparound therapy team (Physiotherapy/Occupational Therapy) that has

supported 30% of local residents to return home, who would not have done so in a straight assessment only placement. This has continued into 22/23.

4. To reduce the rate of admissions where individuals could be supported better in the community through anticipatory care and admission avoidance, NHS North East London have commissioned a community UCR (Urgent Care Response) service across the three places, providing 2-hour crisis response at home service operating 8am to 8pm 7 days a week at a minimum, and using the model in line with national guidance. By the Q4 2021/22 the service was overperforming against the local operating plan target of 70% of people to be seen within 2 hours of referral. For 22/23 the system has also increased the rapid response service for end of life care via the expansion of the hospice 24-hour helpline with additional nursing capacity and a pilot for over-night rapid response nursing as an alternative care pathway.

5. The borough has a Place Based Partnership (PBP) board and is developing a programme of work at each Place. NHS NEL and the boroughs will be working in collaboration to integrate various transformation programmes at Place including older people and frailty and long-term conditions.

6. B&D has been a 3rd wave pilot site for the national Population Health Management (PHM) programme The borough identified a priority cohort using integrated data and analytics as the foundation to drive system transformation The partnership is taking a PDSA approach to trial interventions with local residents to support the development of an anticipatory care model of care for the future. Learning from B&D will be used a blue print to action PHM and anticipatory care in Havering and Redbridge.

7. The impacts of COVID on the care market – financial sustainability, workforce issues and service delivery moving away from building based to more virtual services.

8. Increase in care needs and complexity of conditions due to restrictions in accessing primary care services and people now requiring a higher level of care when entering the system.

9. The impact of COVID on our vulnerable residents with long-term health conditions and BAME communities.

Section 1: Governance (National Condition 1)

1. BHR BCF Governance & Ambitions

Our overarching vision for the Barking and Dagenham, Havering and Redbridge joint plan is to:

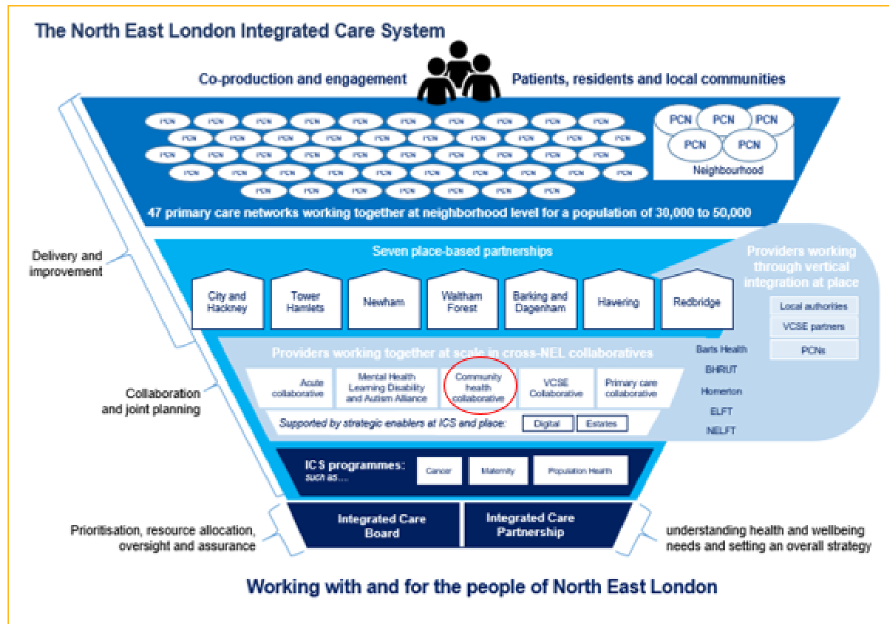
'Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high-quality health and wellbeing services.'

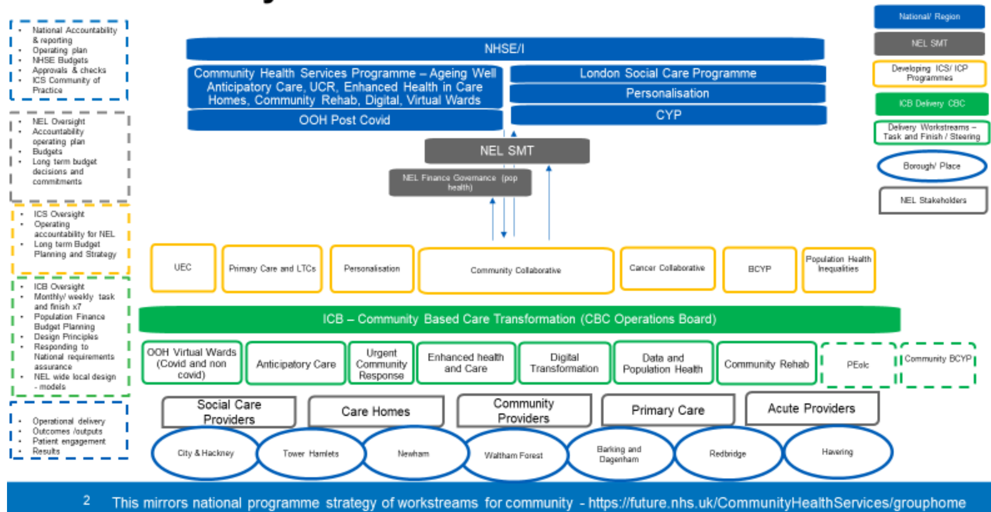
- **Create an environment that encourages and facilitates healthy and independent lifestyles** by enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing

- **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.





Joint BHR S75 Agreement and Joint Working
Overall strategic oversight of partnership working between the Partners is vested in the respective Borough Health and Wellbeing Boards.

The Partners have agreed that the BHR Joint Commissioning Board (JCB) will be responsible for the review of performance and oversight of the partnership agreement. The JCB is a working group of representatives of Barking and Dagenham, Havering and Redbridge Councils, NHS North East London and Place. At least one member from each of the Partners has individual delegated responsibility from their host organisation to make decisions which enable the JCB to carry out its duties and functions. In addition, each partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

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The BCF programme of schemes are governed through our Joint Commissioning Board, the JCB provides the strategic direction of the development and application of the Better Care Fund across BHR Places. From our BCF 2017-19 plan we developed a joint BHR S75 with the BHR LAs and CCGs (now NHS North East London), which was completed and signed back in July 2018 and is refreshed annually. 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 Place, and in addition incorporates the option of utilising a fourth 'pot' to facilitate joint pooled commissioning arrangements between partners and across Places.

The JCB consists of representation between the Barking and Dagenham, Havering and Redbridge Local Authorities, and NHS North East London. The chair alternates between NHS North East London and local authorities with representation consisting of the respective DASSs, DPHs, NHS North East London Leadership, finance representatives and Commissioner Leads as members of the Board. A *BCF Executive group* oversee the delivery of the BCF work in including planning, development and monitor spend and performance. A BCF Operations & Finance group supports the work of the BCF Executive Group including developing reports, reviews, finance templates and developing the submission annually. It is exploring opportunities for further development in relation to integrated services and joint commissioning opportunities. We will review the role of the JCB as the Place Based Partnerships develop over the coming year and whether any changes to governance arrangements are required.

Jointly Agreed Plan Approval

Below sets out the key officers from each organisation responsible for plan sign off and the dates of the Health & Wellbeing Boards for plan agreement.

Barking & Dagenham	
Chair of the HWB	Cllr Maureen Worby, Cabinet Member for Social Care & Health Integration
DASS	Elaine Allegretti, Strategic Director for Children's & Adults
Section 151 Officer	Philip Gregory, Director of Finance
Date of HWB Agreement	13 September 2022

Havering	
Chair of the HWB	Councillor Gillian Ford, Lead member for Adults Social Care & Health
DASS	Barbara Nicholls, Director Adult Social Care & Health
Section 151 Officer	Dave Mcnamara, Director of Finance
Date of HWB Agreement	21 Sept 2022

Redbridge	
Chair of the HWB	Cllr Mark Santos, Cabinet Member for Adult Social Care & Health
DASS	Adrian Loades, Corporate Director of People
Section 151 Officer	Maria Christofi, Corporate Director of Resources
Date of HWB Agreement	Either 12th of September or 21st of November 2022

NHS NEL	
Accountable Officer	Zina Etheridge, CEO NHS North East London
Finance Director	Henry Black, Chief Finance and Performance Officer - NHS North East London

Senior Responsible Officer	Place Directors NHS North East London - Sharon Morrow (Barking & Dagenham Place), Luke Burton (Havering Place) and Tracy Rubery (Redbridge Place)

Section 2: Approach to Integration

1. Summary

An integrated care system (ICS) is one that brings together local health and care organisations and the voluntary sector to deliver the 'triple integration' of primary and specialist health care, physical and mental health services and health with social care. Redbridge, Havering & Barking & Dagenham Place Based Partnerships serve a population of around 780,500 people.

Key objectives of an ICS are to (a) shift care from the hospital to the community where it is appropriate to do so, (b) provide place-based care through more proactive and integrated care across the NHS, social care and the voluntary sector at a neighbourhood level and (c) provide person-centred care by breaking down traditional barriers between organisations and the functions within them, placing a greater focus on the delivery of better outcomes for local people.

Pathway redesign and service model development across BHR places has primarily been delivered through a number of BHR system transformation programmes. These the Urgent and Emergency Care Board- led by the acute trust; a Discharge Working Improvement Working Group (DIWG) - chaired by local authority and NHS community services directors which reviews and manages flow in and out-of-hospital and the BHR Older Peoples and Frailty Transformation Board which is led by NHS North East London. The Joint Commissioning Board (JCB) consisting of BHR LAs and NHS North East London functions at a more strategic level where a range of collaborative commissioning and transformation initiatives are developed and negotiated, which includes the BCF. Commissioners across the three boroughs are also working together on a number of themed programmes and service developments.

Primary Care Networks (PCNs) are one of the key building blocks and the focus of integrated care delivery. PCNs are groups of general practices and social and community care providers that serve areas with populations of about 30,000-50,000 people (although can be larger), and aim to provide person-centred, community-based care through multi-disciplinary teams (MDTs). The formation of PCNs was directed by the NHS Long Term Plan in 2019.

Integration Approaches, Joint Commissioning and transformation approaches

Barking and Dagenham, Havering and Redbridge boroughs and the local NHS (formerly BHR CCGs) have worked collaboratively at a sub-regional level (BHR) prior to the inauguration of the Integrated Care Board and ICS. BHR Integrated Care Partnership has also developed over a number of years. This work and COVID has brought the NHS and boroughs into a much more collaborative relationship across the three borough areas.

With the move to Place, the focus will be on that borough level, however not losing the collaborative work across outer north East London that has developed over the previous years. The Place Based Partnerships have agreed to continue to collaborate on transformation where this makes sense and will be reviewing how this will operate as the Place Based Partnerships develop.

Embedding Integration - Joint and Collaborative Commissioning and transformation
Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge Places and deliver sustainable provision of high- quality health and wellbeing services. This plan sets out a clear determination that the BHR places 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 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 turns supports the whole health and care system. The system is working together to achieve the following aims:

- To enable and empower people to live a healthy lifestyle, have 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 healthy and independent lifestyles.

- Where care and support is organised around the individual's needs, involves and empowers the service user/resident, 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.

Through working in partnership, the local authorities, NHS partners, primary care and the VCS have an ambitious transformation agenda for older people and those who are frail. Through the integration of health and social care, streamlining pathways around the person and by supporting older people to be healthy; preventing hospital admission (both in the community and at the hospital front door), supporting safe effective discharge, preventing people in care homes from being hospitalised and enabling a good end of life experience in a person preferred place of death - we can enable people to be safe and well in community settings.

Having invested in the development of our locality models, bringing greater levels of integration and co-location of teams, we are developing this further with the creation of borough partnership boards which will go live in September 2022 to take a greater role in the commissioning and transforming the provision of services. Increasingly this will draw in the wider range of services than our current community models deliver, such as housing, general practice, voluntary sector services, social care providers and so on.

Improving outcomes for frail and older people is a priority for the BHR places. The planning and delivery of a transformation plan to achieve this has been co-ordinated through a BHR system wide transformation programme for older people and those who are frail. This was established in June 2018 with the aim of improving quality and patient outcomes and ensuring that services are as efficient as possible and integrated around the patient.

The transformation programme provides programme support to the delivery of the BCF outcomes. A number of system workstreams are in place have been established reporting to a transformation board to take forward service transformation through collaboration and shape the BCF plans.

The Older People and Frailty Transformation Programme brought all the work together to describe the entirety of the transformation programme across a pathway of care, the investment requirement to enhance capacity on primary/community care and savings opportunities resultant from a reduction in avoidable hospital activity. It was intended that transformation would be delivered over 3 years – the first year focused on building the foundation, moving to full scale transformation in year 2 and delivery through an ICS in year 3. The Board is planning a refresh of the strategic approach in 2022/23.

The partnership approach involves NHS North East London, NHS provider trusts and Local Authorities across the three boroughs, Havering, Barking and Dagenham and Redbridge. As part of the governance structure a Joint Commissioning Board has been formed to take opportunities for joint commissioning and transformation. Many initiatives and objectives are shared and delivered, and the strategic goals of prevention, integration and partnerships and personalisation resonate across all organisations. The partnership has been in place in various forms over some time and, through lessons learned from the three authorities and through demographic and demand profiling, has developed a localised model for delivery of services based upon Primary Care Network partnerships established within the borough.

Place Based Partnerships

Each borough has now established a Partnership Board that brings system partners including primary care, social care, NHS providers, the voluntary sector, Health Watch, the ICB and the local authority. The partnership has identified early priorities and will need to continue to develop aligned with the model of delegation that is ultimately agreed. The Joint Health and Wellbeing strategy and many organisational cross overs and governance groups set out the already established partnership approach between the Havering and system partners. The membership of the Redbridge Borough Partnership is similar to that of Havering. The Redbridge partnership has agreed its governance arrangements and identified three priority areas (Children's Health, Adult Mental Health and the health impact of overcrowding) which it will use to develop the working of the partnership as well as improving outcomes for residents. The Partnership is undertaking a series of developmental workshops in addition to its regular meetings in order to establish future ways of working. Progress is reported to the HWB at its regular meetings.

Redbridge is also developing its Borough partnership approach and priorities and been undertaking a range of workshops to develop this. Progress is reported to the HWB at its regular meetings.

The B&D Partnership Board will be supported by a programme structure that supports delivery across separate pathways of care for children and adults. This will allow the place to respond to local needs and priorities across the borough and include a wide range of relevant partners to develop solutions. The place based partnership aims to leverage the collaborative expertise to influence system working across NEL and unlocke barriers to the delivery of improvements in B&D. The ability to make informed decisions around health and care will support the partnership in tackling wider issues around inequalities.

Borough Partnerships Visions

Locality Models

Community heath and/or social care services operate on a 'locality model basis'. The localities have populations within them of a size that are largely equal populations though with potentially different needs. The move to a localities model has to be designed so that end users get better services. The concept means that the response to local needs will deliver more value for the residents in that area, because services are aligned with those local needs.

Primary Care Networks

BHR has a number of Primary Care Networks (PCNs) operating as part of a wider joint approach to primary care across north-east London. As part of the localities model, we will explore the establishment of 'community hubs' within each borough which will aim to co-locate a number of health and care services including GP and community nursing walk-in clinics, health and wellbeing programmes, employment support, housing support, healthy living prevention activities, and education services for adults and children. GP Federations are at borough level and are a key platform to expand the benefits of PCNs and enable further joint commissioning and economies of scale at both a borough level and across BHR places. They are a key part of the changing way health and care services are working together to support people in community settings.

Direct Enhanced Services provided by PCNs

Direct Enhanced Service	Service Outline	Workforce Service Support
Structured Medication Reviews	• Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines) • Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. • Can lead to a reduction in adverse events.	Clinical Pharmacist
Enhanced health in care homes	• Access to consistent, named GP and wider primary care services • Medicines review • Hydration and nutrition support • Access to out-o-f hours / urgent care when needed	Clinical Pharmacist Community Paramedic
Anticipatory care with community services	• Thinking ahead and understanding the health needs of individual people • Knowing how to use services better • Helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan.	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Personalised care	• Care tailored to the needs of people and what matters to them • Prevention embedded • Personal Health budgets • Shared decision making	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Inequalities	Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing those services that are provided in an integrated way where this might reduce health inequalities	Social Prescriber Clinical Pharmacist Physician Associate

Section 3: BHR BCF Scheme Summary Overview

1. Summary

This section provides a summary preview of our schemes for the BCF 2022-23. Since the impact of COVID many of our services have had to adapt and amend their delivery models and Place Based Partnerships are now looking at these services going forward and how revised or new models need to be designed and

implemented. This is particularly linked to hospital discharge, the sustainability of homecare, residential care, the care workforce and our prevention and early intervention offer.

2. Schemes & Metrics

BCF National Metrics

Metric 1:	Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Metric 2:	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services
Metric 3:	Unplanned hospitalisation for chronic ambulatory care sensitive conditions
Metric 4:	Discharge to usual place of residence

Other Related Metrics

Many of our services contained within the BCF plan also deliver to a wide range of other outcome measure under ASCOF and NHSOF, such as those supporting carers. For example:

ASCOF Related Domains

1. Enhancing quality of life for people with care and support needs
2. Delaying and reducing the need for care and support
3. Ensuring people have a positive experience of care and support
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

Example ASCOF indicators include:

- 1D. Carer-reported quality of life
- 1I: The proportion of people who have as much social contact as they would like.
- 3D. Proportion of people who use services and carers who find it easy to find information about support
- 4B. Proportion of people who use services who say that those services have made them feel safe and secure

PHOF Related Domains

1. Improving the wider determinants of health: Improvements against wider factors which affect health and wellbeing and health inequalities
2. Health improvement: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
3. Health protection: The population's health is protected from major incidents and other threats, whilst reducing health inequalities
4. Healthcare public health and preventing premature mortality: Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

NHSOF Related Domains

1. Enhancing quality of life for people with long-term conditions
2. Helping people to recover from episodes of ill health or following injury
3. Ensuring that people have a positive experience of care

BCF Priorities and Schemes

Our plan priority schemes for 2022-23 are set out below. The scheme types are those models and/or services that will deliver the priority scheme ambitions.

	BCF Policy Objectives and Scheme Names	SCHEME TYPES*

1	**Enable people to stay well, safe and independent at home for longer.**	• **Population Health Management Pilots** • **Anticipatory Care** • **Personalised Care and asset-based commissioning** • **Rapid Response** • **Telecare** • **Community Based Equipment** • **Carers services** • **Carer advice and support** • **Carers respite** • **DFG Related schemes** •
2	**Provide the right care in the right place at the right time.**	• **Bed based intermediate Care Services** • **Reablement in a person's own home** • **Residential Placements** • **Home Care or Domiciliary Care** • **Housing Related Schemes** • **Low level support for simple hospital discharges** • **Integrated care planning and navigation** • **IMHA**
3	**Market Stabilisation & COVID Recovery**	• **Provider uplifts** • **Fee increase** • **Winter pressures** • **Post Covid Recovery** • **Workforce**

*The scheme types often deliver in more than one priority schemes area to delivery care services in a variety of ways. For example, DFG monies can be used to support hospital discharge and community support and independence in the community.

Scheme Delivery & Management
BCF Scheme delivery will be overseen by the BHR BCF Executive Group and BCF Operations & Finance group which ultimately reporting into our Joint Commissioning Board. Progress reports on the health and care models delivery and spend will be presented to the Executive group. However, Commissioners from all three boroughs and the NEL ICB work closely together on a regular basis in relation to discharge models, system changes, and transformational and commissioning work. Our s75 agreement sets out the governance for these groups.

Approach to Risk
All partners are facing great financial pressures in the life of this plan and continuing to work to addressing ongoing sustainability. Partners to continue to be responsible for overspends on their respective budgets within the BCF. COVID and increased demand across all client groups placed a significant risk on the health and care system and financial landscape across BHR. This is impacting our NHS, social care and provider workforce. Within the local authority, social work and brokerage teams are often severely stretched to meet caseloads and demand and key workforce areas are struggling to meet the demand, for example the number of therapists available at a regional and national level. The system is working to mitigate these workforce issues with agency usage, the new BHR Academy and new apprenticeships through Care City, but these longer-term solutions will take a while to trickle through and mitigate these risks.

Further governance detail to Risk is set out in our joint BHR BCF s75 agreement. A detailed **Risk Log** can be found in **Appendix 1.**

Section 4: Implementing BCF Policy Objectives

Enable People to stay well, safe and independent at home for longer

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.

Admission Avoidance

The key local service for Rapid Response intervention (Community Treatment Team) was comprehensively reviewed in 2021-22. This indicated that with increased demand throughout the day, a larger response team was required and particularly telephone triage capacity. This has led to a considerable investment (£1.2m FYE from Ageing Well) to increase nurses and allied health professionals to meet the new two-hour urgent care response.

Anticipatory Care (AC)

By supporting people differently in the community, including tackling the wider determinants of health, we can prevent some individual's needs escalating or address them in the community rather than in acute services. BHR Places are at varying stages with both Population Health Management and Anticipatory Care. Barking and Dagenham Place are actioning a whole Place level PHM pilot in 22/23 and have identified pre-frail and long-term condition as two key cohorts to focus on. This has led to a PDSA approach with a PCN to test proof on concept for targeted interventions on a small scale. The work has included engagement with the local residents and collaboration with voluntary and community organisations. The outcome from this work will inform a future model of AC with an MDT at PCN level. Learning from the pilot will used to inform the development of AC across both outer and inner NEL.

Homecare & Double Handed Care

Barking and Dagenham have a homecare framework in place which operates on a locality model ensuring our domiciliary care function can support hospital discharge as well as keeping our residents in their own homes and in the community for as long as possible. Throughout 2022-23 our framework providers are working with partners to support discharge pilots that are outlined at other points in this narrative.

The Redbridge Homecare Framework model is a locality-based model with lead providers, back-up and specialist providers for children, LD and mental health. This enables areas to provide improved personalised care for service users to reduce hospital admission; position the market to deliver an enhanced health and social care home care service that reflects our integrated community care service and deliver improved efficiencies and reduce the need for long-term higher needs care.

In Havering a long established 'Active Homecare Framework' based on a Dynamic Purchasing system has established a set of providers that have passed high quality criteria where relationships are based on long term partnership. It has reduced the need for spot contracting to less than 10% from 50% before the framework was established. Recently the market has joined up in an association model, which is now operating its own forums with the LA as a partner. Continuously improving dialogue has led to initiatives and high quality partnership working.

Supporting people to remain independent at home, including strengths-based approaches and person-centred care

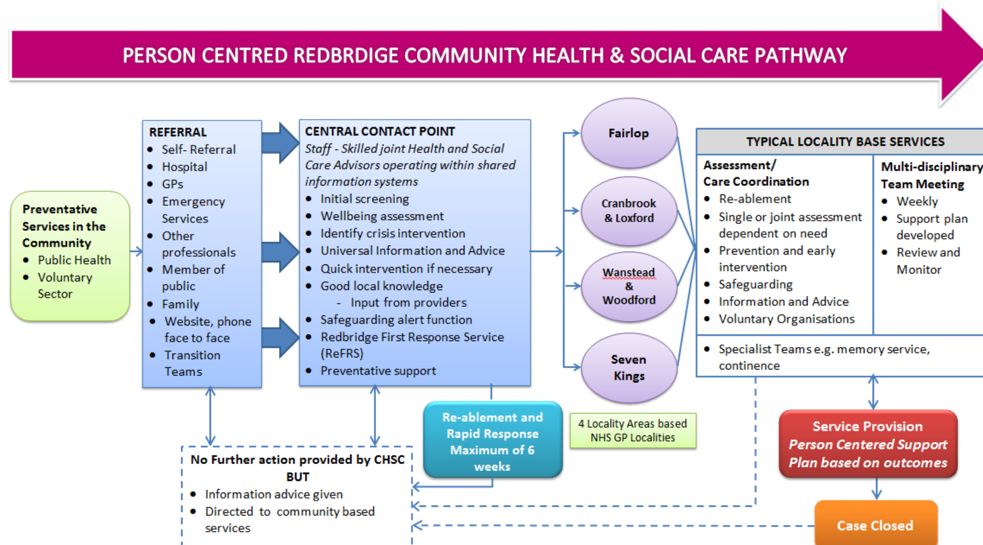
Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives and reduce the need for and dependence on health and social care services. Retaining a level of independence supports both psychical 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.

Urgent Care Rapid (UCR) Response is the key approach to supporting people who are at risk of presenting at the emergency department and potentially being admitted to an acute setting. UCR will assess a patient within two hours if required and provide nursing, AHP and medic input (and prescribing) in the persons home. This is for three days.

Strength-based Model

The Redbridge First Contact team use 'People Matter - Three Conversations' as the default model of social care across all localities in the borough replacing the traditional 'formal' based assessment model. By putting the person at the centre of the conversation as the best placed person to understand their needs, it uses a conversational approach with the person to find out what is really important to them; what they would like to achieve and how they can best maintain their independence, health and wellbeing for as long as possible. By using this approach people feel their lives are improved and has led to a significant reduction in the number of long-term support packages. It supports the promotion of choice, independence and personalised care - through the use of Direct Payments, Self-directed support and complements personalised health budgets. The personalisation agenda will form part of a key workstream for LA commissioners going forward.



B&D have adopted a strengths-based approach as their social work practice model supported by a delivery model and framework which sets out Care and Support Services' intent over the next three years to develop and introduce a 7 strength and asset-based approach that informs our professional and management practice: and organisational culture across adult services. It will be reflected in our service structures and commissioning intentions; our partnership approaches; and most importantly our engagement and relationships with communities and the Third Sector going forwards. The framework represents a fundamental change to how we engage with each other within Care and Support and the Council; and across the whole system with health and social care stakeholders and partners; and fundamentally with the Third Sector and with residents and communities, and how we support community led new and improved ways of working that will deliver greater community resilience and better outcomes.

Modern 21st century social work and social care in B&D seeks to move away from Care Management and a 'deficit' model, away from 'problems and issues' and how professionals can 'solve' this. Instead, we want to improve practice and support better outcomes through true collaboration with people and communities who use services and those who care for and about them. To drive this forward, we recognise that to maximise

empowerment and outcomes for and with people and communities the whole system needs to change, moving from a system built around the assumption that formal services are always the solution, and recognising we are partners in a wider system of relationships and support networks. In B&D, our strength is that we are an ethnically and culturally diverse workforce and population. We do however face significant challenges. On average, communities have less access to resources than the national average. At the same time the population in is growing faster than in any other area in the UK. By moving to a strengths and asset-based model we will seek to be bold, build on our diversity and the knowledge and experience in our communities; and deliver shared community and organisational benefits.

Havering are encouraging the use of 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 actual and 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.

This approach is enshrined in Havering's 'Better Living' approach, whereby social care practice looks to have conversations with service users that first look to find their own or community assets that can address the problems faced without creating a dependency on statutory services. To provide the infrastructure that supports this approach services are commissioned that are complementary. The system we want should support people staying fit and well and keep people out of long-term care as much as possible through interventions that are designed to facilitate people to live as independent a life as possible.

We will use data and establish systems that provide evidence to ensure an understanding of preventative models and to inform where future investment will be best placed. It is important that public health and commissioners work together where there are needs for data and evidence bases to support the delivery of improved health and well-being. Getting to grips with Population Health management is critical to ensure the best outcomes for people over the medium and longer term.

Mental Health & Carers Support

Mental health is a key area that has been impacted upon by the pandemic and a number of local providers are commissioned to provide befriending to reduce social isolation for service users and their carers, therefore complimenting and supporting the more clinically based models of care for mental health.

As part of long-established BCF schemes, the BHR boroughs 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.

We continue to implement its duties as outlined in the Care Act 2014, through promoting wellbeing, prevention, advice and information on care services, and providing strengths-based person-centred care - including support for Carers. Our Carers offer is being reviewed in order to explore ways in which we can provide better support to carers and reduce incidents of carer breakdown. Through working with our providers and carers themselves, we will be able to co-produce an improved model to ensure more flexible support is available when needed. B&D are developing a new Carers Charter to improve services and support to carers in the Borough.

Redbridge is developing a Carer Friendly Borough by aiming to support carers better through meeting the following strategic priorities:

- Identification and recognition: Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care provision and in planning individual care packages.
- Realising and releasing potential: Support people with caring responsibilities to fulfil their educational and employment potential.
- A life alongside caring: Ensure that support for both carers and those they care for is personalised, enabling them to have a family and community life.
- Supporting carers to stay healthy: Support carers to remain mentally and physically well.

- Supporting young carers: Protect children and young people from inappropriate caring roles and ensure they have the support they need to learn, develop and experience positive childhoods.

Havering has invested BCF in re-commissioning its dedicated carers service and works directly with the provider, integrating the service as an important part of Havering's wider preventative offer.

Community Provision
Redbridge LA has a long-established history of working closely with its VCS partners by commissioning and contracting many prevention and early intervention services with VCS providers who are highly experienced in meeting the needs of our diverse community. They provide lower-level cost effective provision, such as our Falls Prevention model provided by Age UK which is now looking to be replicated across the other LAs. Our CVS has been instrumental in both development and delivery of our social prescribing models. In addition, as part of the NHS long-term plan, NHS NEL have been developing their role and commissioning of the VCS over the last year. The VCS are key partners - 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 have been key in driving these agendas 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 Redbridge Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

Community, social connections and having a voice in local decisions are all factors that make a vital contribution to health and wellbeing. These community determinants of health build resilience and can help buffer against disease and influence health-related behaviour. Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. All communities have assets that can contribute to the positive health and wellbeing of residents, including the skills, knowledge, social competence and commitment of individuals, and local community and voluntary groups and associations (both formal and informal

There has been an increased focus on community resilience and social isolation both locally and nationally in the last few years, leading to the rise in practices such as social prescribing. Social prescribing involves GPs, nurses and other health professionals referring patients to non-medical services, typically provided by voluntary and community sector organisations, including, for example, volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and physical activities.

For example, in Redbridge:
- Voluntary Sector: The Borough commissions a number of voluntary sector organisations to support prevention and early intervention including befriending and support for carers to help reduce social isolation. Work to look at future models are being undertaken to understand how needs have changed and can provide an improved more appropriate numbers of services.
- Redbridge Social Prescribing: The Borough and NEL ICB commission a social prescribing service which reaches 42 GP surgeries, the service supports people with low level mental health problems, type 2 diabetes or who were socially isolated with a Health and Wellbeing buddy.
- Day Opportunities: These services, provided both directly by the Borough, and by external agencies promote independence, improve quality of life, and support individuals to socialise and play an active part in their community and provide vital breaks and support for carers of those with LD & MH disabilities. A key feature of developing services going forward is to build in a progression throughout all stages from transition level onwards, to help reduce reliance on (where possible) on high-need care services and promote better life skills for services users and carers.

In Havering, 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. We will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary. The required outcomes include:

- High quality information and advice
- Ensuring people are supported in their journey from hospital to home
- Low level support in the community for vulnerable people that prevents escalation to statutory services

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.
- Carers of all ages are supported in their role – informed by the demographic of Havering and the identification in the 2011 census of 25,000 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 further development has been the introduction of community hubs that are designed to provide support to communities, linking them with voluntary sector services and to other preventative initiatives such as Local Area Coordinators.

Within B&D, our front door service, Community Solutions continues to provide essential frontline support to mitigate hardship for residents with specific concerns and support requirements such as finance, debt, rent, benefits, housing and employment. Community Solutions are also commissioned to provide the Borough's social prescribing service.

We have an increasingly vibrant voluntary sector which is an essential part of our Care and Support Provider market and provides a number of our key services such as Carers Support, Handyman service and the Home, Settle and Support service. Through the BD Collective there are now a number of groups which bring together Care and Support staff and VCS colleagues:

- Re-imagining Adult Social Care
- Early Help
- Joining the dots

Alongside the development of Community Hubs and neighbourhood networks in the Borough, these groups offer an opportunity moving forward for professionals from both sectors to come together and better support our residents and work up ideas collaboratively. Social isolation is a key priority and has played a focus for all partners in 2022.

Local Area Coordination

Local Area Coordination is an essential part of Havering's approach to preventative and personalised services. It is a model of supporting people that is embedded in the community. Local Area Coordinators work within a population of around 12,000 people. They get to know the people and local assets in the area. They are based in the community and work on the basis of introductions. If a person has something they want to change, their Local Area Coordinator will walk alongside them to help them achieve it. Local Area Coordination is a strengths-based approach that focuses on the strengths of the individual and the capacity they have and the contribution they can make, reconnecting people into their community. The service is being actively rolled out as a partnership initiative.

Local Area Coordinators form trusting relationships with people and look at all aspects of their lives, focusing on what is good and motivating people to be in control, building their capacity to take control of their life. Local Area Coordination is actively delivering good outcomes, working with people in the community who face a range of challenges including mental health, issues related to debt, housing or feeling isolated. Building community resilience and linking support with local community assets is central to the aims of Local Area Coordination.

We are piloting this approach in Havering and although management of the team sits within the Council structure, Local Area Coordination will support outcomes from all public sector partners and therefore the pilot

is jointly funded by a range of partners and from the BCF. An evaluation of the service is being developed and, when it has been operational for a sufficient amount of time, evidence will allow partners to make informed decisions about rolling out the service across Havering. Our ambition is that the LAC offer is expanded to cover the whole borough.

Personalisation

Havering is committed to increasing the scope and scale of personalisation and the infrastructure that supports it. There are many issues to be understood, solutions identified and implemented through a programme of change in partnership with service users and their parents/ carers. To build a solid infrastructure for a sustainable system, the activities and approaches needed include:

- Engagement and inclusion of those who are potential and current recipients of self-directed support so that they can shape the model moving forward
- Clear and specific commitment at a leadership level
- Engagement with the market – outlining the drive toward personalisation and the implications, which will include:
    - The opportunities for developing services designed to meet the needs of individual budget holders.
    - Micro commissioning and the need for growth in personal assistants and/or micro commissioned services that meet particular needs
    - Review of levels of payment to direct payment budget holders
- A culture developed across the system that understands and appreciates the power of personalisation, promoting the thinking that is needed to move from the perception of dependent service users and patients to empowered ones
- Use of external information and learning to promote ways of developing personalised services
- Committing to making processes as easy as possible to access and purchase services
- A proportionate and explicit approach to risk around safeguarding and quality within the context of directly commissioned services
- Draw on cross borough initiatives where they are supportive of market development, quality etc.
- Communicate and work with providers to develop the range of services and the support needed to respond to the demand generated for such services
- Have a clear and documented policy framework as the basis for design and decision making
- Clear set of outcome-based measures ensuring movement towards increasingly personalised services for users
- Commissioning services to allow them to be flexible and responsive to individual and family needs

B&D is currently undertaking a direct payment reviews project to ensure that service users have the support available to them in their role as an employer and that they have a Personal Assistant or other service that meets their needs. The Borough's direct payment support service, run by Vibrance, is working closely with social workers to ensure that service users have the right advice and support when they are thinking about choosing a direct payment and can help a service user to find and employ a PA and put the right documentation in place. This service is being used across adults and children's services and the wider project is also reviewing processes and training needs to support the Care and Support workforce.

Integrated Community Equipment Service

Redbridge is the commissioning lead for the Integrated Community Equipment Service (ICES) with its partner - Havering, BHRUT (acute provider), NELFT community health services and the NEL ICB and implemented through a S75 agreement using one equipment provider commissioned via a framework arrangement. The service has just been re-tendered for a new contract and includes sharing management costs and a recycle equipment pool across all partners. This does not currently include B&D who are part of a pan-London community equipment arrangement.

Assistive Technology

Havering invests significantly in Assistive Technology, helping people to stay at home as independently as possible. Whilst current offers support people it is also our intention to look at innovative solutions as they develop to look to use the most effective solutions available. There is also interest in virtual reality providing

the opportunity for remote monitoring and identification of need without the need for face to face personal interactions.

Redbridge currently has a transformation workstream around its approach and investment in assistive technology. It has been working on a app called 'Multi-me' which enables and supports people with LD to networks with services, carers and friends in relation to their care and needs.

Care Technology
B&D have recently procured an Innovation Partner for the management and delivery of an all-age Care Technology solution our residents. This service will deliver in three key areas:

- Innovation and development of technological or digital services to residents which complement their own support and networks. This will also include flexibility and future projects based around arising technology throughout the contract
- Facilitate a cultural change by establishing and embedding a 'Technology First' approach within Care and Support services to include a Care Technology learning and development programme.
- Manage and deliver the service to embed an innovative new operating model for leveraging care technologies and data to support better outcomes in care and support and deliver significant financial benefits. This will include a flexible proactive and reactive response-based service pertinent to both support planning and the immediate welfare of our residents.

This service will move away from the traditional reactive models of assistive technology centred around a conventional monitoring and response alert-based service, to digitally transformed health and social care systems and services centred around technology to achieve better outcomes for residents, fully harnessing the role of the wider community and support networks. This will mean embracing the full suite of technological advancement available now and throughout the contract term ranging from artificial intelligence and machine learning to augmented and virtual realities to offer a truly personalised experience for our residents.

The move to digital represents a huge expansion in the range and depth of available devices and data. Backed up by increased stability and reliability leading to enhanced accuracy and visibility that delivers informed choices for care recipients, their families, caregivers and the wider health and care system. A particular focus will be given to tech-enabled hospital discharge, commencing late summer / early autumn.

LBBD's new Care Technology service represents a significant step for the system's wider digital transformation journey however, there is significant scope to expand the offer, both in terms of the user groups who can access the service and the types of technology available to support them. A Digital Transformation Strategy for Care and Support is currently being developed which will set out our wider ambitions around innovation, our use of data-insights and our commitment to a technology-first culture with service provision and in support of the wider integration agenda.

Provide the right care in the right place at the right time

1. Summary

All of our priorities above are designed to provide a range of services and supporting outcomes to meets the needs and demand of patients, service users and carers within the flow of the health and care system and support the maintenance of people to stay, well and supported within community and home settings – only needing acute settings when necessary. Therefore, our BCF monies are targeted towards our priorities in supporting this flow. This is as set out in schemes and expenditure plans.

We work towards embedding key improvement outcomes around, independence, support and mental health and care within service design and to ensure we meet the national outcome frameworks of the NHS, Adult Social Care Outcomes Framework (ASCOF) and PHOF.

Key to supporting hospital discharge is partnership working between social care and our acute providers BHRUT & Barts, and community health provider NELFT - in developing discharge policies and processes around flow out of hospital in the community and home. Key to this is the Discharge Improvement Working group where engagement was vital to ensure that the new discharge models of our SPA (Integrated Discharge Hub), D2A and Home First can be implanted and delivered. Joint system working groups are in place to ensure that these are being constantly monitored and refined between all partners.

Winter Pressures Support across BHR
Although the Winter Pressures is contained within the BCF (and not subject to ring-fencing) we will use the monies across BHR to support key services and capacity to ensure patient flow through discharge planning, and to ensure there is sufficient capacity to support move on from hospital to other care services (with our Brokerage teams) to fund extra residential placements (residential/nursing care/extra care/supported living); homecare packages; home, settle and support service and reablement (our default offer pathway for hospital services). Further detail is set out in the BHR individual expenditure plans.

2. Models of Care

Social care continues to support getting people out of hospital. 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.

Barking & Dagenham, Havering and Redbridge are adjacent boroughs/places 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 and places to work together to achieve the best outcomes for the whole population

Hospital Discharge Policy
All three boroughs/place have used the BCF to work to support discharges and improve outcomes for our residents when they come out of hospital.

We have worked across all discharge pathways to improve the experience and outcomes for our residents and also to support the local acute hospital system with the demand increases for their bed base. Internally within the health system the BCF has supported the creation of community-based discharge team which has driven care decisions into the community rather than keeping them based in a hospital setting. Developing a single point of access SPA (now called the Integrated Discharge Hub – IDH) for discharges across BHR places, streamlining discharge processes and giving local authorities a greater degree of management over care packages from their start. Key to the success of the IDH is the trusted assessor model which situates trusted assessors of care needs on the hospital wards to increase the efficiency of assessments for placements across care settings.

The BCF is crucial in supporting our pathway 0 offer with respect to providing people support in their home at point of discharge. This includes our home settle and support service provided by the British Red Cross. This is a particular example of joint commissioning; the service being jointly commissioned by all three boroughs and NHS NEL.

Pathway one is supported through the home first pilot which has been referenced above alongside the BCF supporting general crisis intervention from our homecare agencies. In the B&D Crisis Intervention is our free service provided for a period of up to 6 weeks at point of discharge. Social care in the community, including a DOLs assessments are also supported through the BCF to ensure that we have the capacity to meet the demand from hospital discharges. Similarly, for Havering & Redbridge we use reablement as our default offer for this pathway and also Home First sits within these providers. These dedicated reablement services have been modelled around home first principles and is fundamental to ensuring the flow from hospital is maintained.

Pathway 2 and 3 are supported through our jointly commissioned discharge pathways include the discharge to assess pathway referenced earlier. This pathway places individuals into nursing home beds that have a

rehabilitation team supporting the residents for a six-week period. The aim is that these residents will then be able to have their long-term care package reduced after the six-week period. The pathway works with contracted nursing home beds which also eases the discharge process as for those who are eligible for the pathway there are pre-arranged beds available. This initiative, piloted in Havering, was evaluated and has been effective in improving outcomes and cost effectiveness. The scheme has been extended to B&D and Redbridge in 22/23 with a total of 28 beds available with therapy support.

The BCF supports a wide range of other services in B&D that support discharges that are safe and effective. This includes our community treatment team and social care capacity and a Blitz Cleaning and decluttering service provided by the ILA, a voluntary sector organisation. Redbridge also provides a service to help those who hoard to enable them to be able to live safely and return home with care. Havering ensures that its commissioned voluntary sector services are joined up with reablement and 'home settle and support' discharge pathways to enable connection with appropriate services depending on needs.

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 ICB commissioning services with Barts. Therefore, the LA works very closely with both acute providers in supporting its discharge process. Home First is Redbridge will be moving into its next phase which will include developing this with Barts.

The narrative below for our key priorities provides an overview and highlight of the key models of health and care, and key services delivering our ambitions within our BCF plan for 2022-23. This not an exhaustive list of every service provided by every borough and ICB as many of these are the same across the patch, but an illustration of the key components working across BHR. Full details of what is funded is provided within the individual **Planning Expenditure templates**.

The interface between hospital and the community is vitally important in the relationship between health and social care, both for the individual and for the organisations concerned.

The ICS subsystem partners, as the pandemic eases over the next 18 months, must return to its relentless focus on avoiding admissions to the acute hospitals and supporting the reduction in pandemic induced backlogs in care. This will require understanding of vulnerability and early responses to issues without creating dependency. Imaginative approaches to reablement prior to hospitalisation, continued focus on assistive technology, high quality homecare, personalisation of services will all contribute to sustaining people in the community rather than escalating to acute or long-term care.

Developing Discharge Options
Over the past 12 months, there have been a number of key developments around discharge. These are:

- **Discharge to Assess:** Particularly piloting targeted care homes with a wrap-around therapy team, has shown outcomes to support 23% of the patients to be discharged home.

- **Home First:** Each borough now has a Home First approach including a therapy team, reablement care and access to equipment. Havering now have Home First as the default model for discharge:
  - Reablement / Crisis Intervention
  - Homecare
  - Residential and Nursing Care

- **Trusted Assessor (TA):** The TA model has really supported the range of discharges required during the pandemic to care homes including discharge to assess, designated provision and alternative rehab stepdown. The service will be sustainably funding from Q3 with two assessors to work across BHR.

When people do go into hospital and come out with a new or on-going need for support there is a need for a quick and effective response, putting in place all the necessary support mechanisms that will re-able 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. There are a significant number of dependencies on this happening effectively.

- Understanding as soon as possible the point at which clinical need in an acute setting ends, so that the person is identified as ready to go home
- Once this point is understood the rapid transportation home of the person with required support in place (be that equipment or support from a therapist, care worker or an adjustment to the home environment)
- Getting the right assessment of need for the person, recognising that the assessment will be different if done:
    - At the point of crisis in hospital
    - Immediately after the person gets home
    - After a period of reablement and/ or rehabilitation at home.
- Other influencing factors will be whether the assessment is a joint one, with multi-disciplinary input and whether there is a full understanding and application of the principles of personalisation, developing support plans that focus on outcomes.
- How quickly, from the point of return home, the application of high quality reablement and/ or rehabilitation is put in place
- The quality and intelligence applied in determining need for home care
- The messages that are given to the person concerned around dependency and the ability to get them back to independence
- The family response to the situation
- The ability of informal carers to take responsibility for meeting the needs of the person they are caring for
- The quality and appropriateness of the housing situation of the person concerned

All these dependencies, and others, play out in deciding whether or to what extent and how quickly the person might be capable of being fully independent. If the services do not coordinate, the likelihood of recovery being sustainable for the person concerned will be diminished.

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 must continue to join up where possible to design across the end to end process, with the benefit to the end user in mind, and not in silos with the achievement of narrow targets as the measure of success.

Our strategic approach will look to approach things from this perspective and our system design will actively avoid the development of solutions in isolation of partners crucial to the design of an effective end to end process.

One unintended consequence of the nationally prescribed Hospital Discharge Policy, with its 'Trusted Assessor' element is that the borough is seeing far too many patients discharged into care home settings, who then stay there permanently. Whilst on paper it makes complete sense for any assessment of long term need to take place out of the hospital setting, without the right community offer in place (such as access to rehabilitation), the consequence for the patient can be catastrophic, in that they further decondition, become institutionalised and remain in that care home permanently. As a system, we need to review our investments to refocus on keeping people out of hospital in the first place, but where they do have to be admitted, that there are the right services to pull patients back out into community settings not care homes

BHRUT are currently refreshing their Clinical Strategy, and patients and partner organisations are being widely consulted. BHRUT recognise that central to the refresh, is that it must look more outward and play its part in supporting the right health outcomes for people in out of hospital settings.

Integrated Discharge Hub
A key priority across and health and social care was the development a robust and sustainable discharge unit across BHR. The BHR health and social care discharge teams have been brought together under the management of NELFT as a single team that will manage all hospital discharges for pathways 2-3. The operating model was embedded in 21/22 and the service became a formal Integrated Discharge Hub in July 2022 servicing both health and social care.

In 2021/22 external support was sourced to support the system to review discharge approaches. The outcome report has been used to further support understanding and developing services and pathways in 2022/23 alongside the 100-day challenge for the end of September 2022, to address any gaps against the 10 standards to deliver a good discharge offer. Additionally, a series of system wide workshops commenced in July to identify themes and issues for the local system and then prioritise into quick (for winter 22/23), medium- and long-term plans to address these.

All partners have used the BCF to support the integrated commissioning across hospital discharge pathways. The discharge to assess pathway and the home first pathway are both supported by the BCF and commissioned across the local authority and the ICB. Both pathways seek to increase the efficiency of discharges from our acute settings while improving the longer-term outcomes of our patients. The home first pathway uses therapist support to carry out discharge assessments at home where a more accurate package of care can be put in place. This also encourages home as being a default discharge setting.

The discharge to assess pathway sees residents discharged into a named nursing home which has a rehabilitation team wrapped around the nursing homes normal service. This increases the chances of a decrease in long term care needs. The ICB and Local Authority are commissioning 8 beds for the discharge to assess pathway with a rehabilitation team to support these beds. The aim is to improve discharge outcomes in the long term for these residents.

Home First
Whilst the home first pilot in Havering described above initiated a different approach, this is now being rolled out, adapted to meet local needs in B&D and Redbridge.

B&D is currently undertaking a number of hospital discharge pilots which are seeking to improve the hospital discharge pathway for our residents. Therefore, many of these are also focused on supporting our residents to remain at home and with a great level of independence. Chiefly is the Home First pathway pilot which is seeking to ensure that as default the first choice for discharge is back home. This pilot then puts in place a more accurate care package that has been assessed in the home of the resident. This aim is that these residents will be more able to remain at home with an accurate care package suited to their needs. With this more accurate care package there will also be a reduction in readmission to hospital.

Redbridge has also expanded its Home First model which is embedded into our Reablement service. Redbridge hosts the Occupational Therapists for both Barking & Dagenham and Redbridge.

Rehabilitation
NHS North East London continue to commission from NELFT a range of rehabilitation services. There are 61 community rehab beds available to support discharge with rehab and step down. 27 stroke specialist rehab beds are also commissioned to offer step down rehab from the acute stroke wards. Hybrid models working with care homes to offer step down from hospital and rehab beds have also been developed.

The Intensive Rehab Service (IRS) continues to offer 21-day intensive rehab at home post discharge. Longer term rehab is then continued via integrated care teams in the community. Stroke and Neuro rehab is offered with an Early Supported Discharge team at BHRUT and Community Rehab Services offer slow stream rehab.

28 Discharge to Assess block booked across are available across the 3 places and delivered over 3 care home sites. 30% of patients who went through the block booked bed base with a wraparound rehab team are returning home.

Reablement
Redbridge recommissioned and implemented its default Reablement offer with NELFT for hospital inpatient discharge services across both its acute providers - BHRUT and Barts, as well as actively encouraging referrals from community teams. Built into our existing 'Community Health & Social Care Service' S75 agreement where MDTs are co-located within our four locality areas. This provides a platform for the Redbridge Reablement Service (RRS) to deliver a preventative element through the health and adult social care pathway and to proactively interface with the operational service, building on our integrated partnership model which will continue to shape the service in line with service needs. This new default offer is provided using a Trusted Assessor model with our provider and will support discharge and provides a quality service to ensure we maximise the goals and outcomes that service users can achieve reduce the need for long-term care packages and enabling to still be at three months after receiving support. We doubled our investment from £700k to over £1.4m a year to deliver a higher quality outcome focussed Reablement service with increased capacity.

Havering's commissioned service provided by Essex Cares Limited has been in place since 2019 and is a fundamental part of Havering's preventative offer. Demand on the service has exceeded what was expected when the service was commissioned. This has been exacerbated by the pandemic, but demand continues to be at unprecedented levels. If the demand continues the system as a whole will have to consider how the service, which supports hospital flow and allows for delivery of home first principles and outcomes, can be funded. It is a significant challenge but in terms of quality, the service is providing very positive outcomes, which presents at the same time an opportunity for the system to come together to design and deliver a highly effective reablement model that links in with all other aspects of the preventative model. A key priority for health and social care from here on forward is to focus on how reablement services can be funded and tilt towards admission avoidance, in collaboration with CTT, LAS and utilising technological opportunities (such as virtual reality) to stop patients being admitted in the first place.

Crisis Intervention
B&D currently implements a crisis intervention model in which homecare agencies provide support to residents for the first six weeks after discharge into the community to support individuals to live independently at home and prevent re-admission to hospital. We are currently reviewing whether we implement a commissioned reablement approach with stakeholders from across the partnership. We have worked with Care City, an innovation centre for healthy ageing and regeneration in North East London, to support us to research and review international and national reablement models to inform our thinking and we are currently developing an options appraisal in order to pilot a reablement approach in 2022/23.

Home, Settle & Support
The BHR British Red Cross Home, Settle and Support service commissioned by the local authorities and the ICB has continued to support residents on their arrival home from hospital. The service primarily supports residents who live on their own and a large proportion of the people accessing the service have been 70-89 years old. The main goals of the service are to help people feel more safe and secure when they get home from hospital, reduce their anxiety, and increase their ability to manage day to day things when they get home. The British Red Cross staff and volunteers have picked up medication, delivered shopping and signposted residents to onward services during the pandemic. The service has helped residents feel safe when they get home and has often been delivered remotely or in a COVID-19 secure way, again to reduce the risk of transmission.

Accommodation Based Care
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.

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.

Housing designed to meet needs of individuals and their parents/carers will delay and prevent the need for care. It is essential, therefore, that the dialogue between Housing and commissioning is an active one to ensure provision is responsive to community needs.

Social care for various groups requires a property element that is, however, more diverse than general housing. The designs vary depending on what service is being provided. A supported living facility for people with learning disabilities will differ from a residential home for older people. It is often the case that the market will provide properties and have care linked to the property that they own. Whilst this has advantages it also means it is difficult to change providers if similar property is not available. In other cases, property is owned by different agencies from the care provider, creating complications with compatible timelines and strategic objectives of different organisations. Over a period of time, if the Council has none of these properties and do not control where they are based, it can cause problems with finding provisions and costs can escalate.

Where this has happened, or is happening, the issue will be articulated and possibilities around providing Council owned properties or working with other providers to ascertain interests in providing property assets needs to be brought to decision makers attention, jointly from Housing and Social Care.

Property as a means of responding to people's needs, with social care attached in some form, means the two are inextricably linked. This needs a joined-up response formulated that both protects the financial interest of the council but also means people are in the right places and localities to meet their needs.

Within B&D we are currently piloting some extra care assessment flats. These flats are designed to support hospital discharge for those over 55 who have lower level care needs and need time and support to establish a longer-term housing arrangement or who may be interested in extra care longer-term. If the commissioned assessment flats are successful, we will make this a long-term arrangement to support discharge.

As part of its out-of-hospital transition provision Redbridge also operate a number of step-down beds for people being discharge for hospital before going home where people can stay for up to 2 weeks. There are 7 in total across two sites.

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.

Market Stabilisation

Care Market

Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures.   The impact of COIVD has been significant in de-stabilising a number of key care markets – Residential, Homecare and the voluntary sector. This is due to a number of factors:

- Workforce issues relating to care staff leaving the sector to work in other areas where pay is higher. This is proving a huge area of concern for Homecare agencies reducing their ability and capacity to deliver high-quality safe care for people at home and take on new packages.
- An increase in the complexity of care needed in people being discharged from hospital including the need for double-handed care packages, larger care packages with more hours and more care packages for younger older adults - exacerbated by the shortage in workforce.
- Carer breakdowns due to people being looked after at home as a result of building-based services not being open and operating more restricted services. Also, the increased number of hidden carers due to the impact of the pandemic on people heath.
- However, on the flip side, as people have returned to work and are less able to care for relatives as home, we are now seeing an increase in demand again for care services such as Homecare.
- Increase of insurance costs to providers as a result of the increased risk the COIVD pandemic brought with it.
- Voluntary sector providers unable to deliver building-based care and moving towards more virtual models and losing people as they are being cared for at home, as building based services were closed and the increase on the number of hidden carers as a result income generated from this.

Demand for services is predicted to continue to rise across almost all conditions and service user groups across BHR especially in Havering with older people. Demand for services, even though demand management initiatives have been introduced, are therefore likely to rise. Care services are largely people based and it therefore follows that the number of people we will need to provide care in future is likely to increase. This is already manifesting itself in markets like the home care market where across the country the deficit in recruitment is causing shortages in provision. This has had a direct knock on effect on transfers of care from hospital and the challenges around ensuring quality of service. All boroughs are continuing to respond to this by ensuring that investment in the system is targeted where it can make most impact.

Within B&D we are seeing an increase in the acuity and number of placements within nursing and residential care and homecare, throughout 2022/23 there have been times when the residential care market has been full within the borough.

Additionally, the B&D Mental Health service continues to see rising demand with many new referrals considered to be COVID-related. The service is aware of a high number of hospital admissions relating to ill mental health (up by 1/3). Especially young people up to the age of 24 are affected and those who had been discharged from Mental Health services and had remained well in the community for several years. This continues to have an impact on the Services provided by our health colleagues in NELFT and in the longer term will impact on activity levels in our Social Care service. Additionally, the Disabilities service is witnessing significant demand with caseloads above acceptable levels, particularly in young people with disabilities. There are a number of drivers for this additional demand namely that the pandemic has put families under enormous pressure over a prolonged period of time. Additionally, we have seen a rise in families from neighbouring boroughs moving to B&D, with children with complex Learning Disability presentations.

Equipment and Adaptations is being closely monitored due to an increase in demand. This is thought to be a combination of package and placement increases and equipment market pressures due to the combined impacts of COVID and Brexit.

The challenges of COVID have proved to be many and on-going as services and staff responded rapidly to ensure people continue to receive care and support and that new demand is met. Despite the challenges faced, the overall performance of social care was largely maintained.

There are of course other aspects to maintaining a sustainable market. Dialogue with providers is a key element of the strategic approach in this area. The dialogue, through provider forums, through a web portal and through co-production exercises, will be a key factor in the overall strategic approach. It is not only engagement but the tenor of the discussions that are had that is important. The commitment is to operate from an assumption that the Council and providers have a shared objective; to provide high quality services to vulnerable people in a cost-effective way.

BHR as a subsystem is now taking forward joint work on developing an approach for local suppliers to position themselves to bid for procurement opportunities to deliver and supply to Council and NHS services. There is also the development and launch of the BHR health and social care academy (launched in September), to address workforce shortages in the NHS and social care, as well as create opportunities for local people to start and develop their careers in the local care system, including maximising apprenticeships.

The care market has been taking part in the Fair Cost of Care Exercise over the first half of 2022-23 and engagement with the care market has been key in supporting this. The Fair cost of care is important in supporting sustainability within our care market, however there will be key challenges in meeting any identified cost.

BHR Place Challenges
BHR faces a number of system challenges. Given the high population, the impact of COVID within the area, the long-term health conditions and complexity of population challenges, we can identify the following:

1. 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.

2. Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number o key care markets – Residential, Homecare and the voluntary sector. This will only become more acute with the increase in the National Living Wage / London Living Wage, as well as inflationary uplift.

3. 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, as well as a Redbridge receiving a low allocation per head within the BCF.

4. 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.

5. 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 increase in Older People over the next 20 years.

6. 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 with more elective admissions and emergency admissions, plus an additional increase in demand for long term social care by 2030 if the model of care does not change.

7. Havering has the oldest resident population in London and has seen a large inflow of children. 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.

8. 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 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. Whilst discharge and LOS have vastly improved, the system needs to embed learning and good practice and review and develop services to maximise flow.

9. Primary care also faces significant challenges with a large proportion of GPs nearing retirement age, difficulty in attracting new talent and increasing demand.

10. External inflationary pressures impact significantly on social care providers and currently inflation is rising, and it is uncertain whether and for how long these inflationary pressures will continue. To meet the local authority obligation to keep the market sustainable the local authority has to listen and respond to the care market. At some point, however the two priorities, to sustain the care market and to protect local authority budgets, could become incompatible. This needs to be part of the system wide understanding of pressures and not seen as a local authority issue alone.

Section 5: Supporting Unpaid Carers

The pandemic clearly brought into the forefront the issues faced by carers. In addition, it also created an increase in the number of unpaid carers and hidden family carers - highlighting an already underrepresented cohort of people. However, while some of those caring may have since reduced since lockdown eased and service users and their families allow social care services to provide home services and day centres re-open it provided clear evidence of the needs for carers to receive support and wellbeing.

Given the increase of people needing care as we live longer, less people who are less able to self-fund and the complexity of long-term health needs (including LD & MH), the demand and pressure on the health and care system will increase. Therefore, supporting all carers where identified is essential to help manage demand, support those being cared for and provide essential support for carers to reduce and minimise carer breakdown.

The new ONS Census 2021 data releases on Carers will also provide a clearer picture across the individual places and NEL ICB of how this has really changed since 2011.

Across the system we are looking at this in a number of ways:

- BHR Carers Group
- Improved Carers advice, support and MH services
- Targeted and increased identification of unpaid carers through front door services and in speaking with family members and services users
- Promoting services for understanding who carers are and what support they can get
- Carers Forums
- Promoting service benefits on carers for using services such as reablement and implementing a progression model for people with LD to develop independency skills rather than dependency throughout their life
- Closer working with local community and faith groups
- Through the re-commissioning of services, build into services as core work around the identification and support of unpaid carers

In addition to this, Barking and Dagenham have developed a Carers Charter for 2022-2025 and associated Action Plan, which acts as a framework for the delivery and development of services, working practices, identification and support of unpaid or informal carers in the borough, through a partnership approach.

The Carers Charter comprises a series of “I” statements that have been co-produced with carers in the borough alongside key stakeholders from health, social care and the community and voluntary sector.
The Carers Charter supports participation and engagement with residents and partners. The outcomes defined in the “I” statements of the Carers Charter and Action Plan will enable carers and their loved ones to thrive and live independent and healthy lives. This is accomplished through joint working across the partnership and bringing carers to the forefront of service delivery. Building on existing partnerships with health and the

community and voluntary sector, the Charter will work towards developing effective pathways with partners to identify ‘hidden carers’. Hidden carers are those who do not recognise themselves as a carer or are not known to services as providing an informal, unpaid, caring role.

Section 6: Disabled Facilities Grant (DFG) & Wider Services

1. Summary

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 ICB to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes.

Within B&D, work is ongoing between Care and Support, Housing, Community Solutions, Inclusive Growth, Landlord Services, Adaptations team and Be First, our regeneration company on the future of sheltered housing, extra care, bungalow provision, site regeneration, referral processes and adaptations across Council, private and housing association housing. Housing are also involved in hospital discharge where issues arise.

Redbridge People services are working closely with Housing colleagues with those people who experience mental health, addiction homelessness and those with other long-term conditions – including LD and physical disabilities. This includes feeding into the Local Plan and housing strategies.

2. BHR Area DFGs

Barking & 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 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 Barking and Dagenham, 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.

The local authority offers financial help for adapting homes within the Borough through the use of the Disabled Facilities Grant (DFG), with the aim of supporting residents with disabilities to improve their health and wellbeing by addressing problems with unsuitable homes that do not meet their needs and therefore maximising independence. The DFG can help to prevent or delay the need for care and support, both of which are central themes of the Care Act 2014.

Within Barking and Dagenham, a Disabled Facility Grant can be awarded to residents who have a disability and also live in a privately owned property, a privately rented property or a housing association property. The resident must have the intention of living in the property for a minimum of five years. In order to receive a DFG, the resident must have had an assessment from an Occupational Therapist. Once an assessment has taken place and the Occupational Therapist has made their recommendations it will progress to the Adaptations Panel for agreement. 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, working with colleagues throughout the system, to reduce hazards like cold homes, and trips and falls and refer to other services such as the Handypersons Scheme.

In April 2022, the Council's Cabinet approved a new Aids and Adaptations Policy. The Policy was produced in collaboration with Foundations in order to use the potential flexibilities set out within the Regulatory Reform Order (Housing Assistance) Order 2002. The publication of this Policy allowed Barking and Dagenham to enact six new additional grants to the current mandatory Grant usage - these are summarised in the table below. This includes a non means test for anything under £15,000 and some innovative Grants tailored for individuals with more specific needs. We are of the understanding that the Sensory Needs Grant is the first of its kind in the country. The Policy also enables us to designate funding towards four specific social care projects aimed at private residents, including spend towards care and assisted technology, minor adaptations, Handypersons and an OT assessment project. The Policy enables more residents with disabilities to stay in their own home, in an environment that is better adapted to meet their needs and improve their health and wellbeing.

Discretionary Grant	Grant Amount	Means-Tested	Purpose
Adaptations Grant	£15,000	No	uses the same criteria as the mandatory DFG but is **not** subject to a means-test
Top-Up Grant	£15,000	Yes	where the initial means-tested grant is insufficient to cover the full cost of the works
Safe & Well Grant	£5,000	No	enable property clearances and essential property repairs
Relocation Grant	£10,000	Yes	support residents to move to more suitable accommodation where it is not possible to adapt their current home
Sensory Needs Assistance	£2,500	No	make homes "friendly" where the disabled person has dementia, other cognitive impairment, sensory disability or a recognised long term behavioural condition.
Professional Fees Grant	£2,500	Yes	pay for professional fees if the works are unable to proceed and thus unable to be paid under the mandatory DFGs

Havering

Havering Council has an overarching vision that is focused around the Borough's Cleaner & Safer, Prouder, Together and Value for Money strategic themes. By embracing both statutory and discretionary powers that are available to us via the Regulatory Reform Order 2002 the Authority aims to improve the health and well-being of residents (both adults and children) by helping them maintain independence, whilst having a focus on preventative work which will contribute to improving the quality of life of our vulnerable residents.

We will continue to drive up the visibility and take up of the Disabled Facilities Grant (DFG) to applicable residents. We work across social work teams in both Children's and Adults departments, with our Local Area Coordinators, departmental colleagues in Housing, Health, Environment and Public Protection. We also work with housing associations, their tenants, homeowners, private tenants and/or landlords who are able to apply directly.

In Havering the responsibility for the DFG sits within the Strategic Commissioning function which strengthens our understanding of the end user need and demand. We are able to plan, review and analyse demand for services and provisions as well as offer signposting to the DFG as part of a suite of services, available through a variety of providers including the voluntary sector. Through the analysis of demand, we are able to align commissioned and non-commissioned services and identify opportunities for expansion, for example we plan to review the Handyperson Scheme and the use of Assistive Technology (AT).

We provide advice, information and support on repairs, maintenance, adaptations of properties across the Borough and offer a health-based framework of assistance to vulnerable groups and households including those with long term health conditions. Whilst it is recognised that it is the homeowner's responsibility to maintain their own properties the Council will target limited resources to support vulnerable adults and children who are not able to achieve this themselves and will support families to provide safe and effective care to enable vulnerable loved ones to remain at home.

In addition to the mandatory DFG Havering offer a discretionary Housing Assistance Grant, this includes:

- DFG top up - top up of mandatory DFG which exceeds grant limit.
- Discretionary adaptation assistance - financial assistance for those who fail the mandatory means test.
- Moving on assistance - financial assistance to move to a more suitable accommodation.
- Hospital discharge assistance – to prevent delayed transfers of care associated with housing disrepair or access issues.
- Safe warm and well - to provide a safe and warm house for older and disabled people to promote health, wellbeing and independence.
- Dementia aids, adaptations and assisted technology - to enable people with a diagnosis of dementia manage their surroundings and retain their independence.
- Sanctuary Scheme - to provide occupiers at risk of domestic abuse with improved security.

The BCF enables us to aim to reduce delayed transfers of care, minimise avoidable hospital admission, and facilitate early or timely discharge from hospital by tackling housing related matters. We support vulnerable households to ensure they are able to heat their homes at reasonable cost and assist disabled people with adaptations to facilitate their movement in and around their home thereby improving their quality of life.

Havering Council's DFG plan for 2022-23 includes a programme of digitalisation, expansion and promotion. The first steps will be to expand the use of the recently procured Dynamic Purchasing System (DPS), a review of end to end processes and recruitment of additional staff (Technical Officer and DFG Officer). These activities will provide a more robust foundation from which we can expand the reach of the service whilst also seeking more innovative, preventive and personalised applications of the funding.

Redbridge

Home adaptations and assisted living technology 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.

We also fund our Handyperson Scheme using DFG funding through the BCF. Priority is 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.

Redbridge has recently carried out a review of the Home Repairs and Disabled Adaptations Policy to improve the provision of adaptations and repairs for vulnerable residents. We have looked to reduce processing times wherever possible and provide a more comprehensive service to our residents. Proposed changes include:

- An alternative non means tested grant to the current mandatory grant for smaller adaptations, including equipment.
- Provision for fast tracking cases to assist residents requiring end of life care at home.
- A wider scope of adaptations for various conditions such as dementia and MND.
- An increase in available discretionary grants to allow for significant increases in the costs of building materials post pandemic.
- Partnership working with colleagues in Adult Social Care to develop the use of assistive technology for vulnerable residents.

Section 7: BHR BCF Finance Summary

- Refer to individual Planning Templates.

Section 8: Equality & Health Inequalities

Equality and health inequalities

1. Summary

Our BCF 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 BCF 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.

All reports to our Health & Wellbeing Boards are required to consider the implications of the protected characteristics under the Equalities Act and similarly as part of our work in understanding demand and need of our populations, we ensure that we undertake Equalities Impact Assessments when undertaking to design and commission services and these will be subject to ongoing review to consider the EIA implications. Within Redbridge we a Disability Charter – which set out a number of core principles to support service users and carers with all disabilities to being involved within our Commissioning process – from co-production, contract tendering and contract monitoring.

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 section below highlights key data on local areas.

3. Local Area Summary

The detail below provides a highlighted snapshot of the three boroughs. Further details about each borough profiles can be found on the respective websites with their Joint Strategic Needs Assessments (JSNA). As stated, all detail and data contained within this plan was correct at the time of submission.

Barking & Dagenham

https://www.lbbd.gov.uk/joint-strategic-needs-assessment-jsna

Havering

https://www.haveringdata.net/joint-strategic-needs-assessment/

Redbridge

http://moderngov.redbridge.gov.uk/documents/s128909/LBR%20JSNA%202022%20HWBB%20submission.pdf

What has changed since our last plan?
There are two cohorts of patients/residents that will be presenting needs to both health and social care going forward. Firstly, People affected by Long-COVID with respiratory and mobility issues. This is not age defined and is requiring some targeted interventions from local services. There is an increase in care and support needs for those who are below 65 years old which is part of the changing face of health and social care in a post COVID-19 era. This increasing level of demand of the younger cohort is presenting as an issue in a market where the registrations of care providers are, in the vast majority, for over 65s.

Secondly, many older people have been more negatively impacted by the pandemic than other groups. With self-isolating and shielding services are starting to see people who have decondition both physically causing mobility problems and mentally with depression and increased impacts of dementia causing more severe behaviour problems. This is also had a marked impact on informal carers and their ability to cope.

What are we doing to make difference and address this imbalance?
Throughout the COVID pandemic and over 2021-22 the BHR health and social care system have been working in tandem through integrated commissioning and joint decision making. This joint working, which is enabled by the BCF, is a different approach from the past 5 years and will pay dividends in the outcomes for our residents across BHR. Removing silo working across local authority boundaries and providing equitable acute and community services can reduce the risk of inequalities increasing across our system. A joint BHR JSNA is produced and supports the future demand management and planning of services across the patch. Close working with colleagues from Public Health and housing is crucial to understanding the changing needs and impact of wider determinants on both our current and future populations.

The focus on personalised responses to people suffering from experience of inequalities has given insight into the problems faced and the development of responses to them. The clearest example is the development of local area coordination, where people are ‘walked with’ to understand the scope and scale of their problems before jointly devising solutions to change lives. Case studies are illustrating how complex people’s lives are and are not necessarily solved by an isolated service intervention, such as responding to something identified, for example, as a ‘hoarding’ issue if in fact the issue is a result of another more deep-rooted problem. Clearing a house without responding to the root cause of the problem will lead to a repetition rather than a solution. The efficacy of this approach has been recognised and funded, through the BCF, by system partners. Although this is an example the wider philosophy across the partnership is that people’s needs are to be understood and their assets used to devise tailored solutions that are sustainable. The thrust of our commissioning and operational approaches is compatible with this thinking. For those with protected characteristics this approach will identify the issues they face and deal with them in a personalised way.

Engagement with our service users, carers and providers and local community groups is a key component of understanding the issues at both a service delivery level and grass roots level – the lived experience. Feedback

and consultation with our communities is a cornerstone that is and will be embedded in our commissioning work. For example, we know that within Redbridge the Bangladeshi community was particular impacted by the COVID pandemic. By listening to our local community, we are beginning to understand the reasons behind this (such a lifestyle and dietary choices) and therefore provide the targeted support to mitigate the impact of this happening again.

Our public health teams are working closely alongside national initiatives such as NHS Core20Plus5 and the work across BHR on inequalities will be heavily influenced by the health disparities white paper (2022)

Section 9: Stakeholder Engagement

1. Summary

Providing and delivering services in the current climate is challenging and we know that we cannot work in isolation. To maximum the opportunities for achieving the best outcomes for those who use our services, we need to work with and engage those same people in the design and development of services for the future. With an increasing population and growing demand for services, it is essential that service providers and stakeholders work together to ensure that there is maximum benefit for every service commissioned in achieving the best outcomes possible.

Through this we will:

- Ensure all people have an equal opportunity to have their voices heard by increasing the accessibility of consultation and engagement activity
- Measure the impact of consultation on service development, commissioning and provision to ensure that it has a genuine influence
- Ensure that good quality, timely feedback is provided to consultees so that they know how their views have made a difference
- Improve communication between, and increase collaboration by, partners on engagement activity to make best use of limited resources
- Increase community engagement skills among Adult Care, Health and Wellbeing’s workforce to improve the quality of consultation and engagement activity

2. Engagement Activity

Both the LAs and ICB constantly undertake a wide range of engagement activities throughout the year. These form part of the Commissioning Cycle and partnership work, market development and engagement and contract and provider relationship work. The work delivered by the BCF fund is a key theme throughout our engagement activities. The section below outlines some of the key area activities.

Over the last few years the BHR places have been working with Care Providers Voice to engage our social care providers supporting them to access peer support and voice their thoughts and opinions at forums and strategic meetings across the footprint.

In B&D there have been local community engagement sessions to support the Population Health Management approach, the get direct resident feedback. This has support targeted pilot interventions with a small cohort of residents with health needs.

NHS NEL has also consulted falls support groups and other local resident groups in the development of a Falls Strategy across the three places.

Service User & Carers

Barking and Dagenham commissioned the British Red Cross to a undertake piece of research to understand the experience of residents who have gone through each of the four overarching hospital discharge pathways (0-3) as outlined in national guidance. We wanted to understand the experience of residents who go through hospital discharge and use this feedback to improve pathways, support, communication and information and advice. The BRC undertook 16 interviews of Barking and Dagenham residents. The findings and action plan are now being progressed through the Integrated Discharge Hub, Operational teams and the system and enable us to have a baseline to which we can measure the impact of our pathways and pilots as we will repeat the interviews again in 6-12 months time. This methodology is now being replicated across Adult Social Care in order that the voice of the resident drives forward service improvements. An example of an area for improvement included welfare calls within social care/PCNs for residents with no family and friends to help them navigate the system post discharge.

Within B&D the Provider Quality and Improvement Team ring round a random pool of recipients of care and support each month services to understand their experience and any areas for improvement or feedback.

The new Barking and Dagenham Carers Charter engaged over 100 carers, as well as carer groups and system stakeholders between February and August 2021 to develop the Charter's key principles and to inform the action plan. This has been signed off at Cabinet and the Health and Wellbeing Board in January 2022.

Redbridge constantly engages both service users and carers. We have recently updated out Carers offers and engaged our Carers Service to lead on the engagement for us. During our commissioning work we are now embedding service users as part of the commissioning workstream work from beginning to end – service design through to procurement. Our Quality Assurance teamwork with service users to discuss their care and quality of care and feed this back to contacts and safeguarding and locality social work teams where necessary. This ensures that we are providing a consistent quality of care across providers.

In Havering homecare recipients are contacted directly to understand their experience of care and this is now established as a corporate indicator reported to councillors. 'Carers Voice' was a group that met regularly but was inhibited as a result of the pandemic but is looking to be re-energised giving a voice for carers that feeds into the Carers Partnership Board, the delivery mechanism for our carers strategy.

Provider Engagement

- Older People and Frailty Transformation Board (OPF): The board is system wide and oversees and directs the older people and frailty transformation, the contribution to the Integrated Sustainability Plan to reduce pressures on the system and the developing Ageing Well agenda.
- Operational Working Groups (OWG) for the OPF Transformation including acute frailty, Falls, End of Life, discharge improvement working group, prevention. These OWGs sit under the transformation board and deal with the detail of developing business cases to transform services and then mobilise, operationalise and monitor the progress and impact
- Care Provider Forum - established during the pandemic to support providers to manage outbreaks to developing good practice across services. The forum has both care home and community care providers and continues to develop and support services.
- Redbridge hold a number of provider forums throughout the year for service providers and partners to provide updates and listen to issues and share ideas on delivery services.
- B&D have monthly provider forums with care homes and home care providers to share good practice, information and support for providers.
- The BCF has been used to support discharge pathway pilots, which have been developed with providers and partners across health and social care. Particularly important has been the contribution of therapy services in the development of community-based discharge services.
- The large care market in Havering has put significant pressure on both the market and the local authority's relationship with it through the pandemic. However, the response has included extensive communications, information guidance and support and increased communication directly to the market through meeting technology and an online communications hub. This has led to a much closer and improved relationship with the market and has enabled an understanding of issues faced by all sections of the community served by the care market. It has led to a range of initiatives and responses and has meant that stakeholder

engagement has been an ongoing and active part of all the developments and initiatives outlined within this plan.

The British Red Cross Psychosocial and Mental Health Team provide group reflective practice and clinical supervision to partners across frontline sectors to support their work. The British Red Cross have been undertaking sessions with providers particularly focusing on Covid-19, to support social care staff who have faced very tough and challenging times since March 2020.

A peer review of the Adult Social Care provision across Barking and Dagenham was used to engage providers and service users directly in understanding service improvements and where the strengths and weaknesses of the provider market and local authority provision lay. This is now being built into longer-term service delivery and planning.

Voluntary Sector Engagement

BHR ICBs 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. The Barking and Dagenham Collective are a member of the Place Based Partnership within Barking and Dagenham and their network, experience and expertise will be integral to the development of the Place Based Partnership priorities within Barking and Dagenham. 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 this 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 part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

The VCS are commissioned to deliver a number of services including the home from hospital and carers support service and front door services within the local authority are signposting service users to VCS services and support as part of their discharge and social prescribing work.

The Reconnections pilot ended in December 2021. This was a two year pilot in Barking and Dagenham and Havering, joint funded by Independent Age, the two local authorities and the ICBs. The service supported over-65s who felt isolated and disconnected from their local community. Although the pilot's first year ran during the pandemic, they reconfigured their service in order to provide support to older people in a COVID secure way. This included weekly phone calls with a volunteer and support to residents to access and use digital technology to connect with loved ones, undertake shopping and listen to their favourite music. They also encouraged wellbeing walks, step challenges and dog walks. They did virtual coffee mornings, online cook-a-long's and friendly postcards sent through the post. Volunteers supported hundreds of residents across the two Boroughs and the pilot received high rates of satisfaction. In addition to the Reconnections pilot, BD Connect, a group set up to support residents in Barking and Dagenham during the first Lockdown undertook befriending phone calls and social prescribing referrals were made to the group where loneliness or isolation was a factor from GPs.

It is recognised that social isolation remains a significant issue within Barking and Dagenham and the VCS, through the BD Collective and Participatory City, have been running design workshops in the Spring and Summer to develop longer-term approaches to social isolation in Barking and Dagenham. Some seed funding has been provided to progress community-based initiatives and Better Care Fund money has been earmarked to take forward innovative approaches in 22/23 and 23/24. A further update will be provided in the next BCF planning round.

Within Redbridge we are currently undertaking a review of our VCS services with a view to developing a new model to better understand the needs of communities and how these have changed over the past few years and also how providers have developed services and seen needs change to adapt their services throughout the COVID period. This is key to our prevention and early intervention model. This also includes our external Day Opportunities providers. There has also been a strong VCS within Redbridge although this has been impacted by COVID.

In Havering, voluntary sector services have been re-commissioned, enabled by BCF funding. The focus of this voluntary sector commissioning has been on achieving particular outcomes including sustaining carers in their roles and looking to minimise social isolation and develop peer support groups for those facing particular issues. There is a tailored approach to support for those facing issues, for example carers of people with dementia will face different issues to carers of people with learning disabilities. Those facing physical disability will face different problems to those facing mental health issues. The range of organisations commissioned reflects the different issues faced and the specific needs of different groups.
Representatives of the voluntary sector join up with the local authority and the ICB to communicate about issues and initiatives that the voluntary sector can respond to at a regular 'compact' meeting. This has enabled the VCS to be intrinsically involved in the development of the borough partnership, where the VCS has established a more joined up means of engaging with the partnership and providing the particular insights they can bring.

Clinical Engagement
Primary care, the acute trust and community trust continue to be involved as a system in the development of services through operational working groups, transformation boards and other task groups as stated above. Each transformation area has ICB clinical directors allocated to drive the agenda forward and link to primary care and PCNs.

Patient or Service Users Groups
Operational Working Groups (OPF) have patient involvement links which maybe actioned through a patient (and or carer reference group), patient reps on the working group or wider consultation through Age UK and or other forums. Healthwatch's across BHR also engage patient and service user representatives and each of the Borough Healthwatch's provided important reviews of the impacts of COVID across patient, service user, family and provider groups which were used to improve COVID pathways and services. The outcome of the Havering and Barking and Dagenham commissioned patient experience work with British Red Cross will be used to improve and/or redesign pathways across BHR in relation to hospital discharge.

BHR Leadership Health & Wellbeing Boards
The local Health and Wellbeing Board provides system leadership for our health and care economy, including overseeing the implementation of each areas Health & Wellbeing Strategy and how we work to reduce health inequalities. The Redbridge Our 'Caring for Redbridge: Strategic Commissioning Framework for People' is the Redbridge LA strategic plan that provides an overview of our vision, ambitions and aims for the commissioning of services. Our Redbridge CVS have been a key member of the HWB since its inception and represent the views of VCS 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.

We have also engaged through the ICP Board, JCB and Health and Wellbeing Boards for sign-off.

Section 10: Links to other Plans

BHR Area Key Strategies & Plans

- Annual Public Health Reports
- Barts Plans
- BHR End of Life Strategy
- BHRUT Clinical Strategy
- Transformation Nous work on ED @ bhrut
- Discharge strategy
- Falls Strategy
- Health & Wellbeing Strategy's

- PHM work in B&D
- Nel End of Life strategy
- Integrated Sustainability Plan?
- JSNAs
- Market Position Statements
- Older People and Frailty Business Case
- Prevention Strategy
- Primary Care Plans
- Redbridge Commissioning Framework
- Redbridge Disability Charter
- Redbridge Good Practice Commissioning Charter (Draft)
- Urgent Care

Websites:

www.lbbd.gov.uk
www.havering.gov.uk
www.redbridge.gov.uk
www.northeastlondon.icb.nhs.uk/
www.nelft.nhs.uk
www.bhruthospitals.nhs.uk
www.bartshealth.nhs.uk

APPENDIX 1

BCF Risk Log

IDENTIFIED RISK		RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
1.	Demographic and need 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. Complexity of conditions and increase in children and young people with LD transiting in adulthood These budget pressures sit alongside corporate financial pressures faced by the partners	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. Best use of existing community capital and signposting. Encouragement of population to take responsibility for their own health, self-management Upstream preventative / early intervention investment Better planning and management of the Transition process for CYP Working with Public Health teams through a Population Health Management approach	4	4	High	
2.	Costs and benefits fall unevenly across the system and inequitably to the investing partner for areas of change	• Review and transparency of impact and outcomes achieved. • Affordability to be a determinant of further steps. • Risk share remains an option for consideration. • Protection of social care services and consideration of pooled budgets. • Ongoing monitoring of impacts.	4	3	Medium	
3.	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 activity. Effective contract management and the right level of governance.	2	2	Medium	
4.	Three borough complexity slows progress because of differing democratic leadership, priorities and	We have mitigated the challenge posed by taking an iterative approach to our deepening the reach of the BCF plan and improved governance and working relationships across the	2	3	Low	

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
	indeed financial values into specific /shared schemes	Place Based Partnerships and NEL ICS. COVID was a cornerstone in demonstrating the necessity of working together to support the system under a period if extreme pressure. Integrated Care System is responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points.				
5.	Elections at both a local level result in changes to administration(s) and policy direction.	'Watching brief' on policy and guidance changes	1	2	Low	
6.	Budgetary deficits across health and care system	Monitoring of demand and costs in relation to funding to be closely monitored and any remedial action to be agreed and implemented where necessary.	5	5	High	
7.	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 BCF plan to achieve a greater level of integration and available resource utilisation.	3	2	Medium	
8.	Service demand continues to increase for social care	Review of prevention and early interventions services to provide earlier intervention, passporting to alternative, community and universal services is expected to improve management of demand. Utilising new data sets from ONS in relation to the recent Census and refreshed JSNAs	High	High	High	
9.	Increasing costs faced by service providers, insurance, wages increases and workforce issues	BHR commissioners to work closely together and with partners to help stabilise the current market and develop a joint protocol around provider concerns and failure - adjusting rates where it can (if available) and taking a proactive approach to managing demand.	High	High	High	

IDENTIFIED RISK		RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
		Use all available initiatives such as Skill for Care funding to support workforce issues.				
10.	Fair Cost of Care Exercise early indications are that home care and care home rates might need to rise significantly. It is still unclear how this is to be fully funded but it could threaten financial sustainability of Local Authorities if government funding is insufficient.	Work with other local authorities and DHSC to understand how this is to be mitigated	High	High	High	