



**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



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## 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 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.

	<b>National Conditions</b>	<b>Covered in Sections</b>
1	<b>Jointly agreed plan between local health and social care commissioners, signed off by the HWBs</b> - 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	<b>NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution</b>	BHR Expenditure Templates
3	<b>Invest in NHS-commissioned out-of-hospital services</b> <u>Narrative plans</u> should set out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it. <u>Expenditure plans</u> 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	<b>A plan for improving outcomes for people being discharged from hospital</b> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Focus on improvements in the key metrics below:           <ol style="list-style-type: none"> <li>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</li> <li>Improving the proportion of people discharged home using data on discharge to their usual place of residence</li> </ol> </li> </ul>	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 31<sup>st</sup> 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 COVID 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)

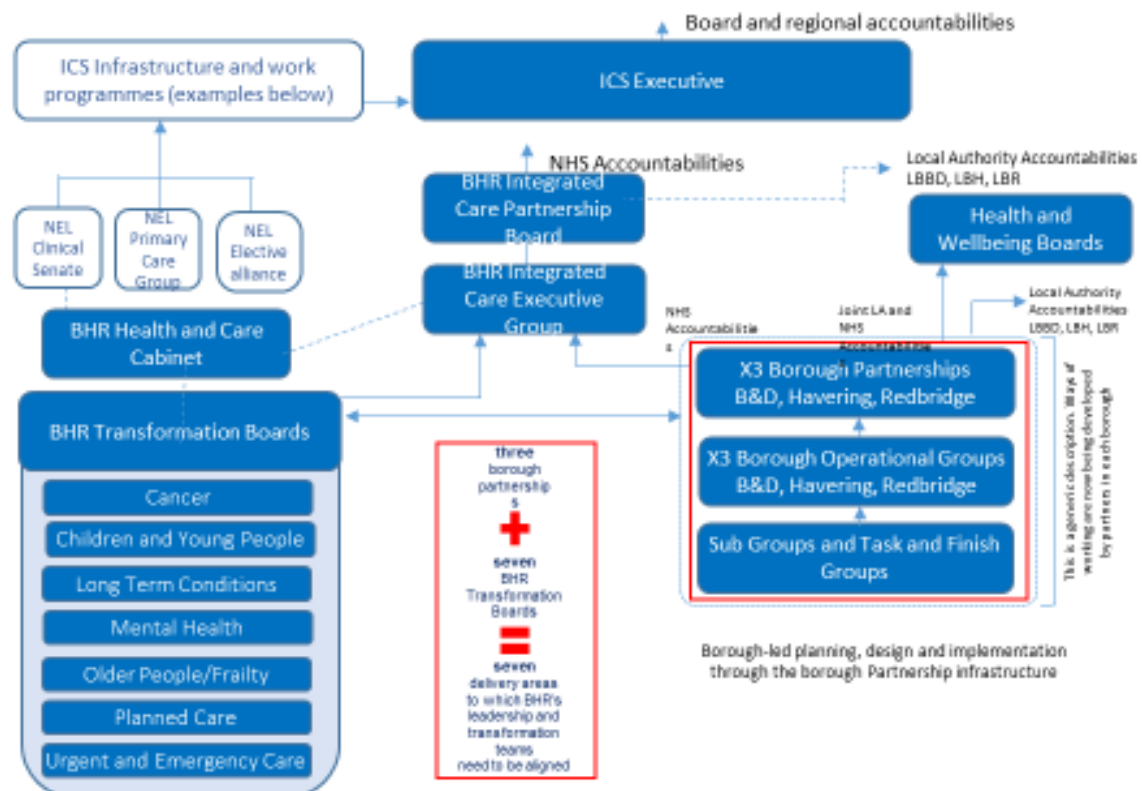
### 1. BHR BCF Governance & Ambitions

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 forward 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.

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

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

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

<b>NEL CCG &amp; BHR ICP</b>	
<b>Accountable Officer</b>	Henry Black, NEL CCG (Interim) & Ceri Jacob, Managing Director, BHR ICP
<b>Finance Director</b>	Steve Collins, Chief Finance Officer, NEL CCG & Ahmet Koray, Director of Finance, BHR ICP
<b>Senior Responsible Officer</b>	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. Other 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**

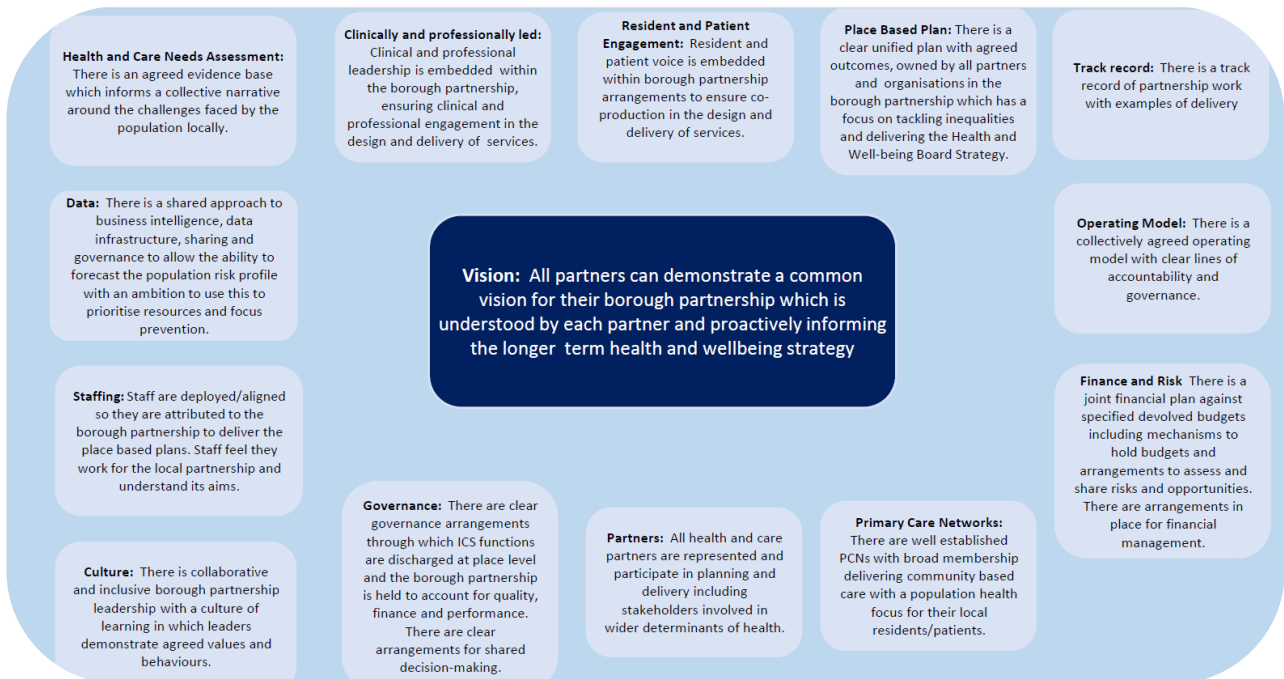
All three boroughs are working towards an integrated care system along with its system partners. Intrinsic to that is the development of the place-based partnerships for each area. For example, the Havering Borough Partnership includes system partners including GPs, social care and NHS providers, the 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 boroughs operate the community health 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
<b>Structured Medication Reviews</b>	<ul style="list-style-type: none"> <li>Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines)</li> <li>Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed.</li> <li>Can lead to a reduction in adverse events.</li> </ul>	Clinical Pharmacist
<b>Enhanced health in care homes</b>	<ul style="list-style-type: none"> <li>Access to consistent, named GP and wider primary care services</li> <li>Medicines review</li> <li>Hydration and nutrition support</li> <li>Access to out-o-f hours / urgent care when needed</li> </ul>	Clinical Pharmacist Community Paramedic
<b>Anticipatory care with community services</b>	<ul style="list-style-type: none"> <li>Thinking ahead and understanding the health needs of individual people</li> <li>Knowing how to use services better</li> <li>Helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan.</li> </ul>	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
<b>Personalised care</b>	<ul style="list-style-type: none"> <li>Care tailored to the needs of people and what matters to them</li> <li>Prevention embedded</li> <li>Personal Health budgets</li> <li>Shared decision making</li> </ul>	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
<b>Inequalities</b>	<ul style="list-style-type: none"> <li>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</li> </ul>	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

<b>Metric 1:</b>	<b>Discharge</b> 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
<b>Metric 2:</b>	<b>Avoidable admissions to hospital</b>
<b>Metric 3:</b>	<b>Reduction in admissions to residential and care homes</b>
<b>Metric 4:</b>	<b>Effectiveness of reablement</b>

### 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	<p><b>PRIORITY: Hospital Discharge Planning &amp; Support</b></p> <p><b>AMBITION: To support safe and timely discharge from hospital and support a home first approach</b></p>	<ul style="list-style-type: none"> <li>• High Impact Change Model for Managing Transfer of Care</li> <li>• Integrated Care Planning and Navigation</li> <li>• Enablers for Integration</li> <li>• Home First (other)</li> <li>• Hospital Discharge Service (other)</li> </ul>
2	<p><b>PRIORITY: Targeted Out-of-Hospital Care</b></p> <p><b>AMBITION: To support people with higher care needs to get as great a level of independence as possible</b></p>	<ul style="list-style-type: none"> <li>• Bed based intermediate Care Services</li> <li>• Reablement in a person's own home</li> <li>• Residential Placements</li> <li>• Home Care or Domiciliary Care</li> <li>• Housing Related Schemes</li> </ul>
3	<p><b>PRIORITY: Community Support &amp; Independence</b></p> <p><b>AMBITION: To support people to remain well in the community - maximise their independence and reduce admissions</b></p>	<ul style="list-style-type: none"> <li>• Prevention / Early Intervention</li> <li>• Personalised Budgeting and Commissioning</li> <li>• Assistive Technologies and Equipment</li> <li>• Care Act Implementation Related Duties</li> <li>• Carers Services</li> <li>• Community Based Schemes</li> <li>• DFG Related Schemes</li> <li>• Community Treatment Team expansion (other)</li> </ul>

ID	SCHEME	SCHEME TYPES*
4	<p><b>PRIORITY: Market Stabilisation &amp; COVID Recovery</b></p> <p><b>AMBITION: To support the stabilisation of the care market and Winter pressures</b></p>	<ul style="list-style-type: none"> <li>• Provider uplifts</li> <li>• Fee increase</li> <li>• Winter pressures</li> </ul>

\*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. Therefore, the LA works very closely with both acute providers in supporting its discharge process. Home First in 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 physical 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.

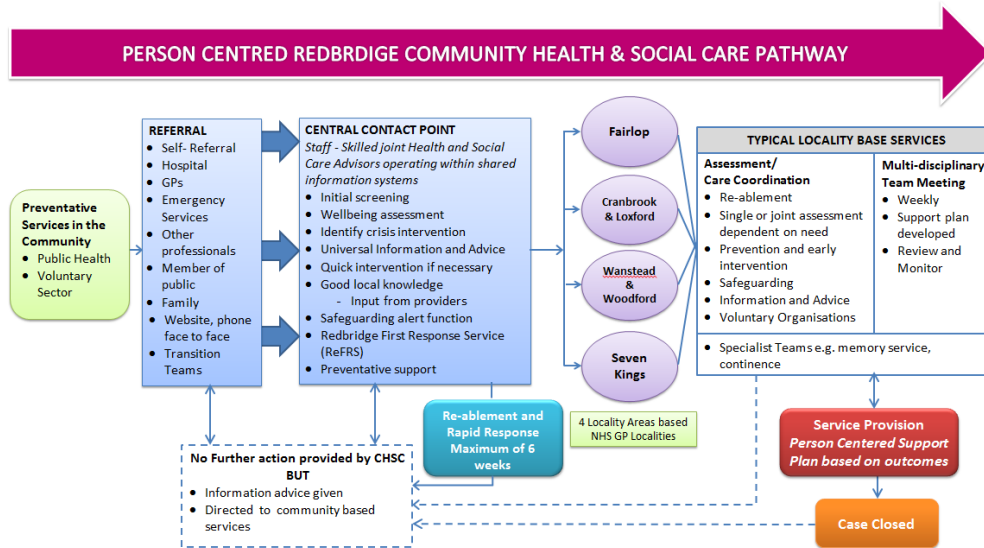
Further to placed based care approaches investigated in 2019-20 and with Anticipatory Care workstream as part of the Ageing Well agenda, BHR will be working through the borough partnerships to development very localised approaches at a neighbourhood and Primary Care network level. Planning work is commencing 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.

Having 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 is 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 psychology 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?

Primary care	Long covid service	Non clinical pathways (Local Authorities and third sector partners)
<p>NHSE/I has released a long covid enhanced service specification for GPs, which will increase the primary care focus on long covid to:</p> <ul style="list-style-type: none"> <li>Educate clinicians to support post covid syndrome</li> <li>Increase coding to improve reporting and insights</li> <li>Reduce inequality</li> </ul>	<ul style="list-style-type: none"> <li>Increasing capacity in occupational therapy and physiotherapy</li> <li>Introducing dietetics</li> <li>Creating a GP with a special interest role to link the primary care and long covid clinics</li> <li>Creating a care coordinating role to manage residents through the pathway and link with the non-clinical pathway</li> </ul>	<ul style="list-style-type: none"> <li>Developing pathways to stepdown residents from physiotherapy to community based exercise services</li> <li>Developing pathways into enterprise and employment service to help residents unable to continue their pre-covid employment</li> <li>Looking at how residents can link with tier 2 weight management services where commissioned in the community</li> <li>Increasing links and use of social prescribing</li> </ul>

### 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 COVID 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 health.
- However, on the flip side, as people have returned to work and are less able to care for relatives at 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 COVID 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 COVID has been significant in de-stabilising a number of 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 Handyman Scheme for minor repairs.

While the Handyman 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	<b>£91,424,858</b>

**Table 2: Breakdown by Fund**

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

**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	<b>£16,313,384</b>
Adult Social Care services spend from the minimum CCG allocations	£6,120,163	£7,683,932	£8,044,889	<b>£21,848,984</b>

**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	<b>£107.00</b>
Havering	260,651	<b>£111.55</b>
B&D	214,107	<b>£134.35</b>
<b>Total Area Estimated Population</b>	<b>780,416</b>	<b>Area average: £116.02</b>

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.

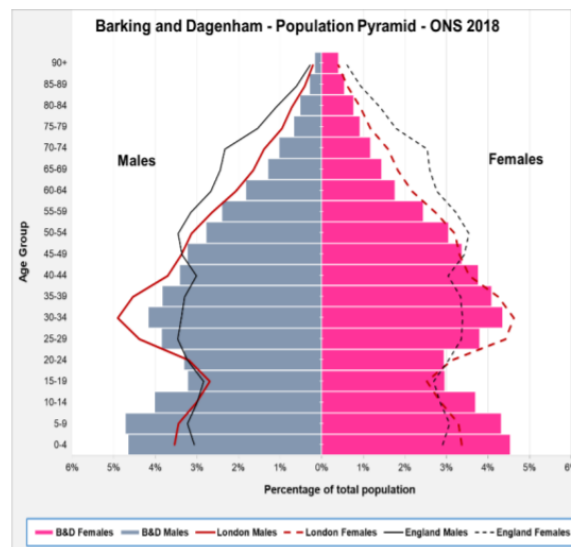
### 3. Local Area Summary

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.

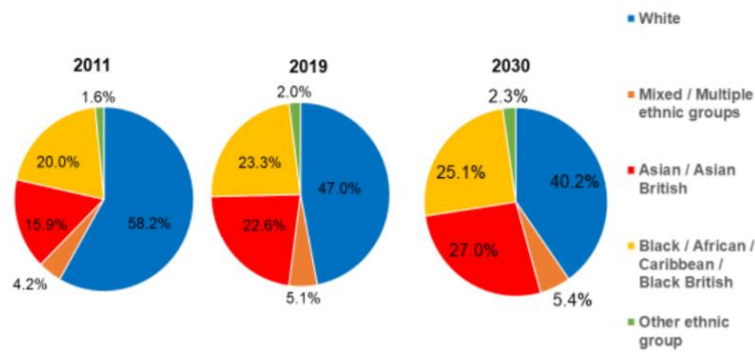
The population of Barking and Dagenham is relatively young in comparison to the rest of London and the BHR ICS. Of 16,000 people aged 85 and older living in the three boroughs comprising the BHR ICS, only 19% live in Barking and Dagenham. Nevertheless the age profile of the Barking and Dagenham population 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

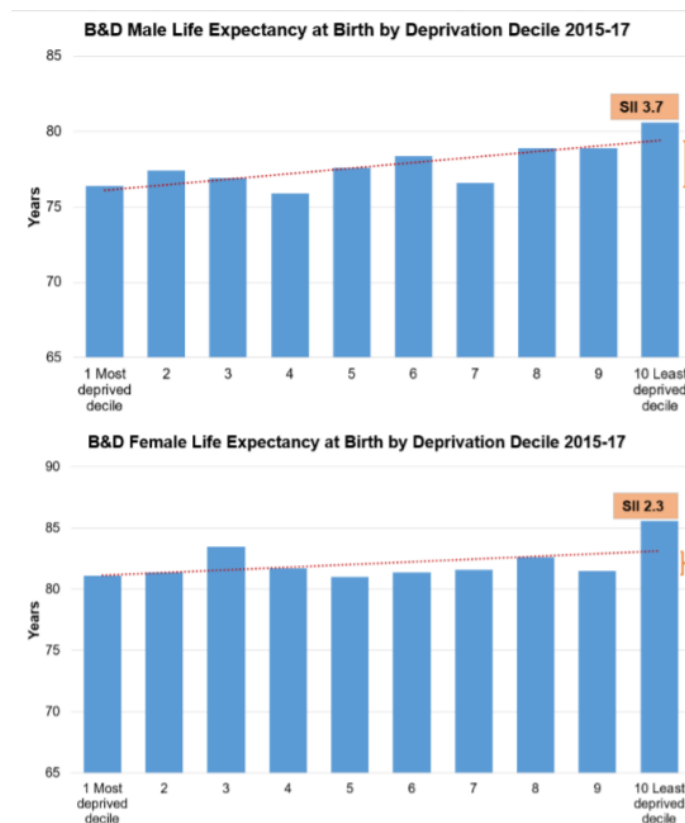
Ethnic diversity in Barking and Dagenham has increased in the recent past. An estimated 53% of Barking and Dagenham residents are from a Black, Asian or Minority Ethnic (BAME) background compared to 44% for London. This proportion is predicted to increase to 60% by 2030.

**Barking & Dagenham Change in Ethnic Proportions 2011,2019,2030**



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.



Data Source: Public Health England

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 miles<sup>2</sup>) 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**

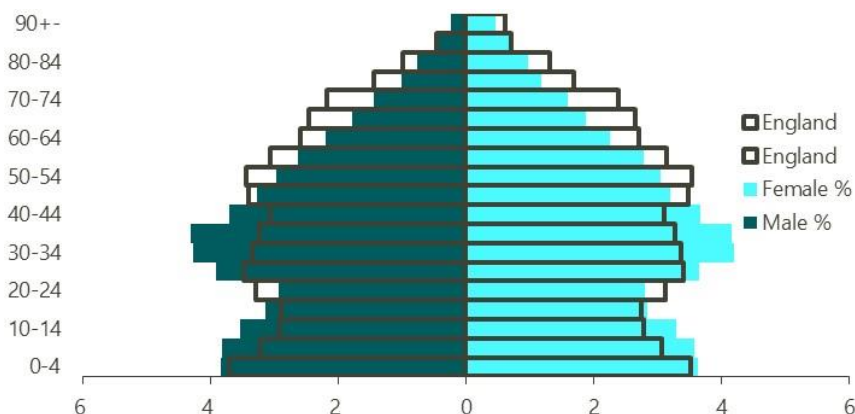
As health and care commissioners we seek to co-produce the design and implementation of our services based on the evidence of our local population needs. This is based a range of data sources including our Annual Public Health Reports, JSNA, health and social data from client management systems, as well 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%).

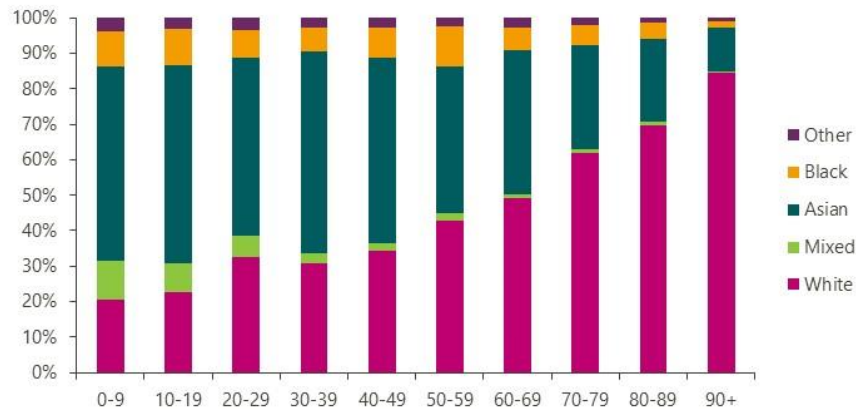
**Redbridge’s population, in five-year age bands, by age and sex, 2019**



**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

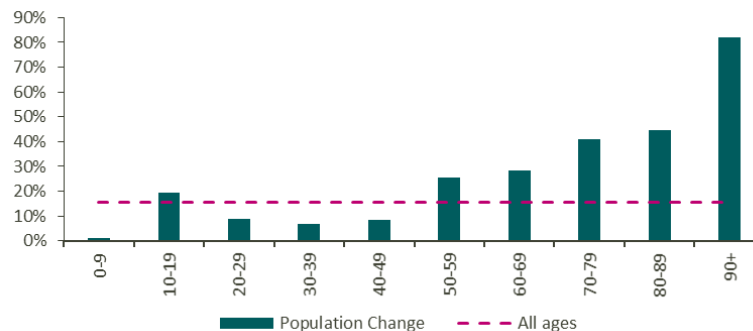


### Population Change

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**

<b>LEVEL 1: Doing to</b>	<b>LEVEL 2: Doing for</b>	<b>LEVEL 3: Doing with</b>
<b>Passive recipients</b>	<b>Engaging &amp; involving people</b>	<b>Equal &amp; reciprocal partnership</b>
<ul style="list-style-type: none"> <li>• Education</li> <li>• Coercion</li> </ul>	<ul style="list-style-type: none"> <li>• Engagement</li> <li>• Consultation</li> <li>• Informing</li> </ul>	<ul style="list-style-type: none"> <li>• Co-production</li> <li>• Co-design</li> </ul>

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 undertake a 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 our 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](http://www.lbbd.gov.uk)

[www.havering.gov.uk](http://www.havering.gov.uk)

[www.redbridge.gov.uk](http://www.redbridge.gov.uk)

[www.northeastlondonccg.nhs.uk](http://www.northeastlondonccg.nhs.uk)

[www.nelft.nhs.uk](http://www.nelft.nhs.uk)

[www.bhruthospitals.nhs.uk](http://www.bhruthospitals.nhs.uk)

[www.bartshealth.nhs.uk](http://www.bartshealth.nhs.uk)

## APPENDIX 1

### BCF Risk Log

IDENTIFIED RISK		RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
1.	<p>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.</p> <p>Complexity of conditions and increase in children and young people with LD transiting in adulthood</p> <p>These budget pressures sit alongside corporate financial pressures faced by the partners</p>	<p>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.</p> <p>Encouragement of population to take responsibility for their own health, self-management</p> <p>Upstream preventative / early intervention investment</p> <p>Better planning and management of the Transition process for CYP</p>	4	4	High	
2.	<p>Costs and benefits fall unevenly across the system and inequitably to the investing partner for areas of change</p>	<ul style="list-style-type: none"> <li>Review and transparency of impact and outcomes achieved.</li> <li>Affordability to be a determinant of further steps.</li> <li>Risk share remains an option for consideration.</li> <li>Protection of social care services and consideration of pooled budgets.</li> <li>Ongoing monitoring of impacts.</li> </ul>	4	3	Medium	
3.	<p>Resources locked into current contracts/ activity cannot be effectively unlocked to support activity where positive evidence of improved outcomes are drawn.</p>	<p>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.</p>	2	2	Medium	
4.	<p>Three borough complexity slows progress because of differing democratic leadership, priorities and indeed financial values into specific /shared schemes</p>	<p>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 of extreme pressure.</p> <p>Integrated Care Partnership is responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points.</p>	2	3	Low	



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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	