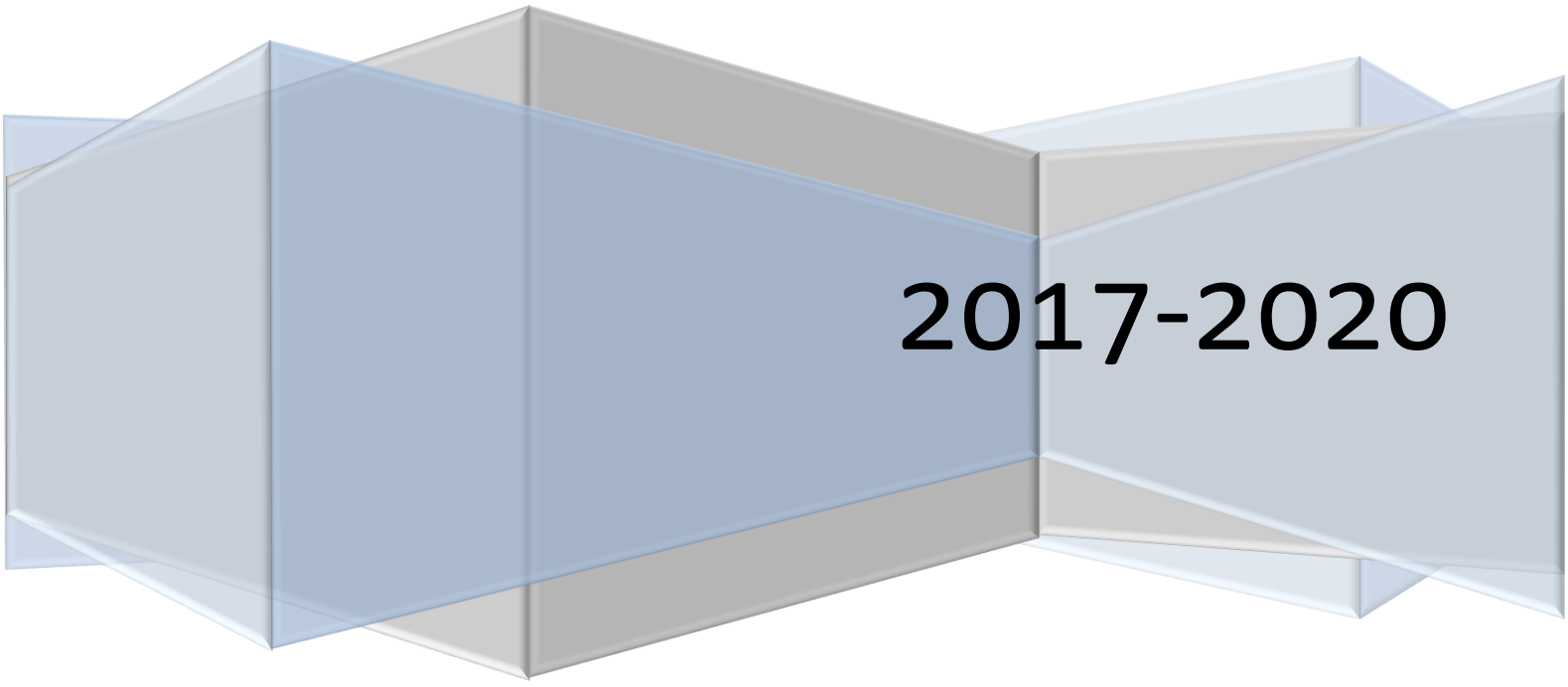
Appendix 1

Havering
LONDON BOROUGH

Draft Joint Commissioning Strategy

Commissioning for Adults, Children and Public Health

London Borough Of Havering



Joint Commissioning Strategy

Introduction:

The Joint Commissioning Strategy, covering Adults, Children's and Public Health, is compatible with and supports the goals of the Havering Health and Well-being strategy.

After consultation it will be a statement for stakeholders as to priorities and strategic commitments, providing the basis for commissioners to deliver change and meet our strategic goals. Behaviour, approach and delivery will be compatible with the commitments made.

It needs to be read in conjunction with:

- The JSNA (Joint Strategic Needs Assessment), including 'This is Havering' – Havering's single point of truth regarding demography and population projections. There are no separate statistics in this document but references will be made where such data is important and relevant to points being made.
- 'Havering's Market Position Statement 2016' – this strategy is compatible with and will cross reference to the MPS
- Children Looked After Sufficiency Statement 2016 -2019
- 'Strategic Procurement Strategy 2016- 2018'

The strategy will specify:

- The high level strategic goals that we want to achieve
- A set of non-negotiable conditions
- A set of commissioning principles that will be observed in all that is done

The strategy establishes the right approaches to achieve higher level strategic objectives. This means managing conflicting agendas and priorities, managing a market of providers and working with and designing cross organisational systems that interact and influence each other. By achieving an effective system design we will look to save money whilst protecting or enhancing services and ensuring markets are sustainable and of high quality.

Havering also has an evolving and increasingly diverse demographic and community profile. Different community groups can and do experience particular health challenges, and our commitment to addressing these, together with any perceived or actual health inequalities is essential in delivering this strategy. Our goal is to ensure the provision of appropriate and accessible services for everyone in Havering; regardless of age, disability, ethnicity, religion, gender, sexuality, or socio-economic status. Practically, our commitment to equality for all will be reflected in the commissioning of culturally inclusive prevention, care, and treatment interventions. We will also endeavour to consult with all community groups, carers, and other appropriate stakeholders, to ensure that our commissioning intentions are informed by actual service user needs and experiences.

Executive Summary

There are three high level strategic goals which Havering commissioning will be working to deliver:

- Prevention - to maximise independence or maintain it for as long as possible
- Increasing the scope and scale of personalisation
- Delivering Integrated services and working in partnerships to achieve improved outcomes

In addition we will have specific programmes that address particular groups, but recognise the same strategic goals apply

- Adults with Disabilities
- Children and Younger People

The Havering commissioning strategy is fundamentally about **Prevention**, managing demand for services by improving the health and well-being of people in the community. This applies to vulnerable groups but also, at a public health level, to the population as a whole, providing services that prevent future demand. This requires the commissioning of universal services as well as taking the opportunity to prompt people at an early stage to consider and take responsibility for their own health, taking all available steps to mitigate demand. To achieve community level health and well-being a whole system design has to interact effectively, no small ask when there are multiple providers, agencies and organisations with their own ideas, initiatives and priorities.

The strategy recognises this complexity and the factors to be taken into account to get the best outcomes for end users. Thus **working toward integrated services and working in partnership** is identified as a strategic goal in itself. Without cross organisational engagement in developing end to end processes that work for the end user, silo based solutions will mean poor experiences for people. This is why, for the future, the region is looking to Accountable Care Organisation or System (ACO or ACS) models as the way forward. In the meantime the best has to be made of current organisational structures and ways devised of making systems work for the end user.

It is the person requiring care, however, who is best placed to understand responses required to meet needs. For this reason, another, complementary, strategic goal is to increase the scope and scale of **personalisation** in Havering.

There has been progress in reaching the current personalisation offer but there is an opportunity to strengthen what is available. Implicit in this is the need for a conversation between service user, carer and commissioner, and the voice of the user is integral to the strategy and will be embedded within practice.

The goals to **support people with disabilities to maximise independence** and to '**support Havering's children and families to lead happy, healthy lives and to reach their full potential'**[1] recognises there will be a specialised response to their needs. This will include those in need because of family circumstances, those with learning disabilities, with dementia, with autism, with mental health conditions or with physical and sensory disabilities. The overarching goals of Prevention, Integration and Personalisation will, however, still apply.

These objectives are interdependent. Prevention is going to be more successful if we are working in partnership successfully with other organisations or services, so communication and a wide understanding of initiatives taking place in each area is essential.

[1] Havering Children's vision

Structure and Approach

Organisational structure needs to be supportive of strategy. The Joint Commissioning Unit has been designed in alignment with the strategic objectives. Programme Managers, with teams of commissioners and project managers, will be responsible for each of the strategic objectives. In addition teams related to quality, placements, financial control and development of personalisation will ensure that all aspects of this strategy are addressed actively. Workforce development, culture and performance management will be aligned with achieving strategic objectives.

Choices about what activities to undertake, what to prioritise, ideas to implement, services to commission and along what timelines, will be made through appropriate programme and change management, service improvement and design methodologies and approaches. This approach will feed into corporate reporting mechanisms allowing for transparency at different levels of detail depending on the audience.

There are also external demands on the service, most obviously legislative ones. The observance of the statutory requirements and guidance relevant is interwoven with this strategy.

Similarly commissioning practice will be apparent from the commitments and aspirations within the document. However our practice commits fully to:

- Outcome Based Commissioning – Specifying the requirements of services that we commission in terms of outcomes. Understanding we need both input and impact and outcome measures. Working actively and intelligently with providers acknowledging that specifications and contracts can describe a service but in real world situations flexibility and design has to be an ongoing process that requires high quality communication and dialogue to achieve beneficial outcomes.
- Ensuring Return on Investment – Ongoing monitoring of impact by ensuring that measures are in place and working with providers through active contract management. Taking necessary action to protect the council's financial interests.
- Co-design and co-production of services – Working with providers and service users and their families and carers, to design shape and understand services that really meet needs.
- Innovation, Improvement and Change – A commitment to curiosity and experiment within the service so that outcomes for service users can be enhanced and the overall system improved. A continual outward look for creativity that can be applied and adapted to the Havering context. For example the successful application and implementation, over three years, of an Innovation bid for regional commissioning for children's residential care, based on the Narey Report[2].

The Strategic Goals

1. Prevention

[2] 'Residential Care in England'. Report of Sir Martin Narey's independent review of children's residential care; July 2016

Utilising 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 service users and their parents/ carers, potential service users and their parents/ 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. It is essential that front line social work, operational management, Public Health, council services like Housing and Culture and other partners work together to implement a preventative model based on conversations that encourage and promote independence. This is not a proxy for leaving people out of a system who need it. It is about empowering and supporting people to use all they have to maintain a healthy and independent life.

Prevention has been categorised as primary, secondary and tertiary[3] depending at what point the intervention or 'nudge' to behaviour change takes place.

In regard to public health services primary prevention can include things like encouragement of breast feeding, improving health at the earliest of stages. Services will include Health Visiting and Sexual Health services, where behaviours can be influenced that prevent later demand.

Public Health statutory mandates include sexual health; health checks and health visiting. The NHS constitution applies to these services which mean a slightly different set of demands around commissioning and clinical governance, which is passed on to the provider. Commissioners need to be assured that services are of high quality and meet clinical standards.

Public Health services will be addressed and understood within the Prevention stream. It is recognised that these have a special intention and element to them which will be recognised in the treatment and commissioning of those services.

It is challenging to measure and monitor how successful preventative measures are and their direct impact on expenditure. As much 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.

The prevention programme will look to improve our offer across a range of commissioned services. Whilst there are many different providers potentially delivering these services for different users (e.g. children looked after; children with disabilities; adults with learning disabilities, older frail adults, people with physical or sensory disabilities) the generic services include:

- Home Care – We have implemented the 'Active Homecare Framework', a dynamic purchasing system (not dependent on externally provided IT solutions) which enables providers to operate in Havering providing they meet quality criteria, which will be further developed over time. They will include service user feedback, leading to an outcomes based commissioning model. There is no price competition or payment by results, simply an understanding of outcomes and a commitment to continuous improvement. We are committed to ensuring home care workers benefit from a reasonable funding regime, not in pushing providers to the lowest possible cost model.

[3] Care Act guidance chapter 2: Preventing, reducing or delaying needs

- Residential Care – The numbers of people going to residential and nursing care can be reflective of actions taken elsewhere in the system. If numbers of children going into residential care show disproportionate increases, for example, it may suggest there are opportunities for improvements in practice and preventative measures earlier in their pathway. The aim is to sustain people in the community where possible working closely with social care partners to understand models of care and response to need. It is important to share intelligence around trends, the market and expectations.

  Nationally the market for placements for children, both for looked after children and for those with special educational needs and disabilities (SEND) is recognised as difficult. This is in terms of availability and cost. We are therefore looking at a regional response by partnering with other Councils through the successful Innovation bid for funding of a three year programme of change. We are also beginning to investigate property options for finding placements within Havering.

  For adults with learning disabilities we are looking at the possibility of working with providers to change residential models and introducing more personalised models of care through Individual Service Funds (ISF). However we will not move away from residential care to supported living unless it is the correct thing to do for the residents.

  Our residential care market for older adults is a large one and we continue to work with our providers to understand the pressures on the market. However we acknowledge that there is a need to get a greater understanding of the market and we have committed to undertake a full review of all provisions in the coming year.

- Voluntary Sector services – 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. The required outcomes include:

  - High quality information and advice – for adults this is a directly commissioned service, Care point, that provides scope for face to face and telephone contact. In addition there is a 'Care Point' website that is being constantly updated with information and advice for adults' services. For children's services the 'Local Offer' is the statutorily required website and this will be developed and opportunities identified for joining up these services.
  - Ensuring people are supported in their journey from hospital to home; 'Help not Hospital'
  - Low level support in the community for vulnerable people that prevents escalation to statutory services; 'Here to Help'
  - Low level support in the home, providing and installing equipment to support independence; 'Havering Safe at Home service'.
  - Short breaks services - short breaks will contribute to the ongoing support of children and young people in their own homes as well as preparing young people for independence and adulthood. In particular, we are keen to work with providers to reduce reliance on centre-based services, and instead support young people to

maintain friendships out in the community e.g. meeting friends for swimming or to go to the cinema or just to meet for a coffee, with the right support.

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. Further explored through a social inclusion project, producing recommendations for change that have informed both the need for preventative services but also the idea of social reablement, integrating a social response to work with the support given from the new reablement service for older people. The approach to short breaks outlined above indicates the importance of building social cohesion and capacity at all ages.
- Carers, both young and old, supported in their role – informed by the demographic of Havering and the identification in the last census of 25000 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 commissioning exercise has been launched for organisations to indicate what service design they propose to best deliver the outcome required. This will go live in 2018.

In regard to voluntary sector support for children with SEND, there is a need to ensure commissioned models meet the needs of service users. This will be addressed and the market developed to enable service users to access both commissioned services and other services through the use of direct payments. The Local Offer will be developed to reflect this choice allowing families to have more control over the services they choose.

Once commissioning exercises are complete we will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary.

- Extra Care Housing – We have aligned our 3 Extra Housing schemes and will re-commission the services from 18/19. We will review the offer during 17/18, with a view to improving the service, maximising benefits and applying lessons to any new schemes identified. There is a case for potential increase in provision over coming years and these will be developed in partnership with Housing, using lessons learnt from our current provisions.
- Shared lives – we have introduced a new shared lives service and will develop this, making connections with the community and delivering cost efficiencies.
- Housing provision for young adults – looking to develop and improve our offer to assist young adults move from semi-independent provision to responsible and equipped members of the community
- Drug and Alcohol services – These are important in managing demand with implications across public services, for health, police, housing, childrens and adults services and community safety if drug and alcohol misuse escalates. We will continue to review impact through our current contract but understand wider implications with public health colleagues.

2. Personalisation

The definition of personalised service involves the concept of choice and control for those who require support. In some cases that is giving the ability, for those with capacity to do so, the choice of what they want to use the money that they need (as defined with social workers) in the way they want to, to meet that need. It is also a wider definition regarding all interactions with service users and their parents/ carers and, potentially, their families that respects them as the best people to make choices about what is required to meet needs. Services need to recognise this and be able to respond and flex to individual need as far as possible – delivering a service around a child/ adult rather than expecting the service user to fit in with how the service is delivered.

Our strategy in 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.

Measures will include numbers of particular types of personalised accounts (direct payments; managed accounts; ISFs) but success will be measured in the real change that is delivered to people's lives as a result of increasing choice and control. Measuring this is more complex but is the reason why we are looking to improve our offer.

To build a solid infrastructure for a sustainable system, the activities and approaches needed include:

- Engagement and inclusion of those who are current recipients of self-directed support so that they can shape the model moving forward
- Engagement with those who are potential recipients of self-directed support.
- 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
    - Emphasis that once direct payments are in place that costs of services are a matter for the provider to communicate to the DP holders and not the Council
- A culture developed (within and outside the organisation) that understands and appreciates the power of personalisation, promoting the thinking that is needed to move from the perception of dependent service users and their parents/ carers 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.
- Develop the approach to support planning to ensure full alignment with the goals of personalisation
- 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

Once the programme of change establishes an infrastructure for personalisation the scope for more imaginative and innovative approaches will be possible.

The corollaries of personalised services, meeting holistic outcomes that support service users and their parents/ carers, are people and families more able to live independently, with reduced dependency.

3. Integration and Partnerships

In many cases integrating services for end users or ensuring that we utilise and align the capacity of partners to deliver strategic outcomes is beneficial. The existence of different priorities, agendas, budgets, contractual arrangements, management and governance structures as well as the reality of differing personal beliefs and agendas means that working in partnership, even across different departments let alone different organisations can be, in practice, difficult.

There is a commitment to take the opportunities available from closer partnership working and/ or integration for improving services. However this is not a passive process. We have to actively work on making partnerships work and change and adapt processes and wider systems to create the right environment.

Our commitment, from a commissioning perspective is to work effectively, where benefits for end users will accrue, with partners. There is a significant list of things that we want to develop and enhance that will be a key stream of work for commissioning as we move forward.

Some of the key partners, and an indication of things that we could work together on to enhance service user outcomes, are summarised below:

Social Care

Whilst this is a commissioning strategy it can only work if it is compatible with social care objectives, and vice versa. This is the crucial link to meeting the strategic objectives outlined.

It is essential that the objectives of this commissioning strategy are reflected in the day to day interactions between social workers and service users and their parent/ carers. This interaction will set the tone for expectations of the service users and their parent/ carers around the purpose of the service, the outcomes that are to be achieved and, where possible, the assets the individual can

access to support themselves. Introducing and understanding of personalisation also depends on social workers' explanation and promotion of the concept, whilst recognising a supportive infrastructure, built by commissioners, also needs to be in place.

If the connection to commissioned services or financing mechanisms is through social workers identifying need, and understanding what is available and appropriate in the market to meet that need, it follows that commissioning and social care has to communicate effectively and continuously.

To get this right the relationship at senior levels and in the day to day operational interface between social workers and the various elements of commissioning has to be positive and of high quality. Processes need to be supportive of achieving a flow from social work into commissioned services that are effective, controlled properly (financially and in terms of quality of provision) and are proportionate to need.

This strategy commits fully to building and maintaining high quality communication and management of flow at all levels.

Public health

The relationship with public health needs to be coordinated and consistent with the aims of the council in place shaping. There is an opportunity to institute and apply the principles of 'Making every Contact Count' within the JCU, establishing the approach to behaviour change that utilises the many day to day interactions that we have with stakeholders, including front line services and providers, to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.

The understanding of wider health and wellbeing aspirations will mean that contracts we commission will have embedded within them commitments to wider health and wellbeing objectives. For example, pushing the idea of flu vaccination to care providers, reducing impact on staff but also reducing the possibility of infection being passed on to service users.

The 'nudge' concept will be understood, to ensure that all engagements shift behaviours in the right way to create resilience in the community. Anything we can do to embed this across the service will build a network of 'right messages' and ensure that health and wellbeing value is maximised in all contracts we commission.

Integrated Care Partnership

The Joint Health and Wellbeing strategy and many organisational cross overs and governance groups indicate an already established partnership approach between the London Borough of Havering and Havering Clinical Commissioning Group (CCG). However this basic partnership is extending to incorporate local authority partners and to reflect the changes to CCG structures.

An Integrated Care Partnership has formed that involves CCGs 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 Localities Model for delivery of services.

The Localities Model

In Havering the localities have populations within them of a size that best suit population based initiatives. There are three such localities; North, Central and South, with largely equal populations though with potentially different needs. The approach is increasingly to look at population based solutions but this continues to be work in progress. Ultimately 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. Design and implementation of change will be a feature of the Integration and Partnerships agenda.

Better Care Fund

The Better Care Fund (BCF) continues to provide opportunities for joint working, ideas and initiatives in Adults Social Care and Health that will be delivered and developed until the local system graduates to a recognisably integrated service. A cross borough BCF, with Barking and Dagenham and Redbridge, will begin in 17/18 and be developed over the duration of the two year plan.

NELFT (community services provider)

The provider of community health services, commissioned largely by the CCG, is the North East London Foundation Trust. NELFT also provide public health commissioned services like Health Visiting, again operating in the community on a daily basis. It is therefore the case that whenever we want to integrate social services with health based community services it is often integration with NELFT that is the key to making services work on the ground. Where necessary then we will actively work with NELFT to ensure that service outcomes are achieved.

In relation to Adults services a Community Services Integration (CSI) programme (part of the overarching strategic objective of Integration and Partnerships) has been developed that is delivering changes to provision. There are three main streams to the programme:

1. Integration of Reablement and Rehabilitation
2. Integrated 'front door' to services
3. Integrated Localities

1. A local authority commissioned reablement service, provided through NELFT, will integrate as fully as possible with NELFT's rehabilitation service, commissioned by the CCG. The local authority commissioned service commenced on the 18th April 2017. Outcomes will be carefully monitored and the partnership fostered between commissioners and providers so that the service is continuously improved. This will provide a significant element of the hospital to

community process (see below), a pivotal aspect of managing demand, where a window of opportunity exists to encourage and guide people back to independence, using all assets available to them, avoiding a slow regression to dependency. It is recognised that the wider intermediate care pathway, a range of services designed to prevent people going into hospital and reabling and rehabilitating them when they come out, could benefit from being more connected. Options to achieve this range from creating a single entity made up of several currently disparate services from different organisations, commissioned as a whole, to more informal cross sector communication facilitated by commissioners. In any case it is acknowledged that this intermediate care pathway is important in preventing people from becoming dependent on care, where possible. This will be focused upon during 17/18 and is already part of the discussion at the Joint Commissioning Board (see above).

2. A redesign of the front door to Adults services is based on a set of principles. Fundamental to this is having expertise on the front line that is capable of understanding and responding to the queries that are brought to it. These will include trying to understand the issues presented as a whole and finding solutions rather than passing people on, providing increasing numbers of resolutions at first point of contact. Where failure of service is identified as a cause of the contact there will be a commitment to review and improve system conditions that reduce the quality of service to the customer. We will design against demand so that if queries are surfacing that cannot be answered appropriate skills or knowledge will be brought into the service to ensure that, increasingly, queries raised can be answered fully.

   To extend and enhance this offer, making it increasingly capable of responding in an holistic way to queries brought to it, there is a commitment to work with NELFT to ultimately join up and provide a single point of access for community health and social care information.

3. The third stream is to create integrated localities based on GP hubs, where ASC and NELFT staff, such as social workers, district nurses and therapists, are co-located so that productive joint working is facilitated. This may extend to other services if the interests of the customer are served by doing so. The development of cultural, strategic, operational and information alignment is required to enable the full benefits of integration to be delivered. However it is recognised that achieving this has levels of complexity and will be carefully managed and introduced incrementally, so that the service slowly shifts to a fully integrated service. In the longer term it remains a possibility that Accountable Care Organisation level integration, exploring capitated budgets across different organisational boundaries, is considered.

BHRUT - Hospital to community for older people

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.

Going into hospital and coming out with a new or on-going need for support demands a quick and effective response, putting in place all the necessary support mechanisms that will reable 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 need 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. It is, for example, quite possible to achieve targets in getting people out of hospital quickly (thereby achieving success if seen as a worthwhile target in itself), whilst providing a poor service to the service user and building on-going problems if the required support at home is not in place as it should be.

The complexity in getting the process right consistently across organisations and on a day to day basis is considerable but, as a prerequisite of success, requires a joint commitment to making things

work to the benefit of the service user. Our design will align with the High Impact Change model[4], ensuring people get home with all the support necessary to maintain independent lives.

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.

Housing and property

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.

Supported Living[5] is a feature of how the needs of vulnerable people are being met, but with growing demand from the groups of people who may need such support in future, there needs to be a joined up strategic response that understands both the housing need and the care that is attached to it.

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 residential care home for children will differ from a supported living facility for people with learning disabilities and this will differ again 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.

Similarly sheltered housing provides support that keeps people independent and prevents escalating demand. The recent improvement of the offer in Havering, whilst managed by Housing, has had an impact on residents who are either current or potential recipients of health and ASC services. The cross departmental communication that took place, and subsequent understanding of the

[4] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

[5] Supported Living is the umbrella term for Housing that is designed with a particular use in mind, normally accompanied by some kind of housing related support and/ or care provision potentially commissioned separately.

implications of the process, is an example of the approach needed to ensure residents get the best possible support when change is implemented by the Council.

Culture and Leisure

The occupation of people in cultural or leisure activities is a powerful preventative measure against physical and mental deterioration. The initiatives in culture and leisure are therefore significant for the agendas outlined in this strategy and dialogue should ensure that opportunities are taken and impact is maximised where it makes sense to do so.

Other Councils

Partnership working between councils can yield significant benefits, particularly where similar issues are faced and where services that address those issues can be commissioned jointly. There are some significant examples where the weight of alliances has drawn significant benefits compared to local commissioning at much smaller scale. The strategic commitment is to identify those areas where this approach yields benefits and to work more actively with regional partners to deliver benefits.

The Joint Commissioning Board (with Barking and Dagenham, Redbridge and Havering) mentioned above will be the forum where commissioning opportunities across boroughs will be identified, along with possibilities around integrating commissioning functions.

Where specific opportunities for improvement arise, such as looking for a regional response to the need for an improved market for children's' residential placements, we will actively look to build partnerships of mutual interest.

Placements & Providers

When vulnerable people need support it is often the case that there is an urgent need to find a place for them to reside, either in the short term or for longer periods, sometimes for life. This means that a good quality placement is essential to protect the interests of the individual. This might be a childrens home providing semi-independent support, or a nursing home designed for older people or a supported housing scheme for people with learning disabilities. Where it is possible to plan for the eventuality then social work and placements teams in commissioning should be prepared to work with the market in advance.

Planning is not always possible when there is an urgent need for a placement. Where the market is limited, choice becomes a problem and costs escalate.

It is the aim of this strategy therefore to ensure that the relationships between social work, placements teams and providers enable the smoothest possible flow from identification of need to high quality, value for money, placement. The issue arises across a range of service user groups, including children in need, children with special educational needs and disabilities, older people coming from hospital needing home care or residential care, people with mental health issues, with learning disabilities etc. In practise this means commissioning will:

- Understand and build a market wherever there is need
- Manage relationships
- Understand flow in designing end to end processes

- Identify and resolve issues that will inevitably arise in such a multi stakeholder, cross organisational process.

At the end of these processes providers, on a day to day basis, provide services to vulnerable people. For the most part these services are provided with consideration and sensitivity, ensuring that the quality of service is sufficient to meet the needs of service users and their parents/ carers. The challenge in supporting people who have social, physical or mental health issues is significant and, as commissioners, we respect the work done. Supporting providers to deliver means clarity in commissioning, listening to issues and working together to resolve situations that arise. Financial challenges are well known by commissioners and providers alike but they can only be met where there is dialogue and appreciation of the limitations each other face.

This commissioning strategy commits overtly to a partnership approach where dialogue is valued and trust is built. There is not always an easy answer to problems faced but it will not be found in an adversarial situation, where each side becomes entrenched in negative assumptions and generalisations based on individual cases where things have not worked effectively.

We will actively work to identify issues and record the response we have to those issues, even where the identified problem cannot be resolved in the way that commissioners and providers would like.

We have established forums for dialogue and will welcome provider participation in those forums.

The interactions with different parts of the commissioning service will be consistent. They will be based on mutual respect and an initial assumption that we are both here to provide the best possible services to end users whilst looking to provide value for money. Where this assumption is proven not to be the case we will deal with such issues openly and understand them as individual cases not as representative of a wider provider market.

Our contract management will be based on the need to continually improve services and we will look to be flexible where possible and where it achieves positive outcomes.

Required conditions

There is an understanding that there are certain conditions, constraints or imperatives that need to be observed in what we do. They are not necessarily strategic objectives but do need to be recognised and accommodated within the strategy. They include:

- Saving money whilst protecting services
- Ensuring quality and safety for service users and their carers
- Ensuring a sustainable market

These conditions can set up conflicting priorities, thereby creating challenges that need to be constantly reviewed.

Saving Money whilst protecting services

Commissioning of services in the Social care and Health arena needs to look at the whole system and be generous in understanding that parochial interests can be detrimental to the whole. This

parochial interest can be driven where budgets are separate or targets are established, so that success can be seen very narrowly in protecting that budget or hitting that target.

Examples of this can be seen in many parts of the social care and health system. It is the strategic aim, therefore, to avoid, where possible, the consequences of this narrow, ultimately detrimental approach, on service users and their parents/ carers and on Council return on investment.

Although this may seem to be self-evident there are areas where it is challenging to acknowledge that targets achieved (sometimes from established practice or long term pieces of work) have not impacted beneficially on service users and their parents/ carers.

The drive will be to continually have integrity in wanting to improve services to end users and deliver savings as a result of successfully re-designing systems. This will be in preference to shunting cost or undermining long term sustainability for short term savings against a particular set of cost centres when the knock on effects are more detrimental to other budgets.

The approach that we will put in place will, therefore, be based on an understanding of the whole system and on-going dialogue with stakeholders who can help inform the proposals and designs that we come up with in future. An openness and ability to listen will be fundamental to this, as well as a developed approach to thinking and consideration around end goals.

There are improvements to be made to the current system that will have immediate budgetary impacts as well as less direct and measurable impacts on expenditure through management of demand. It is for commissioning to identify these opportunities and take all necessary actions, paying due regard to legalities and regulations, to make those improvements. Procuring services in that context is a means of getting to where you want to be, and ultimately secures a competitive, fair and quality protected market. However it is quite possible to be compliant with procurement requirements and regulations whilst building a dysfunctional system that does not work very well for stakeholders to that system. Doing the wrong things right is one way of putting it. It is for commissioners to influence a whole system design that interacts effectively and provides increasingly positive outcomes to service users and their carers whilst providing value for money.

In practice commissioning will work to a set of Medium Term Financial Savings (MTFS) opportunities and will monitor and manage the delivery of those savings carefully. There will be on-going consideration of opportunities for savings coming from the continuous improvement of system design. These will be added to the savings opportunities once they are clear and can be committed to. In this way corporate savings targets will be addressed whilst services to end users are protected or enhanced as much as possible.

It will also be the case that we will look for economies by working with local partners. The joint commissioning of sexual health services are an example of how opportunities to work with boroughs local to us and/or whole London solutions provide benefits in costs.

Improving Quality

The assessment of need for service users and their carers is delivered by social work teams employed by the LBH. The quality of these services is managed and regulated by operational management teams reporting to a Corporate Director.

Need for those not eligible for services is defined and responded to from within the community. Judgements are made by individuals sometimes influenced by their families, or through advice from a range of other sources.

Once need is assessed the large part of Havering's services are delivered through external providers. The responsibility for ensuring that services provided are safe and meet expectations around quality sits with the Council and, more particularly, within commissioning.

The means to do this sits with a dedicated team of quality officers who actively monitor the quality of provision within the borough.

The providers we have can vary in type:

- Voluntary sector providers (commissioned and non-commissioned) ranging from very small, one person offers, to very large organisations employing thousands of people
- Independent providers across a range of disciplines

The services also vary and can be building based or based in the community, for example:

- Residential care for older people, people with learning disabilities, people with mental health conditions and people with some or all three and/ or other conditions like dementia.
- Supported Housing for a range of service needs, similar to those above
- Services that deliver particular outcomes, like befriending, support home from hospital, care navigation, information and advice.
- Short breaks services
- Home care and reablement services that take place in people's homes

The services are sometimes differentiated as being 'registered' (subject to scrutiny by the Care Quality Commission or Ofsted) or unregistered. Either way the Quality team has to play a role in ensuring these services meet quality standards.

The vast range of services means that they cannot all be subject to a detailed visit or analysis.

Our strategy is therefore to take a proportionate approach which can vary from light touch, desk based analysis to intensive visits and detailed reports. Visibility of our approach will be crucial for those who may be held accountable for any deficiencies in quality and it will therefore be necessary to have what we are doing documented and approved.

The approach will to some extent be based around compliance with a set of standards and expectations about the care provided in buildings or at home. This is hugely important in relation to the quality of care provided and safety of service users and their carers.

However if the perceived quality of a service is prescribed by inputs the monitoring of quality can start to impinge on the outcomes of the service and the experience of service users and their parents/ carers. This can also be frustrating for providers. Our strategic approach is to move as far as possible (whilst we recognise that in most cases inputs need to be measured and reported upon) towards outcome based quality monitoring to support outcomes based commissioning.

In practice this means evaluating what service users and their parents/ carers report in terms of their experience rather than providing rules for providers based on numbers, targets around numbers or prescribed times. It should not be under estimated, however, how carefully these approaches need to be managed and introduced. For many of the commissioned services the regime in place at the moment is based on measuring inputs as a mean of ensuring a basic level of service. Our strategy is to retain these aspects where they are essential in ensuring quality but, where appropriate, to develop models where quality is defined by service users and their parents/ carers. The challenge for the Quality agenda in LBH commissioning is to design systems that facilitate this and to ensure that improved service user experience is the key measure and driver for what we commission.

There will also be an understanding and engagement with advice and guidance available from organisations like the Care Quality Commission; the National Institute for Health and Care Excellence; the Social Care Institute for Excellence and other organisations with specific input around quality and best practice. This is of particular relevance when high quality clinical care is required for health services commissioned through public health.

Ensuring sustainable markets

As stated above there is a wide and diverse market that is commissioned to provide services. Our duty is to ensure this market is sustainable. However there are currently many conflicting forces at play that limit the ways that markets behave as you would normally expect in relation to the laws of supply and demand.

In normal circumstances the lack of a commodity in terms of supply would mean that the cost of that commodity would rise.

Demand for services is predicted to continue to rise across almost all conditions and service user groups[6]

Demand for services (even though demand management initiatives will be introduced as much as possible – see section on Prevention) is 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. Normally this shortage would increase the cost of the commodity, in this case the rates of pay for professional carers, but because Council budgets are being constrained this modifying effect is not happening as it would in a true market. This is an example of the impact of treating different parts of an inter related system differently, apparently cutting costs in one area of the system but in fact making the whole, wider system less sustainable and raising costs overall. Recently the government has identified extra funding, through various mechanisms, to mitigate some of these risks.

Havering commissioning is responding to this by trying to ensure that investment in the system is targeted where it can make most impact. Savings will be delivered in the ways outlined above, by taking opportunities to re-design the overall system.

[6] Havering Market Position Statement 2016

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.

This will shape the dialogue as a positive one, with the idea that together we can identify and work on issues that are faced, to the benefits of the end user. If, in the event, it is clear that intentions or practice of providers is incompatible with this assumption the Council will deal with that as required with that particular provider as an exception.

Commissioning principles

To set a basis for understanding of expectations when we embark on commissioning exercises, programmes or projects we have identified a set of principles. These will be used as guides and tests to ensure that the pieces of work we are undertaking and the approaches we are using are compatible with the strategy above. Whilst there is work to do to ensure these principles are fully embedded there is already a commitment to these principles that is shaping Havering's commissioned services and our approach to them. The initial set of principles includes:

1. We will operate an evidence-based, 'intelligent commissioner' approach
2. We will develop and publish clear strategies, consistent with the Council's vision and service plans, for achieving our ambitions.
3. We will enable the purposeful involvement of stakeholders in all aspects of commissioning activity. We will ensure that citizens are part of governance arrangements where possible and engage in a variety of other ways to influence and feedback on the decisions we make and the delivery of the services we commission.
4. Commissioning activity will always be subject to rigorous yet proportionate governance arrangements.
5. Transformation will be a specific and planned part of commissioning practice. Project work arising from this will be robustly managed using established principles and practice.
6. Services will be designed using the principles of normalisation, enablement, reablement and the maximisation of support from natural networks and community resources. The broader principles of individual and community wellbeing will underpin all of our commissioning decisions.
7. Where services need to be procured, we will maximise the choice and control of the person using them and provide both choice and challenges to people to take responsibility for themselves and others.

8. To encourage and sign post residents as early as possible, for example through public health commissioned services, to take healthier choices leading to self-management, self-care and an understanding of the need to plan for the future.

9. All commissioned activity will be subject to positive and robust safeguarding practice and scrutiny, and ensure that safety and well-being are of paramount importance in the delivery of services.

10. Services will be commissioned to deliver outcomes.

11. Our commissioning activity will promote health and wellbeing, social value, equality and diversity.

12. We will design services against demand so that they are responsive to current and real need.

13. We will treat all providers equally. If new provider forms, such as Alliance and Accountable Lead Provider models, Consortia, Social Enterprises, Mutuals and User Led Organisations support better outcomes we will actively encourage the development of these.

14. We seek a diverse range of services and will encourage and support the development of niche providers to help fulfil this.

15. We will base decisions about cost effectiveness on the longer-term costs and outcomes of a service and work with providers to drive out costs and improve efficiencies.

Practical Implementation

This strategy represents high level goals, excluding detailed implementation plans. These sit as part of the programmes we have established that are aligned with the goals detailed. Within each of those programmes sit projects and commissioning exercises and benefit measures that will deliver continuous improvement to the system. The detail within each programme is available if required, from overall programme definition to project initiation and specific plans. In all cases we will endeavour to make them compatible with the commissioning principles, strategic goals and the system conditions described above.