Appendix A: Draft Plan Submission Template

Havering Better Care Fund
Draft Submission

Local Authority
London Borough of Havering

Clinical Commissioning Groups
Havering Clinical Commissioning Group

Boundary Differences
Co-terminus

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

Date submitted:
N/A

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

Service provider engagement

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

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

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

- sustaining and enhancing this engagement will be essential to future sustainability of the ambition represented in this application

- there needs to be a range of approaches to engagement across the whole system to ensure a balanced and inclusive process representative of all interests.

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

Patient, service user and public engagement

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

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

Examples include:

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

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

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

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

- Greater choice and control

- Intervention and responses closer to home

- A broader range of community solutions

- Improved information and access to advice

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

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

Related documentation

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

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

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

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

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

2. VISION AND SCHEMES

a) Vision for health and care services

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

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

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

Whole system care objectives are:

Across BHR localities

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

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

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

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

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

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

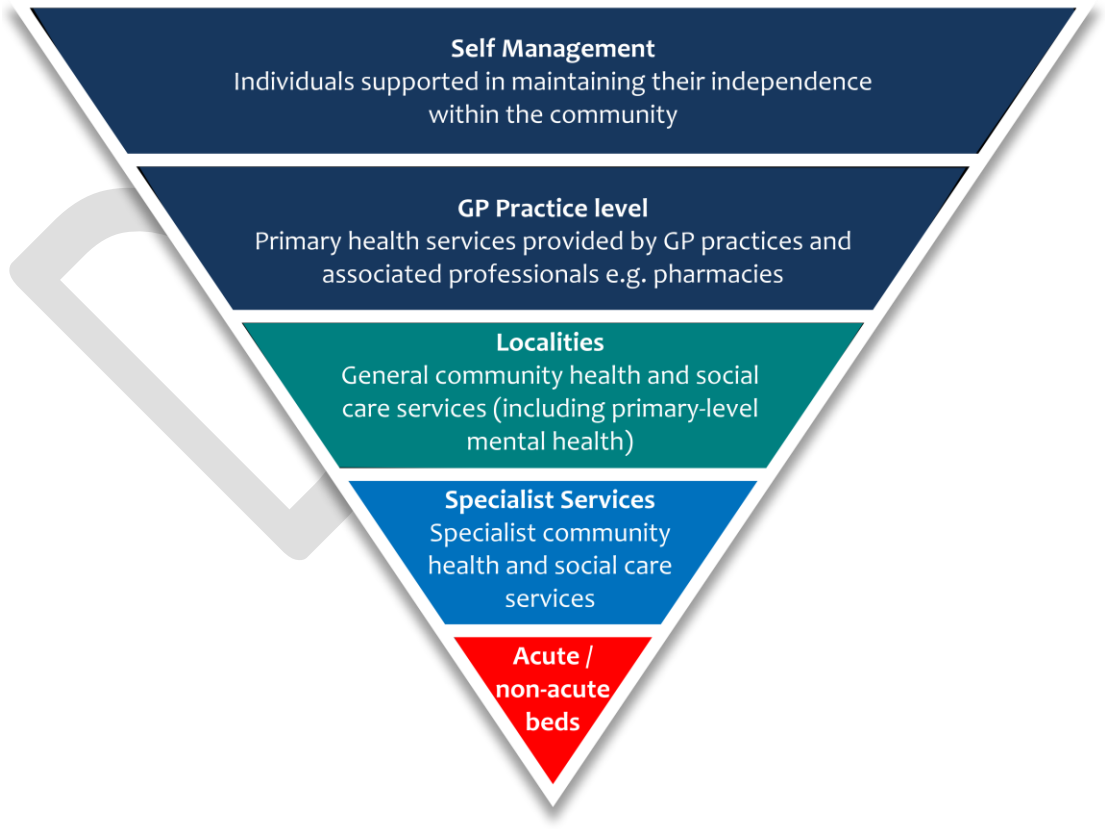


Figure 1: Building From The Community

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

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

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

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

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

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

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

- Joint decision making with collective accountability

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

- Joint Management: maximising opportunities for shared management and leadership

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

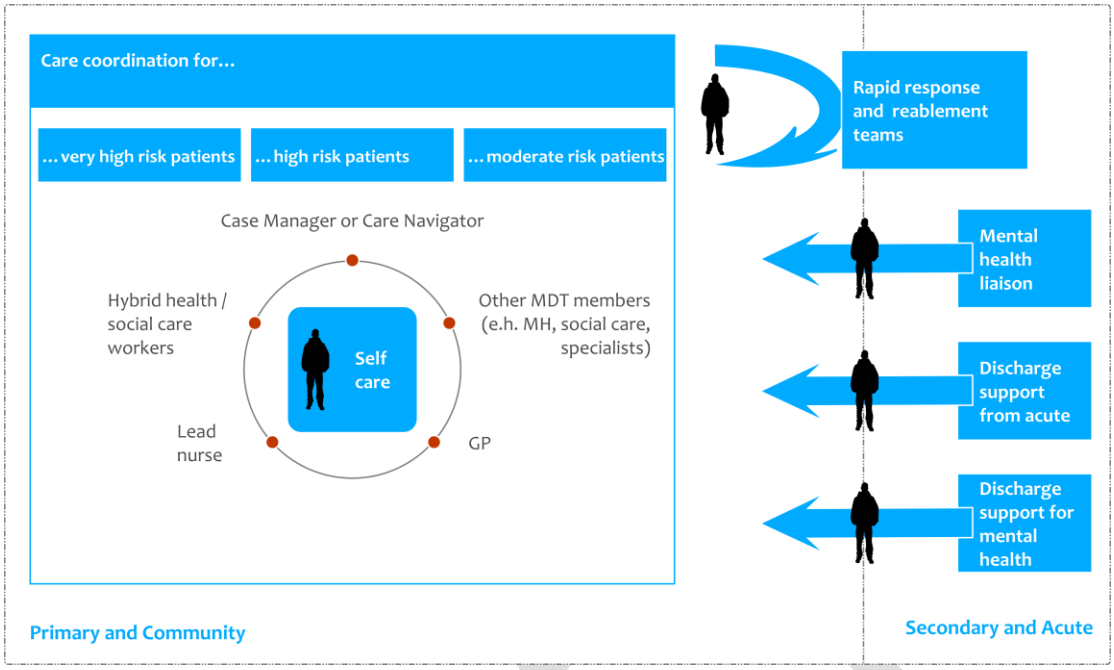


Figure 2: Systemic Approach : Person Focussed

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

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

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

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

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

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

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

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

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

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

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

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

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

VISION AND SCHEMES

b) Aims and objectives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

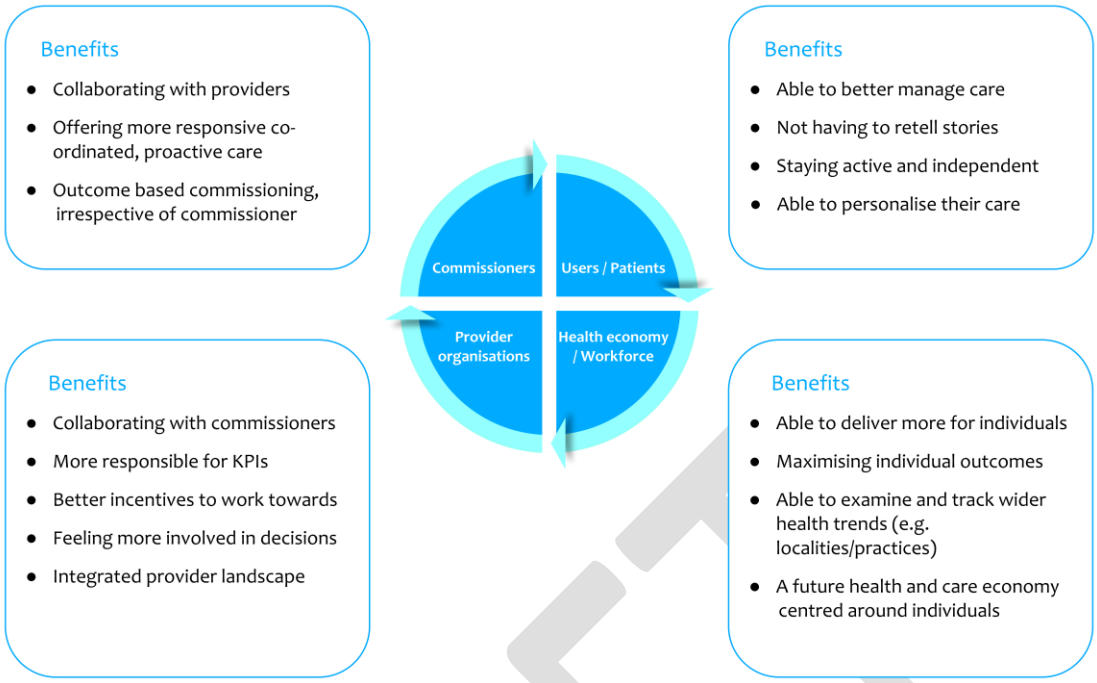


Figure 4: Anticipated Benefits (i)

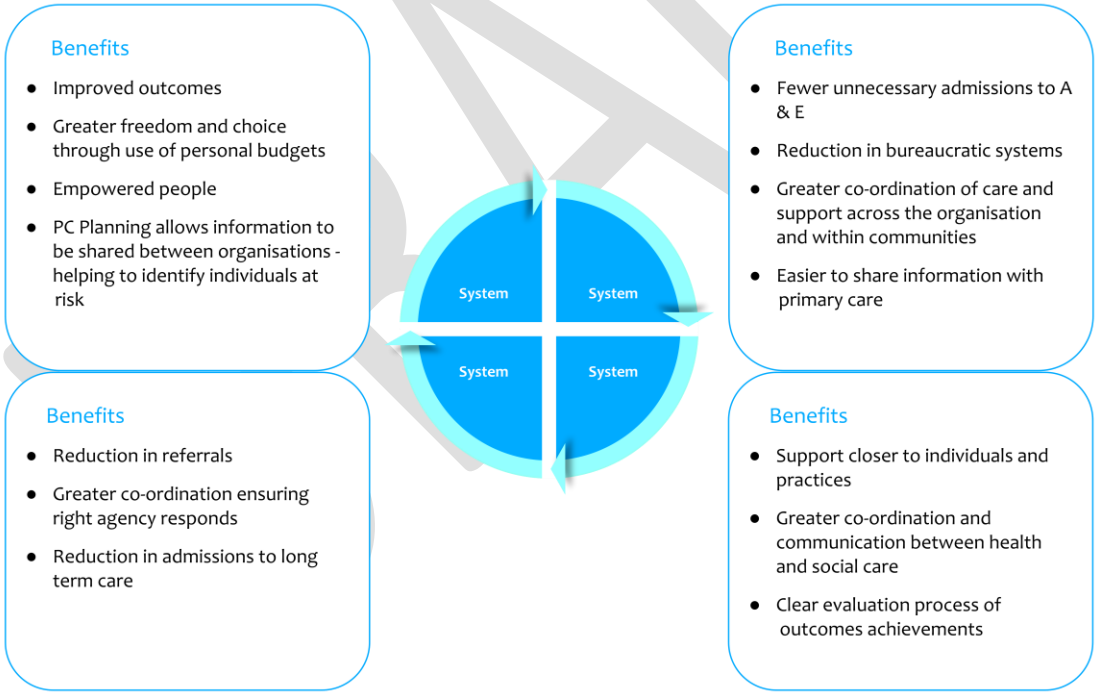


Figure 5: Anticipated Benefits (ii)

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

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

Description of planned changes

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

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

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

What has been done so far?

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

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

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

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

Priorities for the ICC include:

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

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

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

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

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

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

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

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

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

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

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

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

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

The overall aim is to:

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

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

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

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

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

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

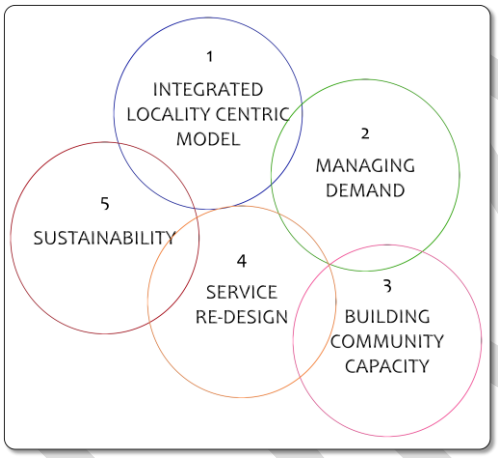
At the centre of this approach is a smaller acute system offering highly specialist care – not when all else fails, but only when all else could never have succeeded

Havering Integrated Commissioning Strategy (Work in Progress)

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

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

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



ELEMENTS (ILLUSTRATIVE)

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

OUTCOMES (ILLUSTRATIVE)

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

NB. All supplemented by ASCOF

Figure 6: The Havering Programme

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

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

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

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

  The JAD has the following aims:

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

  The measurable benefits to be gained have also been identified.

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

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

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

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

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

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

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

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

  (Building Block 4)

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

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

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

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

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

Our Ambition

Figure 7: Integrated and Person Centred

Summary

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

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

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

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

Much is underway already on which to continue to build.

c) Implications for the acute sector

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

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

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

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

d) Governance

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

The governance arrangements are on a number of levels.

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

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

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

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

An evolving approach to shared leadership and governance

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

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

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

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

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

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

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

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

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

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

3) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

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

<u>The Community Treatment Team</u>

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

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

Data sharing

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

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

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

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

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

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

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

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

Joint assessment and accountable lead professional

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

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

Team membership is multi-professional including mental health.

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

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

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

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

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

4) KEY RISKS

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

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

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

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

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