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HEALTH & WELLBEING BOARD

SUPPLEMENTARY AGENDA

Wednesday March 19 2014
1.30 pm – 3.30 pm
Committee Room 2

4. MINUTES (Pages 1 - 14)

   To approve as a correct record the minutes of the Committee held on 12 February 2014 and to authorise the Chairman to sign them.

   The Board are asked to note the amended minutes of the meeting held on 11 December 2013 relating to item 78.

6. JOINT ASSESSMENT AND DISCHARGE TEAM (Pages 15 - 18)

   Lead: Joy Hollister
   Report presented by Barbara Nicholls

8. BETTER CARE FUND (Pages 19 - 78)

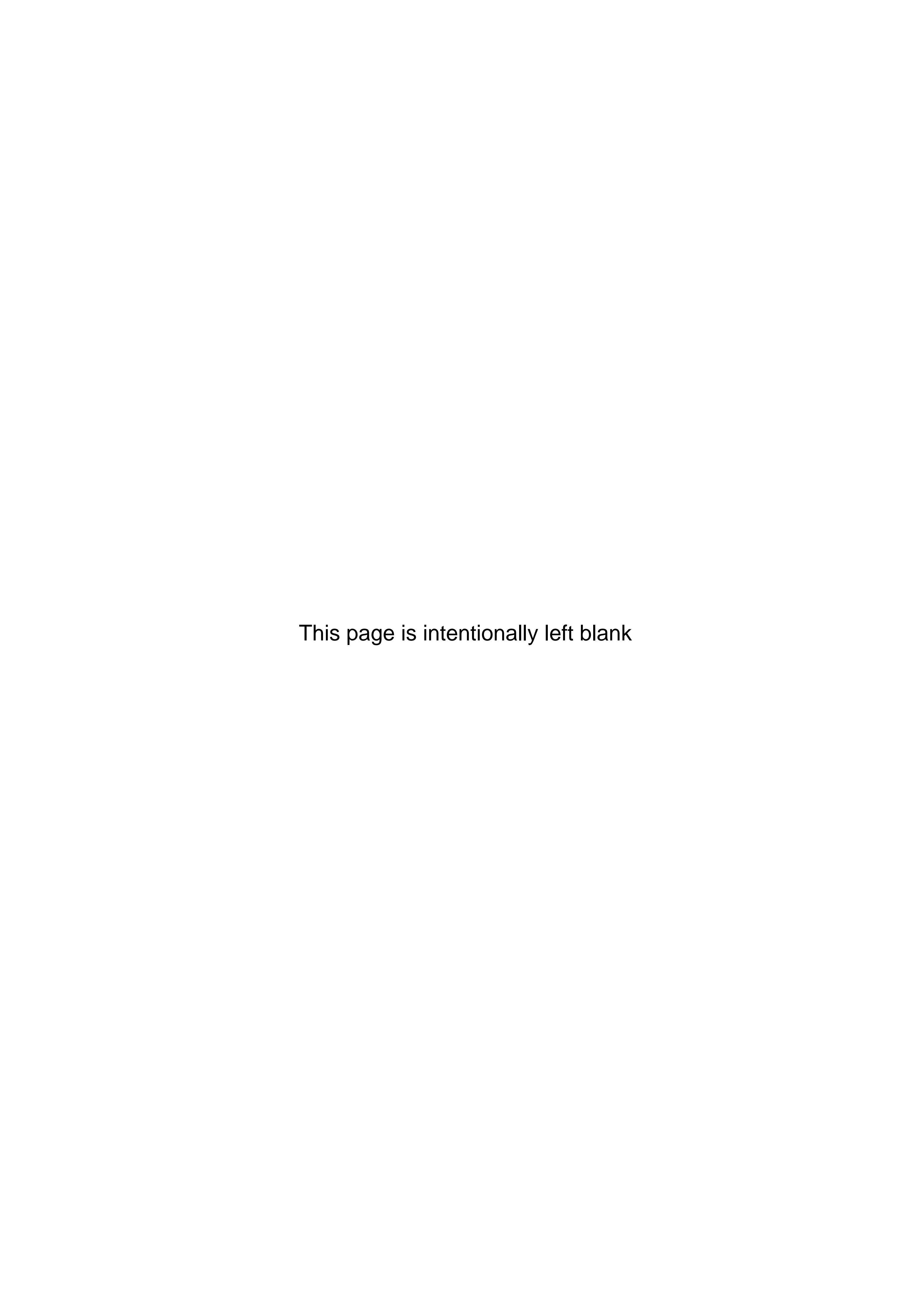
   Lead: Joy Hollister
   Report presented by Barbara Nicholls

9. HAVERING, BARKING & DAGENHAM, REDBRIDGE CLINICAL COMMISSIONING GROUP 5 YEAR STRATEGIC PLAN (Pages 79 - 130)

   To note and approve the plan.
   Report by Alan Steward

10. TROUBLED FAMILIES (Pages 131 - 134)

    Lead: Joy Hollister
    Progress Update by Sarah Thomas



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MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 1-Town Hall - Town Hall
12 February 2014 (1.30 pm – 3.30 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Mark Ansell, Consultant in Public Health, LBH
John Atherton, NHS England
Conor Burke, Chief Officer, Havering CCG
Cheryl Coppell, Chief Executive, LBH
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Cynthia Griffin, Group Director, Culture, Community and Economic Development
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

Lorraine Hunter, Committee Officer, LBH (Minutes)
Barbara Nicholls, Head of Adult Social Care, LBH

Apologies

Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

95. **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.

96. **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

97. **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

98. **MINUTES**

The minutes of the meetings held on 11 December 2013 were agreed in principal pending the reinstatement of item 78.

The Board considered and agreed the minutes of the meeting held on 8 January 2014 and authorised the Chairman to sign them.

99. **BETTER CARE FUND - FIVE YEAR PLAN**

Following the detailed guidance received at the Board meeting in December 2013, the draft submission for the Better Care Fund Programme (formerly the Integration Transformation Fund) was presented to Board members. The report outlined the joint view of the Clinical Commissioning Group (CCG) and the Local Authority in their approach for greater integration in care delivery and commissioning. The draft submission was due to be forwarded to NHS England by 14 February 2014 and that a final version would be formally submitted on April 4 2014, therefore, committed judgements on performance, financial commitments and outcomes needed to be clear by that date. A condition of accessing the funding is that there must be joint spending plans and that these plans must meet certain requirements.

The Better Care Fund (BCF) had 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

Members were advised that a formal pooled fund, totalling circa £16.884m would be created from April 2015. This would combine 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 these monies would be utilised by Havering in meeting the key objectives together with, in part, the protection of Adult Social Care and related expenditure for implementation of the Care Bill.

It was noted that 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. The funding in 2014/15 would be subject to the same conditions attached to the existing transfer.
It was agreed that the Authority and CCG were building on excellent foundations and that the establishment of the Integrated Care Coalition (ICC) had formed a good basis from which to drive the project forward.

The BCF is associated with a number of national performance indicators and targets which would 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;

In addition, one measure would be determined locally, and it was recommended that it be associated with carers so as to complement the emphasis in the Care Bill for a renewed focus on this area of policy. It was noted that the aim was keep people away from hospital, in particular, those with learning difficulties or dementia and to provide more care in their own homes.

The Board agreed that further voluntary and community input would be required and that community groups should be approached. Members were advised that Futuregov had opened the Public Sector Launchpad to bring innovation into local public services and that two members of the Board planned to investigate further.

The Board were asked to note the five year projection plan and the initial two year period of priorities and actions to implement in 2014/2015. Work would continue in developing the document leading up to final submission by April 4th 2014. Members of the Board were asked to forward any comments regarding the submission onto officers prior to that date.

A proportion of the BCF is payable on the achievement of the agreed performance targets with performance in the main, against 14/15 measurement.

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

At a local level, the Health and Wellbeing Board will provide the oversight for the application of the wider change agenda, 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 the submission.

It was noted that from April 2015, the pooled fund will be governed by the Section 75 agreement.

The Board agreed to:

- Approve the draft Better Care Fund bid for submission to NHS England
- Authorise the Chairman to sign the draft submission to NHS England
- To receive, prior to April 4, the final submission in respect of the Better Care Fund.

100. CHILDREN & YOUNG PEOPLE'S PLAN

The Board received an updated report on the progress made against the six priorities in the Children and Young People's Plan 2011- 2014 (CYPP), which sets out the strategic aims of the Children's Trust.

The six priorities are:

- Ensure children and young people are protected from abuse and neglect
- Increase breastfeeding
- Reduce child poverty
- Reduce teenage conceptions and terminations rates
- Support complex families
- Improve access to the most effective therapies

Priority 1

MASH

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. 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. Although there have been some difficulties encountered, this has been overall a successful implementation. Some issues remain, including difficulties in the retention of suitably qualified and experienced staff which is not unique to Havering.

Members of the Board queried whether some children at risk would be overlooked if perhaps they are new to the Borough and/or not registered with a GP. Officers concurred that this could be a possibility and the Board agreed that the Communications team would put information onto the Havering website about GP registration and eligibility for the free nursery scheme.

Early Help

Havering has established a 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. 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.

Troubled Families

The Troubled Families programme is making significant progress in drawing agencies together to work in a new and more effective ways. 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.

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.

Viewpoint

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.

Respite

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.

Priority 2

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 and at the lowest rate bar one when compared to London authorities. Breastfeeding awareness sessions were delivered in ten secondary schools, with positive feedback from teachers and pupils as well as an extensive marketing campaign focused around Breastfeeding Awareness Weeks. 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.

Priority 3

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. 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.

Priority 4

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.

Priority 5

When central government announced the Troubled Families (TF) programme, Havering 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. Department of Communities & Local Government (DCLG) gave Havering a target to identify 415 families by the end of March 2015 (end of the current three-year programme), however, this number of families will have been identified by the end of March 2014, i.e. a year ahead of schedule. The Troubled Families programme will focus on delivering the highest possible quality outcomes for those 415 families.

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).

The TF Programme has assisted the development of the Tier 3 multi-disciplinary team working out of children's centres and includes funding a Domestic Violence worker, and training and development for the teams.

Priority 6

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 early intervention so as to enable maximum independence.

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.

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.
The Children's Trust will continue to oversee and drive achievement against the CYPP priorities. It was noted that the JSNA will be the basis for developing the next Children and Young People's Plan.

101. **UPDATE ON BHRUT**

The Board noted the BHRUT CQC Executive Summary and Report which outlined the key findings and the Special Measures implemented which included the following:

- The requirement for the Trust to develop an improvement plan.
- That an organisational capability review be conducted by Sir Ian Carruthers over the 15 and 16 January 2014.
- A Board to Board meeting in February.
- The Trust Development Agency will appoint an Improvement Director.
- The Trust will receive support from the TDA Special Measures Director.
- The Trust is buddied with a Foundation Trust for peer support.

The Chief Executive informed the Board that a meeting had been held on 10 February 2014 with representatives from Queens and NELFT regarding the Hospital Improvement Plan which required the agreement and input of all three boroughs. It was agreed that this would be a challenge however all parties were equally committed and acknowledged that it was essential that they work together. It was necessary for the Trust to demonstrate that it was addressing financial issues and that systems were moving in the right direction. The outcome of the review on senior leadership was imminent and that an Improvement Manager had been engaged. The Board were advised that the Chief Executive of the Council and the Chief Officer of BHRUT would be meeting with the Trust Development Agency.

102. **ANY OTHER BUSINESS**

The Board agreed to support the bid for Havering GPs together with GP practices from Redbridge and Barking and Dagenham in a collective proposal to the Prime Minister's Access Fund for financing significant improvements in local Primary Care. The Chairman agreed to forward a letter of support, on behalf of the Board, to the Secretary of State.

103. **DATE OF NEXT MEETING**

Members of the Board were asked to note that the next meeting would take place on 19 March 2014 at 1.30 pm.

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Chairman

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MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD

Commitee Room 1 - 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.

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Chairman

HEALTH & WELLBEING BOARD

Subject Heading:	**Progress towards the Implementation of the Joint Assessment and Discharge Service**
Board Lead:	Joy Hollister Group Director – Children, Adults and Housing
Report Author and contact details:	Barbara Nicholls Barbara.nicholls@havering.gov.uk 01708 433069

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

CONFIDENTIAL

SUMMARY

The Health and Wellbeing Board is asked to consider the progress made towards the implementation of the Joint Assessment and Discharge Service and to consider the steps completed.

Since the paper presented to the Board on the 8th January 2014, the following has progressed:

- The Service Manager has been appointed and has begun working with the staff teams around the operational model, including end to end assessment processes.
- Work is underway to draft the S75 agreement that will formalise the governance arrangements, including budgets, staffing and delegated authorities, to the host organisation – London Borough of Barking & Dagenham.
- Staff consultation is planned to begin from the end of March 2014 and meetings are underway with unions to agree the approach.

RECOMMENDATIONS

- The Board is asked to consider the progress made in the implementation of the Joint Assessment and Discharge service and to indicate whether it supports them or not and what comments, if any, it has.

REPORT DETAIL

This report highlights to the board the progress made to date and highlights some detail for the board to note.

The Joint Assessment and Discharge Service (JAD) will consist of around 50 health and social care staff, with a staff budget of c. £2m. It will have a Service Manager employed by the London Borough of Barking and Dagenham, 4 Ward Group Managers and 1 Co-ordination Manager.

The Service will be arranged into Ward Groups within Queen's Hospital and 1 Ward Group in King George's. Each Ward Group will consist of a Manager and 7 or 8 JAD workers, who will work with the wards' multi-disciplinary teams (doctors, nurses and therapists). The JAD will be the single point of contact for all referrals of people who may require health and/or social care support on discharge. As previously agreed, the JAD will not deal with referral of people who may require specialist rehabilitation services from hospital.

Governance:

The development and implementation of the JAD is supervised by the Integrated Care Coalition and the Urgent Care Board. There are regular Executive Steering Group meetings with senior representation from each participating organisation with the London Borough of Barking and Dagenham as the 'host' organisation. The Steering Group reviews progress against milestones established within the individual work streams in the project plan and acts as point of resolution for any issues that are identified. It has been agreed that the Steering Group will become the "governing body" for the service.

Implementation of the JAD has proceeded on the assumption that a s75 agreement is being developed to meet the needs identified within the revised proposals and will cover staffing and budgetary matters. This agreement will provide delegated authority, within an agreed structure for both social care and health, whilst allowing for the processes relating to Continuing Health care expenditure. This will provide sufficient control and monitoring providing assurance to partner organisations.

BHRUT Improvement Plan:

The JAD proposals need to unify with BHRUT improvement plans currently being drafted, to ensure complementary alignment and acknowledging the significance of specialist measures and the requirements they may bring.

Project Plan:

The project plan is in place although it has been established that the following key tasks need to be completed to enable the service to be provided by June. Some are already marked complete:

1. JAD Staffing:

- Service Manager (1 post) – Completed – The Service Manager has now been appointed following panel interviews on the 23rd January. The new Service Manager is currently a Barking and Dagenham Hospital Team Manager. The Service Manager will be leading the interface with existing Team Managers and staff picking up operational delivery issues.

- Job descriptions for the other posts under the new structure are currently being drafted and employing organisations are being consulted to ensure the best fit where possible to existing posts.

The assimilation process will begin soon after the new job descriptions are agreed and the following has taken place:

- A meeting with staff representatives and trade unions has been convened to discuss proposals, agree a consultation process and ensure good engagement.

- The new Service Manager has met with existing staff to ensure they are engaged in the process and are clear about the direction of travel.

2. JAD staff consultation document:

- An additional HR resource was engaged at the end of December to assist with finalising the staff consultation document. They have also amalgamated the respective `Management of Change` policies of partnership organisations contributing to the JAD. This will create a joint process that satisfies the consultation requirements of each partner.

- It is proposed that staff will be assimilated if an employee is assessed as carrying out 65% of the duties contained within the new job descriptions. Should there be any unplaced employees at the end of the process; the redundancy/redeployment process will revert to the employing organisations' respective procedures.

- The formal staff consultation is proposed to start by the end of March 2014 and will run for a period of at least 30 days (given that Havering's change management policy allows for a minimum of 45 days due to the overall number of affected staff in reviews taking place from end of March).

3. Section 75

- Legal capacity has been identified by the London Borough of Barking and Dagenham to lead on the preparations of a full Section 75 Agreement.

4. Accommodation

- BHRUT has identified accommodation for 40 staff at Queen's Hospital and 10 at King George's Hospital. Staff will move into the accommodation as soon as possible, prior to the implementation of the JAD.

5. Operational Policy:

- The service requires a dedicated operational policy which is also under development. Key headings and structure is now being tested against staffing and organisational requirements.

Continuing Heath Care

Following a meeting with NHSE, we are exploring the mechanisms required for delegating decision making to the JAD, which will be via a specific schedule of the over-arching section 75 agreement.

IMPLICATIONS AND RISKS

Financial implications and risks:

The current budget for Havering's Hospital Team is £811,742. The combined cost of the joint team is currently being confirmed and is expected to be in the region of £2.2m. Havering's element is not expected to cost more than current establishment. The exact financial implications and risks as a result of moving to a joint service will be monitored as the implementation progresses. The staffing elements will be captured as part of the change management process.

There will be an ongoing management charge from LBBD, which is expected to be in the region of £43k. There will also be implementation costs, of which Havering's share is expected to be £21.5k.

The section 75 agreement will not result in a pooled budget. However, a finance schedule will be included and the agreement is expected to cover financial governance.

Caroline May – Strategic Finance Business Partner (Children, Adults and Housing).

Legal implications and risks:

There are no direct legal risks or implications associated with agreeing to the proposed direction of travel. However, assuming the JAD is to progress, detailed work will be necessary in order to ensure that the proposals can be lawfully implemented and meet the needs of each of the constituent authorities. A number of agreements will need to be completed.

Stephen Doye – Legal Manager

Human Resources implications and risks:

There are significant HR risks and implications that will directly affect the Council's workforce, which will emerge when change management processes are followed to bring about the new joint structure for the hospital service. The Council will need to consider, and take action to deal with, any HR risks and implications that are likely to arise from the implementation of a joint structure involving the Council and the other partner organisations for the proposed Joint Assessment & Discharge Service now that the project has moved to that stage. This will be dealt with by Adult Social Care management, with HR support, using the Council's HR policy and procedure framework, with due regard taken of relevant employment legislation obligations and terms and conditions of the Havering staff in scope for this project. The Section 75 Agreement will include clear arrangements for the management of Havering staff under the lead organisation, London Borough of Barking & Dagenham, and will set out the entitlements of seconded Havering staff in line with their employment contract with Havering Council to ensure they are maintained.

Eve Anderson – Strategic HR Business Partner (Children, Adults & Housing)

BACKGROUND PAPERS

- Initial Joint Assessment and Discharge Service Report – Health and Wellbeing Board January 2014

HEALTH & WELLBEING BOARD

Subject Heading:	**Draft Submission to NHS (England) for the Better Care Fund Programme - Update**
Board Lead:	Joy Hollister/Alan Steward
Report Author and contact details:	John Green John.green@havering.gov.uk Tel: 01708 43318

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 consideration of, and agreement to, the Better Care Fund draft submission by the Health and Wellbeing Board on 12th February 2014, it was submitted to NHS England on 14th February 2014.

Work has continued on the content of the submission both to strengthen certain elements, and, and is ongoing to complete and confirm the annexe in respect of financial resources and the performance metrics. The most up to date draft of the submission is attached in order to keep members fully informed.

The final date for submission remains 4th April 2014.

However further work remains necessary prior to that date to clarify between the partners of the CCG and LA the means and accountabilities for implementation of the programme detailed in the submission.

RECOMMENDATIONS

1. Delegate the authority to approve the final submission of the Better Care Fund application to the Chairman to sign the final submission to NHS England on 4th April, subject to obtaining approval from the Local Authority and Clinical Group to do so.

2. To receive, post 4th April, the final submission, and subsequently to receive monitoring reports at six monthly intervals.

REPORT DETAIL

Extensive background information on the Better Care Fund was provided to the HWBB at its meeting on 12th February and the draft submission was made to NHS England on 14th February 2014.

It was recognised at that point in time that further work was required to:

- Establish the benefit realisation arising from the investment plan detailed in the annexe, ensuring a robust approach to financial management.

- Clarify the use of the NHS number to ensure improvements both to shared case information and analytics.

- Define the implementation plan for each of the Better Care Fund schemes, together with the accountabilities.

- Continue to seek improvements to the presentation of the final submission.

Work will continue on these elements during the remaining period to 4th April. The attached report reflects the current position in respect of the above.

IMPLICATIONS AND RISKS

Financial implications and risks:

The finance scheme recurrent and non-recurrent spend figures remain the same as at the draft submission. The planned savings at final submission will be based on the metrics. The supplementary guidance issued on 24 Feb 2014 states "it is recognised that the details of planned service changes may be subject to ongoing refinement through 2014/15. This will ensure that plans remain aligned with the ongoing process of developing five-year strategic plans and whole system savings targets."

The figures submitted on 4 April will need to be considered in the context of current savings programmes and future budget strategy. As BCF plans are implemented and whole system impact seen benefit realisation will be tracked.

The maximum support available should savings not be achieved will equate to the benefits shortfall – there is no ongoing additional funding for any contingency, although the budget will need to be balanced.

It should be noted that for 2015/16 performance related funding will not apply. However, although financial sanctions will no longer apply in the first year (guidance on future years is awaited), all areas will still have to meet the following conditions:

- protection for adult social care services;
- provision of seven-day services to support patients being discharged and to prevent unnecessary admissions at weekends;
- "agreement on the consequential impact of changes in the acute sector";

- putting in place an "accountable lead professional" for integrated packages of care.

Good performance on the metrics will also need to be demonstrated. If an area fails to deliver 70% or more against plan then a recovery plan is likely to be required.

Caroline May – Strategic Finance Business Partner

Legal implications and risks:

There are no apparent legal implications in making the recommended decisions

Stephen Doye - Legal Manager (Litigation)

Human Resources implications and risks:

There are no direct HR implications or risks to the Council, or its workforce, that can be identified from the recommendations made in this report.

Eve Anderson – HR Business Partner

BACKGROUND PAPERS

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

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To Whom It May Concern,

On behalf of the London Borough of Havering and the Havering Clinical Commissioning Group

This interim submission was agreed by the Havering Wellbeing Board at its formal meeting on Wednesday 12th February 2014.

It was then subsequently the subject of an Executive Decision by Councillor Steven Kelly, Leader of the Council, Chair of the Health and Wellbeing Board and Portfolio Holder for Individuals on the 13th February 2014.

The signatories below are therefore formally submitting the attached as the interim submission for Havering in respect of the Better Care Fund.

…………………………………

Joy Hollister

Group Director of Children, Adults and Housing

…………………………………

Alan Steward

Chief Operating Officer, Havering Clinical Commissioning Group

…………………………………

Dr Atul Aggarwal

Chair of Clinical Governing Body – Havering CCG

…………………………………

Councillor Steven Kelly

Leader of the Council/Chair of the HWWB

Notice of Non-key Executive Decision

Subject Heading:	**Draft Submission to NHS (England) for the Better Car Fund Programme**
Cabinet Member:	Councillor Steven Kelly – Leader of the Council
CMT Lead:	Joy Hollister Group Director – Children, Adults and Housing
Report Author and contact details:	Barbara Nicholls Head of Adult Social Care
Policy Context	Health & Social Care Act 2012 Care Bill (expected to be made law in 2014) Havering Corporate Plan 2011-2014 (includes 'Living Ambition' agenda) Cabinet Reports – 21st January 2014 and 12th February 2014 Integrated Care in Barking and Dagenham, Havering and Redbridge, 2012 (Integrated Care Coalition) Havering Health & Wellbeing Strategy 2012-2014 Havering Market Position Statement (ASC) 2013
Financial summary	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. In Havering, the funding allocation for 2014/15 is £4.6m, payable to the Council by NHS England; in 2015/16 the allocation is £16.88m and will be governed through a S75 agreement, with the lead agency yet to be determined, but will likely be the Council.
Relevant OSC:	Value
Is this decision exempt from being called in?	Action is required following the taking of the decision so urgently as to justify exemption from being called in and the Chairman of the relevant OSC has agreed to the exemption. The chair of the Value Overview & Scrutiny Committee, Councillor Robby Misir, has agreed by email dated 13th February 2014 that the Cabinet decision in respect of the BCF be exempt from Call-in. An exemption is required in order to meet a statutory deadline set by NHS England. The level of funding put at risk should the Council fail to meet the submission deadlines is in the order of £4.6 million in 2014/15 and £18.66 million in 2015/16.

The subject matter of this report deals with the following Council Objectives:

Ensuring a clean, safe and green borough	[ ]
Championing education and learning for all	[ ]
Providing economic, social and cultural activity in thriving towns and villages	[ ]
Valuing and enhancing the lives of our residents	[x]
Delivering high customer satisfaction and a stable council tax	[ ]

Part A – Report seeking decision

DETAIL OF THE DECISION REQUESTED AND RECOMMENDED ACTION

The leader of the Council is asked to approve the following:

- Interim Better Care Fund Report
- Submission of the Better Care Fund Report to NHS England

Following the announcement, in July '13, to 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 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.

AUTHORITY UNDER WHICH DECISION IS MADE

Constitution Part 3 Section 3.3 (a) to take any steps necessary for proper management and administration of allocated portfolios.

Cabinet, at its meeting on 12th February 2014, delegated the approval of the BCF funding submission for 2014/15 and 2015/16 to NHS England to the Portfolio Holder for Individuals.

STATEMENT OF THE REASONS FOR THE DECISIONS

Background

1. In July 2013, the Government announced the creation of the Integration Transformation Fund, subsequently renamed the Better Care Fund (BCF). Detailed planning guidance was received in late December 2013, including confirmation of the submission dates back to NHS England. The Better Care Fund stipulates that release of funding in 2014/15 and 2015/16 is dependent on local areas agreeing how they will deliver against the objectives of the BCF, and requires formal 'sign-off' by local Health and Wellbeing Boards. The initial draft submission required in relation to this fund is to be submitted by 14th February 2014, with the final submission to be formally received by 4th April 2014.

2. The Better Care Fund (BCF) locally in Havering will total circa £16.88m and will be created from April 2015, bringing together historical Section 256 allocations into a single resource, together with the Disable 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 of the Better Care Fund, together with, in part, the protection of Adult Social Care and related expenditure for implementation of the Care Bill. The Better Care Fund will be delivered through a formal section 75 agreement, signed up to by the Clinical Commissioning Group and the Council, which will provide the governance framework for our plans locally, including performance and finance.

3. Whilst NHS England will be seeking confirmation that BCF plans have been agreed through local Health & Wellbeing Board, the Council must also ensure that the appropriate Executive Decision is obtained as the BCF submission is potential expenditure of circa £16.88m from 2015/16, should the Council be agreed as the lead agency to deliver the Better Care Fund in Havering. The Council's Cabinet was first alerted to the Better Care Fund in the report considered at its meeting on 21st January 2014, with information contained within the report entitled 'Council's Financial Strategy'. Cabinet was asked to further consider the BCF in a report going to its meeting on 12th February 2014 entitled 'The Council's Budget 2014/15'. In the report for Cabinet consideration on 12th February 2014, members agreed to delegate authority to the Cabinet Minister for Individuals to approve the draft submission of the Better Care Fund application to NHS England by 14th February, and the final submission on 4th April 2014.

4. The Health & Wellbeing Board considered the BCF draft submission at its meeting on 12th February 2014, and approved the submission draft, pending final approval from the Havering Clinical Commissioning Group Governing Body and obtaining the appropriate executive decision from Council.

5. The Better Care Fund (BCF) has three key objectives:
   - Ensuring more joined 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

6. Subject to the Leader's approval of the BCF submission, this will be sent to NHS England by 14th February as per the deadline. NHS England will assess the draft submission, providing feedback to the Council and Clinical Commissioning Group, which will be incorporated in the final submission due 4th April 2014.

7. As per the Cabinet approval on 13th February 2014 to delegate the authority to the Lead Member for Individuals to approve the BCF submissions to NHS England, a further delegated authority report will be prepared ahead of the final submission date of 4th April 2014.

OTHER OPTIONS CONSIDERED AND REJECTED

Should the interim submission not be made and received by NHS England by the 14th February 2014 the London Borough of Havering stands to lose significant funding.

PRE-DECISION CONSULATION

Consultation has taken place between all parties involved, including the Leader/Cabinet Member for Individuals, CCG and the HWBB.

NAME AND JOB TITLE OF STAFF MEMBER ADVISING THE DECISION-MAKER

Name: Barbara Nicholls

Designation: Head of Adult Social Care

Signature: Date: 13th February 2014

Part B – Assessment of implications and risks

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)

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 Carer's 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	£829
Capital	£560
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 the £1bn 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 2045 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

HUMAN RESOURCES IMPLICATIONS AND RISKS (AND ACCOMMODATION IMPLICATIONS WHERE RELEVANT)

Any impact on Havering employees as a result of the need for greater integration in care delivery and commissioning in terms of restructure or changes to job roles will be dealt with in accordance with the Council's 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 successful move to greater integration will require.

Geraldine Minchin – HR Business Partner

EQUALITIES AND SOCIAL INCLUSION 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 hen 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. HWBB Report – February 2014
2. Havering Health and Wellbeing Strategy 2012-14

Part C – Record of decision

I have made this executive decision in accordance with authority delegated to me by the Leader of the Council and in compliance with the requirements of the Constitution.

Decision

Proposal agreed

Delete as applicable

Proposal NOT agreed because

Details of decision maker

Signed

Name: Councillor Steven Kelly

Cabinet Portfolio held: Leader of the Council
CMT Member title:
Head of Service title:
Other manager title:

Date:

Lodging this notice

The signed decision must be delivered to the proper officer, Andrew Beesley, Committee Administration Manager, in the Town Hall.

For use by Committee Administration

This notice was lodged with me on____

Signed____

Appendix A: Draft Plan Submission Template

Havering Better Care Fund
Draft Submission (Version 5: 16/1/14)

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	£16,884,018
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 recognised both that:

- 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. This is the vehicle by which the overall strategic leadership will continue to be delivered.

The local community and mental health services provider, North-East London Foundation Trust (NELFT) and the acute provider, Barking and Dagenham, Havering and Redbridge University NHS Hospitals Trust (BDHRT) are members of the Independent Care Coalition (ICC).

Providers have been closely involved in developing the operational aspects of the BCF, for example the development of the service model and implementation plan for the joint Assessment and Discharge service and the developments in Intermediate Care. This will continue.

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 that 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 recognized 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 permanent enhancements to be achieved.
D3	**Joint Strategic Needs Assessment (JSNA) London Borough of Havering ASC Commissioning and**	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/ 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?**	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 pans 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 service 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.

Havering, the Place

Overview

The population of Havering is generally fairly healthy. It has long life expectancy rates, excellent schools, a strong local economy, an active cultural scene and plenty of pleasant green open spaces. As an outer north east London borough, transport connections to the centre of London and surrounding areas are good. However, dig deeper beneath the surface of these facts and there are stark differences in how long people can expect to live, depending on where they live and the circumstances of their upbringing; significant inequalities in how likely certain groups of people are to develop certain illnesses or make unhealthy lifestyle choices; large variations in affluence and poverty; pockets of poor housing; and in some areas, relatively high levels of worklessness.

Population

Havering has 237,200 residents and 243,508 people registered with a Havering GP. It has one of the largest older populations in London, with 21 % (49,000 people) of retirement age. It has a large younger population too, with 24% (56,700 people) aged 19 and under. Population projections show that the population is likely to grow at a faster rate than the London average - 5.4% (12,699 people) by 2016 and 11.5% (27,095 people) by 2021. The projected increase in the older population is likely to result in larger numbers of residents experiencing cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis (and fractures due to falls), incontinence and hearing impairment, placing further demand on local health and social care services, hospitals and community services to help manage long-term conditions.

Deprivation

Havering is ranked 177 out of 326 local authorities for deprivation (with 1 being most deprived and 326 being least deprived). However, pockets of deprivation still exist, with two small areas of Havering falling into the 10% most deprived areas in England (areas in Gooshays and South Hornchurch). When compared to other London boroughs, Havering has a relatively small proportion of children living in poverty. However, 19.3% of children are still estimated to be living in poverty in Havering.

Public perception

Results from the 2011 'Your Council, Your Say' residents survey, carried out by the Council, identified health services as the top priority for local people in making the borough a good place to live. It also found that 25.3% of residents class themselves as having a 'long standing illness or disability'.

Why is this important in Havering?

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer and with a better quality of life.

One of the most effective prevention methods is to reduce the isolation and social exclusion experienced by many older and vulnerable people, which can contribute to mental health conditions such as depression. Tackling isolation will be a focus of our preventative work and more will be done within the community to better support these people.

Our continued focus on reablement and rehabilitation services after a period of illness and support for older and vulnerable people in managing long-term conditions will help to maintain independent living.

What is the current situation in Havering?

Our Joint Strategic Needs Assessment tells us that;

- The retirement population (21 %) is much larger than the London average
- 39,000 people are estimated to have one or more long-term health conditions
- 1,200 older people have particularly complex health and social care needs, with around 900 older people accounting for 38% of all emergency bed days
- A smaller proportion of people receive residential care, nursing care and community services than in England generally
- 16,300 older people are estimated to be living alone and this is predicted to rise to 17,948 by 2020
- Nearly 15,000 older residents are estimated to be unable to manage at least one self-care task on their own and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc.)
- 3,760 older people are estimated to have depression and this is predicted to rise to 4,146 by 2020 (although the level of depression across all age groups is lower than the London and national averages)
- More than 1,100 people are registered blind or partially Sighted
- 5,276 older people are estimated to have diabetes
- There are around 140 excess winter deaths annually, most of whom are older and vulnerable people
- More than 1,900 people are admitted to hospital annually as a result of a fall
- 3,050 older people are estimated to have dementia and this is predicted to rise to 4,691 by 2030
- There are approximately 560 users of learning disability services, of which around 70 are aged 60 plus
- 45.2% (2,656) of adult social care clients receive some form of self-directed support, with 22% of these (578) using a personal budget or direct payment.

- 16,300 older people are estimated to be living alone, which is predicted to rise to 17,948 by 2020
- More than 1,100 people are registered as being blind or partially sighted
- There are around 140 excess winter deaths annually among Havering residents, many of whom are vulnerable older people
- More than 1,900 people are admitted to hospital annually as a result of a fall
- St Francis' Hospice end-of-life care services were used nearly 19,000 times by Havering residents in 2010/11 and demand for services is increasing.

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

- Delivery of Integrated Care Strategy
- Integrated health and social care working through delivering of JAD supporting 7 day working and improved arrangements for admission avoidance and discharge
- Exploring opportunities to utilise joint commissioning roles (notably in MH and LD)
- Supporting a joint and strengthened commissioning role with providers
- Improvements in primary care, improving access to support and interventions in peoples own home and with less reliance upon acute services
- Improvements in prevention, keeping people well and healthy for longer and protecting support for carers
- Improving EoL Care which enables 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.

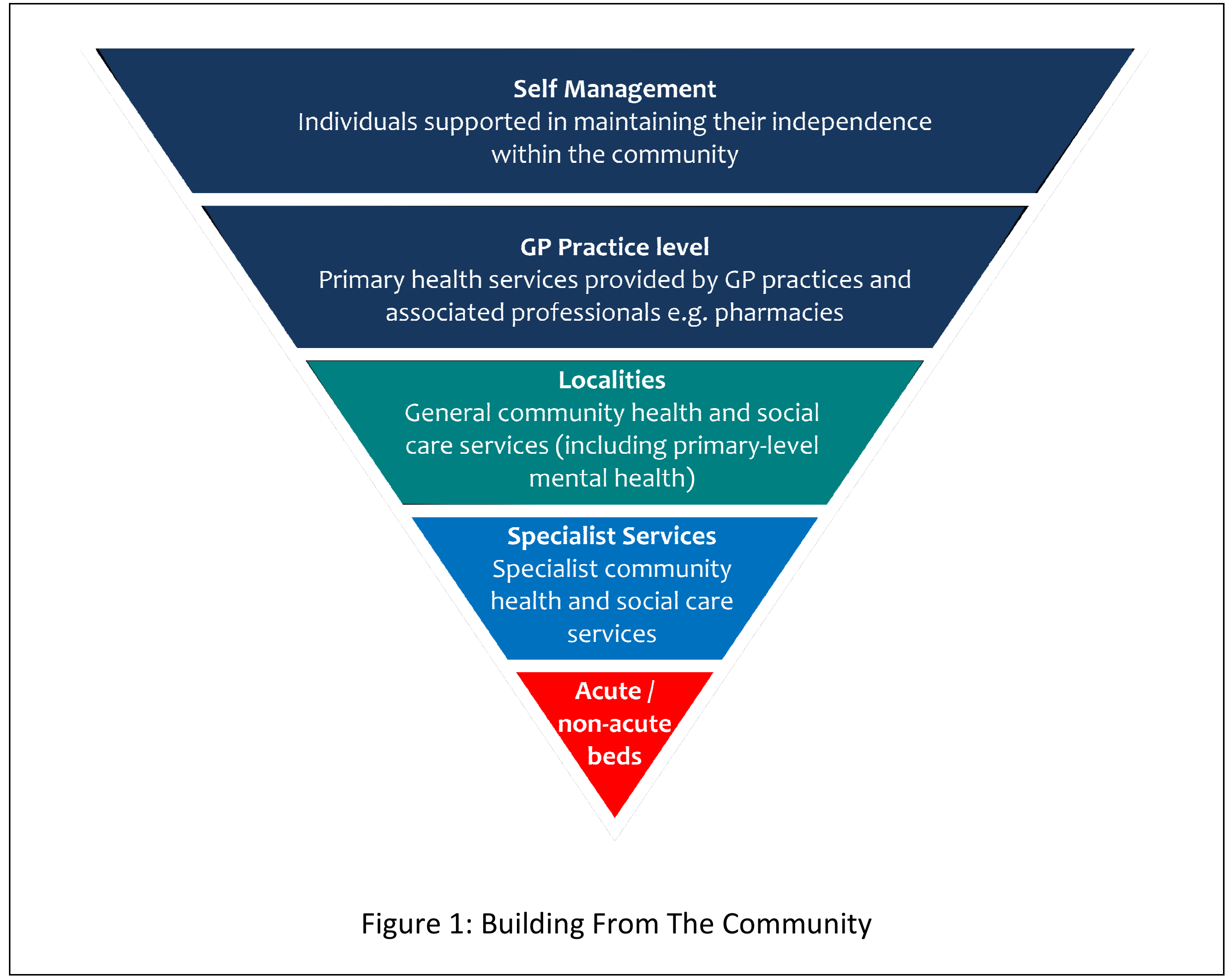


Figure 1: Building From The Community

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 (these are well-represented in our application):

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

- **Putting in place Workforce Development and OD: 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 are 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 maximize 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 our approach are two immediate and important developments (described more fully later in this submission):

- **Establishing a joint assessment and discharge team operating 7 days a week (JAD)**
- **To fully 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. This approach includes mental health professionals to ensure a smooth pathway between locality and specialist provision.**

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, where these are to be employed, and will ensure individuals are familiarized 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 also be reduced and the planned care activity in hospitals will also reduce through 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.

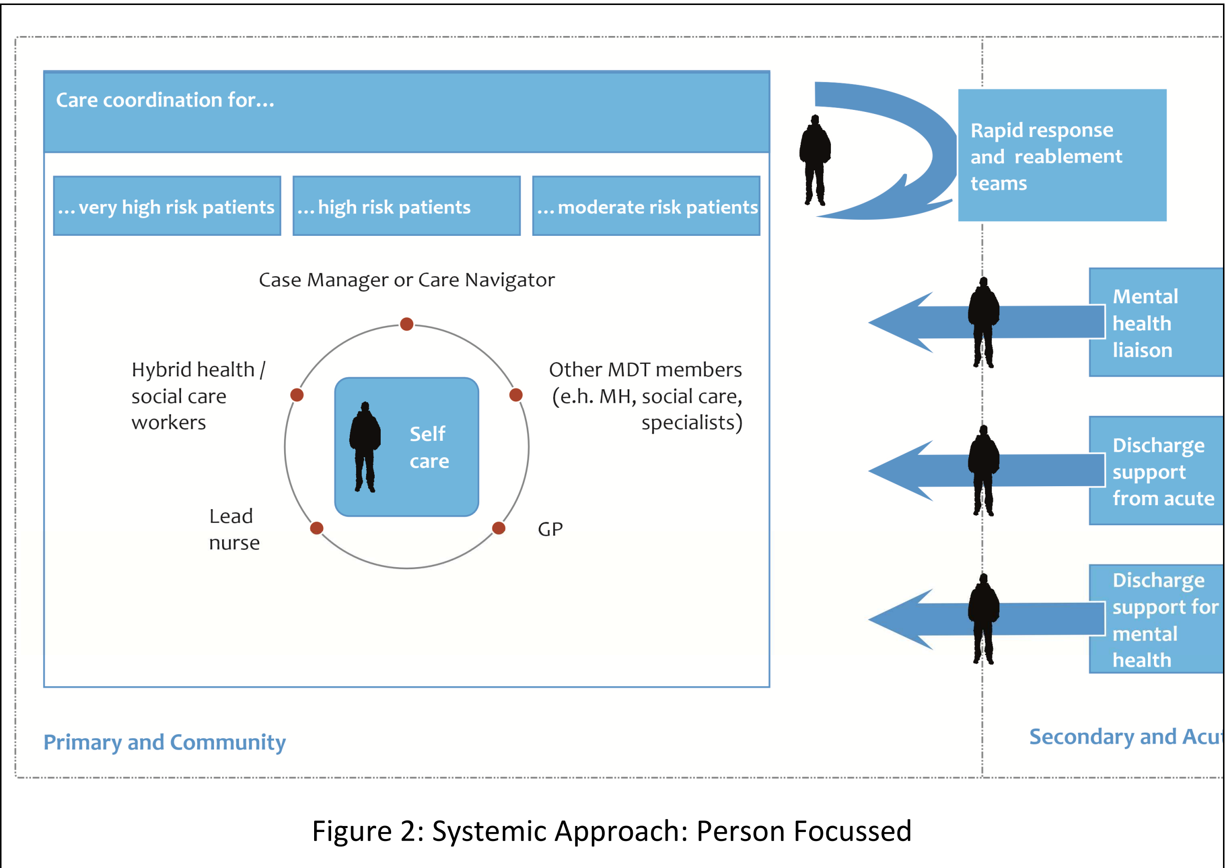


Figure 2: Systemic Approach: Person Focussed

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 morbidities and the cohort where, if not 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 proactive lists/communities are different.
- Increase accountability.
- Would provide the basis for integrating social workers, making them genuinely multi-professional.
- Ensure safeguarding was grounded in locality practice and roe preventative. Both complexity and safety can be subject to localised action, with named coordinators 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.

During the course of '14-15 there will be further detailed development of an integrated community health and social care commissioning function, which will have a jointly agreed land integrated commissioning business plan to support the goals and outcome of this submission. Recruitment to this function is underway.

As a result 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 leverage investments 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.

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.

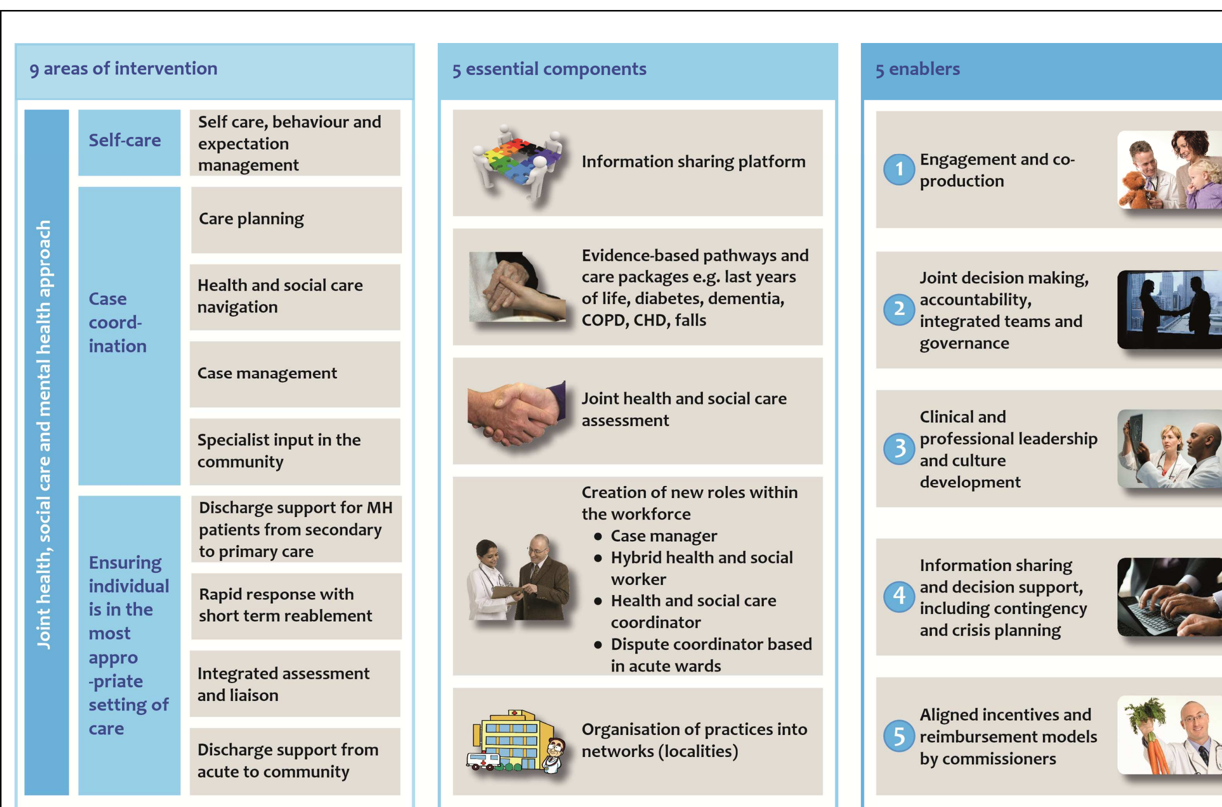


Figure 3: The Change Programme ; Key Interventions for the population, underpinned by components and enablers

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
- Maximising independence by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing
- Through proactive and joined up case management, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to 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, 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 and ensure that our approaches complement alternatives to urgent care, including named GP for the over 75s. 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.

Delivery will reflect the approach visually represented below:

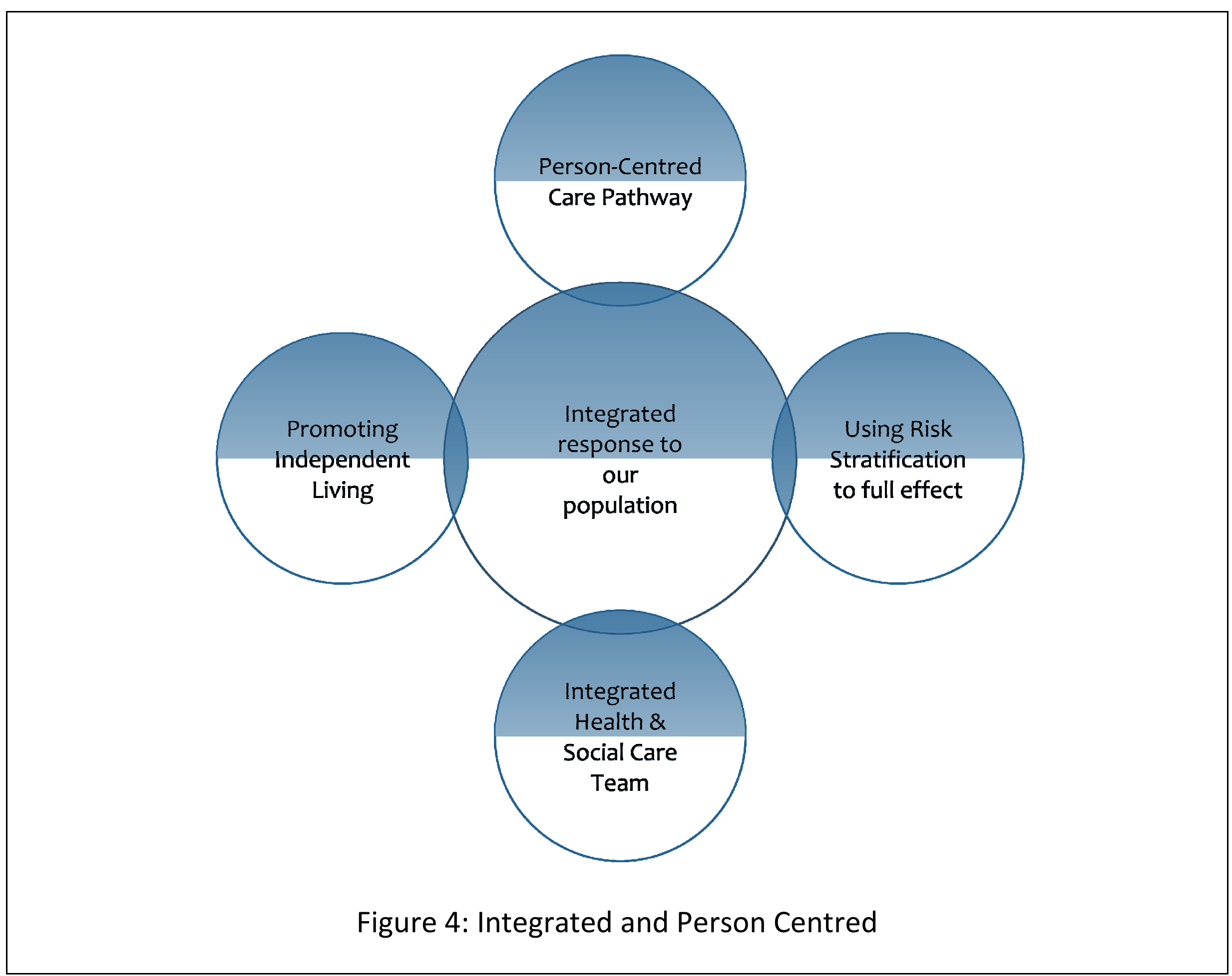


Figure 4: Integrated and Person Centred

Benefits

- Collaborating with providers
- Offering more responsive co-ordinated, proactive care
- Outcome based commissioning, irrespective of commissioner
- Reduced use of expensive resources

Benefits

- Increased choice
- Able to better manage care
- Not having to retell stories
- Staying active and independent
- Able to personalise their care
- Improved outcomes
- Improved co-ordination of care

Commissioners

Users / Patients

Provider organisations

Health economy / Workforce

Benefits

- Collaborating with commissioners
- More responsible for KPIs
- Better incentives to work towards
- Feeling more involved in decisions
- Integrated provider landscape
- Shared Case Record

Benefits

- Able to deliver more for individual
- Maximising individual outcomes
- Able to examine and track wider health trends (e.g. localities/practices)
- A future health and care economy centred around individuals
- Improved VFM and quality

Figure 5: Anticipated Benefits (i)

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 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 agrees 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 JSA 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 under consideration for the wider management of long-term conditions is active.

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 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.

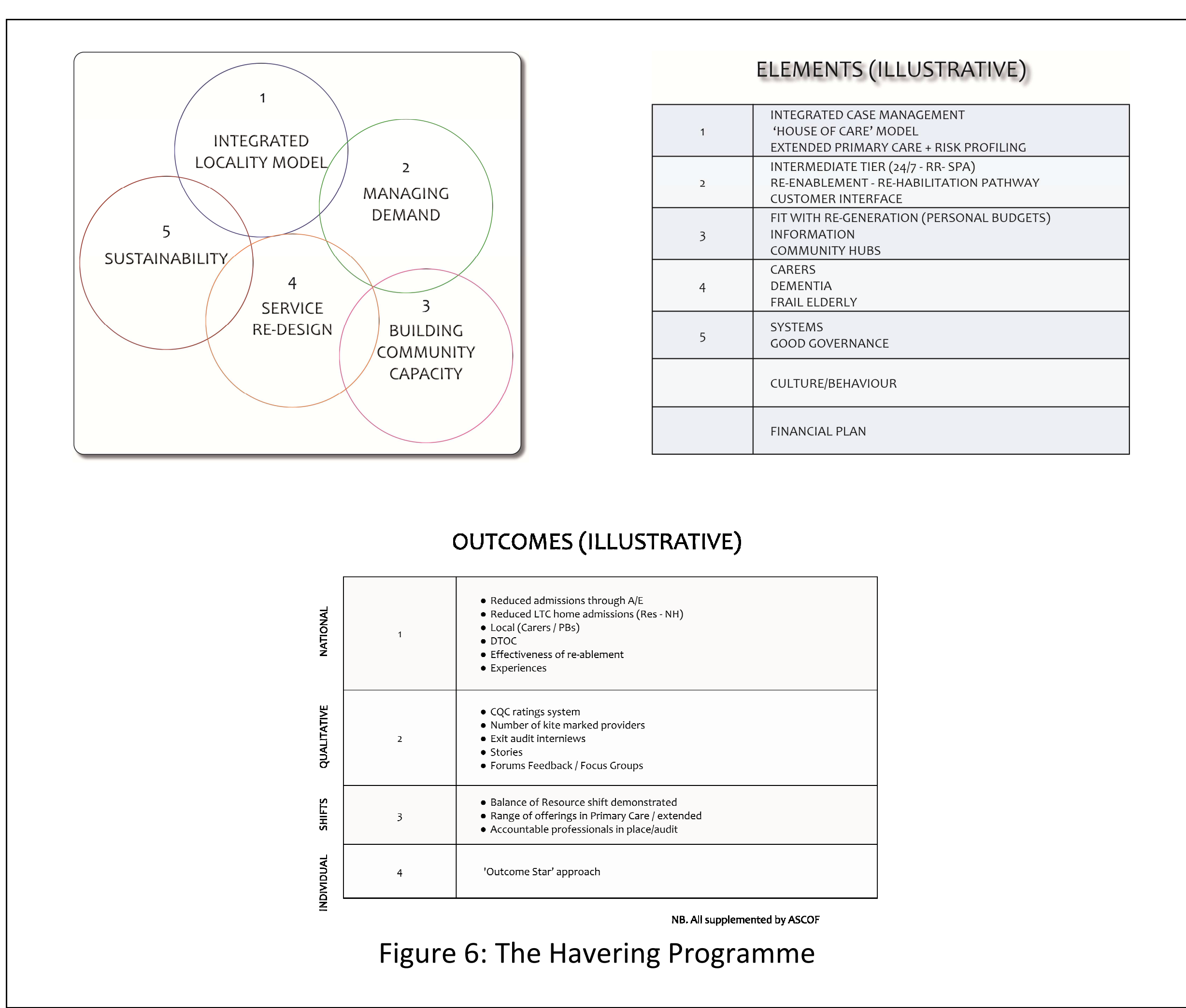
At the centre of this approach is a smaller acute system offering highly specialist care – not when all else fails, but only when all else could never have succeeded

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



ELEMENTS (ILLUSTRATIVE)

1	INTEGRATED CASE MANAGEMENT 'HOUSE OF CARE' MODEL EXTENDED PRIMARY CARE + RISK PROFILING
2	INTERMEDIATE TIER (24/7 - RR- SPA) RE-ENABLEMENT - RE-HABILITATION PATHWAY CUSTOMER INTERFACE
3	FIT WITH RE-GENERATION (PERSONAL BUDGETS) INFORMATION COMMUNITY HUBS
4	CARERS DEMENTIA FRAIL ELDERLY
5	SYSTEMS GOOD GOVERNANCE
	CULTURE/BEHAVIOUR
	FINANCIAL PLAN

OUTCOMES (ILLUSTRATIVE)

NATIONAL	1	• Reduced admissions through A/E • Reduced LTC home admissions (Res - NH) • Local (Carers / PBs) • DTOC • Effectiveness of re-ablement • Experiences
QUALITATIVE	2	• CQC ratings system • Number of kite marked providers • Exit audit interviews • Stories • Forums Feedback / Focus Groups
SHIFTS	3	• Balance of Resource shift demonstrated • Range of offerings in Primary Care / extended • Accountable professionals in place/audit
INDIVIDUAL	4	'Outcome Star' approach

NB. All supplemented by ASCOF

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)**

NB. Work in progress

BCFO 1

Outcomes and Measures

Timescale

BCFO 2

Outcomes and Measures

Timescale

BCFO 3

OUTCOMES AND MEASURES

TIMESCALE

BCFO 4

OUTCOMES AND MEASURES

TIMESCALE

BCFO 5

OUTCOMES AND MEASURES

TIMESCALE

BCFO 6

OUTCOMES AND MEASURES

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TIMESCALE

BCFO 9

OUTCOMES AND MEASURES

TIMESCALE

BCFO 10

OUTCOMES AND MEASURES

TIMESCALE

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 critical part of this submission. It is anticipated that the consequences of the above will reduce unplanned activities, as will the 1475 work on Dementia, Falls and Frail Elderly, taking into account of enhanced case management and improve 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 provides 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 outline 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 specification's procurement and

contracting function for 'community' services (NHS-ASC) with particular emphasis on nursing and residential care, 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 to, work 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. Discussions during '14-15 will focus on the potential for including continuing NHS healthcare, transitions, equipment and FNC.

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 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 require a response and ensure that there are a sufficiency of services in place, extending or procuring new.

[NOTE: Include recent discussions and proposals from Red Cross]

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)

Havering's privacy impact assessment has been completed and signed off by the CCG Governance Board; a template is being populated by Adult Social Care containing client information that will be sent through to colleagues in CCG to obtain the NHS numbers of all our clients. In addition to this we are talking to our software supplier in relation to a script that will be used to import the NHS numbers into the client records on our Swift system. All this is on target for an April deadline. The above is all based on a methodology that has been used by other boroughs.

Once this has been complete we will look to go live with sending information on Social Care Clients through to Health Analytics. This, in turn, will facilitate both the risk and stratification process and active case management of complex needs.

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 there are the top 1% of individuals at a pronounced risk of a hospital admission 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 finalized BCF submission.

Reference/ Rating	**Risk**	**Mitigating Actions**
1 High	With current levels of concern expressed by external bodies in relation to BHR the risk is a failure to make the necessary organisational and system changes that release capacity and resources in line with broader financial and service design requirements. Shifting of resources to fund new joint interventions and schemes will destabilize 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. 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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NHS
Havering
Clinical Commissioning Group

To: Meeting of the Havering Health and Wellbeing Board

From: Alan Steward, Chief Operating Officer, Havering CCG

Date: 19 March 2014

Subject: Draft Five Year Strategic Plan

Executive summary

The purpose of this report is to provide members of the Health and Well Being Board with:
- The draft 5 Year Strategic Plan for the Barking & Dagenham, Havering and Redbridge health economy
- The next steps before to submission of the draft plan to NHS England on the 4 April 2014.

Recommendations

The Health and Well Being Board is asked to:
- Note the draft five Year Strategic Plan and next steps
- Comment on the draft five year Strategic Plan prior to final submission

1.0 Purpose of the Report

This report presents the latest draft of the draft five Year Strategic Plan for BHR systems and provide the opportunity to comment and influence development of the plan prior to submission of the first draft to NHS England on 4 April 2014.

2.0 Background/Introduction

Everyone Counts: Planning for Patients 2014/15 – 2018/19 was released on 20 December 2013. It builds on the 2013/14 planning guidance and sets out a framework within which commissioners need to work with partners in local government and providers to develop strong, robust and ambitious five year plans to secure sustainable high quality care for all.

The Integrated Care Steering Group has been leading the development of the five year Strategic Planning process, as agreed by the Integrated Care Coalition.

3.0 The BHR Strategic Plan

The five year strategic plan comprises a high level system narrative 'plan on a page' and a more comprehensive 'key lines of enquiry' section which includes the system vision, enquiries around current position, improving quality outcomes, sustainability and improvement interventions.

3.1 The draft five Year Strategic Plan has been developed using the CCGs' Operating Plan and the Better Care Fund plans to provide the foundations of the five year Strategic Plan. In addition to this, the development of the strategic plan has been discussed at the following forums and feedback has gone into the latest draft:

- 10 February 2014: The Integrated Care Coalition workshop
- 13 February 2014: CCGs Governing Bodies away day
- 19 February 2014: Integrated Care Steering Group workshop

Outputs from the 'Call to Action' themes have also been considered and incorporated into development of the plan.

3.2 **Next steps**

The next steps for the draft five Year Strategic Plan is as follows:

- The Integrated Care Steering Group meeting on the 19 March will review and update the plan taking into account comments from the stakeholders.
- Integrated Care Coalition will consider the revised draft plan at its meeting on the 31 March before submission on the 4 April.
- The final plan needs to be submitted on the 20 June 2014.

4.0 Resources/investment

There are no additional resource implications/revenue or capitals costs arising from this report.

5.0 Equalities

There are no equalities implications arising from this report.

6.0 Risk

There are no risk implications arising from this report.

Attachments:

1. Draft Strategic Plan
2. Everyone Counts: Planning for Patients 2014/15 – 2018/19 can be accessed via the following link http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Author: Alan Steward
Date: 13 March 2014

Attachment 1: Draft Strategic Plan

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Strategic Plan draft submission

Draft as at 28 February 2014

BHR strategic headline plan on a page

The BHR health economy is comprised of partners from Barking and Dagenham CCG, London borough of Barking and Dagenham, Havering CCG, London borough of Havering, Redbridge CCG, London borough of Redbridge, Barking, Havering and Redbridge University Hospitals Trust and North East London Foundation Trust; who have come together to agree, refine and implement the following vision: Improving health outcomes for local people through best value health care in partnership with the community.

System Objective 1
To reduce the number of years of life lost by 23%

Delivered through prevention and health promotion
Programmes of work informed by local JSNAs and London wide preventative agenda.
Target areas: obesity/dementia/reduce inequalities/diabetes/cardiovascular disease/cancer/smoking cessation/breastfeeding/alcohol and substance misuse

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

Delivered through primary care improvement plan
Providing new ways to access primary care and finding new ways to provide innovative services designed around the needs of the patient to reduce acute admission and A&E attendance and increase positive patient experience.

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

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

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

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

System Objective 5
To reduce the percentage of people reporting a poor experience of inpatient care by12%

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

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

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

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

System Objective 7
To reduce hospital avoidable deaths

Delivered through childrens services improvement plan
Implementation of an Integrated Single Assessment process. Develop assessment process for children needing an EHC plan, Local Offer agreement to be confirmed and put children on EHC plans with cessation of 'statement system'

Overseen through the following governance arrangements

- Health and Wellbeing Boards (HWBB) oversee the process for strategic planning in each borough
- Integrated Care Coalition (ICC): an advisory group to HWBBs - bringing senior leaders together to build a sustainable health and social care system
- The coalition has two subgroups:
  - Integrated care steering group: development and delivery of strategic plan
  - Urgent care board: improvement plan for urgent care
- All work streams have identified leads

Measured using the following success criteria

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

High level risks to be mitigated

- BHRUT quality and performance issues
- Achieving financial targets
- Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership)
- Balancing increased patient expectation with improved outcomes at a time of less resource

Section Two | Key lines of enquiry (KLOE)

Segment	Key Line of Enquiry	Organisational Response	Supported by
Submission details System vision	Which organisation(s) are completing this submission?	The organisations completing this submission comprise of: ▪ Barking and Dagenham Clinical Commissioning Group ▪ Havering Clinical Commissioning Group ▪ Redbridge Clinical Commissioning Group ▪ London Borough Barking and Dagenham ▪ London Borough Havering ▪ London Borough Redbridge ▪ North East London Foundation Trust ▪ Barking Havering and Redbridge University Hospital Trust The senior leaders from the above organisations have committed to work together as the Integrated Care Coalition to support the three Clinical Commissioning Groups (CCGs) and the three Local Authorities in commissioning integrated care and ensuring a sustainable health and social care system. The Integrated Care Coalition (ICC) oversees the development of the 5 year strategic plan but has delegated formal authority to the Integrated Care Steering Group (ISCG) to co-ordinate on its behalf the production of the 5 year strategic plan.	ToR Integrated Care Coalition. Yellow font denotes specific reference to strategic planning Adobe Acrobat Document ToR Integrated Care Steering Group: Adobe Acrobat Document
	In case of enquiry, please provide a contact name and contact details	Ramesh Rajah BHR CCGs, Programme Management Office Tel: 0208 926 5327 Email: Ramesh.Rajah@onel.nhs.uk Jane Gateley	

		BHR CCGs, Director of Strategic Delivery Tel: 0208 926 5136 Email: Jane.Gateley@onel.nhs.uk Emily Plane BHR CCGs, Project Manager – Strategic Delivery Tel: 0208 822 3052 Email: Emily.Plane@onel.nhs.uk	
	What is the vision for the system in five years' time?	The vision for the BHR health economy is improving health outcomes for local people through best value health care in partnership with the community. In 5 years time the BHRUT economy aims to improve health outcomes for local people through best value health care in partnership with the community including: ▪ reducing the number of years of life lost by 23% ▪ improving health related quality of life for those with 1+ LTCs by 4% ▪ reducing avoidable time in hospital through integrated care by 13% ▪ increasing the percentage of older people living independently following discharge (rate to be confirmed) ▪ reducing the percentage of people reporting a poor experience of inpatient care by12% ▪ reducing the percentage of people reporting a poor experience of primary care by 15% ▪ reducing the number of hospital avoidable deaths (rate to be confirmed) In 5 years time patients will have better experiences of inpatient and primary care, will spend less avoidable time in hospital, will have a greater chance of living independently following discharge from hospital and will experience improved health related quality of life for those with one or more Long Term conditions. Services will work together more closely, functioning as a more integrated	PDF DRAFT BHR Plan on a Page.pdf Borough teams will be reviewing trajectories and may be updated for the next submissions.

		system delivering high quality health and social care to patients closer to home.	
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised services concentrated in centres of excellence (as relevant to the	The vision statement for the BHR health economy characterises the six high quality and sustainable system and transformational service models through: 1. The responses from citizens to the local Call to Action events held in response to the NHSE challenge to ensure that future development of services is framed around the 'I' statements to ensure that what the patient wants is at the heart of service development going forward . Local citizens specifically stated that they wanted: ▪ Better access to primary care ▪ Partnership working with social care/integrated care ▪ improved hospital performance ▪ involvement of voluntary sector ▪ more support for carers ▪ improved patient engagement/communication In addition, citizens have also contributed in the development in the following areas ▪ On-going patient experience evaluation for Integrated Care and Community service developments. ▪ Patient involvement is the design and development of the Acute Reconfiguration developments to ensure new services delivers improved performance, better outcomes and patient experience. The following areas have been identified to support the prevention and health promotion programme: ▪ Obesity ▪ Dementia ▪ Reduction in health inequalities ▪ Diabetes ▪ Cardiovascular disease	*Details provided within the activity and financial templates which will be triangulated.*

	locality)	▪ Cancer ▪ Smoking cessation ▪ Breastfeeding ▪ Alcohol and substance misuse 2. Providing new ways to access primary care and finding new ways to provide innovative services designed around the needs of the patient to reduce acute admission and A&E attendance and increase positive patient experience. These include: ▪ Weekend access ▪ Core hours plus ▪ 6-10pm appointments ▪ Triage service ▪ Primary care provider support ▪ Dedicated registered list ▪ Specialist expertise ▪ Implementation of unified point of access 3. Implementation of the BHR Integrated Care Strategy designed to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), and in particular to locality settings. The strategy seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to the quality of experience and outcomes. In 5 years, Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000 – check number) to enable more proactive management of the population. The focus will be on those with LTCs, high service users, and those vulnerable to decline. 4. Acute Reconfiguration programme building on Health for North East London work to reconfigure local A&E and maternity services in order to improve the care for the local people and a new and effective 24/7 Urgent Care Centre facilitated through the UCC procurement process running through to 2014/15.	

	5. Delivered by building on the Health for North East London programme for plan care which should see an improvement in the clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. Other developments include productivity improvements for MSK and ophthalmology pathways, service redesign for the diabetic pathway and a re-procurement of the Independent Sector Treatment Centre. 6. Specialised services narrative to be completed following discussion with NHS England.	
How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?	*A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?* Two year financial projections on all boroughs have been completed and the five year plans are currently being finalised. All plans leading up to 2018/19 will be designed to deliver a surplus. The plans are currently being risk assessed to ensure sustainability. *B)* The schemes / projects identified in the BCF / Operating Plan are consistent with those in the BHR system wide Integrated Care strategy. The schemes are linked to the 6 characteristics outlined on the plan on the page and mapped directly to the 7 ambition areas. C) Each Borough within the BHR economy has reviewed their baseline position for the seven ambitions targets and has planned five year reductions to align performance to equitable levels across the patch, as well as (where possible), closer to, or performing better against the national average. This is reducing health inequalities within the BHR system, which will make a significant change to the lives of patients living in Barking and Dagenham. The supporting evidence to the right illustrates this shift towards equitable performance across the BHR economy.	*BCF Schemes have been mapped to 7 outcome measures* Redbridge: Mapping Schemes against 7 Outcome Measures BHR 5 year target projections.pdf
Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing	The Integrated Care Coalition has endorsed the Strategic Vision. The Integrated Care Coalition (including members of Health and Wellbeing Boards) were involved in development of the Strategic Plan, reviewing the draft plan 10 January 2014 and holding an Integrated Care Coalition workshop on 10 February where members reviewed progress and endorsed the vision.	

	off the plan?	A BHR CCGs Governing Body Away Day took place on 13 February 2014 where members reviewed the plan on a page which was then updated incorporating feedback. The draft Operating and BCF plans submitted on the 14 February were reviewed and signed off by the Health and Wellbeing Board in each Borough on the following dates: ▪ Barking and Dagenham HWBB reviewed and approved on the 11 February 2014. The development of the BCF was overseen by the H&WB Integrated Care sub-group which has membership across health and social care as well as from key providers. ▪ Havering submission was agreed by the Havering Wellbeing Board at its formal meeting on Wednesday 12 February 2014. It was then subsequently the subject of an Executive Decision by Councillor Steven Kelly, Leader of the Council, Chair of the Health and Wellbeing Board and Portfolio Holder for Individuals on the 13th February 2014. ▪ Redbridge HWBB meeting – the draft plans were submitted on the 14 February subject to the HWBB review on the 17 February. The HWBB has now taken place and the draft plans were reviewed and agreed.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	Integrated Care Strategy initiatives are embedded in the Better Care Fund plans, with the focus in years one and two being on the following initiatives: ▪ Integrated Case Management ▪ Community Treatment Teams ▪ Joint Assessment and Discharge Team These are key enablers to deliver the 5 year strategic vision.	
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	To respond to the challenge of the NHSE Call to Action, each borough undertook a series of engagement events over the October to December 2013 period. These involved and covered a wide range of stakeholder groups. Following the sessions, the following themes were identified: ▪ Better access to primary care ▪ Working in partnership with social care/integrated care	

		▪ improved hospital performance ▪ involvement of voluntary sector ▪ more support for carers ▪ improved patient engagement/communication The feedback from the CTA engagement programmes have informed and assisted in the development of CCGs' local and strategic five year plans for their respective populations.	
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included	We will report back to public and patients at our regular CCG Patient Engagement Forums (PEFs) with cascade down to the practice level, Practice Participation Groups (PPGs). This will be based on our identified themes from local Call To Action engagement as described above and how those themes helped shape our strategic plan.	
Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	Yes, the Health for North East London programme of work (2009-2011) and Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case (November 2012) included in-depth assessment of the current state of the BHR economy. Other assessment included the 'Integrated Care in Barking & Dagenham, Havering and Redbridge Case for Change' in 2012 which formed the foundation for development of the BHR Integrated Care Strategy. Supporting Evidence: ▪ Developing a Viable Acute Services Provider Landscape in North East London - INEL and ONEL Sector PCTs and acute trusts Case for Change (03 December 2008) ▪ Decision Making Business Case – December 2010 ▪ August 2012: Integrated Care in Barking and Dagenham, Havering and Redbridge Case for Change ▪ November 2012: Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case	DMBC 021210 FINAL V1.0.pdf NEL Case for change_v20b 081201 C4C.pdf DMBC 021210 FINAL V1.0.pdf

<table>
<tr><td></td><td></td><td> The first draft submission also considered the JSNA and the Health and Wellbeing Strategy to identify and agree the priorities for each borough. In addition to this, each borough also undertook a review of the Commissioning for Value packs to understand the current benchmarked position against similar organisations in London and against statistical neighbours. Following the analysis of the above sources, the schemes identified were mapped against the 7 ambitions areas to deliver the improvements required over the next 5 years. </td><td></td></tr>
<tr><td></td><td>Do the objectives and interventions identified below take into consideration the current state?</td><td> BHR Better Care Fund Plans are directly informed by and build upon the Integrated Care in Barking and Dagenham, Havering and Redbridge Case for Change. Objectives and interventions identified have been developed following a review of the current state of the BHR economy. Ongoing patient engagement and review of performance feeds into service development. Baselines for the 2 year BCF metrics and the 5 year operating plan trajectories take into account the current baseline performance. </td><td></td></tr>
<tr><td></td><td>Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?</td><td> BHR Better Care Fund Plans are directly informed by and build upon the Integrated Care Case for Change in Barking & Dagenham, Havering and Redbridge. Phase 1 and 2 of the strategy, which includes non acute bed quality / productivity improvements, development of the Community Treatment Team and the Intensive Rehab Service, has been delivered. The foundations for the strategic vision is also based on the Acute reconfiguration programme to reduce the number of sites with emergency care provision, centralise the workforce, increase senior cover and improve quality of care for patients and deliver services that meet the London Quality standards. </td><td></td></tr>
<tr><td>Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td><table>
<tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr>
<tr><td>To reduce the number of years of life lost</td><td>Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people</td><td>To reduce the number of years of life lost by 23%</td></tr>
<tr><td>To improve health related quality of life for those with 1+ LTCs</td><td>Health related quality of life for people with long term conditions (sum of the weighted EQ-5D values)</td><td>To improve health related quality of life for those with 1+ LTCs by 4%</td></tr>
<tr><td>To reduce avoidable time in hospital through integrated care</td><td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td><td>To reduce the number of avoidable hospital admissions by 13%</td></tr>
</table></td><td>Data analysis packs for each of the three BHR Boroughs detailing historic performance against each</td></tr>
</table>

To increase the % of older people living independently following discharge	Number of people age 65+ discharged from hospital into reablement/rehabilitation services still at home after 91 days *NB: No indicator available at CCG level to set quantifiable level of ambition against. However CCG plans on this ambition should be making explicit links to the related ambition as part the Better Care Fund, set for 2 years at Health & Wellbeing Board level*	No indicator available at CCG level to set quantifiable level of ambition against
To reduce the % of people reporting a poor experience of inpatient care	Patient experience of hospital care	To reduce the % of people reporting a poor experience of inpatient care by12%
To reduce the % of people reporting a poor experience of primary care	Patient experience of GP services and GP Out of Hours service	To reduce the % of people reporting a poor experience of primary care by 15%
To reduce hospital avoidable deaths	Incidence of healthcare associated infection (MRSA and C.DIFF *NB: Baseline data not yet available at CCG level to set quantifiable level of ambition against. However 'case note review' data will be available to measure progress on local plans in the next few years*	Baseline data not yet available at CCG level to set quantifiable level of ambition

measure, trend analysis, position against national average and position against fellow BHR Boroughs.

How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	The engagement process as part of the development of the BHR Integrated Care Strategy (which is the foundation for the Better Care Fund Plans) included engagement with clinicians and community stakeholders. Clinicians were also actively involved in the H4NEL proposals through the Clinical Working Groups that were established to produce recommendations for the H4NEL programme. Draft plans have been shared and reviewed with the Joint Executive Teams, the Integrated Care Coalition, and at Governing Body workshops; clinicians are key members of these groups and have fed into the development of the Strategic Plan via these groups. Clinical Directors have actively been involved in the development of plans at Borough levels.	
What data, intelligence and local analysis were explored to support the development of plans for improving outcomes	Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case in 2012 reviewed a range of data and local analysis including the A&E attendance and emergency admissions as well as mapping of non acute beds in the community in order to support the development of the strategy.	Redbridge baselines & trajectories.pdf

	and quantifiable ambitions?	The H4NEL Case for Change and business case undertaken in 2008/09 looked at a range of data / intelligence including • Growth in demand linked to projected population growth and changes in medical technology and patterns of care • Reductions in demand for hospital care linked to out of hospital care strategies and commissioning initiatives • Hospital productivity improvements • Activity flows are expected to be affected by the reconfiguration of services Data analysis packs for each of the three BHR Boroughs detailing historic performance against each measure, trend analysis, position against national average and position against fellow BHR Boroughs and review and incorporation of JSNA recommendations for each of the three BHR Boroughs.	B&D Ambitions & BCF baselines & trajectori Havering baselines trajectories narrative
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	The local JSNA / Health and Wellbeing Strategy have driven the identification of the quantifiable ambitions. The outcomes identified have been mapped to the JSNA and the 7 ambitions to ensure alignment and fit.	
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	H&WBB have played an active role in developing plans in each borough; H&WBB members part of Coalition with responsibility for the reviewing and signing off the Strategic Plan. The draft BCF templates were signed off by HWBB Members of the Health and Wellbeing Board have also been involved in the following forums ▪ Integrated Care Coalition Workshop ▪ BHR CCGs Governing Body Away Day ▪ Integrated Care Steering Group Workshop	
Sustainability	Are the outcome ambitions included within the sustainability	The outcome ambitions have been included as part of the sustainability calculations for the 2 and 5 year plans. The finance / QIPP plans for the next 2 years are being finalised. This will be then be used for agreeing the resource	

	calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	plans going forward for years 3-5.	
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Yes, the key themes raised from local engagement were: ▪ Better access to primary care – (See Primary Care [Intervention 2] in Improvement Interventions section of this template) ▪ Linking with social care/integrated care – (See Integrated Care Programme [Intervention 3] in Improvement Interventions section of this template) ▪ Improved hospital performance – (See Integrated Acute Reconfiguration [Intervention 4] in Improvement Interventions section of this template) ▪ Involvement of voluntary sector – engagement of the public and patients in the design of pathways ▪ More support for carers ▪ Improved patient information / communication – relevant to all interventions of the BHR Strategic Plan ▪ Service co-design with patients and voluntary sector – relevant to all interventions of the BHR Strategic Plan	
	Can the plan on a page element be identified through examining the activity and financial projections covered in operational and financial templates?	The plan on a page outcome targets for the BHR economy can be identified through examining of the activity projections covered in the operational templates. A mapping exercise has been completed using the baseline and five year reduction targets for each of the BHR Boroughs to produce a consolidated summary position of the BHR target projections for the BHR strategic plan outcome measures (see supporting evidence). Outcomes 4 and 7 are not covered in the activity projections in the operational template, as baseline data is not available. Ref - NHS England guidance document for commissioners 'Setting 5-year ambitions for improving outcomes' (Gateway reference: 00893) states, baseline data is not available for these outcomes.	

		CCGs however are reviewing local data to make explicit links to the related ambition as part the Better Care Fund.	
Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to success • Confidence levels of implementation	**Intervention One: Prevention and Health Promotion** Prevention and health promotion forms the foundation of our Strategic Plan schemes. JSNAs have identified the following areas for targeting: ▪ Reduction in obesity ▪ Dementia: earlier identification and diagnosis of dementia to improve treatment ▪ Reduction in health and social equalities ▪ Diabetes: earlier identification and diagnosis of dementia to improve treatment ▪ Cardiovascular disease ▪ Improve early diagnosis of Cancer and treatment times ▪ Targeted action to improve smoking cessation ▪ Improve levels of Breastfeeding ▪ Improved treatment of alcohol and substance misuse The London wide elements of the plan is being progressed by Dr Kathie Binysh with borough public health leads. A meeting has been tentatively set for the 10 March to discuss. Expected Outcome ▪ Reduced numbers of patients attending A&E ▪ Reduced health inequalities ▪ Increase in patient Friends and Family test score ▪ Reduced number of non elective emergency admissions ▪ Reduction in the number of patients with multiple LTCs Investment costs	

	The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	▪ Financial costs ▪ Non-Financial costs <u>Implementation timeline</u> ▪ TBC <u>Enablers required</u> ▪ Stakeholder engagement is crucial ▪ Innovative use of social media to raise awareness <u>Barriers to success</u> ▪ Stakeholder engagement ▪ Limited resource **<u>Intervention two: Primary Care Improvement Plan</u>** The Barking & Dagenham, Havering and Redbridge Primary Care Improvement Plan aims to allow local GPs to lead a system that educates patients, reduces unplanned attendance and reduces hospital admissions by: ▪ Extending standard primary care provision ▪ Providing easier access to clinical support prior to A&E ▪ Supporting better planned care <u>Interventions required:</u> ▪ Weekend access ▪ Core hours plus ▪ 6-10pm appointments ▪ Triage service ▪ Primary care provider support ▪ Dedicated registered list ▪ Specialist expertise	

- Implementation of unified point of access

Expected Outcome

- Reduced numbers of patients attending A&E
- Increase in patient Friends and Family test score
- Reduced number of non elective emergency admissions
- Number of patients supported by the complex care service

Investment costs

£000's	NHS England Non-Recurrent	Partner Non-recurrent	Capital	Total
Year 1	5,671	2,000	5,000	12,671
Year 2	0	4,000	0	4,000
Total	5,671	6,000	5,000	16,671

Implementation timeline: **Formal project start/finish: 01.04.14 – 31.03.16**

- Scheme 1: Improved Access; 14.04.14 – 28.02.15
- Scheme 2: Complex Care; 30.06.14 – 28.02.15

Barriers to success:

- Finance – dependence on Prime Minister's challenge fund bid to initiate this plan
- Information Governance – linking IT system across different organisations
- Engagement with key stakeholders
- 6 month timeframe to establish Unified point of access

Intervention three: BHR Integrated Care Programme

Following extensive public engagement the BHR economy published a case for change in August 2012. The resulting vision and strategy for integrated care has been developed with needs of people at its heart, helping them to live well, and independently, for as long as possible and empowering and supporting them to self care.

PERSON CENTRED CO-ORDINATED CARE: designing care around patients making sure that they receive the right care in the right place, at the right time,

and ensuring that different services “talk” to each other, reducing inefficiencies in care

The strategy is to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), and in particular to locality settings. 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.

<u>5 year vision:</u>

Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000 – check number) to enable more proactive management of the population. The focus will be on those with LTCs, high service users, and those vulnerable to decline.

This will result in less demand for community beds, with resources transferred into multi disciplinary team based around GP practices supported by borough level community response teams.

Services will be jointly commissioned based on outcome measures and designed based on the principles set out in National Voices.

<u>Characteristics of new service model:</u>

- Risk stratification of patients
- care planning across the comprehensive needs of individuals
- care co-ordination, with clarity on who is responsible for patients with each level of acuity, linking to established disease pathways as appropriate , and end of life protocols as required
- a single point of access to the team for patients/service users and their carers through co-ordinators and a 24/7 number
- strong partnership and pathways with the voluntary sector.

A Joint Assessment and Discharge Team will operate across the system to facilitate the safe return home of patients

<u>Supported and enabled by:</u>

- The Better Care Fund

		▪ Technology enabling information and data sharing ▪ Aligned funding arrangements and incentives across the system including personal budgets and building on local Year of Care work ▪ Frailty Academy Expected Outcome ▪ Reduced A&E attendances and emergency admissions ▪ Reduced admissions to residential and nursing care ▪ Reduced delayed transfers of care ▪ Effectiveness of re-ablement ▪ Improved patient/user experience ▪ Reduced % of hospital deaths ▪ Shared care record Investment costs ▪ Financial costs ▪ Non-Financial costs Implementation timeline: ▪ TBC Barriers to success: ▪ Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership) ▪ Service delivery across organisational boundaries Confidence levels of implementation: ▪ TBC **Intervention four: Acute re-configuration programme** The Health for NE London programme aims to improve health services for local people. The key objectives are:	

- Urgent and emergency care – to be provided at 5 hospitals in NE London at Queens, Whipps Cross, The Royal London, Homerton and Newham, with urgent care being enhanced at all hospitals (A&E services are therefore transferring from King George Hospital)
- King George Hospital to provide 24/7 urgent care and short stay assessment and treatment services, including location of a GP practice at the polyclinic site
- Maternity - to establish and relocate KGH maternity services on to Queens site
- Planned Care Development; see separate Planned Care Intervention below

Moving forward, implementation plans will take account of Sir Bruce Keogh's recommendations for urgent and emergency care across England:

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

In 5 years time, service users will see

- A transformed Emergency Department at Queens Hospital with improved A&E quality of services
- New and effective 24/7 Urgent Care Centres at Queens Hospital and King George Hospital (facilitated through Urgent Care Procurement process running through 2014/15)
- A centralised and expanded critical care services

- Being treated by a centralised workforce with increased senior cover that will improve quality of care for patients to those that meet the London Quality standards.

Interventions required:

- Emergency Department Business Case
- Urgent Care Procurement
- Maternity reconfiguration has been achieved by working closely with NE London providers. Full relocation of maternity services completed March 2013 following the sign off from NHS London.
- KGH vision - Delivered through the development of KGH as a centre of excellence for Women's and Children's services.

Expected Outcome

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

Investment costs

- Financial costs
- Non-Financial costs

Implementation timeline:

- December 2015

Barriers to success:

- Risk that performance improvements on A&E target, LoS and bed reductions not delivered.
- Possible slippages in the timelines due to delays in the process
- Risk that UCC service model does not deliver the agreed utilisation rates.

Confidence levels of implementation:

- TBC

Intervention five: Planned Care Programme

The Barking & Dagenham, Havering and Redbridge Planned Care Programme aims to improve health services for local people by separating planned surgery pathway from emergency pathway, where appropriate.

Enabled through:

- Moving planned surgery from Queen's Hospital to King George Hospital except where there are benefits in co-locating services or clinical need
- Development of a local kidney dialysis service at King George Hospital.
- Productivity (MSK and Ophthalmology), service re-design (diabetic) and the re-procurement of the Independent Sector Treatment Centre.

Expected Outcome

- To reduce the number of years of life lost
- To increase the percentage of older people living independently following discharge
- To reduce the percentage of people reporting a poor experience of inpatient care
- To reduce hospital avoidable deaths

Investment costs

- Financial costs
- Non-Financial costs

Implementation timeline:

- TBC

Barriers to success:

- Risk that performance improvements will not be delivered

Confidence levels of implementation:

- TBC

Intervention six: Specialised Commissioning Services

The vision for Specialised services commissioned is to consistently deliver best outcomes and experience for patients, within available resources

Interventions required:

- Compliance with service specifications
- Consistent achievement of service standards
- Benchmarked outcomes in London, England and internationally, identifying the best practice to emulate
- Engage patients in service / pathway development and contract management
- Through contract management, ensure patient feedback is heard and acted upon throughout providers commissioned
- Co-commission with CCGs and Local Authorities
- Develop and implement best practice patient pathways for individual services, ensuring they are incorporated into national service specifications
- Understand the cost of services commissioned
- Converge prices
- Alignment of incentives
- Contract management

Expected Outcome

- Specialised services commissioned in London are consistently in the top decile for outcomes across all providers
- Continually improve patient experience for each individual
- Maintain the integrity of the care pathway for patients of specialised

services

- Contain the cost of specialised services through Quality, Innovation, Productivity and Prevention, in partnership with providers and other service commissioners

Investment costs

- Financial costs
- Non-Financial costs

Implementation timeline:

- TBC

Barriers to success:

- Alignment with national specialised services strategy due to strategy developments working to different timelines
- Resource capacity – improved matrix working and new ways of working

Confidence levels of implementation

- To be updated by NHS England

Intervention seven: Mental Health Services

A Strategic Commissioning Framework for Mental Health is currently being developed in response to "Closing the Gap: Priorities for essential change in mental health" which was published on January 2014. The framework is expected to be completed by June 2014 and will be jointly developed through the mental health subgroups of the respective Health and Wellbeing Board.

The completion of the full roll-out of the access to psychological therapies programme by 2014/15 and that every CCG plan will include at least 15% of adults with relevant disorders having timely access to services is reflected within the Borough Operating Plans.

Intervention eight: Children's Services

One of the key priorities being taken forward is the need to have an Integrated

		Single Assessment process with Education, Health and Care Plan (EHC) having similar status to the Statement of Special Educational. The key actions to be in place by September 2014 are: • An assessment process for children needing an EHC plan. • Local Offer (capturing the nature and scale of all services available) agreement confirmed • Start to put children on to EHC plans and the cessation of the current 'statement system'. National guidance expected soon will confirm deadlines on when this should complete by. The CCGs and the Local Authorities will be working in collaborative partnership arrangements to deliver the priority. The CCGs and the Local Authorities will also be working together to deliver the Safeguarding and looked after children outcomes required in the Children and Families Bill.	
Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	The supporting evidence attached details the Governance Structures in place within the BHR economy to ensure future plans are developed in collaboration with key stakeholders. This is underpinned by ongoing engagement with patients (via Patient Engagement Forums, as well as other methods of engagement such as periodical telephone interviews with patients accessing the Community Treatment Team and Intensive Rehab Service, the outcomes of which directly feed into ongoing service development).	Adobe Acrobat Document
Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	The Integrated Care Coalition are signed up to a set of articulated Values and Principles underpinning BCF (final version to be agreed at Integrated Care Coalition meeting on 31.03.14), Operating and Strategic Plans which are embedded in both organisations and programmes of work, promoting joint working.	Adobe Acrobat Document

THE NHS CONSTITUTION
the NHS belongs to us all

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Strategic Plan draft submission

Draft as at 28 February 2014

BHR strategic headline plan on a page

The BHR health economy is comprised of partners from Barking and Dagenham CCG, London borough of Barking and Dagenham, Havering CCG, London borough of Havering, Redbridge CCG, London borough of Redbridge, Barking, Havering and Redbridge University Hospitals Trust and North East London Foundation Trust; who have come together to agree, refine and implement the following vision:
Improving health outcomes for local people through best value health care in partnership with the community.

System objective	Delivered through
System Objective 1 To reduce the number of years of life lost by 23%	**Delivered through prevention and health promotion** Prevention and health promotion forms the foundation of our Strategic Plan. Target areas: obesity/dementia/reduce inequalities/diabetes/cardiovascular disease/cancer/smoking cessation/breastfeeding/alcohol and substance misuse
System Objective 2 To improve health related quality of life for those with 1+ LTCs by 4%	**Delivered through primary care improvement plan** Providing new ways to access primary care and finding new ways to provide innovative services designed around the needs of the patient to reduce acute admission and A&E attendance and increase positive patient experience.
System Objective 3 To reduce avoidable time in hospital through integrated care by 13%	**Delivered through the integrated care strategy** Seamless and integrated health and social care for local people. Continued implementation of local strategy putting the person at the centre of care provided by integrated teams
	Delivered through the acute re-configuration programme Reconfiguring local A&E and maternity services in order to improve the quality of care for local people; developing KGH as a centre of excellence for children's and women's services and new and effective 24/7 Urgent Care Centres at Queens Hospital and King George Hospital (facilitated through Urgent Care Procurement process running through 2014/15)
System Objective 4 To increase the % of older people living independently following discharge	**Delivered through planned care programme** Building on the Health for North East London programme for plan care which will see an improvement in the clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. Other developments include productivity improvements for MSK and ophthalmology pathways, service redesign for the diabetic pathway and re-procurement of the Independent Sector Treatment Centre.
System Objective 5 To reduce the % of people reporting a poor experience of inpatient care by 12%	**Delivered through specialised commissioned services** Commissioning to consistently deliver best outcomes and experience for patients
System Objective 6 To reduce the % of people reporting a poor experience of primary care by 15%	**Delivered through mental health service improvement** Strategic Commissioning Framework for Mental Health being developed and will include completion of full roll-out of the access to psychological therapies programme by 2014/15 with the aim that at least 15% of adults with relevant disorders will have timely access to services
System Objective 7 To reduce hospital avoidable deaths	**Delivered through childrens services improvement:** Implementation of an integrated Single Assessment process. Develop assessment process for children needing an EHC plan, Local Offer agreement to be confirmed and put children on EHC plans with cessation of 'statement system'

Overseen through the following governance arrangements

- Health and Wellbeing Boards (HWBB) oversee the process for strategic planning in each borough
- Integrated Care Coalition (ICC): an advisory group to HWBBs - bringing senior leaders together to build a sustainable health and social care system
- The coalition has two subgroups:
- Integrated care steering group: development and delivery of strategic plan
- Urgent care board: improvement plan for urgent care
- All work streams have identified leads

Measured using the following success criteria

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

High level risks to be mitigated

- BHRUT quality and performance issues
- Achieving financial targets
- Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership)
- Balancing increased patient expectation with improved outcomes at a time of less resource

Section Two | Key lines of enquiry (KLOE)

Segment	Key Line of Enquiry	Organisational Response	Supported by
Submission details System vision	Which organisation(s) are completing this submission?	The organisations completing this submission comprise of: ▪ Barking and Dagenham Clinical Commissioning Group ▪ Havering Clinical Commissioning Group ▪ Redbridge Clinical Commissioning Group ▪ London Borough Barking and Dagenham ▪ London Borough Havering ▪ London Borough Redbridge ▪ North East London Foundation Trust ▪ Barking Havering and Redbridge University Hospital Trust The senior leaders from the above organisations have committed to work together as the Integrated Care Coalition to support the three Clinical Commissioning Groups (CCGs) and the three Local Authorities in commissioning integrated care and ensuring a sustainable health and social care system. The Integrated Care Coalition (ICC) oversees the development of the 5 year strategic plan but has delegated formal authority to the Integrated Care Steering Group (ISCG) to co-ordinate on its behalf the production of the 5 year strategic plan.	ToR Integrated Care Coalition. Yellow font denotes specific reference to strategic planning Adobe Acrobat Document ToR Integrated Care Steering Group: Adobe Acrobat Document
	In case of enquiry, please provide a contact name and contact details	Ramesh Rajah BHR CCGs, Programme Management Office Tel: 0208 926 5327 Email: Ramesh.Rajah@onel.nhs.uk Jane Gateley	

		BHR CCGs, Director of Strategic Delivery Tel: 0208 926 5136 Email: Jane.Gateley@onel.nhs.uk Emily Plane BHR CCGs, Project Manager – Strategic Delivery Tel: 0208 822 3052 Email: Emily.Plane@onel.nhs.uk	
	What is the vision for the system in five years' time?	The vision for the BHR health economy is improving health outcomes for local people through best value health care in partnership with the community. In 5 years time the BHRUT economy aims to improve health outcomes for local people through best value health care in partnership with the community including: ▪ reducing the number of years of life lost by 23% ▪ improving health related quality of life for those with 1+ LTCs by 4% ▪ reducing avoidable time in hospital through integrated care by 13% ▪ increasing the percentage of older people living independently following discharge (rate to be confirmed) ▪ reducing the percentage of people reporting a poor experience of inpatient care by12% ▪ reducing the percentage of people reporting a poor experience of primary care by 15% ▪ reducing the number of hospital avoidable deaths (rate to be confirmed) In 5 years time patients will have better experiences of inpatient and primary care, will spend less avoidable time in hospital, will have a greater chance of living independently following discharge from hospital and will experience improved health related quality of life for those with one or more Long Term	DRAFT BHR Plan on a Page.pdf Borough teams will be reviewing trajectories and may be updated for the next submisions.

		conditions. Services will work together more closely, functioning as a more integrated system delivering high quality health and social care to patients closer to home.	
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised services	The vision statement for the BHR health economy characterises the six high quality and sustainable system and transformational service models through: 1. The responses from citizens to the local Call to Action events held in response to the NHSE challenge to ensure that future development of services is framed around the 'I' statements to ensure that what the patient wants is at the heart of service development going forward . Local citizens specifically stated that they wanted: ▪ Better access to primary care ▪ Partnership working with social care/integrated care ▪ improved hospital performance ▪ involvement of voluntary sector ▪ more support for carers ▪ improved patient engagement/communication In addition, citizens have also contributed in the development in the following areas ▪ On-going patient experience evaluation for Integrated Care and Community service developments. ▪ Patient involvement is the design and development of the Acute Reconfiguration developments to ensure new services delivers improved performance, better outcomes and patient experience. The following areas have been identified to support the prevention and health promotion programme: ▪ Obesity ▪ Dementia ▪ Reduction in health inequalities	*Details provided within the activity and financial templates which will be triangulated.*

<table>
<tr><td></td><td>concentrated in centres of excellence (as relevant to the locality)</td><td>▪ Diabetes
▪ Cardiovascular disease
▪ Cancer
▪ Smoking cessation
▪ Breastfeeding
▪ Alcohol and substance misuse
2. Providing new ways to access primary care and finding new ways to provide innovative services designed around the needs of the patient to reduce acute admission and A&E attendance and increase positive patient experience. These include:
▪ Weekend access
▪ Core hours plus
▪ 6-10pm appointments
▪ Triage service
▪ Primary care provider support
▪ Dedicated registered list
▪ Specialist expertise
▪ Implementation of unified point of access
3. Implementation of the BHR Integrated Care Strategy designed to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), and in particular to locality settings. The strategy seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to the quality of experience and outcomes. In 5 years, Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000 – check number) to enable more proactive management of the population. The focus will be on those with LTCs, high service users, and those vulnerable to decline.
4. Acute Reconfiguration programme building on Health for North East London</td><td></td></tr>
</table>

		work to reconfigure local A&E and maternity services in order to improve the care for the local people and a new and effective 24/7 Urgent Care Centre facilitated through the UCC procurement process running through to 2014/15. 5. Delivered by building on the Health for North East London programme for plan care which should see an improvement in the clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. Other developments include productivity improvements for MSK and ophthalmology pathways, service redesign for the diabetic pathway and a re-procurement of the Independent Sector Treatment Centre. 6. Specialised services narrative to be completed following discussion with Sue Sawyer.	
	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?	*A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?* Two year financial projections on all boroughs have been completed and the five year plans are currently being finalised. All plans leading up to 2018/19 will be designed to deliver a surplus. The plans are currently being risk assessed to ensure sustainability. *B)* The schemes / projects identified in the BCF / Operating Plan are consistent with those in the BHR system wide Integrated Care strategy. The schemes are linked to the 6 characteristics outlined on the plan on the page and mapped directly to the 7 ambition areas. C) Each Borough within the BHR economy has reviewed their baseline position for the seven ambitions targets and has planned five year reductions to align performance to equitable levels across the patch, as well as (where possible), closer to, or performing better against the national average. This is reducing health inequalities within the BHR system, which will make a significant change to the lives of patients living in Barking and Dagenham. The supporting evidence to the right illustrates this shift towards equitable performance across the BHR economy.	*BCF Schemes have been mapped to 7 outcome measures* BHR 5 year target projections.pdf
	Who has signed up to	The Integrated Care Coalition has endorsed the Strategic Vision.	

	the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	The Integrated Care Coalition (including members of Health and Wellbeing Boards) were involved in development of the Strategic Plan, reviewing the draft plan 10 January 2014 and holding an Integrated Care Coalition workshop on 10 February where members reviewed progress and endorsed the vision. A BHR CCGs Governing Body Away Day took place on 13 February 2014 where members reviewed the plan on a page which was then updated incorporating feedback. The draft Operating and BCF plans submitted on the 14 February were reviewed and signed off by the Health and Wellbeing Board in each Borough on the following dates: ▪ Barking and Dagenham HWBB reviewed and approved on the 11 February 2014. The development of the BCF was overseen by the H&WB Integrated Care sub-group which has membership across health and social care as well as from key providers. ▪ Havering submission was agreed by the Havering Wellbeing Board at its formal meeting on Wednesday 12 February 2014. It was then subsequently the subject of an Executive Decision by Councillor Steven Kelly, Leader of the Council, Chair of the Health and Wellbeing Board and Portfolio Holder for Individuals on the 13th February 2014. ▪ Redbridge HWBB meeting – the draft plans were submitted on the 14 February subject to the HWBB review on the 17 February. The HWBB has now taken place and the draft plans were reviewed and agreed.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	Integrated Care Strategy initiatives are embedded in the Better Care Fund plans, with the focus in years one and two being on the following initiatives: ▪ Integrated Case Management ▪ Community Treatment Teams ▪ Joint Assessment and Discharge Team These are key enablers to deliver the 5 year strategic vision.	
	What key themes arose from the Call to Action	To respond to the challenge of the NHSE Call to Action, each borough undertook a series of engagement events over the October to December 2013 period.	

	engagement programme that have been used to shape the vision?	These involved and covered a wide range of stakeholder groups. Following the sessions, the following themes were identified: ▪ Better access to primary care ▪ Working in partnership with social care/integrated care ▪ improved hospital performance ▪ involvement of voluntary sector ▪ more support for carers ▪ improved patient engagement/communication The feedback from the CTA engagement programmes have informed and assisted in the development of CCGs' local and strategic five year plans for their respective populations.	
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included	We will report back to public and patients at our regular CCG Patient Engagement Forums (PEFs) with cascade down to the practice level, Practice Participation Groups (PPGs). This will be based on our identified themes from local Call To Action engagement as described above and how those themes helped shape our strategic plan.	
Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	Yes, the Health for North East London programme of work (2009-2011) and Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case (November 2012) included in-depth assessment of the current state of the BHR economy. Other assessment included the 'Integrated Care in Barking & Dagenham, Havering and Redbridge Case for Change' in 2012 which formed the foundation for development of the BHR Integrated Care Strategy. Supporting Evidence: ▪ Developing a Viable Acute Services Provider Landscape in North East London - INEL and ONEL Sector PCTs and acute trusts Case for Change (03 December 2008)	DMBC 021210 FINAL V1.0.pdf NEL Case for change_v20b 081201

		▪ Decision Making Business Case – December 2010 ▪ August 2012: Integrated Care in Barking and Dagenham, Havering and Redbridge Case for Change ▪ November 2012: Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case The first draft submission also considered the JSNA and the Health and Wellbeing Strategy to identify and agree the priorities for each borough. In addition to this, each borough also undertook a review of the Commissioning for Value packs to understand the current benchmarked position against similar organisations in London and against statistical neighbours. Following the analysis of the above sources, the schemes identified were mapped against the 7 ambitions areas to deliver the improvements required over the next 5 years.	C4C.pdf DMBC 021210 FINAL V1.0.pdf
	Do the objectives and interventions identified below take into consideration the current state?	BHR Better Care Fund Plans are directly informed by and build upon the Integrated Care in Barking and Dagenham, Havering and Redbridge Case for Change. Objectives and interventions identified have been developed following a review of the current state of the BHR economy. Ongoing patient engagement and review of performance feeds into service development. Baselines for the 2 year BCF metrics and the 5 year operating plan trajectories take into account the current baseline performance.	
	Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	BHR Better Care Fund Plans are directly informed by and build upon the Integrated Care Case for Change in Barking & Dagenham, Havering and Redbridge. Phase 1 and 2 of the strategy, which includes non acute bed quality / productivity improvements, development of the Community Treatment Team and the Intensive Rehab Service, has been delivered. The foundations for the strategic vision is also based on the Acute reconfiguration programme to reduce the number of sites with emergency care provision, centralise the workforce, increase senior cover and improve quality of care for patients and deliver services that meet the London Quality standards.	

<table>
<tr>
<td rowspan="2">Improving quality and outcomes</td>
<td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td>
<td>
<table>
<tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr>
<tr><td>To reduce the number of years of life lost</td><td>Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people</td><td>To reduce the number of years of life lost by 23%</td></tr>
<tr><td>To improve health related quality of life for those with 1+ LTCs</td><td>Health related quality of life for people with long term conditions (sum of the weighted EQ-5D values)</td><td>To improve health related quality of life for those with 1+ LTCs by 4%</td></tr>
<tr><td>To reduce avoidable time in hospital through integrated care</td><td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td><td>To reduce the number of avoidable hospital admissions by 13%</td></tr>
<tr><td>To increase the % of older people living independently following discharge</td><td>Number of people age 65+ discharged from hospital into reablement/rehabilitation services still at home after 91 days
NB: No indicator available at CCG level to set quantifiable level of ambition against. However CCG plans on this ambition should be making explicit links to the related ambition as part the Better Care Fund, set for 2 years at Health & Wellbeing Board level</td><td>No indicator available at CCG level to set quantifiable level of ambition against</td></tr>
<tr><td>To reduce the % of people reporting a poor experience of inpatient care</td><td>Patient experience of hospital care</td><td>To reduce the % of people reporting a poor experience of inpatient care by12%</td></tr>
<tr><td>To reduce the % of people reporting a poor experience of primary care</td><td>Patient experience of GP services and GP Out of Hours service</td><td>To reduce the % of people reporting a poor experience of primary care by 15%</td></tr>
<tr><td>To reduce hospital avoidable deaths</td><td>Incidence of healthcare associated infection (MRSA and C.DIFF
NB: Baseline data not yet available at CCG level to set quantifiable level of ambition against. However ‘case note review’ data will be available to measure progress on local plans in the next few years</td><td>Baseline data not yet available at CCG level to set quantifiable level of ambition</td></tr>
</table>
</td>
<td>Data analysis packs for each of the three BHR Boroughs detailing historic performance against each measure, trend analysis, position against national average and position against fellow BHR Boroughs.</td>
</tr>
<tr>
<td>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</td>
<td>The engagement process as part of the development of the BHR Integrated Care Strategy (which is the foundation for the Better Care Fund Plans) included engagement with clinicians and community stakeholders.

Clinicians were also actively involved in the H4NEL proposals through the Clinical Working Groups that were established to produce recommendations for the H4NEL programme.

Draft plans have been shared and reviewed with the Joint Executive Teams, the Integrated Care Coalition, and at Governing Body workshops; clinicians are key</td>
<td></td>
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</table>

		members of these groups and have fed into the development of the Strategic Plan via these groups. Clinical Directors have actively been involved in the development of plans at Borough levels.	
	What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?	Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case in 2012 reviewed a range of data and local analysis including the A&E attendance and emergency admissions as well as mapping of non acute beds in the community in order to support the development of the strategy. The H4NEL Case for Change and business case undertaken in 2008/09 looked at a range of data / intelligence including • Growth in demand linked to projected population growth and changes in medical technology and patterns of care • Reductions in demand for hospital care linked to out of hospital care strategies and commissioning initiatives • Hospital productivity improvements • Activity flows are expected to be affected by the reconfiguration of services Data analysis packs for each of the three BHR Boroughs detailing historic performance against each measure, trend analysis, position against national average and position against fellow BHR Boroughs and review and incorporation of JSNA recommendations for each of the three BHR Boroughs.	Redbridge baselines & trajectories.pdf B&D Ambitions & BCF baselines & trajectori Havering baselines trajectories narrative
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	The local JSNA / Health and Wellbeing Strategy have driven the identification of the quantifiable ambitions. The outcomes identified have been mapped to the JSNA and the 7 ambitions to ensure alignment and fit.	
	How have the Health and well-being boards been involved in setting	H&WBB have played an active role in developing plans in each borough; H&WBB members part of Coalition with responsibility for the reviewing and	

	the plans for improving outcomes?	signing off the Strategic Plan. The draft BCF templates were signed off by HWBB Members of the Health and Wellbeing Board have also been involved in the following forums ▪ Integrated Care Coalition Workshop ▪ BHR CCGs Governing Body Away Day ▪ Integrated Care Steering Group Workshop	
Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	The outcome ambitions have been included as part of the sustainability calculations for the 2 and 5 year plans. The finance / QIPP plans for the next 2 years are being finalised. This will be then be used for agreeing the resource plans going forward for years 3-5.	
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Yes, the key themes raised from local engagement were: ▪ Better access to primary care – (See Primary Care [Intervention 2] in Improvement Interventions section of this template) ▪ Linking with social care/integrated care – (See Integrated Care Programme [Intervention 3] in Improvement Interventions section of this template) ▪ Improved hospital performance – (See Integrated Acute Reconfiguration [Intervention 4] in Improvement Interventions section of this template) ▪ Involvement of voluntary sector – engagement of the public and patients in the design of pathways ▪ More support for carers – referenced as one of schemes in the Barking and Dagenham submission (Havering and Redbridge to clarify position) ▪ Improved patient information / communication – relevant to all interventions of the BHR Strategic Plan	

		▪ Service co-design with patients and voluntary sector – relevant to all interventions of the BHR Strategic Plan	
	Can the plan on a page element be identified through examining the activity and financial projections covered in operational and financial templates?	The plan on a page outcome targets for the BHR economy can be identified through examining of the activity projections covered in the operational templates. A mapping exercise has been completed using the baseline and five year reduction targets for each of the BHR Boroughs to produce a consolidated summary position of the BHR target projections for the BHR strategic plan outcome measures (see supporting evidence). Outcomes 4 and 7 are not covered in the activity projections in the operational template, as baseline data is not available. Ref - NHS England guidance document for commissioners 'Setting 5-year ambitions for improving outcomes' (Gateway reference: 00893) states, baseline data is not available for these outcomes. CCGs however are reviewing local data to make explicit links to the related ambition as part the Better Care Fund.	
Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g.	**<u>Intervention One: Prevention and Health Promotion</u>** Prevention and health promotion forms the foundation of our Strategic Plan schemes. JSNAs have identified the following areas for targeting: ▪ Reduction in obesity ▪ Dementia: earlier identification and diagnosis of dementia to improve treatment ▪ Reduction in health and social equalities ▪ Diabetes: earlier identification and diagnosis of dementia to improve treatment ▪ Cardiovascular disease ▪ Improve early diagnosis of Cancer and treatment times ▪ Targeted action to improve smoking cessation	

<table>
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<td></td>
<td>the description of the large scale impact the project will have
Investment costs (time, money, workforce)
Implementation timeline
Enablers required for example medicines optimisation
Barriers to success
Confidence levels of implementation
The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.</td>
<td>Improve levels of Breastfeeding
Improved treatment of alcohol and substance misuse
The London wide elements of the plan is being progressed by Dr Kathie Binysh with borough public health leads. A meeting has been tentatively set for the 10 March to discuss.

<u>Expected Outcome</u>
Reduced numbers of patients attending A&E
Reduced health inequalities
Increase in patient Friends and Family test score
Reduced number of non elective emergency admissions
Reduction in the number of patients with multiple LTCs
<u>Investment costs</u>
Financial costs
Non-Financial costs
<u>Implementation timeline</u>
TBC
<u>Enablers required</u>
Stakeholder engagement is crucial
Innovative use of social media to raise awareness
<u>Barriers to success</u>
Stakeholder engagement
Limited resource
<u>Intervention two: Primary Care Improvement Plan</u>

The Barking & Dagenham, Havering and Redbridge Primary Care Improvement Plan aims to allow local GPs to lead a system that educates patients, reduces</td>
<td></td>
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</table>

unplanned attendance and reduces hospital admissions by:

- Extending standard primary care provision
- Providing easier access to clinical support prior to A&E
- Supporting better planned care

<u>Interventions required:</u>

- Weekend access
- Core hours plus
- 6-10pm appointments
- Triage service
- Primary care provider support
- Dedicated registered list
- Specialist expertise
- Implementation of unified point of access

<u>Expected Outcome</u>

- Reduced numbers of patients attending A&E
- Increase in patient Friends and Family test score
- Reduced number of non elective emergency admissions
- Number of patients supported by the complex care service

<u>Investment costs</u>

£000's	NHS England Non-Recurrent	Partner Non-recurrent	Capital	Total
Year 1	5,671	2,000	5,000	12,671
Year 2	0	4,000	0	4,000
Total	5,671	6,000	5,000	16,671

<u>Implementation timeline</u>: **Formal project start/finish: 01.04.14 – 31.03.16**

- Scheme 1: Improved Access; 14.04.14 – 28.02.15
- Scheme 2: Complex Care; 30.06.14 – 28.02.15

Barriers to success:

- Finance – dependence on Prime Minister's challenge fund bid to initiate this plan
- Information Governance – linking IT system across different organisations
- Engagement with key stakeholders
- 6 month timeframe to establish Unified point of access

Intervention three: BHR Integrated Care Programme

Following extensive public engagement the BHR economy published a case for change in August 2012. The resulting vision and strategy for integrated care has been developed with needs of people at its heart, helping them to live well, and independently, for as long as possible and empowering and supporting them to self care.

PERSON CENTRED CO-ORDINATED CARE: designing care around patients making sure that they receive the right care in the right place, at the right time, and ensuring that different services "talk" to each other, reducing inefficiencies in care

The strategy is to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), and in particular to locality settings. 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.

5 year vision:

Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000 – check number) to enable more proactive management of the population. The focus will be on those with LTCs, high service users, and those vulnerable to decline.

This will result in less demand for community beds, with resources transferred into multi disciplinary team based around GP practices supported by borough level community response teams.

Services will be jointly commissioned based on outcome measures and designed based on the principles set out in National Voices.

Characteristics of new service model:

- Risk stratification of patients
- care planning across the comprehensive needs of individuals
- care co-ordination, with clarity on who is responsible for patients with each level of acuity, linking to established disease pathways as appropriate , and end of life protocols as required
- a single point of access to the team for patients/service users and their carers through co-ordinators and a 24/7 number
- strong partnership and pathways with the voluntary sector.

A Joint Assessment and Discharge Team will operate across the system to facilitate the safe return home of patients

Supported and enabled by:

- The Better Care Fund
- Technology enabling information and data sharing
- Aligned funding arrangements and incentives across the system including personal budgets and building on local Year of Care work
- Frailty Academy

Expected Outcome

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

Investment costs

- Financial costs
- Non-Financial costs

Implementation timeline:

- TBC

Barriers to success:

- Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership)
- Service delivery across organisational boundaries

Confidence levels of implementation:

- TBC

Intervention four: Acute re-configuration programme

The Health for NE London programme aims to improve health services for local people. The key objectives are:

- Urgent and emergency care – to be provided at 5 hospitals in NE London at Queens, Whipps Cross, The Royal London, Homerton and Newham, with urgent care being enhanced at all hospitals (A&E services are therefore transferring from King George Hospital)
- King George Hospital to provide 24/7 urgent care and short stay assessment and treatment services, including location of a GP practice at the polyclinic site
- Maternity - to establish and relocate KGH maternity services on to Queens site
- Planned Care Development; see separate Planned Care Intervention below

Moving forward, implementation plans will take account of Sir Bruce Keogh's recommendations for urgent and emergency care across England:

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

In 5 years time, service users will see

- A transformed Emergency Department at Queens Hospital with improved A&E quality of services
- New and effective 24/7 Urgent Care Centres at Queens Hospital and King George Hospital (facilitated through Urgent Care Procurement process running through 2014/15)
- A centralised and expanded critical care services
- Being treated by a centralised workforce with increased senior cover that will improve quality of care for patients to those that meet the London Quality standards.

<u>Interventions required:</u>

- Emergency Department Business Case
- Urgent Care Procurement
- Maternity reconfiguration has been achieved by working closely with NE London providers. Full relocation of maternity services completed March 2013 following the sign off from NHS London.
- KGH vision - Delivered through the development of KGH as a centre of excellence for Women's and Children's services.

		Expected Outcome ▪ To improve the A&E 4 hour performance ▪ To reduce avoidable emergency admissions ▪ To reduce the number of years of life lost ▪ To reduce the percentage of people reporting a poor experience of inpatient care ▪ To reduce acute inpatient length of stay Investment costs ▪ Financial costs ▪ Non-Financial costs Implementation timeline: ▪ December 2015 Barriers to success: ▪ Risk that performance improvements on A&E target, LoS and bed reductions not delivered. ▪ Possible slippages in the timelines due to delays in the process ▪ Risk that UCC service model does not deliver the agreed utilisation rates. Confidence levels of implementation: ▪ TBC **Intervention five: Planned Care Programme** The Barking & Dagenham, Havering and Redbridge Planned Care Programme aims to improve health services for local people by separating planned surgery pathway from emergency pathway, where appropriate. Enabled through: ▪ Moving planned surgery from Queen's Hospital to King George Hospital	

except where there are benefits in co-locating services or clinical need

- Development of a local kidney dialysis service at King George Hospital.
- Productivity (MSK and Ophthalmology), service re-design (diabetic) and the re-procurement of the Independent Sector Treatment Centre.

Expected Outcome

- To reduce the number of years of life lost
- To increase the percentage of older people living independently following discharge
- To reduce the percentage of people reporting a poor experience of inpatient care
- To reduce hospital avoidable deaths

Investment costs

- Financial costs
- Non-Financial costs

Implementation timeline:

- TBC

Barriers to success:

- Risk that performance improvements will not be delivered

Confidence levels of implementation:

- TBC

Intervention six: Specialised Commissioning Services

The vision for Specialised services commissioned is to consistently deliver best outcomes and experience for patients, within available resources

Interventions required:

- Compliance with service specifications

- Consistent achievement of service standards
- Benchmarked outcomes in London, England and internationally, identifying the best practice to emulate
- Engage patients in service / pathway development and contract management
- Through contract management, ensure patient feedback is heard and acted upon throughout providers commissioned
- Co-commission with CCGs and Local Authorities
- Develop and implement best practice patient pathways for individual services, ensuring they are incorporated into national service specifications
- Understand the cost of services commissioned
- Converge prices
- Alignment of incentives
- Contract management

Expected Outcome

- Specialised services commissioned in London are consistently in the top decile for outcomes across all providers
- Continually improve patient experience for each individual
- Maintain the integrity of the care pathway for patients of specialised services
- Contain the cost of specialised services through Quality, Innovation, Productivity and Prevention, in partnership with providers and other service commissioners

Investment costs

- Financial costs
- Non-Financial costs

Implementation timeline:

- TBC

Barriers to success:

- Alignment with national specialised services strategy due to strategy developments working to different timelines
- Resource capacity – improved matrix working and new ways of working

Confidence levels of implementation

- TBC

Sue Sawyer (NHSE specialised commissioning lead) to update for next version.

Intervention seven: Mental Health Services

A Strategic Commissioning Framework for Mental Health is currently being developed in response to “Closing the Gap: Priorities for essential change in mental health” which was published on January 2014. The framework is expected to be completed by June 2014 and will be jointly developed through the mental health subgroups of the respective Health and Wellbeing Board.

The completion of the full roll-out of the access to psychological therapies programme by 2014/15 and that every CCG plan will include at least 15% of adults with relevant disorders having timely access to services is reflected within the Borough Operating Plans.

Intervention eight: Children’s Services

One of the key priorities being taken forward is the need to have an Integrated Single Assessment process with Education, Health and Care Plan (EHC) having similar status to the Statement of Special Educational. The key actions to be in place by September 2014 are:

- An assessment process for children needing an EHC plan.
- Local Offer (capturing the nature and scale of all services available) agreement confirmed

		• Start to put children on to EHC plans and the cessation of the current 'statement system'. National guidance expected soon will confirm deadlines on when this should complete by. The CCGs and the Local Authorities will be working in collaborative partnership arrangements to deliver the priority. The CCGs and the Local Authorities will also be working together to deliver the Safeguarding and looked after children outcomes required in the Children and Families Bill.	
Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	The supporting evidence attached details the Governance Structures in place within the BHR economy to ensure future plans are developed in collaboration with key stakeholders. This is underpinned by ongoing engagement with patients (via Patient Engagement Forums, as well as other methods of engagement such as periodical telephone interviews with patients accessing the Community Treatment Team and Intensive Rehab Service, the outcomes of which directly feed into ongoing service development).	Adobe Acrobat Document
Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	The Integrated Care Coalition are signed up to a set of articulated Values and Principles underpinning BCF (final version to be agreed at Integrated Care Coalition meeting on 31.03.14), Operating and Strategic Plans which are embedded in both organisations and programmes of work, promoting joint working.	Adobe Acrobat Document

HEALTH & WELLBEING BOARD

Subject Heading:	**TROUBLED FAMILIES REPORT FOR 3RD QUARTER 2013/14**
Board Lead:	Joy Hollister – Group Director – Children's, Adults and Housing
Report Author and contact details:	Sarah Thomas, Early Help and Troubled Families Manager Tel: 01708 433010 Email: sarah.thomas@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

Programme summary: Troubled Families

As a result of the riots in 2010, and the resulting review of possible causes, Central Government developed the Troubled Families programme in order to address the issue of those households seen as having complex and multiple needs, and especially those that required significant support from a range of national and local services. Government data collected in October and November 2011 estimated that £9 billion is spent annually on troubled families – an average of £75,000 per family each year. By developing a 'whole family' and lead agency approach, local authorities were challenged to reduce expenditure on such families as a means to save both financial and social costs.

The Troubled Families programme is aimed at to turn around the lives of 120,000 troubled families in England by 2015. Local authorities were tasked with identifying and working with an agreed number of families by March 2014, the figure for Havering being 415 households.

Under the Troubled Families programme, the authority receives an 'up-front' attachment fee for identifying families, together with a 'reward' for successfully intervening with them and reducing future need.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the following issues identified by the Council's Troubled Families Team and its partner agencies which have been noted as potentially supporting families that have been identified as having multiple or complex needs. These include:

- Better coordination, collection and use of data especially social care, education, and crime data in order to develop long-term strategies and provide earlier help for vulnerable people.
- Establishing closer links with Homes and Housing, especially as there has been an increase in housing related issues relating to welfare reforms;
- Embedding Whole Family assessments in order to encourage supporting agencies to focus on the needs of the whole household;
- Focussing on Troubled Families in order to develop bespoke thinking that will make real changes for families and the services they receive; and
- Evaluating what services are working and identifying effective practice in order to highlight inefficiencies and the duplication of work.
- Co-locating school nurses with Early Help;
- Embed Troubled Families work and Payment by Results within services to ensure business as usual.

REPORT DETAIL

The aim of the local Troubled Families' Programme is to identify and then address the key factors that cause families to escalate into complex, high cost, high need ones. The national criteria as set down by the Department for Communities and Local Government have been created to tackle key themes which include;

- Crime & Anti-Social Behaviour (including being the victim of domestic violence)
- Education
- Being in receipt of work related benefits

In addition, authorities were given the discretion to add criteria to reflect local needs. For Havering, these included domestic abuse, substance misuse, suffering Mental Health problems, having debts, being a single parent and housing issues.

Based largely on local demographic factors, DCLG required Havering to identify 415 families to join the programme by March 2014, a figure which we have already exceeded , with upwards of 500 families on the list.

In addition to the attachment fee, which based on identifying families, the authority has upward of £160,000 from DCLG for the successful turnaround of families in Havering. This money is being passed on directly to those agencies that have evidenced that they have worked with a family to 'help turn them around'.

Apart from the financial incentive, the Troubled Families programme allows the authority to develop a new way of working. Each family has an assigned Lead Worker (LW) a person that knows the story of the family and who is able to coordinate the support provided by the several agencies that work with the family. Part of this support will include a SMART plan with clearly defined objectives. Moving forward each case will require an early help assessment where a whole family assessment is not available.

The Troubled Families Team is not a service delivery unit, but rather it plays a multi-functional role. Firstly they are a hub for co-ordinating information on families quickly and efficiently in order to support the Lead Worker and the agencies for that family. Secondly, the team acts as facilitators, providing guidance and establishing links across services and, if necessary , escalating issues where necessary to ensure that systematic changes are taking place to enable greater efficiencies and innovation. Finally the team has been working to ensure that the payment by results approach is embedded in the organisation as business as usual.

IMPLICATIONS AND RISKS

Financial implications and risks:

None directly but, as highlighted in the introduction, Troubled Families with complex or multiple needs can be high cost families both in terms of the direct cost they have to central and local government and, in social terms, to the community in which they live. As an example, from our own research one particular family has cost circa £250k over two years, not including police costs. The Troubled Families project seeks to identify the reasons families are getting to this high cost stage and to systematically challenge these working practices which, in turn, will reduce the future costs to the public purse.

A further financial implication is that of the Payment by Result or PBR. This could represent a significant cash injection to services.

Legal implications and risks:

None directly, as the Troubled Families programme is not set up through legislation. Services continue to be provided to families identified as having complex or multiple needs in line with their own specific legislation.

Human Resources implications and risks:

None directly, but it is likely that the lessons learnt from Phase 1 of the Troubled Families programme may result in business re-engineering or a refocus on how services are delivered.

Equalities implications and risks:

Although the Troubled Families Programme has not been designed to specifically address socially disadvantaged or excluded families, by encouraging school attendance, reducing offending behaviour, or increasing employability, families that are successfully turned around will be in a better position within their community.

BACKGROUND PAPERS

- *Introduction to Troubled Families*
- *Troubled Families financial Framework*
- *Early Help strategy*

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