APPENDIX 2

Barking and Dagenham, Havering and Redbridge Integrated Care Coalition

Strategic Plan final submission

June 2014

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups NHS

London Borough of Barking & Dagenham

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Havering LONDON BOROUGH

North East London NHS NHS Foundation Trust

London Borough of Redbridge

BHR strategic headline plan on a page

The BHR health economy is comprised of partners from Barking and Dagenham CCG, London Borough of Barking and Dagenham, Havering CCG, London Borough of Havering, Redbridge CCG, London Borough of Redbridge, Barking, Havering and Redbridge University Hospitals Trust and North East London Foundation Trust; who have come together to agree, refine and implement the following vision:

Improving health outcomes for local people through best value health care in partnership with the community

Consolidation of the three BHR boroughs objectives

System Objective 1
To reduce the number of years of life lost by 18%

System Objective 2
To improve health related quality of life for those with 1+ LTCs by 4%

System Objective 3
To reduce avoidable time in hospital through integrated care by 13%

System Objective 4
To increase the percentage of older people living independently following discharge by 3%

System Objective 5
To reduce the percentage of people reporting a poor experience of inpatient care by 12%

System Objective 6
To reduce the percentage of people reporting a poor experience of primary care by 15%

System Objective 7
To reduce hospital avoidable deaths; reducing the expected mortality rate by 9%

Achieved through the following interventions

Delivered through prevention and health promotion
Programmes of work informed by local Joint Strategic Health Needs Assessments/Health and Well Being Board Strategies and London wide preventative agenda.
Target areas: obesity/dementia/reduce inequalities/diabetes/cardiovascular disease/cancer/smoking cessation/breastfeeding/alcohol and substance misuse

Delivered through the primary care transformation programme
The Programme incorporates three major projects which are intrinsically linked to the ambition to improve patient experience of primary care services, the involvement of patients in the design of these services, and develop a sustainable primary care landscape which delivers accessible, responsive, and co-ordinated care.

Delivered through the integrated care strategy
Seamless and integrated health and social care for local people. Continued implementation of local strategy putting the person at the centre of care provided by integrated teams

Delivered through the acute re-configuration programme
Reconfiguring local A&E and maternity services to improve the quality of care for local people; developing KGH as a centre of excellence for children's and women's services with better co-ordination of services and pathways through collocation of services' leading to enhanced experience for children and families and new and effective 24/7 Urgent Care Centres at Queens Hospital and King George Hospital (facilitated through the procurement of a high quality end to end urgent care pathway running through 2014/15).

Delivered through planned care programme
Implementing the Health for North East London programme for planned care which will see an improvement in clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. Other developments include productivity improvements for Musculoskeletal and ophthalmology pathways, service redesign for the diabetic pathway and re-procurement of the Independent Sector Treatment Centre.

Delivered through specialised commissioned services
Commissioning to consistently deliver best outcomes and experience for patients, working with local stakeholders to develop integrated services and align priorities

Delivered through the mental health service improvement plan
Strategic Commissioning Framework for Mental Health being developed and will include completion of full roll out of the access to psychological therapies programme by 2014/15 with the aim that at least 15% of adults with relevant disorders will have timely access to services

Delivered through the childrens services improvement plan
Develop childrens services improvement plan including assessment process for children needing an Education, Health and Care (EHC) Plan, Local Offer agreement to be confirmed and put children on EHC plans with cessation of 'statement system'

Managed via the following arrangements

Overseen through the following governance arrangements
Health and Wellbeing Boards (HWBB) oversee the process for strategic planning in each borough
Integrated Care Coalition (ICC): an advisory group to HWBBs - bringing senior leaders together to build a sustainable health and social care system
The coalition has two subgroups:

- Integrated care steering group: development and programme management of strategic plan
- Urgent care board: improvement plan for urgent care

All work streams have identified leads

Measured using the following success criteria

All NHS organisations within the health economy report a financial surplus in 18/19 (under review)
Local Authorities manage funding pressures
Delivery of the system objectives
No provider under enhanced regulatory scrutiny due to performance concerns
Shared care records for all patients

High level risks to be mitigated

Barking and Dagenham, Havering and Redbridge University Hospitals Trust quality and performance issues
Achieving financial targets
Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership)
Balancing increased patient expectation with improved outcomes at a time of less resource

Section Two | Key lines of enquiry (KLOE)

Segment	Key Line of Enquiry	Organisational Response	Supported by
Submission details System vision	Which organisation(s) are completing this submission?	The organisations completing this submission comprise of: • Barking and Dagenham Clinical Commissioning Group • Havering Clinical Commissioning Group • Redbridge Clinical Commissioning Group • London Borough of Barking and Dagenham • London Borough of Havering • London Borough of Redbridge • North East London Foundation Trust • Barking Havering and Redbridge University Hospital Trust The senior leaders from the above organisations have committed to work together as the Integrated Care Coalition to build a sustainable health and social care system. The Integrated Care Coalition (ICC) is responsible for the development of the 5 year strategic plan. It is supported by the Integrated Care Steering Group (ISCG), a working sub group of the Coalition that coordinates input from across the system.	ToR Integrated Care Coalition. Yellow font denotes specific reference to strategic planning ICC_ToR.pdf ToR Integrated Care Steering Group: ICSG_ToR.pdf
	In case of enquiry, please provide a contact name and contact details	Ramesh Rajah BHR CCGs, Programme Management Office Tel: 0208 926 5327 Email: Ramesh.Rajah@onel.nhs.uk Jane Gateley BHR CCGs, Director of Strategic Delivery Tel: 0208 926 5136 Email: Jane.Gateley@onel.nhs.uk	

		Emily Plane BHR CCGs, Project Manager – Strategic Delivery Tel: 0208 822 3052 Email: Emily.Plane@onel.nhs.uk	
	What is the vision for the system in five years' time?	The vision for the BHR health economy is improving health outcomes for local people through best value care in partnership with the community. In five years time all people will have a greater chance of living independently longer; they will spend less time in hospital but when they do they will have a better experience than now. Services will be better integrated both within and across organisational boundaries, with more streamlined access and more of them being offered 24/7, delivering high quality health and social care to patients closer to home. Specifically, patients can expect the following outcomes in the next 5 years: • Reduction of the number of years of life lost by 18% • Improved health related quality of life for those with 1+ LTCs by 4% • Reduced avoidable time in hospital through integrated care by 13% • Increase the percentage of older people living independently following discharge by 3% • Reduced percentage of people reporting a poor experience of inpatient care by 12% • Reduced percentage of people reporting a poor experience of primary care by 15% • Reduced number of hospital avoidable deaths by reducing the expected mortality rate at BHRUT by 9%	

	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the	The BHR vision clearly demonstrates the six characteristics: **1. Citizen empowerment:** The BHR vision and supporting interventions put the person at the centre of delivery. The responses from people to the local Call to Action events are addressed in the plan (held in response to the NHSE challenge to ensure that future development of services is framed around the 'I' statements to ensure that what the patient wants is at the heart of service development going forward). Local citizens specifically stated that they wanted: • Better access to primary care • Partnership working with social care/integrated care • Improved hospital performance • Involvement of voluntary sector • More support for carers • Improved patient engagement/communication • Service co-design with patients and voluntary sector Local people have been actively involved in: • Developing and agreeing the case for change for acute reconfiguration and integrated care to ensure new services deliver improved performance, better outcomes and patient experience • Developing resulting new services e.g. A&E, Community Services, Childrens Services • On-going patient experience evaluation for Integrated Care and Community service developments **2. Wider Primary Care at scale:** In response to NHSE's 'A Call to Action', BHR CCGs have established a Primary Care Transformation Programme (see intervention two below for more detail); working with the appropriate commissioning partners and other stakeholders, including patient representative groups. This programme will be the mechanism for delivering change	

	productivity of elective care 6. Specialised services concentrated in centres of excellence (as relevant to the locality)	within primary care through the commissioning of new and innovative primary care services at scale. The Programme incorporates three major projects which are intrinsically linked to the CCGs' ambition to improve patient experience of primary care services, the involvement of patients in the design of these services, and develop a sustainable primary care landscape which delivers accessible, responsive, and co-ordinated care. Two of the projects, Primary Care Improvement and GP Provider Development were specifically designed to deliver upon this ambition. A successful bid has been submitted for Prime Minister Challenge Fund monies to support the provision of new ways to access primary care and finding new ways to provide innovative services designed around the needs of the patient to reduce acute admission and A&E attendance and increase positive patient experience. All three projects have interdependencies and are aligned to many of BHR CCGs' other major programmes such as the urgent care procurement, integrated care programme and frailty programme. **3. Modern model of Integrated Care:** Implementation of the BHR Integrated Care Strategy agreed in 2012 and designed to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), and in particular to locality settings. The strategy seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to the quality of experience and outcomes. In 5 years, Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000) to enable more proactive management of the local population. The focus will be on those with long term conditions, high intensity service users, and those vulnerable to decline (see intervention three for more detail). **4. Urgent and Emergency Care:** The BHR economy faces significant challenges to improve the quality of urgent and emergency care. An Urgent Care Board has been established locally to drive forward improvement in services. Barking, Havering and Redbridge University Hospitals Trust (BHRUT) are in special measures and are currently in the process of implementing the Trust Improvement Plan to deliver tangible improvements through 2014. The Improvement Plan is aligned to the BHR strategic vision and principles.	

		The acute reconfiguration programme targets improvements in urgent and emergency care and sets out the strategic plan for change (see intervention four below for more detail). **5. Elective Care:** Delivered by building on the Health for North East London programme for planned care which will see an improvement in clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. The key developments over the next five years are the re-procurement of the Independent Sector Treatment Centre and a range of service re-design initiatives to manage demand within primary and community settings, improve the patient experience and deliver savings (see intervention five below for more detail). **6. Specialised Commissioning:** The national strategic plan for specialised commissioning has been paused during the national turnaround process. The intention remains to issue a draft strategy for 12-week public consultation in July 2014. Final publication of the 5-year strategy is expected in November 2014.	
	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health	**a) Sustainable NHS** In 2013/14 Barking and Dagenham CCG achieved a 2% surplus, Havering CCG a 1% surplus and Redbridge CCG a breakeven position. The Strategic plan outlines a financial position that allows all CCG's to meet the 1% operating surplus requirement across the 5 year period and B&D CCG to continue to achieve the higher surplus amount. The CCG's will face a number of financial pressures to enable this position.	

	inequalities?	B&D £ 000 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 Surplus/(Deficit) In-Year Movement | 453 | 85 | 148 | 226 | 152 | 151 Surplus/(Deficit) Cumulative | 4,768 | 4,854 | 5,001 | 5,228 | 5,380 | 5,531 Surplus/(Deficit) % | 1.95% | 1.92% | 1.90% | 1.93% | 1.93% | 1.93% Havering £ 000 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 Surplus/(Deficit) In-Year Movement | (0) | 28 | 99 | 78 | 59 | 77 Surplus/(Deficit) Cumulative | 3,098 | 3,126 | 3,225 | 3,303 | 3,362 | 3,439 Surplus/(Deficit) % | 1.02% | 1.01% | 1.01% | 1.01% | 1.00% | 1.00% Redbridge £ 000 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 Surplus/(Deficit) In-Year Movement | (2,919) | 3,019 | 204 | 111 | 112 | 113 Surplus/(Deficit) Cumulative | 0 | 3,019 | 3,223 | 3,334 | 3,447 | 3,559 Surplus/(Deficit) % | 0.00% | 1.00% | 1.00% | 1.00% | 1.00% | 1.00% **Financial Pressures** The three CCGs face a range of significant and ongoing financial pressures. It is estimated that at the end of 2014/15 the total CCG's budget will be underfunded against target in excess of £25m. At the end of 2014/15 Redbridge CCG will be under funded by 6%, and Havering CCG underfunded by 3.8%. It is projected that Havering CCG will continue to move away from target during the operating plan period. As a result of the financial pressures the CCG's are required to deliver large QIPP savings programmes.	*BCF Schemes have been mapped to 7 outcome measures*

B&D

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	8,020	10,916	7,763	5,588	5,596	5,649
Non-Recurrent		-	-	-	-	-
Total	8,020	10,916	7,763	5,588	5,596	5,649

Havering

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	10,778	14,729	11,095	7,740	7,130	7,290
Non-Recurrent		-	-	-	-	-
Total	10,778	14,729	11,095	7,740	7,130	7,290

Redbridge

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	15,600	12,268	11,128	5,735	5,911	5,931
Non-Recurrent		3,063	-	-	-	-
Total	15,600	15,331	11,128	5,735	5,911	5,931

Each of the CCG's faces the bulk of the QIPP requirement over the first two years. Redbridge CCG's requirement for QIPP will reduce most over the five year period as it will sustain a higher level of growth in allocation as it moves closer towards the funding target. Havering CCG's requirement remains relatively higher as a direct result of its lower funding increases.

b) Health outcomes

Each Borough within the BHR economy has reviewed their baseline position for the seven ambition targets and has planned five year reductions to align performance to equitable levels across the patch, as well as (where possible), closer to, or performing better against the national average. This is reducing health inequalities within the BHR system, which will make a significant change to the lives of patients living in Barking and Dagenham, Havering and Redbridge.

c) Reducing health inequalities

The supporting evidence to the right illustrates this shift towards equitable performance across the BHR economy.

The BHR economy is committed to ensuring a parity of service delivery across both physical and mental health conditions.

BHR 5 year target projections_updated.

	Who has signed up to the strategic	All Integrated Care Coalition organisations have signed up to the strategic vision. Health and Well Being Boards as well as individual organisations have been actively involved in	

	vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	the development of plans and both draft and final version of the BCF, Operating Plans and the Strategic Plan go to Boards for sign off. The draft Operating and BCF plans submitted on the 14 February were reviewed and signed off by the Health and Wellbeing Boards in each Borough on the following dates: • Barking and Dagenham HWBB reviewed and approved the strategic plan on the 11 February 2014. • Havering submission was agreed by the Havering Wellbeing Board at its formal meeting on Wednesday 12 February 2014. • 17 February 2014: Redbridge HWBB reviewed and endorsed the draft Strategic Plan Health and wellbeing boards have reviewed a draft version of the Strategic Plan prior to submission on 4 April 2014: • 25 March 2014: Barking and Dagenham HWBB reviewed and endorsed the draft Strategic Plan • 19 March 2014: Havering HWBB reviewed and endorsed the draft Strategic Plan • March 2014: Draft Strategic Plan reviewed and endorsed by the Redbridge Chief Operating Officer and the Redbridge Director of Adult Social Care in lieu of the next Redbridge HWBB which is scheduled for July 2014 Development of the final plan in preparation for submission on 20 June has incorporated: • NHS England feedback • Outputs from the 'Call to Action' themes • Review by the Integrated Care Steering Group including co-production of the 'prevention' element of the plan with BHR Public Health Directors • Review by BHR Patient Engagement Forums The sign off process for the final plan is as follows: • 16 June: endorsement of the plan by the Integrated Care Coalition • June 2014: Governing Bodies to receive the final Strategic Plan	

		• July 2014: Provider Boards to receive the final Strategic Plan • July 2014: Health and Wellbeing Boards to receive the final Strategic Plan	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	There is complete alignment between plans. Integrated Care Strategy initiatives are embedded in the Better Care Fund plans, with the focus in years one and two being on the following initiatives: • Integrated Teams • New model of intermediate care including Community Treatment Team / Intensive rehabilitation service • Joint Assessment and Discharge Team • A move to seven day working	
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	To respond to the challenge of the NHSE Call to Action, each borough undertook a series of engagement events between October to December 2013. These involved and covered a wide range of stakeholder groups. The following themes were identified: • Better access to primary care • Working in partnership with social care/integrated care • Improved hospital performance • Involvement of voluntary sector • More support for carers • Improved patient engagement/communication The feedback from the CTA engagement programmes has informed development of CCGs' local and strategic five year plans for their respective populations.	
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and	Yes, we will report back to public and patients through local forums including our regular CCG Patient Engagement Forums (PEFs) with cascade down to the practice level and Practice Participation Groups (PPGs). The draft Strategic Plan on a page was shared with the following patient groups: • 20 March 2014: B&D Patient Engagement Forum	

	feedback has been included	• 26 March 2014: Havering Patient Engagement Forum • 7 May 2014: Redbridge Patient Engagement Forum Feedback was positive, and suggestions received (for example, the inclusion of a glossary) have been incorporated into the final Strategic Plan.	
Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	Yes, there has been an ongoing assessment of the current state. The key system wide strategic assessments have been the Health for NEL programme (2009 – 2011) and the Integrated Care programme (2012) as evidenced in the following documents: • Developing a Viable Acute Services Provider Landscape in North East London - INEL and ONEL Sector PCTs and acute trusts Case for Change (03 December 2008) • Health for NEL decision Making Business Case – December 2010 • August 2012: Integrated Care in Barking and Dagenham, Havering and Redbridge Case for Change • November 2012: Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case These form the foundation of the system plan. In addition, each borough has refreshed its JSNA and Health and Well Being Board Strategy, and CCGs have had external reviews (2013 and 2014) to support the identification of QIPP opportunities. CCGs have more recently worked with NHS England and both have confirmed back to the ICSG that opportunities identified in the value packs do correlate and have been included in Operating Plans. As part of the North East London challenged economy, the BHR SPG have been working with McKinsey (funded by the Tri-partite panel) who have stress tested the financial analysis across the five year period.	 NEL Case for change_v20b 081201  DMBC 021210 FINAL V1.0.pdf  C4C.pdf  BHR ICS Strategic Outline Case 2012-11
	Do the objectives and interventions identified below take into consideration the current state?	Yes, they respond directly to the current state and agreed case for change.	

<table>
<tr>
<td></td>
<td>Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?</td>
<td colspan="3">Yes, the plans are based on delivery of years one and two of the Strategic Plan.</td>
<td></td>
</tr>
<tr>
<td>Improving quality and outcomes</td>
<td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td>
<td colspan="3">
<table>
<tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr>
<tr><td>To reduce the number of years of life lost</td><td>Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people</td><td>To reduce the number of years of life lost by 18%</td></tr>
<tr><td>To improve health related quality of life for those with 1+ LTCs</td><td>Health related quality of life for people with long term conditions (sum of the weighted EQ-5D values)</td><td>To improve health related quality of life for those with 1+ LTCs by 4%</td></tr>
<tr><td>To reduce avoidable time in hospital through integrated care</td><td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td><td>To reduce the number of avoidable hospital admissions by 13%</td></tr>
<tr><td>To increase the % of older people living independently following discharge</td><td>Number of people age 65+ discharged from hospital into reablement/rehabilitation services still at home after 91 days
CCG plans on this ambition map directly to Better Care Fund plans set for 2 years at Health & Wellbeing Board level. BHR Boroughs, particularly B&D are already performing well against this indicator and are achieving national average, therefore in part the targets for some boroughs involve a level of 'maintaining' current high performance levels</td><td>To increase the percentage of older people living independently following discharge by 3%</td></tr>
<tr><td>To reduce the % of people reporting a poor experience of inpatient care</td><td>Patient experience of hospital care</td><td>To reduce the % of people reporting a poor experience of inpatient care by 12%</td></tr>
<tr><td>To reduce the % of people reporting a poor experience of primary care</td><td>Patient experience of GP services and GP Out of Hours service</td><td>To reduce the % of people reporting a poor experience of primary care by 15%</td></tr>
<tr><td>Reduced number of hospital avoidable deaths by reducing the expected mortality rate at BHRUT by 9%</td><td>Standardised Hospital-level Mortality Indicator (the ratio of the observed number of deaths to the expected number of deaths for a trust (provider).</td><td>To reduce the BHRUT SHMI ratio by 9% and maintain this reduction</td></tr>
</table>
</td>
<td>Data analysis packs for each of the three BHR Boroughs detailing historic performance against each measure, trend analysis, position against national average and position against fellow BHR Boroughs.

Redbridge baselines & trajectories.pdf

B&D Ambitions & BCF baselines & trajectori

Havering baselines trajectories narrative</td>
</tr>
</table>

	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	Strategic plans for change in BHR (the Health for NEL and Integrated Care programmes) have been clinically led and have included extensive clinical engagement across the professions. Supporting corporate processes (e.g. Health and Well Being Boards; Integrated Care Coalition; Integrated Care Steering Group; Organisation level Boards; Executives; Clinical Director Meetings) have strong clinical input. Public Health in each borough have supported teams to produce coherent plans that describe priority areas for improving outcomes and associated interventions.	
	What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?	As described above, a range of intelligence has been used including: • Borough level JSNAs and Health and Well Being Board Strategies • Public/patient feedback • Health for NEL case for change/business case • Integrated Care case for change and strategy • Urgent and emergency care reviews at BHRUT (and supporting diagnosis evidence) • External CCG assessments (those carried out for authorisation process and QIPP reviews) • Local level service reviews • Primary care outcome data • Performance dashboards (e.g. urgent care dashboard, community services dashboard) • Data value packs • Five year assessment of the system wide financial position (McKinsey)	
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	The local JSNA / Health and Wellbeing Strategies have driven the identification of the quantifiable ambitions. The outcomes identified have been mapped to the JSNA and the 7 ambitions to ensure alignment and fit.	

<table>
<tr><td></td><td>How have the Health and well-being boards been involved in setting the plans for improving outcomes?</td><td>As described above, Health and Well Being Boards in each borough have played an active role in both the development of plans and the formal endorsement process. This process includes the BCF, Operating Plan and Strategic plan so that boards can also assure themselves that there is alignment.</td><td></td></tr>
<tr><td>Sustainability</td><td>Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?</td><td>Key Planning Assumptions: Each CCG will attain different rates of growth across the next five years as their allocations move further towards incorporating the revised allocation formula. Redbridge CCGs allocation will continue to increase the most as they are furthest away from their target population driven allocation.

B&D
<table><tr><td>Notified Allocation Change (%)</td><td>3.50%</td><td>2.61%</td><td>3.09%</td><td>2.92%</td><td>2.86%</td></tr></table>
Havering
<table><tr><td>Notified Allocation Change (%)</td><td>2.41%</td><td>1.67%</td><td>2.30%</td><td>2.31%</td><td>2.31%</td></tr></table>
Redbridge
<table><tr><td>Notified Allocation Change (%)</td><td>4.65%</td><td>4.05%</td><td>3.47%</td><td>3.35%</td><td>3.29%</td></tr></table>
A number of planning assumptions that relate to cost and activity changes have been made and are outlined below.

<table><tr><td>Tariff Change - Acute (%)</td><td>-1.50%</td><td>-1.60%</td><td>0.40%</td><td>-0.60%</td><td>-0.70%</td></tr><tr><td>Tariff Change - Non Acute (%)</td><td>-1.80%</td><td>-1.60%</td><td>0.40%</td><td>-0.60%</td><td>-0.70%</td></tr><tr><td>Demographic Growth / Non demographic growth (%)</td><td>4.50%</td><td>4.50%</td><td>4.50%</td><td>4.50%</td><td>4.50%</td></tr><tr><td>Non Demographic Growth - CHC (%)</td><td>1.00%</td><td>1.00%</td><td>1.00%</td><td>1.00%</td><td>1.00%</td></tr><tr><td>Non Demographic Growth - Prescribing (%)</td><td>5.00%</td><td>5.00%</td><td>5.00%</td><td>5.00%</td><td>5.00%</td></tr><tr><td>Non Demographic Growth - Other Non Acute (%)</td><td>1.40%</td><td>1.40%</td><td>1.40%</td><td>1.40%</td><td>1.40%</td></tr></table>
Income & Expenditure: The table below highlights the projected spend profile over the 5 year period.

Income and expenditure for BHR CCG’s includes investments in community services and other programme areas as activity is transferred from secondary care into community settings.</td><td></td></tr>
</table>

		BHR £ 000 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 Acute | 478,822 | 478,092 | 486,988 | 497,488 | 507,797 | 516,935 Mental Health | 87,168 | 87,917 | 89,646 | 93,659 | 96,543 | 99,320 Community | 81,137 | 80,035 | 83,220 | 88,397 | 91,013 | 94,000 Continuing Care | 45,066 | 45,282 | 46,749 | 50,957 | 54,965 | 58,705 Primary Care | 104,794 | 105,320 | 107,048 | 112,215 | 117,106 | 121,946 Other Programme | 19,446 | 33,938 | 58,783 | 55,548 | 56,751 | 59,432 **Total Programme Costs** | **816,432** | **830,584** | **872,435** | **898,264** | **924,175** | **950,338**	
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Yes, the key themes raised from local engagement were: • Better access to primary care – See Intervention 2 below • Partnership working with social care/integrated care – reflected in overall system approach • Improved hospital performance – See Intervention 4 below • Involvement of voluntary sector – reflected in overall system approach but recognised as an area that needs to be developed • More support for carers – recognised in borough BCF plans • Improved patient information / communication – relevant to all interventions of the BHR Strategic Plan • Service co-design with patients and voluntary sector – relevant to all interventions of the BHR Strategic Plan	
	Can the plan on a page element be identified through examining the activity and financial projections covered in operational and financial templates?	The plan on a page outcome targets for the BHR economy can be identified through examination of the activity projections covered in the operational templates. A mapping exercise has been completed using the baseline and five year reduction targets for each of the BHR Boroughs to produce a consolidated summary position of the BHR target projections for the BHR strategic plan outcome measures (see supporting evidence). CCGs are reviewing local data to make explicit links to the related ambition as part the Better Care Fund.	
Improvement	Please list the material	**<u>Intervention One: Prevention and Health Promotion</u>**	

interventions	transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to	**<u>Public Health</u>** Public Health is about improving the health of the population, rather than treating the diseases of individual patients Public health professionals work with other professional groups to monitor the health status of the community, identify health needs, develop programmes to reduce risk and screen for early disease, control communicable disease, foster policies which promote health, plan and evaluate the provision of health care, and manage and implement change. **Public Health Outcomes Framework** The new public health outcomes framework concentrates on two high-level outcomes to be achieved across the public health system. These are: • increased healthy life expectancy • reduced differences in life expectancy and healthy life expectancy between communities The outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Using a measure of both life expectancy and healthy life expectancy will enable the use of the most reliable information available to understand the nature of health inequalities both within areas and between areas. A set of supporting public health indicators will help focus understanding of progress year by year nationally and locally on those things that matter most to public health. The indicators, which cover the full spectrum of public health and what can be currently realistically measured, are grouped into four 'domains': • improving the wider determinants of health – tracking progress in wider factors that affect health and wellbeing such as housing, employment and the environment • health improvement – tracking progress in helping people to live healthy lifestyles and make health choices such as helping people to stop smoking, increase levels of physical activity and improving nutrition • health protection – tracking progress in protecting the population's health from major incidents and other threats • healthcare public health and preventing premature mortality – tracking progress in reducing numbers of people living with preventable ill health and people dying	

	success • Confidence levels of implementation The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	prematurely such as heart disease, stroke respiratory and liver disease All three boroughs have developed a Health and Wellbeing strategy with key priorities for delivery which is based on the needs of its population. Activities carried out to improve the wellbeing of residents in the boroughs will be monitored using a number of outcome measures identified from the following sources: the Public Health Outcomes Framework, Adult Social Care Outcomes Framework and the NHS Outcomes Framework. The public health priorities identified in this plan are key aspirations for the BHR economy. This builds on existing collaborative work between the three Local Authorities, BHR CCGs and other partners. The local Health and Wellbeing Strategies[1] set out the priorities for health improvement for the three boroughs, the objectives outlined below derive from these and can be actioned by individual organisations, or collectively as appropriate. There are a number of documents that offer evidence-based effective ways of achieving our objectives, these need to be reviewed and included in subsequent action plans i.e. • The Institute of Health Equity's "Working for Health Equity: The Role of Health Professionals" [2] - a report and range of Statements for Action (written by Royal Colleges and other representative organisations) regarding the actions health and social care professionals can take to tackle health inequalities through their practitioner role. • The World Health Organisation's health promoting hospitals workstream[3] - providing a useful framework for pulling these areas together in secondary care. National Government organisations have also set out their roles, and examples of actions that can be taken at a local level, around reducing premature avoidable mortality[4]. Our joint aspirations to improve services in the BHR systems will be delivered through the following priorities:	

[1] http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf, http://www2.redbridge.gov.uk/cms/idoc.ashx?docid=DD42296D-14C5-47AC-A1E6-2BF81626B4EC&version=-1 and http://www.havering.gov.uk/Documents/Health-and-wellbeing/HAWBS%20Final%202012.pdf

[2] IHE. 2013. Working for Health Equity: The Role of Health Professionals. University College London
Available at: https://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals

[3] WHO. 2007. The International Network of Health Promoting Hospitals and Health Services: Integrating health promotion into hospitals and health services, Concept, framework and organization. WHO Europe.
Available at: http://www.euro.who.int/__data/assets/pdf_file/0009/99801/E90777.pdf?ua=1

[4] DH. 2014. Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf

Priorities from the Cancer Commissioning Strategy for London 2014/15 – 2019/20

Alongside the rest of London, BHR aims to achieve significant, measurable improvements in outcomes for patients, including the saving of additional lives currently lost to cancer, improved patient experience and effective use of financial resources. This will be achieved through a collaborative, clinically-led, patient-centred approach, maximising the effectiveness of pan-London strategic leadership.

Cancer is one of 4 top priorities for outcome improvement across London and represents one of the top three causes for premature mortality across BHR CCG's. Survival rates, which although are good in places across BHR relative to England, vary with poorer 1 year survival from colorectal cancer in Barking and Dagenham and Havering and for Breast and lung cancer in Barking and Dagenham. It is the aspiration of BHR to achieve European and international best survival rates equating to approximately 135 lives saved per year through:

Priorities for the cancer programme in London include localising and supporting the implementation of the Cancer Commissioning Strategy for London 2014/15 – 2019/2020,[5] which was produced in partnership between NHS England (London), London's CCGs, Public Health England, the Integrated Cancer systems and charity partners, which sets out a plan to boost cancer services, enhance patient experience and raise survival rates. The key areas in the Cancer Commissioning Strategy that the BHR system will aspire to include:

- Prevention - aspire to commission well-evidenced prevention programmes to tackle factors such as smoking, unhealthy diets and alcohol.
- Cancer screening - improve the take-up of national screening programmes.
- Earlier detection of cancer in the community – focus on early detection and population awareness strategy.
- Reducing variation – using contracts to improve hospital performance and in primary care.
- Reducing inequalities - consider all aspects of an individual when planning treatment decisions.
- Improving access to service - use contracts to improve access to some cancer services; alongside the rest of London for breast, colorectal and cancer of the

[5] http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/01/lon-canc-comm-strat.pdf

		unknown primary and acute oncology. • Living with and beyond cancer - improve support and care coordination for the BHR population living with and beyond cancer. • Improving the cancer patient experience for all patients living with cancer. The planning of these initiatives in the above areas will be taken forward through the contracting route. <u>NHS England priorities</u> **Cancer Screening** • Coverage and up take to be increased to at least minimum target (dependant on service) **Immunisations** • Patient experience and values are integrations into the design and delivery of services • Measured through the Friends and Family Test and other patient experience metrics **Military health and Health in the Justice system** • to improve the engagement and support for those in contact with the Health in Justice system • to reduce re-offending for individual offenders • to improve the efficiency and effectiveness through better collaboration of commissioning partners <u>Barking and Dagenham, Havering and Redbridge priorities:</u> **Alcohol** • All service users/patients where alcohol misuse is known or suspected to be screened and managed using an evidence-based pathway[6] (currently in development) **Smoking cessation**	

[6] NICE. 2014. Nice Pathways: Alcohol-use disorders overview. Available at: https://pathways.nice.org.uk/pathways/alcohol-use-disorders#content=view-node%3Anodes-prevention

		• To work towards smoking status being recorded for all patients and social care service users • All smokers should be offered smoking cessation and this should be recorded • Commissioned smoking cessation services should take into account the needs of vulnerable groups e.g. those with mental health issues, as well as carry out targeted work reaching hard to reach groups • All GP practices to ensure chronic disease programmes have an effective smoking cessation component that is integral to the delivery of care • Smoking cessation to be part of all inpatient care including pre and post-operative care and maternity services (to be delivered by midwives) **Sexual health** • A reduction in sexually transmitted infections following the commissioning of a tri-borough integrated sexual health service (in progress) **Obesity** (see also **chronic disease and falls** section below) • Each borough to have in place an obesity care pathway that incorporates prevention, tiers 1, 2 and 3 with services informed by The National Child Measurement Programme **Chronic disease and falls** • Primary care to embed active case-finding, screening and early identification and appropriate management of chronic disease e.g. CVD, diabetes, COPD and those at risk of falling • All GP practices to ensure chronic disease programmes have an effective lifestyle component or linkage with an obesity care or healthy adult/child pathway that is integral to the delivery of care • To identify low uptake of NHS Health Checks and take action in those communities affected **Health promotion messages** • All BHR organisations to ensure borough residents receive appropriate, effective, consistent messages through health promotion literature and campaigns that incorporate and complement relevant national campaigns including, obesity, cancer, diabetes and NHS Health Checks	

		Social determinants of health • Social Prescribing[7] to be embedded in GP surgeries and hospital discharge planning. That is, for a holistic approach to medicine to be taken by identifying any underlying social factors that are impacting on a patient's health (i.e. social determinants of health) and actively referring them to services for appropriate support e.g. existing housing services and poverty mitigation, also to opportunities that enhance social networks and community cohesion e.g. volunteering and timebanking[8]. Thus ensuring a reduction in inappropriate use of healthcare services **Children and Young People** (see also **obesity** section below) • To aim towards Baby Friendly accreditation[9] across the BHR health economy • To ensure women have a healthy pregnancy through targeted work to reduce smoking in pregnancy and encouraging women to access antenatal care early. • To aspire to reaching herd immunity levels of childhood immunisations by including immunisation in treatment and care pathways for children in secondary and social care and by call and recall methods in primary care • In conjunction with the transition of the health visiting service in 2015, an integrated early years programme linked to the 5-19 programme should be developed and commissioned • All boroughs in conjunction with schools to aspire to be Non-smoking Boroughs by preventing children and young people initiating smoking **Mental ill health** • Aim towards all staff to attend Mental Health First Aid training to ensure they recognise the signs and symptoms of anxiety, depression, suicide and psychoses in people in their working and social/family life • Increase access to IAPT services • All boroughs to aim towards becoming Dementia Friendly[10] communities	

[7] Brandling J and House W. Social Prescribing in General Practice: Adding meaning to medicine. Br J Gen Pract. Jun 1, 2009; 59(563): 454–456

[8] Timebank UK: http://www.timebanking.org/about/what-is-a-timebank/

[9] UNICEF. 2014. Moving from the current to the new Baby Friendly Initiative Standards: A guide for those working towards or maintaining Baby Friendly accreditation
Available at: http://www.unicef.org.uk/Documents/Baby_Friendly/Guidance/transition_guidance.pdf

[10] https://www.dementiafriends.org.uk

		Workforce • All BHR organisations to develop a workforce health and wellbeing strategy (e.g. Barts and the London NHS Trust[11]). These strategies should ensure the workplace is a health promoting environment • To improve the income of the poorest members of the population <u>Aspirational milestones:</u> **Year 1** • Working groups to be set up to take forward the objectives above using the Statements for Action detailed in the Institute of Health Equity's report "Working for Health Equity: The Role of Health Professionals" the WHO's health promoting hospitals workstream and The Department of Health's "Living well for longer" report • A digital referral process in place in all GP practices to allow primary care staff to easily refer patients into obesity care pathways and other lifestyle interventions and services that will improve their social determinants of health i.e. Social Prescribing • Hospital discharge planning to be reviewed to ensure that social determinants of health support services are included • A reduction in smoking during pregnancy and late access to antenatal care. • Smoking prevention plans to be developed in conjunction with schools • Working towards all staff across the BHR health economy to complete Mental Health First Aid training • Working towards all smoking status of all health and social care users to be recorded • All smokers to be offered smoking cessation and for this to be recorded • Chronic disease pathways to be developed in primary care **Year 2** • All partners to be working towards gaining Baby Friendly status	

[11] IHE. 2011. Barts and the London NHS Trust: Health promoting hospitals strategy. Available at: https://www.instituteofhealthequity.org/projects/barts-and-the-london-nhs-trust---health-promoting-hospitals-strategy

		• Integrated early years programme to be commissioned • A tri-borough integrated sexual health service to be commissioned • All organisations to have a workforce health and wellbeing strategy and resulting action plan in place • Smoking cessation to be part of primary care chronic disease programmes and inpatient care • Obesity care pathways to be in place across 3 boroughs • All appropriate service user/patients to be assessed against the alcohol care pathway • Primary care to embed active case-finding, screening and early identification of chronic disease and people at risk of falls • Low uptake of NHS Health Checks and screening programmes to be assessed and action taken in those communities affected • A cross-borough communications strategy to be developed that incorporates and complements relevant national campaigns including, obesity, cancer, diabetes and NHS Health Checks **Year 3** • Population / herd immunity levels reached • All boroughs to work towards becoming Dementia Friendly communities These aspirational milestones are subject to further review once the implications of the Care Act, the Child and Family Bill (which includes allocations for the 0-5 year old programmes) and NHS England public health spending allocations from 15/16 onwards are understood. **<u>Intervention Two: Primary Care Transformational Programme</u>** BHR CCGs are committed to playing its part in ensuring that primary care services in the borough meet the needs of local people. The CCGs want to empower and support patients and carers to maintain independence, and work in partnership in an integrated, co-ordinated health and social care system to achieve this. Fundamental to achieving this vision will be the role of general practice and	

		the wider primary care 'family' (i.e. community pharmacy, dentistry and high street opticians), however, primary care needs to transform in three main ways to deliver: 1) Improvement in the quality and performance of primary care 2) General practice working more effectively with others to deliver co-ordinated and integrated care 3) Where appropriate, smaller general practice units working together as a single unit to realise better outcome and benefits for patients and the local health economy The Primary Care Transformation Programme aims to allow local GPs to lead a system that empowers patients to feel more supported to manage LTCs and increase positive patient experience and reduce unplanned attendances and admissions to hospital. The programme has three key areas of focus: • The development of the primary care provider market to ensure that it is fit for purpose and ready to respond to commissioning intentions • Quality improvement: identifying local needs and working with partners to set standards • The co-commissioning of primary care services by NHSE, Public Health and the CCGs to provide a whole-system approach to meet our population needs The programme will be shaped working with stakeholders and other commissioning organisations; ensuring alignment with other transformational programmes relating to urgent and integrated care. The programme will not be limited to general practice but seek to include other independent contractors, in particular community pharmacy, general ophthalmic providers and dentists as appropriate. <u>Interventions required:</u> A successful bid has been submitted for Prime Ministers Challenge Fund monies to support the provision of new ways to access primary care and finding new ways to provide innovative services around the needs of the patient. These will include: • Extending standard primary care provision during the week, from 6.30-10pm • Alternatives to traditional out of hours provision, such as weekend access to routine and urgent GP and nurse appointments • GP-led triage services	

- Specialist expertise provided in a community setting
- Implementation of a unified point of access
- Providing easier access to clinical support prior to A&E

The programme team will work with NHS England, NHS Property Services, the LETB, Local Authorities, Public Health and local professional committees, patient representative groups and other statutory organisations to address gaps in ambitions, smart solutions for IT, health informatics, workforce development and estates issues.

Expected outcome:

- Improved patient experience and satisfaction
- More accessible primary care services, with additional capacity to manage urgent primary care needs
- Reduced numbers of patients attending A&E
- Reduced number of non elective emergency admissions
- Patients supported by the complex care service, and achieving better health outcomes for a range of LTCs
- The project group will develop a full list of scheme specific outcome measures and targets

Investment costs:

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
Prime Ministers Challenge Fund	2,000	4,000	4,000	4,000	4,000
Over 75's Primary Care investment	3,618	3,698	3,808	3,939	4,139
	5,618	7,698	7,808	7,939	8,139

Implementation timeline:

The Primary Care Transformation Programme is a 5-year strategic programme comprising of 3 projects. The Primary Care Improvement project will run for the life of the programme.

The GP Provider Development project will run through 2014/15 only.

The Prime Ministers Challenge Fund project will run from 01.04.14 – 31.03.16, and the two main schemes within this project will be implemented as follows:

- Scheme 1: Improved Access; 14.04.14 – 28.02.15

		• Scheme 2: Complex Care; 30.06.14 – 28.02.15 <u>Barriers to success:</u> • Finance – achieving the shift from secondary care to primary care to enable continuation of schemes beyond the pump-priming of the Challenge Fund • Information Governance – linking IT system across different organisations • Engagement with key stakeholders • 6 month timeframe to establish unified point of access • Workforce – being able to attract suitably qualified, experienced medics, clinicians and non-clinicians to work in our boroughs BHR will work with NHS England to develop practice succession strategies that will enable and support the creation of larger primary care centres with general practice services being provided through a refreshed delivery model so that these services are sustainable. The GP clinical workforce is at the heart of delivery of good family health care. BHR will work with NHS England and the LETB to identify career aspirations for young doctors and nurses so that this can inform the development of the models of service delivery. We believe that new models of service delivery and fit for purpose premises will make BHR a place where young doctors and other primary care clinicians will want to come to work. This element of primary care workforce development will be aligned with joint commissioning and continued delivery of the Integrated Care programme. BHR commissioning of LISs, such as extended weekday and weekend opening, will support the delivery of GP provider federations. Of necessity, this will also include work to improve and modernise the primary care estate also working closely with the Local Authorities, NHSE and NHS Property Services. By the end of the life of this 5 year programme, all GP premises will be DDA compliant and fit for purpose. Like for like premises renewals are not likely to be approved – opportunities for premises developments will be used as a lever for driving federations of practices/practice mergers etc. BHR acknowledges that this is likely to require joint investment with NHS England but will also look to partners in the Local Authorities to maximise opportunities through the Community Infrastructure Levies (CIL) on new developments/regeneration. There is a need to improve general practice. Using the GP High Level Indicators as a proxy for good quality primary care, BHR will work with NHS England and local Public Health teams to identify where improvements need to be made and jointly agree development plans to secure those improvements. Over the life of this programme, BHR	

		expects to have no GP practices with 5 or more outliers (as currently measured) in any of the 3 CCGs. It is our expectation that the nascent federations within each of the boroughs will support the quality improvement agenda too, and aim to achieve all the draft GP Development Standards over-time. Any work on improving access to services will include the thorough investigation of opportunities of service delivery via a wider role for community pharmacy, dentistry and ophthalmic services in the area, recognising their positioning and service availability. BHR will ensure that its IT investment plans for primary care support the concepts of federations and larger groupings of practices. Continuity of care will be enhanced through the appropriate sharing of patient records and care plans between providers, and subject to patient consent, to support clinical decision-making. **<u>Intervention Three: BHR Integrated Care Programme</u>** Following extensive public engagement the BHR economy published a case for change in August 2012. The resulting vision and strategy for integrated care has been developed with the needs of people at its heart, aiming to help them live well, and independently, for as long as possible and empowering and supporting them to self care. Person centred co-ordinated care is being delivered across the system, designing care around patients, making sure that they receive the right care in the right place, at the right time and ensuring that different services “talk” to each other, reducing inefficiencies in care. The strategy aims to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), in particular locality settings. It seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to quality, experience and outcomes. The following patient example and diagram seek to illustrate what this will mean for patients in practice. <u>5 year vision:</u> Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000) to enable more proactive management of the population. The focus will be on those with LTCs, high service users, and those vulnerable to decline. This will result in less demand for community beds, with resources transferred into multi disciplinary teams based around GP practices supported by borough level community	

		response teams. Patients will feel supported to manage their own conditions at home, escalating to community services for support (for example, the community treatment team) when experiencing a crisis. This will enable patients to live independently at home for longer, and will help to shift the focus of delivery of care closer to home. Services will be jointly commissioned based on outcome measures and designed based on the principles set out in National Voices. <u>Characteristics of new service model:</u> • Risk stratification of patients • Care planning across the comprehensive needs of individuals • Care co-ordination, with clarity on who is responsible for patients at each level of acuity, linking to established disease pathways as appropriate, and end of life protocols as required (including Advanced Care Plans that are fully utilised and reflect peoples preferences and choices) • A single point of access for patients/service users and their carers through co-ordinators • Strong partnership and pathways with the voluntary sector • Efficient provision of equipment and adaptations to help people self manage independently A Joint Assessment and Discharge Service (JAD) will operate across the system to facilitate the safe return home of patients <u>Interventions required:</u> • The Better Care Fund • Technology enabling information and data sharing • Aligned funding arrangements and incentives across the system including personal budgets and building on local Year of Care work • System wide focus on Frailty – a frailty academy has been established with UCL Partners to commence work on the priority areas that were identified from a patient audit in A&E. These are: (i) falls; (ii) care homes (iii) community alternatives to admission. A recent triangulation of data – year of care information; BHRUT improvement plan data; LAS deep dive – suggests the focus for teams should be	

on people aged 65+ with 2 or more LTCs. Discussions are beginning with system partners in the context of BHRUTs Improvement Plan to implement a new streamlined pathway for this cohort of people. This will be supported by the development of a Complex Care Hub dedicated to the treatment of a specific cohort of circa 1,000 patients who require more intensive support. A Frailty Director has been appointed and the next stages of the programme are being developed with support from McKinsey; a proposal will go to the Integrated Care Coalition in June.

Led by NELFT and LBBD, system partners are seeking to increase local system resilience through the establishment of Care City. In conjunction with the LETB and the NHS Confederation EU office, Care City will seek to significantly leverage additional investments in to NEL. Care City will build and spread world class 'frailty' knowledge and practice through the establishment of a local centre of research, innovation and care excellence.

<u>Expected outcome</u>

- Reduced A&E attendances and emergency admissions
- Reduced admissions to residential and nursing care
- Reduced delayed transfers of care
- Improved effectiveness of re-ablement
- Improved patient/user experience
- Reduced % of hospital deaths
- Shared care record

<u>Investment costs</u>

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
QIPP Investment	650	600	750	800	800
Integrated Care and CTT	1,463	1,463	1,463	1,463	1,463
Community Initiatives	0	100	350	750	1,300
	1,463	1,563	1,813	2,213	2,763

Locality based funding to be used to support delivery of workforce education and training.

<u>Implementation timeline:</u>

- Newly developed community intermediate care services in place 2013/14, the new intermediate care model will continue to be trialled 2014/15.

		• Integrated, locality based, community health teams will be in place from April 14 with plans to extend integration with partners e.g. social care/secondary care to form a community health and social care service in each locality by Sept 14. • JAD to be operational from June 2014 • Phase 3: Under review <u>Barriers to success:</u> • Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership) • Service delivery across organisational boundaries <u>Confidence levels of implementation</u>: ▪ The confidence levels are good and build on the previous success of delivering the community treatment teams and intensive rehabilitation services	

What does this mean in practice for patients?

Beryl, is an 88 year old widowed female living at home, supported by a social care package whose son who visits her often. One day, Beryl's morning carer (who helps her to get out of bed and washed and dressed) did not arrive and no replacement was sent by the care agency. When Beryl's son arrived at around lunchtime to see his mother, she was still in bed and in a state of distress, so he called 999. The ambulance crew arrived and subsequently conveyed Beryl to Queens hospital A&E. A&E was very busy. When Beryl was assessed, she had a bit of trouble walking (as she normally does) and she was eventually admitted to a ward. When questioned, Beryl and her son identified that they were aware of some of the community services available, but they hadn't attempted to contact them prior to calling 999.

What the Strategic Plan will mean for Beryl and her family in practice:
The BHR Strategic plan sets out a clear vision of improved community services that are more responsive to the needs of patients, aiming to deliver non emergency care closer to home, supporting patients to stay healthy and independent for as long as possible.

In the next 5 years, Beryl and her family can expect the following:

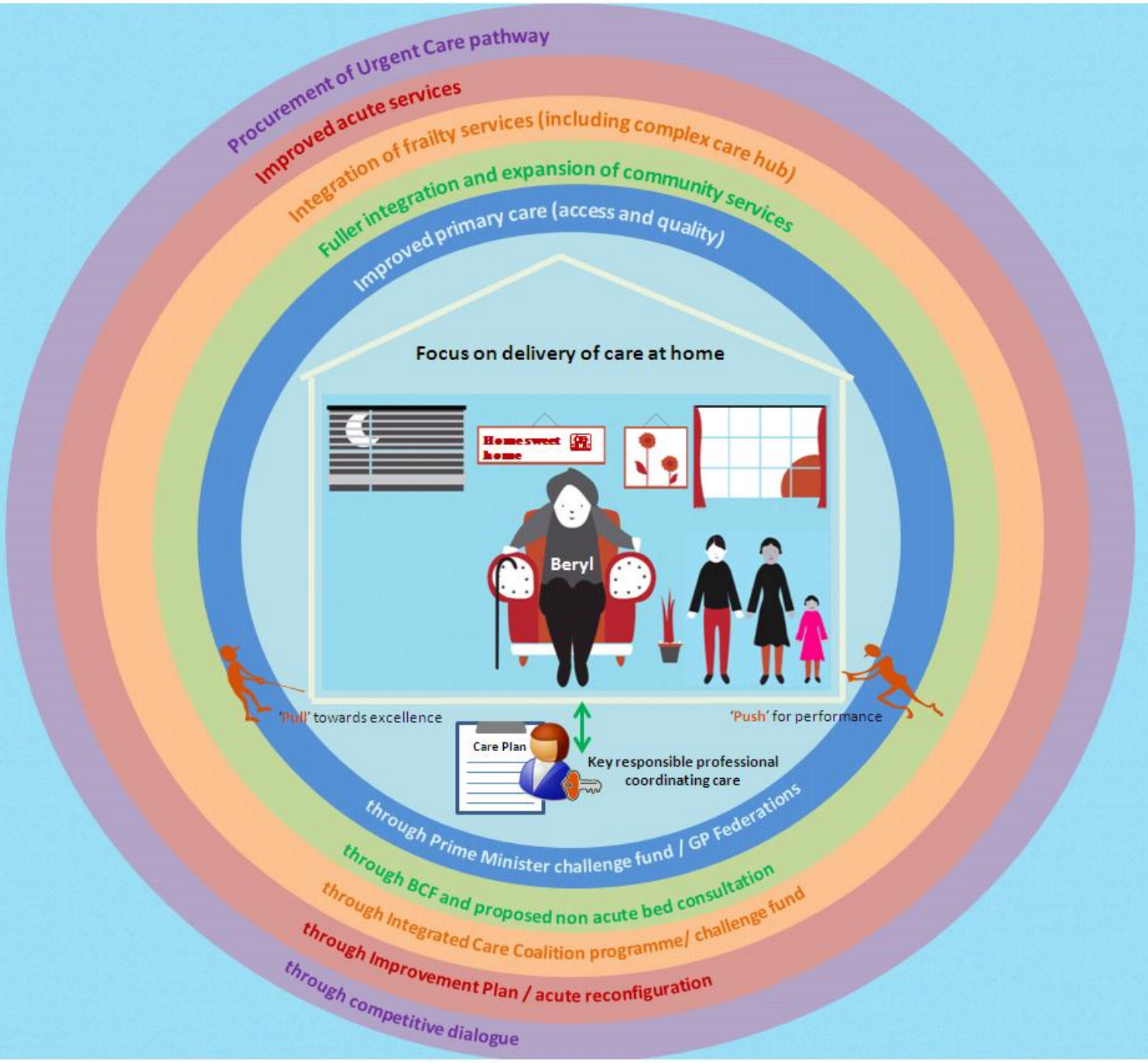
- A single professional responsible for coordinating Beryl's care
- Carers who are aware of alternative services available to them other than calling 999 (in non emergencies) in the community, achieved through better integrated health and social care services.
- A responsive primary care service that will provide improved access to GPs and better quality of care to enable Beryl (and her family) to manage their conditions at home. Beryl could be treated by the Complex Care service to better manage her long term conditions and prevent the need for hospital admission
- An acute hospital service that performs at or above the London Quality Standards of care that is supported by a Joint Assessment and Discharge service that ensures Beryl is discharged in a timely manner should a hospital admission be necessary
- An urgent care pathway that is streamlined, simple to access and responsive
- An enhanced children's service for Beryl's granddaughter with services that are centralised on a single site

The strategic plan includes improvements to the whole BHR system that will ensure that the care that Beryl's family receive is responsive, joined up and of a high quality.

Beryl and her family will receive the right care, in the right place, at the right time.

The illustration on the following page demonstrates the key interventions and improvements within the BHR Economy that will enable Beryl and her family to live at home independently, for longer

Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan – priority interventions



Intervention Four: Acute re-configuration programme

The Health for NE London programme, led by clinicians, was established as a major change programme in response to the case for change.

The key recommendations were:

- To reduce from six hospitals with A&E, acute medical, acute surgical, critical care, maternity and paediatric services, to five; to ensure all A&Es are fully supported by appropriate speciality cover and that there is early senior clinical review for all patients and a full range of available expertise for ongoing care.
- King George hospital, to provide 24/7 urgent care service, and A&E together with unscheduled inpatient medical and surgical services including critical care and paediatrics to be provided at other sites (Queens, Whipps Cross and Newham)

The maternity changes have been successfully implemented through 2013.

The focus is now on:

- Delivering the changes and improvements in emergency and urgent care
- Developing and agreeing the vision for King George Hospital
- Implementing the planned care changes (see intervention five below)

In 5 years time, service users will

- Experience a transformed emergency department at Queens Hospital with improved A&E quality of services
- Benefit from high quality end to end urgent care service delivered by one prime provider that meets or exceeds the London Quality Standards.
- Benefit from centralised and expanded critical care services
- Be treated by a centralised workforce with increased senior cover that will improve quality of care for patients to those that meet the London Quality standards.

Interventions required:

a) BHRUT Emergency Care business case approved

Approval of the full business case and agreement to implement (this will be dependent on the successful delivery of the BHRUT improvement plan, improving performance at Queens ahead of any change/transfer)

b) Urgent Care Procurement

Through 2014/15 BHR CCGs will go to the market to procure a prime provider for the urgent care pathway. This procurement will include a 24/7 urgent care centre at King George Hospital (this service will need to be in place ahead of the move of A&E services from the KGH site).

Plans will take account of Sir Bruce Keogh's recommendations for urgent and emergency care across England:

- Providing better support for people to self-care.
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- Connecting urgent and emergency care services so the overall system becomes more than just the sum of its parts

c) King George Hospital Vision Programme

Redbridge Clinical Commissioning Group are leading this programme to develop KGH as a centre of excellence for woman and childrens services. It will also consider the implications of the Integrated Care Strategy for the site.

The Transforming Services – Changing Lives (TSCL) Programme is considering the longer-term changes that may need to be made to the WEL health economy to meet the national, London-wide and local challenges and drivers for change. The programme is currently in its initial phase identifying the case for change on which any subsequent programme will be based. The BHR system will be represented and where appropriate plans will be updated.

The outcomes of the London quality standards self-assessment in 2013 was published recently. The report also identifies the pan-London benchmark of each standard within the 2013 self-assessment of progress towards meeting the overall London quality standards. To inform planning and commissioning of the London quality standards from April 2014 a self-assessment against the full suite of standards was undertaken by BHRUT to provide a baseline for commissioners. The actions to improve against the baseline position will be taken forward

through existing forums used to improve urgent care performance.

Expected outcome

- to improve the A&E 4 hour performance
- to reduce avoidable emergency admissions
- to reduce the number of years of life lost
- to reduce the percentage of people reporting a poor experience of inpatient care
- to reduce acute inpatient length of stay

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
QIPP Investment	300	200	300	400	400
Other Initiatives	0	100	350	700	1,100
	300	300	650	1,100	1,500

Locality based funding to be used to support delivery of workforce education and training.

Implementation timeline:

- The Trust are working on an implementation timeline

Barriers to success:

- The BHR Economy is in a challenged position with the difficulties faced in meeting the 4 hour A&E target. This is compounded by a difficulty in attracting healthcare professionals to work in the acute trust resulting in a strained workforce. In response to this and the recommendations raised in the recent CQC inspection report, BHRUT is in the process of implementing their Improvement Plan to address these issues. The improvement plan will be aligned to the Acute Reconfiguration programme which builds on Health for North East London work to reconfigure local A&E and maternity services in order to improve care for local people
- Risk that performance improvements on A&E target, length of stay and bed reductions not delivered
- Possible slippages in the programme timelines
- Risk that UCC service model does not deliver the agreed utilisation rates.
- Understanding the WEL system response to managing the flow when A&E service

transfers from the KGH site

Confidence levels of implementation:

- The Trust are working on an implementation timeline

Intervention five: Planned Care Programme

The Planned Care Programme aims to improve health services for local people by separating the planned surgery pathway from emergency pathways where appropriate and improving productivity.

Interventions required:

- Moving planned surgery from Queen's Hospital to King George Hospital except where there are benefits in co-locating services or clinical need (awaiting final BHRUT Clinical Strategy)
- Re-procurement of the Independent Sector Treatment Centre (priorities identified through benchmarking work)

Due to existing variations in local providers, services and contracting arrangements as well as patient demographics, the CCGs have different arrangements but are moving towards a more unified longer term strategy.

New Services

- Development of a digestive diseases service (Havering)
- Community services for diabetes, cardiology, care of the elderly and children's services (Havering)

MSK

- Review MSK pathways to develop a new service model that will manage elements of T&O, pain management and rheumatology activity (B&D and Havering)
- Procurement of MSK triage service to improve the patient pathway for T&O, Rheumatology, Pain, Physio and MSK associated diagnostics, whilst at the same time reducing activity (Redbridge)

Diagnostics

- Implementing the new diagnostic pathways (all modalities) after the recent procurement (Redbridge, B&D, Havering)

- Roll out new diagnostic pathways for calprotectin (B&D and Redbridge)
- Roll out new diagnostic pathways for ECG (B&D)
- Development of Diagnostic work stream, to include Pathology, MSK (MSK and Head) and Ultrasound (MSK and abdomen/pelvis) (Redbridge)
- New MRI pathways for hip and knees (Havering)

Ophthalmology

- Ophthalmology – optimise community eye service contract for glaucoma follow up (B&D)
- Procurement of new Ophthalmology service, including triage services for ophthalmology conditions (Redbridge and B&D jointly)

<u>New models and pathways</u>

- To develop new models for the management of outpatient specialties where the outpatient first appointment is above average (B&D)
- Using benchmarking data, to review pathways for general surgery, urology, gastroenterology, gynaecology and ENT, along with associated investigations, to identify best practice across providers and practices, and reduce referrals (Redbridge)
- Cardiology primary care pathways for heart failure, palpitations, angina and chest pain (B&D)
- Development of a continence pathway (Havering)
- Pilot a new model for dermatology with BHRUT (B&D)
- Implement newly procured community diabetes service (Redbridge)
- Roll out of the new heart failure pathway by introduction of BNP testing (Redbridge)

<u>Expected Outcome</u>

- To reduce inappropriate GP referrals and improve the patient pathway
- to improve patient experience by providing quality care close to home
- To improve equality of access to care for patients across the Boroughs and CCGs

<u>Investment costs</u>

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
QIPP Investment	300	200	450	550	550
Community Initiatives	0	100	300	650	1,050
	300	300	750	1,200	1,600

Implementation timeline:

- The timeline to the progression of planned surgery at Queen's is subject to confirmation from the Trust. CCGs scheme to be taken forward in 2014 – 2016

Barriers to success:

- Risk that performance improvements will not be delivered
- Issues relating to the RTT backlog are resolved

Confidence levels of implementation:

- The planned care movements will be subject to the Clinical Strategy being finalised. CCG schemes will build on success of current community schemes in reducing A&E attendance and emergency admission

Intervention six: Specialised Commissioning Services

The national strategic plan for specialised commissioning has been paused during the national turnaround process. The intention remains to issue a draft strategy for 12-week public consultation in July 2014. Final publication of the 5-year strategy is expected in November 2014.

Intervention seven: Mental Health Services

We will engage with people and communities to help all across society to optimise their mental health and wellbeing. When services are needed they will be accessible, recovery focussed and will strive to help people to stay independent and outside of hospital. When inpatient care is required we will ensure safe, secure high quality mental health services for those who have the greatest need.

A Strategic Commissioning Framework for Mental Health will be developed in response to "Closing the Gap: Priorities for essential change in mental health" which was published on January 2014. The framework will be developed during Summer 2014 and will be jointly updated through the mental health subgroups of the respective Health and Wellbeing Boards.

CCGs and the Local Authorities will build joint commissioning relationships over the next two years and a borough approach is likely for the development of mental health and wellbeing commissioning strategies.

The key areas included in the scope of the strategic framework are likely to include:

- Adults and children
- Parity of esteem
- People diagnosed with mental illness
- Emotional health and wellbeing

The following areas have been proposed as part of the development of a mental health strategic framework/ improvement plan:

- Develop the road map to mental health improvement for the next 5 years
- Parity of esteem for mental and physical health (short term priority) - the BHR economy is committed to ensuring a parity of service delivery across both physical and mental health conditions; developing an Integrated Health and Social Care Service in each of the three Boroughs which will be delivered at locality level. This will include an expanded Integrated Case Management team to include Mental Health Social Workers and will ensure that patients are treated holistically as a whole person allowing mental health issues to be treated alongside physical conditions.
- Transforming the provider - community Service developments include the shift of focus to delivery of care closer to patients' homes including intensive rehab delivered at home, as well as a Community Treatment team. This forms a more inclusive model of care which is especially beneficial to vulnerable patient groups.

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
IAPT	450	450	450	450	450
Community Initiatives	0	100	300	550	850
	450	550	750	1,000	1,300

Locality based funding to be used to support delivery of workforce education and training.

Intervention eight: Children's Services

One of the key developments for children's services in the next 5 years is the development of a

Children's' Commissioning Strategy. The aim of the strategy will be to develop children's services with the point of view of children in mind and increase health gain in the system to save additional years of life, in the context of a cash flat environment. The core principles of the strategy can be described as:

- Built on and driven by real public and patient engagement
- Clinically led – aligned with national clinical strategies
- Outcome focussed – priorities set to optimise outcomes and quality within financial constraints
- Affordable – built on robust and consistent financial basis

<u>Interventions required:</u>

The BHR SPG will be working with the Children's Strategic Clinical Network (SCN) to define the challenges faced by children's services across the BHR SPG. The key areas likely to be included in the scope of the strategic framework are:

- Children with complex needs
- Children with asthma with high prevalence of hospital admissions
- Children with mental health problems
- Primary care prevention
- Children with specific needs
- Assessment process for all children (including disabled) needing an Education, Health and Care Plan (EHC) plan
- Joint Commissioning and Personal Budgets
- Taking forward the initiatives considered under the Children Services in the Life Study programme that is taking place in Redbridge
- The CCGs and the Local Authorities will also be working together to deliver the Safeguarding and looked after children outcomes required in the Children and Families Bill
- Local Safeguarding Boards, and implementation of work needed from CQC and OFSTED inspections

		Expected Outcome Using innovative, new, accelerated joint approach to deliver:- • Improved outcomes • Improved experiences • Efficiencies • Local plans for reducing child poverty • Investment in early years • Early identification, early effective interventions • Improvements in transition • Excellent communication and collaboration between professionals (health, education, criminal justice system and police) Investment costs BHR Investment / 2014/15 / 2015/16 / 2016/17 / 2017/18 / 2018/19 Community Initiatives / 0 / 100 / 200 / 350 / 500 Implementation timeline: Production of the strategy is likely to be a key priority in the first year. Local ownership of the plans is imperative. The CCGs and the Local Authorities will be working in collaborative partnership arrangements to deliver the key priorities that are agreed. Barriers to success: Alignment with national Children's service commissioning strategy due to national strategy developments working to different timelines Confidence levels of implementation The development of the children's services will be closely linked to the development of the KGH site.	
Governance overview	What governance processes are in place to ensure future	The supporting evidence attached details the Governance Structures in place within the BHR economy to ensure future plans are developed in collaboration with key stakeholders. The members of the Coalition also work closely with Waltham Forest and East London (WEL) organisations to promote a shared case for change. This includes regular meetings with	BHR Governance Structure:

	plans are developed in collaboration with key stakeholders including the local community?	organisational leads on cross cutting transformation issues including the Acute Reconfiguration programme and Urgent Care procurement. BHR CCGs have also been working closely with the London Ambulance Service (LAS) to ensure alignment of the respective strategic plans through schedule meetings throughout the year. This is underpinned by ongoing engagement with patients (via Patient Engagement Forums, as well as other methods of engagement for example periodical telephone interviews with patients accessing the Community Treatment Team and Intensive Rehab Service, the outcomes of which directly feed into ongoing service development).	 BHR_Governance Arrangementsv4.pdf
Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	The final values and principles of the Coalition will embed into the BHR system 5 years Strategic Plan to promote joint partnership working across the system. The values and principles provide the foundation for a system wide leadership development programme involving all organisations and a number of coalition members; UCL Partners and NHS Improving Quality have expressed a strong interest to take this forward. The values and principles provide an opportunity for the coalition to demonstrate to the public and stakeholders our commitment to work together to deliver improved outcomes.	BHR values and principles:  BHR System Values and Principles.pdf

Glossary	
A&E target	The four-hour target in emergency departments states that at least 95% of patients attending an A&E department must be seen, treated, admitted or discharged in under four hours.
IAPT	The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available.
ACP	Advanced Care Plan
Acute Reconfiguration	In November 2009, the Health for north east London programme published its pre-consultation business case setting out the case for change across north east London. The key proposals for north east London sites were around unscheduled care, scheduled care and maternity and newborn care. The key recommendations were: • To reduce from six hospitals with A&E, acute medical, acute surgical, critical care, maternity and paediatric services to five, to ensure all A&Es are fully supported by appropriate specialty cover; and there is senior clinical review for all patients and a full range of available expertise for ongoing care. • King George Hospital Ilford to provide 24/7 urgent care services but A&E, together with unscheduled inpatient medical and surgical services, including critical care and paediatrics to be provided at other sites (Queen's, Whipps Cross and Newham)
AML	Acute myeloid leukaemia
BCF	The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.
BH	Barts Health NHS Trust which includes the following hospitals: • Mile End Hospital • Newham University Hospital • The London Chest Hospital • The Royal London Hospital • St. Bartholomew's Hospital • Whipps Cross University Hospital
BHR Economy	Refers to the populations and services encompassed within the Boroughs of Barking and Dagenham, Havering and Redbridge, largely served by King George and Queens Hospitals.
BHRUT	Barking and Dagenham, Havering and Redbridge University Hospitals Trust which includes the following hospitals: • Queens Hospital, Romford • King Georges Hospital, Chadwell Heath
Borough Operating Plans	2 year operational plans detailing how each Borough within the BHR economy (Barking and Dagenham, Havering and Redbridge) will contribute to the achievement of the goals set out in the 5 year Strategic Plan.
CAHMs	Children and Adults Mental Health service

Cardiac cath lab	A catheterisation laboratory is an examination room in a hospital or clinic with diagnostic imaging equipment used to visualize the arteries of the heart and the chambers of the heart and treat any abnormality found.
CCGs	Clinical Commissioning Groups
Community Treatment Team	This team consists of doctors, nurses, occupational therapists, physiotherapists, social workers, and support workers. It: • provides short term intensive care and support to people experiencing health and/or social care crisis to help them be cared for in their own home, rather than be referred to hospital. • Supports people to return home as soon as possible following an acute/community inpatient stay where this is required/appropriate provides a single point of access to intensive rehabilitation at home or a bed in a community inpatient unit if necessary.
CQUIN	Commissioning for Quality and Innovation; The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
Education, Health and Care Plan (EHC)	An EHC Plan looks at all the needs that a child or young person has within education, health and care. Professionals and the family together consider what outcomes they would like to see for the child or young person. This plan identifies what is needed to achieve those outcomes.
Health and Well Being Board Strategies	A Strategy which sets out the ambitions and priorities for the Health and Wellbeing Board with the overall vision to improve the health and wellbeing of people in the local area
ICC	The Integrated Care Coalition acts to bring together senior leaders in the BHR health and social care economy to support the three Clinical Commissioning Groups (CCGs) and the three Local Authorities in commissioning integrated care and ensuring a sustainable health and social care system.
ICSG	The Integrated Care Steering Group has been established as part of the agreed governance architecture of the Integrated Care Coalition to: • Draw together clinical, provider, commissioner, managerial and programme management expertise • Generate recommendations for high impact changes that will deliver integrated care in the BHR economy • Produce a strategy and work plan for delivering the agreed changes
Independent Sector Treatment Centre	Private-sector owned treatment centres contracted within the English National Health Service to treat NHS patients free at the point of use. Typically they undertake 'bulk' surgery such as hip replacements, cataract operations or MRI scans rather than more complex operations.
Information Governance	Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information.
Integrated Case Management	Integrated Case Management Teams aim to deliver appropriate care to patients in the community to reduce avoidable hospital admissions and deliver a high quality service for high risk patients. Each Integrated Case Management team comprises of:

	• GP • Community Matron • District Nurse • Social Care Lead • Care Liaison Officer • Any other relevant staff for specific needs e.g. mental health team.
Intensive Rehab Service	This team consists of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants with access to a geriatrician as required via CTT. It aims to provide an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people within their own homes where it is appropriate to do so. The in-home support provided is intensive and will involve between one and four home visits each day, depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.
JAD	Joint Assessment and Discharge Team; an integrated team including social care and therapy staff working together to improve and streamline the discharge process out of Queens Hospital.
JSNAs	Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population.
LAS	London Ambulance Service
LETB	Local Education and Training Board
Local Authorities	In the context of this Strategic Plan the term 'local authorities' refers to the London Borough of Barking and Dagenham, London Borough of Havering, and London Borough of Redbridge.
Locality	Each borough in the BHR economy is broken down into smaller 'units' called 'localities', within which services and integrated teams work together to serve the health needs of that population.
LoS	Length of Stay (can refer to time spent in a hospital or community bed e.g. for rehab)
LTC	Long Term Condition, for example, Diabetes
MSK	Musculoskeletal; Relating to or involving the muscles and the skeleton
NHSE	NHS England; The main aim of NHS England is to improve the health outcomes for people in England
Ophthalmology	The branch of medicine that deals with the anatomy, functions, pathology, and treatment of the eye
Planned Care	Refers to services where you have a pre-arranged appointment, for example, a GP appointment or outpatient appointment at your local hospital
Prime Minister's challenge	In October 2013, the Prime Minister announced the Challenge Fund to improve access to general practice and test innovative ways of delivering GP services. NHS England was asked to lead on selecting and managing the pilot schemes.

QIPP	Quality Improvement Productivity and Prevention
SHMI	Standardised Hospital-level Mortality Indicator: the ratio between the actual number of patients who die following treatment at a trust, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI gives an indication of whether the mortality ratio of a trust is as expected, higher than expected or lower than expected when compared to the national baseline (England).
SPG	Strategic Planning Group; in the context of this plan, the BHR SPG consists of Barking and Dagenham, Havering and Redbridge.
UCC	Urgent Care Centre
UCH	University College Hospital
UCL Partners	UCL Partners is an academic health science centre located in London; It is the largest academic health science centre in the world.
Year of Care	The Year of Care programme sets out to learn how routine care can be redesigned and commissioned to provide a personalised approach, including support for self management, for people with long term conditions.