North East London Integrated Care Board

Barking & Dagenham

Notice of Meeting

COMMITTEES IN COMMON
HEALTH & WELLBEING BOARD
ICB SUB-COMMITTEE

Monday, 26 June 2023 - 5:00 pm
Council Chamber, Town Hall, Barking IG11 7LU

Date of publication: 16 June 2023

Fiona Taylor
Chief Executive, LBBD
Zina Etheridge
Chief Executive,
North East London ICB

LBBD Contact Officer: Yusuf Olow
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ICB Contact Officer: Anne-Marie Keliris
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Membership

Name	Title	HWBB	ICB
Cllr Maureen Worby (Chair)	Cabinet Member for Adult Social Care and Health Integration, LBBD	✓	✓
Fiona Taylor	Chief Executive (Place Partnership Lead), LBBD	✓	✓
Matthew Cole	Director of Public Health, LBBD	✓	✓
Elaine Allegretti	Strategic Director, Children and Adults, LBBD	✓	✓
Cllr Syed Ghani	Cabinet Member for Enforcement and Community Safety, LBBD	✓	
Cllr Jane Jones	Cabinet Member for Children's Social Care and Disabilities, LBBD	✓	
Cllr Elizabeth Kangethe	Cabinet Member for Educational Attainment and School Improvement, LBBD	✓	
Charlotte Pomery	Executive Director, NHS North East London	✓	
Dr Ramneek Hara	Clinical Care Director, NHS North East London	✓	✓
Sharon Morrow	Director of Partnership Impact and Delivery Barking and Dagenham, NHS North East London	✓	✓
Dr Kanika Rai	Place based Partnership Primary Care Development Clinical Lead		✓
Dr Shanika Sharma	Primary Care Network Director – West One		✓
Chetan Vyas	Director of Quality or nominated rep, NHS North East London		✓
Sunil Thakker	Director of Finance or nominated rep, NHS North East London		✓
Ann Hepworth	Director of Strategy and Partnerships (BHRUT)		✓
Kathryn Halford	Chief Nurse, BHRUT	✓	
Selina Douglas	Executive Director of Partnerships (NELFT)		✓
Melody Williams	Integrated Care Director (NELFT)	✓	✓
Nathan Singleton	Chief Executive, Healthwatch - Lifeline Projects Ltd	✓	
Manisha Modhvadia	Chair, Healthwatch		✓
Elspeth Paisley	Health Lead, BD Collective	✓	✓
Louise Jackson	Chief Inspector, Metropolitan Police	✓	
Pooja Barot	Director, Care Provider Voice		✓

Non-voting members

Craig Nikolic	Chief Operating Officer, Together First CIC, B&D GP Federation	✓	
Dr Uzma Haque	Primary Care Network Director, North	✓	
Dr Deeksha Kashyap	Primary Care Network Director, North West	✓	
Dr Jason John	Primary Care Network Director, New West	✓	
Dr Afzal Ahmed	Primary Care Network Director, East	✓	
Dr Natalya Bila	Primary Care Network Director, East One	✓	
Dalveer Johal	NEL Local Dental Committee Representative	✓	
Shilpa Shah	NEL Local Pharmaceutical Committee Representative	✓	

Standing Invited Guests

Cllr Paul Robinson	Chair, Health Scrutiny Committee, LBBD	✓	
Narinder Dail	Borough Commander, London Fire Brigade	✓	
Anju Ahluwalia	Independent Chair Local Safeguarding Adults Board, LBBD	✓	
Vacant	London Ambulance Service	✓	
Vacant	NHS England, London Region	✓	

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution and the ICB Subcommittee's Terms of Reference, members of the Committees in Common are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes of the Health and Wellbeing Board held on 14 March 2023 (Pages 3 - 8)**

4. **Minutes of the Barking and Dagenham Place based Partnership Board held on 25 May 2023 (Pages 9 - 12)**

5. **Action log (Pages 13 - 15)**

6. **Governance update and ICB sub-committee terms of reference (Pages 17 - 39)**

7. **Progressing our ambition for adults and communities in Barking and Dagenham Overview of strategic landscape locally and nationally to support discussion on our ambitions for our communities (Page 41)**

8. **Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery - Final (Pages 43 - 95)**

9. **Better Care Fund 2023-2025 (Pages 97 - 166)**

10. **Health Inequalities Programme Plan for FY23/24 (Pages 167 - 183)**

11. **Improving Urgent and Emergency Care (UEC) across Barking and Dagenham, Havering and Redbridge (Pages 185 - 233)**

12. **Questions from the Public**

13. **Any other public items which the Chair decides are urgent**

14. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

15. Any other confidential or exempt items which the Chair decides are urgent

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Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

- Residents are supported during the current Cost-of-Living Crisis;
- Residents are safe, protected, and supported at their most vulnerable;
- Residents live healthier, happier, independent lives for longer;
- Residents prosper from good education, skills development, and secure employment;
- Residents benefit from inclusive growth and regeneration;
- Residents live in, and play their part in creating, safer, cleaner, and greener neighbourhoods;
- Residents live in good housing and avoid becoming homeless.

To support the delivery of these priorities, the Council will:

- Work in partnership;
- Engage and facilitate co-production;
- Be evidence-led and data driven;
- Focus on prevention and early intervention;
- Provide value for money;
- Be strengths-based;
- Strengthen risk management and compliance;
- Adopt a “Health in all policies” approach.

The Council has also established the following three objectives that will underpin its approach to equality, diversity, equity and inclusion:

- Addressing structural inequality: activity aimed at addressing inequalities related to the wider determinants of health and wellbeing, including unemployment, debt, and safety;
- Providing leadership in the community: activity related to community leadership, including faith, cohesion and integration; building awareness within the community throughout programme of equalities events;
- Fair and transparent services: activity aimed at addressing workforce issues related to leadership, recruitment, retention, and staff experience; organisational policies and processes including use of Equality Impact Assessments, commissioning practices and approach to social value.

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 14 March 2023
(6:00 - 8:00 pm)

Present: Cllr Maureen Worby (Chair), Elaine Allegretti, Matthew Cole, Cllr Syed Ghani, Cllr Jane Jones, Sharon Morrow, Nathan Singleton and Melody Williams

47. Apologies for Absence

Apologies were received from Cllr Elizabeth Kangethe, Cabinet Member for Educational Attainment and School Improvement, and Elspeth Paisley from BD Collective.

48. Declaration of Members' Interests

The Chief Executive informed the Board that the by-election for Heath Ward would be taking place on 30th March 2023. Therefore, the Council was subject to pre-election restrictions as set out in Section 2 of the Local Government Act 1986, as amended. The Chief Executive reminded the Board that they were required to refrain from making any comments that could be interpreted as supporting or opposing a political party, and to be mindful of the restrictions when discussing matters affecting Heath ward.

49. Minutes - To confirm as correct the minutes of the meeting on 18 January 2023

The minutes of the meeting held on 18 January 2023 were confirmed as correct.

50. Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery

The Interim Public Health Consultant (IPHC) updated the Board.

The Board had a statutory requirement to produce a Health and Wellbeing Strategy (HWS). The present strategy would expire on 1st April 2023. The IPHC presented the Board with the draft strategy which would replace it. The new strategy sought to incorporate all the other strategic plans relating to the place-based partnership. The Integrated Care Strategy, the Joint Local and Wellbeing Strategy and the Council Corporate Plan would be incorporated into the HWS.

The consultation would commence following the Board meeting and the strategy would be published in June 2023. The Board would be invited to approve the new framework at their next meeting, provided that the Joint Forward Plan was ready.

The key principles of the strategywere:

- Addressing health inequalities;
- Place based working; and
- Co-production with communities.

The IPHC indicated that the joint framework had three purposes:

- Best Start in Life;
- Living Well; and
- Ageing Well.

The IPHC gave a short summary of each proposal noting that these would be expanded upon at the next meeting.

The Health and Wellbeing Board agreed to the following areas of the strategy:

1. Vision;
2. Principles;
3. What we are planning to achieve;
4. How we are planning to achieve delivery and plans for co-production;
5. Priorities;
6. Proposed actions;
7. How success is measured;

The Board also agreed to the start of the consultation period, following the publication of the Strategy in June 2023 subject to the Joint Forward Plan being agreed.

51. Health & Wellbeing Board and ICB subcommittee Governance Options

The Director of Public Health (DPH) updated the Board.

The Integrated Care Boards (ICB) replaced Clinical Commissioning Groups on 1st July 2022 following the passing of the Health and Care Act 2022. This act changed the architecture of health provision and necessitated that the Health and Wellbeing Board work closely with North East London ICB (NELICB). However as statutory guidance had not been published, it was not possible to finalise the specific provisions of the relationship.

Following the publication of the guidance, the DPH announced that, following legal advice, a committees in common approach had been proposed which would see the Health and Wellbeing Board and the ICB Sub-Committee meeting together. Legally, they would remain separate bodies; however, would have an overlapping membership. This approach would streamline decision making and avoid duplication whereby different boards and committees discuss the same issues. This would improve services for residents as it would enable decisions to be taken more quickly.

Some sectors were not represented on the Health and Wellbeing Board and the DPH highlighted dentists, primary care networks and primary care contractors as examples and emphasised that this would need to change. Additionally voluntary sector membership of the Health and Wellbeing Board would need to be increased. The proposed model would be in shadow form from 1st April 2023, would continue for a year and would be regularly reviewed for effectiveness including the challenges that the expansion of membership would bring in relation to conflicts of interest.

The Strategic Director of Adults and Children Services (SDAC), added that the

changes to the regulatory framework would have the effect of binding the Health and Wellbeing Board and the ICB closer together notwithstanding existing laws and mechanisms.

The Board noted the update.

52. Joint Forward Plan

The Director of Partnership and Delivery (DPD) at NELICB updated the Board.

The principles underpinning the plan was that it should be fully aligned with the wider system partnership and support subsidiarity by building on existing strategies and plans. The plan should be delivery focused with clear objectives, trajectories and milestones were appropriate. Although it was an NHS plan, the DPD emphasised that it would involve external stakeholders.

The NHS was required to deliver the first plan by June 2023 and to update the plan annually. Engagement events involving health partners were planned before implementation. Drafts of the proposals would be circulated to Board members offline.

The DPD outlined the risks; highlighting the short deadlines and it was possible that the plan would not be completed by the June 2023 deadline. There was also a risk of insufficient resourcing.

The Board noted the update.

53. The SEND Green Paper, SEND Inspection Arrangements and Government Improvement Plan

The Strategic Director for Children and Adults (SDCA) updated the Board.

The Special Educational Needs and Disabilities (SEND) Green Paper was published in March 2022. The SDCA added that the green paper had to be considered alongside the White Paper 'Excellent Education for all' which must include children with SEND.

The SDCA said that the Government's proposal were long awaited noting that, at present, outcomes for children with SEND were poor. Parents, carers and families had expressed frustration at what they felt was a complex and adversarial system. The present system had also come under financial pressure. The Council had seen a large rise in SEND related requests; rising from 250 to 500. Since 2019, the number of SEND related plans rose from 1,500 to over 2,000.

The SEND green paper included the following-

- Children with SEND would be educated in mainstream schools where possible;
- New national standards for every need and every stage would be established;
- Digitised and standardised education, health and care plans;
- Preparing people with SEND for adulthood to access employment;

- A dashboard to compare performance of areas and new inspection framework; and
- Significant additional investment.

The new inspection framework began in 2023 and the SDCA stressed that the inspections were not of the Council but of the local area partnership and SDCA confirmed that notification of an inspection had been received. The inspection would track six children with SEND and to test what was like for them. The inspection would use a sample of eighty children.

The Council undertook a self-evaluation noting that Ofsted had recognised that Barking and Dagenham had highly inclusive schools and that half of mainstream schools had an additional source provision. There was strong alternative provision where mainstream schooling was not appropriate but that this needed strengthening to meet the needs of the borough. The SDCA Residents with SEND still had trouble accessing employment with only 1.6% in employment compared with 7% for London as a whole. Increasing this figure was a priority. However, the SDCA cautioned that growing demand for SEND services was putting pressure on resources and this would be a challenge going forward.

The Healthwatch Representative disclosed that they were carrying out work with parents whose children had applied for EHCP plans regardless of whether they were successful or not. In addition to this, there was a pilot involving advocate mentors for children with special educational needs and have trouble controlling their emotions and behaviour. This was being undertaken in four schools.

The Board noted the update.

54. Covid-19 Update

The DPH updated the Board.

Covid-19 was contributing to pressures; however, was now being managed in the same way that influenza. The DPH added that it was no longer necessary for updates to be given. Instead the focus should be on pressure points noting that there had been effects on the acute sector.

The NELFT Representative emphasised the challenges of mental health whilst the Chief Nurse at BHRUT emphasised that health and social care was under pressure. The Chair suggested that a dashboard be provided to the Board going forward, highlighting the pressure areas and the action being taken.

The Board noted the update.

55. Forward Plan

The Board noted the forward plan.

56. Any other public items which the Chair decides are urgent

The Chief Nurse (CN) at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) updated the Board on the recent doctors strike.

Consultants were carrying the responsibilities of junior doctors. This had required the cancellation of 50% of planned surgeries as well as the cancellation of outpatient appointments. The CN warned that this would result in greater pressure at GP surgeries as patients affected re-present themselves. However, CN was confident that BHRUT would still achieve its target of reducing waiting times to below 52 weeks.

The CN said that further strikes were planned unless the Government and junior doctors come to an agreement.

The Board noted the update.

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DRAFT
Barking and Dagenham Partnership Board
Thursday 25 May 2023
The Chamber, Barking Town Hall

Members:	
North East London ICB	
Sharon Morrow (SM)	Director of Planning. Impact & Delivery, NHS North east London
Dr Rami Hara (RH)	Clinical/Care Director, NHS North East London
NHS Trusts	
Selina Douglas (SD)	Director of Partnerships, NELFT
Ann Hepworth (AH)	Director of Strategy & Partnerships, BHRUT
Local Authorities	
Cllr Maureen Worby (MWo) Co-Chair	Councillor, London Borough of Barking & Dagenham
Matthew Cole (MCo)	Director of Public Health, LBBD
Fiona Taylor (FT)	Acting Chief Executive, LBBD
Elaine Allegretti (EA)	Strategic Director Children and Adults, LBBD
Together First CIC, B&D GP Federation	
Craig Nikolic (CN)	CEO, Together First CIC, B&D GP Federation
Primary Care	
Dr Shanika Sharma (ShaS) Co-Chair	Primary Care Network Director, West One
Dr Kanika Rai (KR)	GP Provider/ PCN representative
Dr Uzma Haque (UH)	Primary Care Network Director (North)
BD Collective	
Elspeth Paisley (EPa)	Health Lead, Lifeline Community Resources
Healthwatch	
Manisha Modhvadia (MM)	Healthwatch, Healthwatch Acting Manager
Care Provider Voice	
Pooja Barot (PB)	Director, Care provider Voice
Attendees:	
Charlotte Pomery (CP)	Chief Participation and Place Officer, NHS North east London
Anne-Marie Keliris (AMK)	Head of Governance, NHS North east London
Debbie Harris (DH)	Governance Officer, NHS North east London
Dotun Adepoju DA)	Senior Governance Manager, NHS North east London
Matt Cridge (MCr)	Head of Borough Partnerships, LBBD
Charlotte Harpin (CH)	Partner, Browne Jacobson
Steve Atkinson (SA)	Associate, Browne Jacobson
Apologies:	
Dr Narendra Teotia (NT)	Primary Care Network Director, North
Sunil Thakker (ST)	Finance, NHS North East London
Dalveer Johal (DJ)	Pharmacy Services Manager, NEL LPC
Dr Jason John (JJ)	Primary Care Network Director, New West
Dr Afzal Ahmed (AA)	Primary Care Network Director, East

Dr Bhawnesh Liladhar (BL)	Dental Lead
Dr D Kashyap (DK)	Primary Care Network Director, North West
Melody Williams (MWi)	Integrated Care Director, NELFT
Georgina Alexiou (GA)	Founder & Project Manager, BDYD
Rhodri Rowland (RR)	Director of Community Participation and Prevention – ComSol, LDDB
Fiona Russell (FR)	Director of Care, Community & Health Integration LBBD
Dr Natalya Bila (NB)	Primary Care Network Director, East One
Michael Armstrong (MA)	Havering Care Association

Item	
1.0	**Welcome, introductions and apologies**
	The Chair welcomed members/attendees to the meeting. All members/attendees joined the meeting in person. Apologies were noted as above.
1.1	**Declarations of conflicts of interest**
	Members were reminded to complete their Declaration of Interest form if they had not already done so. No additional Conflicts of Interests were noted.
1.2	**Minutes of the meeting held on 30 March 2023**
	Notes from the previous meeting were agreed as an accurate record.
1.3	**Action Log**
	The action log was discussed and noted.
2.0	**Matters arising**
	Matthew Cole verbally updated members on the Health Inequalities funding. Highlights included: • The Executive Committee have agreed the schemes for 23/25 funding in principal. • There has been a change to the sign off process with NEL ICB. Sign off will now take place at the Committee's in Common on 26 June 2023. • The LBBD Scrutiny meeting agreed with the proposal but wanted to see more focus on groups we are targeting. The Board noted the update.
3.0	**Big Conversation**
	Sharon Morrow presented the Big Conversation paper that gives an overview of the work being undertaken as part of the wider 'Working with People and Communities Strategy' developed with partners across north east London last year and adopted by NHS North East London's Board in July 2022. Highlights included: • Themes to be explored include: - Equity and variation in outcomes and delivery - Prevention and early intervention - Access to care urgently and in an emergency - End of life and palliative care - How we spend our money and what people think is important - Feedback on the forward plan • There are opportunities to tailor the conversation with local communities and people at Place using local intelligence. • We will build on participation work already in place rather than recreate, looking at information gathered through the Provider Collaboratives. • The paper sets out a timeline that is broken down into 3 phases running from April through to September. • It is anticipated that there will be some resource available from the ICB to support local events. Comments from the Board:

	• This provides a good opportunity to engage in a different way with a broader group of people. • The language needs to be in a format that residents understand and be meaningful. • Would we have the opportunity to have targeted conversations? • There is a need to target certain cohorts. If we can broaden out the conversation it helps with barriers and engagement. • A key learning point in Localities is to have a conversation based on 'curiosity' not in gathering data. • Have two or three key questions with consistency across the system. • We need to ask people what they think we should be measuring to obtain ownership across the community. • A need to know what lies behind this paper. • There is a need to be able to act on feedback in order not to disappoint people who have participated. • BHRUT asked, from a practical perspective, to see the list of activities as they are about to start their own Big Conversation and wish to avoid duplication. • We need to be prepared, as organisations, to make changes that are fed back to us during the conversations. • A need to work with people not doing to people – make it a genuine conversation. **Action:** JT to provide BHRUT a list of activities they are to focus on to avoid duplication with BHRUTs Big Conversation. The Board noted the approach and made suggestions on how best to do this locally.
4.0	**Health & Wellbeing Board and ICB Sub-committee – Committees in Common update**
	Steve Atkinson (SA) provided a brief overview of Committees in Common (CsIC) as a governance option and what they are, followed by Charlotte Pomery (CP) presenting the overarching paper for the B&D Committees in Common. Responses were provided to the following comments from the Board: • Clarity was sought on the differences between Committees in Common and a Joint Committee. • How will these Committee's influence silo working and bring the Partnership together? • Where does the authority to make decisions come from? • Where will the resource come from to support the structure? • Does the CsIC have the same power as the ICB in terms of the Provider Collaboratives? • Clarity was sought on whether meetings will still be held in the Public. • There is a need to ensure agenda planning in advance, having clear minute taking and chairing. Members then broke into 3 groups to discuss the questions below: (one per group) 1. How do we support a healthy debate in a larger group that enables all views to be heard and considered fairly? 2. How do we create an identity/profile for the partnership that demonstrates to our staff and residents who we are and what we want to achieve in a way that is meaningful to them? How do we ensure that our committees in common and the decisions made are transparent to the residents of B&D? 3. We want this CiC to be 'where we do business'. What do we have to do and not do in order to make that happen?

	Highlights from question1: • Information in advance to enable informed conversations and decisions. • Development sessions to explore topics in between formal CsIC. • Excellent chairing. • Planning process to inform separate sessions. • Detailed work at sub groups – chair to ask groups to be clear on their work programme. • Hold delivery Plan for HWBB Strategy. • Disciplined behaviours of all participants to add to the forward plan and to prepare for meetings effectively. Highlights from question 2: • Agreement that we need to create an identity. • The identity needs to be backed up in how we organise and deliver our services. • Need to communicate to our residents that we are seen as 'Place'. • There is a need to champion resources coming from other areas into Barking and Dagenham. • Having good data helps with transparency. Highlights from question 3: • Avoid death by powerpoint at meetings. Build in time for members to be briefed on the detail in advance of the meeting – less time on presentations and more time on solution focused conversations • Discipline around the presentation of papers - (i) be concise, (ii) indicate purpose of paper, (iii) why it has been brought to the Committee and (iv) what is the 'Ask' in the paper of the Committee. Distil language in documentations to allow for general comprehension rather speciality-related jargon • Look at IT platforms such as jamboard, microsoft teams to continue the conversation and encourage contributions between meetings • Establish a regular rhythm of 'Big-Conversation' type of engagement; lived Experience (Residents' Story) at meetings would help drive purpose of what we do. • CsiC to meet face to face to build the relationships across the partnership The Board supported the proposed Committees in Common approach of the Barking and Dagenham ICB Sub-committee and the Health and Wellbeing Board.
7 0	**AOB**
	None noted
	Date of next meeting – Monday 26 June 2023 5pm- 7pm **Council Chamber - Barking Town Hall, Town Hall Square, Barking, IG11 7LU**

Barking and Dagenham Partnership Board Actions Log

OPEN ACTIONS					
Action ref:	**Date of meeting**	**Action required**	**Lead**	**When**	**Status**
ACT010	24.11.22	**Barking and Dagenham Estates programme and governance** ST suggested a further finance update on capital programmes. This will demonstrate key projects in the pipeline that are critical in delivery of the services.	ST	Matters arising 26 June 2023	**Update 25.05.23:** SM advised there is a Local Infrastructure with an update on the governance and programmes plans due. There has not been significant progress with this work due to the ICB reorganisation. An update will is attached.
ACT013	23.02.23	**Collaborative updates - System Diagnostics mental health and learning disabilities collaborative** SD to share the priorities with the Partnership/Board	SD	~~April~~ July/August Complete	**Update 16.03.23:** Recommendations/priorities will be shared once they are received. (April 2023) **Update 25.05.23:** SD advised this is now in the final stages of diagnostics being completed. There are two workshops in June in Ilford. SD to share the dates with members (complete). Update to come back to the in July/August.

ACT014	23.02.23	**Collaborative updates – System Diagnostics mental health and learning disabilities collaborative** Mental health to be considered as a future board workshop	SD/SM	Complete	**Update 25.05.23** – to be considered for one of the Development sessions
ACT016	30.03.23	**Health and Wellbeing Strategy refresh Consultation** Consider setting up some workshops to allow time for some frank conversations.	Chair	Complete	**Update 25.05.23** Cllr Worby advised that the intention was, given that the CsIC will meet every other month, to hold development sessions on the months in between.
ACT017	25.05.23	**Big Conversation** JT to provide BHRUT with a list of activities they are to focus on to avoid duplication with BHRUTs Big Conversation.	JT	Closed	DH shared action with JT 1/6 **Update 12 June** – JT shared a list of activities with AH on 11 June 2023

Barking and Dagenham Local Infrastructure Forum

Chair: Sharon Morrow, Director of Partnership Impact and Delivery

Items to be escalated to the Partnership Board

- There are no items for escalation

Meeting Attendance

31st May 2023: 10 Attendees (circa 66% membership)

Highlight report

1. The group received an update on the development of Place-based Approach to NEL Infrastructure Strategy and the categorisation of assets in B&D as core, flex or tail in accordance with national NHSE ICS infrastructure strategy guidance. The group:

    - Supported the proposal for categorisation, noting that it needs to support a clinical and care model
    - Agreed that it provided the basis for wider mapping of assets across the partnership
    - Agreed an action to present the update to the PCNs and NELFT and work with the Local Authority to map in community assets

2. Partner updates:
    - PCNs are working on capacity and access plans which should be completed in June
    - BHRUT plans are on track for the mobilisation of the Community Diagnostic Centre by December 2023. An operational manager has been recruited – agreed she would engage with the BCH Building Users group to keep them updated on developments
    - LBBD – plans to open 19 community hubs – two to be located with GP practices (Porters Avenue and Broad Street)
    - NELFT (see below)

3. Live schemes
    - Beam Park: Heads of Terms with NELFT are progressing and the building is expected to be signed over by October/December
    - Barking Riverside: Partners engaged in project board meetings

Contact: Sharon Morrow, Director of Partnership Impact and Delivery
Email: Sharon.morrow2@nhs.net

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North East London
Integrated Care Board

Committees in Common of ICB Sub Committee and Health and Wellbeing Board

26 June 2023

Title of report	Governance update and ICB sub-committee terms of reference
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	At the meeting the Barking and Dagenham Borough Partnership Board on 26 May 2023, it was agreed to implement the committees in common of the Integrated Care Board (ICB) sub-committee and Health and Wellbeing Board (HWB). The ICB and London Borough of Barking and Dagenham have been working with legal advisors to develop a framework to articulate the arrangement which is described as a summary in section 1 of the ICB sub-committee terms of reference attached at appendix A. The ICB sub-committee terms of reference have been revised to reflect the committees in common arrangement for approval by the ICB sub-committee. The closer alignment of the ICB sub-committee and the HWB will streamline the current governance arrangements, speed up decision making, improve alignment of actions on priorities and in doing so will improve services through greater collaboration and reduction in duplication. The approach was supported and approved by the ICB Board on 31 May 2023. The governance teams from the ICB and London Borough of Barking and Dagenham have been working to together to develop an operating procedure to ensure a smooth transition to the new arrangements. At its meeting on 26 May 2023, the partnership board discussed a number of questions around the future of the borough partnership and how they would like to the committees in common to operate – the key themes from these discussions will be reviewed by the executive group who will propose how to address these at a future committees in common meeting.
Action / recommendation	The Committees in Common are asked to endorse the proposed governance arrangements.

	The ICB Sub-Committee is asked to endorse the changes and recommend approval of the revised terms of the reference to the ICB Board.
Previous reporting	Barking and Dagenham Health and Wellbeing Board. Barking & Dagenham Executive Group.
Next steps/ onward reporting	ICB Board on 26 July 2023
Conflicts of interest	The Committees in Common will follow the conflicts of interest policy of the respective organisations and a register of interests will be presented at each meeting to ensure conflicts of interests are appropriately managed.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	A closer alignment of the HWB and the ICB sub-committee will improve services through greater collaboration and reduction in duplication.
Impact on finance, performance and quality	The impact on finance, performance and quality will be worked through alongside its governance and will be shared at a later stage.
Risks	The risk to ensuring both partners meet their statutory responsibilities around decision making including management of conflicts of interest will be mitigated through close working of the Heads of Governance of both the ICB and LBBD to review/amending the approach based on testing.

North East London
Integrated Care Board

BARKING & DAGENHAM

SUB-COMMITTEE OF THE NORTH EAST LONDON ICB

TERMS OF REFERENCE

Contents

Barking and Dagenham Place Based Governance

1. From 1 July 2022 the Board of the NHS North East London Integrated Care Board ('**ICB**') established the B&D Sub-Committee ('the **Place ICB Sub-committee**'), to work in tandem with the B&D Partnership Board, thereby forming the B&D Place-Based Partnership. Under these arrangements, which were described in the Place-Based Partnership's suite of terms of reference:

    - The **B&D Partnership Board** was the collective governance vehicle established by the ICS partner organisations to collaborate on strategic policy matters and oversee joint programmes of work relevant to Place.
    - Where a formal decision needs to be taken which relates solely to a function of the ICB, then this is to be taken by the **Place ICB Sub-committee**.
    - The B&D Partnership Board and Place ICB Sub-committee's terms of reference aligned and there was significant overlap in their membership, which enabled the two structures to meet together efficiently within the forum of a single meeting.
    - The Place-Based Partnership was expected to collaborate with the B&D Health and Wellbeing Board but the Health and Wellbeing Board was not a formal part of the Place-Based Partnership governance.

2. Through the arrangements described below, the Health and Wellbeing Board will continue to be an essential part of the Place-Based Partnership. This document describes interim arrangements for a committees-in-common arrangement between the Health and Wellbeing Board and the Place ICB Sub-committee. The partners at Place will keep these arrangements under active review, and work towards formalising their governance through updated terms of reference in due course.

Arrangements from 26 June 2023

3. From 26 June 2023, the following arrangements will apply:

    Governance structures

    (a) The Health and Wellbeing Board and the Place ICB Sub-committee will meet as committees-in-common, in order to promote consistent decisions being taken between organisations at Place. Decisions taken by the London Borough of Barking and Dagenham ('**LBBD**') and the ICB within the forum of the aligned meeting can be taken simultaneously but they will remain separate decisions that each organisation is accountable for.

    (b) The B&D Partnership Board is disestablished. However, the vision, mission and values explained in the former B&D Partnership Board's terms of

reference, and as far as possible its role and responsibilities, will be fulfilled through the aligned meetings of the committees-in-common. Those aligned meetings will be the primary governance mechanism for collaborating on strategic policy matters and overseeing joint programmes of work relating to health and social care at Place.

(c) Other ICS partners[1] may take decisions relating to statutory functions at meetings of the aligned structures through individuals having delegated authority from their organisation, as reflected in the organisation's own internal governance (e.g. schemes of delegation).

Membership

(d) To facilitate its broader work, the Health and Wellbeing Board's membership will be expanded to include the following additional non-voting members:

- Chief Operating Officer (Together First CIC, B&D GP Federation)
- Primary Care Network Director (North)
- Primary Care Network Director (North West)
- Primary Care Network Director (New West)
- Primary Care Network Director (East)
- Primary Care Network Director (East One)
- Primary Care Network Director (West One)
- NEL Local Pharmaceutical Committee Representative
- NEL Local Dental Committee Representative
- Director Care Provider Voice

(e) As non-voting members of the Health and Wellbeing Board, the individuals fulfilling these roles will need to comply with LBBD's requirements for members of its committees (e.g. as to declarations of interests, requirements for training, and adherence to LBBD's code of conduct).

(f) The Place ICB Sub-committee's membership will remain as set out in its terms of reference, except that the Chair of the Health and Wellbeing Board will also be the sole chair of the Place ICB Sub-committee. A deputy chair will be appointed from the membership.

Participation

(g) Any member or standing participant of the Health and Wellbeing Board, who is not a member of the Place ICB Sub-committee, will have a standing invitation

[1] (e.g. NHS Trusts and Foundation Trusts)

to attend meetings of the Place ICB Sub-committee when it meets together with the Health and Wellbeing Board.

(h) Where appropriate, standing invitees will be permitted to contribute to discussions at meetings to help inform decision-making. This is, however, subject to any specific legal restrictions applying to the functions being exercised or to partner organisations, and subject to conflict of interest management.

Administration of meetings

(i) Under these new arrangements, the Health and Wellbeing Board and Place ICB Sub-committee will normally meet together, as part of an aligned meeting of the Place-Based Partnership. Ordinarily, such meetings will be bi-monthly, with a minimum of five meetings each year.

(j) Although either governance structure may meet on its own at the discretion of the Chair, it is expected that such circumstances would be rare. Such circumstances might include, for example, where agenda items do not require a statutory decision of the Place ICB Sub-committee.

(k) It is recognised that the ICB and LBBD operate under different legal frameworks, and work will need to be undertaken to find the most efficient ways to lawfully host and manage meetings. While the updated governance beds in, the arrangements for governance support and agenda planning will be developed by the ICB's Head of Governance and LBBD's Head of Governance & Electoral Services, who will cooperate to devise processes which:

- Best support closely aligned meetings and integrated decision-making;
- Comply with the respective legal, constitutional and policy frameworks which apply to the local authority and ICB;
- Reflect, as far as possible, the Health and Wellbeing Board and Place ICB's Sub-committee's existing terms of reference.

The Chair of the Health and Wellbeing Board, who will also be the Chair of the Place ICB Sub-committee, will be responsible for approving the arrangements for each meeting and for approving agendas.

(l) Management of conflicts of interest will remain essential to the operation of the Place-Based Partnership and will continue to be manged consistently with partner organisations' respective statutory duties and applicable national guidance.

(m) All those who are members or participating in a meeting of the Health and Wellbeing Board or Place ICB Sub-committee shall continue to follow the Seven Principles of Public Life (also commonly referred to as the Nolan Principles), which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Development of aligned terms of reference

(n) The arrangements described above are intended to enable substantive decisions around health and social care to be taken by statutory ICS partners in the forum of a single meeting, in an aligned way – and to do so soon, without any substantive governance amendments being required.

(o) They will also provide an opportunity for the ICS partner organisations operating at Place to continue to develop and embed their arrangements for integrated working. It is expected that the partner organisations will further formalise their arrangements through an updated suite of aligned terms of reference, that describes how the aligned structures will operate. A working group will be established for this purpose and will report periodically to the Health and Wellbeing Board and Place ICB Sub-committee.

Review

(p) The Place-Based Partnership arrangements will be kept under active review, to consider how the governance is enabling the partners to discharge their responsibilities, deliver their objectives and work efficiently for the benefit of B&D residents. In any case, the arrangements will be reviewed within six months.

(q) Any learning which may support arrangements in NEL's other places will be shared with the ICB's Population Health & Integration Committee.

4. Before it takes effect, this document and the arrangements described therein shall be approved by the Board of the ICB and at the first meeting of the committee in common.

North East London
Integrated Care Board

Terms of reference for the Barking & Dagenham Sub-Committee of the North East London Integrated Care Board

Status of the Sub-Committee	1. The Barking & Dagenham Sub-Committee of the North East London Integrated Care Board ('**the Place ICB Sub-Committee'**) is established by the Population Health & Integration Committee (the '**PH&I Committee'**) as a Sub-Committee of the PH&I Committee. 2. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub-Committee and may only be changed with the approval of the Board of the ICB ('the **Board**'). Additionally, the membership of the Sub-Committee must be approved by the Chair of the Board. 3. The Sub-Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Geographical coverage	4. The geographical area covered will be Place, 'Place' for the purpose of these terms of reference means the geographical area which is coterminous with the administrative boundaries of LBBD.
Purpose	5. The Place ICB Sub-Committee has been established in order to: (a) Enable the ICB to exercise the Delegated Functions at Place in a lawful, simple and efficient way, to the extent permitted by the ICB's Constitution and as part of the wider collaborative arrangements which form the Barking & Dagenham Place Based Partnership ('**PBP**'); (b) Support the development of collaborative arrangements at Place, in particular the development of the PBP. 6. The Delegated Functions which the Place ICB Sub-Committee will exercise are set out at **Annex 1** and described in further detail in the Place Mutual Accountability Framework which the annex refers to. 7. The Place ICB Sub-Committee, through its members, is authorised by the ICB to take decisions in relation to the Delegated Functions. 8. Further functions may be delegated to the Place ICB Sub-Committee over time, in which case Annex 1 will be updated with the approval of the Board, on the recommendation of the PH&I Committee. The remit of the Place ICB Sub-Committee is also described in the Place Mutual Accountability

Framework, which may be updated by the Board taking into account the views of the PH&I Committee.

9. The Delegated Functions shall be exercised with particular regard to the Place objectives and priorities, described in the plan for Place ('**the PBP Plan'**), which has been agreed with the PH&I Committee. A summary of the PBP's priorities and objectives can be found here.

10. In addition, the Place ICB Sub-Committee will support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions of:

    (a) The Joint Forward Plan;

    (b) The Joint Capital Resource Use Plan;

    (c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

    (d) The Health and Wellbeing Board's joint local health and wellbeing strategy with the Health and Wellbeing Board's needs assessment for the area;

    (e) The Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework;

    (f) The PBP Plan.

11. The Place ICB Sub-Committee will also prioritise delivery against the strategic priorities of the North East London Integrated Care System (see here) and its design and operating principles set out here.

12. In supporting the ICB to discharge its statutory functions and deliver the strategic priorities of the ICS at Place, the Place ICB Sub-Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

13. The Place ICB Sub-Committee is a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

Key duties relating to the exercise of the Delegated Functions

14. When exercising any Delegated Functions, the Place ICB Sub-Committee will ensure that it acts in accordance with, and that its decisions are informed by, the guidance, policies and procedures of the ICB or which apply to the ICB.

15. The Sub-Committee must have particular regard to the statutory obligations that the ICB is subject to, including, but not limited to, the statutory duties set out in the 2006 Act and listed in the Constitution. In particular, the Place ICB Sub-Committee will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.

Collaborative working

16. In exercising its responsibilities, the Place ICB Sub-Committee may work with other Place ICB Sub-Committees, provider collaboratives, joint committees, committees, or sub-committees which have been established by the ICB or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups.

Collaboratives

17. In particular, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the ICS:

    (a) The North East London Mental Health, Learning Disability & Autism Collaborative;

    (b) The Combined Primary Care Provider Collaborative;

    (c) The North East London Acute Provider Collaborative;

    (d) The North East London Community Collaborative;

    (e) The evolving Voluntary, Community and Social Enterprise Sector Alliance/Collaborative.

18. Some members of the Place ICB Sub-Committee may simultaneously be members of the above collaborative structures, to further support collaboration across the system.

Health & Wellbeing Board and Safeguarding

19. The Place ICB Sub-Committee will also work in close partnership with:

    (a) The Health and Wellbeing Board and shall ensure that plans agreed by the Place ICB Sub-Committee are appropriately aligned with, and have regard to, the joint local health and wellbeing strategy and the assessment of needs, together with the NEL Integrated Care Strategy as applies to Place; and

    (b) The Safeguarding Adults Board for the Place established by the local authority under section 43 of the Care Act 2014; and

    (c) The Safeguarding Children's Partnership established by the local authority, ICB and Chief Officer of Police, under section 16E of the Children Act 2004.

Establishing working groups

20. The Place ICB Sub-Committee does not have the authority to delegate any functions delegated to it by the ICB. However, the Place ICB Sub-Committee

may establish working groups or task and finish groups. These do not have any decision-making powers but may inform the work of the Place ICB Sub-Committee and the PBP. Such groups must operate under the ICB's procedures and policies and have due regard to the statutory duties which apply to the ICB.

Chairing and executive lead arrangements

21. The Place ICB Sub-Committee will be chaired by the Chair of the Health and Wellbeing Board who is appointed on account of their specific knowledge, skills and experience making them suitable to chair the Sub-Committee..

22. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

23. A deputy Chair will be appointed from the membership.

24. If the Chair or deputy Chair has a conflict of interest then the Sub-Committee will select another member of the Sub-Committee to be responsible for deciding the appropriate course of action.

25. The Acting Chief Executive of LBBD will be the Place Partnership Lead.

Membership

26. The Place ICB Sub-Committee members will be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the Sub-Committee.

27. The Place ICB Sub-Committee has a broad membership, including those from organisations other than the ICB. This is permitted by the ICB's Constitution and amendments made to the 2006 Act by the Health and Care Act 2022.

28. The membership of the Place ICB Sub-Committee includes members drawn from the following partner organisations which operate at Place:

    (a) The ICB

    (b) BHRUT

    (c) NELFT

    (d) LBBD

    (e) Barking & Dagenham GP Federation

    (f) PCNs

    (g) BD Collective

    (h) Healthwatch

29. There will be a total of 14 members of the Place ICB Sub-Committee, as follows:

ICB

(a) Place Director for Barking & Dagenham

(b) Clinical Care Director for Barking & Dagenham

(c) Director of Finance or their nominated representative

(d) Director of Nursing/Quality or their nominated representative

LBBD

(e) Cabinet Member for Adult Social Care and Health Integration (**Chair**)

(f) Chief Executive (**Place Partnership Lead**)

(g) Strategic Director Children and Adults

(h) Director of Public Health

NHS Trusts/Foundation Trusts

(i) Executive Director of Partnerships (NELFT)

(j) Director of Strategy & Partnerships (BHRUT)

Primary Care

(k) Place Based Partnership Primary Care Development Clinical Lead

(l) Primary Care Network Director (nominated by the PCN clinical directors)

Others

(m) Chair, Healthwatch

(n) Chair, BD Collective

30. With the permission of the Chair of the Place ICB Sub-Committee, the members, set out above, may nominate a deputy to attend a meeting of the Place ICB Sub-Committee that they are unable to attend. However, members will be expected not to miss more than two consecutive meetings. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

31. When determining the membership of the Sub-Committee, active consideration will be made to diversity and equality.

Participants

32. Only members of the Sub-Committee have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee.

33. The Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion on particular matters.

Resource and financial management	34. The ICB has made arrangements to support the Place ICB Sub-Committee in its exercise of the Delegated Functions. Financial responsibilities of the Place ICB Sub-Committee are contained in the list of Delegated Functions in Annex 1, and further information about resource allocation within the ICB is contained in the ICB's Standing Financial Instructions and associated policies and procedures, which includes the NHS North East London Financial Strategy and developing ICS Financial Framework. 35. The Chair will be invited to attend the Finance Performance and Investment Committee where the Committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.
Meetings, Quoracy and Decisions	36. The Place ICB Sub-Committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Governance Handbook and wider ICB policies and procedures, except as otherwise provided below: *Scheduling meetings* 37. The Place ICB Sub-Committee will aim to meet on a bi-monthly basis and, as a minimum, shall meet on four occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 38. The Place ICB Sub-Committee will usually hold its meetings together with the Health and Wellbeing Board, as part of an aligned meeting of the PBP. Although the Place ICB Sub-Committee may meet on its own at the discretion of its Chair, it is expected that such circumstances would be rare. 39. The Board, Chair of the ICB or Chief Executive may ask the Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice. *Quoracy* 40. The quoracy for the Place ICB Sub-Committee will be six and must include the following of which one must be a care or clinical professional: (a) Two of the members from the ICB; (b) Two of the members from the local authority; (c) One of the members from an NHS Trust or Foundation Trust; (d) One primary care member. 41. If any member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. 42. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting*

43. Decisions will be taken in accordance with the Standing Orders. The Sub-Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Sub-Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. The result of the vote will be recorded in the minutes.

44. Where there is a split vote, with no clear majority, the Chair will have a casting vote.

Papers and notice

45. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

46. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

47. It is for the Chair to decide whether or not the Place ICB Sub-Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

48. Meetings at which public functions of the ICB are exercised will usually be open to the public, unless the Chair determines, at their discretion, that it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for some other good reason.

49. The Chair shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

50. A person may be invited by the Chair to contribute their views on a particular item or to ask questions in relation to agenda items. However, attendance shall not confer a right to speak at the meeting.

51. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Place ICB Sub-Committee and others in attendance.

52. There shall be a section on the agenda for public questions to the committee, which shall be in line with the ICB's agreed procedure as set out on our website here.

Recordings of meetings

53. Except with the permission of the Chair, no person admitted to a meeting of the Place ICB Sub-Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Confidential information

54. Where confidential information is presented to the Place ICB Sub-Committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Meeting Minutes

55. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Place ICB Sub-Committee, together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair.

56. Where it would promote efficient administration, meeting minutes and/or action logs may be combined with those of the Health and Wellbeing Board.

Legal or professional advice

57. Where outside legal or other independent professional advice is required, it shall be secured by or with the approval of the Director who is responsible for governance within the ICB.

Governance support

58. Governance support to the Place ICB Sub-Committee will be provided by the ICB's governance team.

Conflicts of Interest

59. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

Behaviours and Conduct

60. Members will be expected to behave and conduct business in accordance with:

    (a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business.

	(b) The NHS Constitution; (c) The Nolan Principles. 61. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.
Disputes	62. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee in its capacity as a decision-making body within the ICB's governance structure, including uncertainty about whether the matter relates to: (a) a matter for wider determination within the ICS; or (b) determination by another placed-based committee of the ICB or other forum, such as a provider collaborative, then the matter will be referred to the Director who is responsible for governance within the ICB for consideration about where the matter should be determined.
Referral to the PH&I Committee	63. Where any decision before the Place ICB Sub-Committee is 'novel, contentious or repercussive' across the ICB area and/or is a decision which would have an impact across the ICB area, then the Place ICB Sub-Committee shall give due consideration to whether the decision should be referred to the PH&I Committee. 64. With regard to determining whether a decision falling within the paragraph above shall be referred to the PH&I Committee for consideration then the following applies: (a) The Chair of the Place ICB Sub-Committee, at their discretion, may determine that such a referral should be made. (b) Two or more members of the Place ICB Sub-Committee, acting together, may request that a matter for determination should be considered by the PH&I Committee. 65. Where a matter is referred to the PH&I Committee under paragraph 63, the PH&I Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB or to another of the Board's committees/subcommittees for determination. 66. In addition to the Place ICB Sub-Committee's ability to refer a matter to the PH&I Committee as set out in paragraph 63: (a) The PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 63 should be referred to the PH&I Committee for determination; or

(b) The Board of the ICB, or its Chair and the Chief Executive (acting together), may require a decision related to any of the ICB's delegated functions to be referred to the Board.

Accountability and Reporting

67. The Place ICB Sub-Committee shall be directly accountable to the PH&I Committee of the ICB, and ultimately the Board of the ICB.

68. The Place ICB Sub-Committee will report to:

(a) **The PH&I Committee** following each meeting of the Place ICB Sub-Committee. A copy of the meeting minutes along with a summary report shall be shared with the Committee for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.

And will report matters of relevance to the following:

(b) **Finance, Performance and Investment Committee.** Such formal reporting into the ICB's Finance, Performance and Investment Committee will be on an exception basis. Other reporting will take place via Finance and via NEL wide financial management reports.

(c) **Quality, Safety and Improvement ('QSI') Committee.** Reports will be made to the QSI Committee in respect of matters which are relevant to that Committee and in relation to the exercise of the quality functions set out here.

69. In the event that the Chair of the ICB, its Chief Executive, the Board of the ICB or the PH&I Committee requests information from the Place ICB Sub-Committee, the Place ICB Sub-Committee will ensure that it responds promptly to such a request.

Shared learning and raising concerns

70. Where the Place ICB Sub-Committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Board, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees, as appropriate.

Review

71. The Place ICB Sub-Committee will review its effectiveness at least annually.

72. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 29 September 2022 (Initial version by ICB Board on 1 July 2022)

Version: 2.0

Date of review: 1 April 2023

Annex 1 - ICB Delegated Functions

Commissioning functions

In addition to the specific activities set out in this Annex 1 below, the Place ICB Sub-Committee will have delegated responsibility for exercising the functions described in the Place Mutual Accountability Framework at Place. These functions are referred to below as '**the Place Commissioning Functions'**.

The Place Mutual Accountability is contained in the ICB's Governance Handbook and should be read alongside the equivalent accountability framework which describes the role of the provider collaboratives.

Where Place Commissioning Functions relate to a particular service they must be exercised in line with the ICB's relevant commissioning policy for that service.

Health and care needs planning

The Place ICB Sub-Committee will undertake the following specific activities in relation to health and care needs planning, through embedding population health management:

1. Making recommendations to the PH&I Committee in relation to, and contributing to, the Joint Forward Plan and other system plans, in so far as relates to the exercise of the ICB's functions at Place.

2. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery at Place of the Joint Forward Plan, the Integrated Care Strategy and other system plans, in so far as they require the exercise of ICB functions.

3. Overseeing the development of service specification standards needed in connection with the exercise of the Place Commissioning Functions and in line with relevant ICB policy.

4. Working with the Health and Wellbeing Board on behalf of the ICB, to develop the PBP Plan including the Place objectives and priorities and a Place outcomes framework.

    The PBP Plan shall be developed by drawing on data and intelligence, and in coproduction with service users and residents of Barking & Dagenham. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy, the Health and Wellbeing Board's joint local health and wellbeing strategy and associated needs assessment, and other system plans.

    In particular, this shall include developing the Place priorities and objectives to be set out in the PBP Plan, and summarised here, and an associated outcomes framework developed by the PBP.

    The PBP Plan shall be tailored to meet local needs, whilst maintaining ICB-wide operational, quality and financial performance standards. It shall also be consistent with, and aimed at delivery of, the Place Mutual Accountability Framework at Place.

5. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the PBP Plan, in so far as the plan requires the exercise of ICB functions.

6. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Place objectives and priorities, contained within the PBP Plan and summarised here, in so far as they require the exercise of ICB functions.

7. Overseeing the implementation and delivery of the Health and Wellbeing Board's joint local health and wellbeing strategy, in so far as the strategy requires the exercise of ICB functions.

Market management, planning and delivery

The Place ICB Sub-Committee will undertake the following specific activities in relation to market management, planning and delivery:

1. Making recommendations to the Board of the ICB / PH&I Committee in relation to health service change decisions (whether these involve commissioning or de-commissioning).

2. Approving commissioning policies connected with the exercise of the Place Commissioning Functions, in line with ICB policy.

3. Approving demographic, service use and workforce modelling and planning, where these relate to the Place Commissioning Functions.

Finance

The Place ICB Sub-Committee will have delegated financial management and control, as detailed below and within the ICBs SFI's. The Finance, Performance and Investment Committee will continue to have oversight of NEL wide financial decisions, including where coordination/planning for the services concerned is best undertaken over a larger footprint. However, there will be ongoing dialogue in order to ensure a joined up approach, ensure financial sustainability, and as the NHS North East London Financial Strategy and ICS Financial Framework develop.

1. Plan and monitor the budgets delegated to the Place ICB Sub-Committee and take action to ensure they are delivered within the financial envelope.

2. The committee will take shared responsibility, along with partners, for the health outcomes of their population, and will work with those partners to develop a shared plan for improving health outcomes and maintaining collective financial control.

3. Review and understand any variations to plan within the delegated budget and take appropriate action to mitigate these.

4. Oversee any required recovery plans in order to ensure financial balance is achieved at Place.

5. Ensure financial plans are triangulated with performance and quality.

6. Ensure any known financial risks are escalated to the ICB's Finance, Performance and Investment Committee and the ICS Executive, as appropriate.

7. Review performance of the contracts within Place, [in relation to the Specified Services,] to ensure services and activity are being delivered in line with contractual arrangements.

8. Review and understand the financial implications of new investments and transformation schemes, and ensure there is sufficient funding across the life of the investment.

9. Oversee implementation of investments/transformation schemes, ensuring financial activity, KPIs and required outcomes are delivered.

10. Review and agree any procurement decisions in relation to services connected with the Place Commissioning Functions, as appropriate, in line with the ICB's Standing Financial Instructions and Procurement Policy.

11. Ensure financial decisions are taken in line with the ICB's Standing Financial Instructions and NHS North East London Financial Strategy and developing ICS Financial Framework.

12. In relation to financial risk share arrangements (including but not limited to section 75, 76 and section 256 agreements), the Place ICB Sub-Committee shall:

    - Review any current in year arrangements applicable to Place, ensuring that funding is spent appropriately in line with contractual agreements;

    - Review the risks and benefits of the allocation of funding and approve spend on pooled budgets based on recommendations from those leading the work and where all parties are in agreement;

    - Receive reports on the schemes funded through this mechanism to ensure it is delivering the expected outcomes and benefits;

    - Review the funding and arrangements for the subsequent financial year and ensure there is adequate governance and arrangements in Place that is consistent with other places across the ICB's area;

    - Review and make recommendations in relation to proposals for the ICB to enter into new agreements under section 75 of the 2006 Act with the local authority at Place. In accordance with the Constitution, any such arrangements must be authorised by the Board of the ICB.

Quality

The Place ICB Sub-Committee will undertake the following specific activities in relation to quality:

1. Providing assurance that health outcomes, access to healthcare services and continuous quality improvement are being delivered at Place, and escalate specific issues to the Population Health & Integration Committee, the Quality Safety and Improvement Committee and/or other governance structures across the ICS as appropriate.

2. Complying with statutory reporting requirements relating to the exercise of the Place Commissioning Functions, in particular as relates to quality and improvement .

3. In addition, the Place ICB Sub-Committee will have the following responsibilities on behalf of the ICB at Place, in relation to quality:

    - Gain timely evidence of provider and place-based quality performance, in relation to the exercise of the Place Commissioning Functions at Place.

    - Ensure the delivery of quality objectives by providers and partners within Place, including ICS programmes that relate to the place portfolio.

- Identify, manage and escalate where necessary, risks that materially threaten the delivery of the ICB's objectives at Place and any local objectives and priorities for Place.
- Identify themes in local triangulated intelligence that require local improvement plans for immediate or future delivery.
- Gain evidence that staff have the right skills and capacity to effectively deliver their role, creating succession plans for any key roles within the services being delivered at Place.
- Hold system partners to account for performance and the creation and delivery of remedial action/improvement plans where necessary.
- Share good practice and learning with providers and across neighbourhoods.

4. Ensure key objectives and updates are shared consistently within the ICB, and more widely with ICS and senior leaders via the ICS System Quality Group ('SQG') and other established governance structures.

Primary Care

The Place ICB Sub-Committee will undertake the following specific activities in relation to primary care:

1. To develop arrangements for integrated services, including primary care, through local neighbourhoods

Communication and engagement with stakeholders

The Place ICB Sub-Committee will undertake the following specific activities in relation to communications and engagement:

1. Overseeing and approving any stakeholder involvement exercises proposed specifically in Place, consistent with the ICB's statutory duties in this context and the ICB's relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.

2. Overseeing the development and delivery of patient and public involvement activities, as part of any service change process occurring specifically at Place.

Population health management

The Place ICB Sub-Committee will undertake the following specific activities in relation to population health management:

1. Ensuring there are appropriate arrangements at Place to support the ICB to carry out predictive modelling and trend analysis.

Emergency planning and resilience

The Place ICB Sub-Committee will undertake the following specific activities in relation to emergency planning:

1. At the request of the any of the PH&I Committee or the Board, in relation to a local or national emergency, prepare or contribute to an emergency response plan for implementation at Place, coordinating with local partners as necessary.

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COMMITTEES IN COMMON -HEALTH AND WELLBEING BOARD/ICB SUBCOMMITTEE

26th June 2023

Title:	Progressing our ambition for adults and communities in Barking and Dagenham; Overview of strategic landscape locally and nationally to support discussion on our ambitions for our communities
Report of the LBBD Director of Public Health	
Open Report	**For Decision:** No
Wards Affected: All	**Key Decision:** No
Report Author: N/A	**Contact Details:** Yusuf Olow, Senior Governance Officer Yusuf.Olow@lbbd.gov.uk
Sponsor: Sharon Morrow, North East London ICB Director of Partnership Impact and Delivery Barking and Dagenham	

Summary:

The Committees in Common will hold a discussion on delivering on its ambition to improve services to communities in Barking and Dagenham.

Recommendation(s)

The Committees in Common is asked to provide an overview to the Council and the ICB on what is required and expected to fulfil its ambitions for adults and communities in Barking and Dagenham.

Reason(s)

Providing guidance to directors and officers in relation to expectations will enable the Council and the North East London Integrated Care Board to develop approaches that meet the Committees in Common's expectations and serve communities in the borough.

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COMMITTEES IN COMMON OF THE HEALTH AND WELLBEING BOARD AND INTEGRATED CARE SYSTEM SUB-COMMITTEE

26 JUNE 2023

Title:	Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery – Final
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: all	**Key Decision: Yes**
Report Author: Jane Leaman, Consultant in Public Health, LBBD Jess Waithe, Public Health Specialist, LBBD	**Contact Details:** Jane.leaman@lbbd.gov.uk Jess.waithe@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, LBBD	

Summary:

The current Barking and Dagenham Health and Well Being Strategy (HWBS) ends in 2023. In the context of the new place-based partnership and integrated working, this refreshed strategy sets out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of residents' lives by 2028. It provides a framework for action, drawing on a range of other relevant local strategies.

Recommendations

The Health and Wellbeing Board is recommended to agree:

1. The content of the Strategy

2. Its publication in June 2023

Reason

The Health and Wellbeing Board has a statutory responsibility to publish a Health and Wellbeing Strategy.

1 Background and Context

The Health and Social Care Act 2012 requires each local council area to have a Health and Wellbeing Board (HWB), which brings together key leaders from local

health and care organisations to work together to improve the health and wellbeing of local people and to reduce inequalities that are the cause of ill health.

The HWB must produce a Health and Wellbeing strategy (now known as Joint Local Health and Well Being Strategy (JLHWBS)) that describes the key local health and care issues and explains what the board is going to do to make improvements to these issues.

The JLHWS sets out the vision, priorities and action agreed by the HWB to meet the needs identified within the JSNA and to improve the health, care and wellbeing of local communities and reduce health inequalities.

1.1 NHS NEL Integrated Care Strategy

The NHS NEL's Integrated Care Strategy has now been published and should be considered by the HWB in agreeing this JLHWBS to ensure that they are complementary. However, there are no expectations that a JLHWBS is re-written in the light of the ICB Integrated Care Strategy.

The Integrated Care Strategy built on the existing HWBS (2019- 2023) and is complement to the draft JLHWSs, identifying where needs could be better addressed at the system level. It will also bring learning from across the system to drive improvement and innovation.

System partners across North East London Health and Care Partnership have reached collective agreement on NHS NEL's ICS purpose and four priorities to focus on together as a system. The priorities and cross-cutting themes (see below) will set a clear direction for the development of the new NHS Joint Forward Plan due at the end of March 2023 (see Appendix A for what good looks like against the cross-cutting themes).

Priorities:

- To provide the best start in life for the Babies, Children and Young People of North East London
- To support everyone at risk of developing or living with a long- term condition in North East London to live a longer and healthier life
- To improve the mental health and wellbeing of the people of North East London
- To create meaningful work opportunities and employment for people in North East London now and in the future

Cross-cutting themes describing 'how' NHS NEL will work differently as an integrated care system:

- Working together as a system to tackle health inequalities including a relentless focus on equity.
- Greater focus on prevention
- Holistic and personalised care
- Co-production with residents
- A high trust environment
- Working as a learning health system

1.2 Other Relevant Plans and Assessments

1.2.1 LBBD Corporate Plan

The newly published Council Corporate Plan sets out how and what the Council will deliver against agreed priorities – many of which directly or indirectly impact on the health of residents, as well as good health of residents it will also enable the achievement of all. Therefore, the Health and Well Being Strategy is a key overarching strategy for this plan.

The relevant Corporate Plan's priorities are that residents:

- Are supported during the current cost of living crisis
- Are safe, protected and supported at their most vulnerable
- Live healthier, happier, independent lives for longer
- Prosper from good education, skills development and secure employment

LBBDs equality objectives for 2023-27, and the action that sits below the objectives, have been developed in line with the Corporate Plan priorities for the same period. The key relevant objective is:

- **Addressing structural inequality:** activity aimed at addressing inequalities related to the wider determinants of health and wellbeing, including unemployment, debt, and safety. Intersection between poverty, racism and structural inequality.

1.2.2 ICB Joint Forward Plan (JFP)

NEL's ICB, with its partner NHS Trusts and NHS Foundation Trusts, must prepare a 5-year joint forward plan, to be refreshed each year. The plan sets out any steps on how the ICB proposes to implement any JLHWS that relates to the ICB area, and the ICB must have regard to the Integrated Care Strategy when exercising any of its functions.

The plan itself must describe how the ICB proposes to implement this JLHWSs, and the NHS NEL ICB and partner trusts will send a draft of the JFP to the HWB when

initially developing it or undertaking significant revisions or updates. The HWB must respond with its opinion and may also send that opinion to NHS England, telling the ICB and its partner trusts it has done so. If NHS NEL ICB and its partner trusts subsequently revises a draft JFP, the updated version will be sent to the HWB, and the consultation process described above repeated. The JFP must include a statement of the final opinion of the HWB.

Barking and Dagenham are also producing a Local Forward Plan which will set out how the partnership will deliver the JLHWBS.

1.2.3 Performance Assessments

In undertaking its annual performance assessment of an ICB, NHS England must include an assessment of how well the ICB has met the duty to have regard to the relevant JSNAs and JLHWSs within its area. In conducting the performance assessment, NHS England must consult each relevant HWB for their views on the ICB's contribution to the delivery of any JLHWS to which it was required to have regard.

2 Proposals and Issues

The current Barking and Dagenham Health and Well Being Strategy ends in 2023. However, on review following the publication of the refreshed JSNA, and the Babies, Children's' and Young Peoples Plan, and as recommended in the Director of Public Health's report 2021-22, it is proposed the strategy remains but refreshed in the aftermath of the COVID- 19 pandemic and the current 'cost of living crisis', for the period 2023 -2028.

But, as most issues impacting on people's health are outside of the health service, the heart of this will be tackling health inequalities supported by the value of relationships and connecting with residents in designing or delivering changes in services, to meet the individual needs and characteristics of our communities.

In the context of the new place-based partnership and integrated working this refreshed Strategy will set out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of residents' lives by 2028, aspiring to the development of a 'system of health'.

The vision is: "By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere. Our residents will benefit from coproduction and partnerships around their needs and priorities."

It sets out three thematic outcome areas:

Best start in life
We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools and settings, in inclusive communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

Living well
We want to ensure residents live well and realise their potential, and when they need help they can access the right support, at the right time in a way that works for them.

Ageing well
We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions
- Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious
- Their health and wellbeing is improved to support better opportunities (educational, employment, social) and independent living for as long as possible

A draft JLHWS was presented to the HWB on 14 March 2023. A final draft is attached as appendix A.

4 Consultation and Engagement

Final consultation between March and April 2023 was carried out with the following overarching groups:

- Residents
- Internal Council stakeholders
- External Council partners and colleagues

There was general agreement with vision, themes and principles overall. Comments that were summarised and incorporated into the final version around delivering priorities include a focus on:

- SEND provision/special needs support; safety; support with transitions & developing skills for adulthood (Best start in Life).
- Prevention and support for earlier adoption of healthier lifestyles; Emotional wellbeing and mental health; the environment, particularly safety and housing (Living Well).
- Earlier intervention and improved awareness of support available; Improving connection, cohesion and loneliness (Ageing Well).

- Listening to people; making sure the feedback loops are closed and impact of involvement is clear; involving young adults more; making involvement easier/more accessible (Co-production)

3 Mandatory Implications

An Equalities Impact Assessment was approved by LBBDs Strategy Team and is attached as Appendix B for reference.

5.1 Joint Strategic Needs Assessment

The Health and Well Being Strategy is informed by the JSNA.

Public Background Papers Used in the Preparation of the Report:

HWBB Paper 14 March 2023

List of Appendices:

Appendix A: Barking and Dagenham Joint Local Health and Wellbeing Strategy 2023-2028

Appendix B: JLHWS equalities impact assessment

Community and Equality Impact Assessment

As an authority, we have made a commitment to apply a systematic equalities and diversity screening process to both new policy development or changes to services.

This is to determine whether the proposals are likely to have significant positive, negative or adverse impacts on the different groups in our community.

This process has been developed, together with **full guidance** to support officers in meeting our duties under the:

- Equality Act 2010.
- The Best Value Guidance
- The Public Services (Social Value) 2012 Act

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

About the service or policy development

Name of service or policy	Joint Health & Wellbeing Strategy Refresh 2023-28
Lead Officer Contact Details	Jess Waithe, Public Health Specialist Jess.waithe@lbbd.gov.uk

Why is this service or policy development/review needed?
The Joint Health and Wellbeing Strategy is a statutory document. The current Strategy, running from 2019 is due to expire this year and the refreshed version will build on this, setting out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives for 2023- 2028 . The priorities in the document will underpin delivery plans and outline how London Borough of Barking Dagenham and partners will work together to deliver the proposed priorities.

1. Community impact (this can be used to assess impact on staff although a cumulative impact should be considered).

What impacts will this service or policy development have on communities?
Look at what you know. What does your research tell you?

Please state which data sources you have used for your research in your answer below

Consider:

- National & local data sets
- Complaints
- Consultation and service monitoring information
- Voluntary and community organisations
- The Equality Act places a specific duty on people with 'protected characteristics'. The table below details these groups and helps you to consider the impact on these groups.
- It is Council policy to consider the impact services and policy developments could have on residents who are socio-economically disadvantaged. There is space to consider the impact below.

Demographics

Barking and Dagenham (B&D) is the most deprived borough in London, based on Index of Multiple Deprivation score and is ranked 5th in London on the related Income Deprivation Affecting Children Index score- which measures the percentage of all children aged 0 to 15 years who live in income deprived families (23.8%). We also had the highest percentage of children aged under 16 living in absolute low-income families in London (21.2%) in 2020/21.

Around 218,900 people live in the borough and although the local population is the 10th lowest in London, it has seen the 3rd highest growth in numbers in recent years. Between 2011 and 2021, the population size of the borough increased by nearly 33,000 (17.7%).

Our local population is young, with an average age of 33 years old, and the highest proportion aged under 18 within England and Wales (28.9%). B&D also has the highest proportion of under 5s in the UK (8.8%). Nearly a quarter (23.6%) of the borough's population are aged between 5-19 years old and almost a third (31.5%) are aged 19 and under. This younger population has showed considerable growth in the decade leading up to the 2021 Census.

Although nearly six in ten residents (c.128,500 people) were born in the UK (58.7%), the borough has a diverse population, in which 44.9% are White, 25.9% Asian, 21.4% Black, 4.3% Mixed and 3.6% of Other ethnic groups. The last Census data also told us 8.4% of the borough population are migrants (i.e. had a different address on Census day to the same day one year before) and a quarter of the local population had lived in the UK for 10 years or more.

In 2018-2020, life expectancy in the borough for both men (77.0 years) and women (81.7 years) was reduced and is significantly worse than the national averages. We also had the highest rate of premature death in London in 2021 for people aged below 75.

Similarly, healthy life expectancy for males in B&D in 2018-20 was 58.1 years, which was the lowest of the London local authorities and worse than both London (63.8 years) and England (63.1 years). Healthy life expectancy for females in the borough for 2018-20 was 60.1 years, which was the 3rd lowest of the London local authorities and significantly worse than both London (65.0 years) and England (63.9 years).

Potential impacts	Positive	Neutral	Negative	What are the positive and negative impacts?	How will benefits be enhanced and negative impacts minimised or eliminated?
Local communities in general	X			The aim of the Health and Wellbeing Strategy is to improve the health of all residents, but also focus where inequalities exist and	The importance of involving local communities has been outlined within this refresh, with the ambition that more strategic and ongoing

				where action will have the greatest impact. The refreshed strategy will continue to address issues for specific groups within each of its themes.	approaches to engagement will be undertaken throughout the lifetime of the strategy. The development of these approaches will be formed as part of next steps, we will seek input from residents, so they decide how this should be done.
Age	X			We have: The highest proportion (26.1%) of residents aged 16 and under across England & Wales. 65.2% of residents aged 16-64 and the remaining aged 65+. The greatest changes by age group (increases in those aged 0-64 and decreases in those 65+) compared to both England and London.	The refresh takes a life course approach addressing issues under the three themes: Best Start; Living Well; Ageing Well and will look to act on issues that are most relevant to residents at each stage of life. Children, young people and family specific engagement was undertaken as part of the 'Best Chance Strategy' development which this refresh has reflected on. Engagement with adults will be carried out by the delivery group when forming delivery/action plans and specific approaches to doing this will be directed by residents.
Disability	X			We have the highest proportion of households in London where at least one person identified as disabled (29.8%). 13,700 (6.3%) Barking & Dagenham residents considered themselves to be disabled under the Equality Act and considered their day -to -day activities to be limited a lot and 15,300 (7.0%) said a little.	One of the Strategy priorities is to address long term conditions, including the identification of those at risk; support early diagnosis and treatment to prevent long term serious issues and avoidable admissions. The ways in which groups and communities will be involved in agreeing specific actions to address this will be the responsibility of the delivery groups. This

				The last Census also shows after age standardisation we have a higher proportion compared to London and England in terms of residents with fair, bad and very bad health. Cancer, cardiovascular disease (linked with preventable causes such as smoking, alcohol and obesity) are major killers and contribute to the gap in life expectancy and residents from Black and Asian backgrounds developing long term conditions earlier than White British. A higher smoking prevalence is found within our more deprived communities in the borough, as well as those people with severe mental illness. We also have one of the highest adult obesity rates within London for years 2020/21, with inequalities locally for residents who are Black, women and/or in lower socioeconomic areas.	development will begin once the strategy is published.
Gender reassignment		X		Based on the latest Census data for those aged 16 and over: 9 in 10 residents' gender identity was the same as sex registered at birth (90.4%). Of all English & Welsh local authorities, for those aged 16+, B&D had the highest proportion of trans women (0.25%) and the 3rd highest proportion of trans men (0.24%). We also had the 5th highest proportion of people whose	Previously, views of the LGBTQ+ communities and relevant professional stakeholders were accounted for and represented through engagement on the initial Strategy (2019-23), which included those who have undergone gender reassignment. Focus groups were held with Flipside LGBTQ+ members to formulate statements for inclusion in the previous strategy,

				gender identity was different, but no specific identity given (0.64%).	outlining what good health means for residents.
Marriage and civil partnership		X			
Pregnancy and maternity	X			A theme within the strategy is 'Best Start in Life' which focuses on health and wellbeing from the pre- natal period into young adulthood (to positively impact mother and child) and includes healthy pregnancy; developmental support; support for SEND children and young people; mental health as well as domestic violence and addressing adverse childhood experiences. One area of focus within is on obesity and smoking. Our rates for obesity in pregnancy (2018/19) were 27.4%, which is higher than both London and England. High rates of obesity in reception aged children are also greater than regional and national figures. However positively, rates of those smoking at time of delivery (which is linked to low-birth-weight babies and premature births) was 4.5% (in 2021/22), which is much lower than England (9.1%), but the rates of low birth rate babies and premature births still remains poor compared to London and England.	Forums and workshops were conducted in 2022 with stakeholders (multi-agency; children and young peoples voice; education; VCSE; health) to develop the 'Best Chance Strategy' outputs from this inform aims, priorities and outcomes within this document. Engagement will be an ongoing process and the Best Chance Delivery Group will look to address needs- which include those during pregnancy and maternity.
Ethnicity		X		We had the greatest increase in ethnic diversity between 2011-21 and 151,300 residents are non-White British. Of all English & Welsh local authorities, we have the	There are differences in health outcomes and variation across ethnic groups and health conditions. Data will be used to take a targeted approach to ensure

				highest proportion of Black African residents and 4th highest proportion of Asian Bangladeshi residents. Romanian (4.5%) is the highest national identity of residents who do not identify as British or English.	views of different ethnicities are accounted for and relevant actions/approaches are taken to improve equity and inequalities where they exist.
Religion or belief		X		Our borough has a higher proportion of Muslims compared to London and England. The proportion of Christians in Barking & Dagenham has dropped below half since the previous census but is higher than London. A fifth of Barking & Dagenham residents have no religion – lower than both London and England.	
Sex	X			Life expectancy in the borough reduced for both sexes in recent years and is worse than national averages. Although women still outlive men, they live longer in poorer health resulting in poor quality of life and greater need/reliance on services.	The Best Start in Life theme/focus will have a positive impact for women (although equally for both sexes of the child). Areas of action as part of the Best Chance Strategy will seek to uncover any variation between sexes relating to young peoples health issues.
Sexual orientation		X		On Census Day, nearly 9 in 10 Barking & Dagenham residents described their sexual orientation as Straight or Heterosexual (88.6%), which is higher than London (86.2%), but lower than England (89.4%). Of all authorities in England and Wales, we had the 4th highest proportion who described their sexual orientation as all other sexual	Previously, views of the LGBTQ+ communities and relevant professional stakeholders were accounted for and represented through engagement on the initial Strategy (2019-23), which this is a refresh of.

				orientations (0.07%) and 23rd highest proportion who described their sexual orientation as Pansexual (0.38%).	
Socio-economic Disadvantage	X			62.4% households were deprived in at least one dimension (education, employment, health, housing) - the highest in England & Wales. Of all English & Welsh wards, 11 B&D wards were in the highest 10% for deprivation and 5 were in the highest 20%. <u>Households</u> 62.4% households were deprived- the highest in England & Wales 12.8% households were lone parents with dependent children – the highest in England & Wales And 8.6% households were multi-family households with dependent children – 2nd highest in England & Wales <u>Housing</u> Of all English and Welsh local authorities, in terms of households we had the: 3rd highest proportion who rent their home from the Council/Local Authority (24.5%). 2nd highest proportion living in a property without enough bedrooms (17.8%).	An area of action within the strategy is for 'anchor institutions' to develop there roles as such and to deliver a health in all policies approach with partners. This relates to training, education, skills development and housing to help address the wider/social factors that contribute to disadvantage and ultimately impact on health.

				7th highest proportion living in a property without enough rooms (20.4%). <u>Education</u> B&D (2.29) has the lowest Qualification Index score of all London boroughs – and is one of only 4 London boroughs whose index score is below the English average. 22.7% residents aged 16 and over had no qualifications - highest proportion of all London boroughs. 33.3% residents aged 16 and over had Level 4 qualifications- the 3rd lowest proportion of all London boroughs.	
Any community issues identified for this location?		X		Language: 5.1% of residents aged 3 and over cannot speak English well or at all. Romanian (4.8%) is also the most common language of residents whose main language is not English, followed by Bengali and Lithuanian. 41.3% of residents were born outside of the UK – 16th highest in England & Wales. This is 10.4% higher than 2011 Census and the 2nd highest percentage point change in England & Wales. Transience: 14% of residents arrived in the UK between 2001 and 2010, which is the 2nd highest proportion in England & Wales.	

				9/10 residents were living at the same address one year before Census Day, however it's important to note the pandemic limited people's movement.	

2. Consultation.

Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups. If you have already undertaken some consultation, please include: • Any potential problems or issues raised by the consultation • What actions will be taken to mitigate these concerns
Broad consultation took place to create the initial Strategy (2019-23) (consultation with 16 teams and partnerships and 12 resident focus groups with 128 attendees), upon which this refresh is based. This refresh has considered the engagement with children, young people, families and relevant professional stakeholders in the creation of the 'Best Chance Strategy' in 2022 and feeds directly into the 'Best Start in Life' aims, priorities and outcomes within this. It has also considered the extensive engagement undertaken and outputs from the Boroughs Domestic Abuse Commission Report, 2021. Engagement with residents via a One Borough Voice survey was undertaken to 'sense check' the previous priorities and capture any emerging issues; Health Watch also undertook engagement by asking key questions relating to priority areas- long term conditions; healthy lifestyles and employment and education. Consultation between March and April 2023 was carried out regarding the vision, aims, principles and themes in the framework with the following overarching groups: • Residents • Internal Council stakeholders • External Council partners and colleagues Feedback received has been summarised and incorporated into the final version of the strategy.

3. Monitoring and Review

How will you review community and equality impact once the service or policy has been implemented? *These actions should be developed using the information gathered in **Section 1 and 2** and should be picked up in your departmental/service business plans.*		
Action	**By when?**	**By who?**
Form and review plans outlining actions and methods of measurement to achieve outcomes specified in the strategy.	Quarterly	Best Chance Delivery Group Adults Delivery Group
Monitor the outcomes of the strategy.	Annually	Health and Wellbeing Board

4. Next steps

It is important the information gathered is used to inform any Council reports that are presented to Cabinet or appropriate committees. This will allow Members to be furnished with all the facts in relation to the impact their decisions will have on different equality groups and the wider community.

Take some time to summarise your findings below. This can then be added to your report template for sign off by the Strategy Team at the consultation stage of the report cycle.

Implications/ Customer Impact
A renewed vision for improving the health and wellbeing of residents is being set out for the period of 2023-28 is based on key themes and outcomes of the previous Strategy 2018-23, although it has a greater focus on coproduction with communities: • Best Start in Life • Living Well • Ageing Well Once the Strategy refresh is approved at June's health and wellbeing board, specific action plans will be co-created and developed with residents, led by the Adults Delivery Group and Best Chance for Children and Young People Delivery Group to deliver against the priority themes- as part of next steps. The delivery groups will work to establish the best way to involve residents and communities in an ongoing approach to improving co-production, decision making and evaluation.

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

5. Sign off

The information contained in this template should be authorised by the relevant project sponsor or Divisional Director who will be responsible for the accuracy of the information now provided and delivery of actions detailed.

Name	Role (e.g. project sponsor, head of service)	Date
Jane Leaman	Consultant in Public Health	June 2023

BARKING AND DAGENHAM

Joint Local Health and Wellbeing Strategy

2023-2028

Improving and protecting health, wellbeing and reducing health inequalities.

Barking & Dagenham

Foreword

I am pleased to introduce our refreshed Joint Local Health and Wellbeing Strategy. This strategy provides a clear, concise and convincing explanation of what we need to do, and what impact we aim to have for the next 5 years, as a 'framework for action'. It includes the vision of how we can achieve this, and the outcomes and actions required to reduce health inequalities at every stage of residents' lives.

The health and care needs of our residents are unique, but so are the assets within our communities which need support to enable them to succeed, and this strategy reflects this. The challenge is clear in our Borough Manifesto – we need to get to the root cause of problems. Much of Barking and Dagenham's ill health is linked to social, economic, and environmental factors and most of them can be well addressed. Yet, our local health and care system continues to focus on ill-health and illnesses rather than focussing on promoting good health. Establishing a sustainable model of integrated health and social care requires using all resources to influence the wider determinants of health.

The combined impacts of the pandemic, cost of living crisis and demographic change further show the need for a difference in the way we design and deliver services. We cannot meet the rising needs of our population by spending more money on the kinds of services we currently provide. Instead, we need to re-focus what we do so that we identify the root cause of need and tackle it so that residents have a better chance of living more independently now and in the future.

By truly co-producing with residents, particularly those who experience the poorest health, we can understand the root causes of ill heath, the ways we can best meet needs and ensure communitunites are supported and empowered. Through working at a level closest to individuals and families and creating an infrastructure which move us from providing reactive/ transactional services which often intervene too late, to ones that are relational and create social capital to enable residents to live happier, healthier lives.

Good health is vital to an enjoyable and meaningful life free from avoidable illness and, in the worst cases, early death. But the importance of good health needs to be considered, particularly in our aspirational and developing borough, as a crucial factor of economic prospects, both at an individual and a system level. We want residents at all ages to engage and not be compromised by poor health – both physical and mental. To allow all residents to benefit from the new opportunities within Barking and Dagenham we need to ensure health is core to everything we do.

We would like to thank everybody that has been involved in this strategy refresh. Residents for offering their lived experiences; the Health and Wellbeing Board; elected members and individuals who demonstrate their commitment to this important agenda but the success of any plan is in its delivery.

Cllr Maureen Worby
Cabinet Member for Adult Social Care and Health Integration and Chair of the Health and Wellbeing Board

The combined impacts of the pandemic, cost of living crisis and demographic change further show the need for a difference in the way we design and deliver services.

INTRODUCTION

Welcome to the Barking and Dagenham plan for improving and protecting health, wellbeing and reducing health inequalities.

This strategy sets out a renewed vision for improving health and wellbeing of residents and communities and reducing inequalities by 2028. It reamplifies key themes and outcomes from the 2019-2023 strategy – which are still relevant – and defines how we can deliver these over the next 5 years. It recognises and harnesses our new partnerships, with a particular focus on ensuring communities are central to coproduction and delivery.

Local health services have a key role to play in delivering this vision but many issues impacting health are outside of the health service. Therefore the heart of this strategy is to tackle the wider determinants of health. It recognises the need for equity by targeting those with the poorest health and wellbeing and therefore those who would benefit the most from support working with residents to ensure actions meet individual needs and characteristics of our communities.

Following the publication of the refreshed JSNA (2022) and the Barking and Dagenham Best Chance Strategy a partnership plan for babies, children, young people and their families, it was agreed that the key themes within the current HWB strategy (2019 -2023) remain but are refreshed in the context of the new NHS Integrated Care System (ICS) and after the COVID-19 pandemic and the current 'cost of living crisis' for the period 2023 -2028 (as recommended in the Director of Public Health's report 2021-22).

This strategy has been produced at a time of significant transformation to the NHS and wider health and care system. Organisations responsible of health and care services have come together to form. This partnership will have a key role in delivering wider programmes to promote health and wellbeing and integrate services to improve health and experience of care for local people.

An initial programme of community engagement was undertaken to help outline 'what good looks like' against the agreed priorities; and following this we further engaged with residents through an online survey, through Healthwatch and with partner organisations as key stakeholders, to establish what actions we should focus on in our plan.

The strategy sets out an indication of the health needs in the borough, what we want to achieve and key areas for action needed to get there.

This strategy sets out a renewed vision for improving health and wellbeing of residents and communities and reducing inequalities by 2028.

WHERE ARE WE NOW:

OUR POPULATION AND ITS HEALTH CHALLENGES

Our local population is young, with an average age of 33 years old, and the highest proportion aged under 18 within England and Wales (28.9%).

Barking and Dagenham is the most deprived borough in London, based on Index of Multiple Deprivation score (32.8)[1] and is ranked 5th in London on the related Income Deprivation Affecting Children Index (IDACI) score, which measures the percentage of all children aged 0 to 15 years who live in income deprived families (23.8%).[2] Furthermore, B&D had the highest percentage of children aged under 16 living in absolute low income families in London (21.2%) in 2020/21.[3]

Around 218,900 people live in Barking and Dagenham and although the local population is the 10th lowest in the London boroughs, it has seen the 2nd highest growth in numbers in recent years. Between 2011 and 2021, the population size of the borough increased by 17.7%, from around 185,900 to 218,900.[4]

Our local population is young, with an average age of 33 years old, and the highest proportion aged under 18 within England and Wales (28.9%). Barking and Dagenham also has the highest proportion of under 5s in the UK (8.8%). Nearly a quarter (23.6%) of the borough's population are aged between 5-19 years old and almost a third (31.5%) are aged 19 and under. This younger population has also showed considerable growth in the number of residents aged 5-9 (28%), 10-14 (43%) and 15-19 years old (20%), in the decade leading up to the 2021 Census.[5]

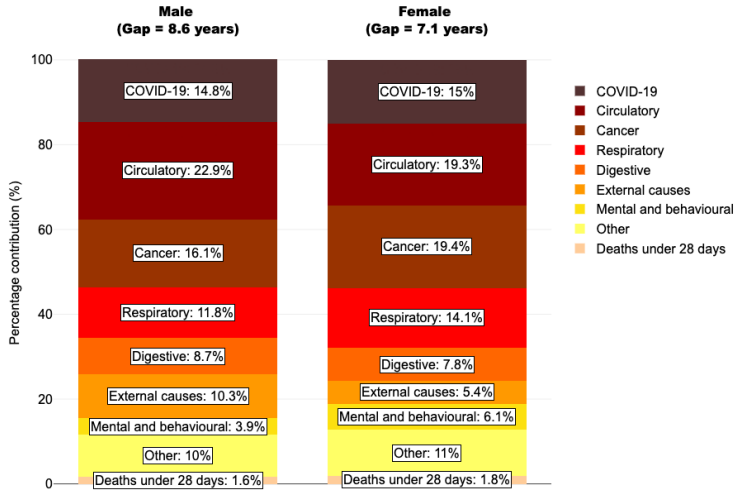
Although nearly six in ten local residents (c.128,500 people) were born in the UK (58.7%), the borough has a **diverse population**, in which 44.9% are White, 25.9% Asian, 21.4% Black, 4.3% Mixed and 3.6% of Other ethnic groups.[5] The last Census data also told us 8.4% of the borough population are migrants (i.e. had a different address on Census day to the same day one year before) and a quarter of the local population had lived in the UK for 10 years or more.

In 2018-2020, **life expectancy** in the borough for both men (77.0 years)[6] and women (81.7 years)[7] was reduced and is significantly worse than the national averages. We also had the highest rate of **premature mortality** in London in 2021, with 511.9 deaths per 100,000 people aged below 75, compared to 358.9 for London overall.[8]

Similarly, healthy life expectancy for males in B&D in 2018-20 was 58.1 years, which was the lowest of the London local authorities and significantly worse than both London (63.8 years) and England (63.1 years).[9] Healthy life expectancy for females in the borough for 2018-20 was 60.1 years, which was the 3rd lowest of the London local authorities and significantly worse than both London (65.0 years) and England (63.9 years).[10]

Both **cancer and cardiovascular disease** (CVD) remain major killers in B&D and contribute to the gap in life expectancy for residents. However, many of these cases are caused by avoidable and essentially preventable lifestyle choices and behaviours linked to smoking, alcohol and obesity.[11]

The diagrams below show the greatest contributors to the life expectancy gap by cause of death for males and females in Barking and Dagenham for 2020/21.



We also had the highest rate of **premature (<75 years) mortality from cardiovascular diseases** in London for 2021, with a rate of 117.6 per 100,000, which was also significantly higher than both London (74.3 per 100,000) and England (76.0 per 100,000).[12]

Barking and Dagenham has some of the worse outcomes for **long term conditions (LTCs)** in London. For example, in 2021, Barking and Dagenham had the 2nd highest rate of premature (under 75) mortality from respiratory disease in London, with a rate of 38.1 per 100,000, which is significantly higher than the rates for both London (22.5 per 100,000) and England (26.5 per 100,000).[13]

However, the number of people with **long term conditions (LTCs)** is substantially lower than expected, which may be related to the young population in Barking and Dagenham, but also indicates that many cases currently go undiagnosed and untreated.

For adults, the borough had the 3rd highest rate of emergency hospital admissions for **COPD** in 2019/20, with a rate of 597 per 100,000, which was significantly higher than both London (358 per 100,000) and England (415 per 100,000).[14] It also had the 2nd highest mortality rate from COPD in London at 59.9 per 100,000, which was significantly worse than both London (34.8 per 100,000) and England (39.8 per 100,000), in 2021.[15]

Smoking is the leading preventable cause of ill health and mortality in B&D and although there has been a national decline in smoking prevalence since the 1950s, 11.3% of adults in Barking and Dagenham in 2021 **smoked**, which is similar to both London (11.5%) and England (13.0%).[16] However, higher smoking prevalence is found within the more deprived communities in the borough, as well as those people with severe mental illness, contributing significantly to health inequalities.

The percentage of women in the borough smoking at the time of delivery has also shown a significant decrease over the last decade falling from 13.1% (in 2011/12) to 4.5% in 2021/22, which is significantly lower than in England overall (9.1%).[17] In contrast, smoking attributable mortality, as well as smoking attributable deaths from cancer, in Barking and Dagenham, have in recent years been the highest in London at 280.9 per 100,000 and 115.7 per 100,000 respectively.[18,19]

Smoking is also linked to the delivery of low birth weight babies and premature births. For premature births (i.e. those less than 37 weeks gestation), Barking and Dagenham has the 3rd highest rate in London (89.1 per 1,000), and significantly worse than London (76.4 per 1000) and England (79.1 per 1,000).[20] In addition, our borough is significantly worse than England on low birth weight of term babies with a rate of 3.8%, compare with 2.8% nationally.[21]

In 2021, Barking & Dagenham had the highest percentage of its economically active population unemployed of all the London boroughs (7.6%).

The borough had the highest prevalence of **obesity** in London for Reception Year (14.8%)[22] and Year 6 children (33.2%), in 2021/22[23] both of which are significantly higher than regional and national averages. Similarly, the borough had the 3rd highest proportion of obese adults (28.6%) within the London local authorities for years 2020/21.[24]

In the year ending March 2023, there were 3,568 **domestic abuse offences** recorded by the Metropolitan Police for Barking and Dagenham, representing a rate of 16.7 per 1,000, which is the highest rate within the London boroughs. This rate is a 2.7% increase on the previous year and a 10.5% rise on the previous month although some of this is due to good reporting. Of these offences, 798 were domestic abuse violence with an injury.[25]

It is estimated that 75.43 per 1000 children aged 0-4 years old in Barking and Dagenham live in households where a parent is suffering domestic abuse, compared with the national rate of 71.33 per 1000.[26]

Overall, in the year ending March 2023, there were 116.3 crimes per 1,000 people in Barking and Dagenham, which is higher than the rate for London (109.7 per 1,000 population).[27]

Similarly, for 2021, the borough had the 5th highest rate of first-time entrants into the youth justice system in London, with a rate of 256.0 per 100,000, which was significantly higher than the national rate (146.9 per 100,000).[28]

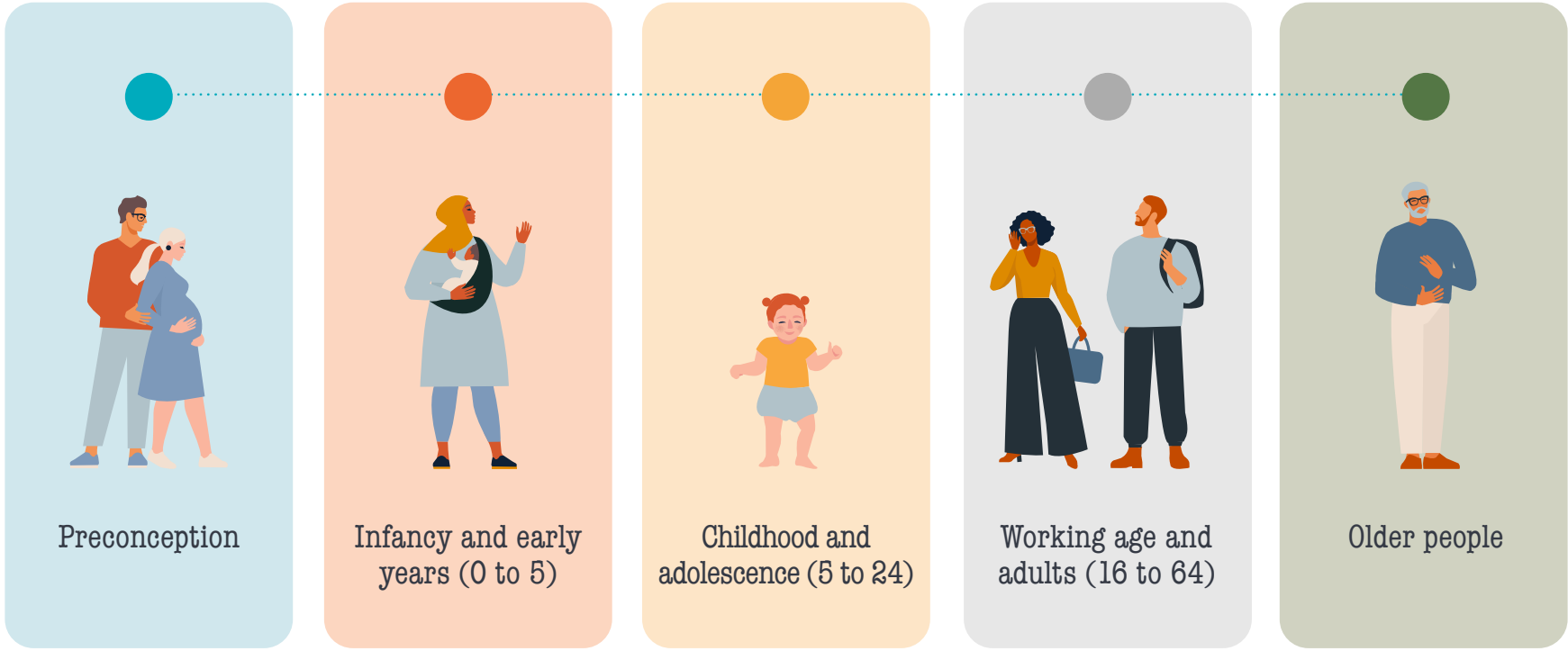
In recent years (since 2019) there has been an increase in the number of children and young people with Education Health and Care Plans (EHCPs) in Barking and Dagenham, with the most common primary needs identified in 2022 being Autistic Spectrum Disorder (ASD) (31.9% of EHCPs) and Speech, Language and Communication needs (18.3%).

Between 2019/20 and 2021/22, the rate of households in **temporary accommodation** in B&D fell significantly from 20.7 to 17.8 per 1,000. However, the borough still had a significantly higher rate than both London (16.3 per 1,000) and England (4.0 per 1,000), on this measure of homelessness.[29]

Fuel poverty in Barking and Dagenham was the worse in London, with nearly 14,000 households in the borough (18.6%) experiencing this form of economic challenge, in 2020.[34] In 2021/22, the borough also had the 7th highest percentage of the working population claiming out of work benefits (8.7%) in England.[35]

In 2021, Barking & Dagenham had the **highest percentage of its economically active population unemployed of all the London boroughs** (7.6%).[30] During 2021/22, the borough also had the 3rd lowest percentage in London of people in employment (67.6%).[31] However, Barking & Dagenham also has the second highest economic inactivity rate (30.2%) of all the London boroughs in 2021/22, which is significantly higher than both London (20.5%) and England (21.2%).[32] Defined as the proportion of the working age population (16-64 years old) who are economically inactive (i.e., neither employed nor unemployed), this measure is associated with negative health outcomes.[33]

Action is required across the life course



	Obesity in Pregnancy % (2018/19)	Low Birth Weight at Term (2021)	Good Development at 2-2.5 yrs (2021)	Children Living in Absolute or Relative Poverty (2022)	Unhealthy Weight at 10/11 yrs (2021/22)	Economic Inactivity 16-64yrs (2021/22)	Domestic Abuse Incidents per 1,000 population (2021/22)	Healthy Life Expectancy M/F (2018/20)	Life Expectancy at Birth M/F (2021)
Barking and Dagenham	27.4%	3.8%	56.0%	49.0%	49.1%	30.2%	35.4	58.1/60.1 yrs	75.6/80.3 yrs
London	17.8%	3.3%	79.9%	29.5%	40.5%	20.5%	35.4	63.8/65.0 yrs	78.8/83.4 yrs
England	22.1%	2.8%	81.1%	37.0%	37.8%	21.2%	30.8	63.1/63.9 yrs	78.8/82.8 yrs

WHAT ARE WE TRYING TO ACHIEVE?

Our Vision:

By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere.

Our residents will benefit from coproduction and partnerships around their needs and priorities.

Themes

The strategy will be based on three themes:

- Best Start in Life
- Living Well
- Ageing Well

Outcomes

The following sets the long-term outcomes for each of the three themes within the strategy, but this strategy will focus on the actions for the Health and Well Being Board over the next five years:

Best start in life

We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools and settings, in inclusive communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

Living well

We want to ensure residents live well and realise their potential, and when they need help they can access the right support, at the right time in a way that works for them.

Ageing well

We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions
- Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious
- Their health and wellbeing is improved to support better opportunities (educational, employment, social) and independent living for as long as possible

HOW ARE WE GOING TO GET THERE?

Core to the strategy is addressing health inequalities by taking a place-based approach, with a fully engaged community.

To help us to do this we have referred to a number of frameworks which exist[36], which help us to deliver throughs system and at scale, depending on audiences contexts and priorities. Drawing on this evidence, the strategy is under pinned by the following principles:

- Coproduction with Communities
- Integrated Care
- Taking Place-Based Action
- Addressing Health Inequalities
- Acting on What Makes Us Healthy

Principles

The following are the principles which underpin the strategy:

Coproduction with Communities

At the forefront of action is a genuine commitment to the value of relationships and coproduction with residents in designing or discovering changes to meet the needs of our communities. Building a connected, effective community infrastructure, where healthy life expectancy is improved, takes commitment and discipline by the whole system. The work being developed around geographical areas known as localities, is building a system where:

- Resources are maximised and organisations are released to do what they do best.
- Referrals to formal services are accurate and appropriate.
- Residents are empowered – getting what they need, when they need it and from the right place (e.g.: a neighbour; a friend; a social sector organisation; place ofworship; the local authority; or primary or secondary care).
- The value of relationship (connection, trust and belonging within the community) is recognised as essential to health and wellbeing as council and health services.

This will take the form of working with the following range of Community-centred approaches[37] for health and wellbeing:

- **Strengthening communities** – Building on community capacities to act together on health and the social determinants of health.
- **Volunteer and peer roles** – Focus on increasing an individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities.
- **Collaborations and partnerships** – Involve communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation.
- **Access to community resources** – Connect people to local resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

Integrated Care

We will work to ensure that residents can access the right support, at the right time in a way that works for them. This requires understanding of assets and roles across sectors, as well as within our communities. 'Shifting the centre of gravity' to make place-based, person-centred health and care a reality can be supported by the following principles:

Building on what already works locally

Expanding the partnership already working effectively to plan and deliver joined-up, person-centred services.

A person-centred approach

Co-production to plan and deliver care and support with individuals and, where they wish, with their families, to achieve the best outcomes. As well as empowering communities to manage their own health and wellbeing.

A preventative, assets-based population health approach

Maximising health and wellbeing, independence, and self-care in or as close to people's homes as possible to reduce their need for health and care services.

Achieving best value

Working together to ensure delivery of care and support represents the best value, including, of securing the best possible health and wellbeing outcomes using safe and high-quality services, while ensuring the sustainable use of resources.

Taking Place-Based Action

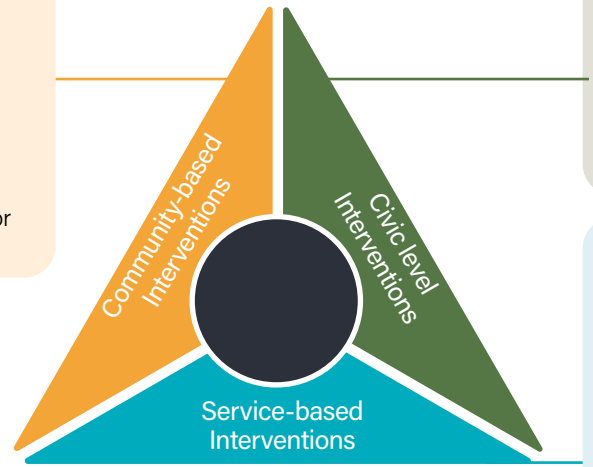
To make a difference, effective action is required at civic, service and community levels as shown by the population intervention triangle. System leadership and planning through our new partnership arrangements will ensure action is effective and is meeting needs of our residents.

This will be done by making sure interventions are:

1. Evidence based
2. Outcomes orientated
3. Systematically applied
4. Scaled-up appropriately
5. Appropriately resourced
6. Sustainable

Population Intervention Triangle

- The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, as building blocks for good health.



- Legislation; regulation; licencing; by-laws
- Fiscal measures: incentives; disincentives
- Economic development and job creation
- Spatial and environmental planning
- Welfare and social care
- Communication; information; campaigns
- Major Employer

- Delivering intervention systematically with consistent quality and scaled to benefit enough people.
- Reduce unwarranted variation in service quality and delivery
- Reduce unwarranted variability in the way the population uses services and is supported to do so.

Addressing Health Inequalities

Addressing avoidable and unjust differences in health between residents is a key underpinning principle in all our work to deliver this strategy.

These differences are a result of health events across the life course from pre-birth, and over 80% are unrelated to access to health services.

In Barking and Dagenham, residents are exposed to more negative risks to health than those in other local areas, i.e., the highest percentage of households suffering multiple deprivations (68%; Census 2021). This will be worsened by the 'cost-of-living crisis', with B&D residents having the fourth highest vulnerability to it out of 307 local areas[33].

Acting on What Makes Us Healthy

Services have an important role in enabling us to be healthy, however improving health and reducing health inequalities requires us to also act on the 80% of health determinants outside of healthcare. Working across partnerships which places the assets and needs of individuals and communities at the centre can enable us to make a real change on 'what makes us healthy' (Health Foundation, 2019).

WHAT ACTIONS ARE NEEDED OVER THE NEXT 5 YEARS?

Priorities

The JSNA has been complemented by other important sources (such as the 2021 Census) to create a set of key priorities agreed by the Place Based partnership. These relate to:

- **Improving outcomes for people with long term conditions in children and adults.**
- **Addressing unhealthy weight and smoking in children and adults.**
- **Providing the best start in life for our babies, children, and young people.**
- **Preventing and addressing domestic abuse.**
- **Preventing exposure to and the consequences of adverse childhood experiences.**
- **Addressing wider determinants of health- for example unemployment, poor housing, low level of training, education and skills development.**

Proposed Actions

Strategic Leadership

For a place to be effective in delivering systematic system wide place or population action to address health inequalities the following needs to be in place[36]:

1. A vison and strategy with measurable goals, coordinating targeted action at all levels
2. System leadership and accountability for action on health inequalities
3. A system approach to data linkage and data and evidence driven policy and intervention development and implementation
4. Building on the evidence base of what works
5. Improved system capability for action on health inequalities and wider determinants of health
6. Use of systematic assessment tools to drive multi-agency cross system action
7. Comprehensive engagement to magnify community voice

Co-production

Working in partnership to design and deliver support together

The strategy's focus includes a core commitment to working in creative partnerships with communities to achieve our aims - to reduce health inequalities so no-one is left behind.

We know communities know best about having access to the right services, in the right place, at the right time and whether services are accessible for the people who need them.

We want to work with communities who face the most inequalities to achieve lasting change – releasing the power of communities to participate in change-making, bring challenge and lead where appropriate.

We want to develop ways that will best help our residents and communities to take part in thinking and developing solutions together for improving health and well-being in B&D and to help us understand progress made with delivery.

To help do this we are proposing that we will focus in year one on:

- Finding new and creative ways of bringing people together to share experiences, ideas and voices
- Developing a new approach to maximise the unique positioning of residents and community organisations to build resilience and where needed, early help when issues arise- which includes their collaboration with statutory services
- Using data, to understand our population - particularly our underserved communities better and consider the relevant approaches required for working together
- Co-creating and co-developing specific actions to deliver this strategy, ending in a co-produced action plan

Our long-term aim is to develop approaches that better enable and empower local communities to shape and contribute to how the strategy tackles health inequalities and improves health and well-being on an ongoing basis.

We know we cannot do this alone.

Developing our approach to co-production

We want to develop our approach to co-production in partnership and to work with a wide range of people, professionals and organisations. We are committed to making this work and the following principles will be part of how we do this:

- Involve everyone who will be taking part in co-production from the start.
- Value and reward people who take part in the co-production process.
- Ensure that there are resources to cover the cost of co-production activities.
- Ensure that co-production is supported by a strategy that describes how things are going to be communicated.

We would like to find the best way with residents and our communities for them to strengthen our approach to co-production; better contribute to the development of the strategy and monitor progress of delivery over time. By doing this we want to build co-production into the following activities as part of what we do:

- **Co-design,** including planning of services and support
- **Co-decision making** in the allocation of resources and funding
- **Co-evaluation** of services and performance

Delivering Priorities

Providing the best start in life for our babies, children, and young people. To be healthy, be happy and achieve by:

- Increasing access to services including maternity, health visitors and early help provision.
- Tackling early causes of childhood neglect.
- Improving poor perinatal mental health and domestic abuse.
- Improving uptake of breastfeeding, immunisations and two-year-old checks.
- Improving school readiness, education outcomes and standards.
- Supporting healthy weight.

To grow up to be successful young adults by:

- Accessing good quality youth support.
- Increasing feelings of safety through reducing serious violence, offending and reoffending.
- Proving supportive pathways into adult services.
- Improving a strong training and local employment offer, especially for care leavers and those with SEND.
- Providing positive diverse and inclusive role models.
- Supporting with transitions & developing skills for adulthood.
    - To thrive in inclusive schools and settings, in inclusive communities by:
        - Accessing Early Help and Support for children, young people, and families with SEND.
        - Providing a better offer for those with social, emotional and mental health needs, including timely access to CAMHS.
    - To be safe and secure, free from neglect, harm and exploitation, by:
        - Supporting good child protection and Child Death Overview Panels decisions and outcomes.
        - Developing contextual safeguarding approaches.
        - Caring for children in care and care leavers.

Preventing the exposure to and the consequences of adverse childhood experiences (ACEs).

Action will include:

- Building resilience through, e.g. parenting programmes/strengthening families; mentoring opportunities; school-based programmes to develop life skills; psychological support to deal with negative impacts of ACEs; community-based programmes that strengthen local resources and relations.
- Raising awareness of behaviour norms and environments that contribute to ACEs.
- Developing Trauma Informed practice within communities and settings.

Delivered through:

- Implementing the national 'Start for Life' programme,
- Strengthening the delivery of the 0-19 Healthy Child Programme
- Setting up three locality-based Family Hubs and a Family Hub Network as the channel for integrated working across the system in the borough.

Living Well

Addressing unhealthy weight and smoking in children and adults

Action will include:

- Development of a system wide approach needed to address unhealthy weight including joined up support for those living with unhealthy weight; increasing access to safe open spaces for play, walking and cycling; opportunities for physical activity and enabling healthier diets.
- Developing a system wide approach to reducing smoking – including stopping children starting and providing access to evidence-based stop smoking services.

Preventing and addressing domestic abuse

Action will include:

- Delivering the Barking and Dagenham Domestic Abuse Improvement Programme.
- Leading the delivery of a broader Public Health Approach to addressing domestic abuse.

Addressing wider determinants of health for example employment (including unemployment, under employment and employment quality), poor housing, low level of training, education, and skills development

Action will include:

- Delivering a Health in all Policies approach (linking to the themes[38] identified within the Barking and Dagenham Together vision document 2017 – 2237) with all partners responsible, to allow opportunities for people through training, education, skills development, and good employment.
- Supporting housing policy to improve health and wellbeing.
- Acting on air quality to improve health.
- Public sector partners developing their roles as 'anchor institutions.'
- Delivering the Serious Violence Duty to reduce child exploitation and crime.

Ageing Well

Improving health and wellbeing for residents, particularly those with long term conditions.

Action will include:

- Improving health behaviours such as smoking and physical inactivity.
- Improving connection, cohesion and reducing loneliness.
- Providing appropriate and accessible services and support for residents to prevent development of health conditions.
- Supporting residents to understand when and how to access services for the assessment and management of long-term conditions.
- Ensuring more residents with health conditions are assessed, identified and provided with condition management as early as possible.
    - Development of integrated teams that allow residents to receive the support and care needed to live independently for as long as possible.
    - Development and delivery of a digital transformation strategy for Care and Support.

HOW WILL WE KNOW WE HAVE BEEN SUCCESSFUL?

Outcomes

Each priority/ theme will have several outcomes (short, medium and long term- up to 5 years).

Performance Indicators

Performance indicators will be identified against which progress with be tracked, to deliver improvements to health and wellbeing and reduce health inequalities.

Delivery Plans

A detailed set of delivery plans will be developed to describe activity to achieve the agreed measures.

Accountability

Responsibility for delivering these plans will sit with our Place Executive Group with implementation of the plans by our system partners through both the Adult, and Best Chance for Babies, Children and Young People Delivery Groups.

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Barking & Dagenham

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COMMITTEES IN COMMON OF THE HEALTH AND WELLBEING BOARD AND INTEGRATED CARE SYSTEM SUB-COMMITTEE

26 June 2023

Title:	**Better Care Fund 2023-2025**
Report of the Strategic Director, Children's and Adults	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: Yes**
Report Author: Louise Hider-Davies, Head of Commissioning, Adults' Care and Support	**Contact Details:** E-mail: louise.hiderdavies@lbbd.gov.uk
Sponsor: Elaine Allegretti, Strategic Director, Children's and Adults	

Summary:

The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. Every year the local authority and the CCG (now ICB) are required to submit a template and/or narrative to NHS England to set out how the BCF is delivered in Barking and Dagenham. This year the template will cover two financial years – 23/24 and 24/25.

Recommendation(s)

The Health and Wellbeing Board and ICS Sub-committee are recommended to:

1. Agree the Better Care Fund submission to NHS England;
2. Agree to enter into a variation to effect the changes to the Section 75 governing the Better Care Fund, reflecting the 23-25 Better Care Fund submission.

Reason(s)

The Better Care Fund enables the local authority and NHS organisations to jointly plan and deliver local services to support Barking and Dagenham residents. The BCF funds projects and services that are delivered by stakeholders from across the system, designed to improve health and social care outcomes, prevent re-admission to hospital, maintain and improve independence and support hospital discharge. The BCF works to deliver the Council's vision and priorities.

1. Introduction and Background

1.1 The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. It brings together ring-fenced budgets from Integrated Care Board (ICB) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

1.2 In summary, this encompasses:

1) Minimum ICB (Min ICB):

- ICB funding including s256 proportion to LAs to support out-of-hospital services such as Reablement funding to maintain reablement capacity in LAs, community health services, independent/voluntary sectors
- Care Act monies to support the implementation of the Care Act 2014
- Carers' Break funding so carers can have a break

2) Disabled Facilities Grant (DFG) paid directly to LAs: for home adaptations and technologies to support people to live independently at home

3) Improved Better Care Fund (iBCF) paid directly to LAs for Social Care Funding:

- Meeting adult social care needs
- Reducing pressures on the NHS, including seasonal winter pressures
- Supporting more people to be discharged from hospital when they are ready
- Ensuring that the social care provider market is supported.

1.3 In addition for 23-25, Discharge Funding has also been incorporated into the Better Care Fund. This will be outlined in more detail below.

1.4 We have a Section 75 that governs the arrangement between us, Havering and Redbridge and NHS North East London. An executive group steers the development of the BCF and in terms of governance, this group feeds up into the Joint Commissioning Board (JCB). This arrangement will be reviewed as the Place Based Partnerships in each area develop over the coming year, although the intention is that each Place will have its own Section 75 with the ICB by April 2024. A follow up report will be brought to the Health and Wellbeing Board setting out these new arrangements and requesting authorisation for a new Section 75. For 23/24 each variation to the current Section 75 will be at Place level and will be agreed by October 2023 as per the national timetable.

2. Proposal and Issues

1.5 Guidance for this year's BCF was released at the beginning of April and a planning template and narrative is required by the regional and national team for submission by 28 June. The policy framework/planning guidance can be found at the following:

- https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2023-25/
- Better Care Fund policy framework 2023 to 2025 - GOV.UK (www.gov.uk)

1.6 The requirements echo previous years and conditions are as follows:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
- NHS contributions to adult social care and NHS commissioned out of hospital services to be maintained in line with the uplift to NHS minimum contribution to the BCF.

1.7 In addition, the two policy objectives from last year have continued into this year and have been articulated as two further national conditions:

- Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time.
- Plans to set out how the services the area commissions will support people to remain independent for longer and, where possible, support them to remain in their own home.

1.8 For both objectives/conditions, areas have been asked to describe their approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care. As we did last year, the narrative at Appendix 1 has been structured around these two policy objectives/national conditions.

1.9 Due to continued joint commissioning activity and capacity challenges, the narrative plan has been updated at a BHR level, with Place updates throughout the document. We will look to disaggregate the narrative to Place level only in future years.

What's changed since previous years?

1.10 **Two year plan:** One of the biggest changes this year, is that the BCF planning is across two financial years to enable longer-term planning for local areas. BCF planning template has two separate parts on section 6a expenditure. Year 2 plans are provisional. Updated spend plans once funding allocations are formally confirmed along with metrics ambitions will be collected in Q4, and systems have had a chance to review progress.

1.11 **Inclusion of Adult Social Care Discharge Fund:** An additional £600m in 2023-24 and £1bn in 2024-25 has been announced by the government to support discharge from hospital and reduce delays allocated across ICBs (£300m) and LA (£300m). Local authorities have been given the funding directly but ICBs have been allocated the other 50% of funding separately to passport to places. Instead of a separate template, the Discharge Fund planning will be incorporated into the BCF planning template for 23/24 and 24/25.

1.12 **Capacity and demand plans:** Capacity and Demand plans were introduced last year and are now being embedded within Better Care Fund planning. Plans will cover health and social care capacity for intermediate care (bed and home based), urgent community response, short-term social care, estimates for discharge and community referrals and estimates for long-term social care. Insights from the

capacity and demand plans are used to inform the plans' approaches to delivering improvement against the programme objectives and metrics.

1.13 **Metrics:** Metrics have remained the same as last year, with an additional metric focused on falls. Metrics are therefore as follows:

- Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)
- Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)
- Improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence).
- Emergency Hospital Admissions due to falls in people over 65 (falls).

1.14 From Q3, areas will be required to set ambitions for a new metric that measures timely discharge. In addition, Hospital trusts will be required to fill in their patients' Discharge Ready Dates from 1st April 2023.

1.15 Discharge funding reporting will also start soon and areas will have to provide fortnightly reporting. Main BCF quarterly reporting will also start from Q2. There will be additional requirements for the second half of 2023-24 including:

- Ambitions for the new discharge metric
- Updates to capacity and demand plans.
- Areas will also need to set ambitions for metrics and capacity and demand estimates for 2024-25 later this year as well as confirming any changes to provisional spending plans for the second year of the programme.

1.16 **5.66% increase in ICB minimum contribution:** The ICB's minimum contribution to social care and commissioned out of hospital care has increased by 5.66% since last year (in line with previous years). We will be reviewing how this increase will be spent.

1.17 **Focus on prevention:** We have ensured that the narrative reflects our Place focus on prevention, proactive care and enablement, particularly in the work that we are envisaging around the edge of care and pre-frail cohort in line with the vision set out in the Health and Wellbeing Strategy.

Documents to be submitted

1.18 The attachments at Appendix 1 and Appendix 2 will be submitted to NHS England for approval. These consist of the BCF BHR Narrative template (Appendix 1) and the Better Care Fund Barking and Dagenham Funding and Metrics Template, including Capacity and Demand Plan (Appendix 2). Please note that both templates may be subject to slight amendments as we finalise them over the coming weeks ahead of the deadline.

Financial summary

1.19 The below table is a summary of the pooled budget that will make up the BCF in 23-25. The DFG and iBCF are directly given to the local authority.

1.20 In summary:

- The NHS (ICB) allocation has increased by 5.66% nationally each year. This is in line with revised overall NHS revenue growth.
- The iBCF in 2023-24 remains at 22-23 levels. The iBCF in 2024-25 is expected to remain at this cash value.
- The DFG allocation has remained the same as per the May funding announcement.
- Discharge funding has been included within the BCF. 50% of the funding is included in ICB allocations and 50% paid to local government via a grant. All Discharge funding must be pooled and jointly agreed in BCF plans. The ICB portion of the funding is allocated at ICB footprint for both 2023-24 and 2024-25. Local authority allocations for 2023-24 are published and pre populated in the BCF template. The local authority allocation for 24/25 has not yet been published but has been estimated below.

1.21 It should be noted that, as in previous years, all BCF money is allocated for 22/23 against schemes and activities apart from the 5.66% increase which is currently being discussed. Any changes in spend in future years would require early planning and engagement with all partners to enable changes to be made as a large majority of spend pays for packages, placements, services and teams that support the delivery of the national conditions/metrics.

Funding Sources	Income Yr 1	Income Yr 2
DFG	£1,856,901	£1,856,901
Minimum NHS Contribution	£18,440,057	£19,483,764
iBCF	£10,707,003	£10,707,003
Additional LA Contribution	£0	£0
Additional ICB Contribution	£295,000	£0
Local Authority Discharge Funding	£1,501,105	£2,491,834
ICB Discharge Funding	£890,553	£890,553 (TBC, assumed at 23/24 levels)
Total	**£33,690,619**	**£35,430,055**

1.22 To provide some context to the above and the financial template in Appendix 2, the below list outlines the key areas that are funded by the Better Care Fund:

- Community Health Services
- Locality multi-disciplinary and integrated case management teams across the community, integrated care and mental health
- The Integrated Discharge Hub that coordinates hospital discharge and the Community Health and Assessment Team (CHAT) of social workers within the local authority that supports discharge and assessment
- The British Red Cross Home, Settle and Support Service

- Home First discharge process to facilitate same day and next day discharge
- Ageing Well urgent care and 2 hour response bridging services
- Packages and placements within extra care, domiciliary care, supported living, residential and nursing care
- Crisis intervention packages for the first six weeks of an individual leaving hospital
- Commissioning and safeguarding resource and systems
- Care Act implementation support
- Mental health and learning disabilities supported employment
- Admiral nurses
- Carers services
- Support for the Personal Assistant market
- Falls prevention
- End of life care
- Equipment, adaptations and care technology
- Social isolation support – in development with the voluntary sector
- Support to stabilise the market and respond to demand

Next Steps

1.23 Once the Board has approved the submission, the authority will be provided to NHS England colleagues. The narrative and template will go through a scrutiny process and we will be hoping to receive assurance in November as per the table below. Once the BCF is approved, the Section 75 arrangement will be put in place.

Activity	**Date**
Submission	28 June
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	28 June – 28 July
Approval letters issued giving formal permission to spend (ICB minimum)	3 September
All Section 75 agreements to be signed and in place	By 31 October

3 Consultation

3.1 As stated in the narrative at Appendix 1, stakeholders, providers and residents are engaged in the BCF development and delivery throughout the year. The Place Based Partnership have been consulted and their comments have been included in the above report. Additionally, the ICB Sub-Committee will be presented with the BCF Plan at the Committees in Common meeting.

4 Implications

4.1 Financial Implications

Implications completed by Paul Durrant, Finance Manager (Care & Support)

Funding which comes under the Better Care Fund Umbrella is Section 75 Agreement under the NHS Act 2006, which allows NHS Bodies and Councils to contribute to a common fund which can be used to commission health and social care related services.

The current settlement is for a 2-year period from 2023-24 to 2024-25.

The confirmed funding allocations are stated in the table above.

There is a jointly agreed spending plan which is targeted on a set of desired outcomes for both parties, which is formally agreed by the Health and Wellbeing Board on an annual basis.

Expenditure is reported monthly, to ensure that the funds objectives are delivered within the budgets provided.

4.2 Legal Implications

Implications completed by: Kayleigh Eaton, Principal Contracts and Procurement Solicitor, Law & Governance

This report sets out an update on the Better Care Fund for the year 2023-2025. The Better Care Fund encourages the integration of health and social care systems locally to support person centred care by requiring the ICB and local authorities to enter into pooled budget arrangements and agree an integrated spending plan. Local Authorities and the ICB formalise these arrangements under a section 75 Agreement as provided for under the NHS Act 2006.

Section 75 of the NHS Act 2006 permits the NHS and Local Authorities to enter into arrangements in relation to the exercise of health related functions of such bodies. A s75 agreement enables joint commissioning and commissioning of integrated services to meet the functions of each body.

This report states that once the Council has approved the arrangements there will be an update to the existing section 75 agreement between LBBD, Havering, Redbridge and the ICB. This variation will be effective until April 2024 when it is then intended that each authority have a separate s75 agreement with the ICB, This will entail terminating the existing s75 agreement which states under clause 22 that not less than 3 months' notice in writing is to be given Council officers should factor this notice into the timeline.

The Legal team will be on hand to assist with these updates to the agreement and also to assist with the new section 75 agreement, when required.

4.6 Risk Management

The sign off of the BCF must be undertaken by the Health and Wellbeing Board otherwise NHS England will not assure our BCF narrative and plan.

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices:

Appendix 1 - Better Care Fund BHR Narrative

Appendix 2 - Better Care Fund Barking and Dagenham Funding and Metrics Template, including Capacity and Demand Plan

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

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, whilst the HWB still is the formal governance for the sign off. Key areas the PBP have inputted into so far include 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 also approve the BCF plan and receive regular updates developments, performance and spend.

Place also has 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.

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.

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.

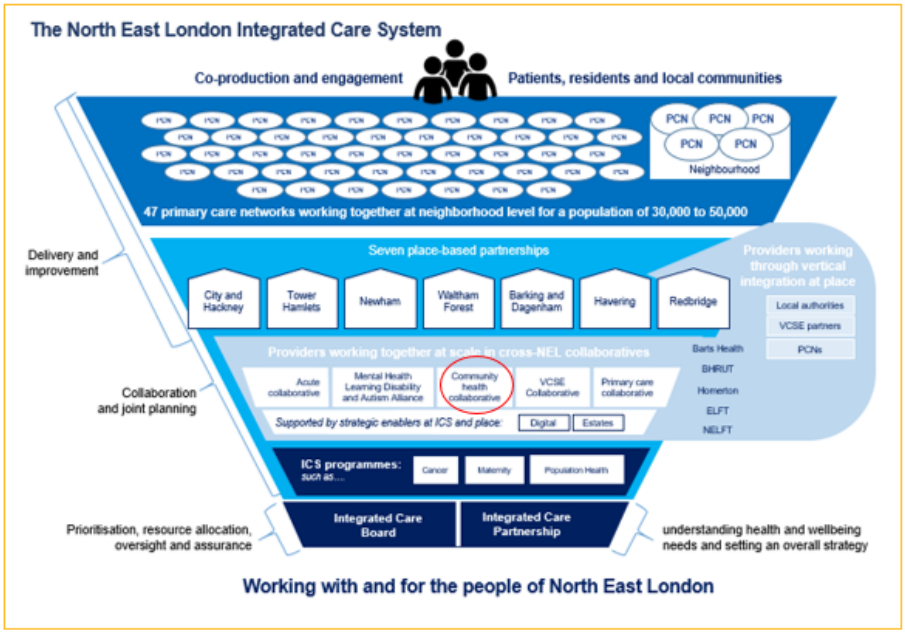
Governance

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 – TBC

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.
- **Health Engagement Bus** which brings number of services and advice and guidance on health issues to local communities and 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.
- **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
    - Support for Asylum Seekers
    - 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 neighbourhoods 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

2.1 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.

2.2 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.

2.3 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.

2.4 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.

2.5 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

2.6 Strength-based approaches and person-centred care

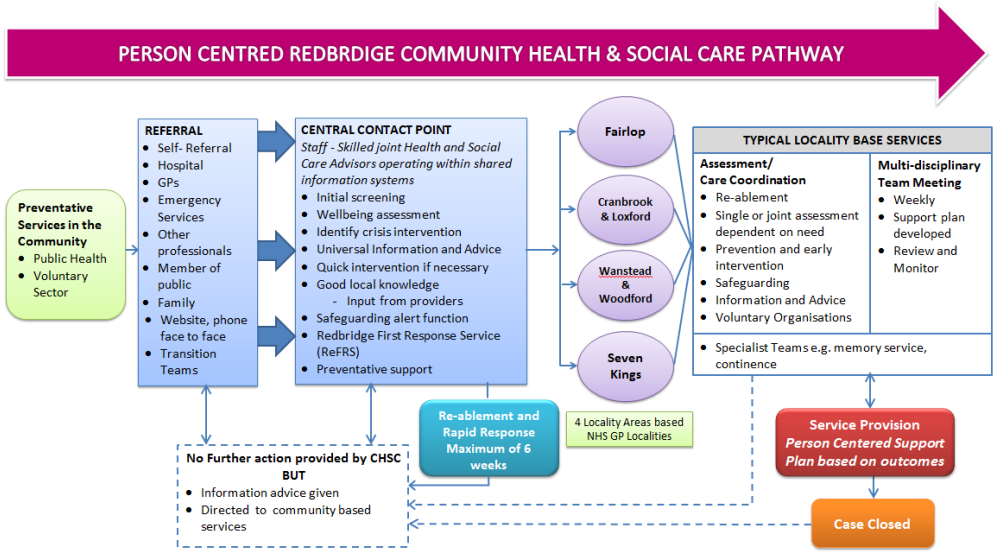
Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives and reduce the need for and dependence on health and social care services. Retaining a level of

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.

2.7 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.

2. 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.

2.9 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.

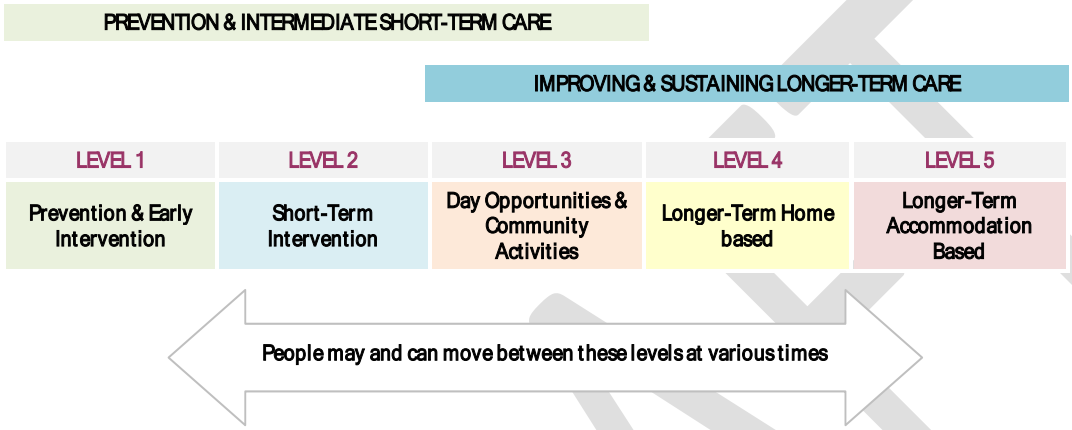
They work as part of our Community Health and Social Care Teams and collaborate closely with our Community Hubs Programme Team and in developing community insight and networks. Our model aims to:

- 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



2.10 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.

2.11 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.

2.12 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.

3. 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. All 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%).

Demand
Whilst the 2- hour response is meeting the target, there are still patients who are not seen on the day due to capacity. From a review of 22/23 data, per month this is 29 in B&D place, 62 in Havering and 41 in Redbridge. This equates to 11% (1,613 patients against of 13,672 referrals). The Community Treatment Team at the ED front have no issues presenting with capacity to demand.

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
The estimates are based on the 22/23 outturn data. The demand is predicated on the referral numbers, less inappropriate referrals. Capacity is those referrals supported versus those that did not get a service recorded through the monthly CTT(UCR dashboard at year end).

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. In terms of social prescribing figures for the voluntary sector, the monthly demand and capacity figure of 60 remained stable and has been projected forward for 23/24.

4. BCF schemes 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 population.

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

5.1 Summary

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.

5.2 Hospital Discharge

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.

5.3 Developing Discharge Schemes

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Accommodation Based Care

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

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

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

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

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

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

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.

Protecting Adult Social Care Services

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.

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 and nursing placements and interventions, particularly in order to meet market pressures caused by a care home closure, increase in residential placements and complexity and acuity
- 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

6. 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.

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

Home Settle and Support

Capacity has increased significantly within the Home, Settle and Support service over the last 12 months for Barking and Dagenham residents discharged from hospital. The Demand and Capacity template for 22/23 stipulated that there was capacity for 34 referrals to the service when in actuality 42 referrals were made on average to the service per month which the service could accommodate. This has been achieved through outreach and awareness raising within Social Care, the hospital and Community Teams and has also been generated via the successful development of the Home First service within Barking and Dagenham. These figures will look to maintain or increase further in 23/24 in order to support hospital discharge and reduction in readmission.

7. High Impact Change Model for managing transfers of care TBC

HICM Area	B&D	Havering	Redbridge
Change 1: Early discharge planning High Impact Change Model - Change 1 Maturity Levels (local.gov.uk)			
Change 2: Monitoring and responding to system demand and capacity High Impact Change Model - Change 2 Maturity Levels (local.gov.uk)			
Change 3: Multi-disciplinary working High Impact Change Model - Change 3 Maturity Levels (local.gov.uk)			
Change 4: Home First discharge to assess (D2A)			

HICM Area	B&D	Havering	Redbridge
High Impact Change Model - Change 4 Maturity Levels (local.gov.uk)			
Change 5: Flexible working patterns High Impact Change Model - Change 5 Maturity Levels (local.gov.uk)			
Change 6: Trusted assessment High Impact Change Model - Change 6 Maturity Levels (local.gov.uk)			
Change 7: Engagement and choice High Impact Change Model - Change 7 Maturity Levels (local.gov.uk)			
Change 8: Improved discharge to care homes High Impact Change Model - Change 8 Maturity Levels (local.gov.uk)			
Change 9: Housing and related services High Impact Change Model - Change 9 Maturity Levels (local.gov.uk)			

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

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

9. 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.

10. Disabled Facilities Grant (DFG) & Wider Services

10.1 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.

10.2 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 more costly 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.

10.3 Havering DFG (TBC)

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

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

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

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

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

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

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

Havering Council's DFG plan for 2022-23 includes a programme of digitalisation, expansion and promotion. The first steps will be to expand the use of the recently procured Dynamic Purchasing System (DPS), a review of end to end processes and recruitment of additional staff (Technical Officer and DFG Officer). These activities will provide a more robust foundation from which we can expand the reach of the service whilst also seeking more innovative, preventive and personalised applications of the funding.

10.4 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.

11. 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:

- Workstreams 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 grantmaking 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

12. 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

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.

12. 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	LAs -TBC	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	

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

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

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.
12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Barking and Dagenham
Completed by:	Louise Hider-Davies
E-mail:	louise.hiderdavies@lbbd.gov.uk
Contact number:	020 8057 5553
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Maureen	Worby	maureen.worby@lbbd.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Charlotte	Pommery	charlotte.pomery@nhs.net
	Additional ICB(s) contacts if relevant		Sharon	Morrow	sharon.morrow2@nhs.net
	Local Authority Chief Executive		Fiona	Taylor	fiona.taylor@lbbd.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Elaine	Allegretti	elaine.allegretti@lbbd.gov.uk
	Better Care Fund Lead Official		Louise	Hider-Davies	louise.hiderdavies@lbbd.gov.uk
	LA Section 151 Officer		Philip	Gregory	philip.gregory@lbbd.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	No
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Barking and Dagenham

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,856,901	£1,856,901	£1,856,901	£1,856,901	£0
Minimum NHS Contribution	£18,440,057	£19,483,764	£18,440,057	£19,483,764	£0
iBCF	£10,707,003	£10,707,003	£10,707,003	£10,707,003	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£295,000	£0	£295,000	£0	£0
Local Authority Discharge Funding	£1,501,105	£2,491,834	£1,501,105	£2,491,834	£0
ICB Discharge Funding	£890,553	£890,553	£890,553	£890,553	£0
Total	**£33,690,619**	**£35,430,055**	**£33,690,619**	**£35,430,055**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,240,141	£5,536,733
Planned spend	£11,025,194	£11,658,281

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£6,832,572	£7,219,296
Planned spend	£7,414,862	£7,825,483

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	181.2	180.5	173.2	156.5

Falls

2022-23 estimated	2023-24 Plan

Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	0.0	0.0
	Count	0	0
	Population	0	0

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)				

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	651	708

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes

NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Barking and Dagenham

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Reablement demand projections relate to short-term crisis packages. The demand forecast is based on historic data, using linear regression. Homecare service data has been excluded from projected totals. There are no waiting lists for short term services. Length of stay is expected to remain stable into 2023-24. Activity levels were higher than forecast figures from the 2022-23 capacity and demand planning. The level of demand in 2023-24 is expected to be similar to the previous year. The integrated system is flexible in response to referrals and capacity is able to meet demand, therefore these figures are aligned.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST		36	39	41	43	45	47	50	52	54	56	59	61
(Please select Trust/s.....)	Reablement at home (pathway 1)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST		64	64	64	64	64	64	67	67	67	67	67	67
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST		19.5	21	20	19.5	20	10	11.7	11.7	13	21	18	18
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST													
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST													
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST		15	14	14	14	14	14	14	15	15	15	15	15
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST		3	3	3	3	3	3	3	3	3	3	3	3
Totals	**Total:**	137.5	141	142	143.5	146	138	145.7	148.7	152	162	162	164

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	60	60	60	60	60	60	60	60	60	60	60	60
Urgent Community Response	201	184	176	193	179	145	157	162	154	117	123	160
Reablement at home	36	36	37	37	37	37	38	38	39	39	40	40
Rehabilitation at home	10.5	11.3	11	10.5	11	5.2	6.3	6.3	7	11.5	9.7	9.7
Reablement in a bedded setting												
Rehabilitation in a bedded setting	1	1	1	1	1	1	1	1	1	1	1	1
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	36	39	41	43	45	47	50	52	54	56	59	61		100%	
Reablement at Home	Monthly capacity. Number of new clients.	64	64	64	64	64	64	67	67	67	67	67	67		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7	100%		
Short term domiciliary care	Monthly capacity. Number of new clients.															
Reablement in a bedded setting	Monthly capacity. Number of new clients.															
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	16	15	15	15	15	15	15	16	16	16	16	16	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	3	3		100%	

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	60	60	60	60	60	60	60	60	60	60	60	60		100%	
Urgent Community Response	Monthly capacity. Number of new clients.	187	158	153	157	147	132	130	124	102	96	99	129	100%		
Reablement at Home	Monthly capacity. Number of new clients.	36	36	37	37	37	37	38	38	39	39	40	40		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	6.9	100%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.															
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	1.1	1	1	1	1	1	1	1.1	1.1	1.1	1.1	1.1	100%		
Other short-term social care	Monthly capacity. Number of new clients.															

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Barking and Dagenham

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Barking and Dagenham	£1,856,901	£1,856,901
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£1,856,901**	**£1,856,901**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Barking and Dagenham	£1,501,105	£2,491,834

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North East London ICB	£890,553	£890,553
Total ICB Discharge Fund Contribution	£890,553	£890,553

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Barking and Dagenham	£10,707,003	£10,707,003
Total iBCF Contribution	**£10,707,003**	**£10,707,003**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North East London ICB	£18,440,057	£19,483,764
Total NHS Minimum Contribution	**£18,440,057**	**£19,483,764**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS North East London ICB	£295,000		Ageing Well contribution
Total Additional NHS Contribution	**£295,000**	**£0**	
Total NHS Contribution	**£18,735,057**	**£19,483,764**	

	2023-24	2024-25
Total BCF Pooled Budget	**£33,690,619**	**£35,430,055**

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

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Barking and Dagenham

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£1,856,901	£1,856,901	£0	£1,856,901	£1,856,901	£0
Minimum NHS Contribution	£18,440,057	£18,440,057	£0	£19,483,764	£19,483,764	£0
IBCF	£10,707,003	£10,707,003	£0	£10,707,003	£10,707,003	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£295,000	£295,000	£0	£0	£0	£0
Local Authority Discharge Funding	£1,501,105	£1,501,105	£0	£2,491,834	£2,491,834	£0
ICB Discharge Funding	£890,553	£890,553		£890,553	£890,553	£0
Total	**£33,690,619**	**£33,690,619**	**£0**	**£35,430,055**	**£35,430,055**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,240,141	£11,025,194	£0	£5,536,733	£11,658,281	£0
Adult Social Care services spend from the minimum ICB allocations	£6,832,572	£7,414,862	£0	£7,219,296	£7,825,483	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110

									Planned Expenditure											
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Targeted out of hospital care	Integrated case management delivered through cluster multi disciplinary staff teams	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,136,902	£2,547,523	100%
2	Hospital discharge, planning and	Services and support to ensure timely discharge from hospital and admission	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£847,610	£847,610	100%
3	Targeted out of hospital care	Crisis Intervention/ Reablement/Homecare	Home-based intermediate care services	Reablement at home (to support discharge)		700	700	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,332,133	£1,332,133	100%
4	Community support and independence	Care Bill Implementation to support prevention, integration, independence	Care Act Implementation Related Duties	Other	Care Act fee increases and safeguarding				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£657,607	£657,607	100%
5	Hospital discharge, planning and	Home is best	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£24,000	£24,000	100%
6	Targeted out of hospital care	Supporting adults of working age with mental health problems to live	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£572,000	£572,000	100%
7	Targeted out of hospital care	Resource and systems to support integration, better processes and provider	Enablers for Integration	Data Integration					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£26,000	£26,000	100%
8	Community support and independence	Care Bill Implementation to support prevention, integration, independence	Care Act Implementation Related Duties	Other	Safeguarding Adults				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£130,000	£130,000	100%
9	Hospital discharge, planning and	Care Home Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,500	£8,500	100%
10	Community support and independence	Preventative services to prevent falls and promote health & wellbeing	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£50,000	£50,000	100%
11	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Community Based Equipment		250	250	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£80,000	£80,000	100%
12	Community support and independence	Care Bill Implementation to support prevention, integration, independence	Care Act Implementation Related Duties	Other	Social Isolation Pilot				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
13	Targeted out of hospital care	Developing joint commissioning to achieve the outcomes of the BCF for	Residential Placements	Care home		20	20	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£947,610	£947,610	100%
14	Community support and independence	Support for the Personal Assistant market	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£150,000	£150,000	100%
15	Community support and independence	Support for service users with dementia and their informal carers	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
16	Community support and independence	Support for carer support organsitons.	Carers Services	Other	Support for carer support organsitons.	950	950	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£75,000	£75,000	100%
17	Community support and independence	Strengthening User and Carer Voice	Carers Services	Other	Strengthening User and Carer Voice	950	950	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£62,500	£62,500	100%
18	Provide the right care in the right place at the right	Home from Hospital - Home, Settle and Support Service (British Red Cross) on	Integrated Care Planning and Navigation	Other	Care Planning, Assessment and Review				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£65,000	£65,000	100%
19	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Other	Care Planning, Assessment and Review	156	156	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£50,000	£50,000	100%
20	Provide the right care in the right place at the right	Care - Coordination to support discharge	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£6,632,116	£7,029,113	100%
21	Enable people to stay well, safe and independent at	Various community based services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£2,842,335	£3,012,477	100%
22	Enable people to stay well, safe and independent at	Various community based services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£56,422	£59,616	100%
23	Enable people to stay well, safe and independent at	Various community based services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£410,570	£425,925	100%
24	Enable people to stay well, safe and independent at	Supported Employment	High Impact Change Model for Managing Transfer of Care	Other	Other approaches				Mental Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£230,064	£245,812	100%
25	Enable people to stay well, safe and independent at	CCG Contribution to the local carers organisation	Carers Services	Other	Carer Advice and Support	950	950	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£12,253	£12,638	100%
26	Enable people to stay well, safe and independent at	CCG Contribution to the local carers organisation	Carers Services	Other	Carer Advice and Support	950	950	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£15,471	£15,957	100%
27	Provide the right care in the right place at the right	Home from Hospital - Home, Settle and Support Service (British Red Cross) on	Integrated Care Planning and Navigation	Other	Care Planning, Assessment and Review				Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£18,590	£19,174	100%
28	Provide the right care in the right place at the right	Home First same & next day discharge - AHPs.	Home-based intermediate care services	Reablement at home (to support discharge)		520	520	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£114,658	£118,946	100%
29	Enable people to stary well, safe and independent	Urgent Care 2 Hour response (Ageing Well)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£298,296	£309,452	100%
30	Enable people to stary well, safe and independent	Urgent Care 2 Hour response (Ageing Well)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£220,738	£228,994	100%
31	Enable people to stary well, safe and independent	Urgent Care 2 Hour response (Ageing Well)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£295,000	£0	100%
32	Enable people to stay well, safe and independent at	Voluntary sector	Carers Services	Respite services		11	11	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£173,682	£180,177	100%
33	Community support and independence	Supporting people to remain in their homes through the provision of adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		150	150	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,856,901	£1,856,901	100%
34	Targeted out of hospital care	Crisis Intervention/ Reablement/Homecare	Home-based intermediate care services	Reablement at home (to support discharge)		300	300	Packages	Social Care		LA			Private Sector	iBCF	Existing	£500,000	£500,000	100%
35	Targeted out of hospital care	Managing homecare and additonal demand over winter in particular within	Home Care or Domiciliary Care	Domiciliary care packages		45000	45000	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£913,062	£913,062	100%
36	Targeted out of hospital care	Support to manage safeguarding of Adults and DoLS	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	iBCF	Existing	£175,000	£175,000	100%
37	Market Stabilisation & COVID Recovery	Market Development/Fee increases	Residential Placements	Other	Fee increase to stabilise the care provider market	500	500	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£1,600,000	£1,600,000	100%
38	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Assistive technologies including telecare		3000	3000	Number of beneficiaries	Social Care		LA			Private Sector	iBCF	Existing	£680,000	£680,000	100%
39	Targeted out of hospital care	Additional Care Navigators, investment in Mental Health, transforming care held cases	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	iBCF	Existing	£1,514,420	£1,514,420	100%
40	Targeted out of hospital care	Develop joint commissioning to achieve the outcomes of the BCF for local residents	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	iBCF	Existing	£2,980,000	£2,980,000	100%
41	Targeted out of hospital care	Supporting adults of working age with mental health problems to live	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Local Authority	iBCF	Existing	£500,000	£500,000	100%
42	Targeted out of hospital care	Supported Employment	Prevention / Early Intervention	Other	Supported employment approaches				Social Care		LA			Local Authority	iBCF	Existing	£100,000	£100,000	100%
43	Targeted out of hospital care	Resource and systems to support integration, better processes and provider	Enablers for Integration	Data Integration					Social Care		LA			Private Sector	iBCF	Existing	£100,000	£100,000	100%
44	Community support and independence	LD Demand growth and Transitions	Residential Placements	Learning disability		6	6	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£1,484,521	£1,484,521	100%
45	Community support and independence	LD Employment and NEETs	Prevention / Early Intervention	Other	Employment support				Social Care		LA			Local Authority	iBCF	Existing	£150,000	£150,000	100%
46	Market Development /Fee increases	Home Care or Domiciliary Care	Workforce recruitment and retention						Social Care		LA			Private Sector	iBCF	Existing	£10,000	£10,000	100%
47	Hospital discharge, planning and	Commissioning project management to support Discharge Fund initiatives	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Local Authority Discharge	New	£80,000	£80,000	100%
48	Hospital discharge, planning and	Support for complex discharge cases	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	ICB Discharge Funding	New	£100,000	£100,000	100%
49	Targeted out of hospital care	Unfunded homecare and crisis intervention packages (single and double handed)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		35000	35000	Hours of care	Social Care		LA			Private Sector	ICB Discharge Funding	New	£700,000	£700,000	100%
50	Targeted out of hospital care	Unfunded residential, nursing and supported living placements	Residential Placements	Care home		18	18	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge	New	£803,105	£803,105	100%
51	Targeted out of hospital care	Unfunded reablement packages/reablement pilot	Home-based intermediate care services	Reablement at home (to support discharge)		100	100	Packages	Social Care		LA			NHS Community Provider	Local Authority Discharge	New	£618,000	£618,000	100%
52	Hospital discharge, planning and	Workforce support	Workforce recruitment and retention						Social Care		LA			Local Authority	ICB Discharge Funding	New	£90,553	£90,553	100%
53	Targeted out of hospital care	Unfunded packages and placements - to be determined for 24/25	Residential Placements	Care home		23	23	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£990,729	100%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Barking and Dagenham

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	308.9	262.2	238.1	162.4	Given performance target in 2022/23 was not met, the indicator will remain the same at 691 FYE for 23/24.	UCR response is now embedded in the local service offer and has been over performing against the 2-hour target (87%/target 70%). Primary Care are reinstating preventative reveiws, interventions, testing to monitor LTCs and identify those at risk through conditions such as hypertension. There is aslo a focus on targeting those who are at higher risk
	Number of Admissions	489	415	377	-		
	Population	212,906	212,906	212,906	212,906		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	181.2	180.5	173.2	156.5		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,966.1			Awaiting BI input. There is an anticipated a 2% target redcution of emergency admissions.	B&D in the last 2 years has commissioned and developed a range of falls prevention and intervention services. This includes Strength and Balance classes run by Age UK, supporting people who are at risk of a future fall, delivered face to face in community venues and online. Community Health services now offer both community
	Count	370				
	Population	19,123				

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.3%	93.6%	93.8%	89.1%	93.6% target based on an average of 22/23 performance.	The system continues to develop the Integrated Discharge Hub (IDH) that supports smoother and more timely discharge to pathways 1-3. The service combined the Discharge Co-ordination Unit and the Hospital Discharge Service in 2021 and continues to develop the co-ordination function and single point of access function. Moving forward, it is
	Numerator	3,450	3,417	3,495	2,007		
	Denominator	3,697	3,651	3,725	2,254		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)						
	Numerator						

	Denominator						anticipated that the IDH will co-ordinate

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	651.3	666.7	775.3	708.0	The target has been increased from 135 to 145. During 2022-23, approximately 157 people were admitted for long term care and the target level was exceeded. Demand is predicted to remain high in 2023-24, based on local demographics and	An increased proportion of admissions are from hospital discharges for people with complex and challenging needs. Despite limited capacity in the care market for such cases we continue to work with our system partners to address these issues. There
	Numerator	129	135	157	145		
	Denominator	19,807	20,249	20,249	20,481		

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.9%	83.9%	81.5%	84.1%	The target of 84% has been retained. The metric has underperformed in recent years and the target remains a stretch one. The proportion of people aged 85 years and older in the cohort increased over the last two years. However, reablement is least	The number of people discharged into short-term crisis services remains high, as the service is offered to as many people as possible. There are a range of commissioned and operational teams supporting this metric, including crisis
	Numerator	131	130	128	132		
	Denominator	158	155	157	157		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Barking and Dagenham

Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	**Confirmed through**	**Please confirm whether your BCF plan meets the Planning Requirement?**	**Please note any supporting documents referred to and relevant page numbers to assist the assurers**	**Where the Planning requirement is not met, please note the actions in place towards meeting the requirement**	**Where the Planning requirement is not met, please note the anticipated timeframe for meeting it**
Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	See narrative plan and expenditure plan		
Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	See narrative plan		
Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	See narrative plan and expenditure plan		
Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	See narrative plan and expenditure plan		

Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	See narrative plan and expenditure plan		
Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	See narrative plan and expenditure plan		
Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	See expenditure plan		

Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	See narrative plan and expenditure plan		
Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	See expenditure plan		

HWB/CIC Comittees in Common

26th June 2023

Title:	**Health Inequalities Programme Plan for FY23/24**
Open Report	**For Decision:** No
Wards Affected: Barking and Dagenham	**Key Decision:** No
Report Author: Dr Mike Brannan, Consultant in Public Health- LBBD	**Contact Details:** E-mail: mike.brannan@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health- LBBD	

Summary:

After securing £1.1 million of funding (for financial year 22/23) to address health inequalities, the Barking and Dagenham Place-Based Partnership will receive a further 777k funding annually, for the remaining three years from August 2023 from North East London Health and Care Partnership.

The attached, provides an outline of how the plan was developed and an overview of the eight projects to be taken forward this financial year (six of which are continued from last). Projects undertaken in year 22/23 will complete evaluations and summarise learning by August and this will be used to finalise the 23/24 programme.

Monitoring of quarterly progress, risks and accounting for spend or funding slippage, by exception will continue to be overseen by the Barking and Dagenham Place-based Executive Group.

Recommendation(s)

The ICB Subcommittee is recommended to:

1. Approve the proposed project plan for the financial year 23/24.

2. Consider how a wider and more strategic approach to health inequalities should be developed and structured.

Reason(s)

The ICB Subcommittee is the designated official signatory for health inequalities programme plans.

1. Introduction and Background

1.1 NEL ICS was allocated £6.5m of funding in 22/23 from a national health inequalities pot from NHS England and undertook a process to allocate most of this money to Place-based Partnerships. Barking and Dagenham was successful in securing the full amount of funding available from the NHS North East London ICB of £1.1m for FY22/23 and delivered a place-based programme across all sectors.

1.2 The NEL ICS will receive £6.6m funding annually for three years from April 2023. Whilst most of the funding allocated will again be to place-based partnerships, some allocation will support system-wide collaborative work that supports delivery at place and improved equity of outcomes across NEL.

1.3 Barking and Dagenham has been allocated £777k annually for 23/24, 24/25 and 25/26. Up to an additional £400k will be contributed from the LBBD Public Health Grant in 23/24 should there be a need, given the reduction in ICB funding.

1.4 Principles for 2023/24 programme funding (agreed by NEL Population Health and Integration Committee) are:

- Clearly focussed on tackling health inequalities in deprived neighbourhoods, those living in poverty and 'underserved' groups (carers; people with learning disabilities and autism; people who are homeless);
- Driven by data, evidence and insight, and supported by co-production with communities/groups;
- Contribute to meeting the outcomes in the ICP strategy;
- Include plans for mainstreaming/ sustainability to support longer term impact;
- May provide additionality and benefit to existing work as well as opportunity to test new ways of working;
- Contribute to strengthened partnership working for health inequalities;
- Contribute to increasing equity of funding/outcomes across NEL;
- Commitment to minimise bureaucracy for those receiving the funds.

1.5 Proposals for this year's programme were prioritised with system partners against a matrix of criteria, ensuring alignment to: Place-based partnership priorities; ICP strategy priorities; 'what works' principles; NHS Core20Plus5 and whether it clearly invested in community coproduction/development and capacity of the sector.

1.6 Funding for 22/23 was limited to confined projects that could be delivered within six months. The new opportunity of three years funding has allowed development of a longer-term approach, e.g.:

- Mixture of programme lengths across the three years.
- Unallocated money to enabled 'pipeline development' of new projects.
- Greater focus on delivery of place priorities / impact.

1.7 A summary of proposed projects is below. Currently other potential workstreams to be considered, subject to further scoping are: Cross- sector work on a specific population (e.g. carers, SEND); CYP polio & MMR catch up campaign in schools and what's next (including challenges / opportunities) for B&D around homelessness.

Project	Continued from 22/23	Funding for 23/24	Funding for 24/25	Funding for 25/26
1. Community Locality Leads	Yes	£215k	215k	-
2. PCN Health Inequalities Leads	Yes	£75k	100k	100k
3. Participatory Grant Making For CYP Mental Health Support	Yes	£100k	£100k	£100k
4. Community Chest for Social Prescribing	Yes	£45k (With £45k match funding from LBBD)	£45k	£45k
5. Targeted Debt Advice	Yes	£120k	-	-
6. Pre-paid Prescription Certificates for Care Leavers	Yes (Was allocated funding through the Waltham Forest bid in 2022/23, with reporting to NEL BCYP Programme)	£6k	-	-
7. Epilepsy Specialist Nurse	No	£75k	£75k	£75k
8. Co-ordinator (Asthma & Allergy Friendly School Initiative)	No	£31k	-	-
Programme Management		£55k	£55k	£55k
Evaluation		£55k	£55k	£55k
Total Unallocated		**£777k** **£431k**	**£645k** **£132k**	**£435k** **£342k**

1.8 Delivery will commence from September 2023 after current workstreams have been evaluated at the end of July and a final decision can be made on projects for 23/24.

1.9 Whilst there is a commitment in principle to fund workstreams in future years for projects set to continue, securing further the yearly funding will be subject to annual evaluations / learning demonstrating impact against priorities.

1.10 Any further projects that are new, will look at proof of concept and evaluation/learning will inform decisions for the following year focusing on: 'does/could it work'; whether the initiative/ intervention is reaching known groups/ residents who do not typically engage with services and its scalability and sustainability.

1.11 The cross-sector, place-based coproduction process continues to create learning itself, including:

- The majority of funding is highly siloed (i.e. aligned with specific conditions) which is increasingly unhelpful and to an extent precludes funding flowing to where it can have most benefit (e.g. targeted services for CYP with additional and / or multiple needs are poorly served).

- Value of these relatively small pots of funding is how we use them to create sustainable change in culture and practice in the wider systems (i.e. £6.5m for health inequalities versus £4.5bn health economy at NEL level).

- Given the rigidity of the existing systems, how to be move at pace to place based that utilises and synergises the unique contribution of the different sectors (NHS, SC and community) to work differently recognising the unsatiable need / demand for services and futility of 'more of the same'.

1.12 The B&D Executive Group will continue taking on the role of monitoring projects, including outcomes. Places are to return a quarterly monitoring template to the ICB, accounting for spend and any risks to delivery or funding slippage by exception.

2 Issues and Proposals

2.1 Areas for priority have been identified for this years programme and up to 400k for this year is available from the public health grant to supplement funds, if needed. There is a requirement to properly review proposals and their impact to decide whether they could be supported. However, the window for 23/24s submission was narrow and there is currently no ongoing process for submitting a proposal against the additional funding.

2.2 Additionally, there is a need to develop a common 'health inequalities 'narrative' for the Partnership, as well as improving alignment of the approach to health inequalities at place. Many projects being funded are siloed and we need to begin developing a strategic approach to addressing health inequalities and equity at place in the short to long term.

2.3 To address these two issues, it's proposed a:

- Suitable process to identify, review and agree proposals for new workstreams to be supported, is established.
- Strategic place-based approach to health inequalities that goes beyond this specific funding is developed, starting with mapping action taking place across the system.

3 Consultation

The plan was developed through engaging place partners in a coproduction process through a series of meetings between January- April 23 followed by a workshop at the April Place-based Partnership Board, to consider approaches to health inequalities and work towards consensus for what should be prioritised.

After, a task and finish group was established to agree priority, unsuitable and potential workstreams (those that require scoping to be considered either within or outside of the funded programme). The Executive Group of the Place Based Partnership Board then provided input and direction on plans ahead of being presented to the ICB subcommittee.

4 Mandatory Implications

N/A.

4.1 Financial Implications

The funding of £777k to the Barking and Dagenham Partnership is yet to be confirmed, but again may be transferred by S256 agreement from NHS North East London ICB to the London Borough of Barking and Dagenham through invoicing. The London Borough of Barking and Dagenham will allocate funding to relevant partners and managing and evaluating delivery.

Management capacity is included and within yearly costs.

4.2 Risk Management

The following risks and/or challenges have been identified:

A. Effective development of approaches for workstreams continuing in 23/24 is dependent on successful evaluation of 22/23 delivery.
B. Without financial support from the inequalities programme, gaps in provision arise for core services that could address health inequalities for specific groups.
C. Information flow and awareness of overlap with existing wider system work (e.g. homelessness, SEND) to prevent double funding.
D. Clear plans are still to be developed for NEL top slice of funding.
    - With a decision on the system ambition and NEL health inequalities academy to be coproduced in coming months.
E. Consideration to how the impact of projects will be sustained post the 3-year funding period.

4.3 Patient / Service User Impact

This work will continue to support reducing health inequalities and improving health equity across residents and communities in Barking and Dagenham. It will include increasing community involvement in decision making and delivery of health and wellbeing support.

4.4 Crime and Disorder

N/A

4.5 Safeguarding

N/A

4.6 Property / Assets

N/A

4.7 Customer Impact

This work will continue to support reducing health inequalities and improving health equity across residents and communities in Barking and Dagenham. It will include increasing community involvement in decision making and delivery of health and wellbeing support.

4.8 Contractual Issues

N/A

4.9 Staffing issues

Any recruitment within projects would only be for the length of the funding allocated to each individual workstream.

Public Background Papers Used in the Preparation of the Report: None

List of Appendices:

Appendix 1: Barking and Dagenham Health Inequalities Place Plan 23/24

Barking and Dagenham Health Inequalities Programme Plan- 2023/24

Developing the Plan
The plan for 2023/24 was developed through engaging place partners (health; local authority and voluntary, community, faith and social enterprise sectors) in a coproduction process. This process initially included a series of meetings with place partners between January-April 23 followed by a workshop at the April Place-based Partnership Board, to consider approaches to health inequalities and work towards consensus for what should be prioritised locally with the funding. The workshop participants included Elected Members of the Health and Wellbeing Board, Clinical and Care Professional Leads and representatives from community-sector led work from the 22/23 programme (Locality Leads and participatory grant making for CYP mental health). After, a cross-sectoral task and finish group was established to agree the priority, unsuitable and potential workstreams (those that require scoping to be considered either within or outside of the funded programme). Proposals were prioritised against a matrix of criteria ensuring alignment to: place priorities; ICP strategy priorities; 'what works' principles; NHS Core20Plus5 and whether it clearly invested in community coproduction/development and capacity of the sector. The Executive Group of the Place Based Partnership Board provided input and direction on plans before being shared prior to presentation at the ICB Subcommittee. Moving forward an ongoing working group at place for health inequalities will be established. The terms of reference are still to be agreed, though whilst the group will consider how to respond to and address inequalities more widely, it may also consider any emerging priorities and opportunities that unallocated funds could be used for.

Overview of Projects

The allocation for the financial year 2023/24 will be used to progress eight workstreams in total, six of which will be continued from the previous year- enabling us to build on learning, as well as funding two new priority areas.

A summary of proposed projects is below. Currently other potential workstreams to be considered, subject to further scoping are: Cross- sector work on a specific population (e.g. carers, SEND); CYP polio & MMR catch up campaign in schools and what's next (including challenges / opportunities) for B&D around homelessness.

Project	Continued from 22/23	Funding for 23/24	Funding for 24/25	Funding for 25/26
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8. Co-ordinator (Asthma & Allergy Friendly School Initiative)	No	£31k	-	-

Programme Management		£55k	£55k	£55k
Evaluation		£55k	£55k	£55k
Total Unallocated		**£777k** **£431k**	**£645k** **£132k**	**£435k** **£342k**

1. Community Locality Leads

Lead Sector: VCSE

Description: Each Locality Lead will continue to act as a focal point for their area, offering a triage service, discovering how, where and who people turn to for help and linking people up with appropriate support.

Continued from 22/23:

Yes, to further develop the model piloted. Last year five VCSE organisations were contracted and six Locality Leads appointed (across six geographical areas), providing local connections in communities and triaging support (also testing a role out with a network of community partners) for residents in need related to welfare; debt; housing; employment; social isolation and health conditions.

The first year focused on establishing Locality leads and their knowledge of the local "connecting places" and the resources residents turn to for support in their community; on working with partners and residents to design prototypes to meet challenges as identified by residents; and applying systems science to issues identified.

Through their Triage process, Locality Leads have held over 1500 conversations with residents, which informs their approaches. They are developing maps of 'connecting places', as identified by local residents; it is estimated that there are around 500+ such places in each locality.

Prototypes that Locality Leads are developing with residents include a Wellness Roadshow, Our House/ Street Champions and drop-ins for residents to talk about shared issues – such as parenting children with SEND - and be connected to others and specialist advice.

In 2023/24 work will be focussed on securing an external partner to identify opportunities for further development from the Community Locality Leads model piloted, and co-produce with systems partners an evolved model of asset-based practice where civil society is at the core of design and delivery within each of the localities.

This would then inform the commissioning of a next iteration of the model, which is expected to run from February 2024 – March 2025.

Funding 23/24:

£215k (TBC) for:
- ~£100k for three months extension of existing Community Locality Leads.
- £TBCk to support coproduction process.

2. PCN Health Inequalities Leads

Lead Sector: Health

Description: PCN Health Inequalities Leads (PCN HILs) will continue to develop relationships and provide leadership to move towards the Fuller Report's 'integrated neighbourhood teams of teams' model. This project will provide the six PCNs with capacity to undertake activities as suggested in NHS England guidance on Tackling Neighbourhood Health Inequalities.

Continued from 22/23:

Yes, during 22/23 PCN HILs championed progress on CORE20Plus5 priorities, including SMI health checks and a young carers register. HILs are contributing to activities across the wider Health Inequalities Programme, including Partners in Practice, Planning NHS services in Community Hubs and Locality Leads.

For the upcoming year each PCN Health Inequalities Lead will continue with one session a week to:

- Develop a wider PCN health inequalities plan aligned with priorities (Core20Plus5).
- Lead focussed action on delivering Core20Plus5 (e.g. SMI physical health checks)
- Work with their locality lead to develop an understanding and relationships with their community to support community engagement in decision making.

Funding 23/24:

£75k for:

- 6x PCN HIL capacity for 1 session a week (at £348.50 a session)
- Programme Clinical Director for 2 sessions/month- undertaken by one of the PCN Clinical Directors

3. Participatory Grant Making for CYP Mental Health Support

Lead Sector: VCSE

Description: The years project aims to continue building capacity within the VCS by bringing organisations together to design a range of projects that tackle effective early intervention for low level adolescent mental health issues.

The model has a central focus on relationship and collaboration between participating partners. Projects taken forward are decided by the group and organisations bring their expertise and unique 'lens' of the issues and potential solutions to the table.

Continued from 22/23: Yes, as there was a demonstrated demand for the service (due to oversubscription of some elements).

Last years funding was distributed across 8 grassroots organisations, supported by BDCVS and:

- Provided community-based and school-based workshops; 1-2-1 and group mentoring; counselling sessions; a trusted adult scheme and safe transport.
- Included establishing a practitioner peer support network for workers working with CYP, exploring emerging mental health and a support & training hub.

An evaluation is currently being drafted, but early analysis shows:

- An increase in resilience levels with the WEMWBS measurement across all projects.
- Self-reported increase in resilience and support for Practitioners.
- Self-reported increase in capacity for 8 local organisations.

This years projects will include the development of:

- The practitioner peer support network
- Training and support for practitioners working with CYP
- Project mentees to be Mental Health First Aiders
- CYP peer support network

And the continuation of fast track counselling and practitioner supervision.

Funding 23/24:

£100k for:

- Facilitating the collaborative process (22k)
- Projects (70k)
- Training and capacity building to upskill smaller VCSE groups (8k)

4. Social Prescribing Community Chest

Lead Sector: Local Authority, with VCSE Leads

Description: The Community Chest for social prescribing is a micro-grant fund for local VCFSEs that social prescribers refer on to, designed to address health inequalities; foster integrated ways of working and support the evolution of social prescribing.

Continued from 22/23: Yes

Last years focus/projects: 15 projects led by grassroots community organisations were funded, from wellness and mindfulness sessions for mothers and daughters, to conversational English sessions for adults with English and a Second or Other Language. Funding was allocated through a participatory budgeting process and overseen by a steering group of VCSE organisations.

This year's funding will be informed by the learnings of the model used in 2022/23 in Barking and Dagenham and in other Places across North East London (each Place-based Partnership sponsored a Community Chest for Social Prescribing project and took different approaches).

Funding 23/24:

£45k funding for voluntary sector organisations.

5. Targeted Debt Support

Lead Sector: Local Authority

Description: Proactive outreach to residents improved their health outcomes and reduced their debt by offering holistic support for debt and general health and wellbeing.

Key outcomes are a: reduction in resident debt; improvement in physical/mental health outcomes; increased financial support (residents) and improved debt recovery (council).

Continued from 22/23: Yes

Last years pilot was a proof of concept to test the approach, 221 phone contacts have been made between April- end of May (full cohort not contacted yet), with the final evaluation to be done in August/September.

Anecdotal evidence from frontline officers suggests that the approach is beneficial, and residents have appreciated being proactively contacted for support (need varied based on need). Currently 18.5% of those contacted are engaging and those unreached will be contacted by letter. Follow up/check in calls will take place (with those initially successfully contacted) at the end of July.

This years funding will continue activities to refine the approach tested to make it scalable and sustainable post 2024, subject to amends following the full evaluation due in September.

Funding 23/24:

£120k for:
- Identification and targeting (30k)
- 3 x Link Workers (80k)
- Partnership development and management (10k)

6. Pre-paid Prescription Certificates for Care Leavers

Lead Sector: Local Authority

Description: This is a NEL wide scheme providing Care Leavers aged 18-24, who are eligible for your leaving Care service- a pre-payment prescription certificate (PPC) so they do not need to pay for items prescribed by their GP. Within B&D 176 care leavers are currently eligible (and a further 116 already receiving free prescriptions).

Continued from 22/23: Yes, with the following undertaken to date:

- A monthly working group established with representation from each Borough leaving care teams, NEL designated nurses and NEL medicines management
- Eligible cohorts agreed
- Process and model developed so eligible (i.e. those who do not already get free prescriptions) care leavers can be provided with a PPC
- Created a communication toolkit for teams
- Monitoring and evaluation datasets agreed
- MOUs agreed with LA DCS to support implementation

This years funding will support these next steps:

- Engagement commissioned from Healthwatch on the wider care leaver health compact with additional funding from the safeguarding team
- Leaving care teams providing data on eligible cohort to support business planning
- Addressing sustainability and ensuring NHSBSA low income scheme is being promoted and utilised especially for UASC
- Monitoring LA implementation and offer of the PPC

Funding 23/24: £6k

7. Epilepsy Nurse Specialist

Lead Sector: Health

Description:

The Epilepsy Nurse Specialist will facilitate a greater understanding of epilepsy to the child & family but also to universal services. The role will support the provision of: clinics in the community and in special schools; specialist advice, training and awareness raising; care planning; working collaboratively with community and tertiary services and providing a point of contact to families.

The role has a participatory approach and will strengthening partnership working through liaising with specialist and universal service health care colleagues, those in general practice, schools and with children/ their families, promoting shared and coordinated care.

The role aligns with:
- B&D place priorities (providing the best start in life for our babies, children and young people: Increasing access to services - for CYP and Families with SEND).
- ICP strategy (improving life expectancy across NEL and the gap between most and least deprived areas/ those living in poverty and the wealthiest is reduced).
- CYP Core20PLUS5 priorities (epilepsy is one of the 5 clinical priorities).

Key Outcomes:

- Increased compliance with medication and understanding when a child is experiencing side effects
- Increase in school attendance
- Reduction in A&E and walk in centre attendance
- Reduction in unplanned admissions

Continued from 22/23: No

Funding 23/24: £75k for 1 WTE, Band 7 Epilepsy Nurse Specialist (including non pay costs).

8. Co-ordinator- Asthma & Allergy Friendly School Initiative

Lead Sector: Health

Description:

This role will support and enable schools to gain Asthma and Allergy Friendly schools (AAFS) programme status through engaging with settings (focussing on those within PCNs that have the highest levels of deprivation and poor air quality) to achieve the specific standards for asthma and allergy management and provide links to GP practices, school nursing and secondary asthma specialists as well as working with children and parents/carers to increase knowledge and confidence.

The role has a participatory approach and will strengthening partnership working as it will be split between two boroughs and settings (BARTS/BHRUT); depends on working in partnership with schools, children, parents and primary and secondary care.

Provision aligns with:

- B&D place priorities (providing the best start in life for our babies, children and young people: to thrive in inclusive schools and settings).
- ICP strategy (improving life expectancy across NEL and the gap between most and least deprived areas/ those living in poverty and the wealthiest is reduced).
- CYP Core20PLUS5 priorities (asthma is one of the 5 clinical priorities and recommends that as part of the ICS system action to reduce inequalities, the AAFS initiative should be encouraged).

And contributes to reducing associated health inequalities because:

- Emergency admissions for asthma are associated with deprivation
- Exposure to air pollution is a driver of asthma development, along with poor quality housing; second hand smoke; diet; obesity and socioeconomic status
- Asthma requires self management, which is harder for those with low health literacy

Key Outcomes:

Health outcomes for children:

- Improved inhaler use
- Accurate register of all asthma/allergies
- Less days from school lost
- Less GP visits
- Less hospital admissions

Continued from 22/23: No

Funding 23/24: £31k for 0.5 WTE, Band 5 Coordinator (including on costs and travel)

Capturing Learning and Evaluating Projects

Its proposed learning and evaluation will be undertaken/captured in the following ways to establish success and identify improvements. This may be provided through quarterly updates and or included the final, annual summary.

For some projects, this may be undertaken by the project leads and for some programmes such as the Community Locality Leads and PCN Health Inequalities Leads evaluation by an external provider may be carried out.

Proposal	Learning and Evaluation
1) Community Locality Leads	Collation of qualitative evidence by the Locality Leads, detailing: • The challenges and successes • Participant feedback • How areas of focus have been/ can be systemised for wider roll-out

	• Demographic data of those engaging with model
2) PCN Health Inequalities Leads	• Qualitative feedback from HI Leads • Quality and breadth of emerging health inequalities plans • Connections between PCNs and community • Improved understanding of gaps and barriers to care within specific communities
3) Participatory Grant Making For CYP Mental Health Support	• Evaluation forms • Increased WEMWBS scores • Case studies • Self reported feedback (e.g. on social isolation)
4) Community Chest for Social Prescribing	• Number of: - Referrals from social prescribing link workers - People directly engaged with - Training sessions • Data and feedback from those engaging with projects - Individual demographics - Happiness, physical and mental wellbeing and attendance at work/education and ability to take part in their community • Achievements from those directly involved in the projects delivery
5) Targeted Debt Advice	• Number of: - Participants engaged (responses to texts; acceptance of support) - Payment plans or budgeting plans set up - Enforcement action written off/withdrawn - Referrals made to services (and subsequent engagement) • Comparison of scores between cohort against a control group • Case notes and improved outcomes across other risk categories
6) Pre-paid Prescription Certificates for Care Leavers	• Demographics of young people • Number of cards provided • Young peoples feedback

	• Challenges faced to implement systems to provide PPC
7) Epilepsy Nurse Specialist	• Family and friends survey outcomes • Adherence to agreed KPIs/evidence of performance: - Including face to face, telephone and indirect contacts
8) Co-ordinator (Asthma & Allergy Friendly School Initiative)	• Number of: - Schools acquiring AAFS status - Staff trained - Parent champions

The Financial Plan

A total of 777k is available from NHS NEL and up to £400k may be allocated from the Public Health Grant for 23/24 if required to invest in any potential/'pipeline' projects, once fully scoped.

This plan is currently based on a commitment to fund projects outlined, in principle with contract reviews after 1 year to provide flexibility with allocation for the remaining years. Projects will be subject to learning and evaluation and this will be concluded at the end of July, after which further development of approaches may be required. A flexible approach ensures that any underspend can be reallocated towards new projects and/or carried forward into the next year.

To ensure projects that have demonstrated impact continue after 3 years, we will look to identify suitable alternative routes and funding streams within the system and make the case for its continued support, to ensure sustainability.

Preferred Contracting Arrangements

Contracting arrangements are to be determined, but are likely to be the same as last years funding i.e. transferred form NHS North East London ICB to LBBD under a S256 agreement for distribution under grant agreements to the project delivery leads of the workstreams.

However, for NHS partner led projects- such as the Epilepsy Specialist Nurse and Asthma and Allergy Friendly School Co-ordinator it may be more suitable for the ICB to directly pay NHS Trust organisations.

Governance Arrangements

Our Place Executive Group is accountable for the delivery of the plan, are provided with issues and monitor ICB returns on a quarterly basis.

An ongoing B&D health inequality working group will be formed. Whilst this won't focus on this particular programmes delivery, it may act as a forum to steer plans for this programme and discuss emerging issues, priorities and opportunities ahead of the Executive Group.

Outside of this, any issues may be fed into the NEL Health Inequalities Funding Working Group; to the NEL Population Health and Health Inequalities Steering Group or NEL Population Health & Integration Committee.

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North East London
Integrated Care Board

Barking and Dagenham Committees in Common of ICB Sub Committee and Health and Wellbeing Board
26 June 2023

Title of report	Improving Urgent and Emergency Care (UEC) across Barking and Dagenham, Havering and Redbridge
Author	Kirsty Boettcher, NHS North East London
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	k.boettcher@nhs.net
Executive summary	Urgent and emergency care is under significant pressure across the country. These pressures are significantly felt across Barking and Dagenham, Havering and Redbridge by our providers, particularly in the acute provider setting. Due to this, several measures have been put in place across the ICB to ensure the effectiveness of the UEC pathway. This has resulted in several improvement programmes being developed. This paper aims to provide an oversight of the above and provide assurance for the work that is being undertaken in regards to improvement
Action / recommendation	The Committees in Common are asked to note and comment on the approach set out in the attached paper and slide deck.
Previous reporting	NEL Urgent and Emergency Care Programme Board
Next steps/ onward reporting	Ongoing oversight and discussion within the Urgent and Emergency Care Programme Board, the BHR Places UEC Improvement Board and the B&D Place Executive
Conflicts of interest	The Committees in Common will follow the conflicts of interest policy of the respective organisations and a register of interests will be presented at each meeting to ensure conflicts of interests are appropriately managed.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money

	• To support broader social and economic development
Impact on local people, health inequalities and sustainability	The aim of the improvement programmes being undertaken is to ensure the UEC pathway across the Barking and Dagenham, Havering and Redbridge Places is effective and efficient, and that all patients receive safe care and a positive experience. This aligns with the region's ambition and supports the UEC access standards. These improvement programmes strive to provide all people across NEL with the right care in the right place, in a timely way. They aim to support more patient centred, personalised care for our population, therefore addressing health inequalities that currently exist.
Impact on finance, performance and quality	The ambitions of the UEC Improvement Programme, highlighted in this report, align with those in NHS England's UEC Recovery Plan. As a result, the impact of these works should see an improvement in performance, particularly in the acute provider setting.
Risks	The risk to ensuring both partners meet their statutory responsibilities around decision making including management of conflicts of interest will be mitigated through close working of the Heads of Governance of both the ICB and LBBD to review/amending the approach based on testing.

1. Background

1.1 Urgent and emergency care has experienced unprecedented demand since the Covid-19 pandemic and continues to do so to this day. This has resulted in a significant increase in demand on our system providers which is impacting on the care we deliver to our patient population. Various measures have been put in place across the north east London (NEL) footprint to ensure that patient safety is maintained and prioritised. This has subsequently resulted in a number of improvement programmes being developed to address these concerns and deliver services in line with NHS England's Urgent and Emergency Care (UEC) Recovery Plan and to meet local priorities.

1.2 This paper aims to provide oversight of the current programmes in place to improve our response to urgent and emergency care and to the measures that are currently in place for both the ICB and some of our providers.

2. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and SOF4

2.1 BHRUT entered into Single Oversight Framework level 4 (SOF4) as the result of a combination of non-elective performance challenges and financial sustainability (deficit) issues. Both areas need to be improved to support both London's quality agenda and reduce inequalities within NEL. To meet the objective of moving from SOF4 to level 3 for both non-elective performance and financial recovery, five broad areas and associated targets have been developed:

- UEC performance: improvement in ambulance handover times, pre-12 discharges stabilised with improved weekend offset by reduced weekday and improved accuracy of recording criteria to reside
- Financial improvement: evidence of achieving net £20m savings in 23/24
- Balanced robust plan within NEL system
- Strengthened financial control, for example evidence of sustained reduction of medical bank and agency usage
- Number of wider enablers including stable executive team, system support, medical engagement and staff wellbeing

3. Care Quality Commission (CQC) inspections

3.1 As noted above, urgent and emergency care in outer north east London has been challenged for some time. A CQC inspection took place in November 2022 at BHRUT focused on urgent and emergency services. This was a follow up to a visit in November 2021 where issues were identified with flow, in and through, the urgent and emergency care pathway. In November 2022 all four urgent treatment centres provided by the Partnership of East London Cooperatives (PELC) were inspected along with both emergency departments and medical care provided by BHRUT.

3.2 A brief summary of the key findings highlights that the CQC found that BHRUT (the trust) faced continued challenges with access and flow into and out of the emergency pathway, people did not always receive timely treatment when needed and further were not always cared for in the best place for their treatment needs. Waiting times in Queens and King George's hospital were also exacerbated by long waits for mental health patients and these patients had to wait too long to receive the right care. The CQC separately found that all four Urgent Treatment Centres (UTCs) delivered by PELC were rated as inadequate and enforcement actions were issued. Inspection findings covered areas such as access to care and treatment in a timely way, a need to improve governance and accountability, a need for clearer vision and strategy and leadership capacity and skills.

3.3 In response to the CQC report BHRUT outlined and is taking forward a number of actions including enhanced support for Emergency Department (ED) teams, improved record keeping (through access to devices for staff and undertaking a post implementation review of electronic systems and ensuring sufficient privacy and dignity for patients waiting in the corridor. Additional BHRUT is

working closely with North East London Foundation Trust (NELFT) on improving the experience for mental health patients in ED and with London Ambulance Service on improving ambulance handover times.

3.4 A number of actions have been taken forward by the ICB and PELC in response to the CQC findings including improved contract management through regular and focused meetings, the establishment of a PELC Assurance Group attended by the ICB Quality Team and chaired by Fiona Smith, Associate Non-Executive Director of NEL, concentrating on quality improvements in line with the CQC recommendations and a focus on governance**.** The Good Governance Institute is providing external support in undertaking a governance review.

3.5 In respect of improvements for mental health patients in ED BHRUT and NELFT are working collaboratively to address the issues raised and NELFT have set out a range of actions to improve this situation including improved crisis support into planned care leading to UTC/ED avoidance, improved conveyance diversion from ED and mental health crisis hub working with the police and LAS, improved access to mental health at point of walk in entry to UTC, enhanced mental health presence at ED to improve patient experienced and conveyancing, better data and improved access to senior clinical support when issues arise.

4. UEC Review by PwC

4.1 In response to the national UEC Recovery Plan and in order to be better prepared for winter through developing a stronger focus on system resilience, the NEL ICB has undergone a rapid review of its current UEC Services under the leadership of PwC with the principal aims of agreeing and implementing a clear plan for delivery of system resilience in 2023/24; ensuring oversight of medium and long-term transformational opportunities and working towards future governance of system-wide improvement across UEC.

5. Tier 1 – interventions for urgent and emergency care

5.1 NEL ICB was notified in May 2023 that it would be designated as Tier 1 (the highest level of support) because of performance against the following criteria:

- 4 hour wait in ED
- Response time for Category 2 ambulance patients
- Proportion of acute beds occupied by patients who do not meet the criteria to reside
- Number of ED patients waiting more than 12 hours for admission

5.2 The National UEC team is clear that support will be aimed at improvement rather than regulatory action, and NEL has requested support in four areas:

- Data and Business Intelligence
- Clinical support, especially in BHRUT
- Implementing frailty pathways

- Designing and running a System Control Centre (mandated from November 2023)

5.3 As part of the Tier 1 status for the ICB a performance management framework has been developed to provide assurance on a limited number of improvement trajectories. These are:

- Providers generated plans to achieve 76% 4-hour ED waits by March 2023 and a 92% maximum bed occupancy as part of the 2023/24 Operational Plan.
- An in-depth focus on the time mental health patients wait in ED, on top of the existing improvement plan for delays in the mental health pathway.
- An additional trajectory is required for delays in handover of patients from the care of the ambulance service to the ED staff

6. BHR Places UEC Improvement Plan

6.1 In light of the significant amount of activity, intervention and focus outlined above, partners – convened by the ICB – have developed a BHR Places UEC Improvement Plan, which is being developed through a partnership BHR Places UEC Improvement Board. This plan, attached as Appendix 1, will continue to be developed as required, and draws together all the actions planned and underway to improve our system locally – from prevention and early intervention through to discharge arrangements, from primary care capacity to the way we deliver Urgent Treatment Centres, from work directly with local people to the role of the voluntary and community sector. Some of the work outlined is short term and will have impact before the winter – other aspects of the work are longer term and involve building a strong, person-centred and prevention focused model.

6.2 A more detailed workplan, with tracked actions, has been developed to support the delivery of the plan and the Improvement Board will use this monthly to track progress and use it to escalate issues and provide updates for the NEL UEC Programme Board. The membership of the Improvement board contains all relevant stakeholders, across a range of pathways given the significant co-dependency in the plans. Work is underway on data analysis to support the prioritisation of the plan. Each Place in BHR is also working closely with the team to make sure there is a strong interface at Place and delivery across the community, primary and social care services required to support people to live well at home.

7. Conclusion

7.1 The Committees in Common is asked to comment on the work underway and specifically on the Improvement Plan and how we take forward the work necessary in Barking & Dagenham Place to enable better outcomes for people requiring urgent and emergency care, across the range of interventions required in the short and longer term.

Appendix 1

Attachment 1: BHR Places UEC Improvement Plan

BHR places UEC
Improvement Strateg

NHS
North East London

UEC Improvement Strategy and Plan: BHR Places

Draft Plan to Committees in Common of ICB Sub Committee and Health and Wellbeing Board

Kirsty Boettcher

Introduction

This pack sets out the BHR Places UEC Improvement plan.

This is a plan in development and is supported by a detailed action plan also in development which is clear on leads, deliverables, outcomes and timelines.

A risk and issues log is being worked on which will sit alongside the plan and it should also be noted that a number of the schemes will only be able to move forward with funding.

Historically the BHR UEC Transformation Programme Board was responsible for the work relating purely to UEC flow, and was supported by sub-groups. Adhoc updates were received from other programmes, with accountability for these sitting at their respective Transformation Boards.

It is proposed that under new governance arrangements, the BHR Places UEC Improvement Board is asked to "hold the ring" on this System Improvement Plan containing all actions that have an impact on the UEC system across the BHR places and hold respective programmes accountable for the delivery of their actions. Its membership will reflect the system and include BHRUT, NELFT, Havering, Barking and Dagenham and Redbridge Councils, Barts Health (Whipps Cross), Primary Care, the VCSE, LAS and NHS NEL as well as a wider set of system contributors

The plan for this requires work-up through the new governance arrangements including clarity for responsibilities on the UEC Improvement Plan to be confirmed and this is outlined in the conclusions on the last page of this slide.

Contents:

Overview of Barking and Dagenham, Havering, Redbridge Places

- **BHRUT is one of the busiest A&Es in the country** - based on ED attendances (all types) in November 2022 – BHRUT was the 12th busiest in the country and the 4th busiest in London
- **Within BHR there are significant areas of deprivation** - based on the 2021 census, out of all London local authorities, Barking and Dagenham has the highest number of households experiencing a dimension of deprivation (the four dimensions of deprivation are employment, education, housing and health and disability)
- **There is a growing population** – in total across BHR over the last five years alone the population has grown by 1.3% (19,618 people). Redbridge is the 11th largest borough in London with the 8th largest increase in population across all boroughs. Havering's children's population grew by 20% between the 2011 and 2021 census (highest in London, second highest in England) and is projected to grow by 15,000 by 2032. B&D's house building programme will result in at least another 50,000 residents over the next 20 years
- **Age demographics** – there is a high proportion of residents aged over 65 – in Havering this is expected to increase by 13% by 2032.
    - **Barking & Dagenham has a relatively young population** compared to the rest of London with 17.7% of residents aged 9 or under
- **Avoidable admissions**
    - Avoidable admissions at Queens appear 3 times higher than other sites. There are practice outliers in B&D and Havering.
- **Primary care – average GPs per 100k of the population is below the north east London (48.2 per 100k) and England (76 per 100k) averages in each of the three Places**
    - Redbridge 37
    - Havering 39
    - Barking and Dagenham 39

System Overview

There is widespread recognition that the system has a role to play in bringing partners together, supporting collaboration and taking other action as required. This improvement strategy sets out how we will work together as a system to ensure UEC services are resilient and delivering well for our local populations. This will need to include reporting from the Collaboratives on the work that support the plan.

We know that individual organisations are undertaking a range of actions, all of which are contributing to improvements, and it is through this Plan that we bring together all these actions to ensure we are co-ordinated, cohesive and having maximum impact. Acting in a system way we aim to reduce duplication and fragmentation and to respond to the needs we have in our system.

The various elements that we are bringing together here include:

- Work at place (Borough) level to tackle drivers of ED attendance and admissions and ensure effective discharge, ensuring reducing avoidable admissions across partners
- Work to improve primary care capacity
- Work with LAS to increase appropriate conveyance avoidance in turn reducing ambulance delays and admission
- Responses to the findings of the CQC in response both to their inspections of UTCs and BHRUT front doors.
- Support to and assurance of, PELC's improvement plan including an independent governance review of PELC
- Significant system work on reducing long waits for those in mental health crisis in our emergency departments
- Work to improve patient flow through each of the hospital sites

System Overview: governance

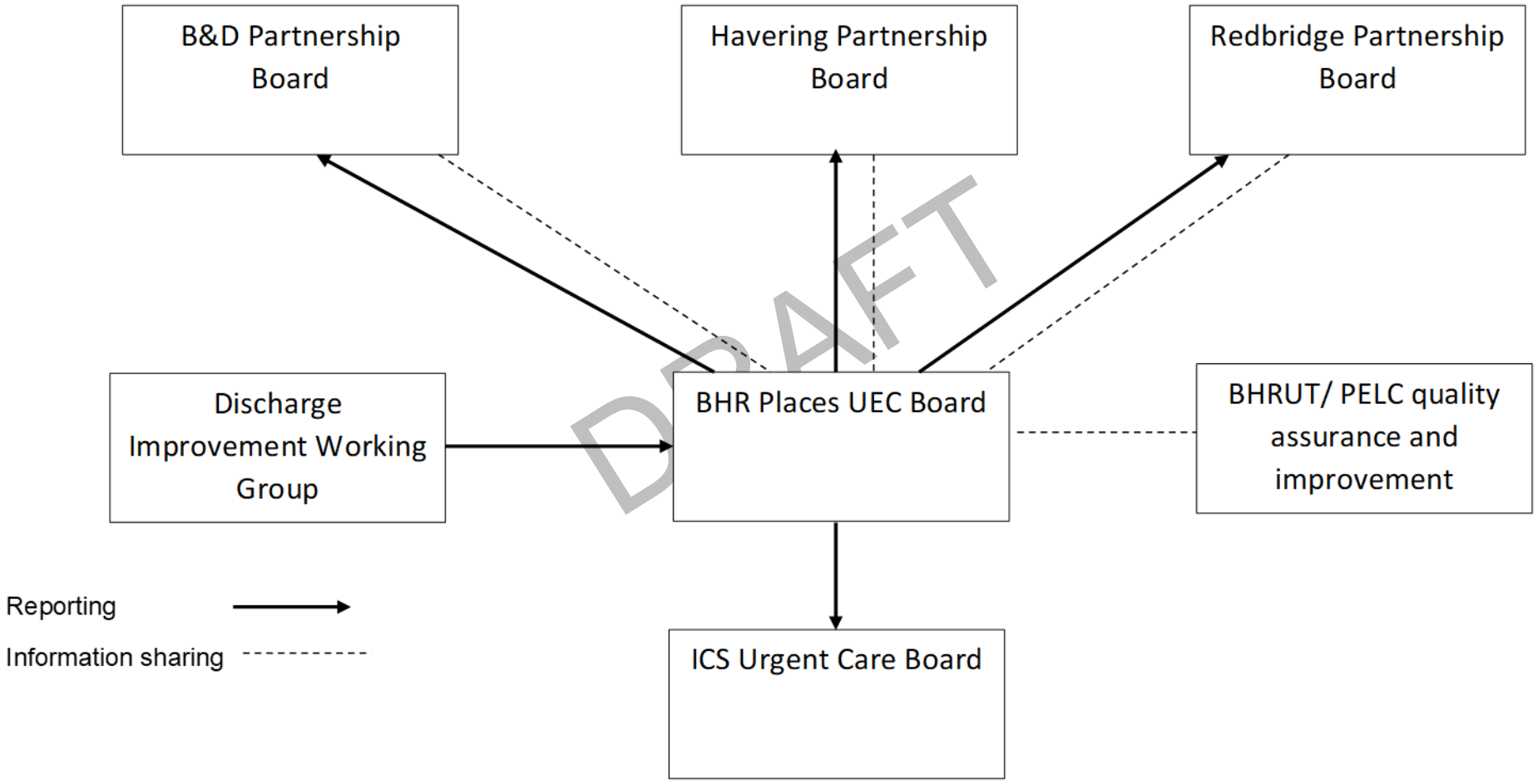
We have increasingly robust system governance designed to enable us to work together to improve the urgent and emergency care pathway including a North East London UEC System Board chaired by the NHS NEL Chief Medical Officer which holds to account the BHR Places UEC Improvement Board for delivery against this Improvement Plan.

The BHR UEC Places Improvement Board is a system level and strategic Board which will oversee the Improvement Plan. The Board is clinically chaired and led, enabled by system leaders with responsibility for a range of deliverables. Reporting to the Board will be a number of sub-groups which deliver on the wide range of workstream activity required. There are group in place (as set out below) but others may be deemed necessary by the Improvement Board:

- Discharge Improvement Working Group
- PELC CQC Assurance Group
- BHRUT UEC Improvement Programme
- NELFT UEC Programme
- Place Partnership work on implementing integrated neighbourhood teams
- Primary Care development of same day capacity to deliver continuity of care

The aim is to retain a focus on structures which are working well, ensuring that they recognise their relationship with the Places Improvement Board and their role in delivering the UEC Improvement Plan. Next step: Primary care, Planned Care and the Collaboratives will need to report into this structure. The arrangements need to be worked through and agreed over the coming weeks.

System Overview: governance structure



System overview: Data

We have seen significant pressures on urgent and emergency care services across north east London, with the greatest pressure on services for residents in Barking & Dagenham, Havering and Redbridge. We can see these pressures reflected in:

- Ambulance handover times against targets
- UTC – 15 min stream and 4 hour wait
- ED waits – 4 hour wait
- Bed occupancy
- 7 and 21 day LOS
- Patients not meeting criteria to reside – by Trust/ partners
- Activity levels in our GP Access Hubs, in Queen's and KGH's EDs and in the four UTCs across this area
- Elective waits

(next stage will add the activity trends for these key metrics)

System Overview: Insight (next stage to be added)

We will add an overview on citizen's experience of our UEC system in BHR which will help to highlight where we need to improve

- Qualitative data from HealthWatch – GPs, LAS, UEC
  - What are local people telling us about what they are seeing – from a primary care (how easy is it to access a GP), UEC (what is their experience of the system) and LAS (most recent work commissioned by LAS) perspective
- Insight reports
- Place level feedback

UEC Improvement Plan: Making a difference - Outcomes

The Improvement Plan pulls together a number of contributing plans in order to demonstrate how we as a system are working strategically to improve our performance against key critical metrics, set out on the next slide. These metrics show how we as a system will achieve the following overarching outcomes, which have already been agreed across north east London:

1. Helping people stay well, independent and healthy, preventing them needing acute levels of care as far as possible;

2. Ensuring that we are planning for and delivering the capacity we need for those who do need it;

3. Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting;

4. When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

The contributing actions are fully meshed into a detailed Action Plan, sitting behind this more strategic Improvement Plan. The more detailed plans include the UEC Improvement Plan for BHRUT, which incorporates the responses to the CQC findings and recommendations; PELC CQC Action Plan; NELFT's UEC Action Plan focusing on 4 workstreams.; (further contributing plans to be identified e.g. Primary Care, Mental Health, other Collaborative Plans). Together these Plans will form the Improvement Plan.

The Improvement Plan sets out how we as a system will work to deliver improvements through a number of workstreams, each of which will in effect operate across three phases: issues to be addressed by winter; medium term issues which require a system response; longer term issues. Action on all three need to happen in parallel to avoid a single focus on the immediate and crisis actions, rather than the longer term and more preventative actions.

UEC Improvement Plan: Making a difference

The Improvement Plan sets out how we as a system will work to deliver improvements across urgent and emergency care measured through the following metrics, some of which are still in development and all of which are being monitored at regional and national level as well:

- People able to access same day urgent care through primary care (including pharmacy)
- Reduction in percentage of people with avoidable admissions
    - Emergency admissions for conditions not usually requiring hospital treatment (NHSOF: 2.3.i); Unplanned hospitalisations for chronic ambulatory care sensitive conditions (NHSOF: 3a); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF: 2.3.ii); Emergency admissions for children with lower respiratory tract infections (NHSOF: 3.2)
- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25 and monitoring of time spent in A&E, including 12 hour waits from time of arrival,
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
- Ambulance handovers 85% within 30 minutes
- Discharge of those patients who do not meet the criteria to reside
- Improvement in experience of local people in staying well and accessing urgent and emergency care

UEC Improvement Plan: Workstreams

The six workstreams have been selected to cluster a range of actions across partners and sectors. They are:

- Keeping People well at home
- Reducing avoidable admissions and same day access for urgent care
- Improving in-hospital flow and discharge
- Ensuring focus on children and young people
- Supporting mental health needs
- Communicating and engaging

There are also two infrastructure workstreams which are being led across north east London as they cannot be facilitated for BHR Places alone. Again, they will need to be considered through the lens of immediate actions, medium term responses and more systemic work to address capacity and sustainability issues in the longer term:

- Ensuring a sustainable workforce
- Supporting 999 and 111 services

In the following slides, we set out our plan for improvement across these workstreams.

LOGIC MODEL

Context: BHRUT is one of the busiest A&Es in the country
Within BHR there are significant areas of deprivation - There is a growing population
Age demographics – there is a high proportion of residents aged over 65 – in Havering this is expected to increase by 13% by 2032.
Avoidable admissions at Queens appear 3 times higher than other sites.
Recent CQC inspections has seen areas of urgent care within the system require improvement
ICB restructure, ICS implementation

Vision: To have a more integrated and more preventative urgent care system across the B and D, Havering and Redbridge Places where citizens are supported to stay well at home where possible and have good quality care when needed, with all services rated at least Good.

Inputs for All Logic Models

- NEL UEC BOARD
- BHR UEC IMPROVEMENT BOARD
- PELC CQC ASSURANCE BOARD
- BHRUT CQC ASSURANCE
- COLLABORATIVES
- DIGITAL
- DATA INSIGHT
- PROGRAMME TEAMS
- DELIVERY TEAMS
- BUDGET PER PROGRAMME

Activities

KEEPING PEOPLE WELL

ADMISSIONS AVOIDANCE / SAME DAY ACCESS

HOSPITAL FLOWS

DISCHARGE

CYP FOCUS

MENTAL HEALTH SUPPORT

ENABLERS

Outputs

- Increase Preferred place of death for EOL Avoidable admissions reduction
- Increase in same day access
- Reduction in ambulance conveyances/ ED attendances/ admissions
- Improve Vaccination rates
- Reduction in attendance and admissions for falls
- Reduction in LOS
- Decrease delay discharge
- Improved Ambulance hand over

Outcomes

Increase of healthy life expectancy

Increase in satisfaction of urgent and emergency care

Increase staff satisfaction

Increase in staff retention

Urgent care providers to be rated at least Good

Improvement Plan: Keeping People Well at Home

A key area of focus is keeping people well at home. We know that good, joined up community services (delivered by a range of partners across health, social care and the voluntary and community sector) can support people to stay well for longer, receiving care closer to home and staying living well with a range of conditions.

Community health services, including therapy services, help keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered in combination with personalised care, they can reduce pressures on hospitals and emergency services by supporting people at home and in the community, as well as provide them with greater choice and control, leading to improved experience and outcomes.

Falls are the number one single reason why older people are taken to the emergency department, and around 30% of people 65 and over will fall at some point. Care outside hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted. Through better joint working and sharing of information between services we can help improve care for people who fall or are living with frailty.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital. Making use of new technology and better collaboration, including between ambulance services and community care, will enable care that would often currently be delivered in a hospital to be delivered closer to people's homes.

Improvement Plan: Keeping People Well at Home

- **Outcome 1:** Our residents will be supported to stay well at home and in their communities during winter and for the longer term, increasing healthy life years. Objectives include:
    - Improve quality of life and ageing well
    - Increase support for carers and community support
    - reduce the demand for unplanned care
    - Increase take up of vaccinations and other health protection measures
    - Support the sustainability of community-based care including care providers
    - Build community resilience
    - Improve support for MH crisis in the community

<u>Contributes to Metrics:</u>

- Preferred place of death for EOL
- Avoidable admissions
- Reduction on ambulance conveyances/ ED attendances/ admissions – including breakdown from care homes
- Vaccination rates
- Reduction in attendance and admissions for falls

Improvement Plan: Keeping People Well at Home

Now and over the winter

- Develop community catheter service
  - Reduce ambulance conveyances and admissions for frail elders
- Maintain delivery on 2 hour target for UCR
  - Link with LAS and increase number of people kept at home
- Monitoring utilisation of UCR cars and PRU
  - Review utilisation of new car and work with LAS and BH to maximise utilisation
- Review of HALO provision and update service specification
  - Monitor impact of reducing conveyance and increased use of ACPs
- Extend REACH equitably across BHR (subject to funding)
  - To deliver enhanced response to keep people at home, avoiding admission
- Mobilise falls service for all of BHR
  - To reduce pressure on EDs: falls is highest risk factor for ED attendances and admissions for frail older people

Improvement Plan: Keeping People Well at Home

Now and over the winter

- Deliver consistent enhanced health offer into care homes
  - To reduce risk of people becoming unwell and requiring urgent assistance
- Facilitate easy access to vaccinations and screening
  - To protect people from infection and to identify need early
- Ensure network of social prescribers, community connectors and local area co-ordinators work well together
  - To provide early intervention and prevention, to reduce social isolation and to reduce impact on clinical and care services
- Roll out Minor Ailments Service across north east London
  - To respond to the acute shock of the cost of living crisis and reduce unnecessary demand on primary care
- ARI hubs (subject to evaluation of 2022/23 winter)

Improvement Plan: Keeping People Well at Home

Medium term

- Evaluate and review impact of REACH, PRU, Community Response
  - To compare the different models currently in place across north east London with a view to a north east London wide implementation of the most effective, sustainable and affordable model
- Develop and respond to Demand and capacity Plan across community care services to define a consistent community offer
  - To ensure all residents have access to a consistent core community services offer
- Review availability of Community equipment needed for winter
  - To ensure people have timely access to community equipment whether living at home or in hospital
- Support people waiting for elective interventions (planned care)

Improvement Plan: Keeping People Well at Home

Longer term

- Implement Continuity of Care workstream in each Place – Fuller
  - To reduce pressure for people with long term conditions and keep people well at home
- Grow capacity in primary care
  - To build the right capacity to meet needs
- To ensure joined up provision across primary care
  - To join up capacity and resources across GPs, nursing, pharmacy, ARRS, etc.
- Supporting people waiting for elective interventions

Improvement Plan: Avoidable admissions/same day urgent access

- **Outcome 2**: Our residents will be supported in crisis to avoid attendance at ED and to prevent an attendance becoming an admittance to hospital or long-term bed-based care. Objectives include:
    - Reduce demand at the front door of ED and waiting times
    - Reduce the growth in demand for institutional care in the longer term
    - Increase quality of life and wellbeing during crisis
    - Increase support carers and community support

- Analysis has been undertaken to understand what is the variation in avoidable admissions across NEL and if there are opportunities to reduce this variation with the aim of *Keeping people well at* home. Analysis was done to understand this variation and to explore what may be driving these and looks at heterogeneity in social demographic factors and underlying health status and also proximity to an acute site. We also look at historical trends in admission rates by place using nationally published data from the NHS outcomes framework.

- Our analysis shows there is considerable variation in the volume of avoidable admissions by site with this type of admission being nearly three times as common at Queen's Hospital than it is at the Royal London. This variation in volume plays out when we create age-standardised rates by GP practice and further when we view rates by GP practice in funnel plots to differentiate what may be random variation from what is non-random. In this analysis, we see noticeable clustering of these rates by place with, in particular, Tower Hamlets showing many practices as having low outlying rates. In contrast Barking & Dagenham and Havering in particular have a higher number of practices where rates are high outliers.

- The analysis of proximity to an acute hospital site shows that this is not a factor in accounting for high rates, there is instead a weak inverse relationship between travel time and avoidable admission rates.

Improvement Plan: Avoidable admissions/same day urgent access

Now and over winter

- Safeguard primary care capacity currently delivered through the five GP Access Hubs (over 100,000 appointments per year) beyond the first six months of the year (subject to funding)
    - To reduce risk of further pressure on UTCs and EDs over the winter months
- Deliver PELC CQC and wider improvement actions, including plan to meet 98% 4 hour target
    - To ensure demand and capacity in UTC over winter are understood and acted on
    - To increase community confidence
- Collaborative working on front door model between PELC/ BHRUT
    - To improve flow and patient experience
- BHRUT deliver CQC actions and operating plan targets for 4 hours and ambulance turnaround times
- Work proactively with people on the elective waiting lists (Planned Care lead)
    - To reduce risk of admissions for these targeted individuals

Improvement Plan: Avoidable admissions/same day urgent access

Now and over winter

- Implement virtual wards for both frailty and ARI
  - Increase capacity for patients to be managed safely in the community and avoid admission
- Review Better Care Fund schemes with evaluation and impact
  - To ensure we are using funding appropriately to reduce admissions and support people to be discharged well
- Deliver consistent speciality advice to GPs, confirming and promoting contacts and pathways
  - To support GPs to offer advice and support in the community
- Improve management of High Intensity users
  - Reduce attendances and improve patient experience
- Extend and evaluate pilot of social workers in acute frailty units
  - To increase early identification of people's needs – evaluation to test effectiveness and affordability of model
- Pilot integrated case manager at KGH ED to support discharge
  - To ensure timeliness of discharge with multi-disciplinary approach avoid admissions

Improvement Plan: Avoidable admissions/same day urgent access

Medium term

- Review Urgent Treatment Centres: what is our model in outer London, have we got sufficient capacity and how do we build for the future (confirm lead in NEL)
    - To build sustainability for the future as demand changes over time
- Conclude deep dive on virtual wards and act on findings (Community Collaborative)
    - To ensure join up of urgent and emergency provision, community beds and care capacity to avoid admissions and to enable discharge

Improvement Plan: Avoidable admissions/same day urgent access

Longer term

- Implement Fuller incorporating same day urgent access model across primary care, UTCs etc.
    - To have a coherent and consistent model in place
- Implement virtual ward deep dive findings
    - To follow through and ensure connectivity between all parts of our system through a community based care model

Improvement Plan: Improving hospital flow

We know from local from people who use urgent and emergency care, and the national UEC recovery plan how important it is to have a smooth experience in hospital, and not to experience too many unnecessary delays, especially where it is not clear why.

The national plans sets out how the NHS will use existing capacity as effectively as possible by standardising processes so that patients get the right care at the right time, including when moving between organisations. There will be a focus on reducing variation in care when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so people avoid unnecessary overnight stays.

There will also be a more standardised approach to the first 72 hours in hospital so that people are assessed, get any required scans, and start their treatment as soon as possible.

The NHS will continue to make effective use of 'system control centres' (SCCs). These pioneering centres use data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will ensure the highest quality of care possible for the population in every area by balancing the clinical risk within and across acute, community, mental health, primary care, and social care services.

The NHS will also work towards implementing new response time standards for people requiring urgent and emergency mental healthcare in both A&E and in the community, to ensure timely access to the most appropriate, high-quality support.

For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Improvement Plan: Improving hospital flow

Now and over winter (needs to be updated with BHRUT plan)

- Implement CQC actions must dos and should dos - BHRUT
  - To build confidence and respond to all findings and recommendations to achieve better outcomes
- Implement and staff fully operational SDEC model on both Queen's and KGH hospital sites
  - To meet national requirements and to enable better flows
- Deliver fit for purpose discharge lounges in both Queen's and KGH
  - To facilitate discharges earlier in the day, with a focus of leaving before 11am

Improvement Plan: Improving hospital flow

Medium term (needs to be updated with BHRUT plan)

- Evaluate impact of Operation Snowball
  - To ensure it is effective, sustainable and promotes patient wellbeing
- Reconfiguration of ED and UTC spaces given relocation of renal unit and Rom Valley Gardens development
  - Opportunity to improve UEC hospital flow

Improvement Plan: Improving hospital flow

Longer term (needs to be updated with BHRUT plan)

Improvement Plan: Discharge

Outcome 4 - When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible. Objectives include:

- Improve quality of life and ageing well
- Improve speed and quality of discharge
- reduce admissions to long term care
- Improve hospital bed utilisation

<u>Contributes to Metrics:</u>

- Reducing number of patients in beds not meeting criteria to reside
- Reduce 7 and 21 day LOS in beds

Improvement Plan: Discharge

<u>Now and over the winter</u>

- Review Integrated Discharge Hub operations, including Trusted Assessor models
  - To build equity across north east London and to reduce the numbers of people with no criteria to reside continuing to stay in hospital
  - To ensure models and pathways meet the needs of all patients including those with a complex history of homelessness
- Develop and implement Discharge to Assess home for more patients
  - Avoid patients losing independence and moving into long term care
- Review and simplify Rehab pathways
  - To ensure efficient use of provision for all, with the correct capacity and in preparation for additional community rehab availability
- Implement Welfare checks pilot in Redbridge
  - Reduce risk of readmission

Improvement Plan: Discharge

Medium term

- Review Intensive Rehabilitation Service (IRS) Capacity
  - To have a fully functioning rehab pathway across a range of provisions to meet a range of needs and to enable timely discharge
- Develop and respond to Demand and Capacity Plan for care across north east London
  - To ensure we have an overview of need and gaps in care provision to plan better for the future
  - To ensure we have the right provision, in the right area, at the right capacity
  - To include reablement, intermediate care as well as care homes

Improvement Plan: Discharge

Longer term

- Build community Stroke and Neuro rehab, implementing business case
    - To enhance community rehab for people with complex needs to enable timely discharge and support in the community

Improvement Plan: Supporting mental health needs

It is critically important to us that our urgent and emergency pathways and responses work well for people who are experiencing poor mental health and are entering a period of crisis as well as for those with a physical health need. We know that people attending ED in mental health crisis may also have physical health issues which may also need a response but it is critical that we reduce the incidences of people with mental health needs in ED waiting for mental health support and a mental health bed.

Our local plans reflect the range of work underway in the area to reduce ED attendances, to support people to stay well, to move people to appropriate provision at the earliest opportunity and to ensure that where delays do occur, people continue to be supported by people who can best respond to their needs.

We are ensuring a focus across each of our workstreams in effect for people with mental health needs, with specific targets to reduce lengths of stay in EDs for people with mental health needs.

For us locally, we are focusing on the following actions over the winter, in the medium term and over the longer term too.

Outcome metrics:

- Length of stay for people with MH Needs in ED
- Numbers of people with no criteria to reside in MH Beds

Improvement Plan: Supporting mental health needs

Now and over the winter

- Improve crisis support and diversion, including building capacity and focusing existing work on diversion working with LAS, Met Police, Primary care and local authorities
    - To reduce numbers of people attending ED in acute mental health need/crisis
    - To enhance partnership working in this space
    - Increase LAS use of MH ACP
- Improve Processes and support into ED and Mental health streaming pilot in Queen's UTC
    - To support people already in ED to receive timely care and support
- Improve quality and timeliness of data and escalation routes
    - To support real time progress updates for all clinicians and ensure effective joint working
- Increase bed capacity through ensuring access to Winter Surge Beds, delivering of new 12 bed ward and a renewed focus on discharge
    - To ensure we have additional capacity and are improving flows, supporting people to receive the right care in the right place at the right time
- Review of MH patients n KGH ED for learning and pathway improvements
- Introduction of Crisis cafes across the BHR Places

Improvement Plan: Supporting mental health needs

Medium term

- Evaluate approach to crisis support and diversion, including with partners
  - To reduce numbers of people attending ED in acute mental health need/crisis
  - To enhance partnership working in this space
- Evaluate UTC MH streaming pilot and enhanced staffing to support in ED
  - To support people already in ED to receive timely care and support
- Embed CDU and reduce ED ALOS
  - To support real time progress updates for all clinicians and ensure effective joint working
- Respond to findings of MH Demand and Capacity Plan across NEL for BHR, ensuring implementation to meet known gaps and capacity challenges
  - To ensure equity and build capacity locally to reduce urgent and emergency pressures for individuals in crisis

Improvement plan: focus on babies, children and young people

Babies, children and young people and their families need and use urgent and emergency care, and yet may not receive the focus required to ensure we as a system can meet their needs. As babies and children's health can deteriorate rapidly it is important that parents, carers and a wide range of practitioners and clinicians have confidence in our systems for early identification and follow through, as well as excellent support for parents and the broad front line workforce working with children and young people daily.

Children and young people's urgent and emergency care services have also faced unprecedented levels of demand, with CYP attendances peaking at 40% above pre-pandemic levels in December 2022, and as high as 60% above pre-pandemic levels for children aged 2-10.

The national plan set out specific interventions to improve urgent and emergency care for children and young people. It highlighted the need to ensure that services reflect the needs of different groups of people, including all age groups. It is crucial that implementation plans meet the specific needs of children and young people, parents/carers, and families. The most common conditions and symptoms experienced by children and young people presenting at ED are:

• Fever • Respiratory: bronchiolitis; croup; asthma • Gastroenteritis • Abdominal pain

Many of these attendances could be managed effectively in primary care or community settings. Meta-analytic evidence suggests key reasons for parents attending emergency departments non-urgently include: parental worry, perceived advantages of paediatric ED, convenience and access, anticipated difficulty in accessing primary care, and the need for reassurance. Scaling up initiatives that provide additional support to children and families, improve flow, manage demand, and divert low-acuity CYP presentations to more appropriate care settings will be crucial to support children, their parents/carers, reduce pressure on ED, and increase capacity and operational resilience in urgent and emergency care

Improvement plan: focus on babies, children and young people

These actions are taken from the north east London discussion about a focus on babies, children and young people. We need to work through any specific actions and emphases for this Improvement Plan

- Expand support and paediatric advice through NHS.UK, NHS111, and NHS111 online to support decision making and management of minor illness including information for Pharmacists and use of the 'What to do if your child is unwell' information for parents and carers
- Increase access to paediatric expertise through further roll out of NHS111 Paediatric Clinical Assessment Service
- Embed Family Support Workers across selected A&E sites to provide support to children with non-urgent issues, as well as outreach and additional support in community settings – consider the development of a BHR Social Care Liaison Officer (SCLO) role
- Expand access to care in the community, including roll out of paediatric acute respiratory infections (ARI) hubs for children ahead of next winter
- Improve acute pathways through consistent adoption of paediatric Same Day Emergency Care
- EOL pathways for CYP – Haven House and Richard House: we will build on the excellent step down from BHRUT in place

Improvement plan: focus on babies, children and young people

- Implement locally the national roll-out of a standardised paediatric early warning system (PEWS) in inpatient settings in 2023/24 to improve identification and management of deterioration in children
- Ensure direct access to urgent mental health support through NHS 111 ‘option 2’, to be universally available by April 2024
- Develop streamlined pathways for mental health patients who need to remain in acute settings until their care can be transferred, with particular reference to better working with children and young people’s mental health services 10. Better support for discharge through clear pathways and escalations including OOA
- Ensure access to 24/7 liaison mental health teams (or other age-appropriate equivalent for children and young people) that are resourced to be able to meet urgent and emergency mental health needs in both A&E and on the wards
- Provide consistent and repeated early parent education – to be developed at Place

This is an area for immediate development given the young populations across north east London and the need to build capability and capacity appropriately through work with Place.

Improvement plan: communication and engagement

Working with local people and communities is critical to improving our urgent and emergency care response. We have a number of opportunities for local voice to be heard through the Healthwatch Community Insights System, through regular PPG meetings, through dedicated co-design work in specific areas, through population level communications and engagement plans and through feedback on specific services. We are keen to develop our mechanisms for people to contribute to this Plan and the many actions which will be in place to deliver against our top level outcomes. Specific actions include:

- Consider feasibility of developing a directory of services for a range of stakeholders; develop electronic model, roll out and training plan
- Ensure Healthwatch insights and information is used as core data in decision making
- Continue to implement all year round system resilience campaign, ensuring it reaches out to communities through other communication
- Evaluation community champion models of health communication
- Develop models for co-design of solutions across the scope of this Improvement Plan

Improvement plan: Data and digital

NEL wide enabler

Placeholder: Improving our data and digital functionality across operational and strategic functions will enable us to operate more efficiently across our system and to understand better the impact of our actions on our intended outcomes both in real time and over time.

Areas such as ease of access to all partners to the Universal Care Plan for shared care models need to be agreed at pace to ensure we can move forward in more integrated ways. This will involve working with Information Governance to ensure we are building resilience and a focus on integration throughout our work.

There is work underway across north east London which will support delivery across this Plan.

Detail to be added

Improvement Plan: Building a sustainable workforce

<u>NEL wide enabler</u>

Placeholder: Ensuring a sustainable workforce

NEL work on a Workforce Strategy is underway and ensuring the right capacity at the right time is critical to the successful delivery of this ambitious Plan.

Detail to be added

Improvement Plan: Enhancing 999 and 111 services

<u>NEL wide enabler</u>

Place holder: supporting 999 and 111 services

- Areas being developed locally include:
  - Additional clinical specialists in LAS
  - Sustainability of Emergency Operations Centre
  - Consideration of Emergency Care Assistants
  - More work on diversions

Improvement Plan: Conclusion

As set out throughout the presentation, this is a Plan under development. It is ambitious in its aims and in its system wide approach which recognises the contributions of Place, Providers, Collaboratives and Programme in improving outcomes in outer north east London. We are asking the Board today to comment on the Plan and on the next steps in its development which are summarised below:

- Finalise the metrics, data and reporting requirements throughout the governance
- Work through the governance arrangements, including the groups reporting into the BHR Places UEC Improvement Board, the role of Place Partnerships, Collaboratives and the oversight through the UEC System Board
- Work with colleagues across Providers, Primary Care, Planned Care and other relevant areas to provide detail on the north east London wide work which will support the delivery of this Plan with a clear focus on data and information governance as an enabling priority
- Develop a risks and issues log which will provide an at a glance picture of progress
- Agree the logic model, with clarity on input, activities, outputs and outcomes including a clear summary on the core outputs and outcomes to ensure focus and understanding
- Work with local people to co-design solutions for the challenges identified

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