Barking & Dagenham Place, Havering Place & Redbridge Place

Joint Better Care Fund Plan 2023-25

London Borough of Barking & Dagenham
London Borough of Havering
London Borough of Redbridge
NHS North East London

Contents

BHR Better Care Fund Plan 2023-25

This joint plan (the BHR BCF plan) covers the following **Health & Wellbeing Board** areas:

- Barking & Dagenham (including NHS Trusts, social care provider representative
- Havering
- Redbridge

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing

- The following organisations have signed off the plan:
- London Borough of Barking & Dagenham
- London Borough of Havering
- London Borough of Redbridge
- NHS North East London

These organisations are part of the North East London Integrated Care System 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

Stakeholder Engagement

Place Based Partnerships and sub-groups

Whilst the HWBB retains formal governance for sign off, in 2022/23 the BCF in 2022/23 commenced as key theme for the Place Based Partnership Boards (PBP) to have oversight of and input into key areas. One key area the PBP have had input into so far is the Ageing Well Non-Recurrent funding planned expenditure, covering the development of such work areas as proactive care. From 23/24 and into 24/25 the PBP board will locally approve the BCF plan and receive regular updates developments, performance and spend. Each PBP includes representation from the acute trusts, housing, community health services, public health, the voluntary sector, ICB, local authority and local resident forums and all partners have been fully engaged in BCF discussions.

At Place level there are also subgroups that manage the detail of service development and performance supported through the BCF including intermediate care, discharge and prevention. This includes an Adults Delivery and Proactive Care steering Group (B&D), steering groups for Ageing Well, Mental Health and Long-Term Conditions (Havering) and Ageing Well in Redbridge. These steering groups work on key priorities and themes at place.

Discharge Improvement Working Group (DIWG) (BHR Places)

The working group is multi-partner and drives and oversees the management of discharge challenges, trouble-shooting and developments. This group supports the performance of meeting the right care, time and place agenda in the BCF. This has included several system wide workshops to develop a local strategic approach to discharge, which has led to a series of task groups focusing on developing targeted themes including the integrated discharge hub, rehab pathways, inpatient rehab beds and the development of discharge to assess at home.

Urgent and Emergency Care Board (BHR Places) (now an improvement board)

The board oversees all admissions avoidance performance, policy and service development. The board also reviews the work around keeping people safe at home, including urgent community response, ED front door, enhanced care in care homes, the LAS and how the upstreaming of care supports the avoidance agenda. Like the DIWG this is multi-partner arrangement.

Local Residents Service Users & Carers

The local authorities ongoing engagement with service users and carers (Residents) is undertaken through tenders, provider quality inspections, service delivery and contract monitoring, CQC preparation activities, consultation activity, the Health Inequalities Programme (see below) and the delivery of the Carers Charter.
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.

Providers

BHR local authorities commission Care Provider Voice (CPV) Northeast London, a care provider run organisation seeking to support the social care sector (and health care). Each local authority area has a Care Provider forum, that seeks feedback from local care home and homecare providers. This included looking at local issues and to address these as system to identifying training needs across services. Themes related to the BCF particularly around how providers interface with intermediate care are regularly discussed.
Redbridge also hold regular Provider Forums where all Providers have the opportunity to attend and meet with Commissioners, Public Health, Safeguarding and Quality assurance teams, and contract officers to discuss a range of issues, updates and upcoming areas of commissioning.

Voluntary Sector Engagement

BHR ICBs 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. The Barking and Dagenham Collective are a member of the Place Based Partnership within Barking and Dagenham and their network, experience and expertise is integral to the development of the Place Based Partnership priorities within Barking and Dagenham and the Health Inequalities programme of work. 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. As stated below, the VCS are also central to our Health Inequalities Programme and our developing work around social isolation.
Within Redbridge our Redbridge CVS sector are key partners on our Health & Wellbeing Board and Place Partnership and work to represent the views of the VCS and have been integral into developing the Place Based Partnership Priorities and our new Health & Wellbeing Strategy. The third sector in Redbridge is very strong and well established and they are heavily involved in delivering our prevention and early intervention agenda, as well as piloting a range of projects focused on Falls Prevention and MH services for Carers.

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 ICB clinical directors allocated to drive the agenda forward and link to primary care and PCNs.

Housing

Each Place area work closely with Housing colleagues on a range of projects within the BCF and are actively involved in the Discharge Improvement Working Group meetings supporting discharge. Housing colleagues are integral to all plans for the DFG and all decision making regarding how the DFG monies is spent. There are BCF schemes relating to Extra Care which Housing are a key partner in.

Governance

1. BHR Places BCF Governance & Ambitions

Our overarching vision for the Barking and Dagenham, Havering and Redbridge places joint plan is to:

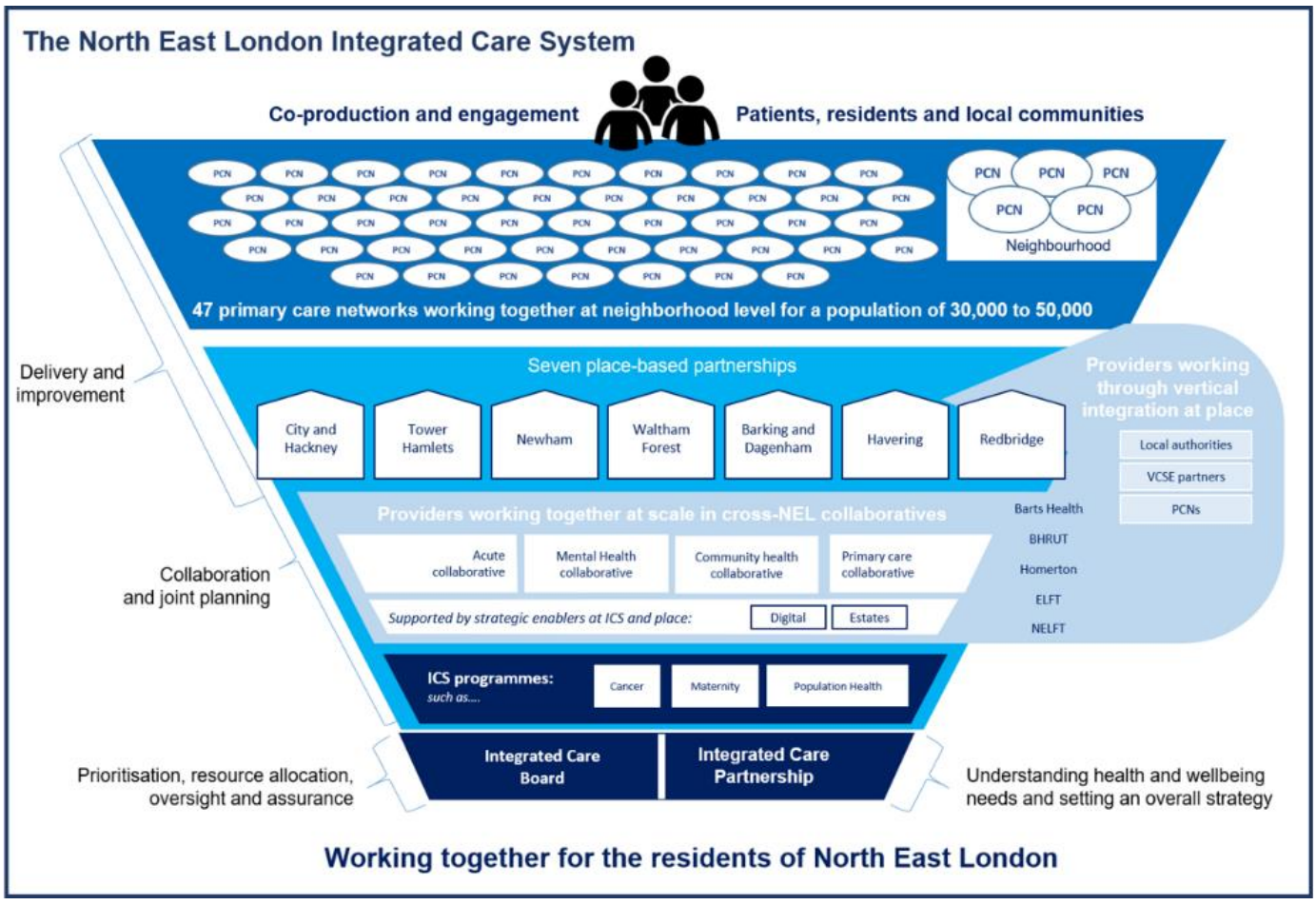
'Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high-quality health and wellbeing services.'

- **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.



Joint BHR S75 Agreement and Joint Working

Overall strategic oversight of partnership working between the Partners is vested in the respective Borough Health and Wellbeing Boards. The Place based Partnerships are also beginning to take oversight of the BCF at Place, with a focus on how the BCF supports local people.

The Partners have agreed that the BHR Places Joint Commissioning Board (JCB) will be responsible for the review of performance and oversight of the partnership agreement in 2023/24. The JCB is a working group of representatives of Barking and Dagenham, Havering and Redbridge Councils, NHS North East London and Place. 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, the JCB provides the strategic direction of the development and application of the Better Care Fund across BHR Places. From our BCF 2017-19 plan we developed a joint BHR S75 with the BHR LAs and ICB – NHS north East London, which was completed and signed in July 2018 and is refreshed annually. This sets 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 Place, and in addition incorporates the option of utilising a fourth 'pot' to facilitate joint pooled commissioning arrangements between partners and across Places.

With the move to Place, during 2023/24 the BHR places BCF section 75 will be disaggregated to place level for a new place level section 75 in 24/25 although the section 75 variation will be place specific for 23/24.

The JCB consists of representation between the Barking and Dagenham, Havering and Redbridge Local Authorities, and NHS North East London. The chair alternates between NHS North East London and local authorities with representation consisting of the respective DASSs, DPHs, NHS North East London Leadership, finance representatives and Commissioner Leads as members of the Board. A *BCF Executive group* oversee the delivery of the BCF work in including planning, development and monitor spend and performance. A BCF Operations & Finance group supports the work of the BCF Executive Group including developing reports, reviews, finance templates and developing the submission annually. It is exploring opportunities for further development in relation to integrated services and joint commissioning opportunities. We will review the role of the JCB as the Place Based Partnerships develop over the coming year and whether any changes to governance arrangements are required.

Jointly Agreed Plan Approval

Below sets out the key officers from each organisation responsible for plan sign off and the dates of the Health & Wellbeing Boards for plan agreement:

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

Havering	
Chair of the HWB	Councillor Gillian Ford, Lead member for Adults Social Care & Health
DASS	Barbara Nicholls, Director Adult Social Care & Health
Section 151 Officer	Dave Mcnamara, Director of Finance
Date of HWB Agreement	29th June 2023

Redbridge	
Chair of the HWB	Cllr Mark Santos, Cabinet Member for Adult Social Care & Health
DASS	Adrian Loades, Corporate Director of People
Section 151 Officer	Maria Christofi, Corporate Director of Resources
Date of HWB Agreement	19th June 2023

NHS NEL	
Accountable Officer	Zina Etheridge, CEO NHS North East London
Finance Director	Henry Black, Chief Finance and Performance Officer - NHS North East London
Senior Responsible Officer	Place Directors NHS North East London - Sharon Morrow (Barking & Dagenham Place), Luke Burton (Havering Place) and Tracy Rubery (Redbridge Place)

Executive Summary

This Joint Better Care Fund plan 2023-25 will refer to developments at both individual places/boroughs in outer north east London and also BHR places, were the initiative is working across the three place areas and/or the acute trust catchment area.

Our Joint Priorities
Across the Barking & Dagenham, Havering and Redbridge places the Better Care Fund plan for 2023-25, we have agreed the following priorities:

Enabling people to stay well, safe and independent at home for longer.
Provide the right care in the right place at the right time.

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 to the 22/23 BCF plan

Integrated Discharge Hub (IDH)
Previously known as the Single Point of Access (SPA), this is a merged service combining the Hospital Discharge Service that was developed during the pandemic (team includes OT and Physio) and the Discharge Co-ordination Unit that focuses on social care discharges. The combined team is the IDH. The service will be developing further in 2023/24 to assume a more extensive role in discharge co-ordination across all pathways.

Keeping People Well and Safe at Home
This is a key theme being adopted across the NEL ICB and Place geographical areas. This is focused on upstreaming care and keeping people away from the hospital front door and non -elective admission. Key work streams include developing proactive care at PCN level, ensuring people and local professionals are aware of the local service offer, services are branded to make them accessible to local people and that there is work to risk stratify local people and populations for targeted intervention. The B&D Partnership, for example, is developing and piloting a proactive care model to provide proactive and personalised health and care for individuals living with multiple long-term conditions (MLTC), delivered through multidisciplinary teams in local communities and taking a data-driven approach to identifying which individuals are prioritised for proactive care. The Fuller report and the development of neighbourhood will be key to this agenda.

Urgent Care Response embedded
The community two -hour response is now embedded in the local system. The Community Treatment Team (CTT) provide an 8am – 10pm service 7 days a week. Additional workforce has been recruited over the last 12-18 months and the service is performing with 80-90% meeting the target of 2-hours.
There is also now additional overnight End of Life (EOL) Rapid Response from Marie Curie. This service will visit a crisis situation supporting the patient and the whole family when a person is end of life. The service runs from 10pm until 8am 7 days a week and provides nurses who can prescribe if needed.

Falls
The Falls offer was invested in from 2020 and now offers a range of service both at place and across the BHR places area. There are Strength and Balance classes offered by the voluntary at various venues and on-line. There is a dedicated NHS falls team for the community offering assessment and intervention (consultant led) and a care homes falls team that focuses on training and quality improvement in how homes manage and prevent falls.

British Red Cross Care home medical escort service for Barking & Dagenham, Havering and Redbridge
This service provides escort and transport to and from medical appointments from care homes where family members are unable to assist. Residents that need assistance can be transported to medical appointments using Red Cross staff and resources.

Home First
Havering continued to develop the Home First model in 22/23 working in partnership with BHRUT and the Reablement provider to streamline the discharge process providing a full assessment at the person's home post discharge. This was trialled as the default

discharge pathway (pathway 1) for a period of time but the demand significantly exceeded capacity so this has been reviewed. The Reablement service is being recommissioned in 23/24 and the Home First assessment model is being developed as part of the specification. Stakeholders are working collaboratively to develop this model ensuring that minimal assessment is required at the point of discharge and there is enough capacity in the service to ensure a same day / next day response.

Redbridge have also used their commissioned Reablement service to pilot a Home First pathway and have increased the number of daily slots available to support discharge. The trend of increased demand for reablement services is likely to continue and further development opportunities will be explored to improve capacity to meet this including periods of peak pressure.

B&D continue to work with Redbridge Reablement Service (RRS) in providing the home first service pathway. We have 10 spots available a week (2 a day Monday to Friday). This accounts for the majority of our pathway 1 discharges from BHRUT hospitals. Throughout 2022/23 the home first model was expanded to include a reablement option which was delivered by RRS. This was funded through the Adult Social Care Discharge Fund and we will be looking to continue expanding this reablement trial through the use of Discharge Fund monies in this BCF planning round.

Place Based Partnerships

All 3 Places now have fully established Place Based Partnerships with recognised governance structures, processes and systems which build on historic local collaboration and integration between organisations. Each Place has agreed a set of priorities which are reference in more detail under National Condition 1.

Residential Discharge to Assess (D2A)

Following the success of the nursing D2A pilot a new scheme is being developed and led by Havering to trial the same concept in a Residential setting. There will be a number of block booked residential beds which will have aligned therapy support for an initial 'assessment' period of up to 6 weeks. It is expected this will improve outcomes for people and we will see an increase in the number of people returning home and will also streamline the discharge process reducing length of stay.

Discharge to Assess - Home

There is a 3rd D2A pilot being initiated in 23/24 which is the D2A Home pathway. Although we have seen great outcomes for the people discharged into the block booked beds, it is likely some of these people could have gone straight home from hospital and received nursing care / therapy support at home during the assessment period. This will be piloted with a view to it becoming an established pathway across BHR.

B&D

Barking and Dagenham is continuing to develop our longer-term approach to enablement and prevention. We have tested a new reablement pilot which we will be further developing with the use of the Discharge Fund in 23/24, aiming to commission a reablement model in 23/24 alongside a tender for a new homecare framework, taking the learning from this pilot and our market engagement work. Additionally, we have further developed our Home First and D2A approaches with our neighbouring Boroughs and the ICB (which will continue to evolve during 23/24) and we have continued initiatives such as extra care trial flats and voluntary sector blitz cleaning to support discharge.

We have also grown and embedded our care technology service which is now supporting 3000 residents across Barking and Dagenham and looking at the way we can use data and insights to target prevention activity. As a Partnership we are reviewing our approach to prevention through our work with the voluntary sector around social isolation, our approach to proactive care and piloting in a PCN and also formulating a new Prevention Strategy targeted at our edge of care and pre-frail cohort to look at holistic, system-wide approaches across Place. This will be a co-produced Strategy and strategy development will begin in Autumn 2023.

Havering

In line with the prevention agenda Havering are piloting a community reablement service in 2023/24 aligned to the PCNs and the Proactive Care model. There will be a direct referral route into reablement from primary care and other aligned community teams to support people remaining independent at home for longer. The aligned reablement workers will be part of the PCN MDT model building relationships with primary care, community health and social care teams, mental health teams and the voluntary sector.

Havering are also trialling a Ward Led Enablement model with a small reablement team working in alongside ward staff to provide reablement support to adults whilst they are inpatients. It is a preventative service which will mitigate against deconditioning increasing the patient's confidence in returning to their home environment and improving the discharge outcome.

Redbridge

In Redbridge we are currently implementing our Homecare Framework. Our new service will deliver an outcome-based commissioning model with lead providers based in each of the four locality areas within our Community Health and Social care teams to promote a strength-based approach that promotes wellbeing and achievable outcomes to enable people to maintain control and independence.

In addition, we have also re-designed and will be implementing in Autumn 2023 our new External Day Opportunities Framework focusing on a 'progression' to promote independence, wellbeing and self-care and employment skill including transitions.

As part of its work to developing community insight and networks, we have implemented our Locality Coordinator model and are continuing to recruit to this. The coordinators will link closely to local people and community groups to provide information, advice and direct support to where it is needed most to prevent escalation of need by intervening early. This community insight will also feed provide valuable data and for future commissioning intentions.

Redbridge continues to support a varied range of integrated health and social care services to prevent unnecessary hospital admission of premature placement in long-term residential or nursing care. We also remain to be the lead commissioner for the Integrated Community Equipment Service (ICES) as a partnership between the three outer London places for the NHS, NELFT and Havering Council and continue supporting hospital discharge by increasing the number of daily reablement slots for which this now supports all of the primary discharge routes for Whipps Cross and BHRUT, including Home First to support rapid discharge from hospitals. This is a joint programme for reablement led by LBR and NELFT.

1.National Condition 1 - Overall BCF Plan and approach to integration

1.1 Summary – BHR Places

An integrated care system (ICS) is one that brings together local health and care organisations and the voluntary sector 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 Place Based Partnerships serve a population of around 780,500 people.

Key objectives 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 proactive and integrated care across the NHS, 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.

Pathway redesign and service model development across BHR places has primarily been delivered through a number of BHR system transformation programmes. These are the Urgent and Emergency Care Board (now the BHR Places Improvement Board) - led by the acute trust; a Discharge Working Improvement Working Group (DIWG) - chaired by local authority and NHS community services directors which reviews and manages flow in and out-of-hospital and the BHR Older Peoples and Frailty Transformation Board which is led by NHS North East London. The Joint Commissioning Board (JCB) consisting of BHR LAs and NHS North East London functions at a more strategic level where a range of collaborative commissioning and transformation 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.

1.2 Approaches to Joint Commissioning and collaboration

Barking and Dagenham, Havering and Redbridge boroughs and the ICB have worked collaboratively at a sub-regional level (BHR) prior to the inauguration of the Integrated Care Board and ICS. BHR Integrated Care Partnership has also developed over a number of years. This work and COVID has brought the NHS and boroughs into a much more collaborative relationship across the three borough areas which has continued.

As we move to Place, the focus will be on that borough level, however not losing the collaborative work across outer north East London that has developed over the previous years. The Place Based Partnerships have agreed to continue to collaborate on transformation where this makes sense and will be reviewing how this will operate as the Place Based Partnerships develop.

1.3 Embedding Integration - Joint and Collaborative Commissioning and transformation

Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge Places and deliver sustainable provision of high- quality health and wellbeing services. This plan sets out a clear determination that the BHR places 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/resident, 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.

Improving outcomes for frail and older people is a priority for the BHR places. 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 work streams are in place 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 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 local system and places are working to disseminate this work down to place level, whilst maintaining a BHR places perspective where appropriate, which includes sitting under the hospital footprint with urgent and emergency care and discharge. Other service areas like dementia, falls and proactive care will be planned and actioned at place.

The partnership approach involves NHS North East London (ICB), NHS provider trusts and Local Authorities across the three boroughs, Havering, Barking and Dagenham and Redbridge. 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.

1.4 Place Based Partnerships

Each borough has now established a Partnership Board that brings system partners including primary care, social care, NHS providers, the voluntary sector, Health Watch, the ICB and the local authority.

B&D

In B&D the top five priorities are: addressing LTC adult and children; obesity & smoking; Best Start in Life (early years); Domestic Violence and addressing adverse childhood experiences (mental health); health in all policies/anchor institutions.

The place-based Partnership alongside North East London Integrated Care Board is in the process of developing a Committees in Common model to align the Health and Wellbeing Board and ICB Subcommittee in order to streamline decision making and rationalise meetings for senior leaders across the Borough. The first meeting as Committees in Common will be on the 26th June. This is a unique model within North East London and is a great example of the will of partners at place and ICB to work closely together for the benefit of residents.

Havering

The Havering partnership is in the early stages of development, but already has strong buy in from partners, and is committed to better meet the needs of local people, and in particular to reduce health inequalities.

The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health. This will be done by:

- Tackling inequalities and reducing deprivation
- Improving mental and emotional support
- Tackling Havering's biggest killers
- Improving earlier help, care and support
- Working with people to build resilient communities supporting them to live independently

An interim strategy has been developed which articulates the key priorities for the Havering Place based Partnership in 2023/24. The strategy takes a life course approach focusing on Start Well, Live Well, Age Well and Die Well.

NHS North East London is in the process of a restructure, which includes the establishment of a new team at place for Havering, structures around the lift course approach set out within this strategy. Once the new team is in place, partners intend to integrate commissioning of health and care in Havering as much as possible to ensure that services are seamless, and commissioned around the needs of local people, including the wider determinants of health.

Redbridge

The has now appointed its Clinical and Care Professional Leads with the LA DASS as the Partnership lead and GP as Clinical Director and a number of Leads in the areas: (1) Planned Care; (2) Long-Term Conditions; (3) Children & Young People; (4) Urgent & Emergency Care; (5) Mental Health; (6) Learning Disabilities & Autism; (7) New Models of Integrated Care and (8) Enablers.

These pathway leads are implementing the Accelerator Programme Priorities for the partnership:

1. Mental Health
2. Children & Young People with a focus on childhood immunisations
3. Housing & Overcrowding
4. Improving Multi-disciplinary team working

Alongside the accelerator priorities, the RPbP is delivering and supporting a range of projects as part of the Health Inequalities programme, these initiatives include:

- **Childhood Immunisation Pilot** which includes the development of immunisation champions.
- **Wearable Tech** to provide holistic interventions to residents in areas of deprivation, by utilising wearable and assistive technologies.
- **Engagement** RCVS Health Buddies, Door to Door engagement team, Culturally specific engagement officers, Schools engagement.
- **Health Engagement Bus** which brings number of services and advice and guidance on health issues to local communities and hard to reach communities through events. These have included: substance misuse event, COVID clinics, Point of Care

Testing (POCT) offer – blood pressure, BMI, diabetes and cholesterol checks. Also looking at additional services such as atrial fibrillation and smoking cessation.

- **Community Chest** Piloting Community Chests in multiple boroughs across NEL to build on best practice of programmes elsewhere.
- **Rolling our Mental Health First Aid Training** including VCS and health and social care staff.
- **Post Covid Project** working with and engaging a number of communities including carers and disabled people on the impacts of COVID.
- **Community Insights** work which includes:
    - Healthwatch Information and Signposting sessions based in the communities that face the greatest health inequalities
    - Homelessness - Support for Asylum Seekers
    - Homelessness - Support and signposting for cost-of-living crisis including Rough Sleepers
    - Bespoke awareness sessions to groups with learning disabilities on cervical, breast, prostate and bowel cancer screening, and the menopause.

Our Health & Wellbeing is currently producing its new Health & Wellbeing Strategy for 2023-27. This links into the priorities of the RPbP and the Councils Redbridge Plan.

Borough Partnerships Visions

1.5 Locality and Neighbourhoods

Community heath and/or social care services operate 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.

With the move to Place, there will also be a drive develop the Fuller neighbourhood's agenda. The direction of travel is being driven by NEL, and the local plans and delivery are through Place partnerships and PCNs. There is also a strong link to the developing proactive care models at PCN level to support ageing well and frailty. Both neighbourhoods and proactive care will be key to delivering keeping people well at home to support the upstreaming of care and reduction in the need for unplanned primary care and admissions avoidance. In Barking and Dagenham, a new Prevention Strategy is being formulated targeted at our edge of care and pre-frail cohort to look at holistic, system-wide approaches across Place. This will be a co-produced Strategy and strategy development will begin in Autumn 2023.

1.6 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, family hubs, 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 places. 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	Workforce Service Support
Structured Medication Reviews	• Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines) • Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. • Can lead to a reduction in adverse events.	Clinical Pharmacist
Enhanced health in care homes	• Access to consistent, named GP and wider primary care services • Medicines review • Hydration and nutrition support • Access to out-o-f hours / urgent care when needed	Clinical Pharmacist Community Paramedic
Proactive care with community services	• Uses Population Health to seek out cohorts of people who are more at risk of using health and social care services more frequently or needing higher levels care in the future • Develops a more collaborative and conversational approach with residents and their families • Care co-ordinates interventions • Involves multiple services and professionals for a holistic care offer	Care Co-ordinator Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapist Link to Integrated Case Management
Personalised care	• Care tailored to the needs of people and what matters to them • Prevention embedded • Personal Health budgets • Shared decision making	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Inequalities	-Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing those services that are provided in an integrated way where this might reduce health inequalities	Social Prescriber Clinical Pharmacist Physician Associate

2. National Condition 2: Enabling people to stay well, safe and independent at home for longer (objective 1)

There are number of key schemes both at BHR and Place level which have been developed to deliver the objective of enabling people to stay well, safe and independent at home for longer.

BCF Objective	Scheme Types
1: Enabling people to stay well, safe and independent at home for longer	Assistive Technologies and Equipment Care Act Implementation Related Duties Integrated Care Planning and Navigation Personalised Budgeting and Commissioning DFG Related Schemes Carers Services Prevention / Early Intervention Integrated Care Planning and Navigation Urgent community response

3. Schemes to support delivery of Objective 1

3.1 Protecting Adult Social Care

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.

3.2 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.

3.3 Proactive Care (PC)

By supporting people differently in the community, including tackling the wider determinants of health, we can prevent some individual's needs escalating and address them in the community rather than in acute services. BHR Places continue to be at varying stages with both Population Health Management and Proactive Care, however there will be a real drive to implement PC in 23/24 to deliver keeping people well at home and support Fuller.

B&D Place actioned a whole Place level population health management pilot in 22/23 and have identified pre-frail and long-term conditions as two key cohorts to focus on. A project group has now been established to take this work forward with a single test PCN, combined with a review of integrated case management.

Havering Place have been working with a single PCN linked to MDT developments and have completed the initial cohort identification, trialled a mock MDT approach and have developed systems to deliver a proof of concept approach in the summer 2023, with a view to roll out the model across PCNs later in 2023 and into early 2024.

Redbridge Place has actioned some initial exploratory sessions with PCNs and is actioning the identification of cohort work in 2023/24, with a view to a proof of concept in the summer 2023 and to roll out in winter 2023 and into 2024.

3.4 Falls prevention

There was considerable investment in falls services from 2020 and particularly as we came out of the pandemic in 2021. There are now strength and balance classes in each place area, on-line and face to face. The Community Falls team (NELFT) delivers a full community offer from assessment to intervention and a care home falls team supports QI and training and advice to all care homes.

A strategy was developed through engagement with local older people, place based partnerships and wider professionals with three key priorities - 1 early identification and triage for risk stratification, 2 access to evidence-based fall prevention programmes and 3 workforce development to collaboratively build capacity and skill mix. This will be implemented at place over the next two years, with a particular focus to identify and support those a risk of a fall at PCN level.

3.5 Homecare & Double Handed Care

B&D have a homecare framework in place which operates on a locality model ensuring the domiciliary care function can support hospital discharge as well as keeping residents in their own homes and in the community for as long as possible. The homecare providers also support the Home First approach. Significantly, 23/24 will see a focus on retendering a new homecare framework. In addition to this there are plans to procure a reablement service which will replace the current crisis homecare provision, with the aim of supporting people at a point of care escalation such as a hospital admission or fall to regain their independence and no longer require ongoing care and support. This will replace the current crisis intervention model.

In Redbridge the new Homecare Framework has been co-designed with key stakeholders including Care Providers, including the provider market who were very responsive to this the development. The new service will be underpinned by an outcome-based commissioning model with lead providers based in each of the four locality areas within our Community Health and Social care teams. A strength-based approach that promotes wellbeing and achievable outcomes to enable people to maintain control and independence.

The Framework integrate with healthcare to deliver an 'Enhanced Health in Homecare' and will use assistive technology and training for carers to provide health monitoring to service users who have long-term conditions to identify early signs of deterioration, allowing health professionals to act early to enable better patient outcomes.

The Framework intends to deliver a Trusted Assessor model allowing care providers the ability to make minor adjustments upwards and downwards to Homecare packages to support the delivery of outcomes, enablement, and greater independence. Trusted Assessors will have the ability to 'prescribe' low-level aids and link Service users to services in the community.

In Havering a long established 'Active Homecare Framework' (now called Light Touch 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

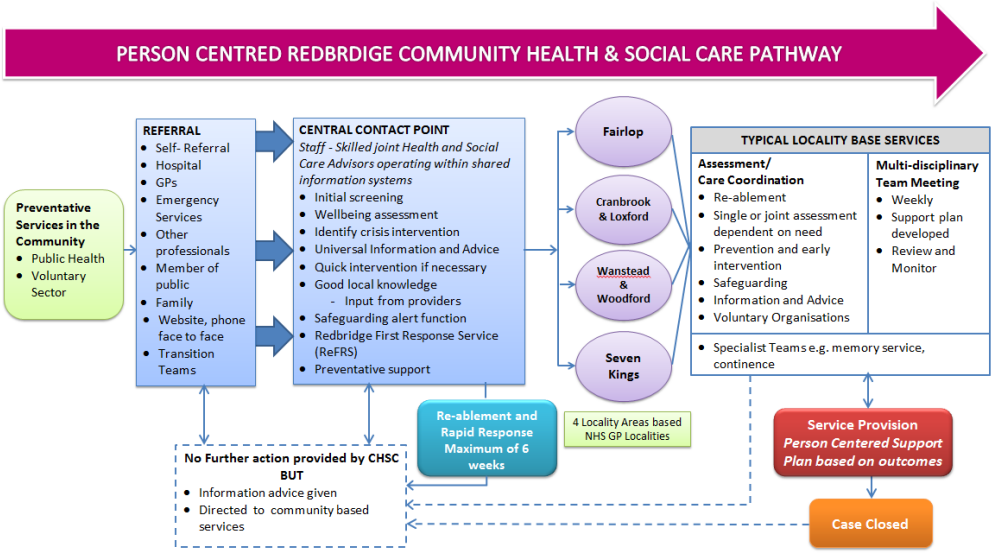
3.6 Strength-based approaches and person-centred care

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

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

Redbridge

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 Personalisation through choice, independence and care - through the use of Direct Payments, Self-directed support and complements personalised health budgets.



B&D

B&D have adopted a strengths-based approach as their social work practice model supported by a delivery model and framework which sets out Care and Support Services' intent over the next three years to develop and introduce a 7 strength and asset-based approach that informs our professional and management practice: and organisational culture across adult services. It will be reflected in our service structures and commissioning intentions; our partnership approaches; and most importantly our

engagement and relationships with communities and the Third Sector going forwards. The framework represents a fundamental change to how we engage with each other within Care and Support and the Council; and across the whole system with health and social care stakeholders and partners; and fundamentally with the Third Sector and with residents and communities, and how we support community led new and improved ways of working that will deliver greater community resilience and better outcomes.

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

Havering

Havering are encouraging the use of all available assets and it 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 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 have supports 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.

Data and established systems are used to 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.

We are committed to keeping Better Living alive through the importance of consistency of practice across all teams a high priority.

3.7 Voluntary Sector

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 a range of lower-level cost effective provision, to support our prevention and early intervention services. 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, NHS NEL 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.

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:

- Community and Voluntary Sector: The Borough commissions a number of community and voluntary sector organisations to support prevention and early intervention, such as befriending and support for carers to help reduce social isolation.
- Redbridge Social Prescribing: The Borough and NEL ICB 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. A new External Day Opportunities DPV has been developed and the inclusion of progression and independence is built into the services and with a focus on transitions. This is key to support reduce the reliance on (where possible) on high-need care services and promote better life skills for services users and carers.

In Havering, the voluntary and community sector is an important part of the market and these services are valuable to the community in preventing / delaying the need for statutory support.
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 and 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 of all ages are 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.
- Support to people coming from hospital – it is important that we ensure a smooth transition back to independent living.

These outcomes are what the services we commission focus in on, recognising that people face different issues and will therefore potentially need tailored services to address those needs:

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, the 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.

There is 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. Through the BD_Collective there are now a number of groups which bring together Care and Support staff and VCS colleagues.

A key element of our work with the voluntary sector has been via the Health Inequalities Programme, overseen by the Executive Group of the Barking and Dagenham Place-based Partnership Board. It uses innovative approaches to address local health inequalities challenges and strengthens leadership, partnership working and capacity building for tackling health inequalities at the Place level.

The cornerstone of the infrastructure investment of the 2022/23 programme is the Community Locality Leads model, led by Community Resources on behalf of BD_Collective, which aims to build a connected, effective infrastructure where resources in the system are maximised, residents are empowered and healthy life expectancy is improved. Locality Lead organisations - voluntary organisations across six areas in the borough - have held over 1500 conversations to date with residents to discover the resources people turn to within their own community in times of need and are mapping the estimated 3000 "connecting places" identified by local people - such as Parent & Toddler groups, places of worship, community gardens. Working with residents and other colleagues across the health and care system, Locality Leads are developing prototypes - such as a drop-in group for parents with children with SEND - that are to address cost-of-living challenges and foster connection, trust and belonging. This prototyping approach represents a new way of working (designing, testing, evaluating, adapting and testing again in an iterative, agile process) and BD_Collective are facilitating a "prototyping hackathon" to help Locality Leads and those they collaborate with succeed with this approach.
Working with BD_Collective, the Partnership has been able to better ensure that lived experience drives the decisions of what the health inequalities funding is invested in. For instance, through BD_Collective, the local community organisation Ultimate Counselling was appointed to lead on resources to better support residents who have No Recourse to Public Funds, and did so by engaging with 157 local residents with lived experience of having NRPF status. Through the Community Chest for Social Prescribing and a Participatory Grant-making pot to support children and young people with emerging mental health concerns, with the voluntary sector the Partnership is exploring how to distribute funding in a way that more grassroots voluntary organisations get to make the decisions. We will be taking the learning from the Health Inequalities Programme in our further work with the BD_Collective, particularly as we develop approaches around prevention and social isolation below.
It is recognised that social isolation remains a significant issue within Barking and Dagenham and the VCS, through the BD Collective have been running design workshops to develop and test longer-term approaches to social isolation in Barking and Dagenham. Some seed funding has been provided to progress community-based initiatives and Better Care Fund money has been earmarked to take forward innovative approaches in 23/24. One of these is to look at piloting a new social isolation model for 100 residents discharged from hospital who do not have support from family or friends. Care City will be running a workshop with system partners to design the model and the new model will be looked to be brought online from the Autumn.

3. 8 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.
Local Area Coordination supports outcomes together with all public sector partners and therefore the team is jointly funded by a range of partners together with the BCF. An early evaluation of the service was carried out and now that it has been operational for three years, partners are in discussion about expanding the service to further areas of Havering. Our ambition is that the LAC offer is expanded to cover the whole borough.

3.9 Locality Co-Ordinators

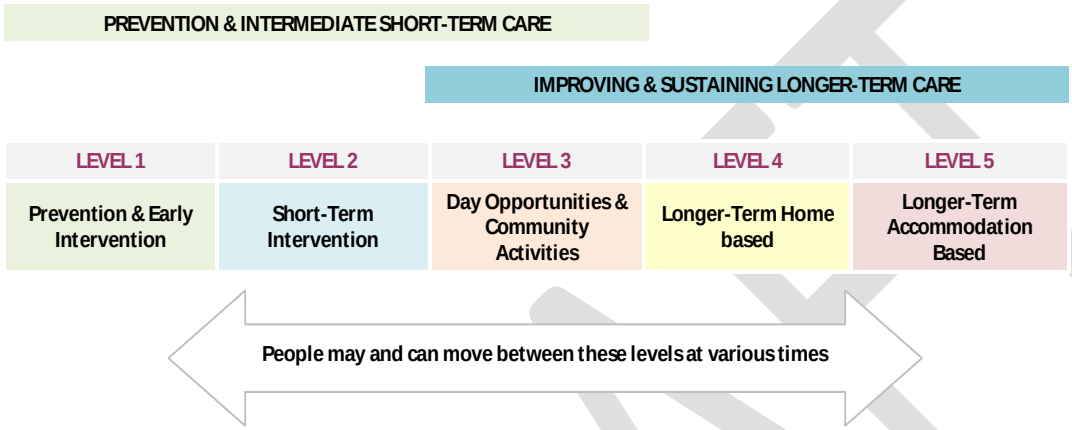
These roles are part of a new approach for Redbridge, designed to draw on the full potential of our community to support people to thrive. As a community coordinator, you will be a friendly face, to listen and understand what a 'good life' means for the people you meet in your work. You will explore how to build on people's strengths, and the strengths of those around them in their area, to understand how they can achieve their goals, and get their needs met, with the right kinds of support from a vibrant network of local partners. You will play a crucial role in connecting the contributions of family, friends, neighbour's, community groups, health and care partners and council service teams, enabling them to combine into effective responses to the needs and wants of older people and vulnerable adults.

They work as part of our Community Health and Social Care Teams and collaborate closely with our Community Hubs Programme Team and in developing community insight and networks. Our model aims to:

- Build individual, family and community resilience
- Reduce isolation and loneliness
- Increase choice, control and contribution
- Build inclusion and citizenship
- Simplify "the system" for the people who use it

Through achieving these outcomes, the overarching objective is to reduce demand for more intensive and costly services and interventions, meeting the needs of some of the most vulnerable in society before they reach crisis point. The primary objective for our model is to contribute to reducing A&E Attendances for people through Levels 1 to 2 as highlighted below, and lesson attendance at GPs.

Redbridge Social Care Support Levels



3.10 Personalisation

Havering

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

The implications for the market will be increased opportunities to respond to the demand that comes from individuals looking for choice in services that meet their outcomes. It will also mean the development of an extended and high quality personal assistant market and we will be looking to further develop regulatory arrangements to ensure quality for service users.

Our approach to contracts will recognise that our long term aim is to increase personalisation and micro commissioning. There are many interdependencies involved in taking personalisation forward. It is therefore intended that a programme of activities is initiated that will address some of the issues that are preventing the development of the market in Havering.

A large number of adults each year attend day services as part of a support package to meet their eligible social inclusion needs. We want to see a much wider and flexible range of services available to meet individual needs and to reduce the need for Havering to take an active role in managing placements into day services through increasing uptake of personal budgets for both service users and carers. This will allow the market to develop services that are more person centred to meet individual outcomes.

We have continued to develop the Personal Assistants (PA) market over the past few years. Going forward, we want to continue developing the PA market to give residents who use self-directed support more flexibility and choice in how they manage their care and support. In addition, the intention is to identify, recruit and accredit personal assistants to provide specialist services for adults and children with complex needs.

B&D

Over the last 2 years, B&D have been 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. As a result of this review, we have redesigned our Direct Payment Support Service to account for changes that our service users and social workers wanted within the service. Four key areas were identified to improve the service for our residents; Simplicity, Transparency, Hands-on Support & Comprehensive Reviews.

The redesigned Direct Payment Support Service is currently out to tender and will provide high quality and experienced information, practical advice, support and guidance on all aspects of Direct Payments. The service will assist residents with innovatively planning the best ways to use personal budgets whilst also maximising the support residents' access by considering services offered by voluntary sector and charity organisations. A key part of the redesigned service specification is employment and recruitment support to support our service users in their role as an employer. In addition to the support to residents, the new service will try to enhance our Personal Assistant market by helping with Personal Assistant retention and recruitment. The service will offer a Hub for Personal Assistants to advertise their availability and will fully vet Personal Assistants, allowing for speedy recruitment. The service will provide access to important training and will ensure all Personal Assistants on the Hub have undertaken Safeguarding training, giving the Council confidence in the Personal Assistants working with our residents. Approximately 28% of Adults receiving community care services are in receipt of a Direct Payment and the new Direct Payment Support Service will be available to all Adults who are either receiving or are interested in receiving a Direct Payment.

Redbridge

In Redbridge both service users and carers have the choice to choose their own services to meet their care and support needs through our Personalisation offer using Direct Payments or Personalised Budget. This can include areas such as:

- Paying someone to support you, such as a support worker or personal assistant
- Purchasing support through a service provider of your choice
- Paying for short breaks (respite care) for yourself or your carer
- Buying social or educational activities that you have been assessed for and need

Our Self-directed Support and Direct Payments teams help resident setup there care and identify appropriate services to meet their needs – either through purchasing a range of Council and/or Community based VCS services. In addition, service users can either manage their own DPs or choose to use a separate company (for a fee) to manage these on their behalf to deal with areas such as paying carers' wages, invoices, reconciliations and advice and guidance.

3.11 Integrated Community Equipment Service

The London Borough of Redbridge continue as the lead commissioner for the Integrated Community Equipment Service (ICES) as a Partnership between the three outer London places for the NHS, the North East London Foundation Trust and the London Borough of Havering through a section 75 agreement. The service was re-tendered and the arrangement includes sharing management costs

and the recycle of equipment which is pooled and utilised across partners. The London Borough of Barking and Dagenham has a separate Community Equipment service in place with Medequip.

3.12 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. 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.

In 2022, the Council's Digital Transformation team conducted an initial feasibility study to highlight the benefits and challenges of AT based on previous implementations. The findings of this feasibility study were presented to the SLT and wider Transformation Board for agreement as to whether AT warrants detailed investigation and the Council is currently producing a detailed Business Case for review and approval in 2023.

The Council's Havering Telecare Service provides several assistive technology products which include smoke detectors, fall detectors and bed/chair sensors to residents who are assessed as in need of this type of support. In 2023, an update of the current service level agreement between Adult Social Care, Housing and Havering Telecare Service will be conducted. As part of an on-going commitment to enhance the Havering Telecare Service, a stakeholders group will be established to regularly monitor the service.

Redbridge currently has a work stream around its approach and investment in assistive technology. We launched an 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. In addition, we have upgraded our Client Management & Care Finance systems with a new supplier and this has recently gone live and we are also upgrading our Lifeline and Telecare system to a digital platform.

In 2022/23, a new Care Technology service went live in Barking and Dagenham, transferring 2,440 residents from the former Careline service to Medequip Connect whilst maintaining service continuity and avoiding any break in connection to the monitoring centre. A series of immediate benefits of the new service have been felt by residents since the new service commenced including:

- The provision of a new falls pick-up service
- Support around ambulance strikes
- 627 new residents connected and over 3000 residents supported overall
- Provision of new digital technology to approx. 1000 residents

The launch of the new Care Technology Service was an important milestone for Care and Support and the local authority. However, the current service with Medequip has presented specific constraints, in particular the extent that the service has embedded within the local health and care system which has led to a reappraisal of our approach, including rethinking the ideal positioning of Care Technology in the wider scope of Digital Transformation, and the best vehicle to advance this agenda in the local health and social care environment. We are looking to develop a new partnership to take this work forward in 23/24 and will discuss more in our future BCF planning.

4. Metrics to support objective 1

4.1 Unplanned admissions for hospital for chronic ambulatory care sensitive conditions

In B&D the performance target was not met in 2022/23. The reason for this was post COVID impacts particularly around the identification and management of LTCs. This is being addressed through re -introduction of reviews and testing including bloods, BP, sugars etc. This may take several years to fully embed and impact on future acute presentation.

Havering met the performance target in 2022/23. However, post COVID impacts particularly around the identification and management of LTCs. This is being addressed through re -introduction of reviews and testing including bloods, BP, sugars etc. This may take several years to fully embed and impact on future acute presentation.

The Redbridge performance target was met in 2022/23. COVID still impacts particularly around the identification and management of LTCs. This is being addressed through re -introduction of reviews and testing including bloods, BP, sugars etc. This may take several years to fully embed and impact on future acute presentation.

4.2 Emergency hospital admissions following a fall for people over the age of 65

Havering, B&D and Redbridge all have a full falls service offer including Age UK Strength and Balance classes for early prevention, a Falls Service managed by NELFT with dedicated AHPs and nurses focused only those who have had a fall offering assessment, 1-1 interventions and falls prevention classes. A Falls practitioner is also working at PCN level to identify those at risk of a fall and what interventions are required. This includes looking at the PCN population who are at risk of a fall and stratifying these.

A separate care home falls team are attached to the main falls service and provide advice, support and training to care homes with a QI focus.

UCR work with those who have had a fall, including a UCR car (Nurse and LAS responder) with apparatus to support safe transition from being on the floor.

4.3 The number of people aged 65 or over whose long term support needs were met by admission to residential or nursing care homes per 100,000

B&D did not meet the target by approximately 18% (total of 789.6 per 100,000 population) in 22/23. This reflects challenges brought about by increasing complexity and acuity post Covid, which have led to the increased use of residential care. An increased proportion of admissions are from hospital discharges for people with complex and challenging needs. In addition, our Brokerage teams are reporting increasing use of residential care in comparison to a reduced use of homecare packages. We are looking at D2A home and D2A residential projects across BHR and will be interrogating the data to determine why there is this increasing use of residential care. We have also noted a slight fall in the average age at admission. In addition, we were asked to set targets based on previous performance and this has meant that performance during Covid has set a precedent for a target that was unrealistic. We stated that this would be challenging to meet in our planning template for 22/23. As such we have increased our target number for 23/24 and see this as a stretching target due to the acuity and complexity and increased discharges that we are experiencing. Despite limited capacity in the care market for such cases we continue to work with our system partners to address these issues. There are a range of commissioned and operational teams supporting this metric, including commissioned discharge to assess therapy beds, extra care discharge flats, the Integrated Discharge Hub and social work discharge and assessment teams. These schemes are listed elsewhere in this document.

Havering performed better than target by 6% (total of 557.2 per 100,000 population) in 22/23. The high proportion of older adults in the Borough always presents a challenge for this indicator so we will continue to monitor admissions closely whilst working to support other discharge pathways to ensure performance is maintained during 23/24. Consequently, the proposed plan for 23/24 has been set at the same number of admissions as this year which translates as a higher target against population growth, 550.1 per 100,000 populations.

Redbridge performed better than target in 2022/23 by 5% and achieved an admission rate of 460.9 per 100,000 of the population aged 65 and over. Redbridge continues to support a varied range of integrated health and social care services to prevent unnecessary hospital admission of premature placement in long-term residential or nursing care. For 2023/24 the planned target has been set by taking account of the level of admissions experienced during 2022/23, the actual figures for the first 2 months of 2023/24 and the ONS projected population increase for 2023/24. The actual number of planned target admissions is slightly higher than the actual figure for 2022/23 but if achieved would represent a performance improvement and a decrease in admissions per 100,000.

5. Demand and Capacity to support people in the community

Urgent Community Response

Whilst services do experience surge periods in the winter, heatwave periods, early autumn, demand which has increased over the last 5 years, now remains fairly stable. Services like urgent community response (the Community Treatment Team - CTT) see on a daily basis service capacity reached around 2-3pm, with demand dropping off as the evening goes on. With the additional Ageing Well funding, the service was expanded to deliver the 2-hour response time, including an additional an additional phone line for managing triage.

Demand

Al BHR places over performing against the 70% target for 2-hour response, which is consistent throughout the year. (B&D 87%, Havering 84% and Redbridge 87%) and demand for the 2-hour response meets capacity available. A quarterly ICB and CTT meeting is held to review performance and themes for the service was established from spring 2023. Work to review the service capacity and demand will be actioned here and report to the BHR places UEC Improvement Board. There is also a twice monthly touch point meeting with the IC services to discuss live issues and future planning.

Rationale
Data included in the BCF Demand and Capacity plans reflects the activity and data submitted for the CSDS.

Barking and Dagenham
The demand and capacity figures for Barking and Dagenham in 22/23 were broadly in line with what was submitted in the Demand and Capacity template for 22/23 in terms of social support referrals and reablement. As outlined elsewhere in this document, residential care home usage is high reflecting challenges brought about by increasing complexity and acuity post Covid, which have led to the increased use of residential care. We are looking at this within our plans for interventions in the community such as low level support at home, reablement, homecare and extra care flats and will be interrogating the data to determine why there is this increasing use of residential care.

Havering
In Havering, the demand and capacity figures in 22/23 were mostly in line with what was expected. There is generally a very low referral rate into Reablement from the community, this will change in 2023/24 when we introduce the new referral pathways into the service directly from primary care. We expect the referrals from the community to significantly increase in 23/24 as we focus on early intervention and prevention.

Redbridge
Work to reduce admissions to residential and nursing homes has been ongoing through using Home First, and Reablement schemes instead where possible. Although demand for bedded care was high the effectiveness of our improved Reablement service to take on more challenging cases has enabled to support the reduction in residential admissions and high-cost care packages. Therefore, there was a significant number of additional clients discharged to the Reablement service during 2022-23, and to meet this demand the service doubled the number of visits per day. Community referrals remain low but work with our Community Health & Care teams is ongoing to increase uptake of this service. Increases in demand and capacity for Reablement are constantly monitored.

It is recognised that demand for the services fluctuates throughout the year and services commissioned need to be able to respond flexibly to these variations.

6. National Condition 3 - Provide the Right Care in the right place at the right time

Barking & Dagenham, Havering and Redbridge are adjacent boroughs/places 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 and places to work together to achieve the best outcomes for the whole population

All of our priorities 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, the BCF monies are targeted towards our priorities in supporting this flow. This is 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 integrated Discharge Hub (IDH) D2A and Home First can be implemented. Joint system working groups are in place to ensure that these are being constantly monitored and refined between all partners.

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.

All three boroughs/places have used the BCF to support discharges and improve outcomes for residents when they come out of hospital.

We have worked collaboratively 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 the Integrated Discharge Hub (IDH) for discharges across BHR places, streamlining discharge processes and giving local authorities a greater degree of management over care packages from their start. Key to the success of the IDH 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. This is now commissioned on a recurrent basis funded by the LAs, ICB and local Acute Trust.

The BCF is crucial in supporting our pathway 0 offer in terms of 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 an example of effective joint commissioning; the service being jointly commissioned by all three boroughs and NHS NEL.

Pathway 1 is supported predominantly through Home First alongside Reablement and crisis intervention from homecare agencies in B&D. Crisis Intervention in B&D is the free service provided for a period of up to 6 weeks at point of discharge. Similarly, for Havering & Redbridge reablement is used as the default offer for this pathway. 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 including discharge to assess. This pathway places individuals into nursing home beds that are supported by a therapy team for a 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 with 30% of people returning home following the 6-week assessment period. The scheme was extended to B&D and Redbridge in 22/23 with a total of 20 beds available.

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, extra care flats 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 B&D 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 ICB commissioning services with Barts. Therefore, the LA works very closely with both acute providers in supporting its discharge process.
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 2022-23. This not an exhaustive list of every service provided by every borough and ICB 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 **Planning Expenditure templates**.

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.

Schemes to support the delivery of objective 2 include

BCF Objective	Scheme Types
2. Providing the right care, at the right place, at the right time	High Impact Change Model Enablers for Integration Residential Placements Home Care or Domiciliary Care Home-based intermediate care services Home First Integrated Care Planning and Navigation Reablement in a person's own home

7. Discharge schemes to support delivery of Objective 2

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

7.1 Discharge to Assess

The D2A pathway across BHR is now fully established with 20 commissioned beds in 2 nursing homes. These beds are supported by a team of therapists who work with the resident for up to 6 weeks during what would traditionally be known as the CHC assessment period. This was initially piloted in Havering and following evaluation was extended out to the other Boroughs. The pathway has been effective in improving outcomes and cost effectiveness with 30% of people returning home following the 6 week period. Other benefits include the streamlining of the discharge process and subsequent reduction in length of stay as a result of having the pre-arranged (block booked) beds available. There have been some challenges regarding people being placed outside of this pathway due to current exclusions and communication issues, this is being managed with weekly operations group meetings. The LA and ICB leads are working in partnership with BHRUT to develop the specification for this pathway going forward to ensure maximum utilisation.

In addition to the nursing D2A pathway, Havering are leading on the initiation of a Residential D2A pathway. This will follow the same principles as the nursing pathway with therapy support aligned to a number of block booked beds. It is expected that similar benefits will be realised with an increase in the number of people able to return to their own homes following an initial assessment period in the residential beds.

Whilst both the D2A schemes are very positive in terms of improving outcomes and ensuring people are able to return to their own home, as a system we need to shift our focus to keeping people out of residential and nursing settings in the first place. In 2023/24 a 3rd D2A pathway will be implemented which will focus on people going home immediately from hospital with 24/7 care (initially) and will receive therapy support and assessment in their own home. This is currently being developed and is expected to be implemented in the Autumn.

7.2 Home First

Each borough now embedded a Home First approach which includes a therapy team, reablement care and access to equipment in the community.

Havering continued to develop the Home First model in 22/23 working in partnership with BHRUT and the Reablement provider to streamline the discharge process providing a full assessment at the person's home post discharge. This was trialled as the default discharge pathway (pathway 1) for a period of time but the demand significantly exceeded capacity so this has been reviewed. The Reablement service is being recommissioned in 23/24 and the Home First assessment model is being developed as part of the specification. Stakeholders are working collaboratively to develop this model ensuring that minimal assessment is required at the point of discharge and there is enough capacity in the service to ensure a same day / next day response.

Redbridge have also used their commissioned Reablement service to pilot a Home First pathway and have increased the number of daily slots available to support discharge. The trend of increased demand for reablement services is likely to continue and further development opportunities will be explored to improve capacity to meet this including periods of peak pressure.

B&D continue to work with Redbridge Reablement Service (RRS) in providing the home first service pathway. There are 10 spots available a week (2 a day Monday to Friday). This accounts for the majority of the pathway 1 discharges from BHRUT hospitals. Throughout 2022/23 the home first model was expanded to include a reablement option which was delivered by RRS. This was

funded through the Adult Social Care Discharge Fund and we will be looking to continue expanding this reablement trial through the use of Discharge Fund monies in this BCF planning round.

There are challenges with the shift towards the Home First / Reablement model being the default pathway namely the significant volume of referrals and associated cost and staffing resource required. The system will continue to work together to specify how this can work most effectively going forward and if a move towards a *true* Home First model is agreed with care being described in the hospital and prescribed in the community – this will need to be properly funded and resourced.

7.3 Ward Led Enablement

Havering are leading on a Ward Led Enablement pilot to trial the introduction of reablement staff on 2 care of the elderly acute wards. It is intensive support that enables adults to begin their Reablement whilst an inpatient, helping the person to do for themselves rather than having everything done for them, changing the culture of staff and patients. The expected outcome is to eliminate the hospital acquired deconditioning many patients experience whilst in acute hospitals increasing the patient's confidence in returning to their home environment. This will result in an improved discharge outcome, reducing average length of stay and being ready for their transition home.

7.4 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 is now recurrently funded by the LAs, ICB and local acute trust. The service will be refreshed in 2023/24 to increase the number of homes accessing and utilising the offer.

7.5 Integrated Discharge Hub

A key priority across and health and social care was the development a robust and sustainable discharge unit across BHR. 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 was embedded in 21/22 and the service became a formal Integrated Discharge Hub in July 2022 servicing both health and social care.

In 2021/22 external support was sourced to support the system to review discharge approaches. The outcome report has been used to further support understanding and developing services and pathways in 2022/23 alongside the 100-day challenge for the end of September 2022, to address any gaps against the 10 standards to deliver a good discharge offer.

The IDH has also been developing a data app for all discharge information that can be accessed by all partners. At present Power BI slides give an overview of pathway flow, however it is intended that this will be an online line with monthly and eventually weekly updates.

7.6 Rehabilitation

NHS North East London 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.

28 Discharge to Assess block booked across are available across the 3 places and delivered over 3 care home sites. 30% of patients who went through the block booked bed base with a wraparound rehab team are returning home.

7.7 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 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.

The LA has increased the number of available daily slots for reablement to support hospital discharges and locally this now also supports all of the primary discharge routes inclusive of Whipps Cross as well as BHRUT. This has included the Home First pilot specifically to support rapid discharge from hospitals – this augments the reablement services available for local residents. This is a joint programme for reablement which is led by LBR and NELFT. The success of the increased capacity demonstrates positive results for individuals receiving the service and directly supports more rapid discharge. The trend of increased demand for reablement services is likely to continue and further development opportunities will be explored to improve capacity to meet this including periods of peak pressure. The approach is twofold firstly direct capacity increases in the service to increase available slots, and secondly to identify alternative delivery or interim / holding positions so that discharges are able to be facilitated during peak periods and for reablement services to then commence as capacity becomes available subsequently.

Preventative strategies to prevent footfall in the acute units and better support treatment for individuals in the community are in active development such as the enhanced homecare model which will provide active monitoring of functions especially for those with long term illnesses and provides an alert and pathway to provide more effective and rapid support in the community avoiding unnecessary escalation to emergency services, or visits to acute units.
The early development of rapid response to peak pressure for example deployment of mobile homecare teams to support hospital discharges has been used successfully to prevent the overloading of reablement services that occurred during strike action and during the winter pressure. The lessons learned from this has identified both the mechanism and expectation to facilitate rapid standing up of these services for the future which is directly supported by the local homecare market.

Step-down facilities continue to present both challenges and opportunities. The extra-care service provides capacity to support interim / step down from hospital and continues to be a facility available. Other alternatives such as repurposing or utilising the capacity available in the supported living market to support both respite, interim and potentially to convert to use for extra care are being considered which would improve the overall capacity to support hospital discharge flow couple with opportunities for assistive technology to promote care at home.

Havering's Reablement 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 significantly exceeded what was expected when the service was commissioned, this was been exacerbated by the pandemic, but demand continues to be at unprecedented levels. This is also partly due to the shift towards Reablement / Home First being the default discharge option for pathway 1. Managing demand is a significant challenge but in terms of quality, the service is providing very positive outcomes. The service is being recommissioned in 2023/24 which presents 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.

7.8 Community Reablement

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. Havering are piloting a community reablement service in 2023/24 which will provide ring fenced community capacity to accept referrals from primary care / the community. It was initially envisioned that this would develop alongside the Proactive care model MDTs however following consultation with primary care this will be piloted with one PCN and will allow referrals outside of the MDT model as well.

7.9 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. Over the winter of 2022/23 we utilised the Adult Social Care Discharge Fund to support innovation in discharge and ensured flow out of hospital beds. One of the main areas that this covered was reablement. We ran a reablement pilot from January 2023 to April 2023 which supported people who were being discharged through the home first pilot. They received 6 weeks of therapy services with the aim of regaining independence and no longer requiring ongoing care. This pilot was a success with over 70% of those going through the pathway not requiring ongoing care which was an improvement in comparison to our crisis intervention model. We will be using the Discharge Fund within the BCF planning round to support a second phase of this pilot to determine our longer-term approach to reablement within Barking and Dagenham, replacing our crisis intervention model, looking to tender for a reablement service later in 23/24.

7.10 Home, Settle & Support

The BHR British Red Cross Home, Settle and Support Service (HSSS)commissioned by the local authorities and the ICB is embedded into the Home First and Frailty hospital discharge pathway, a large portion of the referrals come from these pathways. Welfare calls are carried out upon hospital discharge and assessed for further support. The short term Support includes but is not limited to:

- Meet at home, settle support
- Assessment and Goal Setting
- Prescription collection
- Liaising with family and professionals to support transition from hospital to home
- Form filling and benefits checks
- Light housework such as cleaning fridge, bed making and hoovering etc
- Essential food shopping
- Signpost to other services within the community

The main goals of the service are to help people feel more safe and secure when they discharged from hospital, reduce their anxiety, reduce social isolation and increase their ability to manage day to day things when they get home.
Over 50% of residents using the service live on their own and are aged over 80 years. In April-March 2022, the service received 2933 referrals of which 1315 went on to receive further support after their initial welfare check.

7.11 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 required 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.

B&D piloted 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. The commissioned flats have been successful and will be made a long-term arrangement to support discharge as part of the next iteration of our extra care service.

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.

8. Demand and Capacity for intermediate care to support discharge from hospital

Bedded Rehabilitation Community:

The contract has a baseline of 52 beds with a flex to 57. With current demand, 57 beds are open all year. During the winter period (November to the end of April) 61 beds are open to support demand and flow. The average occupancy is 54 beds pa and increases to 57 during the winter. Full bed utilisation of the 61 beds was reached for two weeks only in 22/23.

Nearly all patients are step down from acute. A small number of step up are patients who are awaiting IRS intervention and on review.

Intensive Rehab Services:

The 21-day rehabilitation team supports over a 100 people per day. Demand has increased (65% increase in referrals since 2017), but the key service pressure is with those needing 2-1 support e.g. non-weighting (68% of support is to double handed patients). This is has led to a waiting list of 30-50 at a single point in time for those discharged, who are safe but awaiting IRS intervention at home. This waiting list is not for those being discharged from acute and these are prioritised to support hospital flow.

Demand is managed in year through additional investment in the winter period and to support waiting list management clearance.

An IRS and ICB monthly meeting is monitoring and managing demand going forward.

Home, Settle & Support (HSSS) – BHR wide

Capacity has increased significantly within the Home, Settle and Support service over the last 12 months for Barking and Dagenham Havering and Redbridge residents discharged from hospital. The Demand and Capacity template for 22/23 stipulated that there was capacity for 34 B&D referrals to the service when there were 42 referrals on average to the service per month. Havering referral capacity was 82 referrals each month and the service received 147 referrals, Redbridge had capacity for 27 referrals each month and received 52 referrals. The majority of these referrals were through the home first pathway. On average 79 per month required further support following welfare check. These figures will look to maintain or increase further in 23/24 in order to support hospital discharge and reduction in readmission.

B&D

In terms of reablement, the figures indicated in 22/23 were broadly in line with the demand and capacity experienced. We are looking to remodel and improve our reablement response through a new reablement model and we will be testing this through a second phase of a reablement pilot and looking to tender this in 23/24.

Havering

In Havering, the demand and capacity figures for reablement have exceeded expectations. There were some changes to the pathway in line with the shift towards Home First which increased the demand for the service, in turn LBH then commissioned additional capacity to meet that demand. The demand and capacity patterns are currently being analysed in more detail for the recommissioning exercise.

9. High Impact Change Model for managing transfers of care

Each Place has recently reviewed progress against all of the HICM areas which are all key themes at the Discharge Improvement Working Group (DIWG.) All of the HICM areas also feature in the key discharge related schemes.

HICM Area	B&D	Havering	Redbridge
Change 1: Early discharge planning	**Mature** Discharge coordinators on most wards working with ward teams to identify issues early. Discharge checklist implemented on admission to raise issues earlier in-patient journey. Daily conference calls with System MDT to raise any issues as soon as they arise.	**Mature** Discharge coordinators on most wards working with ward teams to identify issues early. Discharge checklist implemented on admission to raise issues earlier in-patient journey. Daily conference calls with System MDT to raise any issues as soon as they arise.	**Mature** Discharge coordinators on most wards working with ward teams to identify issues early. Discharge checklist implemented on admission to raise issues earlier in-patient journey. Daily conference calls with System MDT to raise any issues as soon as they arise.
Change 2: Monitoring and responding to system demand and capacity	**Mature** Daily escalation calls and monitoring of internal and external delays are monitored daily. With escalation to partners where necessary. Development of performance dashboard for the Integrated Discharge Hub.	**Mature** Daily escalation calls and monitoring of internal and external delays are monitored daily. With escalation to partners where necessary. Development of performance dashboard for the Integrated Discharge Hub.	**Mature** Daily escalation calls and monitoring of internal and external delays are monitored daily. With escalation to partners where necessary. Development of performance dashboard for the Integrated Discharge Hub.
Change 3: Multi-disciplinary working	**Mature** MDT board rounds in place on each ward. Daily system calls to discuss patients who are medically fit to leave hospital. Review of IDH function. Discharge survey launched internally and externally to review implementation of the discharge guidance during Covid. This will close 30th June and then be evaluated.	**Mature** MDT board rounds in place on each ward. Daily system calls to discuss patients who are medically fit to leave hospital. Review of IDH function. Discharge survey launched internally and externally to review implementation of the discharge guidance during Covid. This will close 30th June and then be evaluated.	**Mature** MDT board rounds in place on each ward. Daily system calls to discuss patients who are medically fit to leave hospital. Review of IDH function. Discharge survey launched internally and externally to review implementation of the discharge guidance during Covid. This will close 30th June and then be evaluated.
Change 4: Home First discharge to assess (D2A)	**Established** Home First offer (Assessment at home and care support) now in place supporting up to 10 same/next discharges per week. Discharge to Assess for pathway 3 also in place with a therapy team supporting a fixed number of beds in the community during the assessment period. There are plans to move towards getting more people discharged to their own home with it being the exception that a bedded placement is required Discharge to Assess for pathway 3 also in place with a therapy team supporting a fixed number of beds in the community during the assessment period. There are plans to move towards getting	**Mature** Home First is embedded in the Havering system of care, with a single provider for assessment and reablement. The service has bene successful and care hours available frequently. There is a plan to have increased hours available going forward. Discharge to Assess for pathway 3 also in place with a therapy team supporting a fixed number of beds in the community during the assessment period. There are plans to move towards getting more people discharged to their own home with it being the exception that a bedded placement is required	**Mature** The Home First offer has developed over the last few years. 15-20 places are offered weekly with assessment and reablement support. Discharge to Assess for pathway 3 also in place with a therapy team supporting a fixed number of beds in the community during the assessment period. There are plans to move towards getting more people discharged to their own home with it being the exception that a bedded placement is required

HICM Area	B&D	Havering	Redbridge
	more people discharged to their own home with it being the exception that a bedded placement is required		
Change 5: Flexible working patterns	**Plans in place**	**Established**	**Mature**
	- B&D currently reviewing arrangements for seven day working in social work teams	- BHRUT lacks sufficient resources to have a successful 7-day discharge plan however LBH have a trusted assessor model which supports restarts, reablement, out of hours support and a Social Worker is available 6 days per week. There are not enough discharges on a Sunday to require a social worker.	The Hospital Social Work team have flexible working patterns in place and cover seven days a week.
Change 6: Trusted assessment	**Established**	**Established**	**Established**
	Care Home TA in places working across BHR places. 52 assessments offered per month.	Care Home TA in places working across BHR places. 52 assessments offered per month. Trusted assessment process in place for ASC at the point of discharge Trusted assessment in place as part of the Home First pathway into Reablement.	Care Home TA in places working across BHR places. 52 assessments offered per month.
Change 7: Engagement and choice	**Established**	**Established**	**Established**
	Leaflet being designed to incorporate guidance for discharge and future signposting for Patients and their carers. This has been done in collaboration with carers group and system partners. Choice and control fundamental part of Care Act duties.	Leaflet being designed to incorporate guidance for discharge and future signposting for Patients and their carers. This has been done in collaboration with carers group and system partners. Choice and control fundamental part of Care Act duties.	Leaflet being designed to incorporate guidance for discharge and future signposting for Patients and their carers. This has been done in collaboration with carers group and system partners. Choice and control fundamental part of Care Act duties.
Change 8: Improved discharge to care homes	**Established**	**Established**	**Established**
	Care home trusted assessors in place, discharge to assess in place and evolving. Care Home Provider Forums explore issues with discharge processes. Named GP in place.	Care home trusted assessors in place, discharge to assess in place and evolving. Care Home Provider Forums explore issues with discharge processes. Named GP in place.	Care home trusted assessors in place, discharge to assess in place and evolving. Care Home Provider Forums explore issues with discharge processes. Named GP in place.
	Established	**Established**	**Established**

HICM Area	B&D	Havering	Redbridge
Change 9: Housing and related services	Housing and homelessness issues are considered as part of discharge and issues worked through at Discharge Improvement Working Group. Discharge Fund supporting complex discharge issues, including homelessness, hoarding and cleaning and extra care discharge flats. Home, Settle and Support service supports housing issues and ongoing referral. Regeneration business (Be First) and Council's Inclusive Growth directorate work closely with Care and Support and health to look at regeneration and market issues in relation to housing/homelessness for long-term planning e.g. Barking Riverside	Housing and homelessness issues are considered as part of discharge and issues worked through at Discharge Improvement Working Group. There is a Homeless coordinator that attends the hospital – joint working across partners to support discharge. Work closely with housing team Extra Care support is utilised to support discharge where appropriate. In response to the increasingly high demand for housing services there is a large regeneration programme being delivered across the Borough	Adult Social Care is working closely with Housing in a number Housing related projects. Redbridge is experiencing a very high demand for accommodation and increasing pressures for temporary accommodation. Our services such as Home, Settle & Support, a Hoarding Cleaning Service, Reablement Equipment services, Telecare and Carers Support Services can provide a range of advice and support in helping people back home into a safe environment. Our Drug & Alcohol services are working with Housing around those residents with addiction to support them in sustaining their accommodation.

10. How we have used iBCF and ASC Discharge fund to ensure that duties under the Care Act are being delivered

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.

Across all three Boroughs, and NEL more widely, £150,000 of the ICB allocation of the Discharge Fund money will be used to undertake some NEL-wide market sustainability work with care providers. This will include the following during 23/24:

- Produce a NEL-wide position for our care market
- Understand the current capacity pressures across our care sector – including home care, residential care, supported living and nursing care
- Understand what current commissioning practice looks like by local authorities and the ICB CHC team recognising the different pressures and drivers
- Consider the development of a process for joint oversight and management of the market across health and care, with options for integration at Place and across NEL
- Develop a mechanism for oversight of demand and capacity pressures within the market
- Develop better relationships with the care market across NEL by having a one NEL approach
- Identify the current and future gaps in provision and work with the care sector and NHS partners to close those gaps
- Consider what new models of care could be implemented

For Barking and Dagenham, the Adult Social Care Discharge Fund money is being used to deliver investment in social care and community capacity to support discharge and free up beds. As seen in our planning template, this includes:

- Phase 2 of our reablement pilot to support discharge to the community and prevent re-admission. This will inform our longer-term approach for reablement and inform our tender process
- Support for complex homelessness discharge cases particularly in relation to accommodation and social work capacity
- Commissioning capacity to support discharge interventions and development of our reablement approach
- Unfunded homecare and crisis intervention packages
- Unfunded residential, nursing placements and supported living placements
- Workforce initiatives to support recruitment and retention market challenges

In Havering the ASC discharge Fund is being used predominantly for unfunded homecare, residential and nursing placements.

In Redbridge, the Adult Social Care Discharge Fund money is also being used to deliver investment in social care and community capacity to support discharge and free up beds. As seen in the discharge fund reporting template, this includes the following scheme types:

- Homecare or domiciliary care (long term)
- Reablement in a person's home
- Care home placements (Residential – long term)
- Care home placements (complex / nursing)
- Workforce recruitment and retention
- Assistive technology and equipment
- Spend on other areas including admin, contingency etc

In Redbridge, the Adult Social Care Discharge Fund money is also being used to deliver investment in social care and community capacity to support discharge and free up beds. The Redbridge ASC Discharge fund supported a number of areas with discharge planning and capacity. There were:

- Additional or redeployed capacity from current care workers including agency staff, local staff banks and redeployment of other LA staff: It proved difficult to recruit additional social workers for mental health due to skilled workforce capacity and the demand for workers in this area. However, the additional funding was used to deliver extra capacity within the urgent discharge team.
- Assistive Technologies - Telecare and Community Based Equipment: The demand for equipment and Telecare services was far greater than had been expected resulting in a much higher spend in this area.
- Bed Based Intermediate Care Services including mental health beds and step-Step down (discharge to assess pathway 2): However, the anticipated demand in step-down intermediate care beds and those for Mental Health was not at the levels planed.
- Home Care or Domiciliary Care packages: The demand for Home Care packages over 2023-24 was high and utilising the ASC discharge monies allowed additional packages to be put in place to support people at home and prevent re-admissions to hospital.
- Residential Placements in Care Home and Nursing Homes: The demand for both Care Home and Nursing Home Placements over 2023-24 was high and additional discharge monies allowed additional placements to be put in place proving essential care to service users.
- Reablement in a Person's Own Home and Reablement, both community and discharge: Extra funding enabled the extra capacity to deliver Reablement services to support people to regain their independence at home and reduce the need for relapse back into hospital or high-cost Home Care support.

In B&D the iBCF is used to support the delivery of the care and support statutory guidance, as well as particularly the Care Act principles of prevention, wellbeing and safeguarding. This is done through a number of functions and services funded via the iBCF including homecare, reablement and crisis intervention, mental health support, support to manage safeguarding and DoLS, care navigation and planning, supported employment, care technology, equipment, adaptations, placements and packages to support demand growth, direct payment support, joint commissioning resource and systems to support integration.
In addition, the iBCF is also used to deliver on our market oversight and stability duties. This includes financial support to ensure market stability and sustainability, as well as support around the key challenges facing the market regarding workforce recruitment, retention and training. Our funding for Grey Matters Learning supports this in particular. Through our Fair Cost of Care exercise and our market engagement work, the local authority has moved to a position of offering an uplift which works towards the Fair Cost of Care, as well as enabling our providers and direct payment recipients to pay London Living Wage to their staff. This has come at a significant cost to the local authority but has considerably supported our market, local economy and workforce. We have also

developed a Health and Social Care Economic Sector Plan which is looking at the way that our local economy supports and boosts career development, progression and pay within the health and social care sector and we are working across the partnership to address these issues.

LBR continues to support the provider market in what continues to be challenging circumstances with the increase in the cost of living and the impact this is having on post Covid recovery. LBR has run a number of forums utilising both in person and digital online facilities available. Providers have been engaged with in terms of the best approach with future engagement through surveys and discussion. There is commitment to run three in person forums along with up to 8 online forums over the course of the year. These are timetabled and providers are actively encouraged to identify topics and themes for discussion.

As expected the key themes affecting the market are fees, inflationary cost pressure and workforce stability. This year following the implementation of London Living Wage with the homecare market we are developing a strategy and phased approach to introducing LLW to all other social care markets. This will likely take place over two years before full implementation can be expected, however, this would support the workforce stability and following the lessons learned from the homecare implementation of LLW support the direct cost increases that providers are facing. There is a further underlying pressure which is affecting certain markets more than others which is under-utilisation and impact of voids this is particularly apparent with Supported Living where there is a large number of providers locally where demand remains low in comparison to supply. We are looking at ways in which supported living could be utilised differently to support the market specifically around transition for young people to adults but also discussing repurposing supported living to provide interim discharge pathways or other forms of support such as extra care. We continue to develop ways in which assistive technology can be utilised to support individuals in their own home including an enhanced homecare model to support preventative strategies in our care offer.

In Havering the iBCF is used to support delivery of care and support as defined under the Care Act. There are a number of services that are funded (wholly or in part) by the iBCF monies, this includes homecare, residential care, nursing care, information and advice and assistive technology. Some of the funding also goes towards our contribution towards the Integrated Discharge Hub which is promoting integration of care and support with health service

11. Supporting Unpaid Carers

The pandemic clearly brought into the forefront the issues faced by carers. In addition, it also created an increase in the number of unpaid carers and hidden family carers - highlighting an already underrepresented cohort of people. However, while some of those caring may have since reduced since lockdown eased and service users and their families allow social care services to provide home services and day centres re-open it provided clear evidence of the needs for carers to receive support and wellbeing.

Given the increase of people needing care as we live longer, less people who are less able to self-fund and the complexity of long-term health needs (including LD & MH), the demand and pressure on the health and care system will increase. Therefore, supporting all carers where identified is essential to help manage demand, support those being cared for and provide essential support for carers to reduce and minimise carer breakdown.

The new ONS Census 2021 data releases on Carers will also provide a clearer picture across the individual places and NEL ICB of how this has really changed since 2011.

Across the system we are looking at this in a number of ways:

- BHR Carers Group
- Improved Carers advice, support and MH services
- Targeted and increased identification of unpaid carers through front door services and in speaking with family members and services users
- Promoting services for understanding who carers are and what support they can get
- Carers Forums
- Promoting service benefits on carers for using services such as reablement and implementing a progression model for people with LD to develop independency skills rather than dependency throughout their life
- Closer working with local community and faith groups

- Through the re-commissioning of services, build into services as core work around the identification and support of unpaid carers

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.

Redbridge

In Redbridge, we have updated and refreshed our All-Age Carers Strategy 2023-2028. We undertook a range of engagement activities in partnership with our commissioned services whereby carers were invited to share and provide feedback on services in Redbridge. The group discussions encouraged carers to consider the services received from the partner organisations, where improvements could be made and recommendations for future services and this feedback was also used to develop the priorities as part of the new Carers Strategy. This also linked in with Carers week where carers had the opportunity to outline the top five priorities. These were:

- Involve, listen and respect the choice carers have in planning the care and support which the carer and cared for person receives – enabling safe, effective and personalised care
- Recognise and raise the profile of carers (of all ages) in the borough: and support residents to identify themselves as a carer early in their caring journey
- Support carers to have a break, access respite services and pursue their personal goals (e.g. educational, employment, recreational)
- Support carers to find information and advice regarding their caring role
- Supporting young carers, so that children and young people are protected from inappropriate caring roles and have the support they need to learn, develop and experience positive childhoods

As a result of our engagement exercise, LBR have produced a strategic Carers Charter that has been developed with unpaid carer and includes informed a subsequent action plan. This will shape our strategic approach to our unpaid Carers offer going forward.

B&D

B&D have developed a Carers Charter for 2022-2025 and associated Action Plan, which acts as a framework for the delivery and development of services, working practices, identification and support of unpaid or informal carers in the borough, through a partnership approach.

The Carers Charter comprises a series of "I" statements that have been co-produced with carers in the borough alongside key stakeholders from health, social care and the community and voluntary sector.

The Carers Charter supports participation and engagement with residents and partners. The outcomes defined in the "I" statements of the Carers Charter and Action Plan will enable carers and their loved ones to thrive and live independent and healthy lives. This is accomplished through joint working across the partnership and bringing carers to the forefront of service delivery. Building on existing partnerships with health and the community and voluntary sector, the Charter works towards developing effective pathways with partners to identify 'hidden carers'. Hidden carers are those who do not recognise themselves as a carer or are not known to services as providing an informal, unpaid, caring role.

Some of the work that has progressed in 22/23 has included:

- The ICB working in partnership with the Carers support service to promoted access to Carers Support through the GP screens.
- The development of training for frontline workers for awareness raising and identifying hidden carers
- A carers discharge pathway is being developed with partners across BHRUT, social care, ICB and the community and voluntary sector. This project focuses on timely information and advice to carers at the point of discharge for the cared for. The project will deliver information tools for all three boroughs that feed into the BHRUT hospitals.

Alongside the Carers Charter, Barking and Dagenham continues to commission the Barking and Dagenham Carers Hub.

Havering

Havering Council commission the Havering Carers Hub to provide support to unpaid carers in the borough. This is an established service, which promotes carer-focused activities and partnership working with other agencies and partners, such as Health, to ensure unpaid carers are identified and supported. If the Carers Hub identify a carer who is in need of respite, they refer them for a carer's assessment to understand their needs. The Council, Health and Carers Hub are also working together to develop ways to identify unknown 'hidden carers' to ensure everyone who needs support can access it.

Beyond the assessment to identify carers needs, the Carers Hub also offer network groups (and days out) for carers in Havering who want to get involved. They provide activities for the cared for person to give their carer a break and offer a range of activities on their site including training workshops for carers, Informal Advocacy, emotional support individually or in a group, peer support groups, social activities, telephone support and online digital forums (for those who cannot get out). In addition, Carers Hub have developed relationships with providers offering specialist support which unpaid carers can access, including the BCF funded services provided by the Alzheimer's Society, MIND and Havering Association for Disabilities (HAD). Carers receive a seasonal newsletter with upcoming events and relevant important information.

Monthly 'coffee mornings' are held in Romford for carers to meet up face-to-face with often specific topics or themes with a space to exchange experiences and provide support to each other. Coming out of the pandemic, meeting up has been valued by carers to not only network with each other, but also provide a balance of socialising and a couple of hours away from their caring duties. As a Council, we use this as a mechanism to engage with carers, for example, in July the Council attended part of the coffee morning to present the creation of our new Carers Strategy and gain input from the carers themselves – as part of the co-production process.

The strategy has been revised and refreshed, with wider stakeholders input, to improve the offer for unpaid carers in Havering. The strategy will be signed off by cabinet in August 2023 and focuses on improving the key priority areas identified in partnership with carers, including:

- information accessibility and availability (e.g. financial or legal advice but also awareness of events being held),
- improvement in the quality and accessibility of the carers assessment to produce meaningful outcomes,
- improved communication with the Integrated Care System to ensure smooth discharge pathways,
- a focus on GP accessibility and awareness of carer roles
- more short-term respite activities.

The new strategy is called "Havering strategy for those who provide informal and unpaid care", which reflects the feedback from people that local carers just don't identify themselves as a carer. It has been created in an easier to read accessible format and in addition a flipping book has been created for Young Carers that will be published on the children's website, which is a first step in using media and technology appropriate for this generation.

In addition, Carers' Voice (a group of carers that meet regularly with professionals) is being relaunched after a hiatus caused by the pandemic. Carers Voice provides an opportunity for carers to have their opinions heard, get involved in the development of local services and represent the wider carer population. Carers Voice can directly influence Council policy and commissioning activity and will be a partner in the development of the carers' strategy.

12. Disabled Facilities Grant (DFG) & Wider Services

12.1 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 ICB 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, work is ongoing between Care and Support, Housing, Community Solutions, Inclusive Growth, Landlord Services, Adaptations team and Be First, our regeneration company on the future of sheltered housing, extra care, bungalow provision, site regeneration, referral processes and adaptations across Council, private and housing association housing. Housing are also involved in hospital discharge where issues arise.

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.

Across all Place areas the DFG monies are fully committed as per the expenditure templates. The three Local Authorities have slightly different structural arrangements for DFG but across the board the Housing and DFG leads are fully involved in decisions regarding how the DFG money is spent.

There are some challenges experienced across all Places regarding the length of time it takes from the initial application through to assessment and finally the adaptations taking place. There is a significant workforce challenge with occupational therapists but they are working closely with the social workers in ASC.

12.2 Barking & Dagenham DFG

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. In Barking and Dagenham, adaptations are designed to meet both current and anticipated needs, thus avoiding the need for costlier interventions e.g., high-cost packages of care /nursing home accommodation.

The local authority offers financial help for adapting homes within the Borough through the use of the Disabled Facilities Grant (DFG), with the aim of supporting residents with disabilities to improve their health and wellbeing by addressing problems with unsuitable homes that do not meet their needs and therefore maximising independence. The DFG can help to prevent or delay the need for care and support, both of which are central themes of the Care Act 2014.

Within Barking and Dagenham, a Disabled Facility Grant can be awarded to residents who have a disability and also live in a privately owned property, a privately rented property or a housing association property. The resident must have the intention of living in the property for a minimum of five years. In order to receive a DFG, the resident must have had an assessment from an Occupational Therapist. Once an assessment has taken place and the Occupational Therapist has made their recommendations it will progress to the Adaptations Panel for agreement. 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, working with colleagues throughout the system, to reduce hazards like cold homes, and trips and falls and refer to other services such as the Handypersons Scheme.

22/23 has been the first year in which the Council's new Aids and Adaptations Policy has operated. The Policy was produced in collaboration with Foundations in order to use the potential flexibilities set out within the Regulatory Reform Order (Housing Assistance) Order 2002. The publication of this Policy allowed Barking and Dagenham to enact six new additional grants to the current mandatory Grant usage. This included a non means test for anything under £15,000 and some innovative Grants tailored for individuals with more specific needs. We are of the understanding that the Sensory Needs Grant is the first of its kind in the country. The Policy also enables us to designate funding towards four specific social care projects aimed at private residents, including spend towards care and assisted technology, minor adaptations, Handypersons and an OT assessment project. The Policy enables more residents with disabilities to stay in their own home, in an environment that is better adapted to meet their needs and improve their health and wellbeing.

Discretionary Grant	Grant Amount	Means-Tested	Purpose
Adaptations Grant	£15,000	No	uses the same criteria as the mandatory DFG but is **not** subject to a means-test
Top-Up Grant	£15,000	Yes	where the initial means-tested grant is insufficient to cover the full cost of the works
Safe & Well Grant	£5,000	No	enable property clearances and essential property repairs
Relocation Grant	£10,000	Yes	support residents to move to more suitable accommodation where it is not possible to adapt their current home
Sensory Needs Assistance	£2,500	No	make homes "friendly" where the disabled person has dementia, other cognitive impairment, sensory disability or a recognised long term behavioural condition.
Professional Fees Grant	£2,500	Yes	pay for professional fees if the works are unable to proceed and thus unable to be paid under the mandatory DFGs

12.3 Havering DFG

Havering Council's new vision was agreed in *"The Havering You Want To Be Part Of: A New Vision for Havering"* in November 2022, this sets out three main themes for the Council: People, Place and Resources. In June 2023 the Councils' Housing Grants and Assistance Policy was reviewed following new guidance from the Department of Levelling Up, Housing and Communities. 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. 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 mandatory Disabled Facilities Grants, Havering offer a range of discretionary Housing Assistance Grant, this includes:

- a DFG top up scheme to meet the needs of people with complex disabilities by topping up grants that exceed the usual financial limit;
- discretionary adaptation assistance for elderly or disabled people who fail the mandatory means test;
- fast track assistance to meet urgent needs;
- hospital discharge assistance to prevent delayed transfers of care;
- a safe warm and well scheme to provide a safe and warm house for older and disabled people to promote health, wellbeing and independence;
- the use of flexibilities to ensure grant applications are dealt with individually on their own merits in accordance with recent guidance;
- aids, adaptations and assisted technology to enable people with a diagnosis of dementia, disabled people, and other vulnerable people retain their safety, security and independence;
- moving on assistance enable disabled people to move to a more suitable accommodation if required;
- a temporary financial assistance scheme to supplement the Council's High Energy Use Medical Equipment Scheme being delivered in partnership with the NHS;

- a pilot scheme to provide discretionary assistance to tenants (with the agreement of their landlord) who are living in private rented sector homes affected by minor damp/mould problems.

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. Where resources allow, Havering Council will increase the availability of accommodation for people with disabilities in line the agreed policy and the needs of disabled people living in the Borough.

12.4 Redbridge DFG

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

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

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

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

We also fund our Handyperson Scheme using DFG funding through the BCF. Priority is 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.

Redbridge has recently carried out a review of the Home Repairs and Disabled Adaptations Policy to improve the provision of adaptations and repairs for vulnerable residents. We have looked to reduce processing times wherever possible and provide a more comprehensive service to our residents. Proposed changes include:

- An alternative non means tested grant to the current mandatory grant for smaller adaptations, including equipment.
- Provision for fast tracking cases to assist residents requiring end of life care at home.
- A wider scope of adaptations for various conditions such as dementia and MND.
- An increase in available discretionary grants to allow for significant increases in the costs of building materials post pandemic.
- Partnership working with colleagues in Adult Social Care to develop the use of assistive technology for vulnerable residents.

13. Equality & Health Inequalities

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 our Disability Charter sets 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. This is now standard within all new service specifications in Redbridge.

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.

Each place has an Inequalities programme and non-recurrent funding source. This is not in the BCF, however supports the BCF agenda to keep people well at home and prevent hospital presentation and non- elective admission.

The B&D inequalities programme includes:

- Work streams building the infrastructure that will support the Barking & Dagenham Partnership to deliver on place-based care to address health inequalities, include the Locality Leads model and PCN Health Inequality Leads. The Locality Leads model, led by Community Resources on behalf of BD Collective, sees community organisations appointed as Leads in the six localities of the borough. As Locality Leads these organisations develop networks across and beyond the VCSE sector, support residents to access appropriate help – be it from neighbours, VCSE organisations or statutory support - and facilitate design groups with residents to develop “prototypes” to address challenges presented by the cost of living and health inequalities. The Locality Leads from the VCSE are working together with appointed Health Inequalities Leads for the PCNs on addressing issues they identify as priorities in the locality they serve.
- Other projects target specific health inequalities issues and explore innovative approaches to meet these challenges. This includes community-led development of resources to better support residents who have no recourse to public funds, by people with lived experience.
- Ongoing health inequalities funding to the Place level has been confirmed by NHS North East London for the next three years on an allocation basis, which sees the total base allocation to Barking and Dagenham at £777k a year (NHS NEL are using the same weighted health inequalities population formula that NHS England use to weight ICB budgets for health inequalities, which is based on a measure of avoidable mortality). Plans for next year include continued investment and development of the Community Locality Leads model, the Community Chest for Social Prescribing and grant making to support children and young people's mental health outcomes.
- Proactive care offers of support for residents not yet receiving care for LTCs like CVD, COPD and diabetes with the case finding project, and holistic support offered in a pilot delivered by social prescribing link workers for residents in debt and with mental health concerns, draw upon data and insight from across partners.

The Havering inequalities programme includes:

- The Increase over 50s uptake of benefits – supporting people aged over 50 to take up benefits they are entitled to
- Launch of Universal Stop Smoking Service – provide Havering with a stop smoking service
- Launch of Stop Smoking Service for those with Mental Health and/or a Learning Disability – provide a tailored stop smoking service for those with a mental health or learning disability diagnosis
- Weight Management Service Pilot – provide lifestyle interventions for children who are overweight or obese
- Primary Care Network (PCN) MDT Pilot – creation of an MDT pilot that will allow more efficient management of complex patients than traditional MDT approaches
- Housebound model development – development of housebound MDT
- Carers Training – providing training to support informal carers
- Community Chest – grant pot available to small community and voluntary sector organisations to support with their valuable work
- Improved Care For Homeless – commissioning additional mental health outreach services, providing lower level counselling and trauma informed care support
- Recruitment to joint commissioning unit post - role to help ensure funds are allocated to end providers and all necessary procurements, contracts and governance processes have been followed

The Redbridge inequalities programme includes:

- Wearable Tech – This initiative provided holistic interventions to residents in areas of deprivation, by utilising wearable and assistive technologies
- Engagement - RCVS Health Buddies, Door to Door engagement team

Culturally specific engagement officers, Schools engagement –

- Health Engagement Bus - build on previous relationships with communities and sites across the borough.
- Community Chest - Piloting Community Chests in multiple boroughs across NEL builds on best practice of programmes elsewhere
- Healthwatch - Expand a number of schemes that Healthwatch Redbridge have implemented which will tackle inequalities across the Borough.
- Homeless Service - Healthy Living, Healthy Lives - The ICB hold a contract with PELC to deliver homeless and rough sleeper outreach services. However, in Redbridge Healthy Living Healthy lives (HLHL) has also supplemented the PELC offer and provided vast range of services to homeless patients including support with GP registrations, comprehensive initial health check, acute care referrals, health promotion/disease.

Local Area Summary
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
https://www.lbbd.gov.uk/joint-strategic-needs-assessment-jsna

Havering
https://www.haveringdata.net/joint-strategic-needs-assessment/

Redbridge
http://moderngov.redbridge.gov.uk/documents/s128909/LBR%20JSNA%202022%20HWBB%20submission.pdf

14. Fair Cost of Care and Market Sustainability

In December 2021, the Department of Health and Social Care (DHSC) released their White Paper – "People at the Heart of Care" which set out plans to prepare adult social care markets for reform. To support this, £162 million was allocation nationally, with £753k allocated to Redbridge to engage with care markets and come to a shared understanding on the local cost of providing care. This fund was used to support operational delivery and increase fee rates to 18+ domiciliary care providers and 65+ residential and nursing providers. The purpose of the exercise was to understand any gaps in funding between the calculated cost of care and the current rates local authorities were paying care providers.

Redbridge

In Redbridge, the local authority collaborated with Care Providers Voice to encourage providers to share business operating costs using ADASS templates. This resulted in 58% and 52% response rate from domiciliary care and nursing/residential markets respectively. Cost of care rates were calculated at Redbridge were £24.26 for domiciliary care, £983 for residential and £1,181 for nursing (including NHS funded nursing care). BHR rates were similar across the local authorities for all markets, and a working group was maintained throughout the project to ensure approaches to data analysis were consistent across the three boroughs.

London cost of care results (22/23) from ADASS show consistent results across BHR and North East London, with homecare rates close to £24 per care hour, residential rates between £900-£1000 and nursing rates between £1,100-£1,200, including NHS-funded nursing care. North East London had the highest homecare median cost per care hour (£24.20), with the lowest being £19.55 in North Central London. Nursing and residential medians in NEL were amongst the lowest across London, with the highest figures being £1,100 and £1,300 per week for residential and nursing respectively in inner/South London. DHSC have obtained local authority level estimates of older people's care home self-funder fee rates in 2022/23 from Carterwood, a market-leading provider of fee data. Data obtained across 22 homes and 985 beds in Redbridge shows private fees ranged from averages of £1,158 in residential care and £1,469 in nursing. These figures display an increase of 18% and 24% from cost of care projections, and a further 50% and 62% increase from the local authority actual unit costs in residential and nursing respectively.

As a result of findings from the cost of care exercise, LBR have invested a gross amount of £5.2m for care provider uplifts for 2023/24 to deal with projected inflationary pressures. This has been informed by the Cost of Care data with the objective that funding gaps identified through that work are stabilised and do not grow as a result of the inflationary pressures on care providers in 2023/24 going under funded. Separately, LBR has a London Living Wage provision that will be utilised to ensure care providers within

residential and nursing and external day care settings are London Living Wage compliant. Cost of Care funding for 2023/24 is helping to support these objectives.

A future uncertainty which is likely to have a consequence for financial modelling for the sustainable Cost of Care is social care reform which is currently delayed. Reform could fundamentally change the current dynamics of the financial modelling for local authorities and care providers alike and will increase cost pressures for local authorities supporting the care of residents.

B&D

As with all other local authorities in the country we undertook the Fair Cost of Care exercise in 22/23 which informed our approach to supporting the care market in 22/23 with the use of Fair Cost of Care funding and our uplift approach for 23/24. We have uplifted our older adult care market rates for this year by 16.2%. The aim of this uplift is to support providers with the increase in cost of delivering care, including paying London Living Wage which will allow them to compete with other sectors who are offering regular pay increases.

Our provider market remained relatively stable throughout 22/23 in terms of provider failure, however in April 2023 we were told that our biggest care home in the Borough is aiming to close by the Summer 2023. This will be taking 120 beds of capacity out of our market. We are currently working with residents and families to source alternative accommodation. This is proving exceptionally challenging in a residential care market that is operating at 95% capacity at all times. This will impact upon hospital discharge as well as the residents currently residing in the home. The use of the Adult Social Care Discharge Fund will support the sourcing of capacity for placements for residents discharged from hospital as we are working through these market pressures. The removal of these beds will also impact market rates, which are already seeing increases across the NEL patch. Once residents are moved in the Summer, the local authority and the ICB will be looking to secure more long-term beds in the market, potentially through the purchase of the home or another site – this will be a considerable endeavour and updates will be provided in future BCF planning.

Recruitment and retention remain an issue across health and social care providers due to ongoing Covid-19 and Brexit issues, as well as the impact of inflation, the rise in living costs and the increase in National Living Wage.

Havering

Havering undertakes an Annual Uplift Project as part of the strategy to support and sustain the Provider Market. The 2022/23 Uplift Project gave uplifts to 240 Provisions, based on detailed research on business demands and pressures.
Since the implementation of these uplifts in April 2022, there have been significant additional economic pressures nationally, and a number of providers have approached the Council raising concerns regarding their ability to sustain their provisions.
The Market Sustainability & Improvement Fund is to be ring fenced to adult social care to support the government objectives of addressing discharge delays, social care waiting times, low fee rates, workforce pressures and to promote technological innovation in the sector. It is of note that this funding was distributed to councils using the Adult Social Care Relative Needs Formulae (ASC RNF), which takes no account of the size of provider market, particularly the care home market, who have larger fixed costs than home care agencies, and therefore have experienced larger cost pressures due to inflation, notably utilities and mortgages. By way of example, one inner North East London borough has seven care homes providing care for people over the age of 65, with a total 254 beds (although it is of note that four of these homes, 72 beds in total, provide care to all adults over the age of 18 and are specialist learning disability or mental health providers), with this borough receiving a grant over £3m. Havering have 34 generic care homes for older people with 1533 registered CQC beds, yet will only receive £2.355m.

This disparity makes it almost impossible for Havering to meet the government objective of moving meaningfully towards a reasonable cost of care, supporting discharges from hospital, social care waiting times, and other workforce pressures, particularly as the 2024/25 grants will be distributed via the ASC RNF (or iBCF RNF) also.

Our uplift approach has endeavoured to start the journey towards the median cost of care, taking into account inflationary pressures but also focussing on higher uplifts for those parts of the social care market (older people's care homes and homecare) where fee rates needed to be raised by a higher percentage, because of the distance from the median cost of care as at October 2022, recognising that the median cost of care as assessed at that time, will have moved on considerably because of the impacts of inflation since the work was done.

To recognise the increased cost pressures, the providers, face and to support the Council to continue to be able to make new placements at standard and enhanced rates. The standard nursing care weekly rate has been increased by 13% to £715.00 and the

enhanced nursing care weekly rate by 11% to £753.00. The standard residential care weekly rate has been increased by 13% to £701.00 and the enhanced residential care weekly rate by 11% to £772.00. The percentages will ensure a rounded number for the usual rates which will reduce the administrative burden for both Council staff and care provider staff.

Care Providers Voice

All 3 Local Authorities supported the development of a provider led model of support during Covid. Care Providers Voice (CPV) was set up by a small number of providers during Covid to promote and give direct support and assist providers who faced challenges. This included acting as a facilitator so that these challenges and issues were being raised with the wider system of LAs, CCGs and NHS trusts for example discharge flow, outbreak management, inconsistencies in policy changes. This was and continues to be invaluable and demonstrably showed where gaps were emerging and facilitated local responses and system changes to address these. It provided the foundation for greater understanding between the statutory agencies across social care and the social care providers.

The support for CPV continues to expand across NEL and London and they have been able to create a specific platform to support recruitment and retention across all social care markets. This includes free training for individuals and employers within social care provided by Grey Matters Learning (GML). This training is directly linked to supporting recruitment locally but has demonstrated an effectiveness at bringing together multiple strands and opportunities in a co-ordinated way, Skills for Care, Work Redbridge, DWP, overseas sponsorship schemes for care workers. This is providing a more impactful support for the wider social care market and opening up the employment opportunities that are available within it through greater awareness and promotion. CPV have been instrumental in supporting both the LA and providers in responding to the 'Cost of Care' exercise and also support both directly and indirectly the borough partnerships and NEL.

To date 432 offers have been made with 162 starters and 21 new entrants into the care sector which has been supported by GML which has had over 33,000 courses completed across BHR being the original three LAs involved in the partnership with CPV.

15. Appendix 1 – Risk Log

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
1	Workforce – Recruitment and Retention	The local system has a workforce academy that is supporting and advising health and social care on developing new workforce strategies including apprentice models, enhanced and advanced practitioners, retention models, training and rotation. This across care staff, AHPs and other specialities. This is a longer-term solution over 3-10 years.	4	4	High	
2	Resources, budget deficits and sustainability	Funding is now seen as system and partnership theme. The ICB, LA and other partners work collaboratively to maximise the use of resources to support the delivery of care and support, this could be through flexible use of budgets e.g. demand and capacity and ASC discharge, estates and shared resource like training.	4	4	High	
3	Demand and Capacity Growing OP population Complexity of need Post Covid impact	The system through such boards as DIWG and the UEC Improvement board will oversee activity – demand and capacity, performance and deep dives around such areas as acuity and RCA to look at what is driving demand or complexity.	4	3	Medium	
4	Increasing cost of services and Fair Cost of Care	The system will use grant funding from the Fair Cost of Care and Market Sustainability & Improvement Fund to ease the pressures for increased costs currently being experienced by the market as well as help support sustainable wage increases (including London Living Wage pressures). Care Providers Voice (CPV), covering BHR, will support market sustainability by supporting recruitment and retention in the care sector.	4	4	High	
5	Move to Place and potential inequity	The system is looking to take a pragmatic approach to maintaining BHR wide approaches were appropriate, whilst developing a place focus. A good example is DIWG (the discharge improvement working group) – that operates under the acute hospital footprints to get a holistic overview, however operationally services may be delivered slightly at place/borough level.	3	3	Medium	