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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD AGENDA

1.00 pm	Thursday 16 December 2021	Remote meeting

Members 20: Quorum 6

BOARD MEMBERS:

Elected Members:	Cllr Jason Frost (Chairman) Cllr Damian White Cllr Robert Benham Cllr Nisha Patel
Officers of the Council:	Andrew Blake-Herbert, Chief Executive Barbara Nicholls, Director of Adult Services Robert South, Director of Children Services Patrick Odling-Smee , Director of Housing Services Neil Stubbings, Director of Regeneration Services Mark Ansell, Interim Director of Public Health
North East London Clinical Commissioning Group (NEL CCG):	Dr Atul Aggarwal Sarah See
Havering Primary Care Networks (PCNs):	Havering Crest – Dr Asif Imran, Dr Narinder Kullar North – Dr Jwala Gupta, Dr Gurmeet Singh South – Dr Nik Rao, Dr John O'Moore Marshall – Dr Sarita Symon, Dr Ian Quigley
Other Organisations:	Healthwatch Havering (Anne-Marie Dean, Executive Chairman) BHRUT (Mehboob Khan, Non-Executive Director) NELFT (Carol White, Integrated Care Director) Voluntary & Community Sector (Paul Rose, Compact for Havering Chairman)

For information about the meeting please contact:
Luke Phimister 01708 434619 Error! Unknown document property name.
luke.phimister@onesource.co.uk

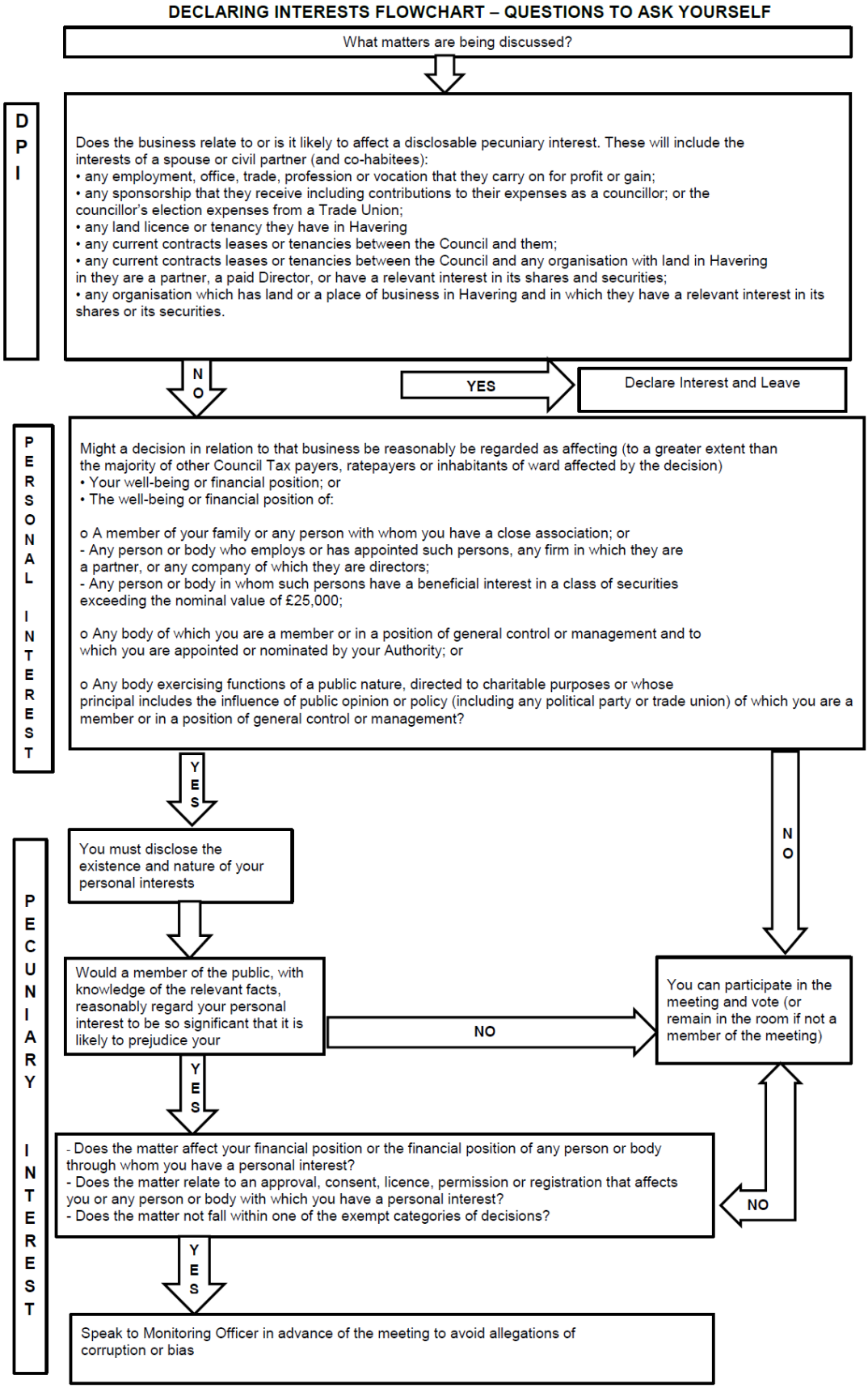
What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information


DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF
What matters are being discussed?
DPI
Does the business relate to or is it likely to affect a disclosable pecuniary interest. These will include the interests of a spouse or civil partner (and co-habitees):
• any employment, office, trade, profession or vocation that they carry on for profit or gain;
• any sponsorship that they receive including contributions to their expenses as a councillor; or the councillor's election expenses from a Trade Union;
• any land licence or tenancy they have in Havering
• any current contracts leases or tenancies between the Council and them;
• any current contracts leases or tenancies between the Council and any organisation with land in Havering in they are a partner, a paid Director, or have a relevant interest in its shares and securities;
• any organisation which has land or a place of business in Havering and in which they have a relevant interest in its shares or its securities.
NO
YES
Declare Interest and Leave
PERSONAL INTEREST
Might a decision in relation to that business be reasonably be regarded as affecting (to a greater extent than the majority of other Council Tax payers, ratepayers or inhabitants of ward affected by the decision)
• Your well-being or financial position; or
• The well-being or financial position of:
o A member of your family or any person with whom you have a close association; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors;
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
o Any body of which you are a member or in a position of general control or management and to which you are appointed or nominated by your Authority; or
o Any body exercising functions of a public nature, directed to charitable purposes or whose principal includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management?
YES
NO
PECUNIARY INTEREST
You must disclose the existence and nature of your personal interests
Would a member of the public, with knowledge of the relevant facts, reasonably regard your personal interest to be so significant that it is likely to prejudice your
NO
You can participate in the meeting and vote (or remain in the room if not a member of the meeting)
YES
- Does the matter affect your financial position or the financial position of any person or body through whom you have a personal interest?
- Does the matter relate to an approval, consent, licence, permission or registration that affects you or any person or body with which you have a personal interest?
- Does the matter not fall within one of the exempt categories of decisions?
NO
YES
Speak to Monitoring Officer in advance of the meeting to avoid allegations of corruption or bias

AGENDA ITEMS

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 INTERESTS

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

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

4 MINUTES (Pages 1 - 6)

To approve as a correct record the minutes of the Committee held on 22nd September 2021 and to authorise the Chairman to sign them.

5 MATTERS ARISING

To consider the Board's Action Log

6 INTEGRATED CARE SYSTEMS ARRANGEMENTS (Pages 7 - 8)

Report attached

7 TRANSFORMATION BOARDS UPDATE (Pages 9 - 32)

Report and appendix attached

8 BOROUGH PARTNERSHIP UPDATE

Verbal update to be given

9 BETTER CARE FUND SIGN OFF (Pages 33 - 120)

Report and appendices attached

10 OBESITY STRATEGY REFRESH (Pages 121 - 124)

Report attached

11 CLIMATE CHANGE ACTION PLAN (Pages 125 - 126)

Report attached

12 DATE OF NEXT MEETING

To agree the next meeting date of 26th January 2022 with a start time of 1pm.

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Town Hall
22 September 2021 (1.00 - 3.00 pm)

Present:

Elected Members: Councillors Robert Benham, Jason Frost (Chairman), Damian White and Nisha Patel

Officers of the Council: Mark Ansell

North East London Clinical Commissioning Group: Sarah See

Havering Primary Care Networks: Dr Asif Imran

Other Organisations: Paul Rose, Anne-Marie Dean

Present via Zoom: Daniel Weaver, Barbara Nicholls, Ratidzo Chinyuku, John Mealey, Nick Swift, Dr Nikhil Rao, Mathew Trainer, Pippa Ward, Mehboob Khan, Remi Odejinmi, Melissa Hoskins, Dr Jwala Gupta, De Sarita Symon, Mark Eaton, Tracy Rubery

11 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman reminded Members of the action to be taken in an emergency.

12 **APOLOGIES FOR ABSENCE**

Apologies were received from Dr Atul Aggarwal and Patrick Odling-Smee

13 **DISCLOSURE OF INTERESTS**

There were no disclosures of interests

14 **MINUTES**

The minutes for the meeting held on 23rd June 2021 were agreed as a correct record.

15 **MATTERS ARISING**

There were no matters arising.
Members were advised that contact had been made with community leads in ophthalmology and dentistry. Members were hopeful that additional representation to the Board would improve accessibility pathways within the borough.

16 BHRUT CLINICAL STRATEGY

The Board was provided with an update on the clinical strategy from BHRUT.

Members noted that during the COVID-19 pandemic mainly digital and phone consultations were used to reduce face-to-face contact. In the approaches to engagement, it was explained to Members that residents were engaged using surveys and workshops while stakeholders were engaged using interviews. Members noted that the pandemic had resulted in widening of health inequalities and particular effort would be made to engage poorly served communities.

Members were advised that BHRUT had learnt from previous digital first approaches and as a result is using partners to engage residents who do not have access to digital means.

Board members noted that the Joint Strategic Needs Assessment and Health & Wellbeing Strategy was being reviewed and the Clinical Strategy would have to consider the revisions. Members were also advised that the strategy was being shaped by inclusive input from community and voluntary sector, as well as partners from wider health and social care.

Members discussed how the referral and discharge pathways between primary and secondary care clinicians could be improved to make the best use of resources and increase capacity for those who require in-person consultations during the winter seasons.

Members were pleased to note that a collaboration with BARTS would not undermine or diminish other partnerships. Rather, the focus would be on delivering operational priorities and improving access to care, for example, by increasing diagnostic opportunities in the community.

Members noted that the draft BHRUT Clinical Strategy document would be finalised in December 2021 and then taken to the Trust Board.

The Board noted the report.

17 BHR INTEGRATED SUSTAINABILITY PLAN

The Board was presented with the BHR Integrated Sustainability 5 Year Plan.

Members noted there had been substantial deficit in previous years. Members were informed that the financial problems began in 2012, and were attributed to an increased rate of growth in non-elective admissions resulting from historical underinvestment in primary and community health care services and social care. This had a knock on effect, resulting in excessive in-patient admission and large excess of secondary care activity, particularly from older population groups.

Members were advised that the revised sustainability plan would rebalance the system and promote care within the system through robust monitoring, transformation board mobilisation and funding to de-risk.

Members noted that BHR were creating a prevention fund for Borough Partners to coordinate. Members noted the proposed investment in elective care and as part of action to reduce waiting times that had risen due to lower availability of beds due to COVID-19 patients and enhanced IPC measures.

Members emphasised the role of primary prevention; an upstream approach to preventing disease and harm before it occurs. Members highlighted the need to align the priorities between the Transformation Boards and Borough Partnership – and for both to take into account local issues. Members were advised that the Integrated Care Partnership had allocated funding to tackle broad prevention activity and health inequalities.

In terms of further improvements to system sustainability, Members addressed opportunities for regeneration including the promise of additional primary care facilities, community hubs to support community care capacity and continued investment for social prescribing pathways.

Actions:
Members discussed how the system could reduce the disproportionate number of falls experienced by Havering residents, for example, through road management, appropriate housing design and disability assessment grants. The Director for Public Health and clinical health colleagues (Tracy Rubery) agreed to bring this back at a later date.

Members **agreed** that that paper should proceed to final approval

18 **PHLEBOTOMY PILOT**

Progress made with a new pilot model for community phlebotomy was described to Board members.

Members noted the pilot went live on 1st July 2021. Members also noted that the service had received a 91% good or very good rating from 3516 service users. Online bookings had been well received by residents and the delays in getting blood samples had dropped dramatically. Members noted that domiciliary phlebotomy demand had dropped and patients were being seen between 2-4 days. Performance indicators had not changed; routine patients had a target of 70% being seen in one week and 100% seen in two weeks.

The Board noted the report

19 BOROUGH PARTNERSHIP UPDATE

The Board were presented with a verbal update on the Borough Partnership.

Members noted that the membership and Terms of Reference had been established and the away day was held in September 2021 to develop a model and review the partnerships priorities which included Social Inclusion and Mental Health. The Board noted there was still a discovery stage to undergo which consisted of mapping commissioned and statutory services, mapping the geographical reach of services, establishing information flows within the system and governance within the wider integrated care system (ICS) context, tracking the spending and holding interviews with community based service providers.

Members agreed that the Borough Partnership would take into consideration statements from the BHRUT Clinical Strategy and Sustainability plans in the development of complementary work plans.

The Board noted the update.

A verbal update on Covid-19 developments was provided. Members noted that Havering had a low mortality rate due to Covid-19. Members noted the need to prioritise vaccine take up in the 'never vaccinated' ahead of the booster programme, and to promote the booster programme due to emerging evidence of waning immunity.

Members were advised that the ever-green offer was still in place, and that vaccination for 12-15 year olds was due to commence as part of the school based programme. NEL CCG highlighted the communications approach to promoting vaccine take up in young people and pregnant women. It was acknowledged that concerns around fertility had been raised in the borough. Clinical partners reiterated that the evidence from clinical trials and real-world observations did not indicate any adverse links to pregnancy outcomes. Members agreed with the approach of providing reassurance through peer to peer support.

Actions:

The Director of Public Health agreed to have a discussion with local midwifery services with respect to promoting vaccine take up in pregnant women and incorporating Covid-19 vaccine in maternity care pathways.

20 DATE OF NEXT MEETING

The Board noted the next date of the Health & Wellbeing Board as the 24th November 2021.

Chairman

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HEALTH & WELLBEING BOARD

Subject Heading:	ICS arrangements and relationship with constituent HWBs
Board Lead:	XXX
Report Author and contact details:	Christopher Cotton Director of ICS Transition christopher.cotton1@nhs.net

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

☒	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☒	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☒	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☒	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☒	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY
This paper briefs members of the health and wellbeing board on work being done across North East London to design and launch the new integrated care system.
RECOMMENDATIONS
This is a briefing paper and therefore does not make any specific recommendations to members of the board.
REPORT DETAIL

IMPLICATIONS AND RISKS

The ICS transition programme maintains a full risk log. Some current risks relate to:

- the need for all partner organisations to focus on heightened operational pressures over the winter, potentially leading to less extensive engagement in the programme and therefore limited co-ownership of plans and slower or less successful implementation;
- the need to articulate the nature and purpose of the ICS in terms more readily appealing to residents and staff within partner organisations, focused clearly on resident and patient outcomes.

BACKGROUND PAPERS

See the paper attached: ‘Designing and delivering North East London’s integrated care system: briefing to the Havering health and wellbeing board’.

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HEALTH & WELLBEING BOARD

Subject Heading:	BHR Transformation Board 21/22 Update and Developing a Proposal for Ongoing Collaboration
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Hanh Xuan-Tang, Deputy Director of Recovery Planning Hanh.Xuan-Tang@nhs.net

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☐	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☐	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☐	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☒	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY
The BHR System Transformation Boards restarted from Q1 21/22, following the return to 'BAU' across the system. As part of the re-start process, all schemes and initiatives under each Transformation Board were reviewed, in light of Covid, and the following assessments were made: • Whether there were any changes to underlying assumptions of the initiatives that altered the activity and finance requirements/impact of the scheme • Whether schemes previously in development were still feasible for continued development • Revision of the 'start' dates for new schemes/schemes in development where appropriate and necessary • Were there any new opportunities/requirements which had arisen, due to Covid or Covid related impact, that required development as a priority This report provides an update on the progress made during 21/22 by each of the Transformation Boards, and the impact of the Transformational initiatives both generally and in respect of the BHR system Integrated Sustainability Plan (ISP). Additionally, this report provides an update on the development of a proposal for ongoing collaboration across NEL, BHR and Place Based Partnerships as we move into the Integrated Care System (ICS) arrangements.
RECOMMENDATIONS
To note the content of the presentation
REPORT DETAIL
None additional
IMPLICATIONS AND RISKS
There is a risk that if Transformation Boards do not deliver/implement schemes as planned, achieving financial sustainability may exceed the time frames set out in the Integrated Sustainability Plan.
BACKGROUND PAPERS
None

BHR Integrated Care Partnership
Better care, better lives, together for all

NHS
North East London
Clinical Commissioning Group

BHR Transformation Board 21/22 Update and Developing a Proposal for Ongoing Collaboration

Meeting name: Havering Health and Well Being Board
Presenter: Tracy Rubery, Director of Transformation (BHR ICP)
Date: November 2021

Background

The NHS services covering the London Boroughs of Barking & Dagenham, Havering and Redbridge System (BHR) have seen declining financial performance since at least 2012 and possibly even earlier. These financial challenges are linked closely to negative changes in the outcomes for our population. The drivers of the challenges are related to a historic and chronic under-investment in Out of Hospital Support for patients with a lack of focus on prevention and early intervention. This has driven a significant increase in Non-Elective Admissions particularly for Older People and those with one or more Long Term Condition.

In 2018/19 the NHS partners in BHR agreed London's first integrated Financial Recovery Plan (FRP) and in the first year of operation saw a significant improvement both in system finances and the start of changes and improvements in outcomes for our population.

Due to the Covid Pandemic, the changes in national contracting arrangements, and the positive impacts of accelerated integration of our system Partners, the original FRP has been reviewed and has resulted in the development of the Integrated Sustainability Plan (ISP). The ISP resets the previous FRP and expands the scope to include redressing historic under-investment in Out of Hospital services. The aim of the ISP is to reduce secondary care activity by Transforming Health and Care services and delivering care differently, closer to home, improving outcomes and investing in prevention.

Background

The Transformation Boards are a key part of the system architecture which will deliver the Transformation required to support the assumptions set out in the ISP. Transformation Boards are responsible for the development of care models for their particular care group within the overall strategic framework set by the Integrated Care Partnership Board. They are made up of all partners across health and care in BHR and have strong clinical representation. They will continue to develop plans through co-production with residents, patients and their families. As they develop, Borough partnerships and providers will then be responsible for delivering those models for their local populations.

There are currently eight Transformation Boards in BHR comprising:

- Cancer
- Children and Young People
- LD and Autism (NEL Board)
- Long Term Conditions
- Mental Health (NELFT/NEL System wide Board)
- Planned Care
- Older People/ Frailty
- Unplanned Care

This pack provides an update on the current progress of each of the BHR system Transformation Boards, and a proposal for ongoing collaboration as we move into the Integrated Care System (ICS) arrangements.

BHR 2020/21 Transformation Board Progress

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

OLDER PEOPLE

- The expansion of the **NELFT Community Treatment Team (CTT)** went live in August-21 with 10 of the 11 additional posts recruited. The CTT supports the delivery of the National 2 Hour Community Crisis Response Standard. Based on August 2021 data, the service is forecast to provide a reduction in emergency admissions of 2,112, providing the BHR System with savings of £4m.
- The new **Single Point of Access Discharge** team, hosted by NELFT launched in October 21, , building on the enhanced Hospital Discharge Service (HDS) that was developed during 2020 in response to the covid pandemic. The service supports patients who require health and/or social care support to be discharged into their own home, or an appropriate community setting, as soon as they are medically fit. The service is expected to support c9 patients to be discharged each day, with at least 3,442 reductions in acute bed days per year.
- The **Acute Frailty Service** continues to support c250 patients a month with at least c80% avoiding an admission. Based on April to August data, the services are forecast to deliver 382 less emergency admissions, saving the BHR system £1.8m. The Queens Frailty Unit which was launched in May 2021 and alongside the King Georges Frailty Unit will continue to focus on seeing more elderly frail patients to help increase the speed at which they are discharged from ED and being managed in the community or their own homes and therefore avoiding an admission.

PLANNED CARE

- The **MSK Single Point of Access (SPA)** went fully operational in April-21, following a delay due Covid, with the **MSK Exercise on Referral (EoR)** due to go live in late November-21. Since April, the SPA has reduced 1,106 unnecessary Outpatient appointments and is expected to deliver a reduction of 2,444 unnecessary outpatient attendances in 21/22. With the procurement of the new e-referral system, the reductions are expected increase next year. The EoR will start to receive referrals from the end of November to provide patients with chronic pain an alternative treatment to clinical intervention.
- A **uro-gynae pathway,** to help reduce inappropriate referrals to the Gynaecology department and aid the long term aim of reducing GP referral volumes through targeted education, has been developed and launched in September 2021. The pathway is expected to reduce the number of referrals to BHRUT gynaecology department of 20% by 6 months post-launch.
- The **Community Minor Surgery** service is at the final stages of the approval process with an expected go live date of December-21. The service aims to undertake an over 2,000 additional minor surgery procedures each year in a Primary Care setting, and therefore reducing the burden on the Acute services and support the clearance of the current Elective backlog post covid. The service will also reduce waiting time for patients.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

URGENT AND EMERGENCY CARE

- A **Same Day Emergency Care (SDEC)** unit was successfully launched on Wednesday 28th July 2021. The service has 10 patient spaces and is located in the Majors facility within Queens Hospital. The service is currently seeing 6,720 patients a month, of which, the unit estimates 510 p/m (7.5%) are an avoided admission.
- The **Hospital Ambulance Liaison Officer (HALO)** service, at both the KGH & Queens sites, are in the process of mobilisation and is on track to go-live in November. The service will operate from 10am to 10pm, to help redirect crews to utilise alternative care pathways instead of the acute based services. This will aid with ambulance crews awareness and utilisation of alternatives services, and therefore, contribute to improved patient care by transferring patients to the most appropriate setting and ensuring that more patients are treated at the right place, at the right time, first time.
- A business case for a **Duty Doctor** Pilot is currently being taken through the CCG governance process for approval. The pilot which will run in Havering aims to have a dedicated doctor who will provide a dedicated call-in service which can be accessed by ambulance crews and community health care professionals when they need to seek advice from a GP about a patient's condition. The expectation is that the advice and guidance provided by the service will help prevent the patients from being automatically conveyed or sent to A&E when this could have been avoided. The service is on track to go live in November to support with winter pressures.
- A winter business case covering the following schemes: additional community rehab beds, additional intensive rehab service staff, additional care home rehab beds, increased PELC capacity, a Therapy Assessment at RAFTing pilot, additional 30 bed unit at Queens and a weekend discharge nursing home pilot has been taken through the Urgent & Emergency Care Transformation Board and governance processes. It is expected that all schemes will go live during November and December 2021 to support with winter pressures. All elements support the hospital with discharging patients so that bed capacity is freed up during the winter months, or provide additional capacity at the front door or within the hospital.

CHILDREN AND YOUNG PEOPLE (CYP)

- The **Paediatric Assessment Unit (PAU)** has been successfully implemented at the KGH site following the implementation at the Queens site last year. The service supports children attending ED to be appropriately assessed and monitored with the aim of reducing unnecessary emergency admissions.
- The integrated **Paediatric Hospital at Home** pathway is currently at the final stages of approval, and the expectation is that this will go-live in January-22. The service will support the PAU service through integrating the pathways between secondary care (from PAU), to care in community and home settings. The expectation is that 1,396 admissions will be avoided each year.
- A collaboration between the CYP Transformation Board and BHR Workforce academy has resulted in the successful delivery of a workforce workshop in September-21. The workshop identified short and long term solutions to address the shortage in the workforce affecting children across BHR, enabling further development of initiative's which was previously constrained by workforce capacity.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

LONG TERM CONDITIONS

- An **Atrial Fibrillation (AF) Case Finding** pilot in Havering has been approved and is in the final stages of mobilisation. The pilot will go-live by the end of November-21. The pilot utilises a specialised algorithm developed by Pfizer, and approved by the MHRA, to detect patients with high risk of AF related stroke. Patients are then admitted to a Rapid Access pathway for diagnosis and treatment, resulting in a reduced risk of imminent strokes. The pilot is expected to prevent 18 strokes between December-21 and March-22.

- The **Urine Albumin to Creatinine Ratio (ACR) Testing from Home/ACR Diabetes** initiative is a 'post covid catch-up plan' which is expected to be implemented in late November-21. Due to the Covid pandemic, and the reduction in face to face contacts with GPs/Nurses, Diabetic patients were not receiving the full 8 care processes required to detect any risks or issues with their condition that could result in complications associated with Diabetes. This initiative provides the ability to deliver a 'catch-up' plan at scale prior to returning to BAU levels and annual check-ups going forward.

CANCER

- A '**C the Signs'** digital tool was rolled out across BHR in Quarter 1. The tool helps to identify patients at risk of Cancer; which cancer or cancers a patient is at risk of and identifies the most appropriate next steps. There are currently 358 users, helping to improve early detection, referral and diagnosis rates and therefore improving the outcomes for the residents of BHR.

- The **Rapid Diagnostic Centre (RDC)** is now fully live and receiving referrals from B&D. Work is ongoing to roll out the RDC across Havering and Redbridge. The RDC is a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer, but do not "fit" into the Pan-London 2ww tumour specific pathways. The service provides personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally. This supports improvements in the Faster Diagnosis Standards (FDS) which is currently at pre-covid levels.

- The **Lung screening project (The SUMMIT study)** delivered by UCLH and GRAIL has to date delivered a service to over 13,000 participants. The aim of the project is to develop & evaluate a new blood test for detecting multiple types of cancer early including lung cancer amongst at-risk residents & contribute to the examination of the feasibility of a large-scale lung screening programme in England. Participants were invited via their GP practice to attend a lung health check, offered a blood test & a low-dose CT scan of lungs. If signs for concern were seen in first scan, these were followed up, either immediately or twice annually depending on severity. The screening project will run until July 2022 but has already impacted patients through early lung cancer detection & patients successfully treated.

BHR Transformation Board 21/22 Scheme Overview (October-21)

Red schemes – denotes progress to next stage of process from previous month

Blue Schemes – New schemes added in current month

Concept Schemes

Ageing Well - OOH - End of life rapid response team
Ageing Well - Hospice End of Life Service (RRT 24hr helpline and Nurse)
Ageing Well - Hospice End of Life Service (Care Home EOL Nurse Specialist)
Ageing Well - Community Falls Care Home Service
Ageing Well - Discharge to assess pilot
EBI Wave 2
ECG LIS
ASD/ADHD
Weekend Nursing Home Discharges
Expansion of Community Falls Service
(ACP) Pharmacist in the Community Treatment Team (CTT)
Community Complex Dementia
LTC Diabetes – out of hospital management
Point of Care Testing (POCT)

Business Case

Hospital Discharge Service
Duty doctor
Winter schemes x8
Community Minor Surgery
Simple Wound Care
Diabetes Assisted Discharge
Tier 3 Weight Mgt
Local NIV Service
Long Covid Extension
Home First Pilot
PINS-Hospital at Home Pathway
ACR Hypertension

Mobilisation

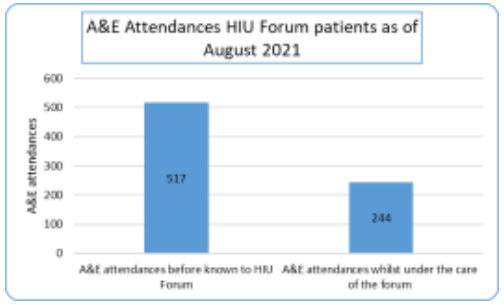
Ageing Well - UCR 2-hour response (CTT Expansion)
AF Case Finding-Havering
Complex Wound care Programme/Dressings and Lymphedema
v Chronic Kidney Disease (CKD) Pilot
Pilot HALO (Hospital Ambulance Liaison Officer)
MSK e-Referral Tool
ACR Testing from Home/ACR Diabetes

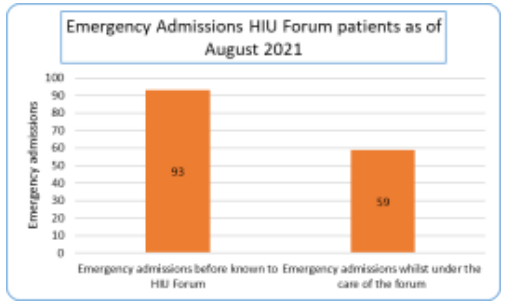
Live Schemes

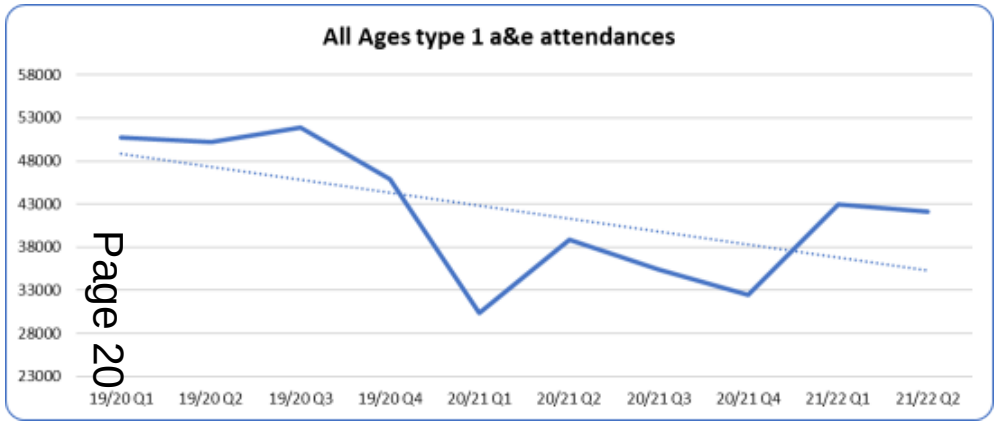
Queens Frailty Hub Service (AFS)
Falls Programme Line - Strength & Balance Service
Local Area Coordination - Havering
Local Area Coordination - Redbridge
Reduce attendances for HIU (ODISH)
Develop SDEC pathways
Advice & Guidance
C2C reduction - Triage/RAS
MSK New Model of Care:
MSK New Model Of Care-EOR
MSK New Model Of Care-Primary Care MSK Team
MSK New Model Of Care-Rheumatology Hub
PIFU (Patient Initiated FU)
Uro-gynae pathway
Children Asthma LISs
LTC LIS - Atrial Fibrillation
LTC LIS - Diabetes Injectables
Respiratory Care - LTC LIS Group 2 (COPD/Asthma)
Diabetes 8CP/3TT

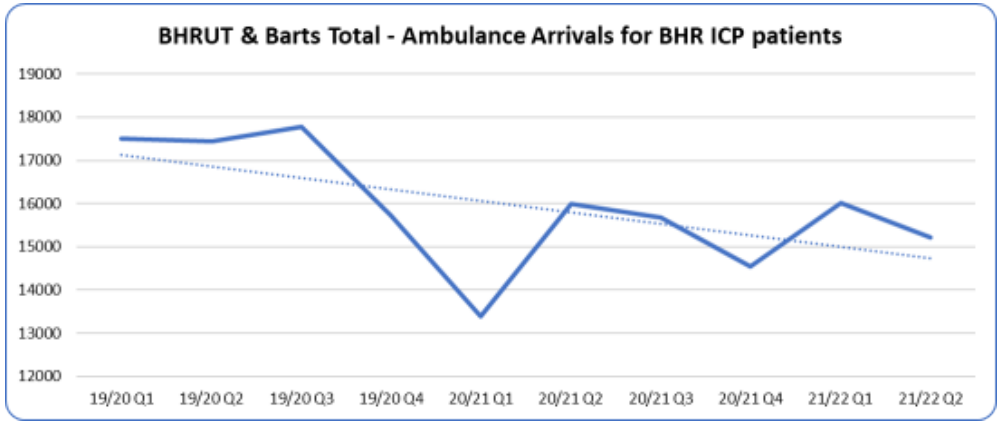
Impact of Transformation

Urgent & Emergency Care Transformation Board Impact Achievements









High Intensity User Forum & Open Dialogue service

The High Intensity User Forum is a multi-disciplinary team, consisting of London Ambulance Service, BHRUT, NELFT, Police, Social Care, patient GPs and others who provide direct care for the patients. They devise care plans and support options for patients who are identified as 'complex high intensity users' to prevent them from utilising urgent and emergency care services when not required, and directing them to more appropriate services to support the needs of the patient.

In 21/22 (as of August 2021), the service has delivered a reduction in emergency admissions of 37% (34 less admissions) and a reduction in A&E attendances by 53% (273 less attendances).

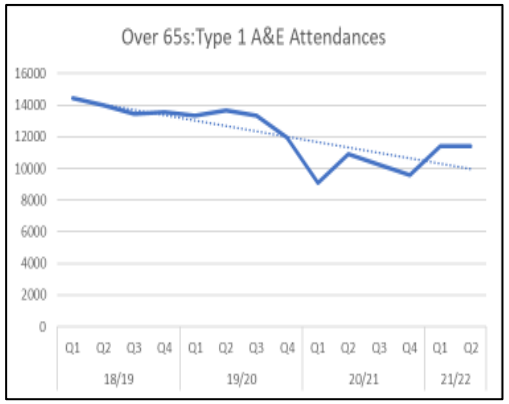
Alternative Care Pathways (ACPs)/Hospital Ambulance Liaison Officer Pilot (HALO)

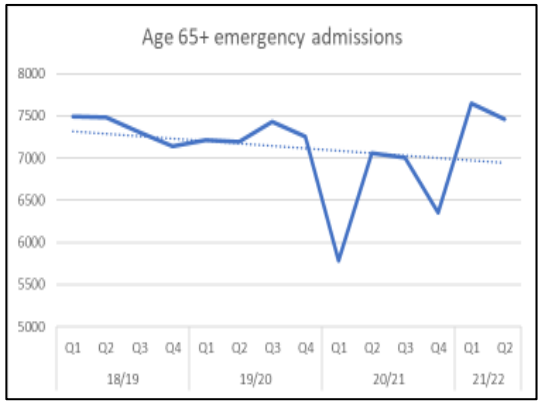
Type 1 A&E Attendances, relating to BHR patients of all ages at BHRUT, continue to show an overall downward trend with a 16% reduction (15,895 less) in A&E attendances in Q1 & Q2 FOT 21/22 when compared to Q1 & Q2 2019/20. Whilst some of the reduction is due to the Covid pandemic, especially in April and May, a significant contributor to this shift has been the successful implementation of 4 UTCs across BHR and the ongoing work to increase utilisation of alternative care pathways so that the emergency department is not the first port of call for patients when clinically safe to utilise alternative services..

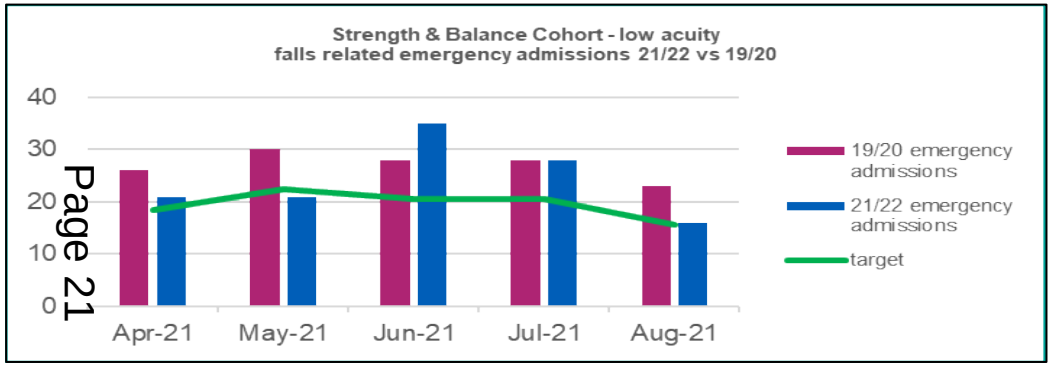
A significant amount of work has been undertaken to ensure alternative care pathways are increasingly available, such as CTT, UTCs, Crisis Centres and Frailty Units. As a result, ambulance crews are now able to take an increasing number of patients to these alternative services. The impact of this can be seen in the reduction of ambulance arrivals, when comparing Q1 & Q2 FOT 2021/22 with Q1 & Q2 2019/20, which shows a 11% reduction (3,699 less conveyances.).

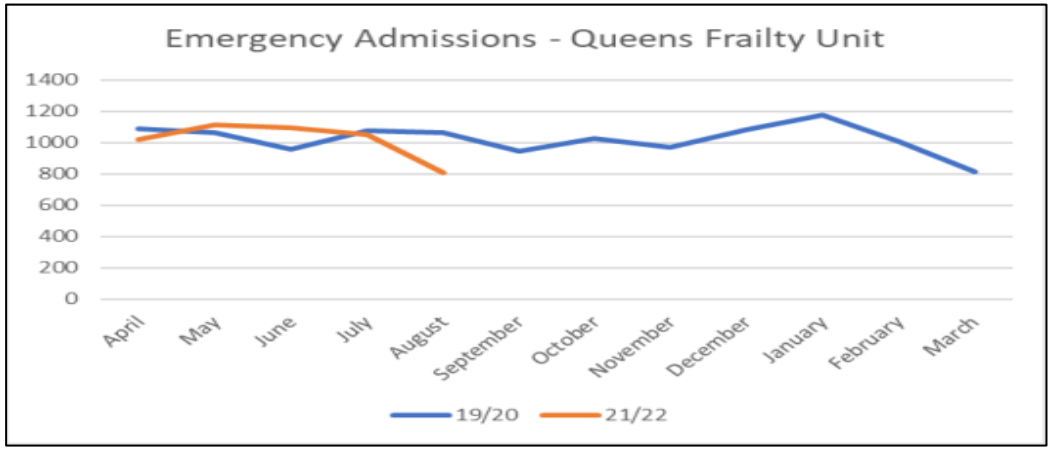
To enhance the usage of ACPs further and to support with winter, LAS has recruited paramedics (HALO) who will review ambulance arrivals, 7 days a week throughout winter and guide/educate their colleagues around the alternatives available. Through doing this, it is forecast to prevent 1,820 A&E attendances throughout winter.

Older People Transformation Board Impact Achievements





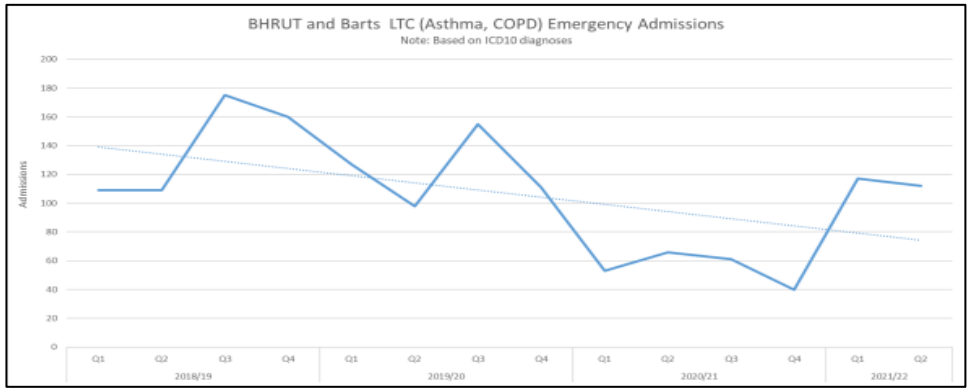


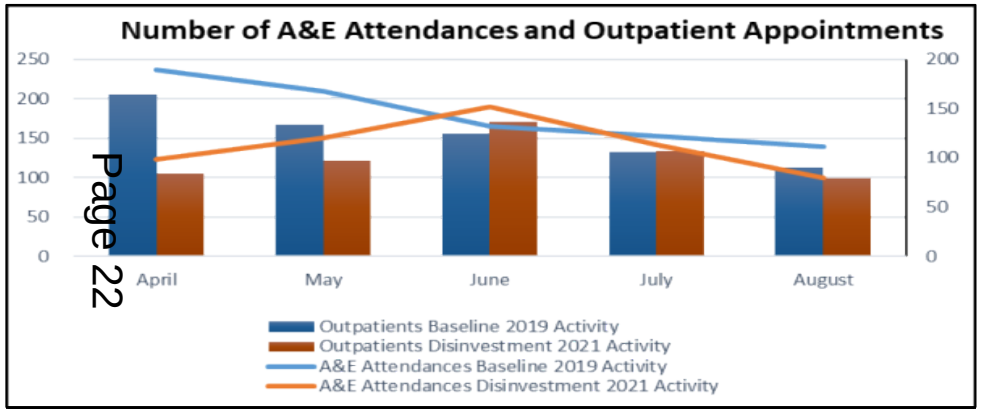


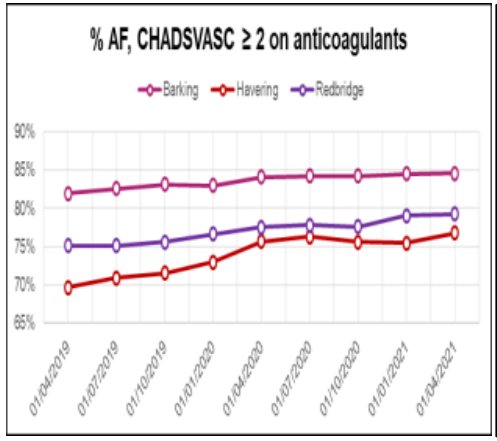
Key Notes

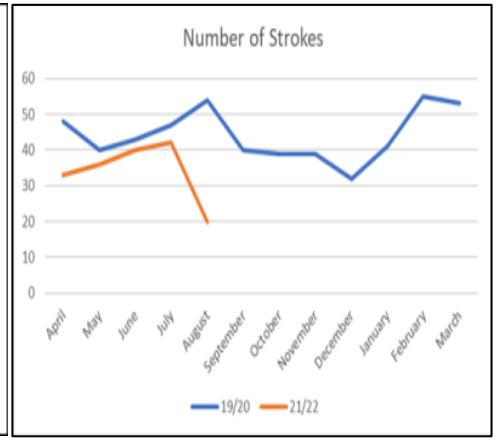
- Due to the impact of covid, the 20/21 position have been skewed and therefore, the 21/22 position have been compared to the 19/20 pre-covid levels.
- The YTD (Q2) level of A&E attendances, for patients aged 65+, is currently 15% (4,167 attendances) lower than the comparable period in 19/20.
- However, the spike in the level of over 65+ admissions in recent months indicates that older patients presenting to Hospital are more complex and with a higher acuity of their condition, in part driven by Covid.
- The Queens Frailty Unit, which was launched in May-21, incorporating the previous 'ED Front Door' and 'Home is Best' services, is starting to impact on the admission rates through a more dedicated and integrated Frailty service aimed at assessing and supporting patients to be cared for in an appropriate setting where an admission is not required. In August-21, there were 24% (258) less admissions than in August-19.
- The Falls Strength and Balance service was impacted during covid due to social distancing measures and the move to virtual sessions. However, despite a spike in June-21, the 21/22 position shows a 10% reduction in falls equating to 14 less falls by August-21 compared to the same period in 19/20.
- As the Strength and Balance classes resume face to face sessions, it is expected that the number of falls will decrease further in future months.

Long Term Conditions Transformation Board Impact Achievements









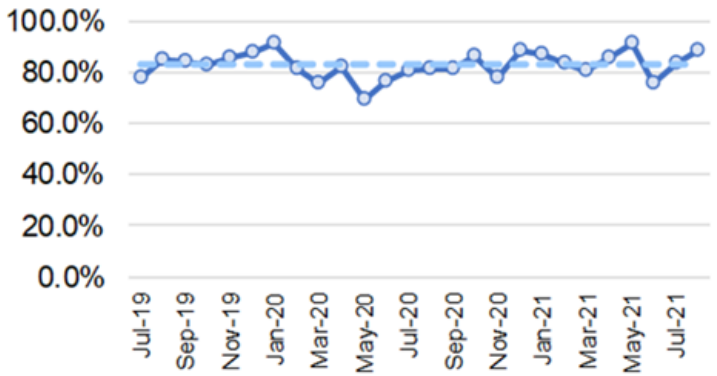
Key Notes

- The LTC Asthma and COPD LIS was implemented prior to Covid, with the purpose of shifting routine spirometry tests, for diagnosis of COPD/asthma, from an Acute setting into Primary Care, and to support patients through the development of care plans to better manage their condition and reduce presentations to Secondary Care.
- Since April 2021, there have been 159 less respiratory related A&E admissions compared to the same period in 19/20.
- COPD and asthma related admissions remain on a downward trajectory, and despite a post-covid surge in admissions in June-21, at Quarter 2, admission remain below the 19/20 position.
- The shift in setting for the delivery of routine Spirometry testing, has resulted in 77% less spirometry activity (reduction of 610 tests between April-21 to August-21) taking place in secondary care. As the Tests are performed in an Outpatient setting, this has resulted in the freeing up of 610 outpatient appointments at BHRUT.
- Since the implementation of the Atrial Fibrillation LIS in 19/20, 93 out of 116 GP practices have had their AF registers reviewed for high-risk patients (CHADVASc >2) who are not on anticoagulation treatment. This review of 769 patients has led to over 200 patients being anticoagulated.
- Due to early detection and intervention, this has contributed to 27% (61) less strokes in 21/22 (to August-21), compared to the same period in 19/20.

Planned Care Transformation Board Impact Achievements

6. Responded within 48Hrs All Specialties (Top 18)

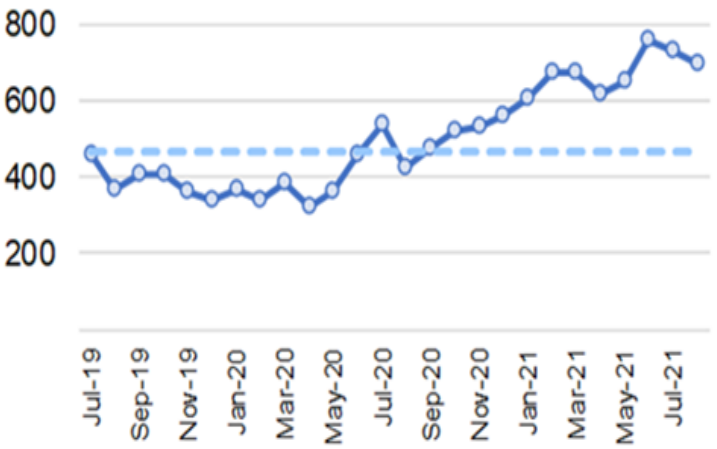
Barking, Havering And Redbridge University Hospitals NHS Trust



Month	Value
Mar-21	80.9%
Apr-21	85.4%
May-21	91.3%
Jun-21	75.6%
Jul-21	83.1%
Aug-21	**88.1%**
Median	82.8%

2. eRS Requests All Specialties (Top 18)

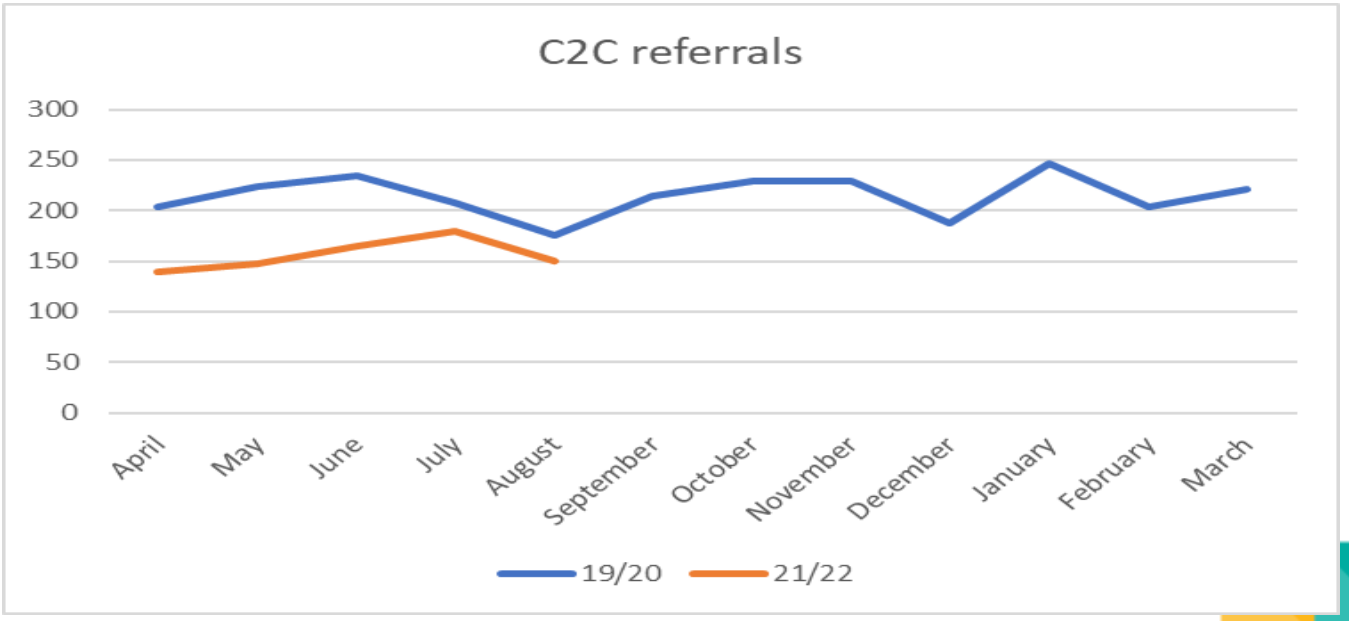
Barking, Havering And Redbridge University Hospitals NHS Trust



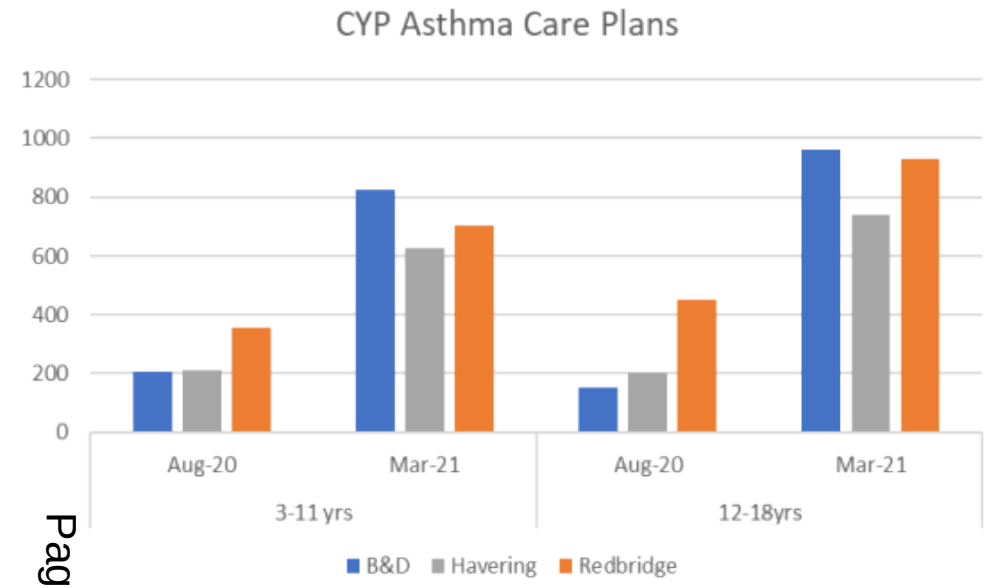
Month	Value
Mar-21	675
Apr-21	618
May-21	652
Jun-21	759
Jul-21	729
Aug-21	**696**
Median	466

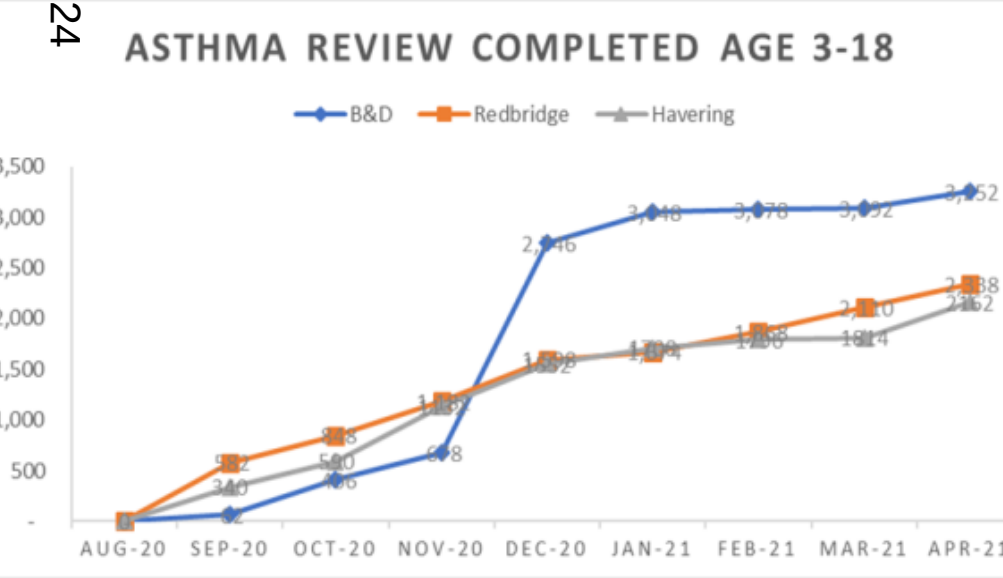
Key notes

- The Advice & Guidance service has continued to improve with an increase in the number of requests for Advice & Guidance on e-RS, whilst maintaining a 83% response rate within 48 hours.
- The improvements in the Trust Directory of Services and combined with the roll out of the Triage/RAS systems, has contributed to a 25% reduction (265 attendances) in the level of Consultant to Consultant (C2C) referrals.
- The C2C policy, following system agreement, is currently suspended and further communication and engagement is ongoing within the Trust to ensure that the legacy processes are reversed to support the reduction in demand on Primary Care.
- The Patient Initiated Follow Up (PIFU) pathways have been piloted in Neurology and the pathway will be rolled out to 4 further Specialties (Trauma & Orthopaedics, ophthalmology, gastroenterology and Prostate Stratified Pathways) in the next few months. The PIFU is aimed at empowering patients, with clinical oversight, to manage their own follow-up pathways based on their condition and requirements. This in turn is expected to reduce the number of unnecessary follow-up attendances going forward.



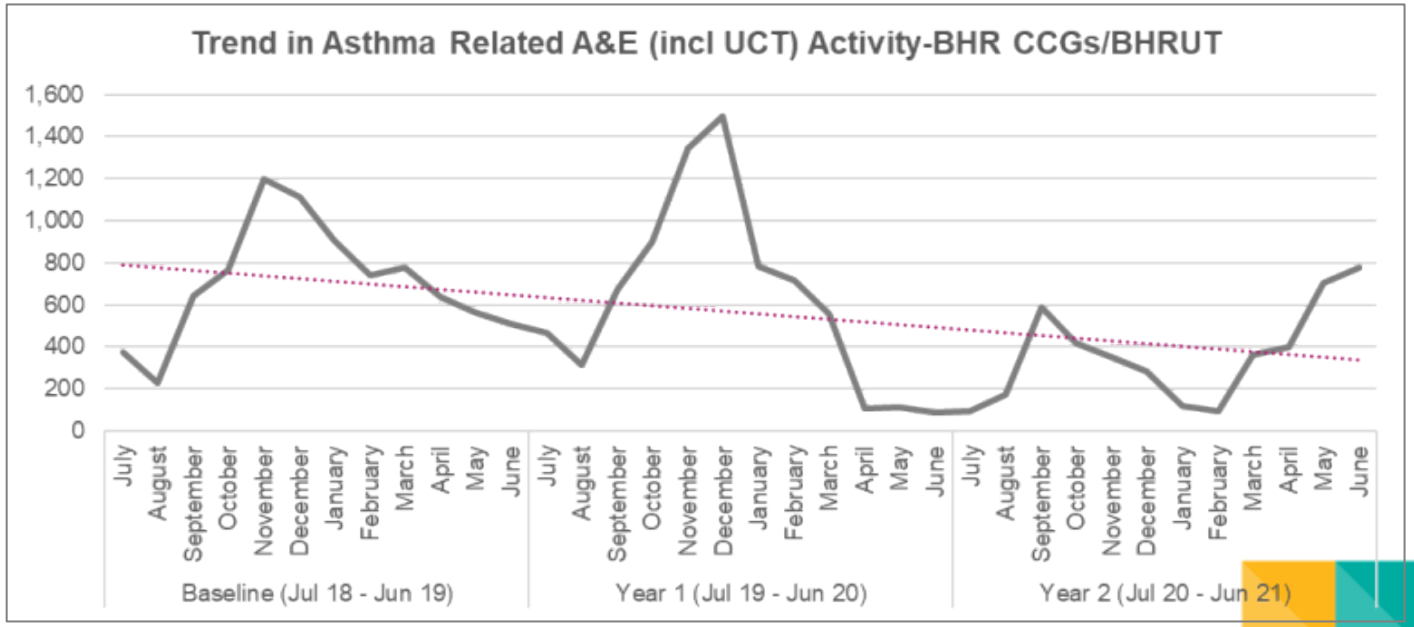
Children and Young People Transformation Board Impact Achievements



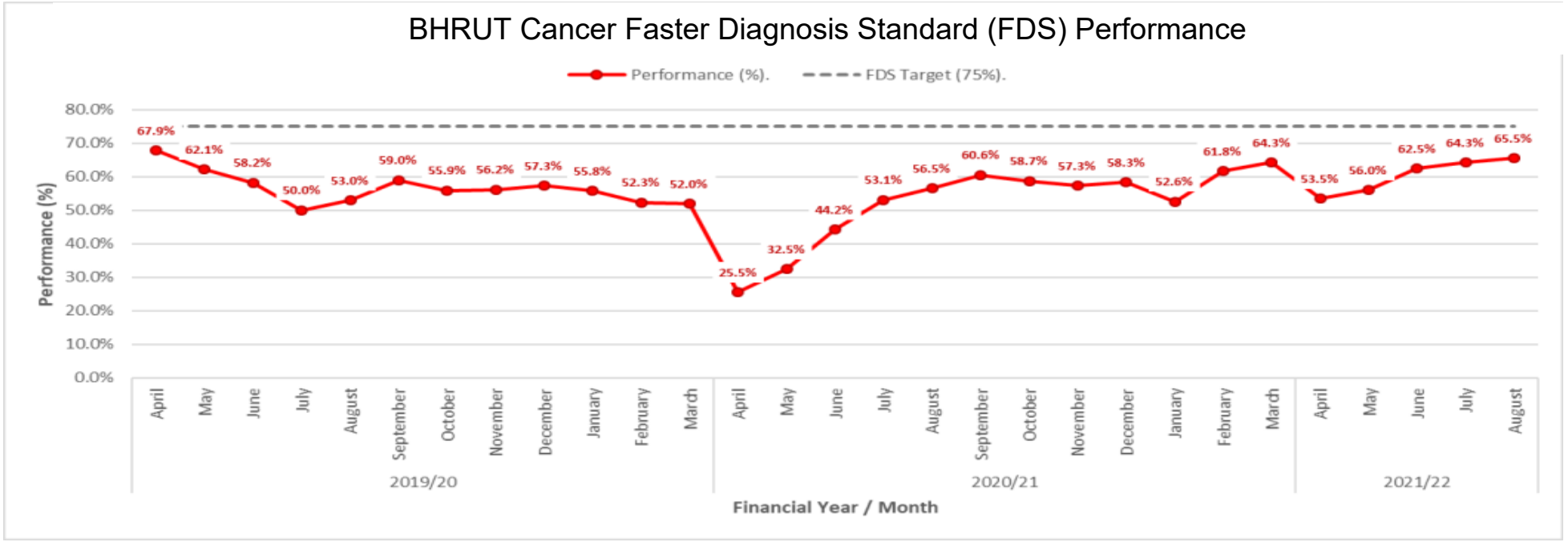


Key notes

- The Sustainable Asthmas LIS, which was implemented in 19/20 in response to the Regulation 28, focuses on providing education and support to children and their families to help manage the Asthma condition through the implementation of Care Plans. The service is an integrated service between Primary Care and Community services.
- The Sustainable Asthmas LIS, has resulted in a 200% increase in the number of care plans issued since its implementation (from 1,574 in August 20 to 4,790 at the end of March 21), with the impact of the care plans seen in the following months and years.
- The implementation of the LIS has contributed to a 48% reduction in Children's Respiratory related A&E/UCC attendances across BHR, (from 8,462 attendances (pre-LIS) to 4,360 over the past year)
- Paediatric Emergency admissions, which are directly attributable to minor Asthma conditions, has also reduced by 48% across BHR, from 405 admissions pre LIS (Baseline Year), to 208 admissions in year 2 of the scheme. Whilst some of the reduction can be attributed to the impact of Covid, admissions have not reached pre-covid levels, in part, driven by the increase community base care provided by the LIS.



Cancer Transformation Board Impact Achievements



Key Notes

- Significant work has been undertaken by the Trust to improve the Faster Diagnosis times including:
  - Dedicated clinical review clinics established with consultant time to sign patient off pathway
  - Local process agreed with Primary Care on endoscopy sign off process to support FDS compliance
  - Clinic capacity increased to reduce median waits
  - Clinical triage team booking directly onto Endoscopy list
  - Increased Radiology scanning capacity to support delivery of FDS and resource has been allocated to support Gynae and Urology specifically.

- This work has resulted in the current performance being back at pre-covid levels. The FDS August-21 Published information indicates a performance of 65.50% (+1.30%) from previous month against the 75.0% Target.

- There has also been an improved position for the 28 Day FDS in Gynaecology and Upper GI seen in September 2021.

Impact of Transformation Against the Integrated Sustainability Plan (ISP)

BHR ALL TRANSFORMATION BOARDS ISP IMPACT

SUMMARY ALL TX BOARD	21/22 ISP Target Reduction	YE Forecast Reduction	FOT Variance to ISP
Activity			
OPD Reduction	5,966	18,599	12,633
DC/E Reduction	996	725	-271
NEL Reduction	523	3,290	2,767
A&E Reduction	0	4,644	4,644
TOTAL ACTIVTY REDUCTION	**7,485**	**27,258**	**19,773**
Finance			
Gross Finance Reduction (£'000s)	£3,637	£12,768	£9,131
Finance Investment (£'000s)	-£1,818	-£7,625	-£5,806
TOTLA (Net) FINANCE (£'000s)	**£1,818**	**£5,143**	**£3,324**

The Transformation Targets for 21/22 above are based on the 6% reductions (phased year 1 reductions) identified in the Integrated Sustainability Plan (ISP). The forecast is based on the schemes identified on the previous slide. The reduction in acute based activity is driven by transformational changes including the provision of community based serviced to allow care to be provided closer to home, prevention and early intervention (detailed above).

- Overall, the BHR Transformation Boards are forecasted to exceed the year 1 target reductions in:
  - Outpatient Activity**
  - Emergency (NEL) Admissions
  - Whilst no targets have been set for reducing A&E attendances, through the interventions to reduce emergency admissions, A&E attendances are also reduced as part of transformational services and pathways.

- Whilst the ISP target has not been met for Daycase and Elective activity, transformational initiatives are currently place and/or in progress to ensure that by year 2 (22/23) the cumulative requirements will be achieved. The full year impact of existing schemes will also be reflected in 22/23.

**** To note: Any reductions in Outpatient and Elective/DC activity may be offset by additional activity undertaken as part of the Elective recovery, and therefore any Acute based monitoring or reporting must be undertaken with caution.**

TRANSFORMATION BOARD KEY MILESTONES

- To support the development and delivery of Transformational initiatives, each Transformation Board has developed a set of key milestones which are monitored on a monthly basis to ensure that any slippages are highlighted and appropriate mitigations are put in place. An example of a ‘milestone tracker’.

Project	Milestone	Completion Date	Status
High Intensity User Forum/Open Dialogue Service at Home (ODISH)	Secure ODISH service as part of High Intensity User Forum as a permanent service	Apr-21	
SDEC (Same Day Emergency Care)	Launch SDEC (Same Day Emergency Care) unit	Jul-21	
HALO (Hospital Ambulance Liaison Officer) pilot	Take HALO pilot business case through governance process, starting with assurance on 19th Aug-21 and finishing with ICEG on 21st Oct-21	Oct-21	
HALO (Hospital Ambulance Liaison Officer) pilot	Launch HALO Pilot	Oct-21	
SDEC (Same Day Emergency Care)	Provide 111 with ability to book into SDEC unit	Oct-21	
HALO (Hospital Ambulance Liaison Officer) pilot	Recruit all paramedics for HALO posts	Nov-21	
Duty Doctor	Take Duty Doctor Scheme through governance process, starting with assurance on 2nd Sep-21 and finishing with Finance Committee on 25th Nov-21	Nov-21	
Duty Doctor	Launch Duty Doctor Scheme Pilot	Nov-21	
Intensive Rehab Service	Launch Intensive Rehab Service Scheme	Nov-21	
Increased PELC capacity	Secure additional PELC capacity	Nov-21	
Therapy Assessment in RAFTing	Pilot therapy assessment in RAFTing	Nov-21	
Additional Queens Hospital Beds	Procure additional 30 beds at Queens	Nov-21	
Increased Community Rehab Beds	Secure additional community rehab beds	Dec-21	
End Of Life Care Home Beds Pilot	Launch End Of Life Care Home Beds Pilot	Dec-21	
Weekend Discharge to Nursing Home Pilot	Pilot weekend discharges to nursing homes	Dec-21	

Key	
Achieved/On Track	
Slippage, but can be mitigated	
Achievement at risk	
Not Started	

Developing a proposal for ongoing collaboration

Introduction

The ICS Design Framework Guidance (June 2021), and draft Health and Social Care Bill (first published July 2021) set out in more detail how NHSE/I expect NHS organisations to respond in the next phase of this system development.

Subject to the passage of legislation, the statutory ICS arrangements will comprise:

- **an ICS Partnership**, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- **an ICS NHS body**, bringing the NHS together locally to improve population health and care

Whilst this element of Integrated Care Systems is clear, what the internal governance will look like, what functions will sit at each level of the system, and the form that delegation will take is currently open for Integrated Care Systems to design, creating a system that works best for their local populations. The key principle that will shape how this is designed is that of **subsidiarity**, with key decisions being taken as close as possible to the communities that they will impact. This places a very strong emphasis on the Place Based Partnerships.

In BHR our Place Based Partnerships are in the process of being established, and there is recognition that the form and functions that they take on, initially in shadow form from December 2021, and officially from April 2022, will evolve over time as they become more established.

There is an ask from Place Based Partnerships to the NEL ICS that a framework is developed, making clear what elements and functions will need to be uniform across the seven NEL Place Based Partnerships, and what will be open to local decision.

BHR Partners have undertaken a process to consider and articulate the key areas that we believe we should continue to collaborate on at a BHR level. A second series of discussions will be held following this to scope what we believe should be held at a Place Based Partnership level. It is intended that this will feed into and shape the NEL framework described above.

This process has involved a series of interviews with partner organisations as set out on the following page, alongside discussion with Place Based Partnerships as a group, seeking views on key areas of ongoing collaboration for BHR partners.

This paper summarises the initial outputs from these ongoing discussions, which will be developed into a proposal to be reviewed by Place Based Partnership Boards (BPBs), ICEG and ICPB members in November, noting that any proposal would need to fit within the emerging NEL ICS framework. Once endorsed, the proposal will be shared with NEL colleagues to feed into and shape the framework that is being developed for the NEL Integrated Care System.

Initial emerging themes from the discussions

Key themes from the discussions that have taken place to date are summarised in the following slides. A full record of the discussions with each partner has been recorded separately and can be shared with partners.

- One of the strongest themes to emerge from all of the partnership discussion to date is that BHR in particular has a strong and successful history of partnership working, with innovative and important partnership programmes that partners are keen to continue to collaborate on, such as the BHR Transformation Boards, the associated Integrated Sustainability Plan (ISP) and the BHR Health and Care Academy. There is a strong belief that there is real value in continuing to collaborate at a BHR and wider multi place based level.
- Recognition that BHR level collaboration seems to lend itself well to delivering innovation and transformation in a timely manner. Discussion noted that there will be benefit and economies of scale for working on a wider (e.g. NEL) footprint around some areas, however, need to ensure that this does not mean that innovation is delayed by working at this level / being across too large a footprint.
- The emerging preferred form of delegation from the NHS Board to Place Based Partnerships is a “committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources”, although this may evolve and change over time as the place Based Partnerships and local arrangements become more mature.
- Keen to allow Place Based Partnerships to develop over time and organically, with recognition that we may initially undertake more at a multi borough level from April 2022, with more then moving to the Place Based Partnerships over time as they become more established. Multi-borough working must not undermine development of the Place Based Partnership Boards (PBPBs) as place is still the main focus.
- Mental Health will sit at a NEL level from April 2022 in terms of the Transformation Board, linking with the Provider Collaborative approach. BHR plans relating to local service changes and the BHR Integrated Sustainability Plan will need to be taken into account.
- Recognition that unpicking some budgets and services to be delivered at a place based level may be tricky initially due to historical commissioning of services on a wider footprint within block contracts, however, there is ambition to deliver more at a place based level over time, and agreement that just because it may be difficult to unpick some services to be delivered more locally/innovatively, this shouldn’t be a blocker to attempting to do this.
- Resource will be absolutely key to delivering at each level of the system, and it is imperative that resource is distributed equitably based on the work that will sit at each level of the system, for example, partners need to consider and put into place the resource that is required at a Place Based Partnership level to ensure that these can progress.
- Whatever governance is established to frame each level of the system needs to be agile and flexible to ensure that we don’t get bogged down in bureaucracy.

Initial proposed areas for continued multi borough collaboration from the discussions

Place Based Partnership

- Service delivery and transformation
- Tailoring services to specific local population needs; population health improvement where certain communities have poorer outcomes
- Integrated Care at a place based level
- New models of care – i.e. community hubs
- Primary Care – Local Incentive Schemes, to be at a Borough level where possible
- Primary Care Transformation / development
- Building closer working relationships with Community and voluntary services
- Closer/more integrated working with local pharmacies / optometry / dentists
- Addressing the wider determinants of health at a local level
- Joining up work around the wider determinants of health with health and care interventions e.g. Redbridge overcrowding
- Addressing variation in quality
- Engagement /relationship building with local people so that they can shape local health and care service development

Multi Borough Collaboration

BHR:

- Translation of strategy into delivery, linked to transformation programmes
- Integrated Sustainability Plan
- BHR Transformation Boards
- BHR Health and Care Academy
- Collaboration around key provider footprints, i.e. BHR for BHRUT based pathways
- Lobbying for equity of investment for BHR
- Collaboration around key population health needs, such as obesity
- Partnership response to key challenges, e.g. winter pressures
- Better/ more collaborative use of all estates
- Joint commissioning of some services to achieve economies of scale, e.g. Sexual Health services
- Workforce training programmes
- Promote BHR as a good place to live/work
- BHR JSNA / PNA
- Anchor Organisations work locally
- Supporting provider market/ CVS

Wider Borough Collaboration:

- Mental Health
- Community services
- Acute where there are key population crossovers i.e. Newham for B&D and Whipps Cross for Redbridge

North East London Level

- Strategy setting and translation of national policy and targets
- Oversight and assurance
- Economies of scale for more specialised service commissioning
- NEL wide digital programme
- Sharing of learning and best practice
- Greater commissioning of joint services where there is benefit of doing so, for example, Sexual Health services have worked well at a BHR level. NHS 111 services at a 7 borough level etc.
- Lobbying for equity of investment for NEL
- Estates planning / strategy
- Contract Management
- Commissioning and contracting of primary care services
- Data management / sharing and BI that can be drawn down by BHR / Boroughs
- Oversight of whole population JSNAs to understand key population health challenges
- NEL wide financial strategy (taking into account the BHR ISP)

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Better Care Fund 21/22
Board Lead:	Barbara Nicholls
Report Author and contact details:	John Green 01708 433018; 07392 782206 John.green@havering.gov.uk

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☐	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☐	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☒	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☐	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

Havering
LONDON BOROUGH

SUMMARY

The Better Care Fund (BCF) is a means of encouraging integration of health and care services. The funding is dependent on developing joint plans with health and social care that meet specified national conditions, report against defined performance indicators and detail how expenditure is distributed to support the local system. Ongoing reporting arrangements monitor plan delivery.

Approval of plans through the Health and Well Being board is a prerequisite of the plans going on to national scrutiny and endorsement.

The planning guidance to follow for the BCF from the NHS for 21/22 was delayed and the plans as presented are representative of actions already underway for this financial year.

This year there is a requirement for a narrative plan, something not required when the pandemic was at its height. Locally the BCF narrative plan was developed as a tri borough plan, with an associated S75 agreement in 2017. This narrative continues as a tri borough plan and endorsement of the same narrative is being sought in both Redbridge and Barking and Dagenham.

The finance and performance template plan is authority specific and each borough will present their own plans for expenditure, allied to their own particular allocations.

RECOMMENDATIONS

For HWB to endorse and agree the narrative and associated expenditure and performance template

REPORT DETAIL

See attached documents

IMPLICATIONS AND RISKS

Without HWB endorsement the plan will not proceed to national sign off and funding would be threatened.

BACKGROUND PAPERS

None

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BHR Integrated Care Partnership

Better care, better lives, together

Barking & Dagenham, Havering & Redbridge (BHR)

Joint Better Care Fund Plan 2021-22

London Borough of Barking & Dagenham
London Borough of Havering
London Borough of Redbridge
NEL CCG

Contents

SECTION HEADINGS

BHR Better Care Fund Plan 2021-22

This joint plan consists of the following Health & Wellbeing Boards:

- Barking & Dagenham
- Havering
- Redbridge

This consists of the following local organisations, submitting the plan:

- London Borough of Barking & Dagenham
- London Borough of Havering
- London Borough of Redbridge
- North East London Clinical Commissioning Group

Collectively the this forms the North East London Integrated Care Partnership with our other partners that includes:

- Barking, Havering & Redbridge University Hospital Trust (BHRUT)
- Barts University Hospital Trust (Barts)
- North East London Foundation Trust (NELFT
- Primary Care Networks
- Emergency Services
- Commissioned services health and social care provider reps
- Patient and Service User reps
- VCS organisations

Summary of National Conditions

Our BHR BCF plan sets out how we will meet these requirements.

National Conditions		Covered in Sections
1	**Jointly agreed plan between local health and social care commissioners, signed off by the HWBs** - or delegated authority if there is no HWB board. Reports will all go to the respective borough HWBs informing them of the plan. Plans should set out a joined-up approach to integrated, person-centred services across local health, care, housing and wider public services. They should include arrangements for joint commissioning, and an agreed approach for embedding the current discharge policy in relation to how BCF funding will support this.	Sections 1, 2, 3 &4
2	**NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution**	BHR Expenditure Templates
3	**Invest in NHS-commissioned out-of-hospital services** Narrative plans should set out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it. Expenditure plans should show the schemes that are being commissioned from BCF funding sources to support this objective.	BHR Expenditure Templates Sections 2,3,5 & 6
4	**A plan for improving outcomes for people being discharged from hospital** • Support improvement in outcomes for people being discharged from hospital, including the implementation of the hospital discharge policy, and continued implementation of the High Impact Change Model for Managing Transfers of Care. • Focus on improvements in the key metrics below: i. Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days ii. Improving the proportion of people discharged home using data on discharge to their usual place of residence	BHR Expenditure Templates - Metric Tab Section 3

*All detail and data contained within this plan was correct at the time of submission.

Executive Summary

Our Joint Priorities

Across the Barking & Dagenham, Havering and Redbridge Better Care Fund plan for 2021-22, we have agreed the following priorities:

Priority 1: Hospital Discharge Planning & Support

- **To support safe and timely discharge from hospital and support a home first approach**

Priority 2: Targeted Out-of-Hospital Care

- **To support people with higher care needs to get as great a level of independence as possible**

Priority 3: Community Support & Independence

- **To support people to remain well in the community - maximise their independence and reduce admissions**

These priorities are key to deliver the ambitions of the BCF programme and deliver the standard and quality of health and care services to meet the needs of our residents.

Key Changes

1. The development of a Single Point of Access (SPA) which includes the Hospital Discharge Service (HDS). The previous joint assessment and discharge service was disbanded in August 2021 and phase one of the move to an SPA for all discharge commenced with referral and discharge co-ordination offer moving to a single team and managed the North East London Foundation Trust. Phase 2 to merge the HDS with the SPA will commence in January 2022. Further scoping is underway to determine the full remit of the SPA going forward from April 2022 and beyond.

2. The roll out of the Home First model of care which was piloted in Havering in 2021-22. The CCG has funded additional therapy staff to extend the Havering services and also roll out to B&D and Redbridge from quarter 3 in 2021-22.

3. Funding for the first four weeks of care post discharge pathway continues to be funded from the Hospital Discharge Fund in 2021-22.

4. To reduce the rate of admissions where individuals could be supported better in the community through anticipatory care and admission avoidance.

5. The CCG has commissioned additional capacity from the NELFT Community Treatment Team as part of the Ageing Well priority to achieve the national requirement that by 31st March 2022, all systems should have universal coverage of a 2-hour crisis response at home service operating 8am to 8pm 7 days a week at a minimum, and using a model in line with national guidance.

6. Preparation for the new place-based Borough Partnership arrangements across the three boroughs.

7. The impacts of COIVD on the care market – financial sustainability, workforce issues and service delivery moving away from building based to more virtual services.

8. Increase in care needs and complexity of conditions due to restrictions in accessing primary care services and people now requiring a higher level of care when entering the system.

9. The impact of COVID on our vulnerable residents with long-term health conditions and BANE communities.

10. Younger people being admitted to hospital with COVID due to a reluctance in uptake of the vaccine.

11. Stronger governance arrangements and closer working as result of the pandemic.

Section 1: Governance (National Condition 1)

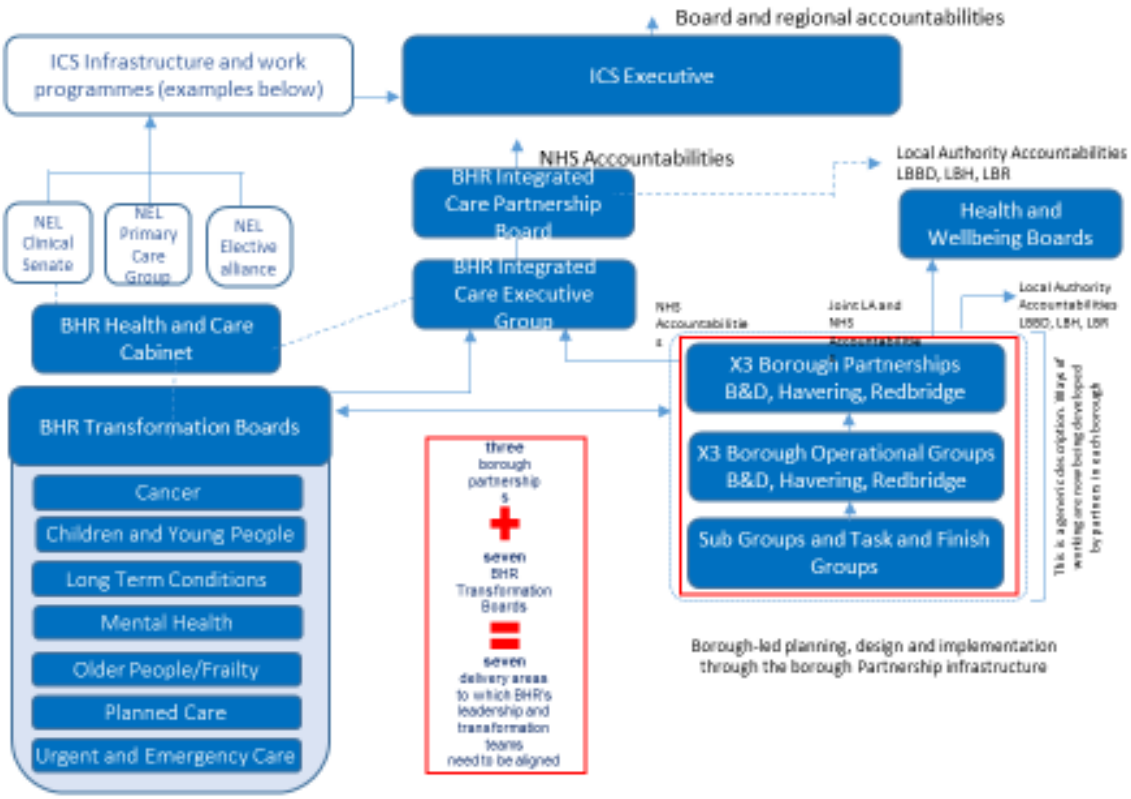
1. BHR BCF Governance & Ambitions

Our overarching vision for BHR is to:

'Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high-quality health and wellbeing services.'

- **Create an environment that encourages and facilitates healthy and independent lifestyles** by enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing
- **Organise care around the individual's needs**, involving and empowering them, integrating across agencies, with a single point of access, and providing locally where possible. It will meet best practice quality standards and provide value for money.
- **Ensure organisations work collaboratively**, sharing data where appropriate, and maximise effective use of scarce/specialist resources (e.g. economies of scale).
- **Remove artificial barriers that impede the seamless delivery of care**, bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.

The diagram below sets out the BCF Governance within the BHR structure.



Joint BHR S75 Agreement
Overall strategic oversight of partnership working between the Partners is vested in the respective Borough Health and Wellbeing Boards.

The Partners have agreed that the Joint Commissioning Board (JCB) will be responsible for the review of performance and oversight of the partnership agreement. The JCB is a working group of representatives of Barking and Dagenham, Havering and Redbridge Councils and North East London CCG. At least one member from each of the Partners has individual delegated responsibility from their host organisation to make decisions which enable the JCB to carry out its duties and functions. In addition, each partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

The BCF programme of schemes are governed through our Joint Commissioning Board, which is part of the Integrated Care Partnership structure, the JCB provides the strategic direction of the development and application of the Better Care Fund across BHR. From our BCF 2017-19 plan we developed a joint BHR S75 with the BHR LAs and CCGs, which was completed and signed back in July 2018. This set out the foundation to strengthen the work across the partners to deliver health and care services across the BHR region using the BCF as a key lever for support integration where this brings efficiencies of quality and sustainability. The S75 sets out three 'BCF aligned pooled funds' for each HWB area, and in addition incorporates the option of utilising a fourth 'pot' to facilitate joint pooled commissioning arrangements between partners.

The JCB consists of representation between the BHR LAs and CCGs. The chair alternates between CCG and local authorities with representation consisting of the respective DASSs, DPHs, CCG Leaderships, finance representatives and Commissioner Leads as members of the Board. A BCF Operations & Finance group support the JCB in undertaking its decision making and setting strategic direction. It is exploring opportunities for further development in relation to integrated services and joint commissioning opportunities. Therefore, it is expected that the BCF plans will continue to develop and evolve as the JCB is a forum to which the key commissioning partners can bring forwarded new initiatives to align with local and regional needs and demands.

Jointly Agreed Plan Approval
Below sets out the key officers from each organisation responsible for plan sign off and the dates of the Health & Wellbeing Boards for plan agreement.

Barking & Dagenham	
Chair of the HWB	Cllr Maureen Worby, Cabinet Member for Social Care & Health Integration
DASS	Elaine Allegretti, Strategic Director for Children's & Adults
Section 151 Officer	Philip Gregory, Director of Finance
Date of HWB Agreement	30th November 2021

Havering	
Chair of the HWB	Councillor Jason Frost, Lead member for Adults Social Care & Health
DASS	Barbara Nicholls, Director Adult Social Care & Health
Section 151 Officer	Jane West, Chief Operating Officer
Date of HWB Agreement	16th November 2021 (24th November for HWB formal sign off)

Redbridge	
Chair of the HWB	Cllr Mark Santos, Cabinet Member for Adult Social Care & Health
DASS	Adrian Loades, Corporate Director of People
Section 151 Officer	Maria Christofi, Corporate Director of Resources
Date of HWB Agreement	30th November 2021 (EGM on 7th December 2021 to be ratified)

NEL CCG & BHR ICP	
Accountable Officer	Henry Black, NEL CCG (Interim) & Ceri Jacob, Managing Director, BHR ICP
Finance Director	Steve Collins, Chief Finance Officer, NEL CCG & Ahmet Koray, Director of Finance, BHR ICP
Senior Responsible Officer	Sharon Morrow, Director of Integrated Care & SRO BHR ICP

Section 2: Approach to Integration

1. Summary

An integrated care system (ICS) is one that brings together local health and care organisations to deliver the 'triple integration' of primary and specialist health care, physical and mental health services and health with social care. Redbridge, Havering & Barking & Dagenham Local Authorities and the NEL CCG are part of the BHR Integrated Care System, which serves a population of around 780,500 people.

The key underlying principles of an ICS are to (a) shift care from the hospital to the community where it is appropriate to do so, (b) provide place-based care through more integrated working across health, social care and the voluntary sector at a neighbourhood level and (c) provide person-centred care by breaking down traditional barriers between organisations and the functions within them, placing a greater focus on the delivery of better outcomes for local people.

Joint commissioning, service model development and pathway redesign in BHR are managed through a number of commissioners, provider boards and working groups. This is led by the Integrated Care Partnership Board (ICPB) and the Integrated Chief Executive Group (ICEG), who lead the strategic direction and decision making for the BHR area. Others key boards include the A&E Delivery Board - led by the acute trust; a Discharge Improvement Working Group (DIWG) - chaired by local authority and NHS community services directors, it reviews and manages flow in and out-of-hospital. The Older Peoples and Frailty Transformation Board is led by the CCG and a Joint Commissioning Board (JCB) consisting of BHR LAs and CCGs functions at a more strategic level where a range of collaborative commissioning initiatives are developed and negotiated, which includes the BCF. Commissioners across the three boroughs are also working together on a number of themed programmes and service developments.

Primary Care Networks (PCNs) are one of the key building blocks and the focus of integrated care delivery. PCNs are groups of general practices and social and community care providers that serve areas with populations of about 30,000-50,000 people (although can be larger), and aim to provide person-centred, community-based care through multi-disciplinary teams (MDTs). The formation of PCNs was directed by the NHS Long Term Plan in 2019.

2. Integration Approaches & Joint Commissioning

Embedding Integration - Joint and Collaborative Commissioning
Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high- quality health and wellbeing services. This plan sets out a clear determination that the BHR area will move increasingly towards that vision with a new model of care, building upon the history and experience we have together to meet the challenges of increasing demand, demographic change and financial constraint. We have defined, and agreed, a series of themes. Each of them is important to the BHR health & care system and all are central to the Better Care Fund. The plan overall is expected to deliver against the key requirements as set out in the National Guidance and Policy Framework, including the High Impact Change Model, market capacity and sustainability, supporting the acute hospitals' 'flow' and ensuring that social care services are protected wherever possible, which in turns supports the whole health and care system. The system is working together to achieve the following aims:

- To enable and empower people to live a healthy lifestyle, have access to preventative care, to feel part of their local community, to live independently for as long as possible, to manage their own health and wellbeing, which creates an environment that encourages and facilitates healthy and independent lifestyles.

- Where care and support is organised around the individual's needs, involves and empowers the service user, is integrated between agencies, with a single point of access, is provided locally where possible, meets best practice quality standards and provides value for money.

- In which organisations share data where appropriate, work collaboratively with other agencies and make more effective use of scarce resources (e.g., economies of scale).

- Where organisational barriers that impede the seamless delivery of care are removed, bringing together not only health but social care, but a range of other services that are critical to supporting our population to live healthy lives.

Through working in partnership, the local authorities, NHS partners, primary care and the VCS have an ambitious transformation agenda for older people and those who are frail. Through the integration of health and social care, streamlining pathways around

the person and by supporting older people to be healthy; preventing hospital admission (both in the community and at the hospital front door), supporting safe effective discharge, preventing people in care homes from being hospitalised and enabling a good end of life experience in a person preferred place of death - we can enable people to be safe and well in community settings.

Having invested in the development of our locality models, bringing greater levels of integration and co-location of teams, we are developing this further, as a part of our ambition for Place Based (Borough) Partnerships to take a greater role in the commissioning and provision of services. Increasingly this will draw in the wider range of services than our current community models deliver, such as housing, general practice, voluntary sector services and so on.

The commissioning and monitoring of BCF plans is overseen by the BCF Executive Group, which reports to the Joint Commissioning Board. The executive group agrees the BCF plan and commissioning arrangements.

Joint commissioning, service development and pathway redesign in BHR are managed through a number of multiple commissioner and provider boards. These include the Discharge Improvement Working Group (DIWG) reviewing and managing flow in and out of hospital chaired by local authority and NHS community services directors, a number of themed change boards: Older Peoples and Frailty, Mental Health and Long-Term Conditions led by the CCG and a Joint Commissioning Board (JCB), where a range of collaborative commissioning initiatives are developed and negotiated, which includes the BCF.

Improving outcomes for frail and older people is a priority for the BHR Integrated Care Partnership (ICP). The planning and delivery of a transformation plan to achieve this has been co-ordinated through a BHR system wide transformation programme for older people and those who are frail. This was established in June 2018 with the aim of improving quality and patient outcomes and ensuring that services are as efficient as possible and integrated around the patient.

The transformation programme provides programme support to the delivery of the BCF outcomes. A number of system workstreams have been established reporting to a transformation board to take forward service transformation through collaboration and shape the BCF plans.

The Older People and Frailty Transformation Programme was approved by the ICP which set out priority areas for improvement. This brought all the work together to describe the entirety of the transformation programme across a pathway of care, the investment requirement to enhance capacity on primary/community care and savings opportunities resultant from a reduction in avoidable hospital activity. It was intended that transformation would be delivered over 3 years – the first year focused on building the foundation, moving to full scale transformation in year 2 and delivery through an ICS in year 3. The Board is planning a refresh of the strategy in late 2021-22.

The partnership approach involves the CCG, NHS provider trusts and Local Authorities across the three boroughs, Havering, Barking and Dagenham and Redbridge. As part of the governance structure a Joint Commissioning Board has been formed to take opportunities for joint commissioning. Many initiatives and objectives are shared and delivered, and the strategic goals of prevention, integration and partnerships and personalisation resonate across all organisations. The partnership has been in place in various forms over some time and, through lessons learned from the three authorities and through demographic and demand profiling, has developed a localised model for delivery of services based upon Primary Care Network partnerships established within the borough.

Borough Partnerships

All three boroughs are working towards an integrated care system along with its system partners. Intrinsic to that is the development of the place-based partnerships for each area. For example, the Havering Borough Partnership includes system partners including GPs, social care and NHS providers, the voluntary sector, health watch, the CCG and the local authority. The partnership has identified early priorities and will need to continue to develop aligned with the model of delegation that is ultimately agreed. The Joint Health and Wellbeing strategy and many organisational cross overs and governance groups set out the already established partnership approach between the Havering and system partners. The membership of the Redbridge Borough Partnership is similar to that of Havering. The Redbridge partnership has agreed its governance arrangements and identified three priority areas (Children's Health, Adult Mental Health and the health impact of overcrowding) which it will use to develop the working of the partnership as well as improving outcomes for residents. The Partnership is undertaking a series of developmental workshops in addition to its regular meetings in order to establish future ways of working. Progress is reported to the HWB at its regular meetings. Redbridge is also developing its Borough partnership approach and priorities and been undertaking a range of workshops to develop this. Progress is reported to the HWB at its regular meetings.

Within B&D it has been agreed that the Partnership Board will be supported by a programme structure that supports delivery across separate pathways of care for children and adults. Delegated authority will be sought for responsibility for pooled health and care budgets, managed under a Section 75 partnership arrangement. An organisational development (OD) session 'bringing the B&D

Borough Partnership to life' will take place in November. The session is aimed at Delivery Group members and executive-level decision makers who will be involved in the Partnership on behalf of their organisation.

Borough Partnerships Visions

Locality Models

All three broughs operate the community heath and/or social care services on a 'locality model basis'. The localities have populations within them of a size that are largely equal populations though with potentially different needs. The move to a localities model has to be designed so that end users get better services. The concept means that the response to local needs will deliver more value for the residents in that area, because services are aligned with those local needs.

Our Joint Priorities

Priority 1: Hospital Discharge Planning & Support

- **To support safe and timely discharge from hospital and support a home first approach**

Priority 2: Targeted Out-of-Hospital Care

- **To support people with higher care needs to get as great a level of independence as possible**

Priority 3: Community Support & Independence

- **To support people to remain well in the community - maximise their independence and reduce admissions**

Priority 4: Market Stabilisation & COVID Recovery

- **To support the stabilisation of the care market and Winter pressures**

Primary Care Networks

BHR has a number of Primary Care Networks (PCNs) operating as part of a wider joint approach to primary care across north-east London. As part of the localities model, we will explore the establishment of 'community hubs' within each borough which will aim to co-locate a number of health and care services including GP and community nursing walk-in clinics, health and wellbeing programmes, employment support, housing support, healthy living prevention activities, and education services for adults and children. GP Federations are at borough level and are a key platform to expand the benefits of PCNs and enable further joint

commissioning and economies of scale at both a borough level and across BHR. They are a key part of the changing way health and care services are working together to support people in community settings.

Direct Enhanced Services provided by PCNs

Direct Enhanced Service	Service Outline	PCN Workforce Service Support
Structured Medication Reviews	• Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines) • Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. • Can lead to a reduction in adverse events.	Clinical Pharmacist
Enhanced health in care homes	• Access to consistent, named GP and wider primary care services • Medicines review • Hydration and nutrition support • Access to out-o-f hours / urgent care when needed	Clinical Pharmacist Community Paramedic
Anticipatory care with community services	• Thinking ahead and understanding the health needs of individual people • Knowing how to use services better • Helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan.	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Personalised care	• Care tailored to the needs of people and what matters to them • Prevention embedded • Personal Health budgets • Shared decision making	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Inequalities	• Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing those services that are provided in an integrated way where this might reduce health inequalities	Social Prescriber Clinical Pharmacist Physician Associate

Section 3: BHR BCF Scheme Summary Overview

1. Summary

This section provides a summary preview of our scheme for the BCF 2021-22. Since the impact of COVID many of our services have had to adapt and amend their delivery models and within commissioning teams across NEL we are now looking at these services going forward and how revised or new models need to be designed and implemented. This is particularly linked to hospital discharge, the sustainability of homecare, residential care, the care workforce and our prevention and early intervention offer.

2. Schemes & Metrics

BCF National Metrics

Metric 1:	**Discharge** i) Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days ii) Improving the proportion of people discharged home using data on discharge to their usual place of residence
Metric 2:	**Avoidable admissions to hospital**
Metric 3:	**Reduction in admissions to residential and care homes**
Metric 4:	**Effectiveness of reablement**

Other Related Metrics
Many of our services contained within the BCF plan also deliver to a wide range of other outcome measure under ASCOF and NHSOF, such as those supporting carers. For example:

ASCOF Related Domains
1. Enhancing quality of life for people with care and support needs
2. Delaying and reducing the need for care and support
3. Ensuring people have a positive experience of care and support
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

Example ASCOF indicators include:
- 1D. Carer-reported quality of life
- 1I: The proportion of people who have as much social contact as they would like.
- 3D. Proportion of people who use services and carers who find it easy to find information about support
- 4B. Proportion of people who use services who say that those services have made them feel safe and secure

PHOF Related Domains
1. Improving the wider determinants of health: Improvements against wider factors which affect health and wellbeing and health inequalities
2. Health improvement: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
3. Health protection: The population's health is protected from major incidents and other threats, whilst reducing health inequalities
4. Healthcare public health and preventing premature mortality: Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

NHSOF Related Domains
1. Enhancing quality of life for people with long-term conditions
2. Helping people to recover from episodes of ill health or following injury
3. Ensuring that people have a positive experience of care

BHR BCF Plan Schemes
Our plan priority schemes for 2021-22 are set out below. The scheme types are those models and/or services that will deliver the priority scheme ambitions.

ID	SCHEME	SCHEME TYPES*
1	**PRIORITY: Hospital Discharge Planning & Support** **AMBITION: To support safe and timely discharge from hospital and support a home first approach**	• High Impact Change Model for Managing Transfer of Care • Integrated Care Planning and Navigation • Enablers for Integration • Home First (other) • Hospital Discharge Service (other)
2	**PRIORITY: Targeted Out-of-Hospital Care** **AMBITION: To support people with higher care needs to get as great a level of independence as possible**	• Bed based intermediate Care Services • Reablement in a person's own home • Residential Placements • Home Care or Domiciliary Care • Housing Related Schemes
3	**PRIORITY: Community Support & Independence** **AMBITION: To support people to remain well in the community - maximise their independence and reduce admissions**	• Prevention / Early Intervention • Personalised Budgeting and Commissioning • Assistive Technologies and Equipment • Care Act Implementation Related Duties • Carers Services • Community Based Schemes • DFG Related Schemes • Community Treatment Team expansion (other)

ID	SCHEME	SCHEME TYPES*
4	**PRIORITY: Market Stabilisation & COVID Recovery** **AMBITION: To support the stabilisation of the care market and Winter pressures**	• Provider uplifts • Fee increase • Winter pressures

*The scheme types often deliver in more than one priority schemes area to delivery care services in a variety of ways. For example, DFG monies can be used to support hospital discharge and community support and independence in the community.

Scheme Delivery & Management
BCF Scheme delivery will be overseen by the BHR BCF Executive Group and BCF Operations & Finance group which ultimately reporting into our Joint Commissioning Board. Progress reports on the health and care models delivery and spend will be presented to the Executive group. However, Commissioners from all three boroughs and the NEL CCG work closely together on a regular basis in relation to discharge models, system changes, and transformational and commissioning work. Our s75 agreement sets out the governance for these groups.

Approach to Risk
All partners are facing great financial pressures in the life of this plan and continuing to work to addressing ongoing sustainability. Partners to continue to be responsible for overspends on their respective budgets within the BCF. COVID and increased demand across all client groups is placing significant risk on the health and care system and financial landscape across BHR. This is impacting our NHS, social care and provider workforce. Within the local authority, social work and brokerage teams are often severely stretched to meet caseloads and demand and key workforce areas are struggling to meet the demand, for example the number of therapists available at a regional and national level. The system is working to mitigate these workforce issues with agency usage, the new BHR Academy and new apprenticeships through Care City, but these longer-term solutions will take a while to trickle through and mitigate these risks.

Further governance detail to Risk is set out in our joint BHR BCF s75 agreement. A detailed **Risk Log** can be found in **Appendix 1.**

Section 4: Supporting Discharge & Plan Priorities (National Condition 4)

1. Summary

All of our priorities above are designed to provide a range of services and supporting outcomes to meets the needs and demand of patients, service users and carers within the flow of the health and care system and support the maintenance of people to stay, well and supported within community and home settings – only needing acute settings when necessary. Therefore, our BCF monies are targeted towards our priorities in supporting this flow. As set out in schemes and expenditure plans.

We work towards embedding key improvement outcomes around, independence, support and mental health and care within service design and to ensure we meet the national outcome frameworks of the NHS, Adult Social Care Outcomes Framework (ASCOF) and PHOF.

Key to supporting hospital discharge is partnership working between social care and our acute providers BHRUT & Barts, and community health provider NELFT - in developing discharge policies and processes around flow out of hospital in the community and home. Key to this is the Discharge Improvement Working group where engagement was vital to ensure that the new discharge models of our SPA, D2A and Home First can be implanted and delivered. Working groups are in place to ensure that these are being constantly monitored and refined between all partners.

Winter Pressures Support across BHR
Although the Winter Pressures is contained within the BCF (and not subject to ring-fencing) we will use the monies across BHR to support key services and capacity to ensure patient flow through discharge planning, and to ensure there is sufficient capacity to support move on from hospital to other care services (with our Brokerage teams) to fund extra residential placements (residential/nursing care/extra care/supported living); homecare packages; home, settle and support service and reablement (our default offer pathway for hospital services). Further detail is set out in the BHR individual expenditure plans.

2. Models of Care

Social care continues to support getting people out of hospital. This approach however of investing to support discharge has led at times to localised market capacity issues and budget pressure (overspends). Greater use of residential care and residential with nursing care places across the boroughs might destabilise those markets locally or push prices up for Local Authorities but there is opportunity to work together to minimise any impact.

Barking & Dagenham, Havering and Redbridge are adjacent boroughs in outer north east London. We share a single major acute provider, Barking Havering and Redbridge University Trust, and a large community and mental health Trust, NELFT NHS Foundation Trust. This creates a natural alignment for health and local authority partners to work together to achieve the best outcomes for the whole population

Hospital Discharge Policy
All three boroughs and have used the BCF to work to support discharges and improve outcomes for our residents when they come out of hospital.

We have worked across all discharge pathways to improve the experience and outcomes for our residents and also to support the local acute hospital system with the demand increases for their bed base. Internally within the health system the BCF has supported the creation of community-based discharge team which has driven care decisions into the community rather than keeping them based in a hospital setting. Developing a single point of access (SPA) for discharges across BHR aims to streamline discharge processes and give local authorities a greater degree of management over care packages from their start. Key to the success of the SPA is the trusted assessor model which situates trusted assessors of care needs on the hospital wards to increase the efficiency of assessments for placements across care settings.

The BCF is crucial in supporting our pathway 0 offer with respect to providing people support in their home at point of discharge. This includes our home settle and support service provided by the British Red Cross. This is a particular example of joint commissioning; the service being jointly commissioned by all three boroughs and the CCG.

Pathway one is supported through the home first pilot which has been referenced above alongside the BCF supporting general crisis intervention from our homecare agencies. In the B&D Crisis Intervention is our free service provided for a period of up to 6 weeks at point of discharge. The BCF supports both the initial 6 weeks as well as a further capacity and support throughout domiciliary care provision. Social care in the community, including a DOLs assessments are also supported through the BCF to ensure that we have the capacity to meet the demand from hospital discharges. Similarly, for Havering & Redbridge we use reablement as our default offer for this pathway and also Home First sits within these providers. These dedicated reablement services have been modelled around home first principles and is fundamental to ensuring the flow from hospital is maintained.

Pathway 2 and 3 are supported through our jointly commissioned discharge pathways include the discharge to assess pilot referenced earlier. This pathway places individuals into nursing home beds that have a rehabilitation team supporting the residents for a six-week period. The aim is that these residents will then be able to have their long-term care package reduced after the six-week period. The pathway works with contracted nursing home beds which also eases the discharge process as for those who are eligible for the pathway there are pre-arranged beds available. This initiative, piloted in Havering, was evaluated and has been effective in improving outcomes and cost effectiveness.

The BCF supports a wide range of other services in B&D that support discharges that are safe and effective. This includes our community treatment team and social care capacity and a Blitz Cleaning and decluttering service provided by the ILA, a voluntary sector organisation. Redbridge also provides a service to help those who hoard to enable them to be able to live safely and return home with care. Havering ensures that its commissioned voluntary sector services are joined up with reablement and 'home settle and support' discharge pathways to enable connection with appropriate services depending on needs.

While Barking & Dagenham and Havering have BHRUT as the one main acute provider, Redbridge also has Barts Health NHS Trust (Barts) in addition to BHRUT through Whipps Cross University Hospital, situated in the north west of Redbridge serving approximately one third of the population and is the provider of choice for a number of residents due to access with Redbridge CCG commissioning services with Barts. Therfore, the LA works very closely with both acute providers in supporting its discharge process. Home First is Redbridge will be moving into its next phase which will include developing this with Barts.

The narrative below for our key priorities provides an overview and highlight of the key models of health and care, and key services delivering our ambitions within our BCF plan for 2021-22. This not an exhaustive list of every service provided by every borough and CCG as many of these are the same across the patch, but an illustration of the key components working across BHR. Full details of what is funded is provided within the individual **HWB Borough Expenditure templates**.

SCHEME 1: Hospital Discharge Planning & Support

The interface between hospital and the community is vitally important in the relationship between health and social care, both for the individual and for the organisations concerned.

The ICS subsystem partners, as the pandemic eases over the next 18 months, must return to its relentless focus on avoiding admissions to the acute hospitals. This will require understanding of vulnerability and early responses to issues without creating dependency. Imaginative approaches to reablement prior to hospitalisation, continued focus on assistive technology, high quality homecare, personalisation of services will all contribute to sustaining people in the community rather than escalating to acute or long-term care.

Developing Discharge Options
Over the past 12 months, there have been a number of key developments around discharge. These are:

- **Discharge to Assess:** Particularly piloting targeted care homes with a wrap-around therapy team, has shown outcomes to support 23% of the patients to be discharged home.

- **Home First:** Each borough now has a Home First approach including a therapy team, reablement care and access to equipment. Havering now have Home First as the default model for discharge:
    - Reablement / Crisis Intervention
    - Homecare
    - Residential and Nursing Care

- **Trusted Assessor (TA):** The TA model has really supported the range of discharges required during the pandemic to care homes including discharge to assess, designated provision and alternative rehab stepdown. The service will be sustainably funding from Q3 with two assessors to work across BHR.

When people do go into hospital and come out with a new or on-going need for support there is a need for a quick and effective response, putting in place all the necessary support mechanisms that will re-able and rehabilitate the person back to independent living as soon as possible. We are committed to the principles of 'Discharge to Assess', the idea of getting people out of the acute setting as soon as they are medically fit, ideally back home, where prompt assessment of needs leads to support in place quickly, in whatever form necessary, to enhance chances of rehabilitation and independence. There are a significant number of dependencies on this happening effectively.

- Understanding as soon as possible the point at which clinical need in an acute setting ends, so that the person is identified as ready to go home
- Once this point is understood the rapid transportation home of the person with required support in place (be that equipment or support from a therapist, care worker or an adjustment to the home environment)
- Getting the right assessment of need for the person, recognising that the assessment will be different if done:
    - At the point of crisis in hospital
    - Immediately after the person gets home
    - After a period of reablement and/ or rehabilitation at home.
- Other influencing factors will be whether the assessment is a joint one, with multi-disciplinary input and whether there is a full understanding and application of the principles of personalisation, developing support plans that focus on outcomes.
- How quickly, from the point of return home, the application of high quality reablement and/ or rehabilitation is put in place
- The quality and intelligence applied in determining need for home care
- The messages that are given to the person concerned around dependency and the ability to get them back to independence
- The family response to the situation
- The ability of informal carers to take responsibility for meeting the needs of the person they are caring for
- The quality and appropriateness of the housing situation of the person concerned

All these dependencies, and others, play out in deciding whether or to what extent and how quickly the person might be capable of being fully independent. If the services do not coordinate, the likelihood of recovery being sustainable for the person concerned will be diminished.

Where commissioned services are part of this, they need to be enabled to play their part in contributing to the desired outcome. This needs to be considered in the design of such services, ensuring that integration is designed as an end to end process and not as an individual, segregated service. Commissioners and providers from different organisations must continue to join up where possible

to design across the end to end process, with the benefit to the end user in mind, and not in silos with the achievement of narrow targets as the measure of success.

Our strategic approach will look to approach things from this perspective and our system design will actively avoid the development of solutions in isolation of partners crucial to the design of an effective end to end process.

One unintended consequence of the nationally prescribed Hospital Discharge Policy, with its 'Trusted Assessor' element is that the borough is seeing far too many patients discharged into care home settings, who then stay there permanently. Whilst on paper it makes complete sense for any assessment of long term need to take place out of the hospital setting, without the right community offer in place (such as access to rehabilitation), the consequence for the patient can be catastrophic, in that they further decondition, become institutionalised and remain in that care home permanently. As a system, we need to review our investments to refocus on keeping people out of hospital in the first place, but where they do have to be admitted, that there are the right services to pull patients back out into community settings not care homes

BHRUT are currently refreshing their Clinical Strategy, and patients and partner organisations are being widely consulted. BHRUT recognise that central to the refresh, is that it must look more outward and play its part in supporting the right health outcomes for people in out of hospital settings.

Single Point of Access
A key priority across and health and social care is to development a robust and sustainable 'Single Point of Access' (SPA). The BHR health and social care discharge teams have been brought together under the management of NELFT as a single team that will manage all hospital discharges for pathways 2-3. The operating model for integrated working is being embedded over quarters 1-3 in 2021-22 and is expected to operate as a fully functional service in quarter 4 of 2021-22.

The NEL CCG has commissioned some external support to work with the system to review the discharge process which will support informing the development of the SPA model.

All partners have used the BCF to support the integrated commissioning across hospital discharge pathways. The discharge to assess pathway and the home first pathway are both supported by the BCF and commissioned across the local authority and the CCG. Both pathways seek to increase the efficiency of discharges from our acute settings while improving the longer-term outcomes of our patients. The home first pathway uses therapist support to carry out discharge assessments at home where a more accurate package of care can be put in place. This also encourages home as being a default discharge setting.

The discharge to assess pathway sees residents discharged into a named nursing home which has a rehabilitation team wrapped around the nursing homes normal service. This increases the chances of a decrease in long term care needs. The CCG and Local Authority are commissioning 8 beds for the discharge to assess pathway with a rehabilitation team to support these beds. The aim is to improve discharge outcomes in the long term for these residents.

Home First
Whilst the home first pilot in Havering described above initiated a different approach, this is now being rolled out, adapted to meet local needs in B&D and Redbridge.

B&D is currently undertaking a number of hospital discharge pilots which are seeking to improve the hospital discharge pathway for our residents. Therefore, many of these are also focused on supporting our residents to remain at home and with a great level of independence. Chiefly is the Home First pathway pilot which is seeking to ensure that as default the first choice for discharge is back home. This pilot then puts in place a more accurate care package that has been assessed in the home of the resident. This aim is that these residents will be more able to remain at home with an accurate care package suited to their needs. With this more accurate care package there will also be a reduction in readmission to hospital.

Redbridge has also been piloting its Home First model which is embedded into our Reablement service. It is now seeking to increase its number of Home First slots and will be hosting the Occupational Therapists for both Barking & Dagenham and Redbridge. The business case has now been approved and recruitment is underway.

System Improvements
The pandemic has prompted even closer partnership working and has led to initiatives to improve all aspects of the care system, including discharge pathways. An example is the insight that provider markets, both residential and home care, have provided in regard to quality of discharge perspectives at their end. With improved dialogue across the system this has now led to a review of the pathway with engagement from the local authorities, the hospital, CCG and provider markets to learn from these experiences,

to include service user perspectives, with a view to improving the quality of discharge as a partner initiative. The governance of this sits in DWIG and illustrates how that is working in practice to improve outcomes for local people.

SCHEME 2: Targeted Out-of-Hospital Care

Rehabilitation
The CCG continue to commission from NELFT a range of rehabilitation services. There are 61 community rehab beds available to support discharge with rehab and step down. 27 stroke specialist rehab beds are also commissioned to offer step down rehab from the acute stroke wards. Hybrid models working with care homes to offer step down from hospital and rehab beds have also been developed.

The Intensive Rehab Service (IRS) continues to offer 21-day intensive rehab at home post discharge. Longer term rehab is then continued via integrated care teams in the community. Stroke and Neuro rehab is offered with an Early Supported Discharge team at BHRUT and Community Rehab Services offer slow stream rehab.

Discharge to Assess block booked beds were piloted in Havering for 6 months in 2021-22. The pilot provided very successful with 23% of patients who went through the block booked bed base with a wraparound rehab team returning home. The scheme has been extended to the end of the financial year. B&D are also commencing a block booked beds pilot from December 2021 until March 2022. The long-term plan is to have a BHR wide facility/facilities from April 2022.

Reablement
Redbridge recommissioned and implemented its default Reablement offer with NELFT for hospital inpatient discharge services across both its acute providers - BHRUT and Barts, as well as actively encouraging referrals from community teams. Built into our existing 'Community Health & Social Care Service' S75 agreement where MDTs are co-located within our four locality areas. This provides a platform for the Redbridge Reablement Service (RRS) to deliver a preventative element through the health and adult social care pathway and to proactively interface with the operational service, building on our integrated partnership model which will continue to shape the service in line with service needs. This new default offer is provided using a Trusted Assessor model with our provider and will support discharge and provides a quality service to ensure we maximise the goals and outcomes that service users can achieve reduce the need for long-term care packages and enabling to still be at three months after receiving support. We doubled our investment from £700k to over £1.4m a year to deliver a higher quality outcome focussed Reablement service with increased capacity.

Havering's commissioned service provided by Essex Cares Limited has been in place since 2019 and is a fundamental part of Havering's preventative offer. Demand on the service has exceeded what was expected when the service was commissioned. This has been exacerbated by the pandemic, but demand continues to be at unprecedented levels. If the demand continues the system as a whole will have to consider how the service, which supports hospital flow and allows for delivery of home first principles and outcomes, can be funded. It is a significant challenge but in terms of quality, the service is providing very positive outcomes, which presents at the same time an opportunity for the system to come together to design and deliver a highly effective reablement model that links in with all other aspects of the preventative model. A key priority for health and social care from here on forward is to focus on how reablement services can be funded and tilt towards admission avoidance, in collaboration with CTT, LAS and utilising technological opportunities (such as virtual reality) to stop patients being admitted in the first place.

Crisis Intervention
B&D currently implements a crisis intervention model in which homecare agencies provide support to residents for the first six weeks after discharge into the community to support individuals to live independently at home and prevent re-admission to hospital. We are currently reviewing whether we implement a commissioned reablement approach with stakeholders from across the partnership. We have worked with Care City, an innovation centre for healthy ageing and regeneration in North East London, to support us to research and review international and national reablement models to inform our thinking and we are currently developing an options appraisal in order to pilot a reablement approach in 2022.

Designated Beds
During the pandemic the BHR health and care commissioners worked together to develop the designated beds offer. The settings identified were in Havering and Redbridge and accounted for more than 35 beds for positive patients to be discharged to. There was a robust process around the admission and discharge of patients from these settings, and additional infection control measures were overseen by the NELFT Infection and Prevention Control Nursing Team.

Home, Settle & Support
The BHR British Red Cross Home, Settle and Support service commissioned by the local authorities and the CCG has continued to support residents on their arrival home from hospital. The service primarily supports residents who live on their own and a large proportion of the people accessing the service have been 70-89 years old. The main goals of the service are to help people feel more safe and secure when they get home from hospital, reduce their anxiety, and increase their ability to manage day to day things when they get home. The British Red Cross staff and volunteers have picked up medication, delivered shopping and signposted residents to onward services during the pandemic. The service has helped residents feel safe when they get home and has often been delivered remotely or in a COVID-19 secure way, again to reduce the risk of transmission.

Accommodation Based Care
We offer a range of specialist accommodation options, including supported living and extra care, and the shared lives programme. Supported living accommodation is commissioned for people assessed as requiring a supported living environment, including people living with or recovering from mental illness or crisis, people with a learning disability, physical disability, at risk of domestic violence, homelessness and for care leavers. Supported living is similar to extra care provision although rather than being based in sheltered housing schemes it tends to be based in shared housing/accommodation. It can also include floating support services where people live independently and receive external support. This housing related support is predominantly provided by registered social landlords that in some cases also provide care to those individuals.

Extra care services provide an alternative approach/model to traditional home care services in people's own homes and to residential and nursing care placements. The transitional service also provides opportunities to individuals who require a higher level of care following hospital discharge to convalesce before returning home when their require level of care improves.

Housing designed to meet needs of individuals and their parents/carers will delay and prevent the need for care. It is essential, therefore, that the dialogue between Housing and commissioning is an active one to ensure provision is responsive to community needs.

Social care for various groups requires a property element that is, however, more diverse than general housing. The designs vary depending on what service is being provided. A supported living facility for people with learning disabilities will differ from a residential home for older people. It is often the case that the market will provide properties and have care linked to the property that they own. Whilst this has advantages it also means it is difficult to change providers if similar property is not available. In other cases, property is owned by different agencies from the care provider, creating complications with compatible timelines and strategic objectives of different organisations. Over a period of time, if the Council has none of these properties and do not control where they are based, it can cause problems with finding provisions and costs can escalate.

Where this has happened, or is happening, the issue will be articulated and possibilities around providing Council owned properties or working with other providers to ascertain interests in providing property assets needs to be brought to decision makers attention, jointly from Housing and Social Care.

Property as a means of responding to people's needs, with social care attached in some form, means the two are inextricably linked. This needs a joined-up response formulated that both protects the financial interest of the council but also means people are in the right places and localities to meet their needs.

Within B&D we are currently piloting some extra care assessment flats. These flats are designed to support hospital discharge for those over 55 who have lower level care needs and need time and support to establish a longer-term housing arrangement or who may be interested in extra care longer-term. If the commissioned assessment flats are successful, we will make this a long-term arrangement to support discharge.

As part of its out-of-hospital transition provision Redbridge also operate a number of step-down beds for people being discharge for hospital before going home where people can stay for up to 2 weeks. There are 7 in total across two sites.

End of Life Care Satellite Service
We are currently introducing a new end of life care satellite service at Kallar Lodge, a residential care home owned by B&D. This will see seven end of life care beds added to the market which will enable older people to live as comfortably as possible at the end of their life in a supportive setting and will ease pressure on the hospital trust, St Francis Hospice and palliative care teams. This is a jointly commissioned service by the local authority and the CCG.

SCHEME 3: Community Support & Independence

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings when necessary. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

Admission Avoidance
The key local service for Rapid Response intervention (Community Treatment Team) was comprehensively reviewed in 2021-22. This indicated that with increased demand throughout the day, a larger response team was required and particularly telephone triage capacity. This has led to a considerable investment (£1.2m FYE from Ageing Well) to increase nurses and allied health professionals to meet the new two-hour urgent care response. A 'Bridging Service' will also be commissioned alongside the additional capacity from quarter 3 (recruitment and mobilisation in quarter 2).

Anticipatory Care (AC)
By supporting people differently in the community, including tackling the wider determinants of health, we can prevent some individual's needs escalating or address them in the community rather than in acute services. Ahead of the fill guidance in 2022 and the DES PCN arrangements expected in the autumn of the same year, BHR will be working the borough partnerships, NELFT and the work Population Health Management pilots in B&D and Redbridge to develop the concept and model. This would include identifying cohorts, care planning and co-ordination.

Homecare & Double Handed Care
B&D are also running a pilot which is seeking to reduce the numbers of double handed care packages across the borough. In this project we are working with occupational therapists to upskill our domiciliary care providers in correct use of equipment and in techniques that can increase independence. The aim of this pilot is to improve the chances in a reduction of care needs and an increase in independence in the community.

Redbridge is now 2 years into its revised Homecare Framework model. This is a locality-based model with lead providers, back-up and specialist providers for children, LD and mental health. This enables areas to provide improved personalised care for service users to reduce hospital admission; position the market to deliver an enhanced health and social care home care service that reflects our integrated community care service and deliver improved efficiencies and reduce the need for long-term higher needs care.

In Havering a long established 'Active Homecare Framework' based on a Dynamic Purchasing system has established a set of providers that have passed high quality criteria where relationships are based on long term partnership. It has reduced the need for spot contracting to less than 10% from 50% before the framework was established. Recently the market has joined up in an association model, which is now operating its own forums with the LA as a partner. Continuously improving dialogue has led to initiatives and high quality partnership working.

Supporting people to remain independent at home, including strengths-based approaches and person-centred care
Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives and reduce the need for and dependence on health and social care services. Retaining a level of independence supports both psychical and mental health through empowering and maintaining those close community links within a familiar environment.

Supporting people in their own homes is an important part of ensuring that people retain their independence. The retention of links to family and community, in places where they are familiar, results in better health and wellbeing outcomes, as well as reducing the need for costly residential care.

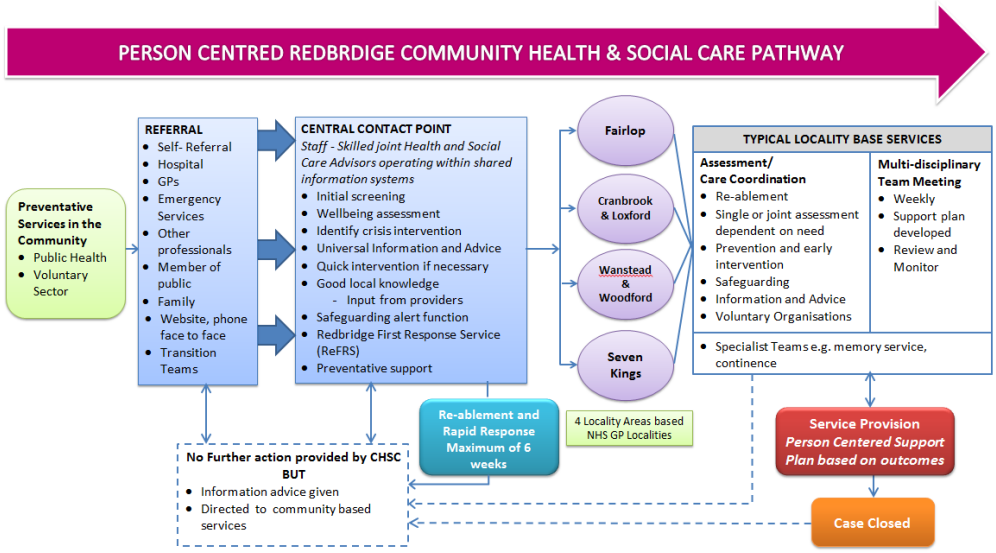
Further to placed based care approaches investigated in 2019-20 and with Anticipatory Care workstream as part of the Ageing Well agenda, BHR will be working though the borough partnerships to development very localised approaches at a neighbourhood and Primary Care network level. Planning work is commencing in the second half of 2021-22, which will include the recruitment of a borough-based project lead, with some pilot schemes in Q3.

Urgent Care Rapid (UCR) Response is the key approach to supporting people who are at risk of presenting at the emergency department and potentially being admitted to an acute setting. UCR will assess a patient within two hours if required and provide

nursing, AHP and medic input (and prescribing) in the persons home. This is for three days. A 'Bridging' service will hold a person for a slightly longer period if they are still at risk of hospitalisation.

Strength-based Model

The Redbridge First Contact team use 'People Matter - Three Conversations' as the default model of social care across all localities in the borough replacing the traditional 'formal' based assessment model. By putting the person at the centre of the conversation as the best placed person to understand their needs, it uses a conversational approach with the person to find out what is really important to them; what they would like to achieve and how they can best maintain their independence, health and wellbeing for as long as possible. By using this approach people feel their lives are improved and has led to a significant reduction in the number of long-term support packages. It supports the promotion of choice, independence and personalised care - through the use of Direct Payments, Self-directed support and complements personalised health budgets. The personalisation agenda will form part of a key workstream for LA commissioners going forward.



B&D have adopted a strengths-based approach as their social work practice model supported by a delivery model and framework which sets out Care and Support Services' intent over the next three years to develop and introduce a 7 strength and asset-based approach that informs our professional and management practice: and organisational culture across adult services. It will be reflected in our service structures and commissioning intentions; our partnership approaches; and most importantly our engagement and relationships with communities and the Third Sector going forwards. The framework represents a fundamental change to how we engage with each other within Care and Support and the Council; and across the whole system with health and social care stakeholders and partners; and fundamentally with the Third Sector and with residents and communities, and how we support community led new and improved ways of working that will deliver greater community resilience and better outcomes.

Modern 21st century social work and social care in B&D seeks to move away from Care Management and a 'deficit' model, away from 'problems and issues' and how professionals can 'solve' this. Instead, we want to improve practice and support better outcomes through true collaboration with people and communities who use services and those who care for and about them. To drive this forward, we recognise that to maximise empowerment and outcomes for and with people and communities the whole system needs to change, moving from a system built around the assumption that formal services are always the solution, and recognising we are partners in a wider system of relationships and support networks. In B&D, our strength is that we are an ethnically and culturally diverse workforce and population. We do however face significant challenges. On average, communities have less access to resources than the national average. At the same time the population in is growing faster than in any other area in the UK. By moving to a strengths and asset-based model we will seek to be bold, build on our diversity and the knowledge and experience in our communities; and deliver shared community and organisational benefits.

Havering are encouraging the use of all available assets is essential in ensuring that public services continue to support those most vulnerable in our communities. Almost every activity, engagement, communication and discussion between actual and potential service users and their carers, and those who are part of the social care and health system should look to utilise and enhance available assets and abilities as, at least, an implicit aspect of the conversation.

This approach is enshrined in Havering's 'Better Living' approach, whereby social care practice looks to have conversations with service users that first look to find their own or community assets that can address the problems faced without creating a dependency on statutory services. To provide the infrastructure that supports this approach services are commissioned that are

complementary. The system we want should support people staying fit and well and keep people out of long-term care as much as possible through interventions that are designed to facilitate people to live as independent a life as possible.

We will use data and establish systems that provide evidence to ensure an understanding of preventative models and to inform where future investment will be best placed. It is important that public health and commissioners work together where there are needs for data and evidence bases to support the delivery of improved health and well-being. Getting to grips with Population Health management is critical to ensure the best outcomes for people over the medium and longer term.

Mental Health & Carers Support
Mental health is a key area that has been impacted upon by the pandemic and a number of local providers are commissioned to provide befriending to reduce social isolation for service users and their carers, therefore complimenting and supporting the more clinically based models of care for mental health.

As part of long-established BCF schemes, the BHR boroughs commission employment support for people with mental health needs and a Carers Support Service. The latter service is commissioned from a voluntary sector organisation and delivered in a variety of health and community settings. The service also helps to lead the delivery of the joint health and social care Carers Strategy.

We continue to implement its duties as outlined in the Care Act 2014, through promoting wellbeing, prevention, advice and information on care services, and providing strengths-based person-centred care - including support for Carers. Our Carers offer is being reviewed in order to explore ways in which we can provide better support to carers and reduce incidents of carer breakdown. Through working with our providers and carers themselves, we will be able to co-produce an improved model to ensure more flexible support is available when needed. B&D are developing a new Carers Charter to improve services and support to carers in the Borough.

Redbridge is developing a Carer Friendly Borough by aiming to support carers better through meeting the following strategic priorities:

- Identification and recognition: Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care provision and in planning individual care packages.
- Realising and releasing potential: Support people with caring responsibilities to fulfil their educational and employment potential.
- A life alongside caring: Ensure that support for both carers and those they care for is personalised, enabling them to have a family and community life.
- Supporting carers to stay healthy: Support carers to remain mentally and physically well.
- Supporting young carers: Protect children and young people from inappropriate caring roles and ensure they have the support they need to learn, develop and experience positive childhoods.

Havering has invested BCF in re-commissioning its dedicated carers service and works directly with the provider, integrating the service as an important part of Havering's wider preventative offer.

Community Provision
Redbridge LA has a long-established history of working closely with its VCS partners by commissioning and contracting many prevention and early intervention services with VCS providers who are highly experienced in meeting the needs of our diverse community. They provide lower-level cost effective provision, such as our Falls Prevention model provided by Age UK which is now looking to be replicated across the other LAs. Our CVS has been instrumental in both development and delivery of our social prescribing models. In addition, as part of the NHS long-term plan, NEL CCG have been developing their role and commissioning of the VCS over the last year. The VCS are key partners - being key contributors into boards, steering and task and finish groups. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF, and the VCS have been key in driving these agendas forward. This includes care home trusted assessors to support patients to be assessed for a care home place in hospital for more rapid discharge; funding additional care navigators to enhance supported discharge and the expansion of Redbridge Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

Community, social connections and having a voice in local decisions are all factors that make a vital contribution to health and wellbeing. These community determinants of health build resilience and can help buffer against disease and influence health-related behaviour. Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. All communities have assets that

can contribute to the positive health and wellbeing of residents, including the skills, knowledge, social competence and commitment of individuals, and local community and voluntary groups and associations (both formal and informal

There has been an increased focus on community resilience and social isolation both locally and nationally in the last few years, leading to the rise in practices such as social prescribing. Social prescribing involves GPs, nurses and other health professionals referring patients to non-medical services, typically provided by voluntary and community sector organisations, including, for example, volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and physical activities.

For example, in Redbridge:

- Voluntary Sector: The Borough commissions a number of voluntary sector organisations to support prevention and early intervention including befriending and support for carers to help reduce social isolation. This sis currently being reviewed in light of the COVID pandemic to understand how needs have changed.
- Redbridge Social Prescribing: The Borough and CCG commission a social prescribing service which reaches 42 GP surgeries, the service supports people with low level mental health problems, type 2 diabetes or who were socially isolated with a Health and Wellbeing buddy.
- Day Opportunities: These services, provided both directly by the Borough, and by external agencies promote independence, improve quality of life, and support individuals to socialise and play an active part in their community and provide vital breaks and support for carers of those with LD & MH disabilities.

In Havering, the voluntary and community sector is an important part of the market. Extensive engagement with both commissioned and non-commissioned voluntary sector services co-produced a set of outcomes important in the Havering context. We will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary. The required outcomes include:

- High quality information and advice
- Ensuring people are supported in their journey from hospital to home
- Low level support in the community for vulnerable people that prevents escalation to statutory services

However, the process also identified three other outcomes that are particularly important in the Havering context:

- Social inclusion – informed by the identification of social isolation as a major driver for demand in Havering.
- Carers, both young and old, supported in their role – informed by the demographic of Havering and the identification in the 2011 census of 25,000 carers within the borough. The Carers Strategy identifies more detailed outcomes for the voluntary sector to respond to.
- Development of self-sustaining peer support networks – responding to the need for the community to use all its assets to provide support to people.

A further development has been the introduction of community hubs that are designed to provide support to communities, linking them with voluntary sector services and to other preventative initiatives such as Local Area Coordinators.

Within B&D, our front door service, Community Solutions continues to provide essential frontline support to mitigate hardship for residents with specific concerns and support requirements such as finance, debt, rent, benefits, housing and employment. Community Solutions are also commissioned to provide the Borough's social prescribing service.

We have an increasingly vibrant voluntary sector which is an essential part of our Care and Support Provider market and provides a number of our key services such as Carers Support, Handyman service and the Home, Settle and Support service. During the pandemic, the voluntary sector provided essential support to shielding and vulnerable residents. Through the BD Collective there are now a number of groups which bring together Care and Support staff and VCSE colleagues:

- Re-imagining Adult Social Care
- Early Help
- Joining the dots

Alongside the development of Community Hubs and neighbourhood networks in the Borough, these groups offer an opportunity moving forward for professionals from both sectors to come together and better support our residents and work up ideas collaboratively. Social isolation is a key priority and will become a focus for all partners in 2022.

Local Area Coordination
Local Area Coordination is an essential part of Havering's approach to preventative and personalised services. It is a model of supporting people that is embedded in the community. Local Area Coordinators work within a population of around 12,000 people. They get to know the people and local assets in the area. They are based in the community and work on the basis of introductions. If a person has something they want to change, their Local Area Coordinator will walk alongside them to help them achieve it. Local Area Coordination is a strengths-based approach that focuses on the strengths of the individual and the capacity they have and the contribution they can make, reconnecting people into their community. The service is being actively rolled out as a partnership initiative.

Local Area Coordinators form trusting relationships with people and look at all aspects of their lives, focusing on what is good and motivating people to be in control, building their capacity to take control of their life. Local Area Coordination is actively delivering good outcomes, working with people in the community who face a range of challenges including mental health, issues related to debt, housing or feeling isolated. Building community resilience and linking support with local community assets is central to the aims of Local Area Coordination.

We are piloting this approach in Havering and although management of the team sits within the Council structure, Local Area Coordination will support outcomes from all public sector partners and therefore the pilot is jointly funded by a range of partners and from the BCF. An evaluation of the service is being developed and, when it has been operational for a sufficient amount of time, evidence will allow partners to make informed decisions about rolling out the service across Havering. Our ambition is that the LAC offer is expanded to cover the whole borough.

Personalisation
Havering is committed to increasing the scope and scale of personalisation and the infrastructure that supports it. There are many issues to be understood, solutions identified and implemented through a programme of change in partnership with service users and their parents/ carers. To build a solid infrastructure for a sustainable system, the activities and approaches needed include:

- Engagement and inclusion of those who are potential and current recipients of self-directed support so that they can shape the model moving forward
- Clear and specific commitment at a leadership level
- Engagement with the market – outlining the drive toward personalisation and the implications, which will include:
    - The opportunities for developing services designed to meet the needs of individual budget holders.
    - Micro commissioning and the need for growth in personal assistants and/or micro commissioned services that meet particular needs
    - Review of levels of payment to direct payment budget holders
- A culture developed across the system that understands and appreciates the power of personalisation, promoting the thinking that is needed to move from the perception of dependent service users and patients to empowered ones
- Use of external information and learning to promote ways of developing personalised services
- Committing to making processes as easy as possible to access and purchase services
- A proportionate and explicit approach to risk around safeguarding and quality within the context of directly commissioned services
- Draw on cross borough initiatives where they are supportive of market development, quality etc.
- Communicate and work with providers to develop the range of services and the support needed to respond to the demand generated for such services
- Have a clear and documented policy framework as the basis for design and decision making
- Clear set of outcome-based measures ensuring movement towards increasingly personalised services for users
- Commissioning services to allow them to be flexible and responsive to individual and family needs

B&D is currently undertaking a direct payment reviews project to ensure that service users have the support available to them in their role as an employer and that they have a Personal Assistant or other service that meets their needs. The Borough's direct payment support service, run by Vibrance, is working closely with social workers to ensure that service users have the right advice and support when they are thinking about choosing a direct payment and can help a service user to find and employ a PA and put the right documentation in place. This service is being used across adults and children's services and the wider project is also reviewing processes and training needs to support the Care and Support workforce.

Integrated Community Equipment Service
Redbridge is the commissioning lead for the Integrated Community Equipment Service (ICES) with its partner - Havering, BHRUT (acute provider), NELFT community health services and the NEL CCG and implemented through a S75 agreement using one equipment provider commissioned via a framework arrangement. The service has just been re-tendered for a new contract and

includes sharing management costs and a recycle equipment pool across all partners. This does not currently include B&D who are part of a pan-London community equipment arrangement.

Assistive Technology
Havering invests significantly in Assistive Technology, helping people to stay at home as independently as possible. Whilst current offers support people it is also our intention to look at innovative solutions as they develop to look to use the most effective solutions available. A pilot is being implemented with technology that monitors movements within the home to ascertain the level of support that is needed with the aim of minimising dependency. There is also interest in virtual reality providing the opportunity for remote monitoring and identification of need without the need for face to face personal interactions.

Redbridge currently has a transformation workstream around its approach and investment in assistive technology. It has been working on a app called 'Multi-me' which enables and supports people with LD to networks with services, carers and friends in relation to their care and needs.

Care Technology
B&D is currently procuring an Innovation Partner for the management and delivery of an all-age Care Technology solution our residents. This service will deliver in three key areas:

1. Innovation and development of technological or digital services to residents which complement their own support and networks. This will also include flexibility and future projects based around arising technology throughout the contract.
2. Facilitate a cultural change by establishing and embedding a 'Technology First' approach within Care and Support services to include a Care Technology learning and development programme.
3. Manage and deliver the service to embed an innovative new operating model for leveraging care technologies and data to support better outcomes in care and support and deliver significant financial benefits. This will include a flexible proactive and reactive response-based service pertinent to both support planning and the immediate welfare of our residents.

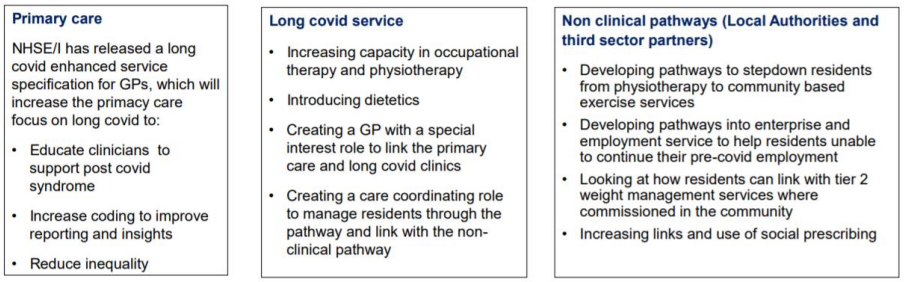
This service will move away from the traditional reactive models of assistive technology centred around a conventional monitoring and response alert-based service, to transformed health and social care systems and services centred around technology to achieve better outcomes for residents, fully harnessing the role of the wider community and support networks. This will mean embracing the full suite of technological advancement available now and throughout the contract term ranging from artificial intelligence and machine learning to augmented and virtual realities to offer a truly personalised experience for our residents.

Impact of COVID
COVID drove forward system working across health, social care and the voluntary sector. An ever-changing environment meant the system had to flexible and very quickly respond and develop to the pandemic. Examples of this were NELFT developing a hospital discharge service from existing services in 3-4 weeks and re-purposing bed bases very quickly to respond to changing needs. Projects such as Home First and D2A quickly developed and have become business as usual as we reach the tail end of 2021-22.

What do we know about Long COVID residents?
- 95% of people require physiotherapy support
- 100% are being supported with their shortness of breath
- 100% can benefit from exercise, however the team need to targeting supporting people back to work and fatigue first 75% of people require occupational therapy support
- 100% suffer from fatigue
- 75% will have difficulties with activities of daily living; dressing, eating etc.
- 40% have financial difficulties
- 50% require support will return to work 60% of people require clinical health phycology support
- 50% will receive neuropsychological interventions
- 50% will receive long COVID specific psychological therapy

What are the differences between first and second wave of COVID?
Wave one residents had more deconditioning due to the length of hospitalisation and/or waiting for the long COVID service to be commissioned and mobilised. More of the sickest in residents were treated by being nursed prone (nursed on their fronts) which has increased long term physical effects. In wave two, BHR were some of the hardest hit parts of London, coined 'the COVID triangle'. There are higher numbers of wave two resident who are developing long COVID, which could be associated with a decrease in mortality and increase in morbidity as the NHS learnt more about how to treat these residents.

What are we doing to address the long-term impacts of long COVID?



SCHEME 4: Market Stabilisation & COVID Recovery

Care Market

Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number of key care markets – Residential, Homecare and the voluntary sector. This is due to a number of factors:

- Workforce issues relating to care staff leaving the sector to work in other areas where pay is higher. This is proving a huge area of concern for Homecare agencies reducing their ability and capacity to deliver high-quality safe care for people at home and take on new packages.
- An increase in the complexity of care needed in people being discharged from hospital including the need for double-handed care packages, larger care packages with more hours and more care packages for younger older adults - exacerbated by the shortage in workforce.
- Staff not agreeing to have the COVID vaccine and therefore being made redundant and unable to work in place-based care settings.
- The impact of the COVID pandemic on people's choice to go into care homes given their mortality rate during the pandemic periods and concern over safety and levels of care. Providers seeing a reduced income as a result leaving them financially less stable and in some cases closing care settings.
- Carer breakdowns due to people being looked after at home as a result of building-based services not being open and operating more restricted services. Also, the increased number of hidden carers due to the impact of the pandemic on people heath.
- However, on the flip side, as people have returned to work and are less able to care for relatives as home, we are now seeing an increase in demand again for care services such as Homecare.
- Increase of insurance costs to providers as a result of the increased risk the COIVD pandemic brought with it.
- Voluntary sector providers unable to deliver building-based care and moving towards more virtual models and losing people as they are being cared for at home, as building based services were closed and the increase on the number of hidden carers as a result income generated from this.
- The impact of compulsory vaccination on the care market and just recently NHS front line staff.

Demand for services is predicted to continue to rise across almost all conditions and service user groups across BHR especially in Havering with older people. Demand for services, even though demand management initiatives have been introduced, are therefore likely to rise. Care services are largely people based and it therefore follows that the number of people we will need to provide care in future is likely to increase. This is already manifesting itself in markets like the home care market where across the country the deficit in recruitment is causing shortages in provision. This has had a direct knock on effect on transfers of care from hospital and the challenges around ensuring quality of service. All boroughs are continuing to respond to this by ensuring that investment in the system is targeted where it can make most impact.

Within B&D we are seeing an increase in the acuity and number of placements within nursing and residential care and homecare e.g., in August we saw a doubling of nursing and residential placements and a doubling in the number of homecare packages in comparison to the previous month.

Additionally, the B&D Mental Health service continues to see rising demand with many new referrals considered to be COVID-related. The service is aware of a high number of hospital admissions relating to ill mental health (up by 1/3). Especially young people up to the age of 24 are affected and those who had been discharged from Mental Health services and had remained well in the community for several years. This continues to have an impact on the Services provided by our health colleagues in NELFT and in the longer term will impact on activity levels in our Social Care service. Additionally, the Disabilities service is witnessing significant

demand with caseloads above acceptable levels, particularly in young people with disabilities. There are a number of drivers for this additional demand namely that the pandemic has put families under enormous pressure over a prolonged period of time. Additionally, we have seen a rise in families from neighbouring boroughs moving to B&D, with children with complex Learning Disability presentations.

Equipment and Adaptations is being closely monitored due to an increase in demand. This is thought to be a combination of package and placement increases and equipment market pressures due to COVID and Brexit.

The challenges of COVID have proved to be many and on-going as services and staff responded rapidly to ensure people continue to receive care and support and that new demand is met. Despite the challenges faced, the overall performance of social care has been largely maintained.

There are of course other aspects to maintaining a sustainable market. Dialogue with providers is a key element of the strategic approach in this area. The dialogue, through provider forums, through a web portal and through co-production exercises, will be a key factor in the overall strategic approach. It is not only engagement but the tenor of the discussions that are had that is important. The commitment is to operate from an assumption that the Council and providers have a shared objective; to provide high quality services to vulnerable people in a cost-effective way.

BHR as a subsystem is now taking forward joint work on developing an approach for local suppliers to position themselves to bid for procurement opportunities to deliver and supply to Council and NHS services. There is also the development and launch of the BHR health and social care academy (launched in September), to address workforce shortages in the NHS and social care, as well as create opportunities for local people to start and develop their careers in the local care system, including maximising apprenticeships.

BHR System Challenges

BHR faces a number of system challenges. Given the high population, the impact of COVID within the area, the long-term health conditions and complexity of population challenges, we can identify the following:

1. Our rapidly increasing and changing population profile means we need a new approach to preventing ill health, targeting people who are more likely to require health and social care in the future.

2. Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number o key care markets – Residential, Homecare and the voluntary sector. This will only become more acute with the increase in the National Living Wage / London Living Wage, as well as inflationary uplift.

3. Resources required per head increase with age therefore any new service model and resource allocation must be appropriately designed to address these challenges given that Havering has one of the oldest populations in the country, as well as a Redbridge receiving a low allocation per head within the BCF.

4. The BHR system has significant challenges to tackle including poor health and inequalities, care and quality and financial sustainability. We have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs and in some cases poor health outcomes. Demand is expected to be highest in more deprived localities.

5. Barking and Dagenham is the 3rd most deprived area nationally with both a prevalence of long-term conditions, below average life expectancy alongside an increasing population specific and marked increases in key groups; an example is a projected increase in Older People over the next 20 years.

6. Redbridge has an increasing prevalence of long-term conditions in an ageing population and the combined effect of this and demographic is projected to result in an increased demand for hospital care of with more elective admissions and emergency admissions, plus an additional increase in demand for long term social care by 2030 if the model of care does not change.

7. Havering has the oldest resident population in London and has seen a large inflow of children. It is estimated to have one of the highest rates of serious physical disabilities among London boroughs and one of the largest proportions of the population in the country with dementia and it is estimated that around half of people living with dementia are as yet undiagnosed.

8. Patients have often found it challenging to access the right service, in the right place, at the right time. Our acute provider has seen significant improvement in emergency flow, staff engagement and financial performance, however, broader system wide partnership is needed to address longstanding access issues, including increasing A&E attendances, admissions and waiting

times for elective care. Whilst discharge and LOS have vastly improved, the system needs to embed learning and good practice and review and develop services to maximise flow.

9. Primary care also faces significant challenges with a large proportion of GPs nearing retirement age, difficulty in attracting new talent and increasing demand.

10. External inflationary pressures impact significantly on social care providers and currently inflation is rising, and it is uncertain whether and for how long these inflationary pressures will continue. To meet the local authority obligation to keep the market sustainable the local authority has to listen and respond to the care market. At some point, however the two priorities, to sustain the care market and to protect local authority budgets, could become incompatible. This needs to be part of the system wide understanding of pressures and not seen as a local authority issue alone.

Section 5: Disabled Facilities Grant (DFG) & Wider Services

1. Summary

Statutory Disabled Facility Grants (DFG) will continue to be delivered via the Better Care Fund which significantly contributes towards helping older and vulnerable homeowners remain in their properties; this meets one of the key aims of the BCF to prevent people from being admitted into hospital or residential care.

The boroughs have a significant population of elderly residents (over 65), particularly Havering, and as such have seen a steady increase in the demand for disabled facility grants. As a system there has been an increasingly joined up approach across health, social care and housing to help deliver adaptations to support people remaining in their own homes.

Traditionally disabled facility grants pay for a range of adaptations to people homes, including Level Access Showers, Ramps, Stairlifts and extensions to provide ground floor bedrooms and bathrooms. However, we are aware that the incorporation of the DFG within the Better Care Fund is to encourage the Council and CCG to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes.

Within B&D, an Older People's Housing taskforce has been set up to strategically shape the future of housing and planning for older people. This group combines stakeholders from across Care and Support, Housing, Community Solutions, Inclusive Growth, Landlord Services, Adaptations team and Be First, our regeneration company. The group is focused on the future of sheltered housing, extra care, bungalow provision, site regeneration, referral processes and adaptations across Council, private and housing association housing.

Redbridge People services are working closely with Housing colleagues with those people who experience mental health, addiction homelessness and those with other long-term conditions – including LD and physical disabilities. This includes feeding into the Local Plan and housing strategies.

2. BHR Area DFGs

Barking & Dagenham
Barking and Dagenham utilise the DFG for adaptations and social care projects in line with guidance. The majority of the DFG (approx. 75%) is spent on adaptations for individuals with disabilities across the life course and the team administering the DFG sits within our all-age Brokerage and Markets service.

Home adaptations and assisted living enable disabled, vulnerable and older people to maintain their quality of life and improve their ability for independent living and self-care in their home. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs.

As well as the Mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Barking and Dagenham offers a discretionary DFG to 'top up' mandatory works on a case-by-case basis at management discretion. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus avoiding the need for more costly interventions e.g., high-cost packages of care /nursing home accommodation.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System)

and will recommend other works to reduce hazards like cold homes, and trips and falls and refer to other services such as the Handypersons Scheme.

The Council's aim for 2021-22 is to revise our DFG Policy to utilise the flexibility to use the DFG as set in the Regulatory Reform Order 2002 and we are working with Foundations in order to do this. In the last year we have begun to use a proportion of the DFG more flexibly to meet the increasing demands to support people to live independently in their homes for longer, keep individuals safe and decrease levels of falls and reduce hospital admissions. We have begun to finance Housing, Health & Social Care initiatives such as the hoarding and decluttering scheme, a double to single handed care reviews project and will be expanding the handypersons service to encompass DFG as well as iBCF funding. The DFG has also been used to finance Assisted Technology services such as 'Breezie' which provides older people with a personalised tablet to be more independent in tasks such as communicating with friends and family and linking in with managing their environment with a touch of a button e.g., adjusting the heating or seeing who is visiting them at the front door. Additionally, it will support the new All-Age Care Technology service as described above.

Havering
Havering Council has an overarching vision that is focused around the Borough's Cleaner & Safer, Prouder, Together and Value for Money strategic themes. By embracing both statutory and discretionary powers that are available to us via the Regulatory Reform Order 2002 the Authority aims to improve the health and well-being of residents (both adults and children) by helping them maintain independence, whilst having a focus on preventative work which will contribute to improving the quality of life of our vulnerable residents.

We will continue to drive up the visibility and take up of the Disabled Facilities Grant (DFG) to applicable residents. We work across social work teams in both Children's and Adults departments, with our Local Area Coordinators, departmental colleagues in Housing, Health, Environment and Public Protection. We also work with housing associations, their tenants, homeowners, private tenants and/or landlords who are able to apply directly.

In Havering the responsibility for the DFG sits within the Strategic Commissioning function which strengthens our understanding of the end user need and demand. We are able to plan, review and analyse demand for services and provisions as well as offer signposting to the DFG as part of a suite of services, available through a variety of providers including the voluntary sector. Through the analysis of demand, we are able to align commissioned and non-commissioned services and identify opportunities for expansion, for example we plan to review the Handyperson Scheme and the use of Assistive Technology (AT).

We provide advice, information and support on repairs, maintenance, adaptations of properties across the Borough and offer a health-based framework of assistance to vulnerable groups and households including those with long term health conditions. Whilst it is recognised that it is the homeowner's responsibility to maintain their own properties the Council will target limited resources to support vulnerable adults and children who are not able to achieve this themselves and will support families to provide safe and effective care to enable vulnerable loved ones to remain at home.

In addition to the mandatory DFG Havering offer a discretionary Housing Assistance Grant, this includes:

- DFG top up - top up of mandatory DFG which exceeds grant limit.
- Discretionary adaptation assistance - financial assistance for those who fail the mandatory means test.
- Moving on assistance - financial assistance to move to a more suitable accommodation.
- Hospital discharge assistance – to prevent delayed transfers of care associated with housing disrepair or access issues.
- Safe warm and well - to provide a safe and warm house for older and disabled people to promote health, wellbeing and independence.
- Dementia aids, adaptations and assisted technology - to enable people with a diagnosis of dementia manage their surroundings and retain their independence.
- Sanctuary Scheme - to provide occupiers at risk of domestic abuse with improved security.

The BCF enables us to aim to reduce delayed transfers of care, minimise avoidable hospital admission, and facilitate early or timely discharge from hospital by tackling housing related matters. We support vulnerable households to ensure they are able to heat their homes at reasonable cost and assist disabled people with adaptations to facilitate their movement in and around their home thereby improving their quality of life.

Havering Council's DFG plan for 2021-22 includes a programme of digitalisation, expansion and promotion. The first steps will be to expand the use of the recently procured Dynamic Purchasing System (DPS), a review of end to end processes and recruitment of additional staff (Technical Officer and DFG Officer). These activities will provide a more robust foundation from which we can expand the reach of the service whilst also seeking more innovative, preventive and personalised applications of the funding.

Redbridge

Home adaptations and assisted living enable disabled and vulnerable people to maintain their quality of life and continue independent living in their home environment. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs. In Redbridge adaptations are carried out using the BCF funded Disabled Facilities Grant (DFG) in a variety of ways.

As well as the mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Redbridge offers a discretionary DFG to top up mandatory works where the cost exceeds the maximum mandatory allowance of £30k. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus reducing the need for hospital stays and residential care. The discretionary DFG is particularly relevant for children's cases as adaptations need to be designed to meet the ongoing complex needs of a growing child and their family.

In some cases, it is not possible to adapt the current home of a disabled resident. This could be because of the size, layout or planning restrictions in place. In such instances Redbridge also offers a Relocation Grant to assist with the cost of moving to a more suitable property.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System) and will recommend other works to reduce hazards like cold homes, and trips and falls. These works are then carried out using other funding set aside for Home Repairs Grants. Alternatively, a referral may be made to the Redbridge Handyperson Scheme for minor repairs.

While the Handyperson Scheme is funded from another budget, we are looking at options to expand on this service using DFG funding through the BCF. Priority is already given to residents about to be discharged from hospital where they need help with moving furniture, fitting of key safes, home security and minor adaptations. Discussions are also taking place with our current provider to expand this service to include things like a home from hospital service which would further contribute to quicker hospital discharge. To support this DFG funding has been used in part to fund our Lifeline and Telecare systems (assistive technology) which allow vulnerable residents to remain independent in their own homes.

Redbridge has developed a Private Sector Housing Renewals Policy which includes major reviews of the provision of adaptations and repairs for vulnerable residents. This reduces processing times for DFGs by including:

- An increase in the available top-up grant for Mandatory adaptations in excess of £30,000.
- An alternative disabled facilities grant to the current mandatory grant.
- A simplified means test and application process to enable speedier processing.
- An increase in the available Relocation Grant to reflect the increased costs of moving in London.
- A minor works grant to supplement social care equipment budgets with minor adaptations that cannot be covered by those budgets.
- Partnership working with neighbouring authorities in the Healthcare Trust to develop lists of competent contractors to work with us to provide quicker adaptations under a framework agreement.
- Partnership arrangements to enable rapid 'off the shelf' adaptations from stock.

Section 6: BHR BCF Finance Summary

1. Summary

This section shows the highly level overview of the Better Care funding across the Barking, Havering and Redbridge areas. Further detail of schemes and services funded by the programme elements (CCG minimum, iBCF and DFG) are detailed in each of the boroughs Expenditure Plans for 2021-22.

2. High Level Funding Overview

The tables below set out the high-level summary in more detail.

Table 1: Total BCF Funding across BHR

B&D	Havering	Redbridge	BHR Area Total
£28,766,458	**£29,951,938**	**£32,706,462**	**£91,424,858**

Table 2: Breakdown by Fund

Fund	B&D	Havering	Redbridge	Area Total
CCG Minimum	£16,517,375	£20,397,102	£20,492,322	**£57,406,799**
iBCF	£10,392,182	£6,624,304	£9,784,945	**£26,801,431**
DFG	£1,856,901	£2,056,802	£2,429,195	**£6,342,898**
Additional LA	£0	£873,730	£0	**£873,730**
Additional CCG	£0	£0	£0	**£0**

Table 3: Required Spend for National Conditions 2 & 3

Allocations	B&D	Havering	Redbridge	Area Total
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,693,770	£5,796,278	£5,823,336	**£16,313,384**
Adult Social Care services spend from the minimum CCG allocations	£6,120,163	£7,683,932	£8,044,889	**£21,848,984**

Table 4: Spend per head of population (no additional funding included)

Borough	LA Boundary ONS Population UK mid 2020 (Estimated)	Spend per head (£) (no additional contributions included)
Redbridge	305,658	**£107.00**
Havering	260,651	**£111.55**
B&D	214,107	**£134.35**
Total Area Estimated Population	**780,416**	Area average: **£116.02**

The table above shows clearly that Redbridge's spend per head of population is significantly below the area average along with Havering.

Section 7: Equality & Health Inequalities

1. Summary

Our BCF draws together a range of strategies and policies which have, in their development been subject to an assessment of their impact upon key groups within our population. In addition, the BCF is driven by national policy, designed to positively impact upon both the health and social care system and importantly, upon individuals improved health, self-care and wellbeing, seeking to address inequalities and improve outcomes informed by our Joint Strategic Needs Assessments.

All reports to our Health & Wellbeing Boards are required to consider the implications of the protected characteristics under the Equalities Act and similarly as part of our work in understanding demand and need of our populations, we ensure that we undertake Equalities Impact Assessments when undertaking to design and commission services and these will be subject to ongoing review to consider the EIA implications. Within Redbridge we a Disability Charter – which set out a number of core principles to support service

users and carers with all disabilities to being involved within our Commissioning process – from co-production, contract tendering and contract monitoring.

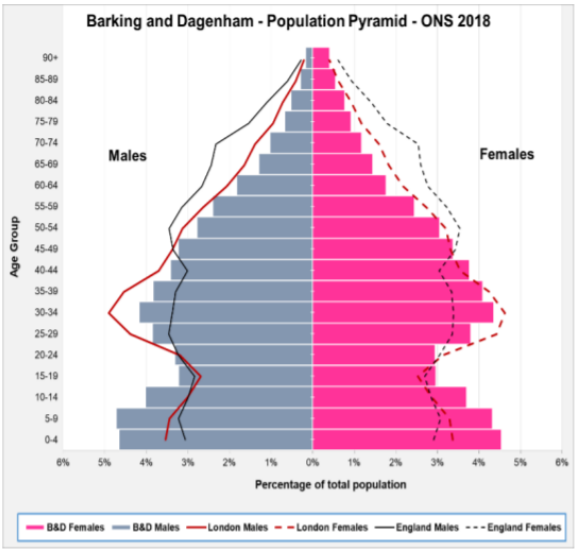
The three boroughs have distinctive populations: Barking and Dagenham has a younger and ethnically diverse population which is the third most deprived in the country; Havering an older, largely white population; and Redbridge an ethnically diverse, majority Asian, median income population. The section below highlights key data on local areas.

3. Local Area Summary

The detail below provides a highlighted snapshot of the three boroughs. Further details about each borough profiles can be found on the respective websites with their Joint Strategic Needs Assessments (JSNA). As stated, all detail and data contained within this plan was correct at the time of submission.

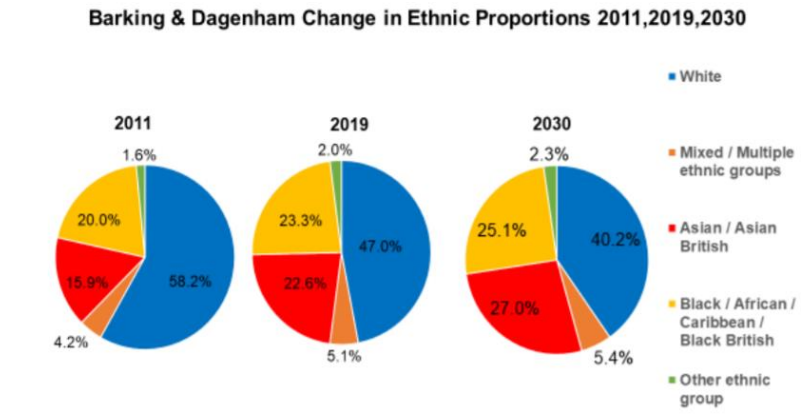
Barking & Dagenham
As health and care commissioners we seek to co-produce the design and implementation of our services based on the evidence of our local population needs.

The population of Barking and Dagenham is relatively young in comparison to the rest of London and the BHR ICS. Of 16,000 people aged 85 and older living in the three boroughs comprising the BHR ICS, only 19% live in Barking and Dagenham. Nevertheless the age profile of the Barking and Dagenham population is projected to change with proportionally greater growth amongst those aged 60-69 e.g. the number of people aged 60-69 living in Barking and Dagenham will increase by 6K (44.8%) from 13.5k in 2018 to 19.5K by 2030. Overall impact of demographic change: If age specific rates of attendance remain unchanged, the demographic change described above will result in a 24% increase in unplanned hospital admissions of Barking and Dagenham residents by 2030.



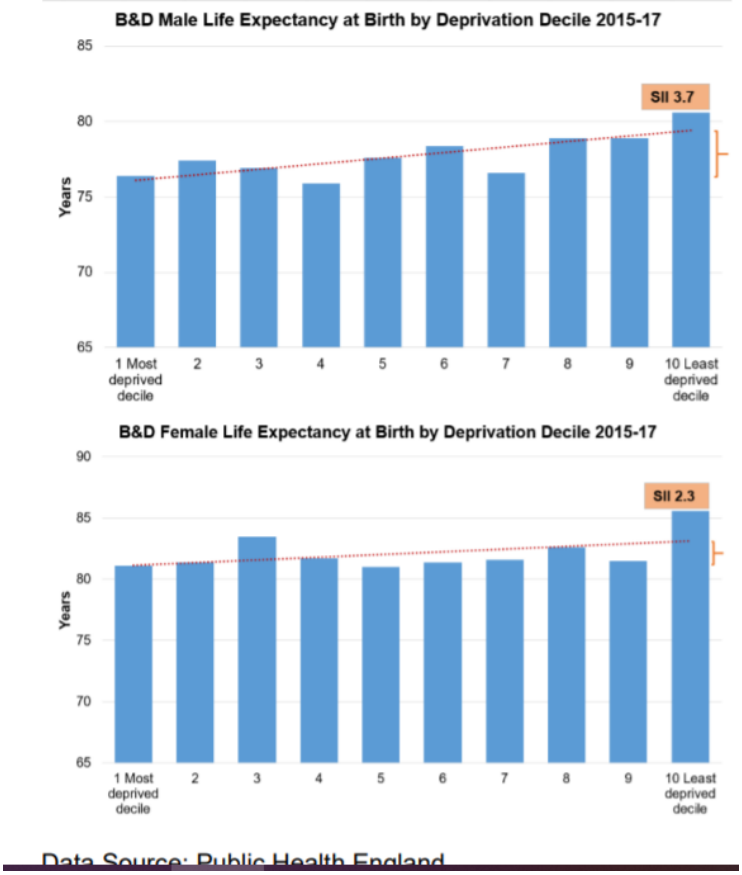
Data Source: ONS mid-2018 population estimates

Ethnic diversity in Barking and Dagenham has increased in the recent past. An estimated 53% of Barking and Dagenham residents are from a Black, Asian or Minority Ethnic (BAME) background compared to 44% for London. This proportion is predicted to increase to 60% by 2030.



Source: GLA Ethnic Group Projections (2016-based central trend)

Life expectancy in Barking and Dagenham has increased steadily over recent decades but remains lower than the national average. The additional years of life achieved in recent decades are often impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services. There is a significant social gradient in life expectancy such that residents living in the most deprived decile of the borough have a lower life expectancy (3.7 years for men and 2.3 years for women) than peers in the least deprived decile. As well as lower life expectancy, people living in deprivation have a proportionally lower healthy life expectancy than less disadvantaged peers.



The Index of Multiple Deprivation (IMD) combines many different facets of disadvantage into a single measure. According to IMD 2019, Barking and Dagenham is the fifth most deprived local authority in the country and the most deprived borough in London.

Levels of deprivation are high in Barking and Dagenham compared to other London boroughs; 19.4% of the population live in income deprived households compared to 12.1% in Redbridge, 10.8% for Havering and an average of 13.8% for London. 20 BHR JSNA profile: LB Barking & Dagenham 2019-20 Work is good for physical and mental health, in part due to the association with higher income. The rate of employment in Barking and Dagenham (69.0%) is lower than the London (74.2%) and England (75.6%) average. The proportion of working age adults in Barking and Dagenham who are economically inactive (26.8%) is correspondingly higher than

the London (21.9%) and national averages (21.1%). However, 5,900 Barking and Dagenham residents are economically inactive and want a job.

In the London Borough of Barking and Dagenham inequalities is at the heart of everything that the Council does, with a corporate strategy focusing on ensuring that no one is left behind.

Havering

Geographical Profile:

- The London Borough of Havering is the 3rd largest borough in London (43 miles2) and contains 18 electoral wards.
- It is mainly characterised by suburban development, with almost half of the area dedicated to open green space, particularly to the east of the borough.
- The principal town (Romford) is densely populated and is an area of major metropolitan retail and night-time entertainment.
- The southern part of Havering is within the London Riverside section of the Thames Gateway redevelopment area and will be an area of increasing development and population change.
- Havering is a relatively affluent local authority but there are pockets of deprivation to the north (Gooshays and Heaton wards) and south (South Hornchurch) of the borough.

Population Profile:

- The estimated population of the London Borough of Havering is 257,810.
- It has the oldest population in London with a median age of approximately 39 years old.
- The Borough experienced a net population loss of 6.3% from 1983 to 2002 but the population has increased year on year from 2002, with a 14.5% increase from 2002 to 2018.
- As well as increases in the number of births in Havering, there has been an increase in the general fertility rate from 58 (per 1,000 women aged 15-44) in 2004 to 68 in 2017. This equates to an additional 10 births per 1,000 women aged 15-44 within the period.
- From 2012 to 2017, Havering experienced the largest net inflow of children across all London boroughs. 4,343 children settled in the borough from another part of the United Kingdom during this six-year period.
- It is projected that the largest increases in population will occur in children (0-17 years) and older people age groups (65 years and above) up to 2033.
- The life expectancy at birth for people living in Havering is 79.6 years for males and 84.2 years for females.
- The life expectancy at age 65 years in Havering is 18.5 years for males and 21.6 years for females.
- Havering is one of the most ethnically homogenous places in London, with 83% (census 2011) of its residents recorded as White British, higher than both London and England.
- About 90% of the borough population were born in the United Kingdom.
- It is projected that the Black African population will increase from 4.4% in 2019 to 5.3% in 2034.
- About 19% of working age people living in Havering disclosed that they have a disability or long-term illness.

Household Profile:

- There are 107,933 households in Havering, according to the Council Tax List (as at 10th July 2019).
- Households are mainly composed of pensioners and married couples with dependent children.
- All adults in 52% of households (40,722 households) are working and no adults are working in 16% of households (12,256 households).
- In 2011, there were 7,224 one-adult households with children under 16 in Havering. This is an increase from 2001 when there were 4,005 lone parent households. There has also been an increase in the number of one-adult households with no children.
- About 73% of the population in Havering are homeowners. This is one of the highest proportions across London boroughs.
- Housing in the borough is mainly Victorian and Edwardian. Houses are generally large with an average of 2.8 bedrooms per household (higher than both London and England).
- The rate of homeless households in temporary accommodation (8.9 per 1,000 households) is lower than London (14.9 per 1,000) but higher than England (2.7 per 1,000).
- The rate of statutory homelessness (eligible people not in priority need) in Havering (0.5 per 1,000 households), in 2016/17, is lower than both London (1 per 1,000) and England (0.9 per 1,000).
- The borough has a rate of short-term international migrants of 165 per 100,000 population, the second lowest of all London local authorities.
- Almost all (99%) of the traveller caravans in Havering were on authorised sites, as at January 2018.
- 32% (13,449) of the population aged 65 years and above are living in one-person households. Almost half (48%) of all one person households in Havering are occupied by persons aged 65 years and over, which is the highest proportion in London

Economic Profile:

- The average gross income per household in Havering (£44,430, as measured in 2012/13) is low in comparison to the London average (£51,770) and slightly higher than the England average (£39,557).
- 77% of households in Havering have at least one car and compared to other local authorities in London, Havering has the second highest proportion of households (32.8%) with 2 or more cars.
- Majority of children in Havering are not poor, but around 8,800 live in income-deprived households. Gooshays and Heaton wards have the highest proportion of children living in poverty.
- About 77.9% of working age residents in Havering were in employment between April and June 2018. Overall employment rate in Havering is higher than London (74.6%) and England (75.9%)
- The proportion of working age residents in Havering claiming out-of-work benefits (6.8%) is significantly lower than England (8.4%).

Redbridge

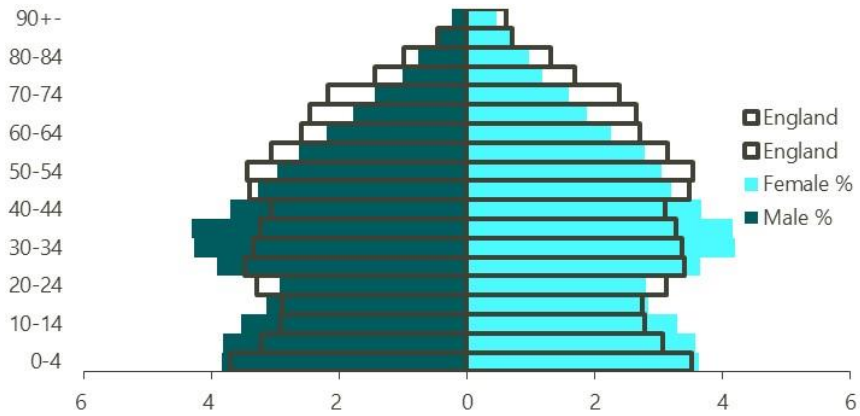
As health and care commissioners we seek to co-produce the design and implementation of our services based on the evidence of our local population needs. This is based a range of data sources including our Annual Public Health Reports, JSNA, health and social data from client management systems, as well as performance outcomes frameworks (including ASCOF, PHOF, NHS outcomes) in the design of services. Undertaking Equality Impact Assessments will ensure we are meeting these needs and our duties to reduce health inequalities for those with protected characteristics under the Equality Act. Redbridge is a very diverse borough with 64% of residents from a BME groups with Indian and Pakistani minority ethnic groups representation the largest proportion of this. In terms of population health 15% of people have a limiting long-term illness compared with 14% across London. Redbridge also has one of the highest prevalence of Diabetes in the country and is expected to increase to 11.9% by 2035. This is due to a high proportion of residents from South Asian ethnicities, prevalence of obesity and low physical activity rates. We are expecting to see increases in the 65-74 and 85+ populations with the proportion of the population aged 65 and over rising from 12% to 14%.

Redbridge has co-produced a 'Disability Charter' with our CCG, local Cllrs, and VCS partners, that sets out a number of principles to inform commissioning processes across the Council and CCG and to improve the quality of life for residents with a disability or mental ill-health. It will ensure that our services are person centred, designed with people who use them and promote independence, choice and control. It has four key areas covering: (1) Working in partnership; (2) Understanding disability; (3) Improving outcomes; (4) Monitoring impact. This will be agreed by our HWB and Cabinet in Dec 2018 and Jan 2019.

Population Overview

Between 2010 and 2019, the population increased by 11.2% and is projected to increase by a further 15% by 2035. Redbridge has a younger population compared to England with the proportion of residents between the ages of 0 and 19 years (28%) and between 25 and 44 years (32%) is higher than the national average (25% and 26% respectively). In contrast, it has a lower proportion of older adults aged 65 years and over (about 12%), compared to nationally (17%).

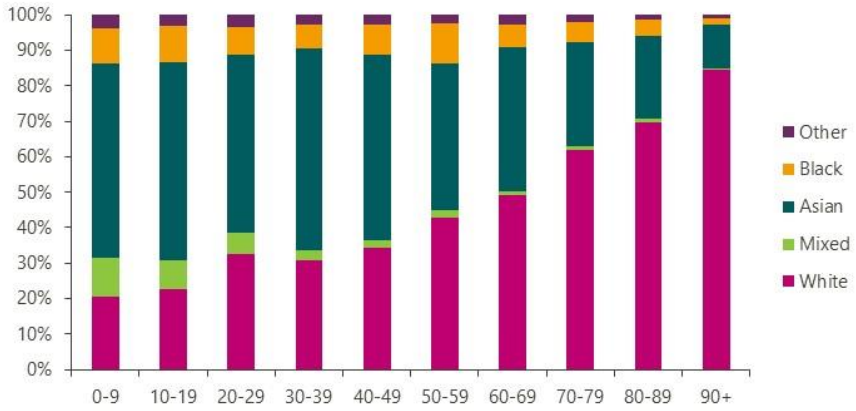
Redbridge's population, in five-year age bands, by age and sex, 2019



Diversity

With over 100 languages spoken on the Borough's streets, Redbridge's population is both culturally and ethnically diverse. In 2019, almost 50% of the population were from Asian ethnic groups and 35% of the population were from White ethnic groups. The proportion of Redbridge residents from White ethnic backgrounds increases among older age groups, while the proportion of Redbridge residents from Asian ethnic backgrounds is higher among younger age groups.

Redbridge's population, in ten-year age bands, by age and ethnicity, 2019

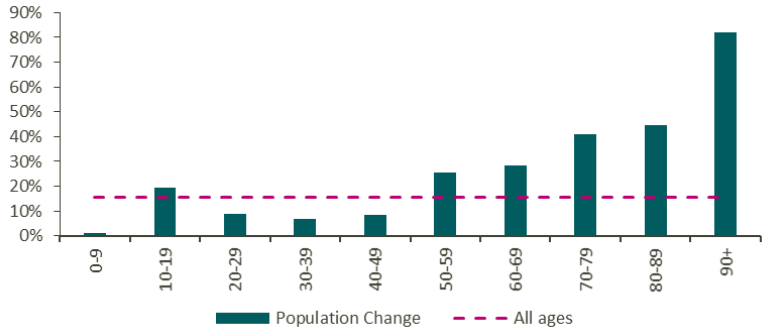


Population Change

Redbridge's population is both increasing and ageing; between 2019 and 2035 the local population is projected to increase by around 15%. Its population is projected to increase the most among those above the age of 50, with the number of people aged 65 years and over in the Borough is expected to grow by 40% between 2019 and 2035.

Older people disproportionately require more health and social care than their younger counterparts. Therefore, we need to ensure the population of Redbridge age as healthily as possible in order to mitigate impacts on individuals, families and local services.

Projection population change in Redbridge between 2019 and 2035, by age



- Asthma, chronic kidney disease, diabetes mellitus, hypertension and coronary heart disease are the most prevalent LTCs in Redbridge.
- The most common LTC in Redbridge is hypertension. The local hypertension prevalence is 11.6%, which is higher than London (11.0%) but remains lower than England (14.0%).
- The second most prevalent LTC in Redbridge is diabetes. In 2018/19, 9% of residents had the condition; the local prevalence is 2.1% higher than the national average
- National statistics estimate that in 2015, 54% of individuals aged over 65 lived with multi-morbidity. This figure rises to 90% for those aged over 85. As the population ages, LTCs will place an even greater burden on the health and social care system.
- The number of people with dementia in Redbridge is set to grow by nearly 36% from 2,838 people in 2019 to 3,853 people in 2030, due to both growth in prevalence and growth in the older population.
- In Redbridge, social care accounts for the largest proportion of the cost of dementia, and this is expected to grow by nearly 70% from £66.6 million in 2019 to £113 million in 2030. The value of unpaid care is expected to grow by nearly 63% from £44.3 million in 2019 to £72.1 million in 2030. Healthcare costs, which account for the smallest proportion of the cost of dementia locally, are expected to grow by 56% from £15.8 million in 2019 to £24.6 million in 2030.
- In 2018, 51% of jobs in Redbridge paid at or above the London Living Wage. This was the lowest rate in London, and significantly lower than the rate for London as a whole (80%). London Borough of Redbridge is an accredited London Living Wage (LLW) employer and, in the Borough Partnership Plan for 2025, has committed to encouraging public services and private employers to achieve LLW status.

*All data used for the borough profiles has been pulled from the respective borough Joint Strategic Needs Assessment (JSNAs) which can be found on the website in section 9 of this plan.

What has changed since our last plan?
There are two cohorts of patients/residents that will be presenting needs to both health and social care going forward. Firstly, People affected by Long-COVID with respiratory and mobility issues. This is not age defined and is requiring some targeted interventions from local services. There is an increase in care and support needs for those who are below 65 years old which is part of the changing face of health and social care in a post COVID-19 era. This increasing level of demand of the younger cohort is presenting as an issue in a market where the registrations of care providers are, in the vast majority, for over 65s.

Secondly, many older people have been more negatively impacted by the pandemic than other groups. With self-isolating and shielding services are starting to see people who have decondition both physically causing mobility problems and mentally with depression and increased impacts of dementia causing more severe behaviour problems. This is also had a marked impact on informal carers and their ability to cope.

What are we doing to make difference and address this imbalance?
Throughout the COVID pandemic and over 2021-22 the BHR health and social care system have been working in tandem through integrated commissioning and joint decision making. This joint working, which is enabled by the BCF, is a different approach from the past 5 years and will pay dividends in the outcomes for our residents across BHR. Removing silo working across local authority boundaries and providing equitable acute and community services can reduce the risk of inequalities increasing across our system. A joint BHR JSNA is currently underway and will support the future demand management and planning of services across the patch. Close working with colleagues from Public Health and housing is crucial to understanding the changing needs and impact of wider determinants on both our current and future populations.

The focus on personalised responses to people suffering from experience of inequalities has given insight into the problems faced and the development of responses to them. The clearest example is the development of local area coordination, where people are 'walked with' to understand the scope and scale of their problems before jointly devising solutions to change lives. Case studies are illustrating how complex people's lives are and are not necessarily solved by an isolated service intervention, such as responding to something identified, for example, as a 'hoarding' issue if in fact the issue is a result of another more deep-rooted problem. Clearing a house without responding to the root cause of the problem will lead to a repetition rather than a solution. The efficacy of this approach has been recognised and funded, through the BCF, by system partners. Although this is an example the wider philosophy across the partnership is that people's needs are to be understood and their assets used to devise tailored solutions that are sustainable. The thrust of our commissioning and operational approaches is compatible with this thinking. For those with protected characteristics this approach will identify the issues they face and deal with them in a personalised way.

Engagement with our service users, carers and providers and local community groups is a key component of understanding the issues at both a service delivery level and grass roots level – the lived experience. Feedback and consultation with our communities is a cornerstone that is and will be embedded in our commissioning work. For example, we know that within Redbridge the Bangladeshi community was particular impacted by the COVID pandemic. By listening to our local community, we are beginning to understand the reasons behind this (such a lifestyle and dietary choices) and therefore provide the targeted support to mitigate the impact of this happening again.

Section 8: Stakeholder Engagement

1. Summary

Providing and delivering services in the current climate is challenging and we know that we cannot work in isolation. To maximum the opportunities for achieving the best outcomes for those who use our services, we need to work with and engage those same people in the design and development of services for the future. With an increasing population and growing demand for services, it is essential that service providers and stakeholders work together to ensure that there is maximum benefit for every service commissioned in achieving the best outcomes possible.

Through this we will:

- Ensure all people have an equal opportunity to have their voices heard by increasing the accessibility of consultation and engagement activity
- Measure the impact of consultation on service development, commissioning and provision to ensure that it has a genuine influence
- Ensure that good quality, timely feedback is provided to consultees so that they know how their views have made a difference

- Improve communication between, and increase collaboration by, partners on engagement activity to make best use of limited resources
- Increase community engagement skills among Adult Care, Health and Wellbeing's workforce to improve the quality of consultation and engagement activity

Levels of Engagement & Co-production

LEVEL 1: Doing to	LEVEL 2: Doing for	LEVEL 3: Doing with
Passive recipients	**Engaging & involving people**	**Equal & reciprocal partnership**
• Education • Coercion	• Engagement • Consultation • Informing	• Co-production • Co-design

Diagram of 'Participation hierarchy', developed by the New Economic Foundation

2. Engagement Activity

Both the LAs and CCG constantly undertake a wide range of engagement activities throughout the year. These form part of the Commissioning Cycle and partnership work, market development and engagement and contract and provider relationship work. The work delivered by the BCF fund is a key theme throughout our engagement activities. The section below outlines some of the key area activities.

Service User & Carers

Barking and Dagenham and Havering have commissioned the British Red Cross to a undertake piece of research to understand the experience of residents who have gone through each of the four overarching hospital discharge pathways (0-3) as outlined in national guidance. We want to understand the experience of residents who go through hospital discharge and use this feedback to improve pathways, support, communication and information and advice. The BRC are undertaking 40 interviews of Barking and Dagenham and Havering residents, concluding in Autumn 2021 and the outcome of this work will inform our BCF schemes, pathways and joint commissioning activities.

Within B&D the Provider Quality and Improvement Team ring round a random pool of recipients of care and support each month services to understand their experience and any areas for improvement or feedback.

The new Barking and Dagenham Carers Charter engaged over 100 carers, as well as carer groups and system stakeholders between February and August 2021 to develop the Charter's key principles and to inform the action plan. This is being signed off at Cabinet and the Health and Wellbeing Board in January 2022.

Redbridge constantly engages both service users and carers. We have recently updated out Carers offers and engaged our Carers Service to lead on the engagement for us. During our commissioning work we are now embedding service users as part of the commissioning workstream work from beginning to end – service design through to procurement. Our Quality Assurance teamwork with service users to discuss their care and quality of care and feed this back to contacts and safeguarding and locality social work teams where necessary. This ensures that we are providing a consistent quality of care across providers.

In Havering homecare recipients are contacted directly to understand their experience of care and this is now established as a corporate indicator reported to councillors. 'Carers Voice' was a group that met regularly but was inhibited as a result of the pandemic but is looking to be re-energised giving a voice for carers that feeds into the Carers Partnership Board, the delivery mechanism for our carers strategy.

Provider Engagement

- Older People and Frailty Transformation Board (OPF): The board is system wide and oversees and directs the older people and frailty transformation, the contribution to the Integrated Sustainability Plan to reduce pressures on the system and the developing Ageing Well agenda.
- Operational Working Groups (OWG) for the OPF Transformation including acute frailty, Falls, End of Life, discharge improvement working group, prevention. These OWGs sit under the transformation board and deal with the detail of developing business cases to transform services and then mobilise, operationalise and monitor the progress and impact
- Care Provider Forum - established during the pandemic to support providers to manage outbreaks to developing good practice across services. The forum has both care home and community care providers and continues to develop and support services.

- Redbridge hold a number of provider forums throughout the year for service providers and partners to provide updates and listen to issues and share ideas on delivery services.
- B&D have monthly provider forums with care homes and home care providers to share good practice, information and support for providers.
- The BCF has been used to support discharge pathway pilots, which have been developed with providers and partners across health and social care. Particularly important has been the contribution of therapy services in the development of community-based discharge services.
- The large care market in Havering has put significant pressure on both the market and the local authority's relationship with it through the pandemic. However, the response has included extensive communications, information guidance and support and increased communication directly to the market through meeting technology and an online communications hub. This has led to a much closer and improved relationship with the market and has enabled an understanding of issues faced by all sections of the community served by the care market. It has led to a range of initiatives and responses and has meant that stakeholder engagement has been an ongoing and active part of all the developments and initiatives outlined within this plan.

The British Red Cross Psychosocial and Mental Health Team provide group reflective practice and clinical supervision to partners across frontline sectors to support their work. The British Red Cross have been undertaking sessions with providers particularly focusing on Covid-19, to support social care staff who have faced very tough and challenging times since March 2020.

Voluntary Sector Engagement

BHR CCGs have been developing the role and commissioning of the VCS over the last year. The VCS are now key players in the transformation agendas being key contributors into boards, steering and task and finish groups. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF and the VCS has been key in driving this forward. This includes care home trusted assessors to support patients to be assessed for a care home place in hospital for more rapid discharge, funding additional care navigators to enhance supported discharge and the expansion of Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

The VCS are commissioned to deliver a number of services including the home from hospital and carers support service and front door services within the local authority are signposting service users to VCS services and support as part of their discharge and social prescribing work.

Reconnections have also been actively supporting older residents in Barking and Dagenham and Havering since January 2020. It is a two-year pilot in Barking and Dagenham and Havering, joint funded by Independent Age, the two local authorities and the CCGs. Reconnections is a service that supports over-65s in rediscovering their love of life in the communities where they live. They introduce friendly local volunteers to lonely older residents and invite them into local activities, gatherings and events ranging from regular chats over coffee to bucket-list experiences that provide meaningful social connections that help break the cycle of isolation and loneliness.

Although the pilot's first year ran during the pandemic, they reconfigured their service in order to provide support to older people in a COVID secure way. This included weekly phone calls with a volunteer and support to residents to access and use digital technology to connect with loved ones, undertake shopping and listen to their favourite music. They also encouraged wellbeing walks, step challenges and dog walks. They did virtual coffee mornings, online cook-a-long's and friendly postcards sent through the post. Volunteers supported hundreds of residents across the two Boroughs and the pilot received high rates of satisfaction. The Boroughs are working to review the pilot which comes to an end in December 2021 and will determine the next steps for the project.

Within Redbridge we are currently undertaking a review of our VCS services with a view to developing a new model to better understand the needs of communities and how these have changed over the past few years and also how providers have developed services and seen needs change to adapt their services throughout the COVID period. This is key to our prevention and early intervention model. This also includes our external Day Opportunities providers. There has also been a strong VCS within Redbridge although this has been impacted by COVID.

In Havering, voluntary sector services have been re-commissioned, enabled by BCF funding. The focus of this voluntary sector commissioning has been on achieving particular outcomes including sustaining carers in their roles and looking to minimise social isolation and develop peer support groups for those facing particular issues. There is a tailored approach to support for those facing issues, for example carers of people with dementia will face different issues to carers of people with learning disabilities. Those facing physical disability will face different problems to those facing mental health issues. The range of organisations commissioned reflects the different issues faced and the specific needs of different groups.

Representatives of the voluntary sector join up with the local authority and the CCG to communicate about issues and initiatives that the voluntary sector can respond to at a regular 'compact' meeting. This has enabled the VCS to be intrinsically involved in the development of the borough partnership, where the VCS has established a more joined up means of engaging with the partnership and providing the particular insights they can bring.

Clinical Engagement
Primary care, the acute trust and community trust continue to be involved as a system in the development of services through operational working groups, transformation boards and other task groups as stated above. Each transformation area has CCG clinical directors allocated to drive the agenda forward and link to primary care and PCNs.

Patient or Service Users Groups
Operational Working Groups (OPF) have patient involvement links which maybe actioned through a patient (and or carer reference group), patient reps on the working group or wider consultation through Age UK and or other forums. Healthwatch's across BHR also engage patient and service user representatives and each of the Borough Healthwatch's provided important reviews of the impacts of COVID across patient, service user, family and provider groups which were used to improve COVID pathways and services. The outcome of the Havering and Barking and Dagenham commissioned patient experience work with British Red Cross will be used to improve and/or redesign pathways across BHR in relation to hospital discharge.

BHR Leadership Health & Wellbeing Boards
The local Health and Wellbeing Board provides system leadership for our health and care economy, including overseeing the implementation of each areas Health & Wellbeing Strategy and how we work to reduce health inequalities. The Redbridge Our 'Caring for Redbridge: Strategic Commissioning Framework for People' is the Redbridge LA strategic plan that provides an overview of our vision, ambitions and aims for the commissioning of services. Our Redbridge CVS have been a key member of the HWB since its inception and represent the views of VCS in Redbridge. This provides the opportunity to ensure that our voluntary sector partners, who we work closely with, are engaged alongside other system leaders in health and social care programmes and services across the borough.

We have also engaged through the ICP Board, JCB and Health and Wellbeing Boards for sign-off.

Section 9: Links to other Plans

BHR Area Key Strategies & Plans

- Annual Public Health Reports
- Barts Plans
- BHR End of Life Strategy
- BHRUT Clinical Strategy
- Discharge strategy
- Falls Strategy
- Health & Wellbeing Strategy's
- Integrated Sustainability Plan
- JSNAs
- Market Position Statements
- Older People and Frailty Business Case
- Prevention Strategy
- Primary Care Plans
- Redbridge Commissioning Framework
- Redbridge Disability Charter
- Redbridge Good Practice Commissioning Charter (Draft)
- Urgent Care

Websites:

www.lbbd.gov.uk
www.havering.gov.uk
www.redbridge.gov.uk
www.northeastlondonccg.nhs.uk
www.nelft.nhs.uk
www.bhruthospitals.nhs.uk
www.bartshealth.nhs.uk

APPENDIX 1

BCF Risk Log

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
1.	Demographic and need demand - increasing numbers of Older People (over 85s and over 65s), people with long term conditions, low number of healthy life years, deprivation etc. raise specific challenges. Complexity of conditions and increase in children and young people with LD transiting in adulthood These budget pressures sit alongside corporate financial pressures faced by the partners	Investment in prevention and managing demand and use of the social care grant to support and protect social care, pending solutions to longer term funding solutions to social care funding. Best use of existing community capital and signposting. Encouragement of population to take responsibility for their own health, self-management Upstream preventative / early intervention investment Better planning and management of the Transition process for CYP	4	4	High	
2.	Costs and benefits fall unevenly across the system and inequitably to the investing partner for areas of change	• Review and transparency of impact and outcomes achieved. • Affordability to be a determinant of further steps. • Risk share remains an option for consideration. • Protection of social care services and consideration of pooled budgets. • Ongoing monitoring of impacts.	4	3	Medium	
3.	Resources locked into current contracts/ activity cannot be effectively unlocked to support activity where positive evidence of improved outcomes are drawn.	Engagement across commissioners and providers with service contracts having sufficient flexibility to allow for adjustments, contract review schedules are considered through governance alongside activity. Effective contract management and the right level of governance.	2	2	Medium	
4.	Three borough complexity slows progress because of differing democratic leadership, priorities and indeed financial values into specific /shared schemes	We have mitigated the challenge posed by taking an iterative approach to our deepening the reach of the BCF plan and improved governance and working relationships. COVID was a cornerstone in demonstrating the necessity of working together to support the system under a period if extreme pressure. Integrated Care Partnership is responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points.	2	3	Low	

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
5.	Elections at both a local level result in changes to administration(s) and policy direction.	'Watching brief' on policy and guidance changes	1	2	Low	
6.	Local authority budgetary deficits and cost of COVID	Impact of costs of COVID are very high. Monitoring of demand and costs in relation to funding to be closely monitored and any remedial action to be agreed and implemented where necessary.	5	5	High	
7.	Commissioning capacity and staffing resources	Improving joint and or lead commissioning across BHR will seek to reduce the burden of individual organisational activity, alongside our intention through the BCF plan to achieve a greater level of integration and available resource utilisation.	3	2	Medium	
8.	Service demand continues to increase for social care	Review of prevention and early interventions services to provide earlier intervention, passporting to alternative, community and universal services is expected to improve management of demand.	High	High	High	
9.	Increasing costs faced by service providers, insurance, wages increases and workforce issues	BHR commissioners to work closely together and with partners to help stabilise the current market and develop a joint protocol around provider concerns and failure - adjusting rates where it can (if available) and taking a proactive approach to managing demand. Use all available initiatives such as Skill for Care funding to support workforce issues.	High	High	High	
10.	Community health services are commissioned under a block contract – lack of transparency regarding service line budgets limits the joint commissioning opportunities	BHR CCGs and NELFT have escalated this for formal resolution through the contractual process.	Medium	Medium	Medium	

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Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.

2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.

4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

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Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Havering
Completed by:	John Green
E-mail:	Joh.Green@havering.gov.uk
Contact number:	01708 433018 mob:07392782206

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Lead member for Adults Social care and Health
Name:	Councillor Jason Frost

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 24/11/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Jason	Frost	CouncillorJason.Frost@havering.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Ceri	Jacob	cerijacob@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Sharon	Morrow	sharon.morrow2@nhs.net

	Local Authority Chief Executive		Andrew	Blake-Herbert	Andrew.Blake-Herbert@havering.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Barbara	Nicholls	Barbara.Nicholls@havering.gov.uk
	Better Care Fund Lead Official		John	Green	John.Green@havering.gov.uk
	LA Section 151 Officer		Jane	West	Jane.West@havering.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Business partner, Finance and Procurement		Emma	English	Emma.English@havering.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Havering

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,056,802	£2,056,802	£0
Minimum CCG Contribution	£20,397,102	£20,397,102	£0
iBCF	£6,624,304	£6,624,304	£0
Additional LA Contribution	£873,730	£873,730	£0
Additional CCG Contribution	£0	£0	£0
Total	**£29,951,938**	**£29,951,938**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,796,278
Planned spend	£12,235,766

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£7,683,932
Planned spend	£8,211,320

Scheme Types

Assistive Technologies and Equipment	£638,152	(2.1%)
Care Act Implementation Related Duties	£436,230	(1.5%)

Carers Services	£640,230	(2.1%)
Community Based Schemes	£2,744,388	(9.2%)
DFG Related Schemes	£2,146,762	(7.2%)
Enablers for Integration	£1,084,924	(3.6%)
High Impact Change Model for Managing Transfer of	£5,443,342	(18.2%)
Home Care or Domiciliary Care	£3,052,936	(10.2%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£6,869,923	(22.9%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£2,117,880	(7.1%)
Personalised Budgeting and Commissioning	£1,415,430	(4.7%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£1,301,180	(4.3%)
Residential Placements	£2,060,561	(6.9%)
Other	£0	(0.0%)
Total	**£29,951,938**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Not published at t	1,079.9

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	12.2%	14.2%
	LOS 21+	6.1%	7.6%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	0.0%	94.8%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	602	594

Reablement

21-22 Plan

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.8%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Havering

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Havering	£2,056,802
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,056,802**

iBCF Contribution	Contribution
Havering	£6,624,304
Total iBCF Contribution	**£6,624,304**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Havering	£873,730	ASC Budget contribution to reablement
Total Additional Local Authority Contribution	**£873,730**	

CCG Minimum Contribution	Contribution
NHS Havering CCG	£20,397,102
Total Minimum CCG Contribution	**£20,397,102**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£20,397,102**	

	2021-22
Total BCF Pooled Budget	**£29,951,938**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Havering

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,056,802	£2,056,802	£0
Minimum CCG Contribution	£20,397,102	£20,397,102	£0
iBCF	£6,624,304	£6,624,304	£0
Additional LA Contribution	£873,730	£873,730	£0
Additional CCG Contribution	£0	£0	£0
Total	**£29,951,938**	**£29,951,938**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£5,796,278	£12,235,766	£0
Adult Social Care services spend from the minimum CCG allocations	£7,683,932	£8,211,320	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

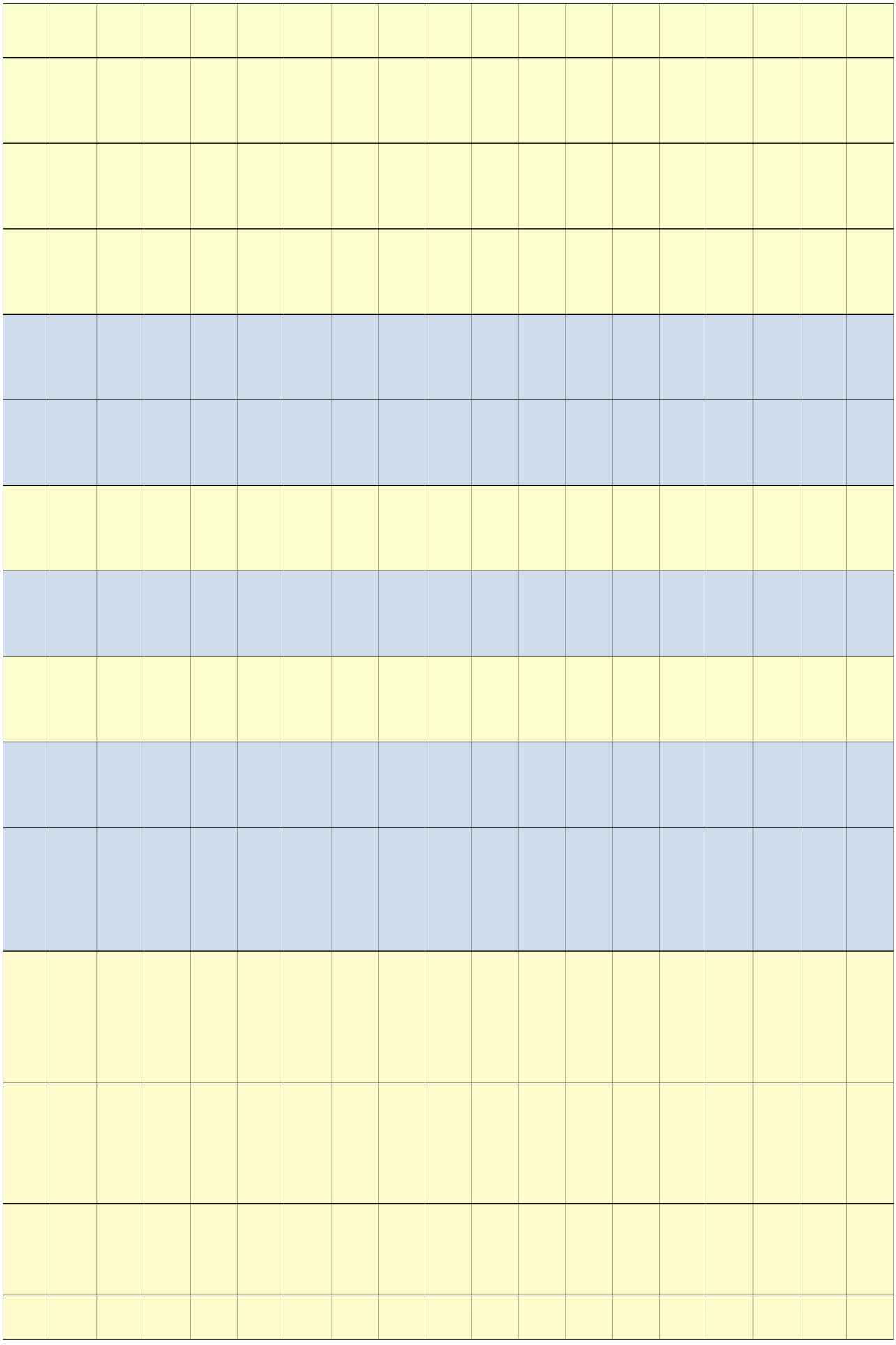
Sheet complete

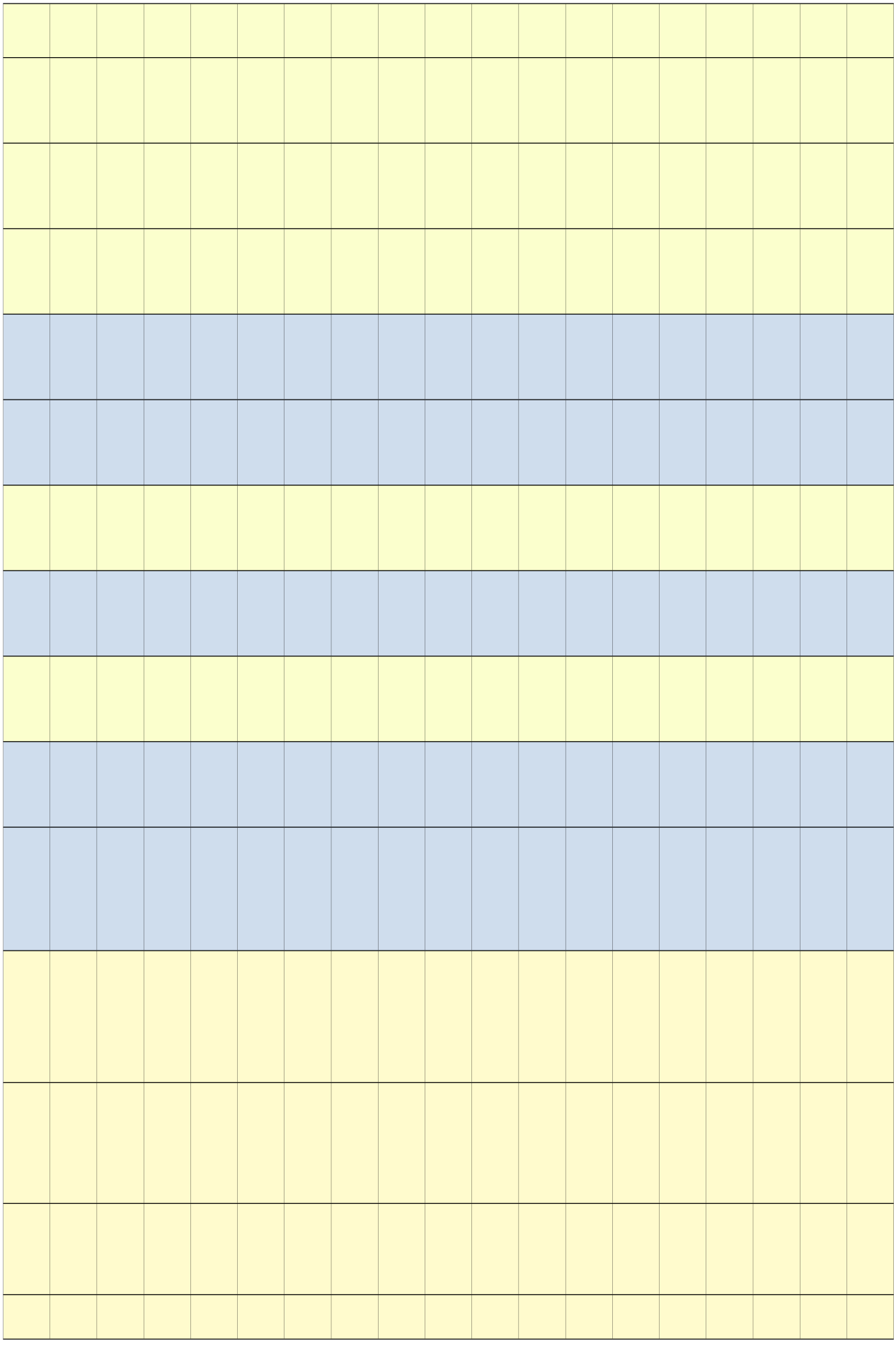
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
11	Community Support and Independence	Provision of a range of AT equipment to support people to live	Assistive Technologies and Equipment	Telecare		Social Care		LA			Private Sector	Minimum CCG Contribution	£602,270	Existing
202	Community Support and Independence	Contribution to the IMCA element of advocacy service	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Private Sector	Minimum CCG Contribution	£93,060	Existing
301	Community Support and Independence	Commission carers Hubs to reduce social isolation, and provide	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£217,710	Existing
303	Community Support and Independence	Care navigation at the ASC front door	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£35,210	Existing
401	Community Support and Independence	Integrated Community locality model	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£446,852	Existing
703	Hospital Discharge Planning and Support	Joint Assessment and Discharge Team	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£600,000	Existing
704	Community Support and Independence	Community Based Locality Teams	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£167,440	Existing

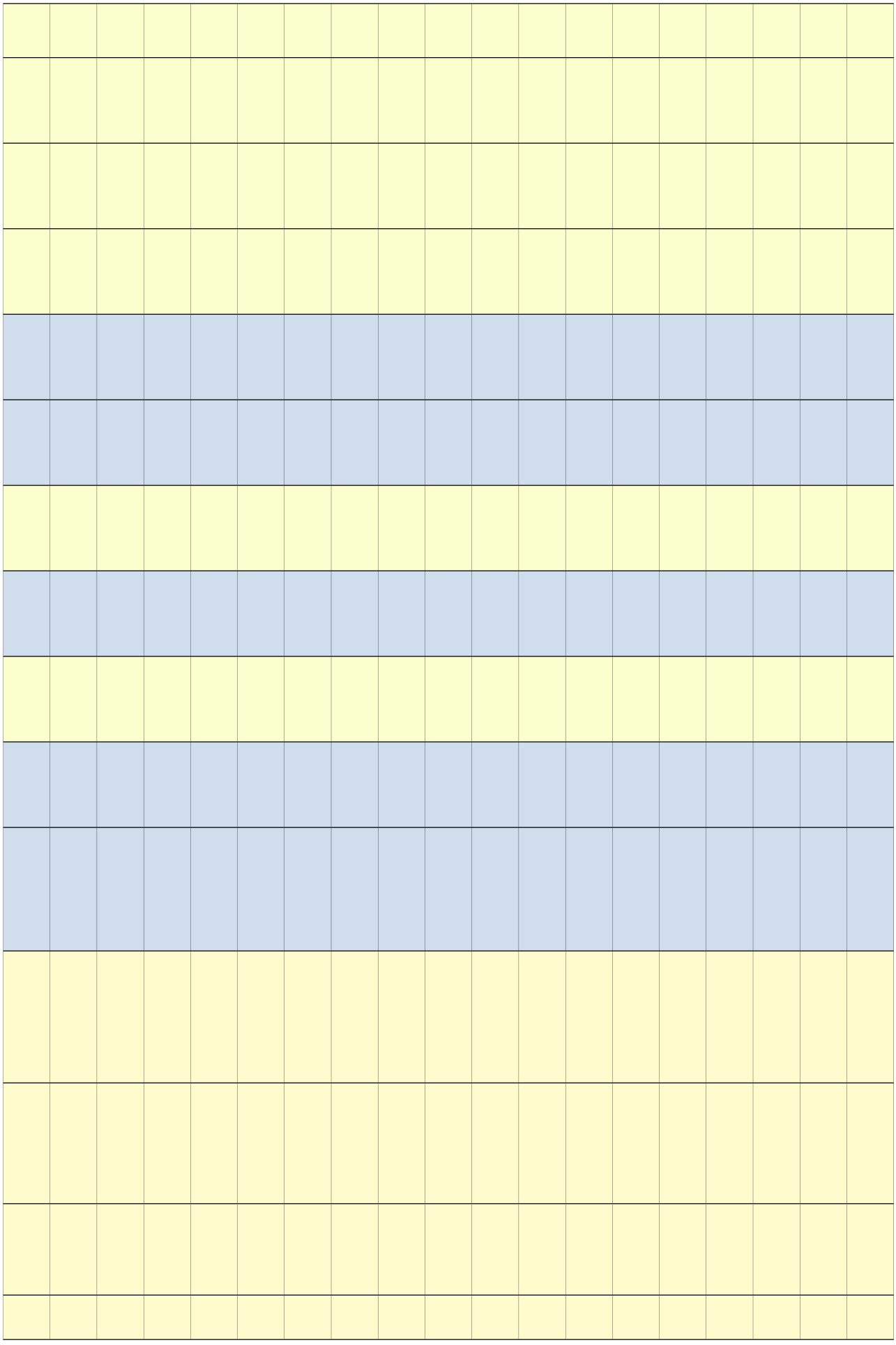
706	Hospital Discharge Planning and Support	Trusted Assessor for care homes	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		Social Care		Joint	50.0%	50.0%	NHS Community Provider	Minimum CCG Contribution	£8,715	Existing
113	Targeted Out of Hospital Care	Provision of Reablement Service	Reablement in a persons own home	Reablement to support discharge -step down (Discharge to Assess		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,244,150	Existing
122	Hospital Discharge Planning and Support	Enabling and developing integrated commissioning	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum CCG Contribution	£815,325	Existing
123	Community Support and Independence	Provision of Direct Payments	Personalised Budgeting and Commissioning			Social Care		LA			Local Authority	Minimum CCG Contribution	£1,025,430	Existing
130	Community Support and Independence	Safe at Home - minor adaptations and handy persons service	DFG Related Schemes	Handyperson services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£89,960	Existing
144	Community Support and Independence	Range of preventative services	Prevention / Early Intervention	Other	Prevention & Managing demand Vol	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£1,217,530	Existing
156	Community Support and Independence	Provision of Respite placements	Carers Services	Respite services		Social Care		LA			Private Sector	Minimum CCG Contribution	£479,190	Existing
160	Community Support and Independence	Locality Teams	Community Based Schemes	Integrated neighbourhood services	Community Team for Long Term Conditions	Social Care		LA			Local Authority	Minimum CCG Contribution	£16,300	Existing
703	Hospital Discharge Planning and Support	Joint Assessment and Discharge Team	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	iBCF	£657,033	Existing
704	Targeted Out of Hospital Care	Domiciliary care packages	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£200,000	Existing
801	Targeted Out of Hospital Care	Provision of homecare packages to support people to live	Home Care or Domiciliary Care	Domiciliary care packages		Primary Care		LA			Private Sector	iBCF	£2,169,071	Existing
123	Community Support and Independence	Provison of Direct Payments	Personalised Budgeting and Commissioning			Social Care		LA			Local Authority	iBCF	£390,000	Existing
124	Targeted Out of Hospital Care	Provision of Individual Nursing Home Placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£1,255,908	Existing
142	Community Support and Independence	Information and Advice service	Prevention / Early Intervention	Other	Information and Advice	Social Care		LA			Local Authority	iBCF	£21,010	Existing
151	Community Support and Independence	Community Based Locality Teams	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	iBCF	£200,000	Existing
152	Targeted Out of Hospital Care	Residential Learning Disability Placements	Residential Placements	Supported living		Social Care		LA			Private Sector	iBCF	£66,000	Existing
154	Targeted Out of Hospital Care	Provision of Care Home placements	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£239,400	Existing
155	Targeted Out of Hospital Care	Provision of Nursing Home placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£150,600	Existing
601	Hospital Discharge Planning and Support	Enabling and developing integrated commissioning	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	iBCF	£269,599	Existing

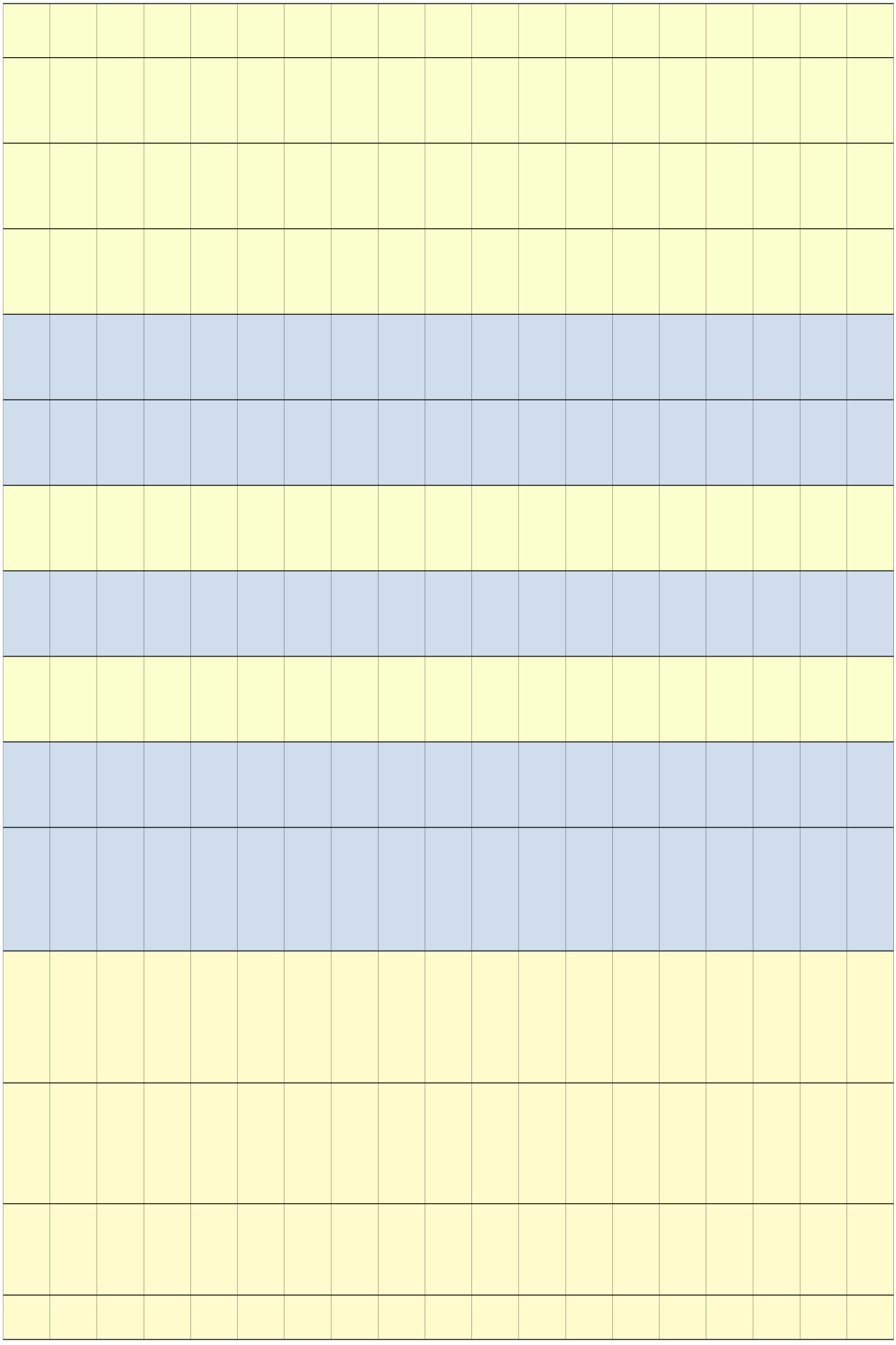
501	Community Support and Independence	Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		Other	Housing/DFG/Support for Independence	LA			Local Authority	DFG	£2,056,802	Existing
113	Targeted Out of Hospital Care	Provision of Reablement Service	Reablement in a persons own home	Reablement to support discharge -step down (Discharge to Assess		Social Care		LA			Local Authority	Additional LA Contribution	£873,730	Existing
113	Community Support and Independence	Community Based Locality Teams	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	iBCF	£125,027	Existing
154	Targeted Out of Hospital Care	Provision of Care Home placements	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£130,739	Existing
124	Targeted Out of Hospital Care	Provision of specialised placements	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£130,739	Existing
801	Targeted Out of Hospital Care	Provision of homecare packages to support people to live	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			NHS Community Provider	iBCF	£553,126	Existing
11	Community Support and Independence	Provision of a range of AT equipment to support people to live	Assistive Technologies and Equipment	Telecare		Social Care		LA			Private Sector	iBCF	£35,882	Existing
701	Hospital Discharge Planning and Support	Joint Assesment & Discharge Team	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Charity / Voluntary Sector	iBCF	£30,170	Existing
901	Community Support and Independence	Local Area Co-ordinators	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£200,000	Existing
902	Hospital Discharge Planning and Support	Home Settle and Support Service	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£178,232	Existing
903	Community Support and Independence	Emergency Duty Team	Care Act Implementation Related Duties	Other	Information and Advice	Social Care		LA			Private Sector	Minimum CCG Contribution	£125,460	New
904	Targeted Out of Hospital Care	Supported Living	Residential Placements	Supported living		Social Care		LA			Private Sector	Minimum CCG Contribution	£217,914	New
905	Community Support and Independence	Locality Teams	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£384,946	New
302	Protecting Social Care & Maintaining	Voluntary sector	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£161,040	Existing
144	Prevention & Managing Demand	Voluntary sector	Prevention / Early Intervention	Other	Falls Classes	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£62,640	Existing
101	Prevention & Managing Demand	Voluntary sector	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£12,480	Existing
113	Home From Hospital Services	Night Sitters	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Community Health		CCG			Local Authority	Minimum CCG Contribution	£13,320	Existing
114	Home From Hospital Services	Rapid Response	Community Based Schemes	Other	Community Based Schemes	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,027,756	Existing

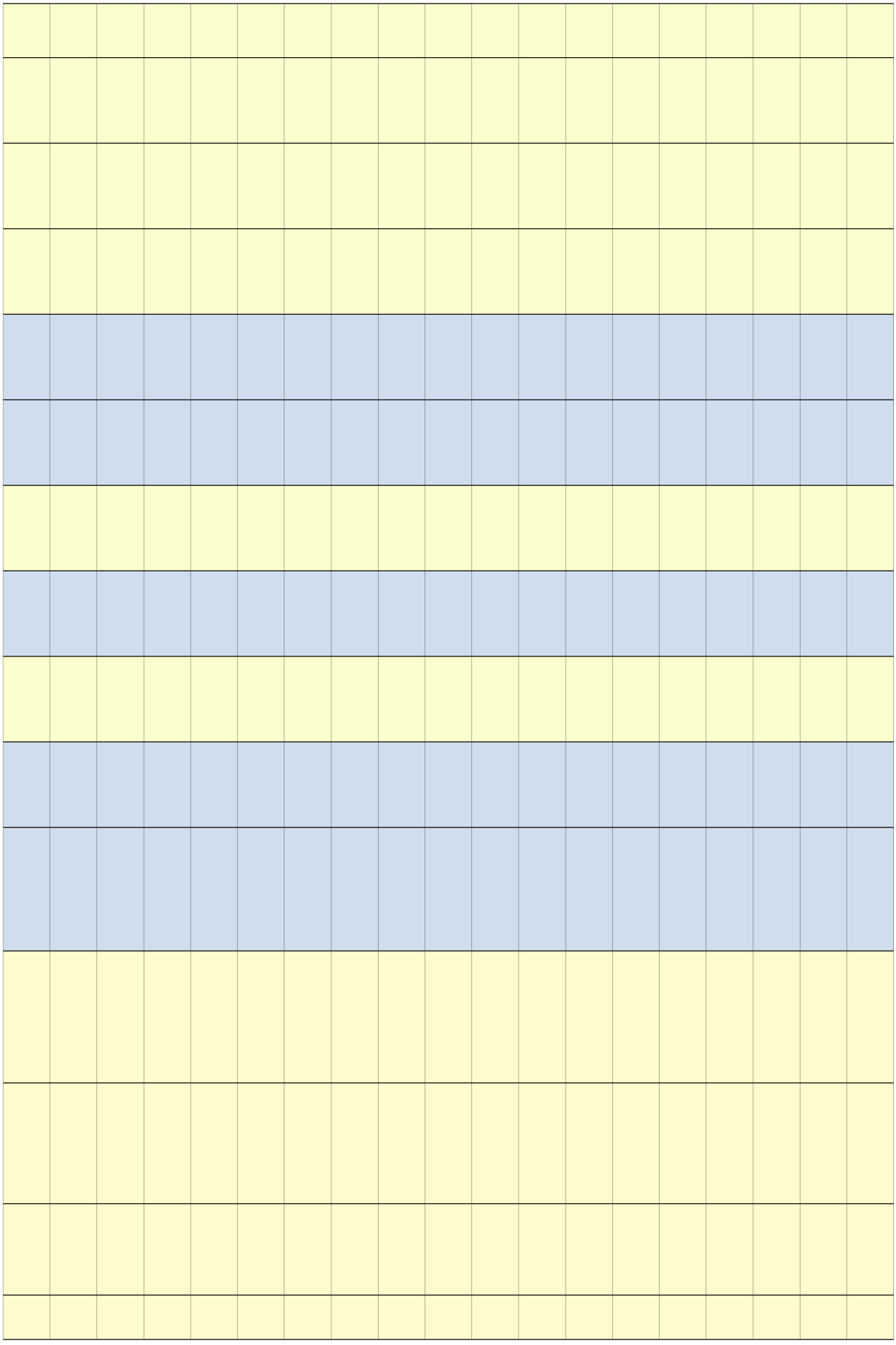
113	Home From Hospital Services	Rapid Response	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,955,872	Existing
104	Home From Hospital Services	Intermediate Care	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,576,607	Existing
1	Home from Hospital	Trusted Assessor	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		CCG			NHS Community Provider	Minimum CCG Contribution	£45,626	Existing
1	Home first	Same & next day discharge services on dischareg pathway 1	Community Based Schemes	Low level support for simple hospital discharges (Discharge to		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£49,705	New
1	Ageing Well	Urgent Care 2 Hour response and Bridging services	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£326,362	New

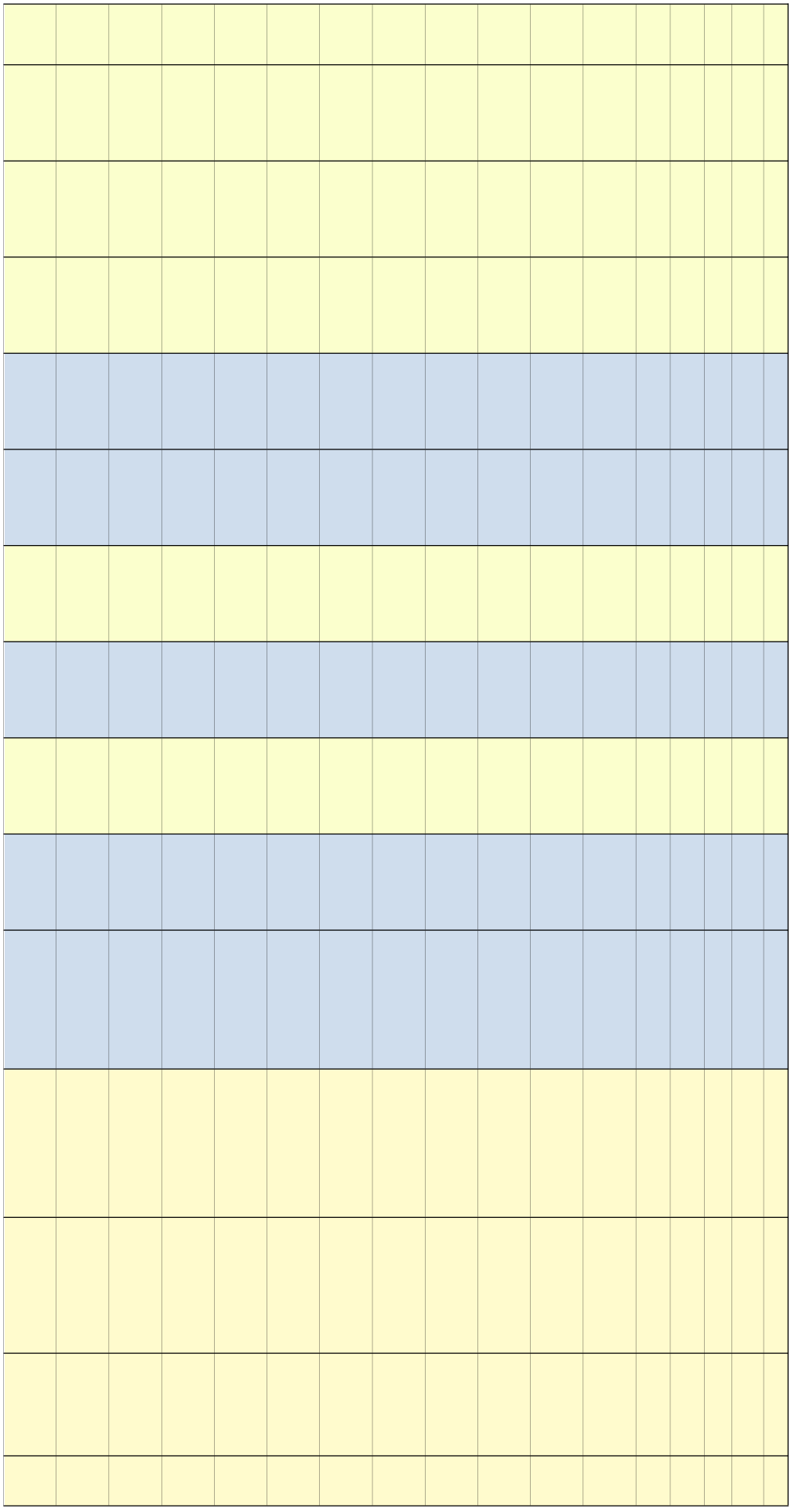












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2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Havering

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)		Available from NHS Digital (link below) at local authority level. Please use as guideline only	Not published at time of BCF submission	1,079.9	Plan to maintain the pre covid rates, if not improve on.

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	12.2%	14.2%	We are utilising 19/20 Performance as the plan for 21/22.
	Proportion of inpatients resident for 21 days or more	6.1%	7.6%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.8%	We are utilising 19/20 Performance as the plan for 21/22.

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	600	632	602	594	There are many services based in the community that look to enable people to remain at home rather than go into residential and nursing care. These include assitive technology, use of DFG, voluntary sector partners who support carers, look to reduce social isolation and build peer support networks in the community. The quality of
	Numerator	285	295	280	280	
	Denominator	47,500	46,709	46,518	47,166	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.0%	89.3%	89.8%	We continue to work with our provider to improve the impact of reablement itself. Assistive technology is considered to support people when they are going through the reablement process. Wider preventative services are brought together with the reablement provider in dedicated sessions to ensure links to
	Numerator	187	200	211	
	Denominator	210	224	235	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Havering

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

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HEALTH & WELLBEING BOARD

Subject Heading:	Update on obesity workings and proposed approach to future strategy development
Board Lead:	Mark Ansell, Director of Public Health
Report Author and contact details:	Jack Davies, Public Health Specialist Jack.Davies@havering.gov.uk 01708 432693

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
☒	Lifestyles and behaviours • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☐	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.
☐	Local health and social care services • Development of integrated health, housing and social care services at locality level.
☐	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY

A presentation will be delivered to give the board an overview of workings which have taken place since the last update on Haverings Obesity Prevention workings.

The board will then be delivered an overview of a proposed approach for developing a new longer-term obesity strategy. Underpinning this strategy will be taking a Whole Systems Approach with partners to work across the interacting causes of obesity.

RECOMMENDATIONS

The board is asked to:-

- Approve the proposed approach to refresh the Havering Prevention of Obesity Strategy.
- To endorse and support a long-term Whole Systems Approach for the new Havering Obesity Strategy.

REPORT DETAIL

The pandemic has resulted in officer's time being diverted away from obesity limiting the progress being made. Despite this new workings have taken place locally and nationally. This update will provide oversight on the new workings such as the government's new obesity strategy as well as funding for a local weight management service.

The presentation will then update on how Havering proposes to prevent obesity growing locally through utilising a Whole Systems Approach working with local partners across the borough. The board will receive a proposed approach to refreshing the Havering Obesity strategy.

Presentation to follow after the meeting.

IMPLICATIONS AND RISKS

None

BACKGROUND PAPERS

None

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HEALTH & WELLBEING BOARD

Subject Heading:	Climate Change and Sustainability
Board Lead:	Dr Mark Ansell, Director of Public Health
Report Author and contact details:	Elaine Greenway Consultant in Public Health Elaine.greenway@havering.gov.uk

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

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☐ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☐ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☐ Theme 4: Quality of services and user experience

SUMMARY

Changing climate is cited as one of the most challenging threats to health, in both the long and short term.

Long term impacts of extreme weather include indirect harms, such as those that result from economic harm, as well as direct harms to health, such as a projected increase in heat related deaths; expected to triple by 2050.

The shorter term impacts of extreme weather include those that arise as a result of flooding, including on mental health.

The Health and Wellbeing Board will receive a presentation that sets out in more detail the impact of climate change on health and wellbeing. This to be followed by a

discussion when members of the Board will have the opportunity to highlight the actions that their respective organisations are taking in response to the immediate and long term impacts.

Following discussions, the Health and Wellbeing Board is asked to consider the recommendation below.

RECOMMENDATIONS

It is recommended that the Board add the following priority to the existing priorities of the Havering Health and Wellbeing Strategy “Providing local leadership on climate change and air quality”.

REPORT DETAIL

No further detail

IMPLICATIONS AND RISKS

No implications at this stage

BACKGROUND PAPERS

None