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HEALTH & WELLBEING BOARD

SUPPLEMENTARY AGENDA

Wednesday, 12th February, 2014
1.30 pm

Committee Room 1 - Town Hall

4. MINUTES (Pages 1 - 14)

To approve as a correct record the minutes of the Committee held on 11 December 2013 and 8 January 2014 and to authorise the Chairman to sign them.

6. BETTER CARE FUND - FIVE YEAR PLAN (Pages 15 - 62)

To discuss the allocations for 2015/2016 and agree priorities**.**

Written report by Joy Hollister. Presented by Alan Steward and Barbara Nicholls.

7. CHILDREN & YOUNG PEOPLE'S PLAN (Pages 63 - 80)

To note the acheivements for 2013 and priorities for 2014.

Written report presented by Kathy Bundred.

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD

Commitee Room 2 - Town Hall

11 December 2013 (1.30 pm – 3.45 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Dr Mary E Black, Director of Public Health, LBH
Conor Burke, Accountable Officer, Havering CCG
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG
Alan Steward, Chief Operating Officer (non- voting) Havering CCG

In Attendance

Suman Barhaya, NHS England
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Cheryl Coppell, Chief Executive, LBH
John Atherton, NHS England
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

71 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman announced details of the arrangements in the event of a fire or other event that would require evacuation of the meeting room.

72 **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

73 **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

74 MINUTES

The Board considered and agreed the minutes of the meeting held on 13 November 2013 which were signed by the Chairman.

75 MATTERS ARISING

Following the NELFT presentation at the previous meeting, the Chairman announced that the organisation would be invited to provide another update to the Board at a future meeting.

The Chairman and the Chief Officer of Havering Clinical Commissioning Group (CCG) had recently met with Specialised Cancer Services. The outcome of the discussions had been outlined in a letter from the CCG Chairman to Specialised Cancer Services and that the letter would be circulated to Board members.

76 INTEGRATED CARE COALITION REPORT

The Board received a verbal update from the Group Director of Social Care. Members were advised that the planning and hard work had resulted in bringing benefits to the Borough and the Clinical Commissioning Group in working to remove pressure from Acute Services. Discussions were on-going between Integrated Care Management and the Medical Discharge Teams on patient care plans following release from hospital.

In response to a query as to whether there were sufficient resources, the Board were advised that it was not a question of resources but that professionals were working in a different way. The Community Treatment Team were assisting to keep people out of hospital and helping patients on release from hospital with GP support and Telehealth. The team had the capacity to make 160 contacts per month spending up to 2 hours with patients. Approximately 92% of people contacting the Telehealth service are treated in the community rather than hospital. The Discharge Team were working a seven day rota and, from a patient perspective, all was going well. It was noted that Redbridge had recently decided to engage with Barking & Dagenham and Havering in the JAD project from January 2014. The scheme was due to commence in May/June 2014, however, there were still issues around lack of support over seven days from pharmacy and IT that had to be addressed.

There had been an increase in numbers using Telecare and Telehealth and the scheme had recently won a national award. A further review of the service was due and a report would be made available in the New Year.

77 WINTER PRESSURES/WINTER PLANNING & GP SURGE

Members of the Board received a presentation from the Chief Officer of Havering Clinical Commissioning Group on schemes to relieve winter

pressures on A&E. The Board were informed that BHRUT A&E had only achieved the 4 hour wait target twice since April 2013 owing to the following:

- Increasing London Ambulance Service conveyance to Emergency Department.
- A&E assessment breaches contribute to the largest proportion of breaches.
- Delays in specialist response, clinical response and bed waits.
- Urgent Care Centre (UCC) under utilised. Few patients being streamed to the UCC. Only 30-35% of patients attending A&E are streamed to UCC.
- Few patients diverted to GPs or other community services.

The Board were advised that BHRUT would be prioritising the improvement and maintenance of A&E performance over December and the preservation of Delayed Transfer of Care (DToCs) at summer levels. There were also plans to increase adult bed capacity by 72 beds during the winter peak assigning 54 to acute and 18 to rehabilitation as well as aiming to reduce bed demand and improve community access. The following schemes funded by winter monies (£7 million) were now being progressed:

- Emergency department recruitment and use of flexible staff
- 7 day working – expanded capacity over weekends
- Increase of Urgent Care Centre use
- Primary care – increase the number of GP appointments
- Discharge and support packages
- Frailty – targeted initiatives for the BHR system via patient audit
- LAS – robust capacity management system for managing patient flows
- Integrated Care – expansion of CTT/establish Intensive Rehab service
- Ambulatory care – using ambulatory pathways with MDT support
- ED flows – discharge lounge, high risk groups, supported discharge from emergency department
- Nursing Home scheme – use of community matrons to enhance care
- Communications – winter campaign to raise public/staff awareness
- Bed capacity – funds used to open additional beds at Queens Hospital

The CCG would be holding the Trust to account in achieving the 95% A&E four hour wait target from early January 2014. Members were further advised of the system requirements for Commissioner and Provider A&E reporting. These included a daily call to the Trust to check performance and issues, escalation calls to NHS England on how the Trust was performing and weekly bed review meetings.

78 PHARMACY SERVICES

The Chairman welcomed Surman Barhaya from NHS England to present a written report on Pharmacy Services following a request from the Health and Wellbeing Board. Members of the Board were asked to note the following:

The report focused on current government guidance for pharmacists, delivery expectations and on their role in general.

Pharmacists play a key role in providing healthcare to patients. Working in the community, primary care and hospitals, pharmacists use their clinical expertise together with their practical knowledge to ensure the safe supply and use of medicines by patients and members of the public. Community pharmacy is the service which NHS England commission via the contractual framework. Further services are also commissioned through community pharmacy such as minor ailments and public health services e.g. substance misuse services, stop smoking services.

Pharmacists have to meet standards of conduct, ethics and performance set by the General Pharmaceutical council (GPhC). A community pharmacist works within the contractual framework and is responsible for controlling, dispensing and distributing medicine. The responsibility of performance management of this contract sits with NHS England. Community Pharmacies work within legal and ethical parameters such as the Pharmaceutical Regulations and the Medicines Act to ensure the correct and safe supply of medical products to the general public. They are involved in maintaining and improving people's health by providing advice and information as well as supplying prescription medicines. Pharmacists are the third largest health profession. For many patients, this is the first point of call and that a person will visit a pharmacy 16 times a year not only for medicine expertise but also for health related issues such as minor ailments, healthy living advice and long term conditions. The service is usually convenient and anonymous.

It was noted that there were plans to further integrate pharmacies into providing primary and public health services – eg Emergency Hormonal Contraception access, condom distribution and contraception advice. There was also a plan to provide an emergency contraception service across a majority of London boroughs in line with JSNA recommendations. Pharmacies would also have opportunities to provide easy access to sexual health services such as Chlamydia testing, screening and preventative interventions on areas with high sexually transmitted infection rates.

NHS England (London Region) had recently launched a new community pharmacy initiative that would see over 1100 pharmacies across London working together to provide free NHS flu vaccinations to at-risk groups this winter thus complimenting the existing service provided by GP practices.
Thus far, the initiative was progressing well and data on the project would be available at the end of February 2014.

The Board were surprised to learn of the above scheme, as to their knowledge, none of the pharmacies in Havering were offering this service. The Board requested that further information be made available as to the areas covered and what the arrangements were to process unused vaccine.

The presenter acknowledged that there were several areas where pharmacy services could improve particularly around patient discharge from hospital. Pharmacy services could also further support A&E and other Primary Care services.

Board members representing the CCG were of the opinion that the system was generally fragmented and that the CCG would be holding discussions with stakeholders such as NELFT, GPs and pharmacies on working together to improve Primary Care services.

79 EMERGENCY HORMONAL CONTRACEPTION

The Board received an update from Dr. Mary Black on the pharmacy provision of free Emergency Hormonal Contraception to young people and were asked to note the following:

Almost all London boroughs have free Emergency Hormonal Contraception (EHC) although historically Havering did not contract pharmacies to provide fee EHC. A teenage pregnancy report was commissioned to better understand local issues which included a recommendation for pharmacies to provide EHC.

A number of issues were being resolved in order to launch an EHC scheme in Havering on February 1 2014. It was estimated that the cost of the service annually would be 20K with inflationary increases and that this figure would provide 833 consultations/doses.

Plans were now in place for the first cohort of pharmacists to receive Patient Group Direction training and to provide feedback on three on-line CPD programmes covering Sexual Health, Contraception and EHC by the end of January. The future aim was to ensure integration with other sexual health providers, GP, School Nurses and to link in with the Condom Card scheme.

80 HAVERING CCG COMMISSIONING STRATEGIC PLAN 2014/2015

The Board received an update about Havering CCG's progress in developing commissioning intentions, a Commissioning Strategic Plan, a Joint Commissioning Plan and a QIPP Plan for 2014/15. The report covered the activity that had taken place thus far by the CCG to shape plans, and to outline the next steps in the planning process. Members were advised that the paper was a "work in progress" and that draft plans were due for submission to NHS England by February 14. The Board agreed to hold a special meeting on January 29 2014 to discuss the plans in more detail and to approve the final draft at the February 12 Health and Wellbeing Board meeting.

The provision of a Dementia Centre in Havering was raised using a site that had been empty for two years which would be ideal for all related activities. It was agreed that the Chairman, Director of Adults, Children's and Housing and the Chief Officer of the CCG would discuss this further.

81 **ANY OTHER BUSINESS**

The Director of Public Health tabled a draft paper summarising the key findings from the Havering JSNA to assist in the CCG commissioning process.

The aim of the paper is to gather evidence on areas of major opportunity both to improve health outcomes from Havering residents and to increase value for money of the services commissioned by the authority in the borough.

The paper discussed the challenges involved with regard to borough demographics, National Outcome Frameworks for Adult Social Care and Public Health, the prevention of health problems by addressing lifestyle issues and supporting the most vulnerable. In addition, the paper gave a summary of the findings and commissioning implications.

It was noted that the paper was a working draft that required further input from key colleagues, particularly from Social Care, and should be viewed as a continuous briefing document. Further updates to the document would be made upon receipt of new data.

82 **DATE OF NEXT MEETING**

Members of the Board were asked to note that the next meeting would be held on 8 January 2014 at 1.30 pm.

Chairman

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD

Commitee Room 2 - Town Hall
8 January 2014 (1.30 pm – 3.30 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Conor Burke, Chief Officer, Havering CCG
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG
Alan Steward, Chief Operating Officer (non-voting), Havering CCG
John Atherton, NHS England
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH

In Attendance

Mary Pattinson, Head of Learning and Achievement, LBH
Elaine Greenway, Consultant in Public Health (Acting), LBH
John Green, Transformation Programme Manager, LBH
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Cheryl Coppell, Chief Executive, LBH
Dr Mary.E. Black, Director of Public Health, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

83 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman announced details of the arrangements in the event of a fire or other event that would require evacuation of the meeting room.

84 **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

85 DISCLOSURE OF PECUNIARY INTERESTS

None disclosed.

86 BHRUT - CQC INSPECTION AND SPECIAL MEASURES REPORTS

The Board held a discussion on the recent implementation of special measures at Queen's Hospital following the CQC Report.

Member representatives from BHRUT stated that there had been nothing in the report that they were not aware of. It was a government decision to put BHRUT into special measures which at the time were not clearly defined and that this was the first occasion for BHRUT under the new regime. The appointment of a National Hospital Inspector has deemed the organisation as performing poorly based on inspections over the years. It was to be hoped that this was now an opportunity for the organisation to transform. Following the Trust Development Agency review of the organisation's leadership and governance, Ian Carruthers, formerly Chief Executive of the South West Health Authority, had been appointed to review leadership arrangements. The Board had previously expressed their concerns about governance. The CCGs were due to be interviewed the following week and that Local Authorities were also invited. On a positive note, the implementation of initiatives through the Urgent Care Board and Integrated Care were making progress and it was important that these continue so as to build on the good work done thus far.

The Board agreed to await the outcome of the leadership review by Ian Carruthers when there should be an opportunity for the Health and Wellbeing Board to respond.

87 SAFEGUARDING UPDATE

Members of the Board received an update on Safeguarding issues within the borough.

Brian Boxall, the new Chair of the LSCB was also chairing the Adults Safeguarding Board.

Additional resources had been allocated by BHRUT following several issues around Learning Disability clients receiving treatment. There had also been some concerns around the lack of engagement with GPs, however, there was now a GP representative sitting on the Havering Learning Disability Board.

Child deaths in the borough were small in number and no significant trends had been identified.

The NSCPP were launching the Underwear Campaign on 13 January 2014 raising awareness on child sexual abuse aimed at both children and parents.

The LSCB would be discussing the issues around self-harm within ethnic communities at their next meeting following referrals from certain wards in the borough. There was currently on-going dialogue with the Black and Minority Ethnic (BME) Forum and that the Chairman of the LSCB would receive an update in due course.

88 **INTERIM REPORT ON CHILDHOOD OBESITY**

The Board received a presentation from Elaine Greenway on Tackling Obesity in Havering.

In 2006/2007 Obesity cost the NHS £5.1 billion per year in comparison to £3.3 billion caused by disease associated with smoking. In comparison to other countries, the UK was on a similar gradient to that in the US. The health risks posed to obese Adults and Children are listed as follows:

Adults

- risks to health: heart disease, stroke, Type 2 diabetes, some cancers
- associated with muscular skeletal and respiratory diseases
- social difficulties (e.g. isolation / mental health)
- employment (employability, sickness absence)
- implications for social care (housing adaptations, specialist carers)
- associated with socio-economic status

Children:

- risks to health, including Type 2 diabetes
- can lead to stigmatisation, bullying, low self-esteem and
- exclusion from social interaction
- associated with socio-economic status

It was noted that during 2006-2008, Adult obesity in Havering was 27.3%, Children at Reception class was 11.2% but this figure doubled to 19.9% by the time children reached Year 6.

Obesity is not just a medical problem but a complex issue influenced by many associated factors such as:

- Physiology (genetic predisposition, resting metabolic rate)
- Individual physical activity (recreation, occupational activity, domestic activity)
- The environment (school sport, transport policy planning)
- Social psychology (education, media, peer pressure)
- Individual psychology (self-esteem, body image, stress)
- Food production (food labelling, salt content, fat content)

- Food consumption

The Foresight Report of 2011 into obesity made the following recommendations:

Local leadership
Strong partnerships between Local Authority (public health, transport, licensing, planning, environment, regeneration, etc.) CCG, other professional groups, voluntary sector, and community

Address the obesogenic environment: the healthy choice is the easy choice:
- the built environment
- active travel and transport policy, review local schemes and enhancements from a pedestrian or cyclist perspective
- nutrition: standards / signposting to healthy food options

Support to individuals
- advice and signposting by health professionals (preventative and for weightless: physical activity, nutrition, behaviour change)
- weight management services

Training:
- Education and training programmes for healthcare and frontline professionals
- Health impact assessment

Havering had a number of assets in place to address the problem of obesity including:

- Leadership (Health and Wellbeing Board)
- Sports infrastructure (parks / facilities / public and private gyms)
- Physical activity strategy
- Schools support for healthy lifestyles (e.g. Schools Sports Partnership, free breakfasts)
- Voluntary sector (Havering Sports Council, Havering Circle)
- School meals and Meals on Wheels
- Healthy walks & Havering Active
- Active travel: walk to school programme / cycling
- Love food / hate waste

- Library services (on-line resources / newsletters / volunteers)
- Primary care (GPs (Health Checks) / pharmacists)
- School nurses, health visitors, midwives
- Data: National Child Measurement Programme & Active People
- Breastfeeding friendly environment

Havering would require a joined up long term commitment to tackle the obesogenic environment. It was recommended that an action plan be put in place over the next eight weeks to give support to settings and individuals that can influence children's health and weight including pre-conception, maternity, early years, school nurses and health visitors. In addition, to provide advice, signposting and support for adults via primary care, libraries, business, voluntary, community and faith sectors.

The Board agreed that obesity is a complex subject and requested that the presenter report back in two months following more research, in particular, into how other boroughs are addressing the issue.

89 **JSNA DEMOGRAPHICS CHAPTER**

Members of the Board agreed to defer this item to a later meeting.

90 **ASSISTED TECHNOLOGIES**

The Board received the report on Assisted Technologies presented by John Green and were asked to note the following:

Since 2011, significant work had been undertaken that has resulted in greater use of AT by adult social care clients, underpinned by improved operational efficiency in assessing, referring, providing, installing and monitoring equipment. The provision of Fair Access to Care Services (FACS) eligible AT now stood at nearly 1,500 individuals, predominantly pendants, with a further 2,500 or more FACS eligible clients under consideration to have AT as part of their care package.

To identify the benefits delivered by AT, two cohorts had been monitored over an extended period of time to provide an analysis of a number of key measures. The monitoring is to continue on a quarterly basis to further improve the robustness of the analysis reported. The cohorts are:

- Cohort A - ASC clients who receive AT and homecare (70 at outset)
- Cohort B - ASC clients who only receive homecare (407 at outset)

The three key benefits measures are:

- Benefits Measure 1: General impact on hospital admissions as indicated in ASC systems

- Benefits Measure 2: Reductions in admissions due to falls from health data
- Benefits Measure 3: Impact on admission to residential/nursing care from ASC data

Benefits measure 1

Cohort A, (AT and homecare) is less likely to be admitted to hospital than cohort B (homecare only) after a period of 18 months by a margin of 25.02%. This indicates that the application of AT will have a beneficial impact on reducing hospital admissions. To validate this there should be an actual impact on hospital admissions.

Benefits measure 2

Having used ASC data to evidence the apparent decline in hospital admissions health data relating to admissions due to falls has been analysed. This indicates that there is a correlation between the increased number of pendants in the community and a reduction in hospital admissions due to falls of 44% in 2013 compared to 2011 – which would convert to an estimated annual saving of £2.24M3 – or if attributing 50% of this to AT then £ 1.12M.

Benefits measure 3

Cohort A (AT and homecare) are less likely to be admitted into residential or nursing care by a margin of 5.9% than cohort B (homecare only). Cohort A also demonstrates that of those who are admitted there is significant delay in the elapsed time from when they start to receive services until admitted of at least 3 months but this is likely to be significantly longer. A delay of 3 months in the start of a typical residential care package costing £25,000 indicates a gross benefit of £6,250. However, the average cost of domiciliary care prior to admittance to residential care is £12,500 or £3,125 per quarter. The net saving is therefore £3,125 per person (£6,250 less £3,125). If these numbers are factored up, with approximate numbers entering residential care of 300 per year, the projected minimum annual saving would be £937,500.

In January 2013 a survey was conducted for recipients of AT and their carers. The survey asked a series of questions focused on general feelings of wellbeing and safety, levels of help and support and incidents of admission to hospital. Generally the responses were extremely positive from both carers and users. Other observations included:

- In regard to questions around feelings of well-being, 80% - 90% of users and carers agreed that people generally ‘feel better’ with the AT in place
- Between 50% and 60% of respondents agreed that AT prevents escalation to hospital or residential care
- There is a general similarity of response between users and carers

- In light of the more tangible benefits, the survey included indicating the sense of well-being imparted by the AT and the support service behind it. It provides some explanation, by explicit answers and by the implied 'feel good', why some of the benefits identified are being delivered.

The Health and Wellbeing Board noted and supported the benefits of AT and that Havering Adult Social Care and Havering CCG were working together in partnership to increase the use of AT and maximise benefit realisation. AT is currently funded through S256 funding and this is to be continued throughout 2013/14 and is committed for part of 2014/15.

91 **UPDATE ON SEN BILL**

The Board received the Havering Special Educational Needs Project Update presented by Mary Pattinson.

It was noted that the legislation was currently going through parliament and is due to become law next year. The report outlined the key measures, provided progress reports and highlighted any implications or issues. A SEND Project Team with representatives from across education, children's, adults, parents and health services had been set up. A project plan had been produced and working groups had been set up to cover all of the major changes. There was also a Parents Forum and an advocacy group working at gathering the views of children and young people.

It was important to ensure that Havering is well placed to implement the changes in time for September 2014. In addition, a number of Local Authorities across the country had received funding as pathfinders for the new approach. Havering was working with Bexley and Bromley who are London Pathfinder Champions. A major communications strategy was also being planned so as to avoid misinformation.

92 **REPORT ON JOINT ASSESSMENT AND DISCHARGE**

The Health and Wellbeing Board received the report on the revised proposals with regards to the Joint Assessment and Discharge Service (JAD). The new proposals had been discussed at the Integrated Care Coalition meeting on 14th October. While all partners signed up to the principle of a joint discharge team for patients with complex needs, London Borough of Redbridge was unable to join an integrated service covering BHRUT at this stage. The Integrated Care Coalition partners asked for an urgent redesign of the JAD proposal to take into account London Borough of Redbridge providing a separate hospital social work service for Redbridge residents who may need social care services at the point of discharge. Revised staffing structures and operating procedures have now been developed taking into account the reduced budget available and the need to ensure Redbridge residents are not disadvantaged. Board members were referred to Appendix 1 of the attached report.

The Board considered the revised proposals and agreed to support them. It was noted that a review on JAD resources would be presented to the Board in six months.

93 **ANY OTHER BUSINESS**

No other matters were raised.

94 **DATE OF NEXT MEETING**

Members of the Board were asked to note that the next meeting would take place on 29 January 2014 at 1.30 pm (Special Meeting). The next scheduled Health and Wellbeing Board meeting was on February 12 2014 at 1.30 pm.

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Chairman

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Draft submission to NHS (England) for the Better Care Fund Programme
Board Lead:	Joy Hollister / Alan Steward
Report Author and contact details:	John Green Tel 01708 433018 john.green@havering.gov.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Following the announcement, in July '13 of the Integration Transformation Fund, subsequently renamed the Better Care Fund; the detailed planning guidance was received in December '13. The initial draft submission required in relation to this fund is to be submitted by February the 14th with the final submission to be formally received by April 4th. In particular committed judgements on performance, financial commitments and outcomes need to be clear by that date.

This report outlines the joint view of the CCG and the LA in their approach both to the desire for greater integration in care delivery and in commissioning. The report describes the five year ambition of both and identifies the initial two year actions to achieve that vision.

RECOMMENDATIONS

The Board is asked to:

1. Subject to receiving approval from the London Borough of Havering [and the CCG] the draft Better Care Fund bid be approved for submission to NHS England.

2. Give authorisation to the Chairman to sign the draft submission to NHS England, subject to obtaining approval from the Local Authority and Clinical Commissioning Group to do so.

3. To receive , prior to April 4th , the final submission in respect of the Better Care Fund.

REPORT DETAIL

The Better Care Fund (BCF) has three key objectives:

- Ensuring more joined up and effective commissioning including procurement, specification and contracting of NHS and ASC services
- Delivering more integrated solutions for citizens /service users and patients at the most appropriate and local level possible
- Ensuring improved management of the use of high cost resources through targeted and GP centric and locality interventions , so avoiding hospital and long term care home admissions

A formal pooled fund, totalling circa £16.884m will be created from April 2015, bringing together historical Section 256 allocations into a single resource, together with the Disabled Facilities grant and Adult Social Care capital grant. During the course of 2014-15 an allocation of £4.6m is to be utilised in preparation for meeting the objectives above, together with, in part, the protection of Adult Social Care and related expenditure for implementation of the Care Bill.

The BCF is associated with a number of national performance indicators and targets which require sign off at a national level against local benchmarking and self-identified ambition. The performance targets are:

- Reducing admissions to long term care homes
- Effectiveness of reablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient and service user experience;

with one additional measure to be locally determined. The recommendation would be for a measure associated with carers to complement the emphasis in the Care Bill for a renewed focus on this area of policy. Work is ongoing to identify this metric and set a baseline from which improvement can be identified.

A proportion of the BCF is payable on the achievement of the agreed performance targets with performance, in the main, against 14/15 measurement. In total this represents some 25% of the total £16.884m.

The submission attached reflects joint work between the CCG and the LA describing a five year vision for integrated delivery of care and effective integrated commissioning where that is appropriate. Within that five year horizon a more detailed approach to the next two years is described including clarity of priorities and the actions to implement in 14/15.This is entirely convergent with previous decisions on Section 256 expenditure.

The annexe describes the initial position on the resource allocation, the performance targets and contingency. It will continue to be developed by the CCG / LA during the course of the next two months leading up to final submission by April 4th 2014.

IMPLICATIONS AND RISKS

Financial implications and risks:

The draft and final submissions will cover financial years 14/15 and 15/16.

The national position is that in 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the BCF in 2015/16. NHS England will only pay the additional £200m if jointly agreed and signed off two-year plans for the BCF have been submitted. Havering's allocation using the social care relative needs formula (RNF) is expected to be £4.609m, of which £838k is related to the additional funding. 2014/15 funding will be subject to the same conditions attached to the existing transfer.

The 2015/16 national £3.8bn BCF fund will be created from:

- £1.9bn of NHS funding
- £1.9bn based on existing funding in 2014/15 that is allocated across the health & care system:
    - £1.1bn existing transfer from health to adult social care.
    - £130m Carers' Break funding.
    - £300m CCG reablement funding
    - £354m capital funding (including £220m Disabled Facilities Grant)

Havering's 2015/16 BCF allocation is expected to be:

DFG £829K
Capital £560k
BCF £15,495

Total £16,884

A condition of accessing the funding is that there must be joint spending plans and these plans must meet certain requirements.

The spending round indicated that £1bn of the £3.8bn will be linked to achieving outcomes, both national and local. Half of the funding is expected to be released in April 2015. £250m of this will depend on progress against four national conditions, and £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015, and will relate to further progress against the national and locally determined metrics.

From April 2015 the pooled fund will be governed by section 75 agreement.

Caroline May – Strategic Finance Business Partner

Legal implications and risks:

There are no apparent legal implications in approving the draft submission. If the bid is approved in due course legal advice will be necessary for the detailed aspects of implementation.

Stephen Doye - Legal Manager (Litigation)

Human Resources implications and risks:

Any impact on Havering employees as a result of the need for greater integration in care delivery and commissioning in terms of restructures or changes to job roles will be dealt in accordance with the Councils Managing Organisational Change and Redundancy policy and procedure.

All Havering employees in management positions are required to participate in the Management Development Programme during 2014/15 which will support and embed leadership, coaching and change management skills and help prepare managers to deal with the cultural changes that a success move to greater integration will require.

Geraldine Minchin – HR Business Partner

Equalities implications and risks:

Equality and Diversity issues are a mandatory consideration in decision-making for the LA and CCG pursuant to the Equality Act 2010. The LA, CCG and all other organisations acting on their behalf, must have due regard to the equality duties when exercising a public function. Individual schemes and initiatives funded by the Better Care Fund will be subject to an equality analysis to ensure compliance with the Equality Act 2010.

All identified opportunities for integrated delivery of care and effective integrated commissioning in Havering will be informed by the local population needs identified in the Joint Strategic Needs Assessment and the priorities for health improvement and wellbeing set out in the Health and Well-Being Strategy. The proposed programme of integration initiatives should enable partner organisations to identify more effective ways of meeting future demographic challenges in the delivery of health and social care services across Havering, such as the significant and growing proportion of older people in the Borough and increasing ethnic minority population.

Shirani Gunawardena - Corporate Policy and Diversity Advisor (Interim)

BACKGROUND PAPERS

1. Havering Health and Wellbeing Strategy 2012-14
2. Developing a Commissioning Strategy for Integrated Health and Social care services in Barking and Dagenham, Havering and Redbridge
3. Joint Strategic Needs Assessment (JSNA) London Borough of Havering
4. Market position statement / ASC / Summer 2013
5. Joint commissioning paper dated 2/1/14
6. Development of Intermediate Care Community Services / CCG / 24/9/13
7. Health and Wellbeing Board Report : Section 256 funding / 13/11/13
8. Council plan: The Way Forward , a Connected Council
9. CCG Commissioning Strategic Plan 2015/19
10. Everyone Counts : Planning for Patients: 2014-2019
11. Local Government Association : various
12. Integrated Care , Better Care Fund Guidance / Toolkit

Appendix A: Draft Plan Submission Template

Havering Better Care Fund
Draft Submission

Local Authority
London Borough of Havering

Clinical Commissioning Groups
Havering Clinical Commissioning Group

Boundary Differences
Co-terminus

Date to be agreed at Health and Wellbeing Board:
February 11th 2014

Date submitted:
N/A

Minimum required value of BCF pooled budget	2014/15	£838,000
	2015/16	£16,884,18
Total proposed value of pooled budget	2014/15	£6,946,590
	2015/16	£18,914,018

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This document reflects the joint work of the Havering Clinical Commissioning Group and the London Borough of Havering. It is also informed by the cross-borough work undertaken by the Tri-Borough Integrated Care Coalition (represented by Barking and Dagenham, Havering and Redbridge) and articulated in its "Case for Change" publication together with its Integrated Care Strategy.

The approach to the development of this application is one of co-production with providers, whether these be NHS, ASC, community, independent or voluntary. It is recognized both that:

- sustaining and enhancing this engagement will be essential to future sustainability of the ambition represented in this application
- there needs to be a range of approaches to engagement across the whole system to ensure a balanced and inclusive process representative of all interests.

A joint commissioner and provider group The Tri-Borough Integrated Care Coalition has been in existence for twelve months providing leadership and direction, and committed to whole system solutions. It will continue to be a critical element of overall leadership and governance of the implementation process.

Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

The vision for whole system integrated care is based on what individuals, constituencies of interest, and organisations have said is most important to them. The differing strategic contributions to this application (as captured in the section titled Related Documentation) have been discussed and tested across patients, service users and community groups, but this is only a beginning. Varying means for discussions have been adopted from workshops, forums, service user groups and organisational meetings.

Examples include:

- The Patient Engagement and Reference forums in developing the priorities in relation to carers, initiating methodologies which will be important in identifying carers central to the Care Bill implementation and to integrated GP and locality working.

- The consultative and engagement process undertaken in relation to the further development of the Intermediate Care model, where a total of 123 individuals were involved in a range of approaches, including surveys and follow-up interviews.

It is recognised that what has occurred so far is but the initial step in developing engagement which fosters co-production methods with individuals, communities and community groups. **Implementing these processes will be a priority for us in the course of 2014-15.**

Through the range of dialogue and discussion it is apparent that there is a desire for (amongst others):

- Greater choice and control

- Intervention and responses closer to home

- A broader range of community solutions

- Improved information and access to advice

It is intended to apply the metrics developed through National Voices as a local means of identifying both success and where progress needs to be made. These will be built into the development of the broader engagement processes referred to above, and committed to as a priority for 2014-15.

It is anticipated that the Health and Wellbeing Board will be central to this inclusive approach.

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref	Document	Synopsis
D1	**Havering Health and Wellbeing Strategy 2012-14**	Sets out the vision for the people of Havering to live long and healthy lives and to have access to the best possible health and care services. To move towards this vision the Strategy identifies the most critical issues and prioritises the actions. It focuses on three over-arching themes and eight priorities for action
D2	**Developing a Commissioning Strategy for Integrated Health and Social Care Services in Barking and Dagenham, Havering and Redbridge (Strategic Outline Case)**	Describes the range of system improvements that the integrated care programme will contribute to the overall strategic plan. Identifies clearly permance enhancements to be achieved.
D3	**Joint Strategic Needs Assessment (JSNA) London Borough of Havering ASC Commissioning.**	Joint local authority and CCG assessments of the health needs of the local population in order to improve the physical, mental health and wellbeing of individual communities. A supplementary analysis of critical priorities for action in the integrated commissioning approach has informed this submission.
D4	**Market Position Statement/ASC/ Summer 2013**	Indicates a dialogue with citizens, carers, providers and service users about future demand, and need and the range of contemporary service design and solutions that will be necessary as responses. Sets out current analysis of what is in the market, what needs to change and where the gaps are identified. Initiates a dialogue.
D5	**Joint Commissioning paper dated 6/1/14**	Sets out the processes adopted for the development of the joint

		commissioning approach including Children, Housing and Public Health, together with the initial governance. Both the objectives/outcomes and actions recorded in the paper reconcile with the wider Tri-Borough vision for integrated care. An additional paper identifies priorities and funding streams.
D6	**Development of Intermediate Care Community Services of 24th September '13**	This provides an overview of the proposals submitted by NELFT for the development of intermediate care community services including re-provision of bed based rehabilitation services and support in the community. Details include an expanded community treatment team and intensive rehabilitation service.
D7	**Integrated Care in Barking and Dagenham, Havering and Redbridge – the case for change**	The Tri-Borough Integrated Care Coalition 'Case for Change' sets out the plans for the shift of resources from acute to community.
D8	**Health and Wellbeing Board report: Section 256 Funding of 13.11.13 (including Appendix)**	Identifies the Section 256 funding alongside proposals/services that compliment the Health and Wellbeing Strategy. Outcomes are highlighted, with many seeking to achieve change in delivery models, accelerate integration where appropriate. Proposals in the paper reflect synergy with the submission of this integrated strategy.
D9	**Council Plan**	Titled "The Way Forward, a Connected Council." Outlines the Council's Transformation Programme that has been underway since 2010 arising from revenue allocation reductions, the need to modernise services and respond to residents' priorities. It captures what has been achieved and the ambition of the future. It takes as its themes "Connecting"

		to its stakeholders and describes the roadmap for change together with the benefits to be gained.
D10	**CCG Three Year Commissioning Strategy (25/11/13)**	Describes the strategic objectives (5) and vision developed in the CSP, which have been prioritized for action. Contributions to these five strategic priorities are reflected in this submission.

2. VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcome?*

Through the publication of BHR, Developing an Integrated Commissioning Strategy together with the Havering Health and Wellbeing Strategy the key whole care system objectives (for the Tri-Borough approach) and the health and wellbeing themes for Havering are well laid out and summarised below.

Whole system care objectives are:

Across BHR localities

The Barking & Dagenham, Havering and Redbridge localities (both local authorities and CCG's) signed up to a shared set of priorities namely:

- Delivery of the Integrated Care Strategy
- Integrated health and social care working through the development of a Joint Assessment and Discharge Team, supporting 7 day working and improving 'flow' and discharge arrangements and improving admission avoidance.
- Exploring opportunities to utilise joint commissioning roles (notably in Mental Health and Learning Disability)
- Supporting a joint and strengthened commissioning role with providers
- Improvements in primary care, improving access to support and interventions in peoples own home and reducing reliance upon acute services
- Improvements in prevention, keeping people well and healthy for longer and protecting support for carers
- Improving End of Life Care enabling greater numbers of people to be effectively cared for at home or in the place of their choice.
- Protecting social care services
- Ensuring integrated service delivery to those families with the most complex needs.

The three localities have also agreed to a tri-locality S75 agreement from April 2015 to deliver against our shared priorities for integrated working, with each locality having the benefit of a 'localised' set of priorities where it makes sense to do so.

This is supported by the Havering Health and Wellbeing Strategy with the following critical themes:

- Prevention, keeping people healthy, early identification, early intervention, early intervention and improving well-being
- Integrated support for those people most at risk
- Quality of services and patient experiences

The above represents the BHR whole economy vision for integrated care and has been developed with needs of people at its heart. This means ensuring that the right support and care is available to people in their own homes or closer to home, shifting both activity and resources from acute to community, and in particular to locality settings. It seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to the quality of experience and outcomes.

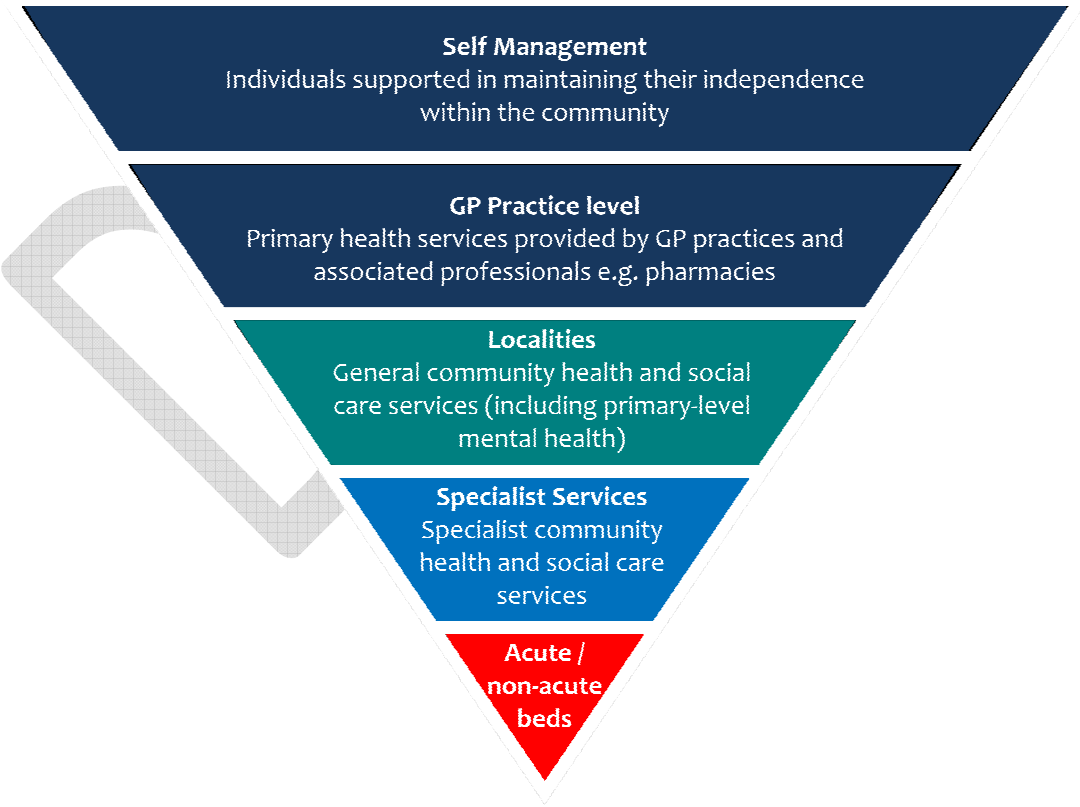

Figure 1: Building From The Community

In a wholly integrated system the four principles that will be consistently applied in our approach are:

1. Individuals and communities (of interest) will be empowered to direct their care and support and to receive the care they need in their homes or local community as a priority.

2. The 'locality' identity will be at the centre of organising and co-ordinating people's care.

3. Services will be integrated around GP registration to simplify access and make co-ordination and integrated delivery easier.
4. Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving the outcome goals, and will be required to show how this delivers efficiencies across the system.

We recognise that success and sustainability of these principles of integrated care will be dependent on making progress on the key enablers of :

- Ensuring User and Carer involvement in active co-design, maximising engagement and involvement

- Putting in place Workforce and Organisational Development: changed cultures and behaviours will be central to sustainability.

- Joint decision making with collective accountability

- Clear financial planning through an effective pooled budget allied to outcomes, utilising integrated personal budgets as a means of shaping the care market in a consumer driven way.

- Joint Management: maximising opportunities for shared management and leadership

- IT Systems: integrated as the basis for information sharing, decision support and a shared case record

As a result of the changes arising from our ambition, individuals will feel confident about the care being received. The (self) management of their conditions is improved and the reliance on A&E attendance in crisis and potentially hospital admission is much reduced. If there is a need for a stay in hospital then the individual is helped to regain their independence and they are appropriately discharged as soon as ready, with certainty about the continuity of care to be delivered.

We want Individuals to routinely report that they feel in control of their care, informed and included, know who to contact if need be, and empowered and enabled to live well.

We expect overall pressures on hospital budgets to have reduced as the shift from high cost reactive spend to spend on lower cost preventative services and greater self- management bear fruit
We will have new integrated commissioning arrangements in place, supported, whenever appropriate with joint specifications and contracts delivering better value and improved care at home, with commensurate reductions in long-term care placements. The care market will have greater plurality, demonstrating more choice and delivered to a high quality through a kite mark contracting approach.

To achieve this we intend to further our engagement with individuals, the public, organisations (public and private) to co-design models of care that meet people's aspirations and needs.

Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around home. **Moves towards this goal are already underway, and will accelerate in '14-'15 as one of our priorities.**

The teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring, self-management and time-banking programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing. Co-production will be the basis for this work at a local level.

At the heart of this are two important developments: (described more fully later in this submission)

- Establishing a joint assessment and discharge team operating 7 days a week (JAD)

- Mainstream and integrate commissioning of the community treatment team and integrated case management on a locality basis. Initially through bringing together health professionals but subsequently by integrated social work and social care into the model.

These will provide a rapid response to support individuals in crisis and help them to remain at home. The I(H)T will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use. This will be further enhanced by the alignment of social workers

and subsequently their integration into the teams. This is already underway and will be a priority for '14/15.

Underpinning all of these developments, the BCF will enable us to start to release funding to extend the quality and reach duration of our reablement services, as part of a substantive ('14-'16) proposal to establish the level of critical mass important to offset changes to the Acute Sector. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;

- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

In doing so our plan is to go far beyond using BCF funding to substitute for existing social care budgets, instead working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

The volume of emergency activity in hospitals will be reduced along with planned care activity through provision of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the Integrated (H) Teams provision, will mean we will eliminate delays in transfers of care, reduce pressures in our A&E's and wards, and ensure that people are helped to regain their independence after episodes of ill-health as quickly as possible.

We recognise that there is no such thing as integrated care without mental health. Our plans therefore are designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

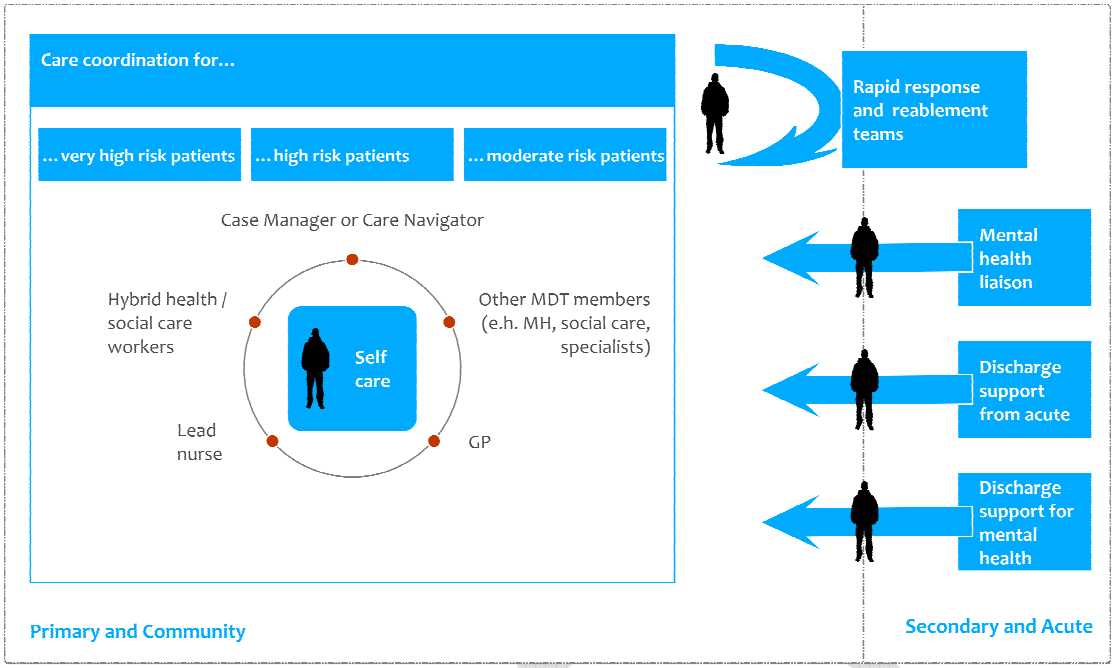

Figure 2: Systemic Approach : Person Focussed

Building on the clusters of GP's forming localities we intend that these:

- Provide the essential infrastructure for the pro-active management of long-term conditions (both the most complex multiple co-morbidities and the cohort where if no proactive intervention will merely move into the complex and/or high resource user cohort).

- Are a means by which it is possible to focus on engagement, listening and co-design, recognising that the demographics of practice lists/communities is different.

- Increase accountability,
- Would provide the basis for integrating social workers making them genuinely multi-professional.

- Ensure safeguarding was grounded in locality practice, and more preventative. Both complexity and safety can be subject to localised action, with named co-ordinators in local teams alongside other professionals.

- Will provide a basis for locality analysis of need and prevalence informing how to localise response to the specific pattern.

Our CCG and Social Care commissioners will be commissioning and procuring jointly, focused on improving outcomes for individuals within our communities.

We are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care;.We are committed to the implementation of integrated personal budgets and the performance management and governance arrangements to ensure effective delivery of this care.

In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible, and in doing so live healthy and well lives. The Health and Wellbeing Board will take leadership for ensuring this is implemented.

In order to track the results, we will invest in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the NHS/ASC are integrated around the NHS number, and individual information shared in an appropriate and timely way (see later in submission).

We are ensuring related activity will align by working in close collaboration with the other boroughs in northeast London in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

Figure 3: The Change Programme ; Key Interventions for the population, underpinned by components and enablers

VISION AND SCHEMES

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and social care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Our aim is to provide care and support to people in their own homes and communities, with services that:

- Co-ordinate around individuals and are targeted to their specific needs
- Improve outcomes, reducing premature mortality and reducing morbidity
- Improve the experience of care, with the right services available in the right place at the right time
- Maximise independence by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing
- Avoid unnecessary admissions to hospitals and care homes through joined up case management enabling people to rapidly regain their independence after episodes of ill-health.

We recognise that this journey will involve further significant changes to the way in which services are designed and delivered. That journey is already underway. From 2014/15:

- Our CCG and Social Care commissioners will be commissioning and procuring jointly, focused on improving outcomes for individuals within our communities.
- Our community providers are and will be implementing new models of service delivery, led by clinicians, driven by professional staff on the ground, and integrated with our broader health and wellbeing strategies.
  This will involve evolution towards a single approach to assessing and meeting the needs of individuals in their homes and communities, with increasingly integrated solutions and delivery of health and care functions.

- Our GP practices will be collaborating in localities focused on populations of approximately 40,000 within given geographies.

  Community, social care services and specialist mental and physical health services will be organised to work effectively with these localities, enabling GPs to ensure their patients are getting the very best person-centred care.

We are committed to and will promote a model of extended primary care, seek continuous improvements including access, ensure that our approaches complement alternatives to urgent care, including named GP for the over 75's. The locality model adopted will provide an important means to achievement of this ambition, embracing a genuinely integrated approach with social care

- We will be investing in co-ordinated care that promotes a holistic view of individual needs and works with people to empower them and enable them to stay as independent as possible.

  This means ensuring there is a good quality care plan, consistent and universally available to professionals and service user, in place for all those at risk, backed by co-ordinated provision commissioned to deliver on the required support and outcomes envisaged in each and every plan.

- The volume of emergency admissions and planned care activity in hospitals, together with the number of residential and nursing care placements, will be reduced through enhanced preventative and community independence functions, and improved support in the community and in the home. However the local demographic together with the acuity of individuals will continue to apply real pressure to this particular objective.

  By improving individual health and wellbeing, and access to home and community based services, we will relieve pressures on our acute services and help eliminate the costs that arise from failures to provide adequate help to those at greatest risk of deterioration.

  In parallel, results of investment in 7 day health and social care provision and critical capacity areas such as rehabilitation and reablement will help us to eliminate delayed transfers of care.

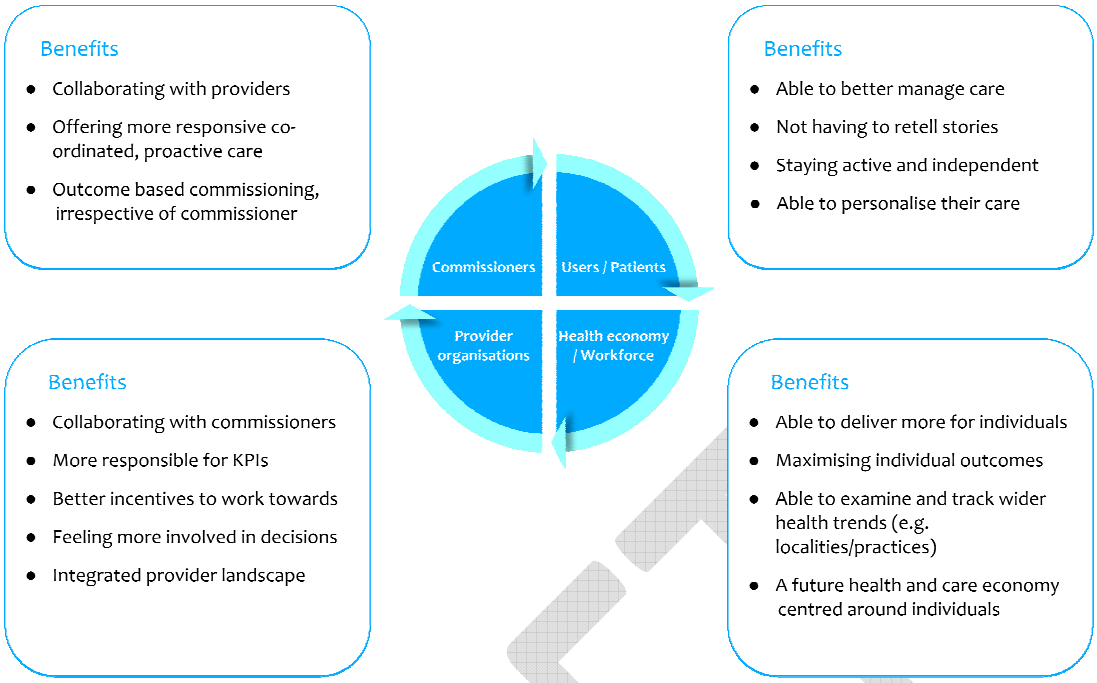

Figure 4: Anticipated Benefits (i)

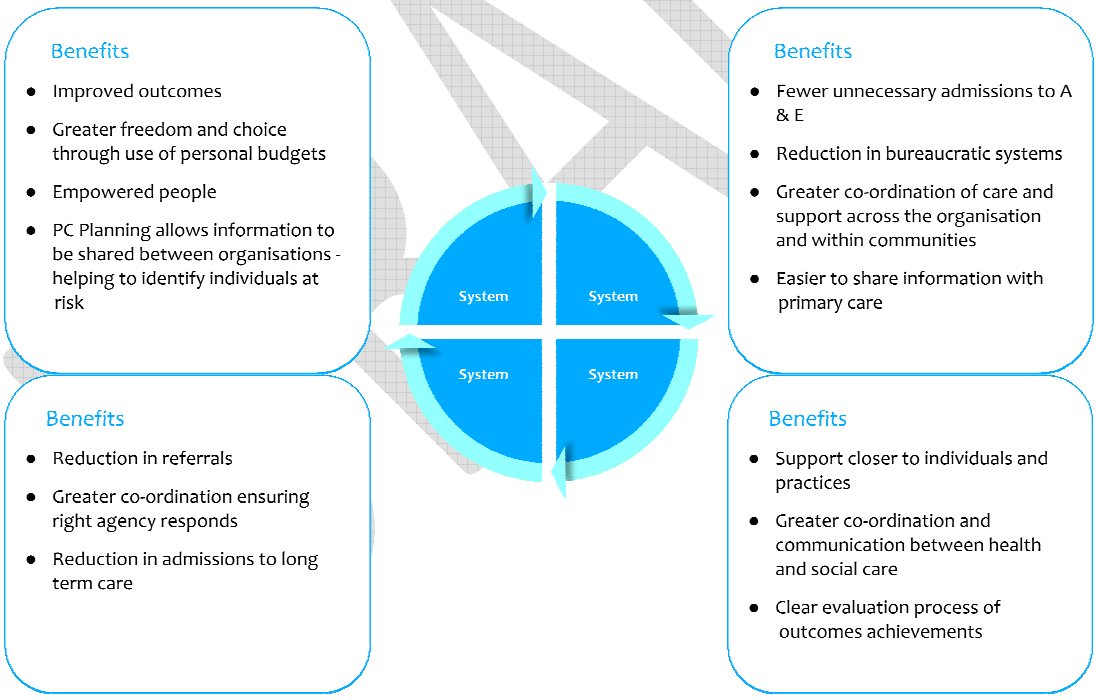

Figure 5: Anticipated Benefits (ii)

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience, and aggregated to allow effective identification and management of need and outcomes across our health and care economy as a whole.

In parallel, we will be investing in developing our infrastructure around understanding the experience of care, including introducing in 2014/15 regular mechanisms for measuring the National Voices metrics through targeted 'audit' of experiences and enhanced 'listening'.

Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

We recognise that our shared ambition will mean significant challenge and change for all –citizen, service user, patient, professional, organisations – and require culture, systems and behaviour change. However both the CCG and the London Borough of Havering are committed to these goals.

What has been done so far?

Senior leaders across health and social care in BHR have committed to working together in a coalition of strategic partners that will develop a joint approach to integrated care.

The Integrated Care Coalition (ICC) therefore brings together senior executive leaders in the BHR health and social care economy to support the three CCG's and the three local authorities in commissioning integrated care and ensuring the building of a sustainable health and care system.

The ICC is responsible for developing recommendations for a system wide integrated care strategy for consideration by commissioners, the Health and Wellbeing Boards and CCG's.

The ICC receives updated reports from BHRUT and all Partners on its improvement programme (LTFM/Clinical Strategy and A/E Improvement Plan) and agree areas and actions where a system response is required.

Priorities for the ICC include:

- Integrated Case Management (ICM): work has focussed on improving the recording and quality of care plans and a higher focus on managing the throughput of the service and caseloads.

  The next stage development which is underway, (and is reflected in this submission) is to further progress the NELFT proposals to develop Integrated Health Teams. (Havering is committed, as the next stage in

this development to integrate social work and social care delivery into this element. It is referred to as Building Block 1)

- The Joint Assessment and Discharge team (JAD): this brings together five current assessment and discharge teams to become one single, integrated, ward based team, able to discharge to any of the three boroughs (April 2014). This is reflected in the submission.

- Frail elders' project: the four agreed programmes Ambulances, Falls, Care Homes, and System rethink. Three of these are reflected in the Havering submission.

- End of Life care services with two principle areas for improvement, namely training for domiciliary care providers and long-term care homes, together with strengthening co-ordination of end of life care services.

Whilst we recognise GP's and the localities will play a pivotal role within this, all providers of health and care will need to change how they work, and particularly how they interact with each other as well as the end user. The CCG and the local authority as commissioners in Havering are committed to working together to shape and create a marketplace and effect the required behavioural and attitudinal change across the system to ensure that this happens at scale and pace.

Across Havering our process for achieving, as set out in our developing Joint Commissioning Strategy and its associated intentions means, for 2014/16 we, as commissioners, will work towards:

- Identifying what populations would most benefit from integrated commissioning and provision: the outcomes for these populations, the budgets that will be contributed, the performance and governance arrangements to ensure vfm and safe and effective delivery of this care.

- Co-designing with communities, health and care providers, the care models that will deliver the desired outcomes, agree the processes for managing risks and savings, and establishing information flows to support delivery, ensuring effective alignment of responsibilities and accountabilities across all the organisations concerned.

- Putting in place the supportive systems, culture and related infrastructure to ensure sustainability of the integration ambition within the financial envelopes available.

  In specific terms, at a local Havering level our intention is to utilise both the Section 256 and 2014/15 BCF ensuring continuity and sustainability of changes already incorporated into the local approach.

The local emphasis adopts work undertaken by the Integrated Care Coalition, the Joint Commissioning Strategy between the CCG/LA, the Market Position Statement (ASC), the JSNA and associated analysis over the past 12-18 months.

The overall aim is to:

i. Integrate and co-ordinate around individuals through the development of an integrated locality model based on clusters of GP's, but remaining sensitive to practice list profiles and ensuring that risk profiling incorporates the adult social care FACS criteria. This will enable integrated targeting of the most at risk cohort, ensuring that services dovetail and plans are aligned.
Consideration of developing the 'House of Care' model is active. This would facilitate the wider management of long-term conditions.

ii. Improve the experience of care with the right services in place at the right time; particular importance is being given to a major development of the intermediate tier of services extending the menu of choice through the development of a pathway into an integrated re-enablement rehabilitation continuum of care, through non-hospital based solutions.

iii. Maximising independence through the benefits of (i) (ii) but also complementing these with a development strategy to build greater community capacity with an emphasis on support for carers (priority: breaks for carers), enhanced community support at the point of avoidable admission and supported discharge, and in the locality application of approaches to self-management.

iv. Seek to innovate and learn. Our success in finding community solutions through co-production will emerge from participation in Launchpad, becoming a pilot site for learning disability ASC efficiencies programme and in introducing non-crisis reablement as a step up intervention. These mark Havering out as being both innovative and open to change and adaptation.

As a joined up health and care community Havering will have left behind the disease based and reactive model with an agreed vision to focus on well-being, prevention, self-care and reablement – always striving for maximum independence – so that the people of Havering can "start well, develop well, live and work well, age well and die well."

We will have a vibrant primary care model integrated with the community in the widest sense – with the whole spectrum of health and care but also with the voluntary and community sector which can do so much to offer support for self-care and peer support and help to get services right.

At the centre of this approach is a smaller acute system offering highly specialist care – not when all else fails, but only when all else could never have succeeded

Havering Integrated Commissioning Strategy (Work in Progress)

The 'funding' strategy for 14/15 (together with the use of existing 256 monies) will accelerate implementation of the initial elements described throughout this submission.

There are five 'building blocks' which may well provide the basis for implementing the five year plan, with differential pace and funding currently under discussion.

1. Developing the Integrated Locality Centric Model
2. Managing Demand
3. Building Community Capacity
4. Service Redesign
5. Sustainability

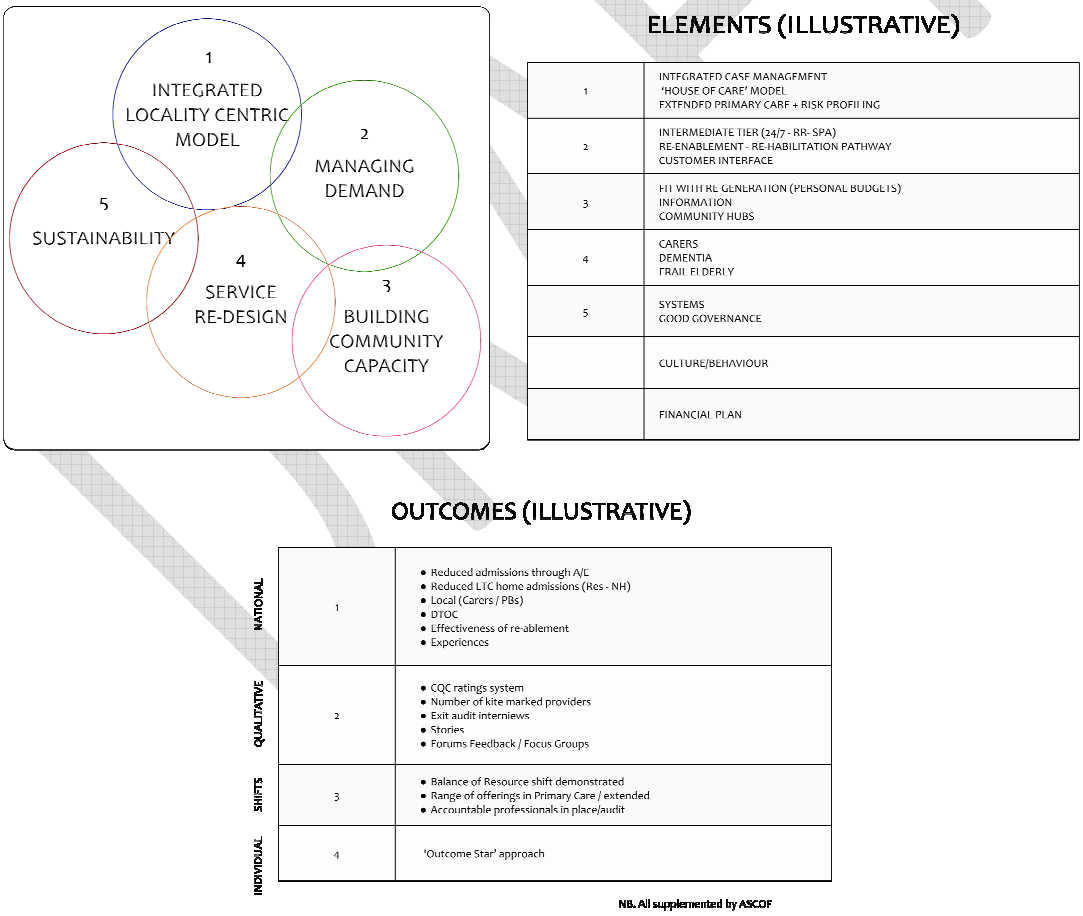

Figure 6: The Havering Programme

We will initially use the BCF to prioritise spend against each building block and schemes which emphasise whole systems approaches and which will

deliver against the critical performance indicators. It should be remembered that the BCF allocation includes the need for a local decision about the financial allocation to protect ASC where appropriate and allow for development costs in relation to the Care Bill. We have taken this into account. During the early part of '14-'15 alignment of spend in Section 256 with the BCF financial plan will be undertaken.

However we will initially use Section 256/BCF to develop the following:

- Joint Assessment and Discharge – Establish a joint assessment and discharge team. Efficient and safe discharge of patients from hospital into the community is a key priority for both CCG and LBH, and will draw from the review carried out by the Patient Discharge sub-group of the Health Overview and Scrutiny Committee. The joint team will be operational at weekends as well as during the week linking with the national push towards seven day working in primary and secondary care. **(Building Block 2)**

  The JAD has the following aims:

  - To facilitate safe return home through collaborative working
  - To provide the integrated health and social care support required to discharge patients with social and/or complex medical needs
  - To identify end of life patients who wish to be looked after at home and ensure they receive expedited discharge with the right health and social care support
  - To minimise delays arising from problems with inter-agency liaison
  - To focus decision making with the service user at the centre of processes
  - To analyse trends e.g. frequent attenders, borough trends, reduction in bed use, increase in community care packages.

  The measurable benefits to be gained have also been identified.

- Locality-based Integrated Community Care – fully mainstream and integrate commissioning of the Community Treatment Team (CTT) and Integrated Case Management (ICM) on a locality basis. In the interim Section 256 will be used to fund CTT and ICM, being topped up by the £5 per capita payment for over 75's Planning for integration will take place in 2014/15 and 2015/16, followed by pooled budgets through the Better Care Fund thereafter. **(Building Block 1/2)**

- Building on ICM to date – the intention is to extend the scope of ICM into an 'ICM Plus' scheme that covers patients with dementia, frail

elders and End of life patients. This will then cover some of the most complex needs that require a multi-agency, person-centred approach to reduce their admissions to A&E and improve their quality of life through community-based care. **(Building Block 1/2)**

- Pathways for long term conditions - Patients with long-term conditions are a priority cohort for both CCG and LBH. The intention is to improve the pathways for these individuals, using evidence from JSNA to prioritise which long-term conditions will be targeted. Targeting will be on a locality basis, so the long-term conditions that are most prevalent and/or most in need of pathway review within each locality will be dealt with. Through an integrated approach, we will seek to reduce A&E admissions for long-term conditions through improved support available to individuals in the community. **(Building Block 1)**

- Develop an Intensive Rehabilitation Service to reduce A & E admissions and reliance on community beds through increasing individuals' independence. It will enable individuals to have rehabilitation/reablement at home. **(Building Block 2)**

- Invest in Pulmonary rehabilitation and smoking cessation as a wider programme for management of Cardiovascular Disease (CVD) **(Building Block 1)**

It is anticipated that other priorities of the first two years ('14-'16) of the five year plan ('14-'19) will include:

- Agreement to, and implementation of an integrated strategic commissioning framework for:
  - Carers
  - Dementia
  - Frail Elders

  (Building Block 4)

- The accelerated development of a systems solution (IT) which provides the means for a single case record, the integration of personal budgets (ASC/NHS in anticipation of the '15-'16 introduction of personal health budgets for those with long term conditions) and the sharing of contingency and crisis planning approaches to individual care, and most importantly, a single assessment approach embedded in genuinely integrated teams. **(Building Block 5)**

- Developing a multi-layered model for the management of falls; primary prevention to acute with effective pathway**. (Building Blocks 1/2/3/4)**

- A step change in the citizen/customer interface through the provision of improved information, diversion, from service-based solutions together with improvements in self-management (locality based) **(Building Block 3)**

- A range of housing and accommodation solutions to take account of both an aging population but also those with significant disability. **(Building Blocks 3/4)**

- Extending the telecare and telehealth solutions, as well as roll out across Havering. **(Building Blocks 2/3)**

Our Ambition

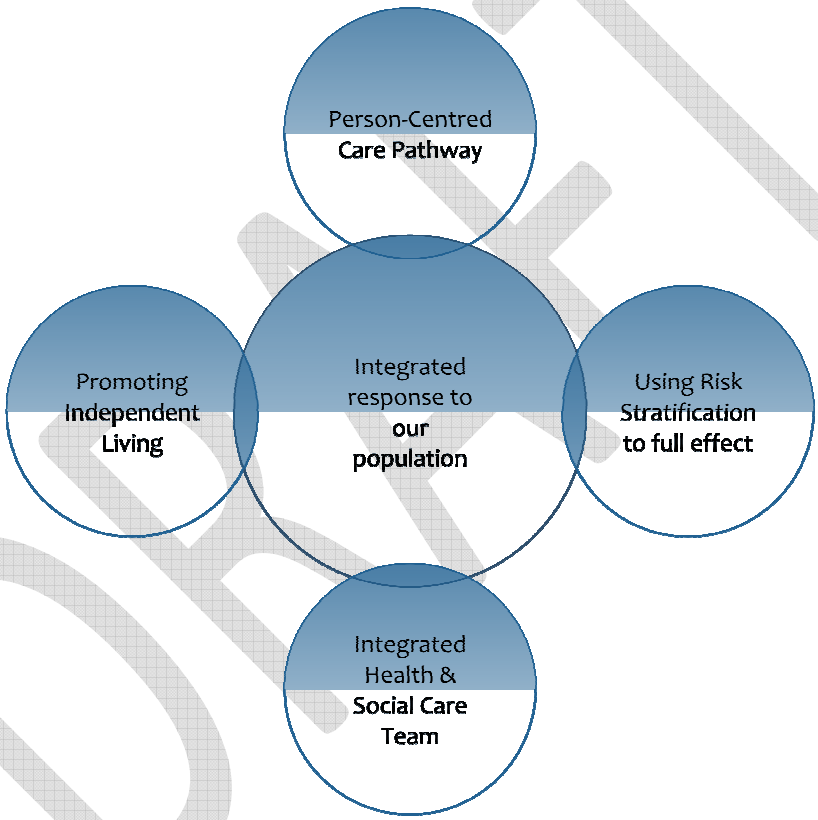

Figure 7: Integrated and Person Centred

Summary

Commissioners in Havering recognise the inherent challenges represented by this submission.

It will require a whole system change at all levels if it is to be successful. Effective joint leadership, integrated commissioning and contracting and increased value for money whilst improving quality and ensuring safety are central to the Havering commitment.

The role of the HWBB in providing the local policy direction and guidance necessary to deliver sustainable change will be critical.

The newly developing governance arrangements between the CCG and LA represented through the Joint Commissioning Board, the developing integrated commissioning function and the pursuit of the locality as the footprint for delivery are important parts of how the submission will be delivered.

Much is underway already on which to continue to build.

c) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The level of change on the acute sector will be significant, but evolutionary. The implementation of an increased range and breadth of community provision is being accelerated through the utilisation of the BCF and the redesign and integration of pathways [i.e. Reablement – Rehabilitation and the design of integrated services i.e. Dementia, Frail Elders, Falls]. The combination of these, together with the introduction of the JAD and Locality Integrated Teams will change the demand patterns for hospital services. Improvements are already in evidence.

The level of disinvestment against community re-investment and savings will be part of the modelling work it is envisaged being undertaken in 2014-15. As a consequence we will better understand the opportunities for commissioning alternative non-hospital-based interventions through the use of community NHS providers, ASC and the third sector. Any anticipated reduction in bed capacity and/or length of stay reductions will be built into our modelling.

Enhancing through 2014-15 and 2015-16 the capabilities and critical mass of the reablement-rehabilitation continuum is a crucial part of this submission. It is anticipated that the consequences of the above will reduce unplanned activities, as will the 14/15 work on Dementia, Falls and Frail Elderly taking account of enhanced case management and improved pathways.

d) Governance

Please provide details of the arrangements that are in place for oversight and governance for progress and outcomes

The governance arrangements are on a number of levels.

At a local level the Health and Wellbeing Board will provide the oversight for the application of the wider change agenda (as above), the local application and interpretation of the wider strategic requirements, together with driving forward both the integrated Health and Wellbeing Strategy and the Joint Commissioning intentions of the emerging Havering CCG and Local Authority. It will hold the commissioners in Havering accountable for both the financial and performance metrics outlined in this submission.

Additionally there are regular meetings of senior officers of the CCG/LA, who ensure the programme project arrangements to deliver the collective plans, are achieved, delivering the required outcomes, within the envelope of costs. Issues of concern, or requiring resolution, are addressed in this forum, which also has clinical leadership within it. This is now constituted as the Joint Commissioning Board for Havering and includes clinical representation.

In addition, and to ensure a consistent and integrated response to the concerns that have been expressed in relation to the acute sector the governance for this interface is reflected in a tri-borough (Barking, Havering and Redbridge) approach. The emphasis is on developing a 'corporate' way forward and model of collegiate working which complements the common provision of acute sector care throughout the Boroughs. This body, which brings together both commissioners and providers across the Local Government and NHS Sectors, provides the leadership and design of a whole system approach to health and care in which, where appropriate, consistency is achieved in the interface between hospital(s) and community responses/interventions.

However we recognise that these arrangements may well need more testing given the collective ambition for genuine integration in depth and at pace. It is recognised that strengthening these with the critical provider partners is necessary. Arrangements are underway to secure this.

An evolving approach to shared leadership and governance

To deliver the ambition contained in in our submission we recognise the need to develop further both the strategic and operational governance requirements.

It is intended through this process to seek the maximum (but appropriate) opportunities for integrated working. Currently these priority opportunities have been identified as:

- Utilising a single and integrated specifications procurement and contracting function for 'community' services (NHS-ASC) with particular emphasis on nursing, residential and end of life care, together with the development of a step- change in community and voluntary activity.

- The integration of personal budgets, both NHS and ASC which will not only ensure 'wrap around' services for the individual, but the basis for creating the reality of an accountable/co-ordinating professional able towork with the individual to ensure 'holistic' outcomes are achieved.

- The development of a single case record enabling all those professionals engaged in co-ordinating and/or delivering to ensure consistency and continuity. It will also provide the basis for ensuring that 'contingency' plans in the light of a crisis are well documented and managed.

- The development of an integrated reablement - rehabilitation pathway ensuring the individual has access to the appropriate intervention through an integrated delivery model.

- The move underway to locality teams will be further enhanced by ensuring that social work is integrated fully into this localised approach.

We recognise that there are opportunities in the above for enhancing the pooled fund, creating real savings in more efficient and earlier interventions, and, most importantly in improving the individual personalized experience.

Tackling improvements to the quality and safety of provision is viewed as a fundamental gain through this genuinely integrated approach to market shaping and management.

We recognise over the course of 2014/15 that, as a result of the above, we will need to ensure 'fit for purpose' governance arrangements are in place, inclusive, and which facilitate high performance. The Health and Wellbeing Board will be central to this as will the development of the Joint Commissioning Board already referred to earlier.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Protecting social care services in Havering means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services.

Please explain how local social care services will be protected within your plans

A proportion of funding currently allocated under Section 256 has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation/reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharges and prevent unnecessary admissions at weekends.

This has already been covered in the submission through identification of the Tri-Borough approach and its initiatives, complemented by the development of the locality model and the development of the integrated locality teams. Set out below are the specific elements currently being put in place.

- A Joint Assessment and Discharge Team across the Tri-Boroughs. Efficient and safe discharge of individuals from hospital into the community is a key priority for both the CCG and LA. This team will be operational at weekends as well as during the week.

- Jointly it is intended to fully mainstream and integrate commissioning of the Community Treatment Team (CTT) and Integrated Case Management (ICM) into a locality based (x6) team. The aim is to pool budgets to achieve an integrated commissioning approach to these services. Planning for full and comprehensive integration will take place in 2014.

  Havering commissioners plan to extend the scope of the case management function to capture the most complete individuals with a dementia, frailty or at end of life. This build on the initial 1% cohort within the risk stratification process.

- A phone support provider for the weekend to specifically be available to ensure discharge at weekends is able to occur safely.

- There is the potential for the development of an intensive rehabilitation service at the front-end of A&E to facilitate avoidable admissions.

<u>The Community Treatment Team</u>

This is an expanded service in Havering running 8 am – 10 pm, 7 days a week. It constitutes short-term intensive care and support to individual with a health and/or social care crisis to help support them at home, rather than in hospital. Teams include health and social care professionals.

- We intend that, as 7 day working continues to develop, we will evaluate the specific need that requires a response and ensure that there is a sufficiency of services in place.,

Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We are not currently using the NHS number as the primary identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by.

Arrangements are in place for the matching of the NHS number into the SWIFT case record by April 2014. This will be accompanied by the submitting of case information (with the NHS number) into health analytics. This in turn will facilitate both the risk stratification process and active case management of complex needs.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)

Appropriate system based on Open APi's and Open Standards are in process and will be completed by April'14.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Ensuring appropriate IG controls is paramount to us. We have met IG toolkit requirements and consequently have N3 connection in place.

Joint assessment and accountable lead professional

a) *Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.*

An Integrated Case Management (ICM) system has been in place since November 2012. It is being applied as a model of practice which aims to ensure that individuals aged 18 and over who have complex needs receive optimum and timely care. The application of this methodology ensures the utilisation of a systematic framework which brings together a multi-disciplinary team to discuss, action appropriately, manage risk and co-ordinate care planning.

Team membership is multi-professional including mental health.

For ICM purposes Havering has been divided into six GP clusters with between five and ten GP practices in each cluster. Each practice holds fortnightly multi-disciplinary case conferences at which between three to five of the most complex cases are discussed, together with updating the collective understanding of previously discussed individuals.

At that meeting the most appropriate professional is deemed to be the accountable lead professional. Additionally crisis plans are in place which are shared, including with A & E.

b) Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Currently the top1% of individuals at a pronounced risk of a hospital admission are identified through use by GPs of health analytics, added to by clinical and professional judgements. All have a care plan, crisis management plan and a lead accountable professional.

The plans already referred to in this submission for integrated locality teams will provide the basis for extending the above. The approach will then embrace the top 5%.

4) KEY RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers.

The table below provides an overview of some of the key risks identified through the co-design process to date. A full risks and mitigations log is being produced in support of our finalised BCF submission.

Reference/ Rating	Risk	Mitigating Actions
1 High	Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	Ensure use of available resources utilised to support progressive withdrawal of recurrent expenditure, and enhance immediacy of the development of community resources pre-acute reductions. Maintain current rate of progress through effective sharing of information and problem resolution. Continuously appraise trends and performance to ensure that direction of travel appropriate and sustainable over time. Share information and perspectives at regular intervals and stay informed and informing.
2 High	A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable	Ensure that business support functions particularly analytical are in state of preparedness for initiating 'real time' reporting. Ensure commissioners (integrated and joint) are sensitive to the need to decommission where outcomes/outputs not being met. Put in place enhanced provider reporting.

3 High	Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality	Ensure clarity between partners about consequences of addressing the change items v operational needs. Flexibility in timescales important. Be jointly clear about priorities for action and why. Maintain information flows between partners and public on the change agenda. 'Frontload' the thoroughness of preparation in order to ensure that any subsequent barriers are manageable.
4 High	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing/care home activity by 2015/16, impacting the overall funding available to support core services and future schemes	Build in a safety margin to expectations of pace of reductions in ITC placements and gate-keep admissions effectively. Expand capability and capacity of the intermediate tier maximising referrals to the continuum of rehabilitation and reablement. Accelerate actions/plans to support carers positively by expanding breaks and developing early identification/prevention strategies.
5 High	The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	Undertake modelling to fully and better appreciate the financial and workforce consequences of the Act. Communicate these across the partners. Re-appraise all funding commitments in light of above to ensure overall financial envelope is maintained.
6 High	The development of new ways of working, new behaviours and styles takes infinitely longer than the required pace of change	Ensure that from the beginning there is an active OD programme targeted at behaviour and culture change. Identify the change leaders

		and champions in organisations, and in professional groups tasking them with leadership and influence.
7 High	A lack of transformational leadership and change management skills is not available in all organisations and at all levels	Establish small groups of influential senior managers committed to integrated working and delivery across the piece, tasking them with briefing and communicating the benefits and potential of the programme, together with influencing the design and requirements of OD. Communicate effectively the success of changed ways of working and stories of both individual professional success as well as individual case material.

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Finance Workings - Templates for Draft Submission 14 Feb 2014 (this sheet internal use only)

BCF Investment	2014/15 spend					2014/15 benefits		2015/16 spend					2015/16 benefits	
	Recurrent	Recurrent CCG	Total Recurrent	Non-recurrent	Total Non-recurrent	Recurrent	Non-recurrent	Recurrent	Recurrent CCG	Total Recurrent	Non-recurrent	Total Non-recurrent	Recurrent	Non-recurrent
BCF 01 - Integrated Locality Team Inc. Case Management Plus	350,000		350,000	150,000	150,000	TBD	TBD	500,000	6,184,337	6,684,337		0	TBD	TBD
BCF 02 - JAD (Joint Assessement Discharge Team).	800,000		800,000		0	TBD	TBD	600,000	400,263	1,000,263		0	TBD	TBD
BCF 03 - 7 Day Intensive Rehab/A&E - NYK			0		0			0	748,394	748,394		0		
BCF 04 - Reablement ASC	850,000	1,433,622	2,283,622		0	TBD	TBD	850,000	1,433,622	2,283,622		0	TBD	TBD
BCF 05 -Royal Jubilee Court - Reablement	200,000		200,000		0	TBD	TBD	0		0	400,000	400,000	TBD	TBD
BCF 06 - Assistive Technologies	500,000		500,000		0	TBD	TBD	599,000		599,000		0	TBD	TBD
BCF 07 - Information & Advice: Care Point Redesign; Customer interface;Broker Role;Sign Posting;E-Market Place	200,000		200,000		0	TBD	TBD	300,000	79,075	379,075		0	TBD	TBD
BCF 08 - Carers including: Assessment Processes; Information/Advice;Dementia Cafes; Respite/Breaks/Day Opportunities	819,000	603,968	1,422,968		0	TBD	TBD	920,000	593,096	1,513,096	190,000	190,000	TBD	TBD
BCF 09 - Long Term Conditions/Priorities: COPD/Pulmonary Rehab; Falls : Roll out/Re- design; Stroke (ASC)	90,000		90,000	150,000	150,000	TBD	TBD	90,000	1,699,718	1,789,718		0	TBD	TBD
BCF 10 - Learning Disabilties : New Models of Care/Transitions	500,000		500,000		0	TBD	TBD	800,000		800,000		0	TBD	TBD
BCF 11- Integrated Commissioining Structure and Commissioning - Governance ;Implementation Resource; Systems (i.e. NHS Number/DILNOT/Case Record); Joint Funders;ASC Finance/Welfare Benefits (Staffing).	300,000		300,000		0	TBD	TBD	800,000		800,000		0	TBD	TBD
BCF 12 : Emergency Admission Avoidance			0		0				337,513	337,513		0		
Disabled Facilities Grant			0		0			0		0	829,000	829,000		
Social Capital Grant			0		0			0		0	560,000	560,000		
			0		0					0		0		
Total	4,609,000	2,037,590	6,646,590	300,000	300,000			5,459,000	11,476,018	16,935,018	1,979,000	1,979,000		

LA Baseline	4,609,000
Difference	850,000
Funded by ASC Base budget - reablement	

Total 15/16 spend per above (rounded to nearest £'000)		18,914,000
Total available min cont funding		16,884,000
Difference -		2,030,000
Funded by:		
LA s256 (one off funding)		590,000
CCG		590,000
ASC Base budget		850,000
		2,030,000
Difference		-

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Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF 01 - Integrated Locality Team Inc. Case Management Plus		350,000	150,000	TBD	TBD	6,684,337	0	TBD	TBD
BCF 02 - JAD (Joint Assessement Discharge Team).		800,000	0	TBD	TBD	1,000,263	0	TBD	TBD
BCF 3 - 7 Day Intensive Rehab/A&E		0	0			748,394	0		
BCF 04 - Reablement ASC		2,283,622	0	TBD	TBD	2,283,622	0	TBD	TBD
BCF 05 -Royal Jubilee Court - Reablement		200,000	0	TBD	TBD	0	400,000	TBD	TBD
BCF 06 - Assistive Technologies		500,000	0	TBD	TBD	599,000	0	TBD	TBD
BCF 07 - Information & Advice: Care Point Redesign; Customer interface;Broker Role;Sign Posting;E-Market Place		200,000	0	TBD	TBD	379,075	0	TBD	TBD
BCF 08 - Carers including: Assessment Processes; Information/Advice;Dementia Cafes; Respite/Breaks/Day Opportunities		1,422,968	0	TBD	TBD	1,513,096	190,000	TBD	TBD
BCF9 - Long Term Conditions/Priorities: COPD/Pulmonary Rehab; Falls : Roll out/Re- design; Stroke (ASC)		90,000	150,000	TBD	TBD	1,789,718	0	TBD	TBD
BCF 10 - Learning Disabilties : New Models of Care/Transitions		500,000	0	TBD	TBD	800,000	0	TBD	TBD
BCF 11- Integrated Commissioining Structure JT Commissioning - Governance ;Implementation Resource; Systems (i.e. NHS Number/DILNOT/Case Record); Self Funders;ASC Finance/Welfare Benefits (Staffing).		300,000	0	TBD	TBD	800,000	0	TBD	TBD
BCF 12 : Emergency Admission Avoidance		0	0	TBD	TBD	337,513	0	TBD	TBD
Disabled Facilities Grant		0	0	TBD	TBD	0	829,000	TBD	TBD
Social Capital Grant		0	0	TBD	TBD	0	560,000	TBD	TBD
Total		***6,646,590***	***300,000***			***16,935,018***	***1,979,000***		

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority - London Borough of Havering	Y	4,909,000	1,389,000	2,829,000
CCG - Havering CCG	N	2,037,590	15,495,018	16,085,018
BCF Total		**6,946,590**	**16,884,018**	**18,914,018**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may

The monitoring and assurance processes initiated in relation to the targets will enable proactive actions to be taken if adverse analysis , or trends , should emerge against the six targets. We recognise that there may well be target specific actions that need to be taken but would not wish, at this stage , to anticipate those actions . Our planning has been based on the recognition that the care system is an interdependent whole and that therefore the cause may lie outside

Contingency plan:			2015/16	Ongoing
- Re- examine gatekeeping process.	Planned savings (if targets fully		TBD	TBD
	Maximum support needed for other services (if targets not achieved)		TBD	TBD
- Increase admission avoidance through targeted reablement	Planned savings (if targets fully		TBD	TBD
	Maximum support needed for other services (if targets		TBD	TBD
- Re- examine operation of JAD in relation to Havering	Planned savings (if targets fully		TBD	TBD
	Maximum support needed for other services (if targets not achieved)		TBD	TBD
Outcome 4 - Strengthen prescence at A&E	Planned savings (if targets fully		TBD	TBD
	Maximum support needed for other services (if targets not achieved)		TBD	TBD
- Detail not yet known nor definition.	Planned savings (if targets fully		TBD	TBD
	Maximum support needed for other services (if targets		TBD	TBD
Outcome 6 - Ensure priority of Carer	Planned savings (if targets fully		TBD	TBD
	Maximum support needed for other services (if targets		TBD	TBD

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Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

1 REDUCED ADMISSIONS	•Improved numbers maintained Independently •Enhanced home care provision: quality • Prolonged carer support	Adult Social Care Outcomes Framework
2 REHABILITATION/REABLEMENT	• Promotes Independence and reduced re-admissions • Reduces costs of care packages • Delay in need for long term care	Adult Social Care Outcomes Framework
3 DTOC	• Reduces loss of independence • Efficient use of hospital capacity • Reduces length of stay • Enhances 7 day working	http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
4 AVOIDABLE ADMISSIONS	• Enhances appropriate use of resources • Enhances independence • Improves management of demand	Hospital Episode Statistics
5 Patient Experience	Not applicable	Not Yet Known
6 Carers - We are undertaking a process of discussions with Service leads and CCG in developing some options for a metric which reflects the philisophy of the Care Bill. -We intend to adopt a co/production methodology with the carer forum to test the options, amend or indeed change the metric in the light of their views. -We will design the approach to data collection with them.	• Maintains relationships through active support • Enhances development of community capacity • Shapes the market through enhanced information of need	TBD

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National Guidance not yet available

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

1 REDUCED ADMISSIONS	*All metrics will be measured and montiored on a monthly basis by Adult Social Care/CCG and presented to our Joint Commissioning Board monthly and to Health and Well Being Board twice yearly. Dependent on analysis, exception reporting would be introduced on any areas of concern and would be monitored and actioned more frequently. Performance within each scheme will be monitored and fed into the overall 6 metrics.Complimenting this approach, we will enhance our engagement with Service Users,patients and carers in order to obtain direct experience of the receipt of service, it's quality and safety. A formal part of our performance arrangements will be to use personal stories to enhance our reporting analysis.*
2 REHABILITATION/REABLEMENT	
3 DTOC	
4 AVOIDABLE ADMISSIONS	
5 Patient Experience	
6 Carers	

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB

N/A

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	675.7	N/A	588
	Numerator	295		267
	Denominator	43,955		45,503
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	82	N/A	87
	Numerator	185		
	Denominator	230		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	153.64	147.75	147.76
	Numerator	3523	3425	3463
	Denominator	191,083	193,177	195,300
		(January 2013 - December 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	184.1	178.4	178.4
	Numerator	5297	5282	5350
	Denominator	239733	246731	249882
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		*(insert time period)*	N/A	*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Children and Young People's Plan 2011-14: an update on progress and achievements
Board Lead:	Joy Hollister – Group Director, Children, Adults and Housing
Report Author and contact details:	Simon Jolley, Strategic Lead – Performance and Policy, Children, Adults and Housing (x3886)

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☒ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report is intended to update the Health and Wellbeing Board on the progress made against the six priorities in the Children and Young People's Plan (CYPP), which sets out the strategic aims of the Children's Trust.

The six priorities are:

1. Ensure children and young people are protected from abuse and neglect
2. Increase breastfeeding
3. Reduce child poverty
4. Reduce teenage conceptions and terminations rates
5. Support complex families
6. Improve access to the most effective therapies

These priorities fall into three broad themes:

1. Support families to be at the heart of strong, safe and prosperous communities

2. Break negative cycles

3. Improve healthy lifestyles

The themes and priorities were defined in collaboration with a range of partners, through detailed assessment of local needs, consultation with professionals and the public, priorities of related bodies (e.g. Local Safeguarding Children's Board (LSCB)), with the final decision on inclusion made by members of the Children's Trust.

Partner agencies, including those from the Police, and the Health, Education and voluntary sectors, are collaborating well to deliver against these shared priorities.

This document highlights particular successes and areas of progress / challenge; the breadth of work underway is such that it cannot be articulated in full in this report.

For sake of brevity, "children and young people" is shortened to "CYP" in this report.

RECOMMENDATIONS

Board members are asked to note the contents of the report.

REPORT DETAIL

Priority 1: Ensure children and young people are protected from abuse and neglect

Strengthened multi-agency working practices

The Multi-Agency Safeguarding Hub (MASH) went live in 2012, with colleagues from the Metropolitan Police and Health representatives co-located with specialist social care staff in Mercury House. Havering is in the vanguard for MASH, both nationally and across London, having adopted more than the traditional safeguarding triage service which is in place in some other boroughs.

A detailed review of the effectiveness of MASH implementation and operation has revealed that the development and implementation of MASH has been achieved with the necessary governance and commitment. As well as social care triage and assessment teams, co-located partners comprise the Police, Probation, Early Help staff and NELFT Health Visitors. Virtual partners (i.e. not co-located) comprise Housing, BHRUT, Youth Offending Team, Adult Mental Health, Education and Drug and Alcohol Services.

There are more referrals progressing to Assessment (94% Jul-Sep13 vs. Apr-Sep12), indicating improved decisions on referrals received; fewer CYP are subject to more than one referral within six months (8% vs. 14%), and MASH is referring more CYYP to Children's Centres and other Early Help services (9% vs. 2%).

Although there have been some difficulties encountered this has been overall a successful implementation. It is pleasing that Havering MASH Health staff have been invited to present to a London wide conference in February 2014 to talk about the Havering MASH journey in respect of health involvement.

Early operational issues were identified through a pilot with appropriate consequent action taken to address. Some operational issues remain, including difficulties in the retention of suitably qualified and experienced staff. This is not unique to Havering. MASH now operates a rota system to ensure that Triage staff continue to develop their social work skills. The Council funds its social workers' membership of the College of Social Work and the approach to workforce development, recruitment and retention will be subject of detailed review to ensure the borough remains competitive and able to attract and retain the best staff.

Early Help, i.e. services provided or made available to CYP (and their families) who have some form of presenting need but who are not at risk of harm (where a child protection plan would apply) has undergone significant development, building on the established successes of the borough's children's centres and implementing innovative developments. This includes the creation of a multi-agency Tier 3 team

(see below) and combining Children's Centres into pairs to deliver a more co-ordinated and broader offer within their respective localities.

Children's centres continue to be hubs for delivery of Tier 2 services, with a critical role to play in supporting vulnerable families, particularly where there are children living in or at risk of living in poverty (see Reducing Child Poverty priority later in document).

Havering has established one multi-disciplinary team in the central children's centres locality, which delivers a coordinated service to families whose children may not be at immediate risk of harm but who still require some form of support. That support spans a range of intensity, depending on a family's circumstances, but focusing on Tier 3 support. By addressing problems at the earliest opportunity, such provision will reduce the risk of the needs of these families increasing to a point at which they are in crisis and social care needs to intervene in a more robust and legally-based manner.

As evidence of the effectiveness of Early Help services, Havering has low numbers of children on Child Protection Plans per 10k population (24 vs. 38 national average and 35 statistical neighbour average) and Looked After Children (LAC) per 10k population (36 vs. 60 national average and 59 statistical neighbour average). Some outcomes measures for these groups of CYP (LAC or on Child Protection Plans) are set out later in this section.

Different areas of Children's Services are collaborating to develop an **online directory of community-based services**, building on the existing Family Information Service, so that families and professionals who want to find out about available early help services can do so in an easier manner than is currently possible and appreciate the quality of available services (e.g. via a Tripadvisor-style model) . As the scope of needs is so broad this is a significant piece of work which will involve all agencies which provide any early help service, as well as the voluntary and community sector, which but one which will bring significant benefits to Havering residents.

The Troubled Families programme is making significant progress in drawing agencies together to work in a new and more effective ways. This is an integral part of the CYPP priority to Support Complex Families and is thus elaborated upon later in this document.

Closer collaboration of partners involved in the protection of CYP, be it through MASH or through other support mechanisms, will help Havering adapt to potential challenges brought by population migration from other London boroughs.

Improved participation of families

There are several strands to the work to ensure that the views of CYP and families can influence service design and strategic direction: developing culture and

capacity, building service user views into work to evaluate service quality, building the right structures to enable increased participation and embedding all of this into practice.

LB Havering has implemented **Strengthening Families**, a new approach to child protection, which uses families' strengths and protective factors to develop child protection plans with greater input from that family. Based on constructive relationships and innovative use of words, pictures and child-friendly tools, the approach has been well-received by professionals and families alike.

The **Children in Care Council (CiCC)** is essential in meeting Council, Government and OFSTED priorities around the involvement of Looked After Children (LAC). A new CiCC was launched at MyPlace in November 2012 and work continues to develop the group so that it can have a greater strategic influence, be representative of all LAC, play a part in recruitment, training and commissioning, and contribute to ongoing learning and service improvement.

Viewpoint, a new web-based tool for LAC or subject to a child protection plan, to contribute their views to the review of their plan, was launched in late 2012.

More than 50 children on Child Protection Plans or in the care of the Council have given their views through Viewpoint. This has revealed that:

- 87% of CYP feel they get the right amount of support. When asked 'how does your social worker help you', the most popular response is 'listens to me', followed by 'makes sure I am safe';
- CYP feel their social worker listens to them (average score out of 10 = 8);
- CYP feel safe at home, in school and in their local area (average score out of 10 = 9). This is comparable to CYP not in receipt of support from statutory services (views gathered from annual CYP survey in schools), and
- The most common issue that children want sorted out at their review is contact arrangements with their family. Most children want to go to their review and the most common preferred place to have the review is in school. Children and Young People's Services (CYPS) is acting on this feedback.

Havering continues to ensure high levels of participation of LAC at review – 99% for 2013-14 (just two LAC out of 310 subject to a review did not participate in that review).

The **tenders** for the Short Breaks (aka Respite) provider contracts were evaluated with CYP, their views contributing to 10% of the overall score. There was also the opportunity for parents to influence final decision making. For the tender for Advocacy Services, CYP designed case study scenarios for bidders to work through. The direct involvement of CYP in commissioning of sizeable contracts is an excellent example of CYP views impacting on service design, and can be replicated in future commissioning activity.

The Council trained up several LAC and care leavers to deliver **Total Respect Training**, which teaches social workers and other members of the children's workforce about the experience of being in care. At the end of the training, delegates document a personal pledge to work in a different way; the young people subsequently challenge that delegate around progress against their pledge. As well helping to develop the children's workforce, it is an excellent opportunity for LAC and care leavers to develop skills and confidence.

Professionals use the right tools and procedures for the specific needs of the child

The **Early Help Assessment**, which has replaced the Common Assessment Framework, is an improved and vitally important tool to identify families' and individual CYPs' needs at an early stage. CYPS has worked particularly closely with private, voluntary and independent service providers to ensure that they can use the tools to identify and support families they believe are in need of early help services.

Social workers are now equipped with updated practice guides and toolkits, which have helped them to support CYP to achieve sustained positive outcomes. This is evidenced in a range of indicators, e.g.:

- The stability of placements for LAC has improved significantly, with 6.7% (actual no. 13) of LAC having three or more placement moves, down from 14% in 2012-13 and 20% in 2011-12;
- 68% (actual no. 29) of LAC placements last two or more years, up from 63% in 2012-13;
- 12% (actual no. 10) of CYP who ceased to be looked after in 2013-14 have done so through adoption, up from 9% in 2012-13;
- 5% (actual no. 5) of CYP are on a Child Protection Plan for second or subsequent time in two years, higher than last year but improving.

7% (actual no. 6) of CYP who ceased to be subject to a Child Protection Plan had been on that Plan for more than two years. This is worse than 2012-13, better than 2011-12, and is improving.

The most significant development to the tools available to social care staff is the implementation of the **new improved social care IT system**. The new system, CCM, is now used by all social work staff and Children's Centres and is enabling supervisors and managers at all levels of CYPS to maintain a better oversight of children's social work.

Priority 2: Increase breastfeeding rates

In 2011/12, 71.1% of mothers in Havering gave their babies breast milk in the first 48 hours after delivery, an increase of 2.4% from 2010/11 rates. This put Havering at the bottom of the third quintile when compared to all England local authorities. When compared to London authorities, Havering had the lowest rate of breastfeeding initiation, bar one. 2012-13 initiation rates were comparable, at 71.3%.

This affects continuation rates (at 6-8 week check), although performance has improved from 39.5% (2010-11) to 45.6% (2012-13), which brings Havering close to the national average of 47%.

Increase awareness of breastfeeding to all cultures and age groups

Breastfeeding awareness sessions were delivered in ten secondary schools, with positive feedback from teachers and pupils.

There has been an **extensive marketing campaign**, focused around Breastfeeding Awareness Weeks. The most recent promotion was through Billboard campaigns and bus-signage campaign for high-risk locations.

Support mothers to feel confident to breastfeed in public

The **Breastfeeding Friendly Scheme** is proving highly successful with over 100 venues signed up, including GP surgeries, libraries, children's centres, early years education providers and local businesses. The Scheme benefitted from national television publicity in 2011. The Scheme sets out a range of criteria to which members must adhere, so that their specific service location is a welcoming and supportive environment for mothers who choose to breastfeed.

An evaluation of the scheme in February 2012, comprising over 900 people, shows that confidence and tolerance of breastfeeding in public has increased vs. June 2011 (when the scheme began). 4% of respondents said that women should not breastfeed in public (8% in June 2011); 74% said it was a good idea for women to breastfeed (vs. 69% in June 2011).

The scheme received national recognition in 2012, being recognised as an example of innovative practice by the Centre for Excellence and Outcomes (C4EO).

Priority 3: Reduce child poverty

Around 8,800 children aged 16 or under live in poverty in Havering, equating to 18% of the population, which is comparable to our statistical neighbours and reduced from over 9,000 (approximately 20%) in 2011.

Children living in poverty are concentrated in Gooshays, Heaton, Brooklands, Havering Park and South Hornchurch.

Some of the impacts of current welfare reforms are set out below:

- Caps to local housing allowance (LHA) has restricted the level of support that families can receive with their rents to the 30th percentile of rents within a local area, and set absolute limits depending on the number of bedrooms the claimant is allowed under the size criteria. These began to take effect in April 2011;
- The benefit cap restricts the total amount of support received by any one household to £500 a week for families with children and £350 for single people;
- Under-occupation charges will reduce the level of support for families in social rented housing if they are deemed to have an extra bedroom, and
- Universal Credit and Direct Payments - its rollout has been delayed but its impact on families could be significant. This restricts the total amount of six common benefits received by any one household to £500 a week for families with children and £350 for single people.

Although the overall number of CYP living in poverty has decreased, this will be partly due to the decrease in national median wage (a child is living in poverty if household income is < 60% of median wage). A broad range of activity is underway, in close collaboration with partners, to address the causes of poverty.

Develop a network of integrated services for families, focusing on the Foundation Years

Children's Centres are hubs for multi-agency working, and all new registrants are offered benefits advice.

Health Visitors work directly out of a range of Children's Centres across the borough.

Children's Centres developed as hubs for multi-disciplinary integrated teams, focused on support for Tier 3 families, as part of Early Help developments (see

Priority 1.). The team includes family support workers, Family Intervention Project Workers and a Domestic Violence coordinator.

Reduce barriers to employment

Uptake of high-quality formal childcare continues to increase. The average uptake of the three/four year-old offer was 3,648 in 2012 and 4,275 in the summer term of 2013. This gives children's development a good start and enables parents to attend work and generate household income.

The offer of **free childcare places for two year-olds** from disadvantaged families remains popular, with 280 children benefitting from the offer in academic year 2012-13 and 646 in Autumn term 2013. This is an increase from just 71 when the scheme first started in 2009.

These children are consequently more likely to access early years education (94% finished the two year-old offer in Summer 2013 and took up the three/four year-old offer in autumn 2013. Funding for the two year-old offer is increasing and it is projected that 1,120 children will be able to access a place in September 2014. Nationally, the current eligibility criteria is expected to cover 40% of two year-olds in September 2014.

4.9% of Havering 16-19 year-olds are **Not in Education, Employment or Training** (NEET), lower than national, London and statistical neighbour averages. This performance is comparable with previous years.

Improve financial wellbeing

The **Financial Inclusion Strategy** was approved in June 2012 with an embedded action plan. The six themes are Banking & saving; access to credit; increasing financial capability; home and contents insurance; addressing fuel poverty, and income maximisation.

To advance these themes, the follow actions have taken place or are underway:

- Banking Liaison Officer appointed and leading discussions with banking sector to agree ways to help more customers to access basic bank accounts (will increase employability and sustainability of tenancy for those currently without bank accounts. Risk of fuel poverty reduced if people can pay via direct debit);

- Front line staff are being trained to identify and support people who are victims of loan sharks;
- Residents are being supported to safely release equity from their homes to pay for refurbishments / repairs, avoiding loan sharks, so that older and vulnerable residents are able to stay in their homes for longer and avoid costly residential care (as self-funders and / or to the Council);
- Care Point (through its shop in Romford High Street) offers support with money management, including in-house advice or signposting to more specialist organisations;
- All new Council home residents receive a welcome pack detailing how to access home and contents insurance, and
- Welfare Rights Unit (Children, Adults and Housing Directorate) is supporting residents to maximise their benefits take-up. Between April and December 2013, this team dealt with 2,235 client enquiries, resulting in £1.1m benefit gains for the clients and £450k income gains for the Council.

Address health inequalities

Examples of work to address these inequalities include an influenza vaccination programme to children with complex health conditions, delivering MEND programmes in schools to tackle childhood obesity (by improving eating habits and increasing physical activity), and contracting smoking cessation services.

Vaccine coverage in Havering is generally in line with comparators, although is lower for Hib / MenC (exp. booster), Hib, MMR (1st dose) and DTaP at age 2. Low numbers of requests for MMR lab tests suggest that current provision and uptake of immunisations in Havering are suitable to meet the population level need.

Priority 4: Reduce teenage conceptions and terminations rates

When this was chosen as a priority for the Children's Trust, Havering's local conception figures were worryingly high with 190 conceptions in 2009 – a rate of over 40 per 1,000 girls. In 2011, this had fallen to 131 conceptions – a rate of just 28 per 1,000 girls (below the national and regional rates).

The most recent (provisional) data shows Havering has an under 18s conception rate of 27.8, slightly below the England average and above the London average. Average conception rates over the first three quarters of 2012 are in line with comparator authorities.

This is the lowest ever rate of teenage conceptions in this borough and is testament to the effectiveness of the well-coordinated partnership working which has been central to the work to achieve this priority.

There is significant variance in different parts of the borough. Wards in the far north of the borough and Brooklands recorded statistically significant higher rates of under-18 conceptions over this period; wards in the centre of the authority had significantly lower rates.

Access to Contraceptive and Sexual Health (CASH) services

Havering's Condom Card (C-Card) **scheme is one of the highest performing in London, with over 4,000 young people are registered, 63% of whom are male.**

The most commonly-used outlets are local colleges and Youth Zone. New schemes are in place with Lloyds Pharmacy and Mim Pharmacy. It is anticipated that a further seven pharmacies will join following training in early 2014. The Lead Nurse Specialist for Looked After Children (LAC) Team provides C-Cards at each LAC's annual review. Colleagues have approached many GP Practices but the lack of remuneration for participation remains a barrier to their involvement. In local sexual health surveys, young people cite GPs as their preferred source of information and advice about contraception, pregnancy and sexual health so it would be useful for GPs to join this already successful scheme.

Six schools, including one pupil referral unit, based in three TP hotspots (Harold Hill, Rainham, and Romford) have joined the C-Card scheme (i.e. they issue the cards, but signpost to other locations which provide the condoms).

15,000 foldout wallet-sized young persons' sexual health information booklets **have been distributed through C-Card centres, NHS walk-in centres and other key locations. Initial print-run was 5,000 but demand far outstripped this initial supply.**

Targeted work with vulnerable groups

The targeted sexual health service, Youngaddaction, and Children and Young People's Services (CYPS) have collaborated in the development of effective referral pathways for at-risk teenagers and make tailored interventions. Youngaddaction is the current provider of the young people's substance misuse service; there are proven links between teenage conceptions and young people's use of drugs and alcohol.

The referral pathways include six secondary schools / academies in TP hotspots, the Youth Offending Service, the Phoenix Counselling Service and the CYPS 12+ team.

Sex and Relationship Education (SRE) has been targeted at six schools in high-risk areas. In the most recent Sexual Health Survey of young people, 90% of respondents stated they had received SRE, with two-thirds rating the education positively. This is an improvement from previous years.

Workforce development

Since April 2012, three providers have delivered specialist courses to over 300 staff who work with children and young people.

Priority 5: Support complex families

When central government announced the Troubled Families programme, Havering, unlike many other boroughs, had already begun to plan how it would address the complex and inter-related risk factors affecting a section of the population, to help them to break their negative and often inter-generational cycles of behaviour and deprivation. The aim is not to create a new service; rather, to re-design our existing services and improve cooperation with partners to maximise the impact of our interventions. The step change is to ensure that the needs of the whole family, rather than individual members, are considered together and that agencies collaborate to deliver services which are in line with the whole family assessment.

The direction from central government usefully aligns with the approach we were already taking; the council will receive £700 for every family identified with potentially thousands more for those families with whom lasting positive outcomes (i.e. sustained after six months) are achieved. These outcomes fall into three areas: reduction in unemployment, improved attendance at school, reduced anti-social behaviour and youth crime.

In January 2013, representatives from the Department for Communities and Local government, who sponsor the Troubled Families work nationally, visited Havering and were delighted with the progress made, particularly in relation to the relationships forged with partners and teams which are helping to develop new systems and processes for achieving sustained outcome improvements for families.

Identifying families

DCLG gave LB Havering a target to identify 415 families by the end of March 2015 (end of the current three-year programme). This number of families will have been identified by the end of March 2014, i.e. **a year ahead of schedule**. The impact of welfare reforms has contributed to the higher-than-projected identification of families with complex needs.

Rather than identifying more families than the DCLG target, the Troubled Families (TF) programme will focus on delivering the highest possible quality outcomes for those 415 families. No further payments-by-results will be received for any families over the 415 DCLG target.

By the end of March 2014, the TF programme will have submitted **payment-by-results (PBR)** claims for 160 families, bringing the total of families for whom PBR claims are submitted to 164. This represents a good level of progress as PBR claims can only be made once six months have passed since the family achieved the positive outcome(s) specific to their own circumstances (e.g. regaining and sustaining employment, ceasing anti-social behaviour, or sustaining improved attendance at school).

Redesigning services

There has been **extensive journey mapping** with families to identify issues with existing processes and potential solutions. There is a growing bank of data and information from those families who have already been supported through the programme, which will be used to define improved operating models for inter-agency collaboration on a single family (see workforce development in next section).

Some families have upwards of 12 different agencies / professionals providing some form of support or intervention; this is clearly too many. The programme is funding an officer to **develop a strategic approach to workforce development** across the workforce, i.e. not focused solely on workforce for adults' or children's services. This work, which will also draw upon families' experiences, will need to be broader than Council workforce, to include Police and Health professionals and will ensure that professional develop skills outside of their immediate professional remit. This common approach to workforce development, with professional up-skilling and a more sophisticated operating model will help to reduce the number of professionals which a family sees and ensures consistency for families throughout the time in which they receive support from public agencies.

TF Programme has assisted the development of the **Tier 3 multi-disciplinary team** working out of children's centres (mentioned in Priority 1, above). This includes funding a Domestic Violence worker, and training and development for the teams.

The Programme is joint funding a volunteer coordinator post with Action For Children, who have implemented a **new Family Partners project** (similar to Family Intervention Projects) in Harold Hill, with neglect as the target issue. This will assist in development of Family Graduates and Family Advocates, who will be critical to success of TF Programme. Family Graduates are former service users; Family Advocates are former professionals.

The Programme is **working alongside Job Centre +** to explore opportunities to use the Flexible Support Fund to access employment for the TF cohort. One example is the creation of a 16-week training programme for TF with the schools catering workforce.

There remain some issues with information sharing, although this has been in a relatively isolated set of cases. The support and commitment from Health partners is still sometimes inconsistent, including no firm commitment of resources or staff development.

Troubled Families – Phase 2

The Government has confirmed that the **TF programme will continue for a further five years**, from April 2015 to March 2020, with an emphasis on early help. The approach is under consultation and the London Coordinators Group (of which LB Havering is an active member) has expressed its views. Details are not yet confirmed but it is likely to follow a PBR model and it is hoped that there will be greater local discretion of PBR criteria as local needs differ.

Priority 6 Improve access to high-quality therapies

Access to effective therapies has been a concern for parents and professionals alike. The broad themes of activity for this priority are to redesign services, to improve commissioning and collaboration with partners, and to ensure that we are able to intervene early and enable maximum independence.

Speech and Language Therapy (SLT)

Investment in 2010-11 (£270k into Health, £85k into Education) has delivered tangible improvements to provision of this essential service, including in the historically difficult area of hearing impairment. The extra funding allowed for the recruitment of more therapists which allows more children to receive the therapy they need. Teaching Assistants have also been trained to provide a degree of support and allow the qualified SLT therapists and technicians to support children with more complex needs. Between October 2012 – September 2013, 5,127 children registered with a Havering GP accessed SLT; 56% of whom were aged 5-10.

Redesign services

Work is ongoing to **redesign CAMHS** (Child and Adolescent Mental Health Service), based on a clear understanding of local needs and customer requirements.

A priority for the redesigned service is to ensure that the voice of the service user and the family is involved in Commissioning and decision making.

The **CAMHS Partnership Board** is re-established and is consistently well-attended by partners. This group plays an integral role in ensuring that mental health services for CYP in Havering meets identified needs. A new CAMHS Strategy is in development and will be in place in early 2014-15.

Improve commissioning and collaboration

The council will continue its work to develop more robust commissioning frameworks, to deliver improved value for money through consistent standards from multiple providers and strengthened monitoring arrangements. Substantial commissioned areas so far addressed include Domiciliary Care provision and Respite Care provision (ref. the Short Breaks tender in Priority 1).

The **forthcoming SEN Bill** presents exceptional opportunities for improved collaboration between education, health and social care services. Each child whose SEN meets locally-agreed criteria will be jointly assessed and supported through an Education, Health and Care (EHC) Plan.

A robust governance structure is in place to lead local preparations for the SEN Bill, which will come into force in September 2014, focusing on:

- Detailed analysis of local SEN populations, financial modelling and the impact of existing services;
- Joint commissioning processes;
- Our local offer and development of Personal Budgets;
- Single contact and assessment processes, and

A consultative forum with parents and CYP.

There has already been extensive work to **improve clients' transition** between care as a child to care as an adult. There is now improved information passing between to the two care services, through regular transitions meetings, and established governance arrangements for planning for young people's transition. In many cases, the aim is to provide sufficient support at an early stage, as young as 13 or 14, to improve the young person's independence, particularly if they are unlikely to be eligible for Adult Social Care services. A High Support Transitions Group is identifying and ensuring the best possible support for those CYP with particularly complex, and hence expensive, care needs. Exploration of the most effective operating models to ensure a smooth transition is underway.

NELFT has taken over from Whizzkids as the provider of wheelchairs and is now ensuring that CYP receive wheelchairs in a timely fashion, which has helped to address the concerns of parents and CYP in this area.

Early targeted interventions to increase independence

36 CYP and six adults with a learning disability have successfully completed the **travel training programme** with the Disability Association of B&D to help them to use public transport independently. A four-year travel training contract is in place to continue this service.

The most important benefit of the scheme is to the CYP involved and their families, although the work will ultimately contribute to transport savings, particularly where the CYP were previously using taxis. Savings on bus costs are more difficult to realise as removal of one child from a bus does not reduce the cost of running that vehicle.

The Children's Trust will continue to oversee and drive achievement against the CYPP priorities. Its bi-monthly meetings focus on one priority area, which allows more thorough discussion on progress, challenges and how to ensure that the priority objectives are achieved.

IMPLICATIONS AND RISKS

Financial implications and risks: None for Members to consider

Legal implications and risks: None for Members to consider

Human Resources implications and risks: None for Members to consider

Equalities implications and risks: None for Members to consider

BACKGROUND PAPERS

There are no background papers.

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