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HEALTH & WELLBEING BOARD

AGENDA

Wednesday July 9 2014
1.30 pm – 3.30 pm
Committee Room 2 – Town Hall

1. CHAIRMAN'S ANNOUNCEMENTS

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. APOLOGIES FOR ABSENCE

   (If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

   Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.

   Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 12)

   To approve as a correct record the minutes of the Committee held on 7 May 2014 and to authorise the Chairman to sign them.

5. MATTERS ARISING

6. COMMUNITY ENGAGEMENT IN LEARNING DISABILITIES AND DEMENTIA (Pages 13 - 36)

   Written report by Anne-Marie Dean

7. PRIME MINISTER'S CHALLENGE FUND UPDATE

   Verbal Report by Alan Steward

8. CARE ACT/BETTER CARE FUND - QUARTERLY UPDATE

   Verbal report from Joy Hollister

9. HEALTH AND WELLBEING FIVE YEAR STRATEGIC PLAN (Pages 37 - 88)

   Written report by Alan Steward

10. FUTURE PRIORITIES, CHALLENGES AND OPPORTUNITIES FOR THE HAVERING HEALTH AND WELLBEING BOARD

    Presentation by Phillipa Brent-Isherwood. *Report to follow*

11. ANY OTHER BUSINESS

12. DATE OF NEXT MEETING

    Board Members to note that the next meeting will be held on Wednesday 13 August 2014 at 1.30 pm.

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
7 May 2014 (1.30 pm - 3.45 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, BHR CCGs
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chair, Health Watch
Cynthia Griffin, Group Director, Culture, Community and Economic Development
Alan Steward, Chief Operating Officer (non-voting), Havering CCG

In Attendance

Dr Maurice Sanomi, Havering CCG
Phillipa Brent-Isherwood, Head of Business and Performance, LBH
Barbara Nicholls, Head of Adult Social Care, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG

34 **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.

35 **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

36 **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

37 MINUTES

The Board considered and agreed the minutes of the meeting held on 19 March 2014 and authorised the Chairman to sign them.

The Board considered and agreed the minutes of the meeting held on 9 April 2014 and authorised the Chairman to sign them.

38 MATTERS ARISING

The Joint Assessment Discharge project is due to go live on 1 June 2014, in the meantime, staff consultations are proceeding.

It was noted that the regulations on the Care Bill would be available at the end of the month.

A letter from NHS England providing feedback on the Better Care Fund had been received by the Health and Wellbeing Board. The Board member representing NHS England advised that there had been some national anxiety regarding the political inferences and that more work was required by NHS England, however, Havering was one of six successful boroughs in bidding for funds.

The Board were informed that Havering was the best performing borough in London and 13th nationally in turning around "Troubled Families." The Chairman suggested that Havering should offer to conduct borough pilots for other schemes.

The Chairman commented that officials at NHS England appeared to be less than timely in approving GP surgery buildings and cited a practice in Rainham as an example. It was agreed that the NHS England Board member would investigate and requested that the Chairman forward all relevant data on the site.

39 CHALLENGE FUND UPDATE

The Board were advised that the tri-borough bid for government funds paid from the Prime Minister's Challenge Fund had been successful, and the Chief Officer of BHRUT CCGs thanked all those on the Health and Wellbeing Board and at NHS England for their support. The allocation of funds at £5.6m was one of the largest in the UK which would be used to improve Primary Care in the borough. A number of plans were currently being looked into jointly with NHS England colleagues and it was agreed that a report would be made available to the Board at the July meeting.

40 INDEPENDENT CARE COALITION UPDATE

The Board received a presentation from the Chief Executive Officer of Havering who also chairs the Independent Care Coalition (ICC).

The Independent Care Coalition was originally formed because of issues around the local hospitals. The ICC brought together key partners within Outer North East London to develop improvement programmes across health and social care. Since the establishment of the ICC, NHS (London) had asked that a number of partnership tasks be undertaken and these had been added to the original role of the ICC so as to prevent a range of difference partnership groups operating in a unco-ordinated manner. The Urgent Care Board (UCB) acted as a sub group of the ICC. The ICC was not a decision making body and all decisions on contracts or spending were enacted through the relevant governance structures such as Health and Wellbeing Boards, Clinical Commissioning Group (CCG) Boards and Provider Trust Boards.

The original programme, agreed by the ICC was to improve community capacity in order to prevent avoidable presentations at Accident and Emergency and hospital admissions. Due to the high incidence of frailty, including older people presenting at A&E, the community responses were targeted at this group. In order to reduce unnecessary hospital admissions, a range of services were piloted and these have now been mainstreamed as part of the CCG contractual arrangements and the Better Care Fund. These are as follows:

a) Integrated Case Management (ICM)

The Havering Integrated Care (IC) Team comprise of a GP, Community Matron, District Nurse, Social Care Lead and Care Liaison Officer and deliver appropriate care to patients in the community so as to reduce avoidable hospital admissions. In addition, they also deliver a high quality service for high risk patients. There are six clusters across Havering with a Community Matron and Integrated Care Liaison Officer allocated to each.

Quarter 4 data identified that Havering was on target for caseloads with 2053 service users receiving support in 2013/14. Key Performance Indicators for 2014/15 would aim to facilitate improved performance in areas identified in the in-year diagnostic e.g. a greater focus on effective management of caseloads and throughput of the service.

b) Community Treatment Teams (CTT)

The CTT consists of doctors, nurses, occupational therapists, physiotherapists, social workers, and support workers. The CTT provide the following:

- Short term intensive care and support to people experiencing health and/or social care crisis to help them be cared for in their own home rather than be referred to hospital.
- Support for people to return home as soon as possible following an acute/community inpatient stay where this is required or appropriate.
- A single point of access to intensive rehabilitation at home or in a bed in a community rehabilitation unit if necessary.

- CTT runs in all three boroughs from 8am – 10pm, seven days a week which align with peak attendances in A&E and therefore should help to relieve the pressure on A&E.

Performance data for 2013/14 indicated a good performance in the Queens hub with 1576 referrals received of which 78% did not go on to be admitted to hospital. The community spoke was also rated green on performance against target, with 2707 referrals received; 94% of which were treated and maintained at home without the need for an acute admission.

c) Intensive Rehabilitation Service (IRS)

The team consists of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants with access to a geriatrician as required via the Community Treatment Team. It aims to provide an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people in their own homes where it is appropriate to do so. The in-home support provided is intensive and involves between one and four home visits each day, depending on the patient's needs. The service operates from 8am – 8pm, seven days a week.

Trial of the new intensive rehabilitation service went live from November 2013 allowing people to be rehabilitated at home rather than in a non-acute bed. Performance data for 2013/14 showed that Havering received 159 referrals against a target of 69. Patient satisfaction was good and continues to be monitored monthly.

Nursing Home Scheme

Baseline conveyances by London Ambulance Services (LAS) from nursing homes was 320 in the first quarter. In the second quarter, this reduced to 294 and 317 in for the third quarter.

In order to prevent unnecessary conveyances to hospital from nursing homes, 31 homes in Havering have signed up to the scheme.

Intermediate Care (CTT/IRS)

A paper detailing progress and performance of the trials of these programmes and recommendation as to next steps following the trial period was submitted to CCG Governing Bodies in January 2014. All 3 CCGs agreed the continuation of the trial of CTT/IRS 2014/15 with a view to:

- A review of the model in one year following further evidence
- finalising the proposed model of intermediate care in partnership with the local authority, and;
- consulting on any significant service changes for 2015/16.

A nomination for the HSJ value in healthcare awards regarding the new model of intermediate care has been submitted by NELFT and the CCGs.

Community Health and Social Care Service (CHSCS)

Community Health and Social Care Teams development to progress in 2 stages:

1. NELFT are to reconfigure identified services (community nursing, ICM, Therapies, MH link worker) into locality based teams. In Havering, the first stage of CHSCS went live on 28 April 2014.

2. Plans to consider integration of partners outside of NELFT e.g. Social care and others. In Havering, proposals are currently being discussed re: piloting better integration between community (CHSCS) and secondary care via an MDT approach for those particularly complex patients that ICM are finding difficult to manage within the average 8 weeks. The pilot is due to go live in one cluster in May.

Non Acute beds

2013/14 data identified that referral to transfer rates continued to meet 72 hour targets (22 hours on average). Some additional 'winter pressure beds' opened during the first week of January 2014 and closed in early April 2014. The number of beds required to manage demand in this period was significantly less than in previous years and was also less in number than predicted which may have been due to winter capacity modelling.

A&E Attendances and LAS conveyances to BHRUT

Latest information shows that there were reductions in A&E attendances within BHRUT and that Local Ambulance Service conveyances to local hospitals in BHRUT were also showing a reduction. The Chief Executive tabled the following figures which depicted the impact of the ICC on the reduction of emergency, hospital admissions and care transfers.

BHR – Quarter 3 in13/14 compared to Quarter 3 in 12/13

A&E attendances – reduced by 6.59%
Non Elective Admissions - reduced by 14.35%
Delayed Transfers of Care – reduced by 25.5%

Havering – Quarter 3 in 13/14 compared to Quarter 3 in 12/13

A&E attendances – reduction in overall attendances by 12%
Non- Elective Admissions – reduced by 9%

End of Life Care

The Integrated Care Coalition have agreed that end of life care will be a priority. The Barking & Dagenham, Havering and Redbridge end of life

subgroup of the Integrated Care Coalition (ICC) have agreed five priority areas which are:

- GP end of life training
- Strengthen co-ordination of end of life services
- Case for investment in community nursing
- Consider the BHR approach to CMC
- Provide guidance on local applications following he recommendations from the national independent review of the Liverpool care pathway (LCP)

Havering end of life group has the following key actions:

- **BHRUT Improvement plan -** Contains actions to improve consistency of end of life care across sites and BHRUT wards and improve end of life training.
- **Dying matters week -** 12th to 18th May 2014. Havering CCG is working with St Francis Hospice, London Borough of Havering and other local organisations on this project aimed at raising public awareness of end of life issues.
- **Standardised DNR forms** - the group is working up a plan for introducing and implementing a fit for purpose 'do not attempt cardiopulmonary ressusitation' (DNARCPR) form. NELFT have a policy already for this.

The Frailty Academy has been set up to ensure that lessons from all of these initiatives are learned and developed with effective mainstream services. The Frailty Academy is a virtual academy comprising clinicians and other staff such as the Local Authorities, Social Care, nursing professionals and academics from University College London. There are currently 34 participants enrolled in the Academy from multi-professional and multi-agency backgrounds including LAS, NELFT, BHRUT, Age UK Redbridge, and Havering Care Association. The curriculum is well developed and a range of improvement and innovation materials have been designed across four phases of delivery: Understand, Co-create, Plan & Test, Adopt & Diffuse.

There are further projects planned including the setting up of a website to provide a starting point for discussions around frailty.

Resources

Confirming resources for the programme work remains a priority. Immediate needs for the project teams include administrative and analytical support, and communications support. It is proposed that the Programme Director is asked to scope requirements.

In linking to the rest of the system, it was noted that a manager has been appointed to the Joint Discharge team and staff consultation processes were continuing. The Re-commissioning of urgent care centres at the acute hospitals was underway. The BHRUT Improvement Plan was submitted

following special measures introduced at BHRUT hospitals. The new plan ties more directly into ICC work streams that demand management into and out of the acute trust and efficiency and improved clinical leadership inside the acute trusts.

The Chairman commented on the need to maintain discussions about the provision of future health services within the three boroughs particularly due to the increase in populations.

The Chief Executive advised that there was a lot more work to do over the coming two to three years, however, the five year plan for the local health and social economy would be available in June 2014.

The Chairman on behalf of the Board thanked the Chief Executive Officer for a most detailed and informative report.

41 DEMENTIA STRATEGY/DEMENTIA CENTRES

The Chairman welcomed Dr M. Sanomi, Clinical Director and Chairman of the Dementia Partnership Board who gave a presentation on the Havering Dementia strategy. The Board were asked to note the accompanying report including the draft document on the Joint Dementia Strategy for Havering 2014-2017 and the Dementia Strategy Toolkit.

Dementia remains a high national and local priority. Since the launch of the Government's National Dementia Strategy in 2009 (Living Well with Dementia: a National Dementia Strategy), numerous additional national policy guidelines and initiatives have followed, which included:

- Prime Minister's Challenge on Dementia
- The Mandate
- Joint Commissioning Framework: National Dementia Strategy
- Outcomes Frameworks for Public Health, Adult Social Care, and Health, all with specific reference to dementia
- Establishment of National Dementia Action Alliance
- The Care Bill
- Dementia: A state of the nation report on dementia care and support in England

Dementia and dementia care, therefore, is a key issue at a national level and would remain so, given the overall changing and ageing population. Within the National Dementia Strategy (DH, 2009), there is a requirement for all local areas to have a joint commissioning strategy for dementia. Despite the fact that the National Strategy ends in 2014, it is felt both important and timely to produce a joint strategy for Havering. It is vital that the public, stakeholders, commissioners and providers develop a shared vision of aspirations for the future with regard to dementia care and services.

Havering has one of the highest proportions of older people in London and it is estimated that 3,275 people aged over 65 years have dementia. This figure is

predicted to rise to 3,794 by 2020. Further work is required to fully understand the local level of need for people with early onset dementia (before the age of 65). Dementia in Primary Care aims to identify specific groups of people at higher risk of developing dementia including those with a learning disability, at an early stage.

Both key commissioning organisations, that is, Havering CCG and LBH, are committed to working together, with dementia identified as a key shared priority area by the Health and Wellbeing Board. New and emerging structures within both organisations will provide an added impetus and focus for co-ordinated commissioning in the future.

The local Dementia Partnership Board meets on a bi-monthly basis and is accountable to Havering's Health and Wellbeing Board. The Dementia Partnership Board brings together key commissioners across the health and social care economy. The Board will oversee and monitor the delivery of this strategy and implementation plan. The key highlights being:

- Setting out the vision and principles of dementia care
- Describing the current position, mapped against the locally agreed pathway
- Developing an integrated community based service model for Memory Services
- Work being undertaken with BHRUT to improve services within the hospital for people with dementia
- Mapping of total resource for dementia across the system, amounting to £14,673,914
- Supporting the Implementation Plan to be overseen and monitored by Dementia Partnership Board
- Prototype of Dementia Dashboard in development

Thus far, a number of actions had been completed included the development of the local Dementia Action Alliance (DAA) and the multi-agency Steering Group was in place and reporting to the Dementia Partnership Board. A review of the Dementia Advisory Service had also been completed with agreement to commission the service for a further three years and there was a revised service specification in place for the Memory Service. The Board were also asked to note that there had been an improvement in local dementia diagnosis rate from 39% to 46%.

A number of outstanding priorities remain and there is still much to be done in achieving the vision for dementia care and support in Havering such as:

- Further awareness raising across the community, via the vehicle of sign up to the Dementia Action Alliance, which is the favoured model for the development of 'dementia friendly' communities and is effective in reducing stigma.
- Developing a cohesive and whole system approach to the commissioning of dementia services via partnership working with health, public health and social care.

- Commissioning and providing a range of high quality services which are accessible, integrated and in line with local levels of need, both now and in the future. This will need to take full account of the predicted increases in levels of need and demand on services.
- Developing robust data and reporting systems for services across the dementia pathway, in order to fully understand the impact of the predicted increase in demand and its impact on services.
- Ensuring that the workforce is trained to develop and acquire appropriate competencies and skills in dementia care and end of life care.
- Providing access to high quality services in the community, including advice, information, housing support and leisure activities which enable people with dementia and their carers to live well.
- Ensuring that people have access to early intervention support and advice, as well as timely access to assessment and diagnosis, in line with the Government's aspiration for achieving a diagnosis rate of at least 66% for each local area by 2015.
- Co-production of service specifications and delivery with providers/ commissioners / service users.

The Board noted the contents of the presentation and accompanying reports. It was confirmed that hospital staff received training in dementia care, however, the Board wanted reassurance with regards to patients with dementia who were receiving specialised end of life care and what provisions were made for them and for staff training. It was therefore agreed that the Clinical Commission Group would provide an update on this particular aspect.

The Chairman thanked Dr Sanomi for his presentation and requested that a more detailed plan and update be provided at a later meeting.

42 INTEGRATED MASH AND DEVELOPMENT OF COMMUNITY MARAC FOR ADULTS

The Board received a presentation from the Head of Business and Performance on the integrated Multi Agency Safeguarding Hub (MASH) pilot and development of the Community Multi-Agency Risk Assessment Conferences for adults.

Following the development of the MASH scheme for children and young people in Havering, a pilot scheme to include the safeguarding of adults would be commencing on June 9 2014. Officers advised there were many benefits in utilising the MASH hub for adult safeguarding. The unit was secure, had strong protocols and there was the opportunity to share vital information with partners so as to make informed decisions.

The Children's and Young People MASH had been operating since 2012 which had resulted in fewer contacts actually becoming referrals to Children's Services. In addition, more referrals were becoming assessments and there had been a reduction in the duplication of reports to Children's Services. In addition, cases were also being referred to other services. The Police were currently receiving 20 alerts a week through the MASH hub.

In integrating children's and adults, there would be the benefit of managing demand and again the opportunity to share information. This would also prompt change in police alert (MERLIN) analysis as currently a third of the number of MERLIN alerts received weekly received no services. It was also important to note that many adult issues affected children such as domestic violence, parental substance misuse and adult mental health. A number of children's MERLINS had led to raised concerns about the adults within the same household.

The Board were advised that upon receipt of a referral, this would be triaged and rag rated on a risk basis. Red equated to immediate serious harm and action would be taken within four hours. Amber was not considered as immediate and action would be taken within one working day. Green stipulated that there were concerns about an individual but these were not critical.

Officers advised that the scope of the pilot was somewhat limited to acting on Adult Merlins and Safeguarding Alerts. The co-location of the Child Abuse and Investigation Team (CAIT) desk and the development of community MARACs – Multi-Agency Risk Assessment Conferences Panel would lead to a more efficient use of resources.

Partners in the scheme were London Borough of Havering, Metropolitan Police, NELFT, Clinical Commissioning Group, Probation Service and London Councils.

In setting up the scheme, the following had been arranged:

- Staffing structure agreed and new jobs being advertised
- Referral process and pathways for adults agreed
- Terms of Reference, Risk Assessment, referral form and chairing arrangements for Community MARAC agreed
- Accommodation and IT
- Governance arrangements and Steering Group
- Performance Management Framework
- Communications Plan

It was planned to enter into an Information Sharing Agreement and Table top exercise. In addition, there were plans to hold a "Dry run" of a Community MARAC meeting.

The next steps are:

- Deliver Communications Plan
- Go live 9 June
- Sources of contacts
- Reasons for contacts
- Turnaround times
- Agency participation in information sharing
- Changes in RAG ratings

- Outcomes of contacts
- Referrals to Social Care progressing to assessment
- Repeat referrals
- Professional disagreements
- Compliments and complaints
- Case studies
- Case audits
- Qualitative evaluation in September or October 2014

The Chief Executive Officer thanked the presenters for an informative report and requested that the Health and Wellbeing Board received future reports on how the project was proceeding and to highlight any issues.

43 **ANY OTHER BUSINESS**

None raised.

Chairman

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Have your say with healthwatch Havering

Services for people who have dementia or a learning disability

A review of services in Havering

A report of a series of workshops held by Healthwatch Havering
February and March 2014

What is Healthwatch Havering?

Healthwatch Havering is the consumer local champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary. There is also a full-time Manager, who co-ordinates all Healthwatch Havering activity.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

Introduction

In late February and early March, Healthwatch Havering held a series of workshops at five locations in Havering. The purpose was to find out what services were available in Havering for people who have dementia or a learning disability and what needed to be done to secure improvements.

The participants included people who use services and carers, volunteers from local third-sector organisations working with people who have dementia or a learning disability and social and health care professionals from Havering Council and local NHS organisations.

We chose Learning Disability and Dementia because these two groups are among the most vulnerable within our community.

Acknowledgements

Healthwatch Havering would like to thank all the participants for the open and frank contributions to the discussions at the workshops. The range of participants' experiences, knowledge and hopes, and their collective desire to secure the best possible outcomes for people who use services and carers made the exercise particularly valuable. Everyone who attended will be provided with a copy of the report

As a direct result of people coming together at the sessions, who would not ordinarily have come into contact, several initiatives have developed that might not otherwise have done so. We would like to thank the professional staff who took up these initiatives so quickly.

The conclusions and recommendations reached are entirely those of Healthwatch Havering.

How the sessions were organised

Five sessions were held between 25 February and 4 March at venues across the borough: in Central Romford, Collier Row, Cranham, Harold Hill and Hornchurch.

Attendees included service users and carers, a number of representatives from the voluntary sector, NHS organisations and local authority departments, everyone made significant contributions to the discussions.

The framework for each meeting and both topics was:

"What is missing?"

"What would make a difference?" and

"What have you experienced that is good?"

Attendees worked in individual groups sharing their knowledge and experience on both dementia and learning disabilities. Each group was chaired by a member of Healthwatch Havering. At the end of each session there was an open forum and each group fed back and shared the experience of their group.

Conclusions and recommendations

Our conclusions are:

- Overall services for people who have a learning disability or dementia appear adequate and there have been some good, innovative developments.
- Service planning over the years has taken account of the needs of people who have dementia; but much remains to be done, especially in early diagnosis
- Services for people who have a learning disability appear to be less advanced. The challenges are across all the age groups, but many parents felt very strongly about the support and access to basics such as aids and equipment.
- A more contemporary and intuitive care model for learning disability and dementia, which addresses the inequity of service and access across the Borough, is needed.
- The feedback indicates that people who use services and carers need better means of communicating their views and a better understanding of how to seek the support and help that they need.
- That is not necessarily a criticism of the services – there was no suggestion that staff do not listen, or seek views, or try to tailor services to individual need. However, the statutory provisions under which services are provided tend to be aimed at common needs rather than individual circumstances.
- Personalised budgets will undoubtedly help people choose what they want rather than what is on offer. However, it may take time both to give people the confidence to make their own choices and for "the market" to develop service packages that are tailored to

individual choice. **A clear message from the five events is that people will need help and support in taking on this responsibility.**

- Service users and carers appeared to be confused regarding the services on offer, the role of various voluntary sector organisations and who to contact and when.
- Service delivery problems are not confined to one sector: and there is evidence of joint planning and working across the agencies. However, from the comments given by users and carers, there is no doubting professional staff commitment and passion to achieve the best possible care standards for the residents in the Borough.

Our recommendations are:

Health checks

- To review the arrangements for providing and monitoring annual health checks
- To consider developing a dedicated, centralised service for health checks, creating a cadre of clinical staff with special expertise in learning disability and dementia
- To publicise the access and entitlement of health checks

General Practice awareness

- To ensure that all General Practitioners have the right level of training and expertise in dementia and learning disability
- To use those providers which are recognised as exemplars in good practice to mentor and support other general practice
- To determine where under-diagnosis of dementia is occurring within the Borough and establish a programme to address this
- To ensure that patients who need primary care services such as optometry and dentistry are promptly referred as appropriate
- To eradicate the delays between diagnosis and treatment
- To ensure that everyone has the opportunity, either by themselves or with the help of others, to discuss their health and social needs with practitioners

Communication and Awareness

- To develop a Borough information pack for learning disability and dementia which all organisations contribute to – simplicity is the key, and information overload must be avoided
- To consider something similar to the Butterfly scheme for learning disability
- To support the work of the Dementia Alliance
- To encourage closer collaboration between the statutory and voluntary organisations
- To establish befriending schemes

Staffing

North East London Foundation Health Trust to clarify the position in respect of Admiral nurses and their future role in the borough

One stop shop

- For residents to have their community services delivered in one location, consideration should be given to providing a 'one stop shop'. This would benefit service users and carers, improving the opportunity for information sharing, faster referrals and access to services.
- To design IT systems that work between all the different organisations, ensuring that information is up to date and relevant

Joint Strategic Needs Assessment

- To improve the level of local detail about learning disabilities and dementia, thus facilitating a better opportunity to plan and design care for the longer term.

Reachability

- To introduce 'Reachability' as the new criteria for measuring access to services, because unless services are 'reachable' they will not be used to their best advantage for the most vulnerable in our community

Specific points made during the five sessions

On the following pages is a summary of the contributions, discussions and comments made at the five events. The comments are set out using the question format of the sessions and under each question some key themes that emerged for both learning disability and dementia.

Learning disability

There are approximately 700 people recorded with a learning disability in the borough. Population statistics suggested that there should be a higher number something of the order of 2,500. Problems seem to arise with the recording and categorisation of learning disability. Autism was not labelled as learning disability as it is a condition in its own right.

Our understanding is that there are:

- 27 homes for adults with Learning Disabilities, the largest has 34 beds and the smallest 3 beds (average 7 places).
- 15 supported living units
- 7 day providers

A more comprehensive data base, perhaps within the JSNA, and a more detailed study of the residents of Havering with learning disabilities would help to provide more comprehensive and accurate information which could support the design of the wider range of provision and care that is needed.

What is missing?

Annual Health Checks

- Concern was expressed that Annual Health checks of people who have a learning disability are simply not being carried out. Annual health checks are the responsibility of the person's GP but the GP cannot be forced to do them. Health checks can take 30 minutes, and GPs are paid to do them, some GPs seem reluctant to spend that time.
- Competing priorities, such as ordinary consultations take much less time and several consultations could be done in the time taken to do a health check

- There appeared to be a need to raise awareness of the issue, it was not clear whether this was a matter which the CCG or Healthwatch England had responsibility.
- An idea suggested was to have one designated GP to do all health checks for learning disabilities in the borough. This would not only provide a recognised focal point for this care, but would develop a clinical team with a much more detailed knowledge of working with learning disabilities.
- This was felt to be particularly relevant when looking at diagnosing dementia within this group. People who have a learning disability, particularly those with Down's syndrome, often develop dementia far sooner than the general population; it can be hard to spot and, when it develops, does so more aggressively.
- It can be difficult to get a diagnosis of learning disability or dementia, with the result that support is in turn delayed.
- There was a suggestion that many people of the Asian community are unaware of dementia and learning disability issues for cultural reasons and a dedicated Health check service would help to support this group

Communication with professionals

- Any communications from health care providers, including hospital appointments – should be written in easy-to-read styles, so that people with a learning disability that included difficulty with reading could nevertheless read them for themselves.
- GPs, dentists and optometrists and other healthcare professionals are rarely trained to deal with learning disability.
- Although, understandably busy and therefore having little time to spare, staff at all levels in A&E need to be aware of how to deal with people who have such a disability – with particular awareness of the difficulty that some face in explaining their symptoms and feelings.
- Good practice is developing on learning disability within the Barking, Havering & Redbridge University Hospitals Trust (BHRUT) but the sharing of information between hospital staff and social care staff can be delayed and the social care team can sometimes not be made aware of an admission until a late stage.

- When admitted to hospital, people with learning disabilities still need support from carers particularly in communicating their needs and understanding what is happening to them. More input is needed from staff with a working knowledge of learning disabilities.
- Carers may need to stay in the hospital but this is not always possible. A short term budget increase may be needed to cover any extra costs and people need to know who to go to for advice
- Help is also needed for young people with learning disability in presenting their needs to the GP or other health care professionals.
- There was a feeling that there was a lack of support for people on the autistic spectrum. Quite often, a GP had to be convinced to refer them on to a specialist.

Helping people to be more independent

- The development of facilities to enable people with a learning disability to access as much as they could for themselves without others' interventions was an urgent need.
- Living in a supported environment rather than with relatives enables a person to be more independent; carers can be over protective. But it is important to avoid isolation – a buddy system can be invaluable.
- There is no befriending scheme, and people do not understand the needs of those who have a learning disability, and especially those developing dementia.
- It is important that individuals be encouraged to help themselves more. For example, with public transport, carers can help a person gain the confidence to use it appropriately.
- There is need to know how to access funding and what is available – for example if a person wants to attend college, currently there is a lack of assistance in understanding what is in the care package.

Finding out what is available

- People with a learning disability, especially those whose carers are themselves elderly, find it hard to access mainstream services. They often do not know how to, and thus cannot, communicate their needs to others.

- There was a call for more information generally, for example why not advertise more, or have slogans and adverts on buses. Letting people know where to go for advice: for example, how is the right to an annual health check communicated to the public?
- People who have a learning disability, and have never been in the system do not always get an inheritance from deceased parents or other relatives and so they become the responsibility of Adult Social Care.
- Carers of people who have a learning disability need to be aware of how to cope with dementia; the period following diagnosis can be a particularly traumatic time.
- If a carer has a problem, where do they go first? There is a lack of information, carers often not knowing where to start seeking support.

About how the services work

- Services for children with a learning disability are generally good and, if a user is known to Adult Social Care, for example, on transferring from Children's Services at 18, then they are more likely to continue to receive appropriate care
- Parents of children with a learning disability need to know the key person who is there to support them.
- Those who do not receive intensive support – perhaps because all care is arranged within the family - seem to slip through the gaps.
- As parents get older, natural family support can be lost and those who live at home with family as carers generally do not become known to Adult Care Services until an elderly carer dies, at which stage continuity of care becomes a crisis rather than a managed transition.
- The various strands of learning disability need to be looked at to ensure that people are getting the correct support.
- Although awareness is improving, there is a tendency to categorise rather than address the very many different types of need.

What would make a difference?

Help with managing health care issues

- To raise awareness, there was a need for better training of health and social care professionals, voluntary sector helpers and carers.
- A welcome improvement is the forthcoming reinstatement of the providers' forum.
- Better sharing of information across service providers and quicker notification to social services when a person was admitted to hospital was essential.
- BHRUT should improve their communication with other organisations as this was vital to assisting the patient and the dedicated community support
- Information should be kept up to date, between BHRUT, the GPs and the social care teams.
- A central office/conduit could be set up to encourage the co-operation between such services.

Families

- Families needed to be aware that people with Downs Syndrome were more likely to develop dementia earlier, and that the effects of the syndrome can mask the onset of dementia, making it harder to detect.

Residential homes

- The signs of dementia in learning disability needed also to be understood by staff of residential homes accommodating people with learning disabilities.
- This should form part of the 'routine' training because of the high turnover of staff in those homes.
- Once dementia has been detected, it was necessary to forget the learning disability and deal with the dementia, and staff and carers needed to be aware of this.
- When a service user goes from a care home to hospital, they should be accompanied by a carer from the home, who knows all there is to know about the person.

GP care

- GP services needed to be more aware of, and ready to respond to, the problems of people who have a learning disability.
- It was suggested that a scheme similar to the Butterfly scheme used by BHRT for dementia patients could be developed for the GP notes of people with learning disability this would alert reception and clinical staff to be alert and prepared.
- There would be an improvement in GPs monitoring of patients with learning disabilities if they could follow a learning disability health action plan.

Queen's Hospital (BHRT)

- Improved education and training for staff to enable them to identify the needs of a learning disability service use when being admitted to hospital
- Could a scheme similar to the Butterfly scheme be developed for learning disability patients
- Clinicians need to be aware about the additional needs of their patients who have learning disabilities, particularly communication needs
- There is a new learning disability nurse in place at BHRUT, which should improve matters and was seen as a very positive approach
- This new post should be communicated/ published more widely, so learning disability service users know who to contact.
- There is a communication book from BHRUT and this should be made more available public

Carers

- Families who are without other relatives support should be offered more respite care hours. They tend to use the hours up quickly when compared to families who have family support.
- There was a lack of understanding that carers and families had other responsibilities: their jobs, their homes, raising their children. They should not be made to feel guilty because they could not provide a home and full-time care for their relative
- There was concern that the Government was now expecting carers who were in receipt of welfare benefits to seek employment and report to the Job Centre, even though they were caring full-time.
- Carers also need to be aware of their entitlements to benefits.

- Service users and carers will need help and support in making sense of personal budgets
- Improved access to advice on financial matters from organisations that do not have a business interest in providing the information

Community learning disability passport

- The learning disability passport gives information but is missing practical advice.
- Community passports need to be updated to show what date they are admitted into hospital
- Person-specific information such as by what name a person likes to be called, what they like and dislike and what upsets them. This applies to dementia as well as learning disability.

Practical support

- It would be useful if there were more clubs and cafés for people with learning disabilities
- If clubs, cafés and other facilities for the general public were more welcoming of people with learning disabilities, perhaps develop a learning disabilities friendly logo
- A befriending scheme would help.
- Recognition of people with learning disabilities needs in using public facilities such as public toilets.

It was recognised work has started on many of the issues raised above and that good progress was being made. This is identified in the section below.

What have you experienced that is good?

Support

- Havering Adult Care Services were praised and appreciation was expressed of support from St Francis Hospice. The work of the new learning disability nurse at Queen's and residential homes staff were also praised.

Awareness

- The overall view was that it was good.

- The professionals from the different teams were working together.
- Meetings such as this series of events were seen as a real opportunity for non-confrontational, open and frank discussion between the professionals, service users and carers.

Care services

- There is good multi-disciplinary working, which should ensure that communication is used in the right way
- Mystery shopping takes place, and has worked well in identifying good practice and practice that needs change or developing
- There is a good partnership board that addresses employment issues.
- Supported living schemes help individuals to make better lives for themselves.
- In residential care settings, annual health checks are done.

Health services

- There is a lot more awareness in hospitals, with recent training in BHRUT and consultants are attending these training sessions. Nursing staff receive learning disability training in their inductions
- There has been good feedback about A&E and end of life care from learning disability service users and carers.
- The handling of cases with complex discharge issues from BHRUT has been vastly improved.
- There is demonstrable good practice in dealing with learning disability
- The learning disability team at the Hermitage centre has created a learning disability pathway.

Dementia

Havering has the highest proportion of older people in London and has experienced a 44% increase in the very elderly age groups 84 – 89 years; almost double that of London and England overall.

It is estimated that around 3,275 people in Havering (aged 65+) have dementia. This is predicted to rise to 3,794 by 2020.

There are 42 registered care homes for dementia but, of course, that figure will rise as residents living at home develop dementia.

What is missing?

Carers

- The view was expressed that there is little or no support for carers and the person with dementia, leaving people feeling isolated and unable to find help in the community but reluctant to involve Social Services initially.
- Once registered with Adult Social Care it is easier for people to gain access to the "front door".
- Carers have a right for their own needs to be assessed but need encouragement to come forward.
- Carers need greater awareness of the clinical issues affecting people with dementia
- There is no use giving people money in personal budgets if they do not know how or where to use it.
- An inability to find help in the community and leaving carers unable to get respite. There is very little respite, which is stressful for families.
- There is confusion over who is offering services. Age Concern no longer offers an advocacy service and there is no support for carers.
- Some patients refuse to visit the memory service – carers of people with dementia are told that the carer must compel the patient to attend the memory clinic, if not this would be a violation of the patients human right - but what about the carer's human rights?
- A crisis line to call for carers when a person becomes violent would be a significant help.

Access to information

- Information points are needed; there is a lack of information in hospitals, libraries and other public areas.
- More is needed for the growing BME population – a multi-cultural approach, making services acceptable.
- People with dementia may not know much English or even revert to speaking their native language, which not only exacerbates the already difficult nature of communication with dementia patients but leads to isolation
- Because of language barriers, people may not be aware of the services available to support them.
- A unit that can offer translation services within the community would help address this.
- The voluntary sector lacks communication with health professionals.
- There was a suggestion that people are unaware of the resources, voluntary organisations and professional health and social care resources available in the borough.
- A more co-ordinated approach between professional to ensure that accurate information is shared about service users prior to visiting peoples home.
- There is a lack of communication between Adult Social Care and voluntary organisations, and referrals are not always treated appropriately.

GP Care

- There is a lower than average diagnosis rate in Havering, possibly because of coding in GP practices if the incorrect code is used it sometimes is not picked up
- Demographics suggest there should be around 3,000 people with a formal diagnosis of dementia but only about 1,000 have been so diagnosed; the "missing" 2,000 should be identified quickly.
- Individuals and families did not know who to turn to when a diagnosis of dementia was made
- It seems that NELFHT and the CCG/GPs do not use the same coding systems.
- GPs need encouragement to diagnose under 50's.

- People can become lost between diagnosis and follow up and there are some very unacceptable delays
- It can be difficult to get GPs to make home visits
- When service users are discharged from clinics there is no continuity or follow-up service and carers and users seem to be left to fend for themselves.

General comments

There is a hidden population – people in care homes who not are not necessarily known to Adult Social Care or voluntary organisations, never go to memory clinic sessions and receive care from their GP only if their behaviour worsens.

Health passports are not being used enough, nor up-dated.

It would appear that they are only mentioned when someone is admitted into hospital.

It would help if facilities could be shared: with say NELFT, Physiotherapy and voluntary organisations together on one site, in a "one stop shop".

What would make a difference?

GP Care

- GPs are the first port of call.
- When people go to see their GP about dementia the GP often holds back; how can this be overcome?
- GPs need better awareness and understanding of, and training about, dementia.
- When a diagnosis is made it would be really useful to have someone on hand for a chat about relevant information and telephone numbers.
- An information pack is being prepared, but care is needed to avoid information overload, could organisations work together to provide one concise pack.
- The waiting time from Memory Clinic to receiving a prescription is too long; it can take weeks. GPs blame the system but medication should be available immediately.

- Better liaison is needed between GPs and NELFHT; it is improving but more need to be done. Consultants now give out mobile numbers.
- Isolation exacerbates dementia – not just age – people with mental illness need more help from GPs.
- GPs lack empathy – some GPs say what you would expect from a person who is aged 80.
- Clinicians and receptionists need to listen more – even though they are busy, they should take time for the small things that matter, like getting names right.
- There used to be regular talks given by the PCT in particular at St George's Hospital; this should be reintroduced as the talk was usually given by clinicians and it was very useful.
- Patients often have other health needs, for example, diabetes and it is often very difficult to get medication changes and follow up care organised as the GP does not always fulfil the role of the link clinician

General comments

- There is also concern about the lack of Admiral Nurses – and when one retires later this year, is understood that NELFHT will not be replacing her. That decision needs to be reversed.
- Age Concern raised their concern that they were no longer invited to attend multidisciplinary meetings and felt their input could make a positive difference.
- Wider membership of multi-disciplinary team would be helpful to share information before crisis point is reached
- The public need educating about dementia in order to overcome the possibility of stigmatising people.
- There are new national schemes working with children which have proven to have very positive outcomes
- Better information needs to be available on websites, or when calling centres.
- Advice on legal and financial help should be readily available.
- Carers need better training and overall support, it is a heavy burden 24 x 7
- A "buddy" scheme and a link so that carers and service users do not feel abandoned would help

- Carers need to know how to follow up problems before service users reach crisis point.
- Relatives should be given more information about their kin in care homes. What activities are being employed and how their time is structured.
- More awareness and information should be available. For example, people have commented that their friend is showing signs of dementia, who do they go to for advice about their friend?

What have you experienced that is good?

Health services

- There is good support from some GPs and the Admiral Nurses.
- The Council is investing in more liaison with carers. Carers forums are held and there is a single point of access at the Council
- Co-operation between the CCG and BHRUT is improving; information is being shared between them which they plan to send to The Memory Clinic and it is envisaged that a pattern will emerge. This should help identify the "missing" 2000 who have yet to be diagnosed with dementia
- Good community care can avoid the need for admission to hospital.
- The CTT and the CCG are proposing to provide facilities at night.

Social Care

- Good support from Adult Care Services
- Occupational Therapists are supportive and give advice as to what is needed in the home, such as alarms.
- Havering is passionate about dementia services in the borough and there is now a Dementia Programme Manager.

The voluntary sector

- There is good support from Age Concern, St Francis Hospice
- There are support groups for carers, lunch clubs and Alzheimer's cafés: these are well run, but people who are not in the "loop" find it difficult to access them.
- The Alzheimer's Society has issued a leaflet called "This is me" about the need of a dementia patient when they are receiving

treatment – it was originally for those going into hospital, but has been updated for all dementia patients undergoing treatment either in hospital, GP or in the home.

- The Alzheimer's Society has dementia champions, with training not only for their own staff and volunteers but for others.

Other

Joint Strategic Needs Assessment

- The JSNA is the document which helps to form the basis of informed decision making for commissioning services.
- It is robust in having well-documented national statistics, but it appears to be weaker in local data.
- Aspects of the JSNA such as statistics on learning disability and dementia should be provided in a simpler and shortened format for organisations working within this sector. The current format is a bit indigestible for people outside of the professional public health arena.

Library Services

- This service is well respected by all the agencies.
- Libraries are really committed to helping support groups, and support anyone wishing to hold an event.
- A Dementia Action Alliance is being formed in Havering. It would be helpful if local shopkeepers could put a sign up saying that they are a "dementia-friendly" shop. This would make those with dementia and the carers feel more comfortable as they can feel alienated when visiting shops.

Making a difference – actions already taken

In the course of the discussions, several issues were mentioned and it was agreed people felt should be taken forward as quickly as possible

. The following is a brief summary of some of the action taken:

- Following a suggestion that GPs lacked training in dealing with dementia, BHRUT agreed to investigate the position
- In respect of training for carers' groups, Adult Social Care is working with the CCG to find suitable premises as a matter of urgency
- NELFT and Age Concern are to discuss what happens when a person who has dementia refuses to see a GP or the memory service –
- Enquiries are being made about overcoming the obstacles to Age Concern and potentially any other relevant voluntary organisation resuming attendance as part of multi-disciplinary meetings
- The CCG is to discuss with NELFT the concern about the lack of Admiral Nurses – in particular, the suggestion that when one retires Note CCG have picked up on this and written to NELFT.
- A lead GP agreed to take forward the concerns on providing Health Checks to people with learning disability

Individual cases that came to light in the course of the events have been taken up with the relevant providers.

Participation in Healthwatch Havering

We need local people, who have time to spare, to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering. To achieve this we have designed 3 levels of participation which should allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Lead Members

To provide stewardship, leadership, governance and innovation at Board level. A Lead Member will also have a dedicated role, managing a team of members and supporters to support their work.

Active members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call our Manager, Joan Smith, on **01708 303 300**;
or email **enquiries@healthwatchhavering.co.uk**

Healthwatch Havering is the operating name of
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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Barking and Dagenham, Havering and Redbridge Integrated Care Coalition five year Strategic Plan**
Board Lead:	**Alan Steward, Chief Operating Officer, NHS Havering Clinical Commissioning Group**
Report Author and contact details:	**Emily Plane, Project Manager, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups** **Emily.Plane@onel.nhs.uk** **0208 822 3052**

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

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

SUMMARY

The purpose of this report is to provide Health and Wellbeing Board members with the final version of the BHR 5 year Strategic Plan, and detail of the development process of the Strategic Plan including input from BHR stakeholders before submission was made to NHS England on 20 June 2014.

RECOMMENDATION

The five year strategic plan sets out how we will work collaboratively across the Barking Havering and Redbridge Strategic Planning Group (SPG) in order to achieve our shared vision, deliver improved outcomes and patient experience, ensure a financially sustainable system, and meet the expectations of patients and the public. Health and Wellbeing Board members are asked to note the content of the Strategic Plan.

REPORT DETAIL

1. Brief Background

1.1 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 5 year plans to secure sustainable high quality care for all.

1.2 The Integrated Care Joint Health and Social Care Steering Group (ICSG) led the development of the 5 year Strategic Planning process, as mandated by the Integrated Care Coalition on 10 January 2014.

1.3 A draft version of the BHR Strategic Plan was submitted to NHS England by the mandated deadline of 4 April (following review and endorsement by the Integrated Care Coalition on 31 March) accompanied by a cover letter recognising several areas that would be further strengthened in the plan prior to final submission in June.

2. The BHR Strategic Plan

2.1 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.

2.2 The 5 Year Strategic Plan builds on the CCGs Operating and Better Care Fund plans which provide the foundation for the Strategic Plan. In addition, the development of the Strategic Plan has been discussed at the following forums and feedback has been incorporated into the final version including direct patient feedback to make the document more 'user friendly'.

2.3 Development of the final plan in preparation for submission on 20 June has incorporated:

- NHS England feedback
- Outputs from the 'Call to Action' themes
- Further review by the Integrated Care Steering Group
- Review by BHR Patient Engagement Forums

2.4 The sign off process for the final plan took place as follows:

- 16 June: endorsement of the plan by the Integrated Care Coalition
- June: CCG Governing Bodies received the final Strategic Plan
- July: Provider Boards to receive the final Strategic Plan
- July: Health and Wellbeing Boards to receive the final Strategic Plan

Appendix 1: BHR Integrated Care Coalition five year Strategic Plan

IMPLICATIONS AND RISKS

Financial implications and risks: There are no specific financial implications that arise from this report at this stage.

Legal implications and risks: There are no specific legal implications that arise from this report at this stage.

Human Resources implications and risks: There are no specific Human Resource implications that arise from this report at this stage.

Equalities implications and risks: An equalities impact assessment has not been undertaken. The priorities of the planning process places emphasis on reducing health inequalities and improving health outcomes of the population.

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Barking and Dagenham, Havering and Redbridge Integrated Care Coalition

Strategic Plan final submission

June 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

Consolidation of the three BHR boroughs objectives

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

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

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

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

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

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

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

Achieved through the following interventions

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

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

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

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

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

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

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

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

Managed via the following arrangements

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

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

All work streams have identified leads

Measured using the following success criteria

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

High level risks to be mitigated

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

Section Two | Key lines of enquiry (KLOE)

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

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

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

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

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

inequalities?

B&D

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	453	85	148	226	152	151
Surplus/(Deficit) Cumulative	4,768	4,854	5,001	5,228	5,380	5,531
Surplus/(Deficit) %	1.95%	1.92%	1.90%	1.93%	1.93%	1.93%

Havering

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(0)	28	99	78	59	77
Surplus/(Deficit) Cumulative	3,098	3,126	3,225	3,303	3,362	3,439
Surplus/(Deficit) %	1.02%	1.01%	1.01%	1.01%	1.00%	1.00%

Redbridge

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(2,919)	3,019	204	111	112	113
Surplus/(Deficit) Cumulative	0	3,019	3,223	3,334	3,447	3,559
Surplus/(Deficit) %	0.00%	1.00%	1.00%	1.00%	1.00%	1.00%

Financial Pressures

The three CCGs face a range of significant and ongoing financial pressures. It is estimated that at the end of 2014/15 the total CCG's budget will be underfunded against target in excess of £25m. At the end of 2014/15 Redbridge CCG will be under funded by 6%, and Havering CCG underfunded by 3.8%. It is projected that Havering CCG will continue to move away from target during the operating plan period.

As a result of the financial pressures the CCG's are required to deliver large QIPP savings programmes.

BCF Schemes have been mapped to 7 outcome measures

B&D

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

Havering

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

Redbridge

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

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

b) Health outcomes

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

c) Reducing health inequalities

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

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

BHR 5 year target projections_updated.

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

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

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

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

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

Redbridge baselines & trajectories.pdf

B&D Ambitions & BCF baselines & trajectori

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

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

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

B&D
<table><tr><td>Notified Allocation Change (%)</td><td>3.50%</td><td>2.61%</td><td>3.09%</td><td>2.92%</td><td>2.86%</td></tr></table>
Havering
<table><tr><td>Notified Allocation Change (%)</td><td>2.41%</td><td>1.67%</td><td>2.30%</td><td>2.31%</td><td>2.31%</td></tr></table>
Redbridge
<table><tr><td>Notified Allocation Change (%)</td><td>4.65%</td><td>4.05%</td><td>3.47%</td><td>3.35%</td><td>3.29%</td></tr></table>
A number of planning assumptions that relate to cost and activity changes have been made and are outlined below.
<table><tr><td>Tariff Change - Acute (%)</td><td>-1.50%</td><td>-1.60%</td><td>0.40%</td><td>-0.60%</td><td>-0.70%</td></tr><tr><td>Tariff Change - Non Acute (%)</td><td>-1.80%</td><td>-1.60%</td><td>0.40%</td><td>-0.60%</td><td>-0.70%</td></tr><tr><td>Demographic Growth / Non demographic growth (%)</td><td>4.50%</td><td>4.50%</td><td>4.50%</td><td>4.50%</td><td>4.50%</td></tr><tr><td>Non Demographic Growth - CHC (%)</td><td>1.00%</td><td>1.00%</td><td>1.00%</td><td>1.00%</td><td>1.00%</td></tr><tr><td>Non Demographic Growth - Prescribing (%)</td><td>5.00%</td><td>5.00%</td><td>5.00%</td><td>5.00%</td><td>5.00%</td></tr><tr><td>Non Demographic Growth - Other Non Acute (%)</td><td>1.40%</td><td>1.40%</td><td>1.40%</td><td>1.40%</td><td>1.40%</td></tr></table>
Income & Expenditure: The table below highlights the projected spend profile over the 5 year period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

unknown primary and acute oncology.

- Living with and beyond cancer - improve support and care coordination for the BHR population living with and beyond cancer.
- Improving the cancer patient experience for all patients living with cancer.

The planning of these initiatives in the above areas will be taken forward through the contracting route.

NHS England priorities

Cancer Screening

- Coverage and up take to be increased to at least minimum target (dependant on service)

Immunisations

- Patient experience and values are integrations into the design and delivery of services
- Measured through the Friends and Family Test and other patient experience metrics

Military health and Health in the Justice system

- to improve the engagement and support for those in contact with the Health in Justice system
- to reduce re-offending for individual offenders
- to improve the efficiency and effectiveness through better collaboration of commissioning partners

Barking and Dagenham, Havering and Redbridge priorities:

Alcohol

- All service users/patients where alcohol misuse is known or suspected to be screened and managed using an evidence-based pathway[6] (currently in development)

Smoking cessation

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

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

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

[7] Brandling J and House W. Social Prescribing in General Practice: Adding meaning to medicine. Br J Gen Pract. Jun 1, 2009; 59(563): 454–456
[8] Timebank UK: http://www.timebanking.org/about/what-is-a-timebank/
[9] UNICEF. 2014. Moving from the current to the new Baby Friendly Initiative Standards: A guide for those working towards or maintaining Baby Friendly accreditation
Available at: http://www.unicef.org.uk/Documents/Baby_Friendly/Guidance/transition_guidance.pdf
[10] https://www.dementiafriends.org.uk

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

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

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

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

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

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

Expected outcome:

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

Investment costs:

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

Implementation timeline:

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

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

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

- Scheme 1: Improved Access; 14.04.14 – 28.02.15

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

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

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

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

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

Expected outcome

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

Investment costs

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

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

Implementation timeline:

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

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

What does this mean in practice for patients?

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

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

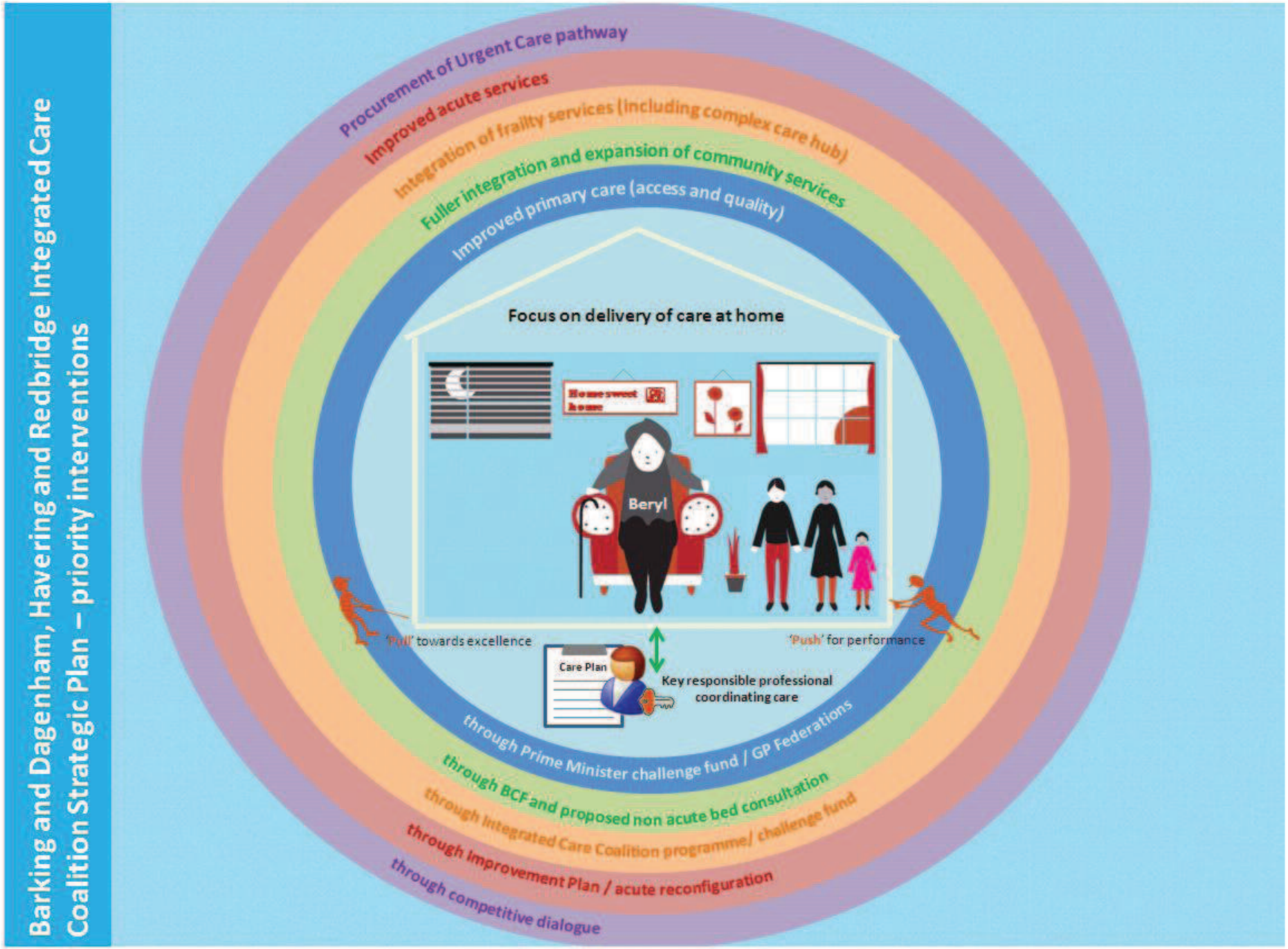
In the next 5 years, Beryl and her family can expect the following:

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

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

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

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


Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan – priority interventions
Procurement of Urgent Care pathway
Improved acute services
Integration of frailty services (including complex care hub)
Fuller integration and expansion of community services
Improved primary care (access and quality)
Focus on delivery of care at home
Home sweet home
Beryl
'Pull' towards excellence
'Push' for performance
Care Plan
Key responsible professional coordinating care
through Prime Minister challenge fund / GP Federations
through BCF and proposed non acute bed consultation
through Integrated Care Coalition programme/ challenge fund
through Improvement Plan / acute reconfiguration
through competitive dialogue

Intervention Four: Acute re-configuration programme

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

The key recommendations were:

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

The maternity changes have been successfully implemented through 2013.

The focus is now on:

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

In 5 years time, service users will

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

Interventions required:

a) **BHRUT Emergency Care business case approved**

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

b) Urgent Care Procurement

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

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

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

c) King George Hospital Vision Programme

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

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

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

through existing forums used to improve urgent care performance.

Expected outcome

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

Investment costs

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

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

Implementation timeline:

- The Trust are working on an implementation timeline

Barriers to success:

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

transfers from the KGH site

Confidence levels of implementation:

- The Trust are working on an implementation timeline

Intervention five: Planned Care Programme

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

Interventions required:

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

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

New Services

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

MSK

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

Diagnostics

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

		• Roll out new diagnostic pathways for calprotectin (B&D and Redbridge) • Roll out new diagnostic pathways for ECG (B&D) • Development of Diagnostic work stream, to include Pathology, MSK (MSK and Head) and Ultrasound (MSK and abdomen/pelvis) (Redbridge) • New MRI pathways for hip and knees (Havering) Ophthalmology • Ophthalmology – optimise community eye service contract for glaucoma follow up (B&D) • Procurement of new Ophthalmology service, including triage services for ophthalmology conditions (Redbridge and B&D jointly) <u>New models and pathways</u> • To develop new models for the management of outpatient specialties where the outpatient first appointment is above average (B&D) • Using benchmarking data, to review pathways for general surgery, urology, gastroenterology, gynaecology and ENT, along with associated investigations, to identify best practice across providers and practices, and reduce referrals (Redbridge) • Cardiology primary care pathways for heart failure, palpitations, angina and chest pain (B&D) • Development of a continence pathway (Havering) • Pilot a new model for dermatology with BHRUT (B&D) • Implement newly procured community diabetes service (Redbridge) • Roll out of the new heart failure pathway by introduction of BNP testing (Redbridge) <u>Expected Outcome</u> • To reduce inappropriate GP referrals and improve the patient pathway • to improve patient experience by providing quality care close to home • To improve equality of access to care for patients across the Boroughs and CCGs <u>Investment costs</u>	

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

Implementation timeline:

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

Barriers to success:

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

Confidence levels of implementation:

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

Intervention six: Specialised Commissioning Services

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

Intervention seven: Mental Health Services

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

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

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

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

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

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

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

Investment costs

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

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

Intervention eight: Children's Services

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

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

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

<u>Interventions required:</u>

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

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

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<u>Expected Outcome</u>
Using innovative, new, accelerated joint approach to deliver:-
• Improved outcomes
• Improved experiences
• Efficiencies
• Local plans for reducing child poverty
• Investment in early years
• Early identification, early effective interventions
• Improvements in transition
• Excellent communication and collaboration between professionals (health, education, criminal justice system and police)
<u>Investment costs</u>
<table>
<tr><th>BHR Investment</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18</th><th>2018/19</th></tr>
<tr><td>Community Initiatives</td><td>0</td><td>100</td><td>200</td><td>350</td><td>500</td></tr>
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<u>Implementation timeline:</u>
Production of the strategy is likely to be a key priority in the first year. Local ownership of the plans is imperative. The CCGs and the Local Authorities will be working in collaborative partnership arrangements to deliver the key priorities that are agreed.
<u>Barriers to success:</u>
Alignment with national Children's service commissioning strategy due to national strategy developments working to different timelines
<u>Confidence levels of implementation</u>
The development of the children's services will be closely linked to the development of the KGH site.
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<tr>
<td>Governance overview</td>
<td>What governance processes are in place to ensure future</td>
<td>The supporting evidence attached details the Governance Structures in place within the BHR economy to ensure future plans are developed in collaboration with key stakeholders.
The members of the Coalition also work closely with Waltham Forest and East London (WEL) organisations to promote a shared case for change. This includes regular meetings with</td>
<td>BHR Governance Structure:</td>
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	plans are developed in collaboration with key stakeholders including the local community?	organisational leads on cross cutting transformation issues including the Acute Reconfiguration programme and Urgent Care procurement. BHR CCGs have also been working closely with the London Ambulance Service (LAS) to ensure alignment of the respective strategic plans through schedule meetings throughout the year. This is underpinned by ongoing engagement with patients (via Patient Engagement Forums, as well as other methods of engagement for example periodical telephone interviews with patients accessing the Community Treatment Team and Intensive Rehab Service, the outcomes of which directly feed into ongoing service development).	 BHR_Governance Arrangementsv4.pdf
Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	The final values and principles of the Coalition will embed into the BHR system 5 years Strategic Plan to promote joint partnership working across the system. The values and principles provide the foundation for a system wide leadership development programme involving all organisations and a number of coalition members; UCL Partners and NHS Improving Quality have expressed a strong interest to take this forward. The values and principles provide an opportunity for the coalition to demonstrate to the public and stakeholders our commitment to work together to deliver improved outcomes.	BHR values and principles:  BHR System Values and Principles.pdf

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

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

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

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

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