Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 10 March 2020 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 2 March 2020

Chris Naylor
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	LBBD (Cabinet Member for Social Care and Health Integration)
Dr Jagan John	Barking & Dagenham Clinical Commissioning Group
Elaine Allegretti	LBBD (Director of People and Resilience)
Cllr Saima Ashraf	LBBD (Cabinet Member for Community Leadership and Engagement)
Cllr Sade Bright	LBBD (Cabinet Member for Employment, Skills and Aspiration)
Cllr Evelyn Carpenter	LBBD (Cabinet Member for Educational Attainment and School Improvement)
Melody Williams	North East London NHS Foundation Trust
Matthew Cole	LBBD (Director of Public Health)
PS Kimberly Cope	Metropolitan Police
Sharon Morrow	Barking & Dagenham Clinical Commissioning Group
Fiona Peskett	Barking Havering & Redbridge University NHS Hospitals Trust
Cllr Lynda Rice	LBBD (Cabinet Member for Equalities and Diversity)
Nathan Singleton	Healthwatch - Lifeline Projects Ltd.

Standing Invited Guests

Cllr Eileen Keller	LBBD (Chair, Health Scrutiny Committee)
Terry Chaplin	London Fire Brigade
Brian Parrott	Independent Chair of the B&D Local Safeguarding Adults Board
Vacant	London Ambulance Service
Ian Winter CBE	Independent Chair of the B&D Local Safeguarding Children Board
Vacant	NHS England London Region

AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes - To confirm as correct the minutes of the meeting on 22 January 2020 (Pages 3 - 8)

BUSINESS ITEMS

4. Domestic Abuse Update (Pages 9 - 19)

5. Tri-Borough Suicide Prevention Strategy Update and Regulation 28 (Pages 21 - 27)

Presentation by Jill Williams, Shared Coordinator, Public Health

6. NEL Long Term Plan - Update (Pages 29 - 30)

Presentation by Mark Scott (ELHCP) and Sharon Morrow

7. NEL Integrated Care System - Update (Page 31)

Presentation by Henry Black, Chief Finance Officer - NELCA

8. BHR System Update (Pages 33 - 50)

Presentation by Alison Blair and Matthew Cole

9. BHRUT Clinical Strategy - Update (Pages 51 - 64)

Presentation by Tony Chambers, Interim Chief Executive BHRUT and Nick Swift, Chief Financial Officer BHRUT

10. Health and Wellbeing Strategy Outcomes (Pages 65 - 79)

Presentation by Wassim Fattahi-Negro, Principle Manager Performance & Intelligence

11. Development of Appt-Health product; digitally transforming preventative healthcare for local GPs. (Pages 81 - 85)

STANDING ITEMS

12. Integrated Care Partnership Board - Verbal update from the Chair

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

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

A New Kind of Council

- Build a well-run organisation
- Ensure relentlessly reliable services
- Develop place-based partnerships

Empowering People

- Enable greater independence whilst protecting the most vulnerable
- Strengthen our services for all
- Intervene earlier

Inclusive Growth

- Develop our aspirational and affordable housing offer
- Shape great places and strong communities through regeneration
- Encourage enterprise and enable employment

Citizenship and Participation

- Harness culture and increase opportunity
- Encourage civic pride and social responsibility
- Strengthen partnerships, participation and a place-based approach

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MINUTES OF
HEALTH AND WELLBEING BOARD

Wednesday, 22 January 2020
(6:00 - 8:15 pm)

Present: Cllr Maureen Worby (Chair), Cllr Saima Ashraf, Cllr Evelyn Carpenter, Matthew Cole, Kimberly Cope, Sharon Morrow and Nathan Singleton

Also Present: Cllr Jane Jones

38. Apologies for Absence

Apologies were received from Dr Jagan John (Deputy Chair); Elaine Allegretti, Cllr Sade Bright, Cllr Lynda Rice, Bob Champion, Fiona Peskett, Ian Winter and Terry Chaplin.

39. Declaration of Members' Interests

There were no declarations of interest.

40. Minutes - To confirm as correct the minutes of the meeting on 13 November 2019

The minutes of the meeting held on 13 November 2019 were confirmed as correct subject to the inclusion of Melody Williams, NELFT in the list of those present.

41. Vulnerable Children Outcomes- Call to Action

Following concerns raised by the LSCB and Ofsted around the outcomes for vulnerable children in Barking and Dagenham across the health and care system, the Board noted the key findings of a review conducted by the Director of Public Health (DPH) to understand the key challenges facing vulnerable children and young people and their access to services. The full report was presented to the LSCB in November 2019, and which was appended under agenda item 16 following the passing of a resolution to exclude the public and press from the meeting.

The DPH stressed to the Board the need to take collective responsibility to address the issues highlighted in the review, the findings from which highlighted in many ways what was already known and which illustrated that in the case of vulnerable children and young people there are gaps in dealing with such high demand which is posing considerable challenges in workforce recruitment in the context of a highly competitive market, when compared to neighbouring boroughs with less challenging environs.

It was noted that a joint meeting was held earlier today between the CCG and the Council to look at the process of achieving more joined up working through commissioning. This should include looking at ways to encourage the Schools Improvement Partnership to take an active part.

By way of example the Chair commented that themes emerging out of the pilot Thames Locality Board shows that the growth in the local population means more vulnerable families require support, and demonstrates why as a Board it cannot ignore the challenge of dealing with the unprecedented demand in this area whilst at the same time making the 'space' to look at new ways of delivering services. In this respect transformation monies could be made available through the CCG to create the capacity to allow this strategic thinking to take place.

This will inevitably include improving data sharing between partners, notwithstanding the implications of GDPR, although as the Chair pointed out this should not be seen as a barrier as in most instances the issues of GDPR can be got around.

In the light of the presentation and following the detailed discussion the Board agreed to:

(i) Consider reviewing current data sharing agreements between the partners to provide relevant individual level data for Child & Adolescent Mental Health Service (CAMHs) and Speech & Language Therapy (SALT). This will improve data-driven planning and delivery of care to achieve maximum impact. By facilitating segmentation, stratification and impact modelling to identify local 'at-risk' cohorts and, in turn, the designing of more cost-effective integrated arrangements for targeting interventions to improve care and reducing unwarranted variations in outcomes, and

(ii) Consider the need for an agreed whole system strategic commissioning plan that sets out a clear integrated universal and targeted pathway from Tier 1 to Tier 4 setting out clear thresholds for access.

Other key considerations include:

- working towards a multi-agency autism service/pathway across early help, education, health and social care;
- putting in place an effective behavioural pathway; and
- better use of specialist resources caught up in Section 75 and multi-disciplinary arrangements including Looked After Children (LAC) and the Community Learning Disability Team in this space. This includes reviewing specialist provision for Looked After Children (LAC) within CAMHs as they need to reach Tier 3 threshold before being seen.

- the challenge sits across both children and adults' commissioning for example, vulnerable children sit in families with domestic abuse and adults with mental health needs.

(iii) Consider the opportunities created by 'Place based Care'. For example, where the newly created Primary Care Networks can add value through their development of a Social Prescribing offer to enhance comprehensive universal prevention for children, young people and their families, and

(iv) Recommend that the findings be reviewed to ensure improving outcomes for vulnerable children and safeguarding is at the heart of the transformation of programmes by both the BHR Joint Commissioning Committee and the BHR Children and Young People Transformation Board.

42. NHS Long-Term Plan- Response of ELHCP- Strategic Delivery Plan

Further to Minute 16/9/19 the Board received an update from the East London Health Care Partnership (ELHCP) on its response to the NHS England Long Term Plan setting out a 5 year strategic delivery plan known as the System Operating Plan (SOP) showing how the Partnership will work with partners to known challenges and deliver improvements to health and care services that was published in January 2019.

Given the theme of the meeting the presentation focused on those aspects of the SOP addressing the health needs of children. A report on the aspects of the Plan addressing the specific needs of adults will be presented to the Board in March 2020, albeit there is some crossover between both.

Whilst welcoming the objectives the Board asked what if any monies were behind the Plan to improve the outcomes for children? The ELHCP responded that there were elements of funding associated with mental health and end of life work programmes. Likewise, CCG transformation monies will come on-line to help deliver outcomes.

At the request of the Board more information about the details of funding for end of life care will be provided.

The Chair referenced the recent meeting of the Integrated Care Partnership Board (ICPB) where with providers and health partners the challenge of joint commissioning was discussed. Similar discussions also took place at the joint meeting earlier today between the CCG and the Council arranged to discuss integrated commission for children, looking at what outcomes all would wish to see and at which a good level of progress was made.

It was not obvious from the NE London Plan where the responsibility of the seven London Boroughs that make up the Region compared to the three local Boroughs including LBBD lies. Consequently, with the needs of each Borough being so different joint commissioning becomes very challenging.

That said it was confirmed by NELFT that under their transformation work streams

they are looking at commissioning models across the Boroughs, the challenge to which is how to achieve coordination at Borough, BHRUT and NE London region levels.

43. Demand for Places for Pupils with Special Educational Needs and Disabilities

The Board received and noted a report and presentation from the Group Manager, School Investment, Organisation and Admissions outlining the increasing demand for primary and secondary school places for pupils with Special Educational Needs and disabilities (SEND), with indications of the anticipated level of demand over the next four-year period based on a new SEND forecasting model.

The presentation outlined the four areas which are generally acknowledged to have contributed to the significant rise in local children with a statement of SEND or an Education, Health and Care Plan (EHCP) and the number of children who have been permanently excluded and or who require alternative provision. These were seen as legislation, underlying demographic factors, policy decisions impacting on inclusion and funding pressures.

A common strand of tonight's discussions at the Board had centred on commissioning, and how in this instance it can come together around the significant challenges highlighted in the report and presentation such as poor Ofsted reports and children with complex needs being repatriated in the Borough. Barking & Dagenham has seen a significant rise in the number of children with complex health and/or education needs, and therefore what is urgently required is a new model of health commissioning established within an education setting.

Given the lack of available funding and recognising other practicalities such as the struggle to recruit health specialists such as speech & language therapists, the Chair commented that there needs to be a broad discussion about models of support that can be offered to parents/carers, which given the increasingly level of demand needs to build in flexibility, something recognised by both the CCG and NELFT.

From the Council's perspective under the new operating model they are looking at Community Solutions to provide a gateway for early interventions such as rapid diagnosis of children so that plans can be put in place to accommodate their specialist needs for their continued education.

44. Maternity Services

The Board received presentations from the Head of Maternity Programme, ELHCP providing an overview of the current position of maternity services and future planning across NE London Maternity Providers, and the Director of Midwifery, BHRUT outlining the context and position at Queen's Hospital including birthing trends, numbers of women accessing the hospital maternity services who live outside the catchment boundaries, and how this is being addressed as a system.

The Board noted that the East London Local Maternity System (ELLMS) made up of NHS providers and commissioners of maternity services across NE London are undertaking a 4-month review until March 2020 looking at current and anticipated future demand and capacity across maternity and neonatal services in the region.

This review will include engaging with local women to find out where and why they chose to give birth to give a greater understanding to the issues and so as to ensure that local women and babies have safe and high quality care, and that the local maternity and neonatal services workforce are supported to make this happen.

ELLMS undertook to brief the Board about the findings from the review at a future meeting.

45. Early Years Transformation Academy (Briefing)

The Board received a report and presentation updating on progress with the Early Years Transformation Academy 2019/20, an Applied Learning programme for staff working across maternity and early years. The vision for the Academy was set out as an appendix to the report.

The programme is being delivered in partnership with the Early Intervention Foundation (EIF), a Government supported charity established to champion and support the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes.

In the light of the presentation the Board agreed to:

- Continue to support staff capacity to make the most of this opportunity that has been secured for Barking and Dagenham;
- Support the mobilisation and delivery of the transformation plan developed during the process of the Academy;
- Encourage partner organisations to make the most of this opportunity and to support mobilisation of the transformation plan following completion of the Academy, and
- Discuss and explore the applicability of the Academy learning model to other health and wellbeing transformation initiatives.

46. Out of Schools Settings Project Update

The Board received a presentation from the Out of Schools Setting (OOSS) Project Officer on:

(i) the considerable progress to date with the first phase of a DfE funded pilot project designed to improve the oversight of, and safeguarding in OOSS by:

- Strengthening the understanding of these settings and the associated risks
- Identifying and sharing best practice on identification and intervention, and
- Further developing the evidence base to inform a national approach, including the case for potential future action.

(ii) That a formal partnership strategy will be developed which sets out a clear, comprehensive, and transparent approach to dealing with unregistered educational settings in the Borough.

In response to an observation from the Chair the Project Officer informed the

Board that guidance was being worked on for parents and carers to make them aware of things to look out for in OOSS.

The Project Officer undertook to update the Board as the project develops.

47. Child Death Overview Panel (CDOP) Annual Report

The Board received and noted the Safeguarding Children Board Child Death Overview Panel (CDOP) Annual Report 2018-19, the final one prior to combining the three Borough (Barking & Dagenham, Havering and Redbridge) CDOP's and child death review process in line with the requirements from 'Working Together to Safeguard Children Government guidance issued in 2018.

48. Domestic Abuse Update - New Domestic and Sexual Violence Service and Barking and Dagenham Domestic Abuse Commission

The Board agreed to defer this item until the next meeting in March 2020.

49. Integrated Care Partnership Board - Update

The Chair updated the Board during the meeting with developments at the Integrated Care Partnership including details of a meeting held with health providers looking at the challenges of joint commissioning.

50. Forward Plan

The Board noted the current draft edition of the Forward Plan.

HEALTH AND WELLBEING BOARD

10 March 2020

Title:	**Domestic Abuse Update**
Report of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Hazel North Stephens, Commissioning Manager Florence Henry, Domestic Abuse Commission Programme Manager	**Contact Details:** E-mail: Hazel.NorthStephens@lbbd.gov.uk Florence.Henry@lbbd.gov.uk
Sponsor: Elaine Allegretti, Director for People and Resilience Mark Tyson, Director of Policy and Participation	

Summary:

Domestic abuse is a priority for both the borough and the Health and Wellbeing Board as outlined in the 2018-2022 Health and Wellbeing Strategy.

There is important work going on in this area which partners are asked to note and provide any comments on.

Firstly, the borough has launched a Domestic Abuse Commission which brings together a panel of national experts, chaired by CEO of Shelter Polly Neate, to understand the attitudes, perceived normalisation and tolerance of domestic abuse in the community. The commission will be working until October 2020 and presenting a series of recommendations on how to tackle the issue in the borough.

Secondly, after a competitive tender process, Refuge Charity have been awarded the contract for a new domestic and sexual violence service in Barking and Dagenham – the new service started on 1st October 2019 and will run for three years with the possibility of a 2-year extension. This report provides a brief of the new service.

Finally, a brief update of the wide range of work happening across the system in relation to domestic abuse.

Recommendation

The Health and Wellbeing Board is recommended to:

(i) Note the updates relating to domestic abuse

(ii) Provide any comments

1 Introduction and Background

1.1 Domestic abuse is a key priority for the Council. Domestic violence and abuse have been a longstanding problem for Barking and Dagenham. Figures from the Metropolitan Police Service, Barking and Dagenham has consistently had the highest recorded rate of domestic abuse for the last 10 years compared to other London boroughs. Prevalence is reported 23 incidents per 1000 of the population.

1.2 The 2019 Violence Against Women and Girls Strategy was approved by Health and Wellbeing Board in November 2018. It outlines four priorities – support survivors, educate and communicate, challenge abusive behaviours and include lived experience.

1.3 The Joint Health and Wellbeing Strategy 2019-2023 also contains Domestic Abuse as a separate outcome as outcome 7 – a borough with zero tolerance to Domestic Abuse that tackles underlying causes, challenges perpetrators and empowers survivors.

1.4 This covering report provides an update on two key developments around Barking and Dagenham's approach to Domestic Abuse – firstly, a domestic abuse commission looking specifically at the attitudes around domestic abuse in the community sponsored by Councillor Maureen Worby, Cabinet Member for Social Care and Health Integration and Chair of Health and Wellbeing Board. Secondly, the new strategic partner following a competitive tender process in Refuge.

1.5 In addition, a brief update on several pieces of work across wider systems in Barking and Dagenham is offered.

2 Updates: Domestic Abuse Commission

2.1 The Domestic Abuse Commission has been launched by the borough to look into the attitudes around domestic abuse, and perceived normalisation and tolerance of abusive behaviours. The commission brings together a panel of national experts to explore the attitudes in the borough around domestic abuse and make a series of recommendations. The commission was launched in the borough on 25th September and aims to publish a report with a series of recommendations by around October 2020.

2.2 This report provides an update of the 25th September and the emerging and ongoing work as part of the commission. On 25th September, commissioners were taken on a bus tour of the borough and took part in a workshop with the Borough Expert Panel. There was then an evening launch event at Eastbury Manor House to launch the commission to wider stakeholders and the local press.

2.3 The chair of the commission, Polly Neate, CEO of Shelter and former CEO of Women's Aid has invited a range of commissioners who reflect the areas which interlink with the issue of Domestic Abuse. As well as those from the domestic abuse sector, the commission brings together those with backgrounds in key issues that interlink with domestic abuse, such as poverty, homelessness, mental

health and local government to get a range of perspectives. It was also key for the commission to ensure diversity in the commissioners.

2.4 The confirmed commissioners represent a range of high profile and national experts, which will help the commission to gain national attention for the work it is doing. The full list of 12 confirmed commissioners is as below:

Polly Neate - Chair and CEO of Shelter, former CEO of Women's Aid
Donna Hall - Former Chief Exec of Wigan Council and chair of New Local Government Network
Simon Blake - Chief Executive of Mental Health First Aid and is also Deputy Chair of Stonewall
Amna Adbullatif - Community psychologist who is currently working as national lead on children and young people for Women's Aid
Nicki Norman - Director of Services Women's Aid/acting co-CEO of Women's Aid
Becky Rogerson – Chief Executive at My Sister's Place and acting Director at Wearside Women in Need
Sarah Hughes – CEO of Centre for Mental Health
Raji Hunjan – CEO of anti-poverty charity, Z2K (Zacchaeus 2000 Trust).
Jo Todd – CEO of Respect
Jess Phillips – MP of Birmingham Yardley, Chair of APPG on Domestic Violence and Abuse
Rick Henderson – CEO of Homeless Link
Junior Smart – Founder of SOS Project, Director of SmartCC

2.5 Alongside the commissioners, importantly there is a Borough Expert Panel who are providing expertise on the borough, and the connections needed to support the commission. The second meeting of the Borough Expert Panel took place on 4th December and will work through activities relating to who in the community we need to ensure we are engaging with, and how we should be framing these conversations. Members of the Borough Expert Panel will also be invited to the next meeting of the commission to give evidence to commissioners.

2.6 We are also in the process of recruiting to a survivor panel to ensure that survivors of domestic abuse can play a key role in the work of the commission.

2.7 As well as the local launch, given the national significance of the commission, a central London launch is being planned to launch the commission to the press and the wider Violence Against Women and Girls sector. As the first of its kind in the country, the launch will ensure that the commission gains national recognition. We have now arranged a Central London Launch through our London Assembly member, Unmesh Desai to take place at City Hall. The event will take place on 4th February and will be an evening event for 80-100 people with speeches. Invites have been circulated to Cabinet members, our commissioners, the Borough Expert Panel members, the survivor panel, senior council officers, the press and domestic abuse sector.

2.8.1 **Workstream 1: Quantitative data**

Currently, the understanding of domestic abuse in the borough focuses on police-reported data. Part of the work of the commission is to deepen our understanding of

the issue of Domestic Abuse. Data requests have been submitted to NELFT, the Police, BHRUT, and CCG around Domestic Abuse.

Alongside these requests, the commission will use data on domestic abuse from B&D One View. Further analysis of council data including social care data, homelessness data and wider service-level data is also underway.

The 2019 School Survey was completed in the summer term, and the full results have now been sent by the provider. As headline figures these show that similar percentages of young people think that abusive behaviours are sometimes acceptable – across age groups, in 2017 26% of secondary school students think it's sometimes acceptable to hit your partner, and in 2019 this figure is 28%. The survey provider, SHEU have provided a breakdown of the acceptance of abusive behaviours for a range of characteristics including gender, LGBT, Free School Meals and those from single parent families which the commission will analyse to understand the acceptance of behaviours further.

2.8.2 **Workstream 2: Understanding residents' experiences and attitudes**

Quantitative data around resident attitudes around domestic abuse will be collected as part of the commission. Qualitative insight will be key as part of the commission. - Community Engagement Officer is in now in role and will be in post until June. The Community Engagement Officer has been making connections in the borough to engage with residents and interviewing frontline staff.

2.8.3 **Workstream 3: Cultures and history**

This workstream came from a question at the workshop around how the culture, history and oppression in the borough links to domestic abuse. This workstream will explore the different cultures which exist in communities in Barking and Dagenham and engage in conversations around how domestic abuse remains hidden in different communities. For instance, the chair of the commission has met with representatives from the Hive Women's Group at Al Madina Mosque to discuss how to engage with women at the Hive around domestic abuse.

In addition to this, as part of this workstream, the commission have visited the borough archives to explore gender roles and gender violence and see how this has been presented in the borough previously. When exploring the borough archives around domestic abuse, became reminded that the first appearance of violence against women in Parliamentary politics was in 1976 when Jo Richardson introduced a bill to give women who suffered from domestic violence the right to apply for an injunction, in partnership with the local Women including the below quote from Jo Richardson in Barking and Dagenham Post in 1986:

"*Women's lives are being made a misery and Barking is no better or worse than elsewhere in London. But people in Barking tend to sweep it under the carpet and pretend it isn't happening here. I see many women in my surgery who are desperate to be rehoused because of their husband's violence"*

2.8.4 **Workstream 4: Future proofing**

This workstream focuses on how in the context of huge growth in the borough, how we can ensure that the work of the commission has a legacy and in the long-term helps to create a borough where domestic abuse is not tolerated. Part of this work includes looking at how the regeneration of the borough can benefit women and create spaces in which women feel safe. Specifically, this will include looking at the ask around domestic abuse within the social value policy which the Inclusive Growth team are currently working through. This will enable the council to use its commissioning powers to have a positive impact on domestic abuse in the longer term.

This workstreams also includes understanding and working with young people in the borough. As a borough with the highest proportion of under 16s in England and Wales, we have a great opportunity to change the attitudes of our young people. A Votes for Schools session with young people is being planned for January, a range of events are planned in the Youth Zone during the 16 days of activism and further engagement is ongoing with Healthy Schools leads.

2.8.5 **Workstream 5: National best practice**

Although the commission is the first of its kind nationally, there is a range of academic research on areas relating to domestic abuse which the commission can learn from. As well as producing a literature review, the commission will engage with key academics about the work of the commission. The commission will also look at national best practice from within the women's sector and beyond. The commission will look at key learnings from campaigns and successes to change attitudes around areas such as mental health and drinking.

2.8.6 **Workstream 6: Staff**

Within the council, just under 40% of council staff work for the borough. Although, we don't have the figures for partner agencies, the council and its partner agencies play a key role in training their staff. A mapping of the training offer for frontline council staff around domestic abuse is underway, and questions have been planned with the chair of commission and council Behavioural Insight Lead for the upcoming staff temperature check.

We will also be engaging with partner agencies to understand their training offer around domestic abuse, and the attitudes of staff. The Community Engagement Officer has also been conducting and arranging interviews with frontline council staff.

2.8.7 **Workstream 7: Creating a national methodology**

Part of the work of the commission is to add to the national dialogue around how a local area can tackle the issue of domestic abuse at its root. The commission will therefore make sure that it keeps a note of the work its done, any lessons learnt and challenges so that it can provide a blueprint for other local areas. Officers working on the commission have already had conversations with the Violence Reduction Unit at the Mayor of London's Office, who are interested in the work of the commission and how the learning can be shared across London and beyond.

3. NEW Domestic and Sexual Violence Service

3.1 Following a competitive tender process Refuge Charity have been awarded the contract for a new domestic and sexual violence service in Barking and Dagenham – the new service started on the 01st October 2019 and will run for three years with the possibility of a 2-year extension.

3.2 Refuge opened the world's first safe house for women and children escaping domestic violence in Chiswick, West London, in 1971. Since then, Refuge has led the campaign against domestic violence. They have grown to become the country's largest single provider of specialist domestic and gender-based violence services

3.3 On any given day Refuge supports more than 6,000 clients, helping them rebuild their lives and overcome many different forms of violence and abuse; domestic violence, sexual violence, so-called 'honour'-based violence, human trafficking and modern slavery, and female genital mutilation

3.4 The new Barking and Dagenham Domestic and Sexual Violence Service replaced the existing refuge accommodation service and independent advocacy delivered by Hestia and Victim Support respectively.

3.5 Under the new 3-year contract, Refuge Charity will be delivering the following:

- **One front door, no wrong door:** *With one phone number (0300 456 0174), one referral form making it easy to refer and easy to self-refer.*

3.6 **Support for Victim/Survivors**: *Four IGVAs (Independent Gender Violence Advocates). The service will work with all victims of gender-based violence at all risk levels; allowing for consistency of support across the victim/survivor journey to recovery; following timelines dictated by the service-user. The team won't just be there to respond to crisis situations, but to help victims recover and rebuild their lives. Each of the IGVAs will have extensive specialist training to represent different responses to different community groups. This includes specialisms in approaches for LGBT people, men, disabled people, and BME people particularly where there is NRPF support required.*

3.7 **Support for Children:** *Children's support includes access to a Children's outreach worker who will work across the service to support recovery and rebuild relationships, working one-to-one with young people and supporting younger children alongside their non-abusing parent. They will work alongside partner agencies including children's centres, social care and schools to provide a holistic package of support. This worker will work with 0-11 year olds.*

There is also an Early Intervention Worker (EIW) who will provide one-to-one support to 11-17-year olds who have witnessed or experienced abuse. The EIW will support young people to build resilience, act for themselves, keep safe and become more independent through:

- Advocating for their needs
- Providing emotional support; boosting mental health and resilience
- Establishing boundaries

- Discussing healthy relationships
- Sexual health advice
- Advising how to use technology safely

3.8 **Perpetrator Intervention:** *The perpetrator service will work with perpetrators identified by care management in children's care and support. A practitioner will be embedded within children's care and support, facilitating partnership working and providing advice and support. The service will work with perpetrators using an intensive case management approach, co-ordinating a multi-agency response to disrupt abuse and drive attitudinal and behaviour change.*

3.9 **Sanctuary Schemes:** *Victims at risk of domestic violence often have to leave their homes because of the risk of repeat incidents of abuse. Refuges and other forms of emergency and temporary accommodation can provide a safe and supportive environment for households fleeing violence, but many victims do not wish to leave their homes or choose to return to their homes after a short stay in temporary accommodation despite the risks. Sanctuaries are an additional accommodation option for households at risk of domestic violence which can, where suitable and appropriate, offer households the choice of remaining in their homes.*

The service will provide a range of security installations including door and window locks (for emergency support only, the locks will be changed. This can be done in 4 hours), security lights, letterbox protectors, personal attack alarms. All necessary security installations will be completed within 5 days from referral.

3.10 **Refuge Accommodation:** *The service maintains and supports the existing capacity of 13 bed spaces across two venues in the borough (one in Barking and one in Dagenham). One space is fully disabled access and some spaces allow room for two to three children. 2.5 FTE Refuge staff will ensure the smooth running of the refuges, providing 1:1 case management, group work, support planning and housing management.*

The service will run a 6 month move-on policy to ensure enough time for women to access support to keep safe but to allow for a throughput that helps as many women as possible.

3.11 **Schools Support:** *The service managers will also work with schools to build capacity to deliver healthy relationships workshops. Refuge will work with school safeguarding leads to provide support to families flagged by Operation Encompass. As an aside, the Health Education Partnership have separately been funded to deliver whole school approach to domestic abuse across 15 schools in the borough. The two offers are linked to ensure cross referrals and consistent messaging is robust.*

3.12 **Employment Support:** *Refuge's employability programme will facilitate return-to-work pathways, linked to local employers, developing understanding of the needs of VAWG survivors, with a focus on creating tailored, meaningful employment opportunities.*

3.13 **Community Champions Training:** *To build capacity in the community Refuge will deliver a programme of training to agencies, voluntary sector organisations and local businesses in Barking and Dagenham: training individuals to act as champions*

within their organisation; providing ongoing support through the service as required. Training will include prevalence and dynamics of gender-based violence, understanding risk, responding safely (including to children) and referring to appropriate services. Refuge will also be able to offer bespoke training for specialist community groups in Barking and Dagenham depending on need.

3.14 **Peer Mentors:** *There will be opportunities to volunteer through Refuge's peer mentor programme. The peer mentor team will be a valuable asset for supporting victim/survivors to engage in community activities, whether by accompanying a client to existing assets, or giving a tour of the borough. This will begin to be developed towards the new financial year.*

Barking and Dagenham survivors will receive training and supervision to become peer mentors too; providing aftercare activities including organising workshops, speakers, activities, providing practical and emotional support. This will be a high value volunteering opportunity, offering genuine opportunities for progression: former Refuge peer mentors are now volunteering on the National Domestic Violence Helpline, working in Refuge's services and receiving media training to act as ambassadors for Refuge.

3.15 **Tech Abuse Team:** *Technology facilitated abuse is evidenced throughout Refuge's national caseloads and Refuge have funding from Google for a Tech Abuse Team which will provide support for complex cases in Barking and Dagenham, reducing pressure on the team.*

Barking and Dagenham will have access to tech empowerment workshops, and the service will have a trained tech champion.

Refuge's tech and economic empowerment training programme will be delivered across Barking and Dagenham on a rolling basis to raise awareness of the impact of tech abuse and how to remain safe whilst being empowered to use technology safely in everyday life.

4. Whole System Updates*:*

4.1 The Health Education Partnership will be working in 10 local primary schools and 5 local secondary schools to develop a whole school approach to domestic abuse, including advice around policy and strategy, workshops with key stakeholders: governors, teachers, parents and young people. This is an exciting piece of work running as a pilot for one year from September 2019, and Refuge will be linked in to ensure pathways into specialist support are supported through the work.

4.2 The Violence Reduction Unit announced on 25th November that they have awarded £1m to social enterprise IRISi (which enables IRISi to work with local partnerships to deliver their flagship intervention across seven boroughs until the end of 2020/21). IRISi is an evidence based, domestic violence and abuse training, support and referral programme for general practice. Barking and Dagenham is one of the seven boroughs in which the service will be rolled out. Connections have already been made to link IRISi into the CCG and social prescribing clinical and council leads, and we are hoping to mobilise working with a local specialist service provider by the new financial year.

4.3 DV FLAG East (family law access group). DV Flag East is run by Citizens Advice Barking & Dagenham. Local accredited experienced family solicitor firms volunteer to provide free independent confidential advice to people experiencing domestic abuse. Visit www.dvflageast.org.uk for further information. This is funded by social value monies raised by the Barking and Dagenham legal team who are also volunteering their own time alongside local family solicitors to develop a best practice pro bono model for families that fall out of scope of the limited legal aid eligibility.

4.4 We have recruited a domestic abuse housing coordinator to work with housing colleagues in Community Solutions to prepare us for the Domestic Abuse Housing Alliance accreditation process. This is funded through the MHCLG. A steering group has come together, and the next 12 months will be used to take stock of our approach and explore ways to adopt best practice in our housing response to domestic abuse.

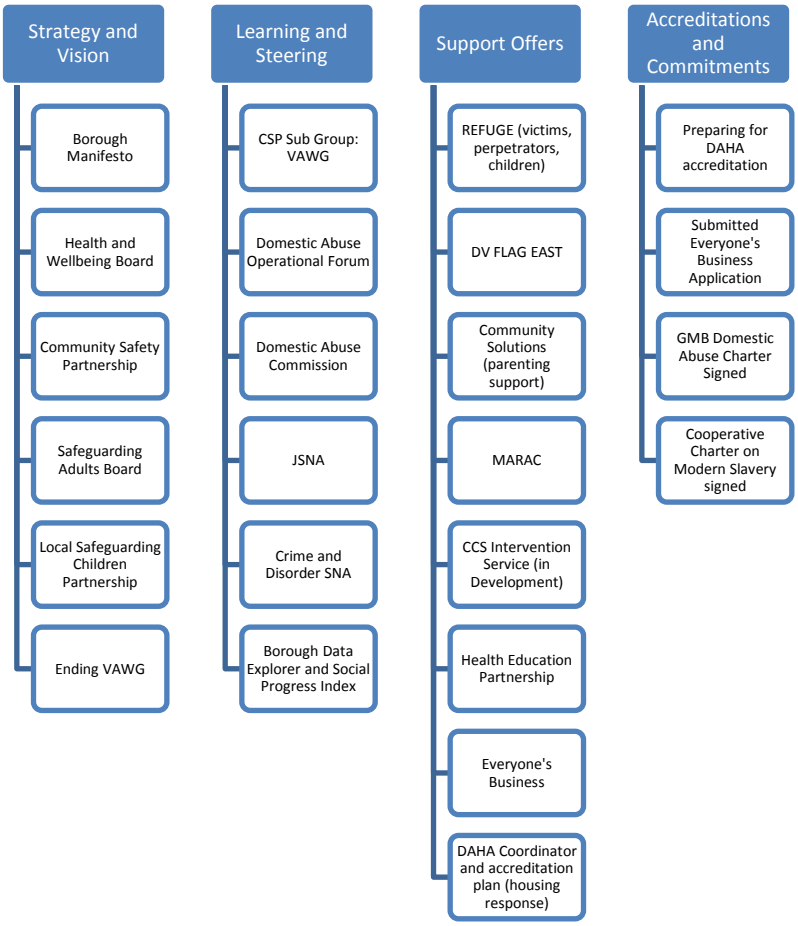
4.5 Community Solutions have been delivering community ava groups from September 2019: a group work weekly programme for young people who have experienced domestic violence. A concurrent mothers group runs alongside it and the aim is to create a space where mothers and their children are able to contextualise their experiences and develop renewed bonds. Feedback has been excellent and the domestic abuse have recruited several women to take part in the Survivors Panel in 2020.

4.6 Huggett Women's Centre continues to deliver East London Rape Crisis services, although currently it is not running group work or drop ins as a result of funding coming to an end in July 2019. Ashiana Network are delivering VAWG counselling services in the centre.

4.7 A new women's hub has been initiated at Al Madina Mosque. It is called The Hive and consists of several women coming together and leading projects for the local community. The main focus is on empowering women in order to empower the wider community. A soft launch was held in August 2019 alongside Eid celebrations, and a more formal launch is being planned. The Hive is offering several strands of support based on what local women want and need, including parenting groups, links to permaculture and the natural environment, sport and leisure activities and awareness of social inequality factors such as domestic violence, female genital mutilation and forced marriage.

4.8 The LBBD Addressing Domestic Abuse at Work Statement and Guidance has been launched, and 17 supportive points of contacts known as staff advocates have been trained to support employees across the workforce experiencing domestic abuse. This has been made possible by working with everyone's business, an initiative looking at addressing domestic abuse in the workplace. We also have access to a workplace independent domestic violence advocate (for men and women) and up to 18 weeks counselling through Women's Trust for women who have experienced domestic abuse. As part of this area of work the Council has also signed up to the GMB Domestic Abuse Charter and have submitted an application to Everyone's Business as part of a best process accreditation process and are planning to submit an application to the Excellence in People Management Awards in 2020.

4.9 There is a significant amount of work happening in relation to domestic abuse. For ease of reference the graphic below attempts to help focus the golden thread from vision to strategy to operational support.



5. Mandatory Implications

5.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment 2018 has a section on domestic abuse, detailing the health impacts for children experiencing domestic abuse and the impact on social care, such as an estimated 32% of children living in income deprived families. It also outlines adverse childhood experiences, and how these are linked to multiple health risk factors and poor health outcomes in adulthood.

5.2 Joint Health and Wellbeing Strategy

The Joint Health and Wellbeing Strategy focuses on three themes – giving children the best start in life, early diagnosis and intervention and building resilience. Within resilience, there is a specific outcome relating to Domestic Abuse. A borough with zero tolerance to Domestic Abuse that tackles underlying causes, challenges perpetrators and empowers survivors.

5.3 Financial Implications

There are no direct financial implication arising from this report

Implications completed by David Folorunso, Finance Business Partner

5.4 **Legal Implications**

Implications completed by Lindsey Marks, Deputy Head of Law.

There are no legal implications directly arising from this report.

5.5 **Risk Management**

Through approaches to service commissioning, there are mechanisms for ensuring that the risks around individuals who have experienced domestic abuse in any form and managed, jointly as necessary with the systems in place for perpetrators of domestic abuse

The VAWG CSP sub-group will have in place a risk management system to ensure that delivery remains on track and action can be taken as necessary.

6 Non-mandatory Implications

Crime and Disorder

6.1 Domestic and sexual violence impacts on many other types of crime and is correlative with all types of violent crime, anti-social behaviour and offending. There are clear correlations with child sexual exploitation, criminal exploitation and youth violence.

6.2 Under the Community Safety Partnership, work is taking place to design preventative approaches to tackling violent crime, including domestic and sexual violence which is underpinned by trauma informed ways of working, and recognising the damaging impacts of childhood adversity.

Safeguarding

6.3 Domestic and sexual violence presents a range of behaviour that pose a risk to the individuals themselves and others around them and can give rise to a range of safeguarding concerns.

6.4 The strategy recognises the impacts of domestic violence on children in the home and recommends working closely to support the victim to safeguard their children, whilst tackling the risk: the perpetrator. Working with the whole family provides a framework to reduce risk, reduce the use of abusive behaviours, and to address trauma experienced by the victim and children.

6.5 The borough's systems for reporting and investigating both adult and child safeguarding concerns have established links to specialist support services, and the Strategy recognises the need for commissioning interventions to continue to foster these links and provide training for those involved in safeguarding.

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HEALTH AND WELLBEING BOARD

10th March 2020

Title:	**Tri-Borough (BHR) Suicide Prevention Strategy UPDATE- Prevention of Future Deaths**
Report of Health and Wellbeing Board	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: No**
Report Authors: Jill Williams Shared Care Coordinator, LBBD Public Health Usman Kahn Consultant, LBBD Public Health	**Contact Details:** Email: jill.williams@lbbd.gov.uk Usman.kahn@lbbd.gov.uk
Sponsors: Elaine Allegretti, Director of People and Resilience Matthew Cole, Director of Public Health	

Summary:
The recent tragic death by suicide of a young woman from Dagenham prompted a Regulation 28 Report from the coroner (Prevention of Future Deaths). Suicide prevention must be embedded across commissioning, service delivery and workplaces to prevent future deaths. While Barking and Dagenham has a lower rate of suicide then other parts of London one death by suicide is one too many. The Barking, Havering and Redbridge (BHR) Suicide Prevention Strategy (2018-22) coordinates effort across BHR to reduce suicide rates by 10% by 2021. The realisability of this target needs to be considered against the national backdrop of an increase in suicide rate in 2018 and the change of evidential standard for classifying suicide. This Strategy now sits within the context of both the Sustainability and Transformation Partnership (STP) and BHR Mental Health Transformation Boards and focuses on a place-based approach to suicide prevention. Nationally, more men than women die by suicide. The peak age for suicide is the middle years, although increasing age is associated with greater risk of suicide. More recently, there has been a marked increase in suicide for young girls and women between the ages of 10-24 years.

Recommendations
The Health and Wellbeing Board is asked to:

1. Consider how to develop a suicide prevention culture and how to raise awareness of the issue
2. Consider how to roll out appropriate training to frontline staff
3. Consider a place-based approach to prevention on how commissioners and other partners can work together to support suicide prevention
4. Explore working with LDN Thrive, LB Havering, LB Redbridge and NELFT in relation to having a real time suspected suicide surveillance system.

1. Introduction

1.1 Health and Wellbeing Board Members will be aware of the tragic death of Karis Braithwaite, aged 24 years, who died by suicide on 24 September 2018. The Inquest concluded on 17 September 2019 saying:

> *Karis Braithwaite took her own life, in part because of the risk of her doing so was not adequately assessed and appropriate precautions were not taken to prevent her from doing so*

1.2 The circumstances of Karis's death prompted the coroner to issue a Regulation 28 Report. As you know a Regulation 28 Report is issued where the coroner believes that action should be taken to prevent further deaths. This was responded by NELFT who instigated a number of changes in relation to admission and assessment processes, an important review which aligns with the BHR Strategy. The death of Karis highlights the tragedy of suicide in relation to the loss of life and the devastating impact of suicide on families and friends of the deceased.

1.3 Preventing suicide requires not just a coordinated approach across agencies but the willingness to view it within the wider context of individual and community health and wellbeing. The purpose of this report therefore is to update the Health and Wellbeing Board on the progress made against the aims and objectives and 6 priority actions of the BHR Suicide Prevention Strategy 2018-22 to date with reference to Barking and Dagenham. This update report was commissioned to provide update information to the Adult Safeguarding Board and the Health and Wellbeing Board. The report was presented at the LBBD Adults and Disabilities Improvement Board in December 2019.

2. What do we know about suicide?

Data

2.1 Suicide prevention is linked to the wider agenda of promoting mental health and wellbeing. The World Health Organisation (WHO) defines mental health as "*not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."*[1] Suicide is preventable.

2.2 Barking and Dagenham has the lowest rates of suicide in London at 5.1 deaths per 100,000[2], (Havering and Redbridge' have 7.8 and 7.1 deaths/ 100,000 respectively)

[1] Cited by Mind at https://www.mind.org.uk/information-support/your-stories/what-is-mental-health-and-mental-wellbeing/#.XiCFRvZ2u1N accessed on 16/01/20

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority accessed on 15/01/20

2.3 It is estimated that in Barking and Dagenham 1-10 children (5-16 years) experience mental health disorders while for adults, estimates suggest 1 in 6 patients registered with a local GP experience mental health problems.[3]

2.4 The latest available figures (2017/18) show that Barking and Dagenham had 143 emergency hospital admissions for intentional self-harm, a decrease from the previous year.[4] These admissions do not tell us about the individuals who self-harm, nor do they necessarily represent an attempted suicide however a history of self-harm is associated with suicide especially in young people.[5] Prevalence of self-harm in the community is likely to be higher than represented by admissions.

2.5 National data shows that in 2018[6]

- Overall, London has the lowest rate of suicide in the UK with an overall rate of 4.1 deaths per 100,000.
- There were 6,507 suicides registered in the UK, around 11.2 deaths per 100,000 (the first increase seen since 2013)
- Males account for three quarters of registered suicides in the UK. The male suicide rate of 17.2 deaths per 100,000 has increased from 2017, while the female rate of 5.4 deaths per 100,000 is consistent with rates over the past ten years
- The suicide rates for people under 25 is generally low but has increased in recent years, particularly in females aged 10-24 years old where the rate has increased significantly to 3.3 deaths per 100,000 females in 2018 (the highest recorded level since 1981). Historically, males between 10-24 years had the lowest suicide rate in the male cohort but this increased to 9.0 deaths per 100,000 males in 2018.
- Risk of suicide increases with age peaking with both male and female at 45-49 years (27.1 and 9.2 deaths per 100,000 respectively). Historically, males aged 75 years had the highest age-specific suicide rate which fell to its lowest point in 2017 in the UK (12.1 deaths per 100,000 males). However, 2018 saw a significant increase in the suicide rate in this group (16.0 deaths) when compared to all other age groups.
- The most common method of suicide for both male and females was hanging accounting for 59.4% of all male suicides and 45% of all female suicides
- Self-harm is a common antecedent of suicide in people with a mental health condition. More than half of young people who die by suicide have a history of self-harm.[7]
- Two thirds of people dying by suicide are not in contact with mental health services. Around half of those attempting suicide do not seek specialist support.[8]

[3] Barking and Dagenham JSNA 2018 p. 47

[4] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/3/gid/1938132834/pat/6/par/E12000007/ati/102/are/E09000002/iid/21001/age/1/sex/4 accessed on 15/01/20

[5] https://www.thriveldn.co.uk/core-activities/suicide-prevention/ accessed on 23/10/19

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations accessed on 15/11/19

[7] https://www.thriveldn.co.uk/core-activities/suicide-prevention/ accessed on 23/10/19

Risk Factors

2.6 While data are important, they do not tell the whole story. There is no single explanation of why people die by suicide, a phenomenon found in both high- and low-income countries.[9] Suicide is thought to involve a mix of social, psychological and cultural factors that lead a person to suicidal thoughts or behaviour.[10] Even how suicide is reported - for example in a sensationalist manner or where the method is described - can have an adverse impact on vulnerable groups.[11]

2.7 WHO reports that while the link between suicide and mental health issues such as depression and alcohol use is established it may also occur impulsively to crisis events such as financial problems or relationship breakdown. It is also associated with abuse, loss and isolation. Groups that experience discrimination such as LBGT+ are also vulnerable in relation to suicide.[12] The very elderly show a higher propensity for suicide, a phenomenon found globally and thought to be associated with chronic illness and social disconnectedness. By far the strongest risk factor for suicide, however, is a previous suicide attempt.

2.8 Public Health England regard suicide as an inequality issue: "*it has been known for some time … disadvantage, vulnerability, including losing your job, being in debt and having insecure housing, makes a person more likely to die by suicide.*"[13] Barking and Dagenham is an area of multiple deprivation.[14] The role of social prescribers attached to the PCNs offers a tangible way to reduce inequalities, including the mental distress that may make someone vulnerable to suicide. An approach which is in line with Barking and Dagenham's Joint Health and Wellbeing Strategy[15] and Hilary Cottam's approach[16] to community engagement.

Prevention

2.9 The importance of suicide and its prevention is recognised at a wider policy level. The prevention of suicide is a key policy element across the board. The Mayor of London's Suicide Prevention strategy aims for London to be a 'Zero-Suicide city'.[17] This is based on the view that suicide is preventable which is recognised in the BHR Strategy. The 10% reduction in suicide by 2021 in relation to the BHR Strategy is in line with the national target specified by the NHS Five-Year Forward view.

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[8] Ibid
[9] WHO at https://www.who.int/news-room/fact-sheets/detail/suicide accessed 14/01/20
[10] https://www.mentalhealth.org.uk/a-to-z/s/suicide accessed on 14/01/20
[11] https://www.samaritans.org/about-samaritans/media-guidelines/ accessed on 08/01/20
[12] WHO at https://www.who.int/news-room/fact-sheets/detail/suicide accessed 14/01/20
[13] https://www.nspa.org.uk/wp-content/uploads/2017/10/NSPA_InfoSheet_SocioeconomicDeprivationSuicidalBehaviour_v1.pdf Accessed on 24/10/19
[14] https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e09000002.html?area-name=barking%20and%20dagenham accessed on 16/20/20
[15] https://www.lbbd.gov.uk/health-and-wellbeing-strategy accessed 08/01/20
[16] https://www.hilarycottam.com/ accessed 08/01/20
[17] https://www.nspa.org.uk/members/thrive-ldn/ accessed on 23/10/19

2.10 NICE guidance[18] recommends a coordinated approach to developing a multi-agency strategy with clear leadership for implementation, mapping of existing services, health needs assessment and considering meaningful preventive activities. The guidance further recommends a deeply embedded approach including how services are commissioned.

3. BHR Suicide Prevention Strategy

3.1 Since the Strategy was drafted some changes have taken place in the wider structure. The STP now has a suicide prevention steering group which is likely to focus on self-harm and bereavement, while the Mental Health Transformation Board is likely to review progress in relation to NHS mental health care. While the arrangement of workstreams has yet to be formalised it is likely the BHR Strategy Group will continue to meet and to focus on training, awareness of suicide and place-based interventions.

Aims

3.2 The BHR Strategy has two aims agreed by all partners:

1. To reduce rates of suicide across BHR by 10% by 2021 and,
2. To ensure that people who are affected by suicide receive timely help and support.

3.3 It is too soon to report on the Strategy's primary aim of reducing the BHR rates of suicide by 10% as data has yet to come through. LDN Thrive is establishing a suspected suicide surveillance system and has invited LBBD, LBH, LBR, the CCG and NELFT to join. This is still in its early stages and a meeting to discuss the system is being arranged. The system will not include self-harm.

3.4 Nationally, the rates of suicide are increasing, this together with the changes in evidential standard may spike rates going forward. Since May 2019[19] suicide is now concluded on the civil standard of evidence i.e. on the balance of probabilities as opposed to the higher criminal standard of beyond reasonable doubt, which is expected to lead to an increase in deaths recorded as suicide.

Objectives

3.5 The objectives of the Strategy are grouped into three themes

- Prevention
- Support at times of crisis
- Support and help for those affected by suicide

Priority Actions

3.6 The Objectives are grouped into six priority actions.

1. Learning from deaths by suicide and attempted suicides in BHR to allow improved measures to be put in place to reduce risks.

[18] Preventing suicide in community and custodial settings NICE guideline [NG105] Published date: September 2018

[19] *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire (Chief Coroner of England and Wales intervening) [2019] EWCA Civ 809 [2019] (D) 46 (May)*

2. Raising awareness of suicide across local workforce,

3. Developing a central resource for people affected by suicide

4. Strengthening crisis support for those individuals identified at immediate risk of suicide.

5. Reviewing the care of people that self-harm, and

6. Assessment of suicide risk by GPs is incorporated into routine care of patients known to be at an increased risk of death by suicide.

Progress- to- date

3.7 Progress against the six priority actions has been achieved although with some gaps.

- **Priority Action 1** – *Learning lessons* – there is multiple borough attendance at twice yearly meetings with the Coroner to discuss suicides that have occurred in Walthamstow Coroner's footprint (Walthamstow, B&D, Havering, Redbridge, Newham and Tower Hamlets). There is a Public Health representation from boroughs along with Consultant Psychiatrist from NELFT and from LDN Thrive (a pan London organisation working to reduce London's suicide rate). Consideration is being given in relation to the surveillance scheme mentioned in section 2.3 of this report.
- **Priority Action 2** - *Raising awareness* – Training has been promoted by BHR with some funding available from Health Education and NHSE. ComSol works with people in distress (debt, homelessness and unemployment) has delivered Mental Health First Aid training to its staff, however, there appears to be less training with a specific focus on suicide prevention. The focus on suicide prevention was the theme for last year's World Mental Health Day in October, a variety of campaign materials were used in Barking and Dagenham to mark this important awareness raising event.
- **Priority Action 3** - *Developing an online central resource* – LBBD compiled an online directory[20] of support for people bereaved by suicide, this has been shared with Havering and Redbridge and available on their websites.
- **Priority Action 4** - *Strengthening crisis support* -London arrangements for health-based place of safety have been revised. These are being monitored by NELFT to ensure the new arrangements meet the need. NELFT is conducting an audit of care plans following discharge from hospital to mental health care. Progressing work with the NHS is likely to be taken up by the Mental Health Transformation Board
- **Priority Action 5** – *Reviewing care of people who self-harm* - Action has not yet commenced. It is likely that this work will be tackled at the STP level
- **Priority Action 6** – *Assessment of risk* – A pilot in LBH is looking to increase referrals among people with long term conditions (diabetes and COPD) to Talking Therapy services to improve their mental health and wellbeing. Assessment of

[20] https://www.lbbd.gov.uk/support-for-people-bereaved-or-affected-by-someones-suicide

suicide risk is a potential area where more work could be done in the community to help identify the high-risk cohorts and provide them with timely help and support. The role of the social prescribers in Barking and Dagenham offers a potential for working closely with the communities and identifying suicide risks earlier and signposting them to the appropriate services.

4. Conclusion

4.1 Despite deprivation and the relatively high prevalence of mental health issues, Barking and Dagenham's suicide rate is low. Barking and Dagenham has a diverse population and different communities may have a stronger bias against suicide than others. However, suicide can and should be prevented. It does not exist in a vacuum; the prevention of suicide is linked to a wider agenda of promoting mental health and wellbeing for individuals, families and communities. The main priorities in relation to the Strategy going forward locally is to develop a suicide prevention culture within the Council, services and our partners and to consider how best to implement interventions at a place-based level to support prevention.

4.2 The Board is asked to consider:

- How does suicide prevention fit within the Council's wider vision set out in the Borough Manifesto and the Health and Wellbeing Strategy?
- How can we effectively embed a suicide approach and culture and raise awareness across Barking and Dagenham?
- What is the role of various partners in implementing the key actions within the Strategy?

Appendix – Power point presentation

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HEALTH AND WELLBEING BOARD

10 March 2020

Title:	**NHS Long Term Plan – Response of the ELHCP – Strategic Delivering Plan**
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Authors: **Mark Scott, Deputy Director of Transformation**	**Contact Details:** ELHCP PMO office, 2nd Floor, Unex Tower, 5 Station Street, London E15 1DA 020 3688 2300 enquiries@eastlondonhcp.nhs.uk

Sponsor: Not applicable

Summary

In January 2019, NHS England published it's Long Term Plan (LTP). It set out the NHS' ambitions for improvement over the next decade. Patients and their families, NHS staff, the public and a wide range of organisations were involved in developing the plan. There are a number of priority areas of work ranging from mental health to focussing on key enabler areas such as workforce.

The East London Health and Care Partnership (ELHCP) have been working with partners (CCG's, providers and local authorities) to develop a local response to the LTP, which sets out how the Partnership will work together to respond to known challenges and deliver improvements to health and care services.

An update on the development of the response was first presented to the Board in September 2019. The System Operating Plan, published in April 2019, forms the first year of this plan. The final draft of our 'local LTP response', also known as the strategy delivery plan, (SDP) was submitted to NHS England/Improvement in November 2019. The intention is that the detail of the SDP will form the basis of engagement and discussions at both Health and Wellbeing Boards and Overview and Scrutiny meetings. The SDP has now been published on the ELHCP website: https://www.eastlondonhcp.nhs.uk/ourplans/

Given the focus of January Board's meeting we presented those aspects of the SDP which addressed the health needs of children. This presentation and discussions will centre on the remaining sections of the Plan.

Recommendations

The Health and Wellbeing Board is asked to:

1. Note the report and presentation on the Strategic Delivery Plan and

2. Provide any feedback and comments.

Reasons

The National Long-Term Plan was released in early 2019. It sets out how to make the NHS fit for the future, delivering a range of benefits as set out below:

By giving everyone the best start in life through better maternity services, including a dedicated midwife looking after a mother throughout her pregnancy, by joining up services from birth through to age 25, particularly improving care for children with long term conditions like asthma, epilepsy and diabetes and revolutionizing how the NHS cares for children and young people with poor mental health with more services in schools and colleges.

By delivering world-class care for major health problems to help people live well with faster and better diagnosis, treatment and care for the most common killers, including cancer, heart disease, stroke and lung disease, achieving survival rates that are among the best in the world, supporting families and individuals with mental health problems, making it easier to access talking therapies and transforming how the NHS responds to people experiencing a mental health crisis.

By helping people age well with fast and appropriate care in the community, including in care homes, to prevent avoidable hospital admissions for frail and older people, and by significantly increasing the numbers of people who can take control of their healthcare through personal budgets.

HEALTH AND WELLBEING BOARD

10 March 2020

Title:	**An Integrated Care System (ICS) for North East London (NEL)**

Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Melissa Hoskins, Head of Communications and Engagement, BHR CCGs	**Contact Details:** Melissa.hoskins@nhs.net 020 3182 2922

Sponsor:
Henry Black, Chief Finance Officer for NELCA

Summary
We are developing an Integrated Care System (ICS) for North East London so that we can deliver all that is set out in the Long Term Plan (LTP) to benefit local people in Barking and Dagenham, as well as across the wider north east London area.

It is intended that by April 2021, the ICS will be supported by a single CCG, three local systems (BHR, City and Hackney and WEL) and seven place-based partnerships to maintain focus at a local level.

Our vision is to:
'*Create a new way of working together in North East London, across all health and care provision, which gives local people more options, better support and properly joined-up care at the right time, in the best care setting. This will help improve the long-term health and wellbeing of the local population.'*

To deliver the LTP, we need to change the way commissioners, providers, clinical leaders, GP members, local authorities, partners and voluntary organisations work together to meet the needs of local people. The ICS will help us do this through:

- Driving forward more partnership working in a truly integrated way, encouraging greater collaboration (a significant cultural change)
- Enabling commissioners and providers to share responsibility for the way finances are managed and contracts delivered, as well as manage population health for the benefit of local people
- Reducing the statutory burden to free up resources at a local level to support challenges across the whole of North East London, such as population growth and homelessness

Recommendations:

The Health and Wellbeing Board is asked to:
1. Note the report and presentation on the Integrated Care System for North East London, and
2. Provide any feedback and comments.

Appendices

- Slide pack - An Integrated Care System (ICS) for North East London (NEL)

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HEALTH AND WELLBEING BOARD

10 March 2020

Title:	Health and Care System Development in Barking and Dagenham, Havering and Redbridge
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Alison Blair, BHR System Transition Lead	**Contact Details:** Alison.blair3@nhs.net 07960 214489
Sponsor: Not applicable	

Summary:
Building on the local direction of travel to create more coordinated health and care services, a programme of work is taking forward plans which culminate in a significant change in the way care is planned from April 2021. This is in line with national policy to join up health and care planning and provision to improve outcomes for residents. Our local model builds on previous work and is being co-designed through the leadership and involvement of all system partners.

The attached paper (appendix 1) provides a briefing on how this work is progressing and seeks comments on the direction of travel. Furthermore, detailed proposals will be presented in the autumn which will require approval from partner's key governance bodies.

Recommendations

The Board is being asked to:

- Comment on any aspect of this report on progress so far on the development of the BHR system
- Continue to support further development of the BHR system, and
- Note that more detailed operating model will be developed for approval in the autumn 2020

Reasons for report

For the past few months, a Design Group reporting to the BHR Integrated Care Partnership Board has been meeting to develop initial proposals for the BHR system.
Establishing the BHR system will take time to develop. However, we are building on significant recent progress to ensure change in April 2021 and beyond. It is not a new direction of travel. In recent years there has been significant partnership work and relationship building. However, BHR has been a challenged health and care system for many years, trying hard to deal with rapid population growth and deprivation whilst facing financial pressures, significant workforce challenges, poor estates utilisation and underinvestment in digital technology. BHR partners have done much to respond but delivery remains difficult given the history, culture and the lack of strong system wide accountability.

By April 2021, we aim to build on the legacy of strong partnerships and shared values across all partners, to establish a system for BHR responsible for planning across health and care, taking responsibility for shared resources and delivering improved outcomes for the population. This will require an acceleration of progress to date.

By working in a system way we will improve the health and well-being of the residents and patients we serve. In order to focus our work, we will build on previous work to identify those health and care outcomes we will improve and by which we will measure our success. The outcomes framework previously developed identified specific areas and is based on conversations with local people and staff about what is most meaningful to them.

Outcomes have also been identified as part of the work of the BHR Transformation Boards. These outcomes will be refined in the light of the BHR System Strategy to ensure they are meaningful in targeting those areas that are priorities and where there is unwarranted variation. A final system outcomes framework will be developed by the summer 2020.

Appendix 1 – Briefing paper

APPENDIX 1

Health and Care System Development in Barking and Dagenham, Havering and Redbridge

Summary

Building on the local direction of travel to create more coordinated health and care services, a programme of work is taking forward plans which culminate in a significant change in the way care is planned from April 2021. This is in line with national policy to join up health and care planning and provision to improve outcomes for residents. Our local model builds on previous work and is being co-designed through the leadership and involvement of all system partners.

This paper provides a briefing on how this work is progressing and seeks comments on the direction of travel. Furthermore, detailed proposals will be presented in the autumn which will require approval from partner's key governance bodies.

1. Background

Across Barking and Dagenham, Havering and Redbridge (BHR), all health and care partners want to significantly improve the health and well-being of local people. We recognise that we need to work even more closely together to address significant challenges, keep people healthy, tackle the causes of illness and deal with wider issues that influence health and well-being such as housing and employment.

We want to join up health and social care, physical and mental health services and GPs and hospitals so care is coordinated for local residents. We will work together to improve the standard of services across the area and make sure, wherever people are, they receive a consistent standard of care.

To do this, the **BHR system** is being developed to be up and running by April 2021. It is a new way of working to make sure health and care statutory and voluntary organisations work together to plan and provide services with and for local people. This will mean coordinating services for the population of BHR and sharing resources to best meet people's needs. It is not the creation of a new organisation. It will mean services working together across current organisational boundaries.

2. Progress So Far

Establishing the BHR system will take time to develop. However, we are building on significant recent progress to ensure change in April 2021 and beyond. It is not a new direction of travel. In recent years there has been significant partnership work and relationship building. However, BHR has been a challenged health and care system for many years, trying hard to deal with rapid population growth and deprivation whilst facing

financial pressures, significant workforce challenges, poor estates utilisation and underinvestment in digital technology. BHR partners have done much to respond but delivery remains difficult given the history, culture and the lack of strong system wide accountability.

We do have a foundation on which to build:

- Devolution pilot (2016/7) which, although it did not more forward as intended at the time, provided resource to engage with the public and staff. The outputs of this have informed the initial design work and are just as relevant now. This involved partners from across the system including voluntary and community organisations
- A deep dive into the financial position across the system and we now have a financial recovery plan across the NHS with agreed targets
- The BHR Local Authorities continue to make significant savings to respond to local government financial challenges
- In the NHS, the NELFT and BHRUT Boards have recently approved moving to a Group Model from April 2021 following shadow running, alert to the need to secure strong executive presence at the two Trusts and attract system leadership into the newly formed Group executive roles
- Primary care networks are now in place across all of BHR with a focus on GP practices working together to improve primary care and extend the range of services available to the population
- Transformation Boards have been established to develop new care models for key care groups with strong clinical and professional leadership
- Local authority transformation programmes are in place to develop and delivery new ways of working to improve the lives of local residents
- Partnership governance arrangements are in place including the Integrated Care Partnership Board, the Integrated Care Executive Group, the Health and Care Cabinet and Health and Wellbeing Boards

We are learning from the many examples of integrated care systems nationally and internationally to understand what makes them successful and the obstacles they have faced. We are drawing on these to inform our design in BHR.

By April 2021, we aim to build on the legacy of strong partnerships and shared values across all partners, to establish a system for BHR responsible for planning across health and care, taking responsibility for shared resources and delivering improved outcomes for the population. This will require an acceleration of progress to date.

3. North East London Integrated Care System

The BHR System will operate within a wider North East London Integrated Care System (NEL ICS). The NEL ICS will support decision-making, planning and delivery within local systems and will oversee our arrangements to ensure we are doing a good job and tackle large scale

challenges where we need to work across a bigger area. This is in line with the NHS Long Term Plan which says that 'by April 2021 all of England will be covered by integrated care systems, involving a CCG or CCGs working together with partners to ensure a streamlined and single set of commissioning decisions at system level.' As part of this, a proposal is being developed for there to be one CCG in NEL rather than seven. This will remove barriers to integration through streamlining local governance structures so that key decisions can be made at a local level by local partners. This will support local system development.

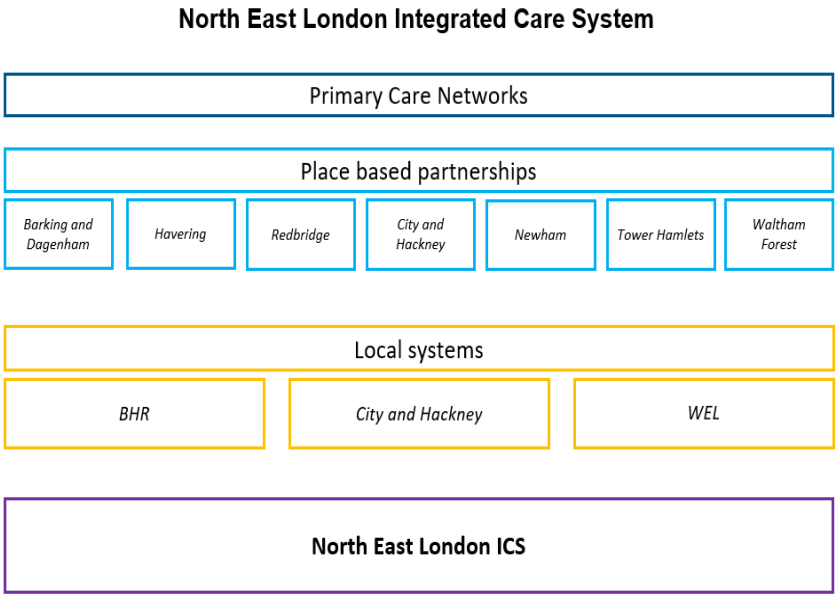
The purpose of the NEL ICS will be based on the functions of strategic leadership, oversight and commissioning. In particular it will:

- Be the place where partners come together to shape the vision for North East London
- Tackle the big health and care challenges and reducing inequalities
- Optimise resource use across the whole system and managing financial risk
- Oversight and assurance for the delivery of health and care across the whole system
- Co-ordinate large scale action to make NEL a great place to work

Some principles have been developed to underpin the development of the NEL ICS:

- Decision-making sits as locally as possible
- Decision-making is at the local level unless it satisfies one of three question tests (Increase our chances to improve population health or reduce inequalities (unwarranted variation), make decision-making smoother and/or quicker, better align accountability for decision-making with accountability for money)
- This is about delegation to primary care networks/localities as well as upwards to NEL when it makes sense
- There are some 'must dos' for a NEL CCG that cannot be delegated e.g. signing contracts
- Some responsibilities will come down from London to NEL e.g. specialist commissioning
- NEL ICS will provide system oversight to check local systems doing what they need to
- Whilst sovereignty and regulation framework remains the same we intend to change the systems and processes, behaviour and culture to improve the way we work
- We will ensure openness and transparency in new ways of working.

The NEL ICS will contain three local systems – BHR, City and Hackney and WEL (Tower Hamlets, Newham and Waltham Forest) which in turn have place based partnerships at a borough level with primary care networks/localities playing a critical role as fundamental building blocks for care delivery.



4. Developing the BHR System

For the past few months, a Design Group reporting to the BHR Integrated Care Partnership Board has been meeting to develop initial proposals for the BHR system.

There are other partners who will be involved in system development and working (e.g. CareCity, Barts Health NHS Trust, Partnership of East London Cooperatives (PELC), broader voluntary sector and community organisations, as well as social care providers) and we are/will be discussing with them how best to do this as our model develops.

5. BHR System Strategy

A BHR system strategy is being developed (initial stage completed early in 2020 and further work to be planned) which provides:

- A case for change
- A vision for the future
- A set of strategic objectives

This draws on a range of existing plans and strategies across partners. These include local health and well-being strategies, the BHR devolution strategic outline case (2017), the draft BHRUT clinical strategy, the NELFT clinical strategy, and the north east London response to the NHS Long Term Plan.

A workshop of the Integrated Care Partnership Board was held in January 2020 to discuss these areas including a vision statement. It was agreed that the vision statement that most clearly captures the involvement of all organisations and residents is:

"Communities working together for better health"

At the workshop, the discussion around system priorities focused on a number of areas:

- It was felt that **prevention cut across a lot of issues** and was a priority that everyone had a part to play in, as well as benefit from
- Given the high birth rate, and length of time spent in BHR by children, **young people and their families, this was felt to be a necessary area of focus**, which should **start with prevention**
- There are real **workforce shortages** faced in the system, particularly by primary care and this needs to be addressed.
- There is a real need to **standardise services across BHR, where appropriate**, to ensure that residents know where to go and staff know where help can be accessed
- Standardisation starts with relationships. There **needs to be trusted relationships** across the system, and this will feed into clinical/professional models, contracting and delivery efforts
- The need to **engage 'as one system' with neighbours**, such as Waltham Forest and Essex was also noted, but this would start with relationships
- **Integrated data** will allow for a focus on wider determinants of health and having a population health management system. This is an unlocking point for the rest of the priorities
- Ensuring that **external communications and engagement** are consistent across the system to make sure that priorities executed consistently
- To understand the scale of reinvestment, and workforce requirement there is a need for a **full demand and capacity assessment.**

Through further discussion, strategic priorities were highlighted for the BHR System to take forward for immediate action:

1. Embrace a population health management approach
    - Create **effective services for children and young people**, as well as their families and **supporting them to age well** through **effective prevention**
    - **Develop trusted relationships** throughout the system, this could include **investing in the development of MDTs** and the review of **contracting and financial management** to provide the environment for MDTs to operate
    - **Data sharing** should be universal within the system and deliver **identification of individual, as well as population needs** and include shared care records and a digital platform

2. Enhance the **retention of local staff** and creating **attractive new job roles**, focusing on future needs to **drive recruitment**
3. A more coherent approach to **communication and engagement**, which delivers **consistent and clear messages** to the public, signposting services clearly, collecting the views of the public and **celebrating the success** of BHR.

These immediate priorities will be scoped to take forward overseen by the Integrated Care Partnership Board.

In order to deliver the strategy and take forward a collective vision, partners have recognised that they need to operate in a new system way of working. This is the design we have been developing.

6. Benefits of the BHR System

In our new model people using health and social services will be equal partners in planning, developing and monitoring care to make sure it meets their needs. For a resident, they will live more independent lives keeping as well and fulfilled for as long as possible. When they need it, they will get earlier intervention and more coordinated, planned care with no join between the organisations that provide it. This will involve all services working together to the same plan, with the same information. More treatment and support will be received at home rather than go to hospital if it is not necessary. If people do need to go to hospital, they will be helped to get home quickly with the right support.

We want to make services less fragmented. In recent years, national policy has encouraged competition as a means to improve quality and choice that can incentivise behaviours and processes that had a detrimental impact on working collaboratively and improving outcomes through coordinated care. This has meant a more fragmented health and care system has emerged. This can mean delays, gaps in care, duplication or missed opportunities to make better use of resources and a system which is difficult for patients and staff to navigate.

By working together the BHR partners aim to:

- Ensure residents are healthier for longer and delay the need for care and support
- Work collaboratively to deliver better outcomes focussing on the wider determinants of health to improve life outcomes for residents (e.g. housing,

education, jobs, environment) and ensuring our children and young people have the best possible start in life
- Make services more coordinated and less fragmented
- Address the quality and performance improvements, including focussing on outcomes, that are needed in local services
- Create services which will attract and retain a skilled workforce, including working to make the best of the ambitious regeneration opportunities across the three boroughs
- Consider the opportunities and benefits of developing the concept of anchor organisations[1] to invest in local infrastructure and job growth/opportunities for local residents.

7. A Focus on Outcomes

By working in a system way we will improve the health and well-being of the residents and patients we serve. In order to focus our work, we will build on previous work to identify those health and care outcomes we will improve and by which we will measure our success. The outcomes framework previously developed identified specific areas and is based on conversations with local people and staff about what is most meaningful to them:

- People to be able to look after themselves and improve their own health and wellbeing and live in good health for longer e.g. reduce the number of years of lost life, reduce childhood obesity, get the community more active.
- The right care delivered at the right time e.g. preventing attendances and admissions to hospital, reducing avoidable time in hospital, reducing the number of people reporting a poor experience of care, increasing the number of people living independently following discharge from hospital.
- Developing improved ways of working in an integrated fashion and using money more effectively e.g. people who work in health and care feel supported to deliver their best, delivery of new care models, reduce demand for more hospital treatment and care.

Outcomes have also been identified as part of the work of the BHR Transformation Boards. These outcomes will be refined in the light of the BHR System Strategy to ensure they are meaningful in targeting those areas that are priorities and where there is unwarranted variation. A final system outcomes framework will be developed by the summer 2020.

8. How the BHR System Will Work

The Design Group developed a set of principles to underpin the new BHR system model:

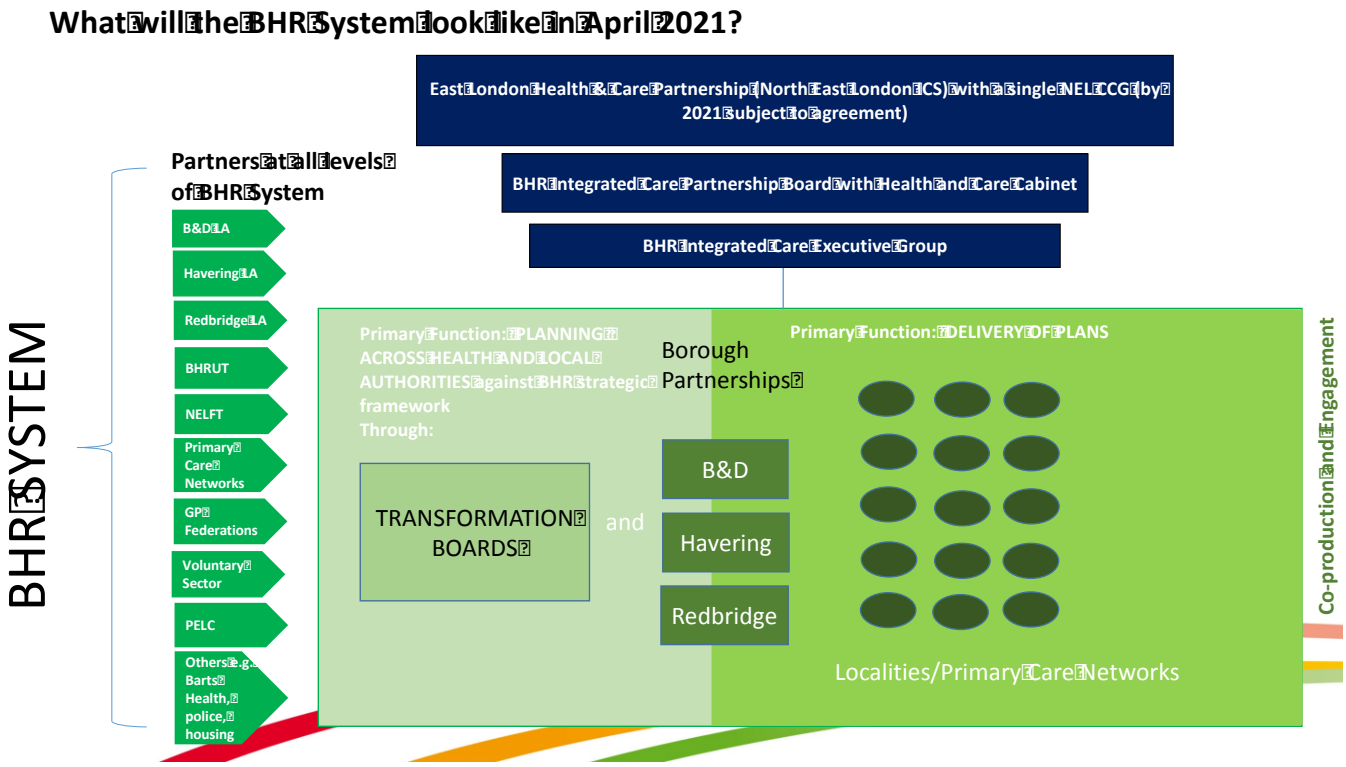
[1] the term anchor institutions refers to large, typically non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to move, given their connection to the local population, and have a significant influence on the health and wellbeing of a local community.

- All the participants of the BHR system will work together as a partnership to improve the health and care of our local residents, including a visible focus on the wider determinants of health
- Together we will devote our capacity and capability to resolve our biggest challenges
- All our collective resource is public money and will be used to best meet the needs of local residents and deal with significant local challenges
- Residents are partners in planning, developing and monitoring care to make sure it meets current and future needs
- We will make decisions as locally as possible working with residents to ensure we focus on the areas that make the biggest difference across the boundaries of health and care
- We will support our workforce to deliver more joined up models of care for individuals and populations
- We will be open and transparent in the ways we work
- We will work together to address risks as they arise across the system
- Whilst the statutory frameworks we all work within may remain, we will change our systems, processes, behaviour and culture to support the way we work collectively.

The BHR system in 2021 will comprise a number of inter-related building blocks as represented in the diagram below. The NEL ICS/single CCG will enable the functions and resources to plan and deliver health care are vested with the BHR system. They will require assurance that BHR system enacts these functions properly. We will develop the existing governance structures (ICPB, Health and Care Cabinet and ICEG – see below) to set the strategic framework, oversee how the BHR system operates and be responsible for the achievement of desired outcomes.

All key partners will be involved in planning and delivery at BHR and borough levels. Primary care networks and localities will be key components of the new BHR system to deliver coordinated care for residents and local populations. Borough partnerships will plan and coordinate service delivery for their respective local populations. Transformation Boards will develop care models for their particular care groups within the overall strategic framework set by the Integrated Care Partnership Board. Through all the system working co-production and engagement will be a key feature.

An outline operating model is attached to this paper as Appendix A.



8.1 Borough Partnerships

Borough partnerships are in various stages of development in BHR. These will involve local partners in planning and delivery. There will need to be a degree of commonality across each borough by April 2021 so local structures deliver the functions set out in the operating model and are responsible for delegated resources, albeit they might operate differently. This will need to be worked through building on the experience of local developing arrangements. In principle, we need to:

- Support collaboration and pooling resources where it makes sense for local areas and communities and explore opportunities to work together within existing and new governance arrangements.
- Be open to pooling resources across partners at a borough level in line with our respective priorities and delivery arrangements.
- Be open to new ways of commissioning and delivering services at a borough level.
- Support the allocation of prevention resources to support joint, strategic commissioning across the partnership.

8.2 Primary Care Networks

There are 15 newly formed primary care networks in BHR. They are fostering a strategic voice for primary care that represents practices individually and collectively, along with GP Federations.

8.3 Localities

These are developing broader locality based partnerships as a focus for local communities to

shape and influence the services that are delivered in their area. They are a mechanism for marshalling the strengths and assets of local communities and ensuring they are at the heart of delivering responsive, preventive services. They can provide a way or organising health and social care for an area. There are examples of locality development in each Borough in BHR, for example the new Thames Locality Board.

8.4 Transformation Boards

There are nine transformation boards leading healthcare planning and transformation across BHR. In the autumn 2019 a report on how to continue their development was completed. This work concluded that progress was being made on transformation and service redesign in an attempt to join up the system for particular care pathways, populations and services to overcome fragmentation. However more work is needed on a more dispersed leadership model to get broader ownership as they have been predominantly CCG-led, as well as a refocus on planning and overseeing delivery. Key next steps agreed were to produce a strategic framework within which all the transformation boards work.

There is borough based transformation programmes in each of the three local authorities. These focus on local planning and delivery to improve the lives and well-being of local residents and improve the health and vibrancy of the boroughs.

8.5 Other

There are also statutory ad other governance arrangements in place which have a responsibility for integrated planning and service delivery such as Health and Well-being Boards (see section 9) and local adult and children safeguarding arrangements. We will build on these and learn lessons for their experience to provide a more joined up approach to health and care.

9. Governance

The Design Group are developing a model of governance for shared decision-making within the current statutory frameworks assuming there will be no change prior to April 2021. This presents some challenges in terms of how partners can work together across boundaries and we will need to work through these. In the first instance the existing three BHR system structures will be developed to be responsible for BHR system and strategy development. These are the Integrated Care Partnership Board (ICPB), the Health and Care Cabinet and the Integrated Care Executive Group (ICEG).

Health and Well-Being Boards will continue to be a critical part of the system infrastructure post 2021. In determining their future contribution in addition to their statutory functions, we can be informed by the Kings Fund Report on HWBBs (2019) which concluded:

- The promised statutory guidance on ICS development should reinforce the positive role of local government, citing examples of where local government is already engaging and the benefits of this engagement
- The current role and functions of HWBs should be reviewed and refreshed, and

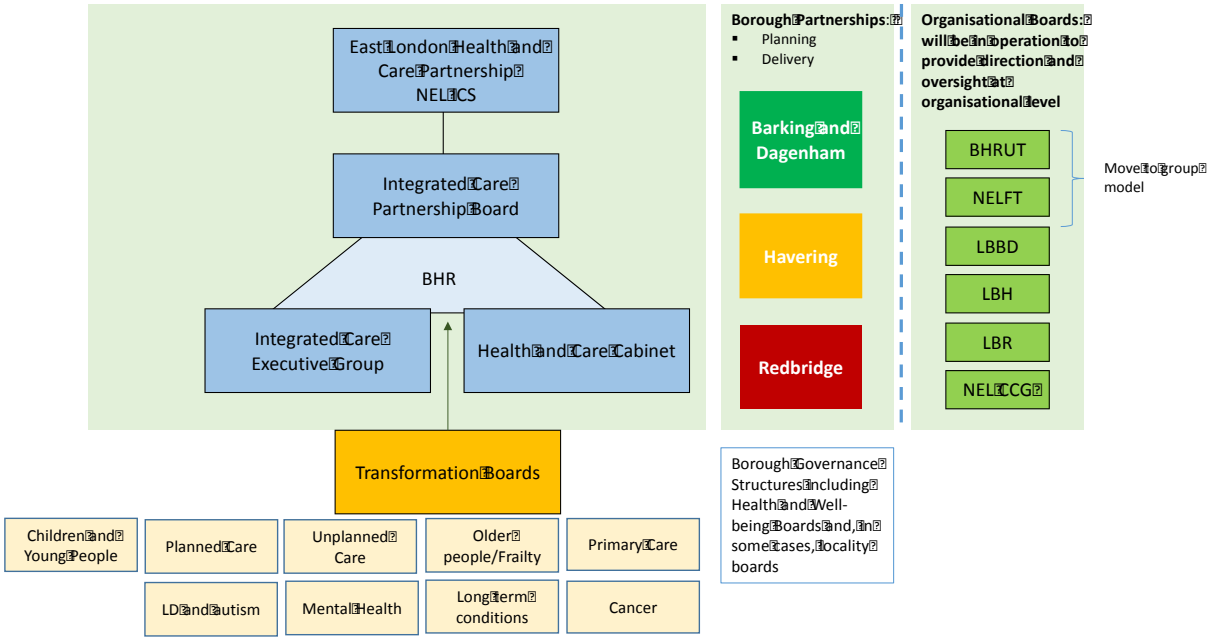
consideration should be given to whether any changes would improve their effectiveness, for example, by strengthening NHS membership and giving boards more powers over budgets and decision-making, subject to local agreement.

- Local authorities can learn from the experience of their colleagues in the first wave of ICSs by making sure they are working together effectively to offer a strong local government contribution to the ICS in their area, based on a clear vision for the health and wellbeing outcomes for their local population.

Within the BHR system, we will work with HWBBs to collectively consider these areas with a view to developing a model for their potential future roles. This could be as the core future governance of borough partnerships incorporating an extended role in decision-making and accountability to residents.

The three BHR governance bodies (ICPB, ICEG and the Health and Care Cabinet) and HWBBs will need revised membership, terms of reference, operating guidelines by 2021. By the autumn 2020 we will have developed the governance arrangements at BHR and borough level in more detail for approval by constituent bodies.

Future Outline Governance Arrangements for Shared Decision Making



10. Maturity Matrix

A national integrated care system maturity matrix (June 2019) was developed to outline the core characteristics of systems as they develop. These were developed from observing and talking to the earliest ICSs, and from the objectives set out in the NHS Long-Term Plan. It is based on similar tools used by the Local Government Association and others, who have experience in supporting system development and change. It provides a consistent framework for all regions and systems across the country.

The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS in the following domains:

- System leadership, partnerships and change capability
- System architecture and strong financial management and planning
- Integrated care models
- Track record of delivery
- Defined and coherent population.

It uses a progression model which shows a journey rather than a series of binary checklists, recognising that systems will not develop all domains at the same pace and will therefore have varying levels of maturity across each domain. By doing this, it seeks to support more nuanced and reflective discussions about system maturity.

The BHR system undertook a self-assessment against the domains in September 2019. The self-assessment identified some gaps we need to address along with some areas that will need particular attention over the next year to make sure BHR is on track. Regular reports will go to the Integrated Care Executive Group to understand progress and risks.

The areas which were identified as needing more work in BHR were:

- Development of primary care networks
- Workforce strategy
- Achievement against NHS constitutional targets
- Population health management.

These areas will be addressed through the BHR system strategy priorities and through current structures.

11.Risks

There are significant risks to the implementation of the BHR system and how it will operate. The Design Group has identified the following initial risks:

RISK TO BHR SYSTEM DEVELOPMENT
If the different accountability structures across health and social care (planning regimes and funding frameworks) are not reconciled to a degree with the new governance structures, system working may be compromised
If there are changes in senior leadership in the BHR system it will have a detrimental impact on the pace of progress and direction of travel (need to re-form relationships, may have different

views/approaches)
If the immediate requirement is to improve performance and financial positions it may mean that solutions are put in place which limit the ability to develop and implement new models of care across the BHR system
If clinical leadership and capacity is lost in the change process due to uncertainty and system changes, strategy development and delivery will be compromised
If the timing of implementation of Group model across BHRUT/NELFT and the development of the BHR system model is not aligned it will lead to uncertainty/confusion for staff and the system, a loss of confidence and delays in implementation
If primary care networks and federations do not reach sufficient stages of maturity, it will impact on the system's ability to improve quality and implement new models
If cultures and behaviours across organisations do not change (e.g. organisational 'protectionism' and competitive behaviours), it will not be possible to work effectively as a system in BHR
If the workforce is not available to deliver new system models of care, as well as keep services going in the meantime, then delivery will be severely compromised now and in the long-term future
If the political environment means a change in the policy environment and national policy changes, it will result in delays to progress and, possibly, a different direction of travel
If digital investment is not forthcoming, the BHR system cannot implement population health models and share information at resident and population levels
If the NEL ICS programme does not deliver in agreed timescales, the BHR system model may be delayed or need to change mid implementation.

These are all significant risk areas. Further work will be undertaken to understand, assess and mitigate these risks to inform a comprehensive approach to risk management.

12. Roadmap

A roadmap up to 2021 is being developed. An outline is attached as Appendix B. 2020/21 will be a preparation year and four work streams are being established to develop more detailed plans in the following areas alongside taking forward the BHR system strategy priorities (section 5) and addressing those gaps against the maturity matrix (Section 10):

- Communications and engagement
- Governance
- Financial framework
- Developing borough partnerships.

13. Recommendations

Members are asked to:

- Comment on any aspect of this report on progress so far on the development of the BHR system
- Continue to support further development of the BHR system
- Note that more detailed operating model will be developed for approval in the autumn 2020

APPENDICES

A BHR System Outline Operating Model
B Initial Roadmap

BHR System – Outline Operating Model

Appendix A

	Role and Activities	Population
Primary Care Networks/localities CO-ORDINATES DELIVERY OF CARE FOR LOCAL RESIDENTS	• Targeted interventions aimed at individuals and families who have increased risk of developing needs, where the provision of services, resources or facilities may restore independence, slow down or reduce any further deterioration or prevent other needs developing • Focused interventions aimed at maximising independence and minimising the effect of disability or deterioration for residents with established or complex health problems • Through multi-disciplinary and multi-agency working, provides the ability to better manage or coordinate the care of individuals • Form partnerships with community groups to support and develop interventions that fill gaps in care • Empower and prepare residents to manage their care • Residents will be at the centre of care and will be equal partners in the design, delivery and monitoring of services • Deliver at scale services which serve populations larger than individual GP practices • Lead on improvement of quality and performance across partners	31-106k
Borough partnerships Delegate LEADS PLANNING AND DELIVERY FOR LOCAL POPULATION	• Shapes and ensures delivery of health and care transformation plans including implementation of new models of care and pathways tailored to local population within framework set by BHR system • Enhanced sharing of data to undertake population care management of demand and early intervention • Removes barriers and shifts resources to produce greater value and better outcomes • Supports the development of PCN/localities and mobilise community resources to meet the needs of residents • Delivers at scale services which serve borough wide population • Focus on wider determinants of health and care including housing, business, leisure and employment • Escalate issues and risks to BHR system for resolution or wider learning	200-300k
BHR Delegate SETS SERVICE AND FINANCIAL STRATEGY	• Overall responsibility for how BHR system works in practice • Overall strategy development supported by Health and Care Cabinet and Transformation Boards • Set outcomes framework, quality and performance standards • Receives full NHS allocation for BHR and develops financial strategy, resource allocation to boroughs, collective risk management approaches within NEL framework • Assures borough partnerships and their delivery of effective, efficient care and support • Custodian of partnership approach – involvement of all partners including wider community, clinical engagement and co-production • Ensures BHR system efficiency through new commissioning and payment models • Cross cutting BHR wide programmes where need to work together e.g. workforce	800k

Outline Roadmap for BHR System Development (in development) Appendix B

	Programme set up and partner commitment		Detailed Development		Approval and Set Up	Pilot and Implement	Go Live
	February 2020	March 2020	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	From 1st April 2021
1. BHR Strategy Implementation	Receive and consider BHR System Strategy including: • Case for change • Vision • Strategic priorities	Agree plan to take forward strategic priorities under leadership of ICPB/ICEG/cabinet including key 2020/21 milestones		Milestones dependent on plans			
2. Setting up the System	Simulation event (26/2) to test design so far with senior leadership and identify further work	Share design proposals with all partners for comment and to endorse direction of travel	Options for borough partnerships developed (scope, governance) based on extending current arrangements where in place	Devise and agree organisational development programme to support system development	Final operating model for approval (Sept/Oct) including revised governance arrangements	Pilot operating model in advance of 1st April covering new governance framework	ICS for NEL and single CCG created (subject to approval) with NHS delegated functions to BHR system
	Programme set up: • Establish work streams (finance, governance, borough partnerships and comms/engage) • PMO approach including risk	Develop communications and engagement plan		Develop single outcomes framework	Establish new 'shadow' governance arrangements for BHR system	Agree operating plan (2021/22) for the BHR system	Ongoing work to ensure BHR system operates effectively
	NEL-led functions work completed – test coherence with local operating model	Transformation Boards refreshed (based on CF recommendations Nov 19) – part. leadership, capacity and focus					
3. Addressing maturity matrix	Understand plans against gaps: PCN development, workforce strategy, achievement against performance	ICEG progress review whole matrix		ICEG progress review whole matrix		ICEG progress review whole matrix	

Ongoing engagement with broader partners and public/patient engagement

Ensure alignment with national policy, NEL ICS development work etc

HEALTH AND WELLBEING BOARD

10 March 2020

Title:	Update on development of BHRUT Clinical Strategy
Open Report:	**For Information**
Wards Affected: N/A	**Key Decision:** No
Report Author: Gurvinder Sidhu, Head of External Communications, BHRUT	**Contact Details:** Tel: 01708 435 000 Ext: 3914
Sponsor: Not applicable	

Summary:
The presentation will give an overview of the current position in developing BHRUT's clinical strategy and future developments to improve patient care.

The slide deck also highlights the local context of the Trust within the North East London Integrated Care System, emerging priorities and themes to improve patient care, following recent public and stakeholder engagement activity and developing proposals for working within the wider BHR system.

The Trust wants to plan for the longer term to ensure that our hospitals deliver the right services to our growing and changing population, and that there is greater synergy with the wider health and social care provision across the integrated care system.

Recommendation(s):
The Health and Wellbeing Board is recommended to:

1. Note the presentation on the current development position of the clinical strategy, emerging priorities and future planning.
2. Provide any feedback and comments on the presentation and future plans.

Reasons for report:
BHRUT started reviewing the clinical strategy in May 2019, to plan services for the next two, five and 10 years, led by the Trust's clinicians in partnership with health and social care partners across Barking & Dagenham, Havering and Redbridge.

The review created principles and objectives, case for change and 10 priority areas to improve patient care. This was followed by stakeholder communications and engagement activity since last summer, with staff, patients, residents, and all health and social care partners.

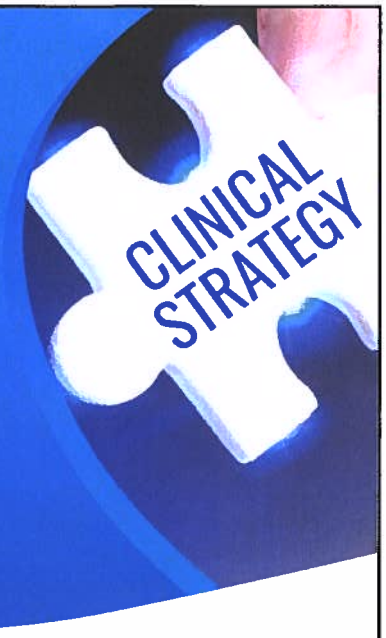
There are three emerging priorities to improve patient care and we want to engage on where we are to date, before sharing the proposed intentions within the first draft of the

strategy.

Appendices:
Appendix 1 – Power-point presentation

DEVELOPING OUR NEW CLINICAL STRATEGY

January 2020



TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

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OUR HOSPITALS

Queen's Hospital, Romford

King George Hospital, Goodmayes

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WHAT IS A CLINICAL STRATEGY?

It is a plan that will describe what we think our services should look like in years to come.

It will help to ensure everyone in Barking and Dagenham, Havering and Redbridge has access to safe, high quality and sustainable healthcare.

We are developing our clinical strategy with staff, patients, residents and healthcare partners.

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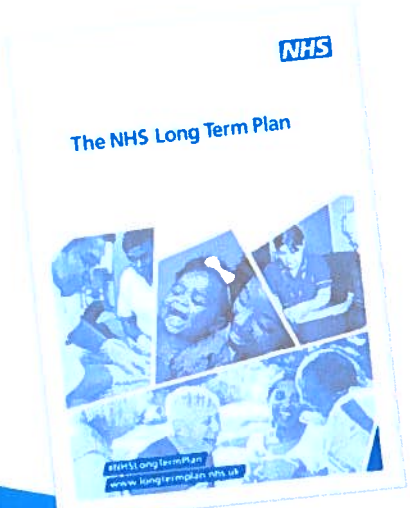
OUR LOCAL CONTEXT

NHS Long Term Plan



North East London Integrated Care System

Working together with NELFT

NELFT NHS
NHS Foundation Trust

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WHY DO WE NEED TO CHANGE?

Our population is growing (expected to increase by 100,000 in 10 years) and changing

Our maternity unit is one of the largest single site units in the country. We care for around 8,200 women each year, and this is set to grow

Some patients could be more appropriately seen by other services. Around 90% of patients arriving by ambulance at King George Hospital are discharged the same day, meaning they could have been seen by a less specialist service

Many patients are waiting too long for treatment. We are not meeting national standards for waiting times

We could make better use of our capacity, for example our beds, appointment slots and theatres

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WHY DO WE NEED TO CHANGE?

We want to make sure we work in the most effective way – based on the latest evidence

We can't recruit enough specialist staff in some services, which affects our ability to deliver consistently good, resilient services

We could treat more patients currently using other NHS or private hospitals, which would boost our income

Some services could be improved if they were based at fewer locations, saw more patients or had more staff

We can improve our use of technology and digital innovations, and make better use of our current buildings and infrastructure

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OUR EMERGING PRIORITIES TO IMPROVE PATIENT CARE

Our work is focused on three different themes

- Work to improve services that can begin immediately
- Potential consolidation of some services onto fewer sites where there is evidence this would benefit patient care and make services more sustainable
- Work to build partnerships with other organisations to provide the best possible specialised services for our population

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THEME ONE: WORK TO IMPROVE, AND OPTIMISE OUR SERVICES, FOR EMERGENCY AND PLANNED CARE, FOR ADULTS AND CHILDREN

The following case studies are based on:

- Urgent and emergency care
- Planned care
- Maternity care
- People with ongoing care needs
- People with complex needs
- Cancer care

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URGENT AND EMERGENCY CARE: NOW AND IN THE FUTURE

Pooja is 45 years old and lives in Redbridge. She has had asthma for many years. Over the last two days she has developed a nasty cough and is having difficulty breathing. Her husband takes her to Queen's Hospital's emergency department.

Now	Future services
Pooja is reviewed by multiple professionals before a decision about her treatment is made. This results in delays and duplication of effort by staff	An initial assessment is done virtually by a consultant and Pooja is referred to the same-day emergency care centre in Queen's Hospital
Pooja is admitted to the medical assessment unit for tests and due to her existing long-term condition, she needs to stay in hospital	Tests show that Pooja has mild pneumonia. She goes home the same day with antibiotics and an appointment to see a lung specialist at the rapid access clinic in two days
After two days of antibiotics, she is discharged home from hospital back to the care of her GP	Pooja is much better when she visits the rapid access clinic. She is discharged back to the care of her GP who has access to a specialist through an advice line should it be required

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PLANNED CARE: NOW AND IN THE FUTURE

Albert, 76 years old from Havering, is active and regularly plays golf. He has hip pain which is getting worse and hasn't been helped by physiotherapy or steroid injections. The pain is affecting everyday life so his GP refers him to an orthopaedic specialist at Queen's Hospital

Now	Future services
At the first outpatient appointment the surgeon thinks a hip replacement may be needed and refers Albert for a CT scan, and organises a second outpatient appointment	The orthopaedic team review Albert's referral and arrange for a CT scan and an appointment with the surgeon to take place on the same date
Albert has his CT scan	At the appointment, the surgeon reviews the CT scan and recommends hip replacement surgery. Albert completes the necessary forms for surgery, and agrees discharge plans and follow-up treatment
At the second outpatient appointment, hip replacement surgery is agreed	Albert's operation is successful. He stays in hospital for three days and then goes home with pre-arranged care in place. Albert's GP is advised of his surgery should any problems occur
The surgery is successful, but Albert stays in hospital longer than needed as care needs to be organised at home. Albert's GP is advised of his surgery should any problems occur	The consultant checks on Albert by phone within 72 hours. As he is recovering well, they organise a Skype appointment in six weeks. In the meantime Albert completes his physiotherapy exercises at home
Albert completes the exercises the physiotherapist gave him at home. He has a hospital appointment six weeks later to check on his recovery	

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MATERNITY CARE: NOW AND IN THE FUTURE

Oni is 26 years old and lives in Barking. She is pregnant with her second child. As a single parent she is concerned about being at home as much as possible to care for her two year old son.

Now	Future services
Oni completes an online booking form and meets a midwife to develop a care plan. Oni's risk is assessed by a clinician and it is decided her birth can be midwife led. She has antenatal support throughout her pregnancy	Oni had anaemia during her first pregnancy so she visits the pre-conception service for a check-up before she tries for another baby
	Once pregnant, Oni completes an online booking form and meets with a midwife to develop a care plan. Oni's risk of complications is assessed using a decision-making tool and she and the midwife agree her care can be midwife led. Oni has both individual and group antenatal appointments where she meets other mums-to-be.
When Oni goes into labour she calls the midwife led unit to let them know. She is advised to go in to hospital when she feels she needs more support or help with pain relief. Oni gives birth at 3pm and needs to stay in hospital with her baby overnight as there is no one to discharge her in the evening	When Oni goes into labour she calls the midwife led unit to let them know. She is advised to go in to hospital when she feels she needs more support or help with pain relief. Oni gives birth in the unit at 3pm. Because there is a 24/7 care coordinator she and her baby are able to go home at 7pm
Initially, Oni receives postnatal care at home and then starts to visit the baby clinic regularly for support with her and her baby's wellbeing	Initially, Oni receives postnatal care at home and then starts to visit the baby clinic regularly for support with her and her baby's wellbeing
At one of her clinic visits, Oni raises that she is feeling low. Oni is advised to visit her GP to discuss how she is feeling	At one of her clinic visits, Oni raises that she is feeling low. The clinic team give her details of a virtual support group which Oni joins and finds helpful. Her GP is also made aware in case the low mood develops into postnatal depression

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PEOPLE WITH ONGOING CARE NEEDS: NOW AND IN THE FUTURE

Arjun, 19 from Dagenham, was diagnosed with type 1 diabetes when he was 17. He has been able to control it well with insulin injections, but over the last month his blood sugar levels have been very high in the morning which is causing him concern.

Now	Future services
Arjun books an appointment with his GP to discuss his blood sugar levels. The GP refers him to a diabetic nurse	Arjun was enrolled into the long term condition management programme when he was diagnosed. This means he can arrange a virtual appointment with a diabetic nurse when he needs to
Arjun and the nurse discuss his symptoms and the nurse provides advice to help manage it. He will continue to keep daily records of his blood sugar levels and they will discuss this at his next appointment. If Arjun has concerns before then he can contact the clinic direct to make an appointment to go and see a diabetic nurse	Arjun and the nurse discuss his symptoms, look at his shared care record and the nurse provides advice to help manage his blood sugar. The nurse also suggests Arjun joins a peer support group, so he can meet other people his age with type 1 diabetes. Arjun continues to keep daily records of his blood sugar levels to discuss at his next appointment or at another virtual appointment if he has concerns before then
In the future if Arjun struggles to manage his condition he would need to book an appointment with his GP to be referred to a diabetic nurse	In the future should Arjun struggle to manage his condition he has rapid access to specialist opinion through his GP who can contact specialists to advise on his care via a 24 hour hotline

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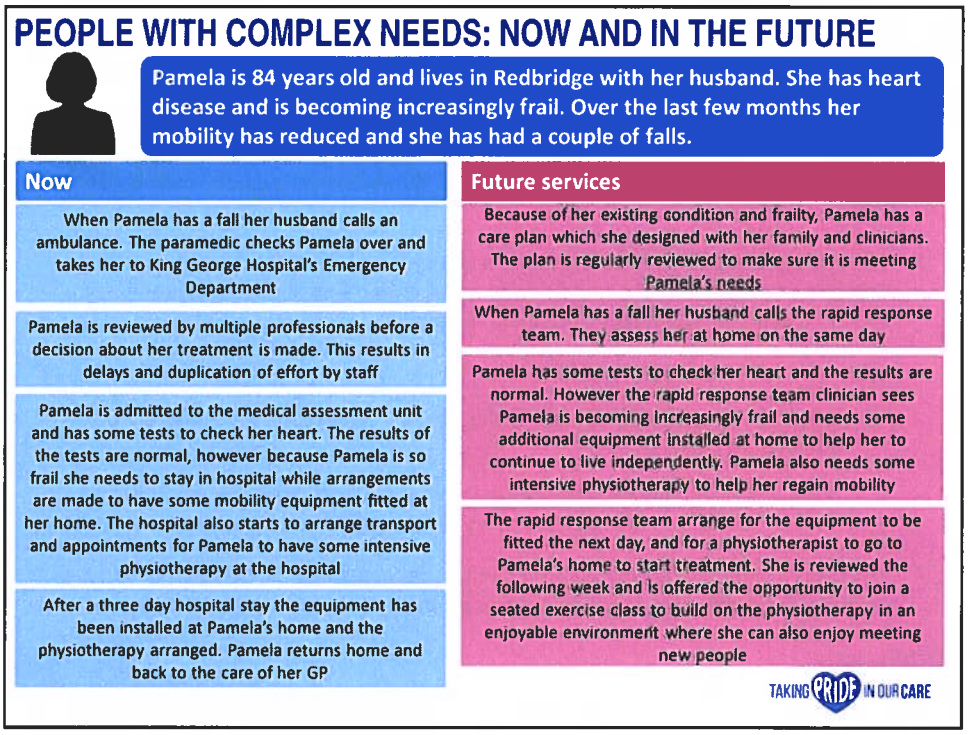
PEOPLE WITH COMPLEX NEEDS: NOW AND IN THE FUTURE
Pamela is 84 years old and lives in Redbridge with her husband. She has heart disease and is becoming increasingly frail. Over the last few months her mobility has reduced and she has had a couple of falls.
Now
When Pamela has a fall her husband calls an ambulance. The paramedic checks Pamela over and takes her to King George Hospital's Emergency Department
Pamela is reviewed by multiple professionals before a decision about her treatment is made. This results in delays and duplication of effort by staff
Pamela is admitted to the medical assessment unit and has some tests to check her heart. The results of the tests are normal, however because Pamela is so frail she needs to stay in hospital while arrangements are made to have some mobility equipment fitted at her home. The hospital also starts to arrange transport and appointments for Pamela to have some intensive physiotherapy at the hospital
After a three day hospital stay the equipment has been installed at Pamela's home and the physiotherapy arranged. Pamela returns home and back to the care of her GP
Future services
Because of her existing condition and frailty, Pamela has a care plan which she designed with her family and clinicians. The plan is regularly reviewed to make sure it is meeting Pamela's needs
When Pamela has a fall her husband calls the rapid response team. They assess her at home on the same day
Pamela has some tests to check her heart and the results are normal. However the rapid response team clinician sees Pamela is becoming increasingly frail and needs some additional equipment installed at home to help her to continue to live independently. Pamela also needs some intensive physiotherapy to help her regain mobility
The rapid response team arrange for the equipment to be fitted the next day, and for a physiotherapist to go to Pamela's home to start treatment. She is reviewed the following week and is offered the opportunity to join a seated exercise class to build on the physiotherapy in an enjoyable environment where she can also enjoy meeting new people
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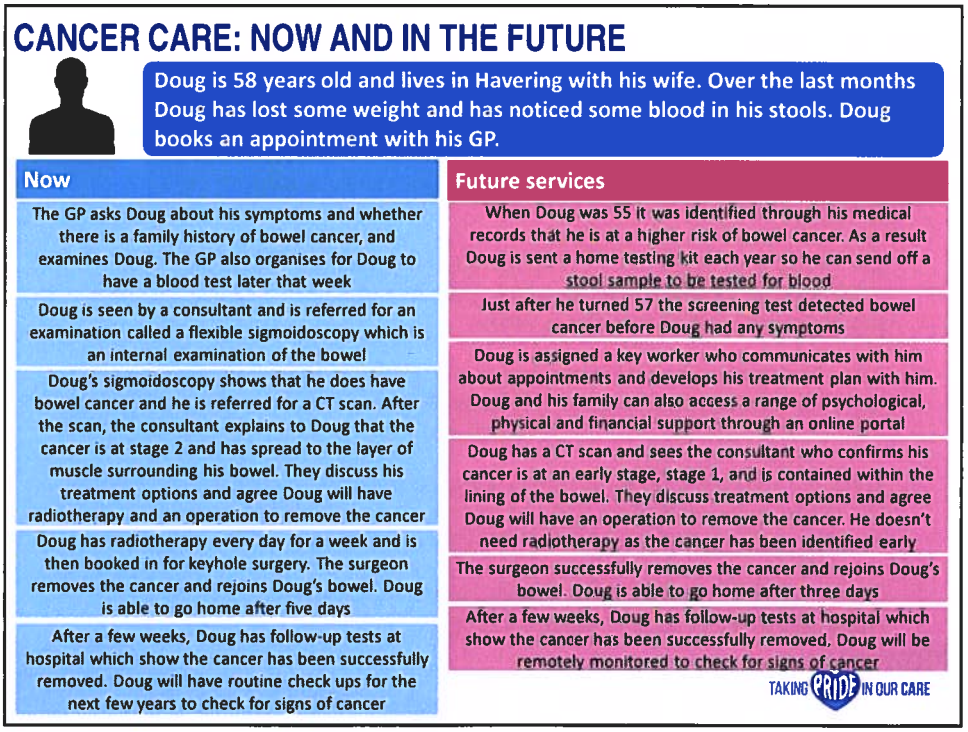
CANCER CARE: NOW AND IN THE FUTURE
Doug is 58 years old and lives in Havering with his wife. Over the last months Doug has lost some weight and has noticed some blood in his stools. Doug books an appointment with his GP.
Now
The GP asks Doug about his symptoms and whether there is a family history of bowel cancer, and examines Doug. The GP also organises for Doug to have a blood test later that week
Doug is seen by a consultant and is referred for an examination called a flexible sigmoidoscopy which is an internal examination of the bowel
Doug's sigmoidoscopy shows that he does have bowel cancer and he is referred for a CT scan. After the scan, the consultant explains to Doug that the cancer is at stage 2 and has spread to the layer of muscle surrounding his bowel. They discuss his treatment options and agree Doug will have radiotherapy and an operation to remove the cancer
Doug has radiotherapy every day for a week and is then booked in for keyhole surgery. The surgeon removes the cancer and rejoins Doug's bowel. Doug is able to go home after five days
After a few weeks, Doug has follow-up tests at hospital which show the cancer has been successfully removed. Doug will have routine check ups for the next few years to check for signs of cancer
Future services
When Doug was 55 it was identified through his medical records that he is at a higher risk of bowel cancer. As a result Doug is sent a home testing kit each year so he can send off a stool sample to be tested for blood
Just after he turned 57 the screening test detected bowel cancer before Doug had any symptoms
Doug is assigned a key worker who communicates with him about appointments and develops his treatment plan with him. Doug and his family can also access a range of psychological, physical and financial support through an online portal
Doug has a CT scan and sees the consultant who confirms his cancer is at an early stage, stage 1, and is contained within the lining of the bowel. They discuss treatment options and agree Doug will have an operation to remove the cancer. He doesn't need radiotherapy as the cancer has been identified early
The surgeon successfully removes the cancer and rejoins Doug's bowel. Doug is able to go home after three days
After a few weeks, Doug has follow-up tests at hospital which show the cancer has been successfully removed. Doug will be remotely monitored to check for signs of cancer
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THEME TWO: THE POTENTIAL TO BRING SOME SERVICES TOGETHER TO IMPROVE CARE

1. Our clinicians are reviewing multi-site services to see if care could be improved and services made more sustainable and efficient if they were consolidated onto fewer sites
2. Services not being considered are the Emergency Departments at Queen's and King George hospitals, the hyper-acute stroke unit at Queen's Hospital and radiotherapy and in-hospital chemotherapy at Queen's Hospital
3. When this work has progressed further:
   - We will provide information about the services that are being considered for potential consolidation
   - We will engage and talk with you - and all our partners, stakeholders, staff and local communities - about any services being considered
4. Proposals to consolidate services would require formal public consultation before any decisions are made. This would be led and planned by our local commissioners.

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THEME THREE: BUILDING PARTNERSHIPS WITH OTHER ORGANISATIONS TO IMPROVE SOME SPECIALIST SERVICES

1. We are working with our colleagues across north east London to see where it makes sense to work in partnership to improve the quality and outcomes of some specialised services
2. Specialised services are those best delivered over a wider catchment area. This makes sure our specialist staff see higher volumes and a range of patients to make sure they keep up their specialist expertise
3. Specialised services needing a large catchment area include neurosurgery (a surgical specialty dedicated to management of diseases of the brain and nervous system) and vascular disease (a disease of the blood vessels)
4. When this work has progressed further we will provide information and will engage and talk with you - and all our partners, stakeholders, staff and local communities - about any services being considered for improvement through partnership working
5. Some proposals may require formal public consultation before any decisions are made. This would be led and planned by our specialised commissioners.

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GETTING YOUR VIEWS

- We used an online survey to ask local people and Trust staff for their views about our principles, objectives, case for change and priorities to support the development of our clinical strategy
- We asked respondents to rank the principles, objectives, case for change and priorities in order of importance
- Some questions asked people to choose their top three most important issues and some asked people to rank every issue on the list in order of importance
- We will use the feedback of this survey to help inform the development of our clinical strategy.

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PRINCIPLES

The top three principles, from a list of seven, were:

Principle	% of people who put it in their top three
Having services that have enough capacity to meet demand, follow best practice and meet national standards, such as waiting times and can work within their budget	75%
Making sure everyone in Barking and Dagenham, Havering and Redbridge has equal access to consistent, high-quality services, regardless of where they live	67%
Making sure our clinical strategy is focused on the needs of patients and is in line with the wider aims of the NHS to better join-up health and social care and do more to prevent ill health	61%

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OBJECTIVES

The top three objectives, from a list of five, were:

Objective	% of people who put it in their top three
Ensuring we can provide a 24/7 consultant-led A&E department, with full resuscitation facilities at both Queen's and King George hospitals	81%
Using our resources effectively to improve the quality of patient care and staff experience; get the best value for money; and be able to deliver services within our budget	77%
Establishing ourselves as an effective partner with other NHS and care organisations in our area, embedding excellence, innovation and partnership working into our strategy to improve patient outcomes and experience	59%

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CASE FOR CHANGE

The top three most important 'case for change' issues, from a list of 11, were:

Objective	% of people who put it in their top three
We could make better use of our capacity (for example, beds, appointment slots, theatres etc)	54%
Some patients could be more appropriately seen by other services, particularly for emergency care	46%
Staffing challenges are affecting our ability to continue to deliver sustainable services	42%

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PRIORITIES

People were asked to rank 10 priorities in order of importance. The top five overall were:

No.	Priority	% of people who placed the priority in this position*
1	Make it easy to access the most appropriate urgent or emergency care service	54%
2	Develop joined up teams of health and care professionals to proactively care for patients with complex needs to help them stay as well as possible and avoid admissions to hospital	36%
3	Reduce variation in quality of care, and make the best use of capacity and resources by consolidating some services and developing centres of expertise (and keep A&E at each hospital)	25%
4	Redesign outpatient services to make best use of workforce capacity and resource	23%
5	Reorganise planned care (operations/treatments booked in advance) to make best use of capacity and resources, and become a provider of choice so patients choose treatment with us instead of private providers	33%

*i.e. the position that the highest percentage of people chose

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NEXT STEPS

Next few months
Continued engagement on the development of our clinical strategy, particularly on theme one and our potential immediate improvements

Spring
Immediate improvements agreed and clinicians start to implement changes

Beyond
Further engagement around themes two and three with some proposals undergoing formal consultation

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OVER TO YOU FOR QUESTIONS AND COMMENTS
TAKING PRIDE IN OUR CARE
Barking, Havering and Redbridge NHS University Hospitals

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Health and Wellbeing Board

10 March 2020

Title: Presentation of the revised Health and Wellbeing Outcomes Framework	
Report of the Director of Public Health	
Open	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Wassim Fattahi-Negro, Principal Performance Manager	**Contact details:** Wassim.FattahiNegro@lbbd.gov.uk
Accountable Director: Matthew Cole, Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti, Director of People and Resilience	

Summary

The Health and Wellbeing Outcomes Framework has been revised to align with the Barking and Dagenham Joint Health and Wellbeing Strategy (JHWS) 2019-2023 as proposed to the Board in September 2019.

The new Outcomes Framework draws on the three priority themes, seven key health and wellbeing outcomes and thirty-one measures presented in the JHWS, as well as the measures presented in the tri-borough Joint Strategic Needs Assessment 2020.

From these a shortlist of measures has been selected, which will assist the Health and Wellbeing Board in monitoring progress towards the vision of *Improving Health and Wellbeing, Reducing Inequalities and Increasing Resilience with no-one being left behind*.

This shortlist of measures which is being presented to the Board for review and approval so that the reporting of the measures can begin in Quarter 1 of the new reporting year (2020-21).

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Review and provide feedback on the proposed Outcomes Framework and supporting measures
- Highlight any gaps in the proposed set of measures; whilst this framework is intended to provide a compact list of overarching measures it is important that it reflects and represents the wide remit of the Health and Wellbeing Board
- Agree the proposal for all parties to contribute to the ongoing production of the new framework, and
- Agree the frequency of reporting

Reason
The measures selected to support the JHWS must represent the wide remit of the Health and Wellbeing Board. It is therefore important that Board members use this opportunity to review the Outcomes Framework and ensure the measures meet this requirement.

The data for the measures will come from an equally wide range of sources. It is therefore essential that all parties represented by the Board agree to support the delivery of the Framework through the routine provision of data and commentary for the measures in line with the agreed timeline.

Appendix – Power point slide pack

Health and Wellbeing Outcomes Framework

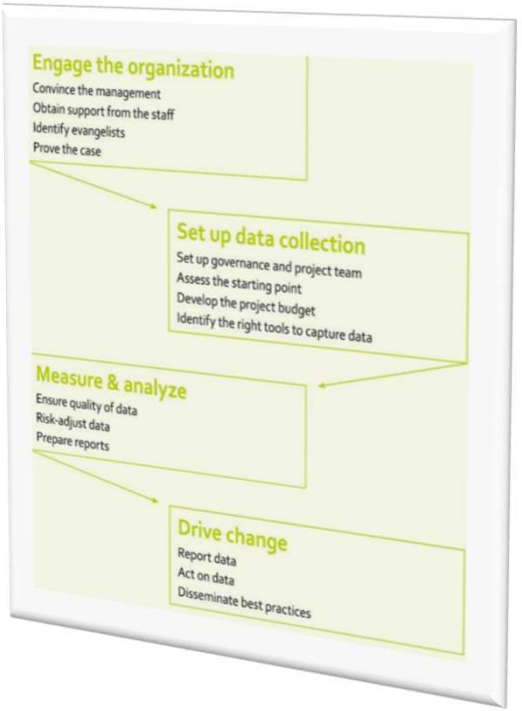
March 2020

Performance & Intelligence Team

one borough; one community; no one left behind

This workshop is…

- A follow up on September's paper actioning the HWBB mandate to deliver an outcomes framework, replacing the outdated outputs performance reporting
- Aims to finalise the list of measures to be reported, ensuring the representation of all parties
- Allocate individual leads to report on measures and decide on frequency of reporting to the HWB

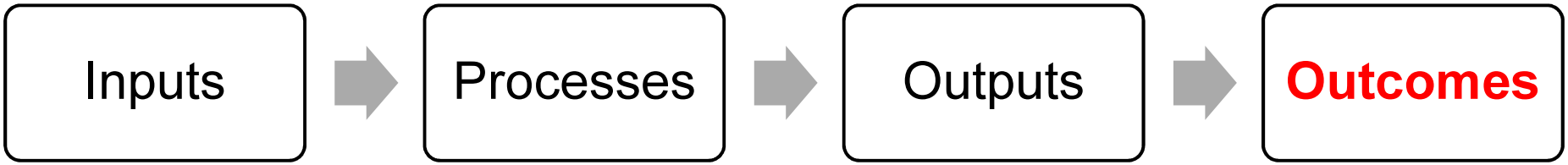


Barking & Dagenham

The new framework

"Residents will benefit from partners working together around their needs and priorities, focusing on **outcomes**, as opposed to a focus on process and outputs."

Joint Health and Wellbeing Strategy 2019-2023



Health and Wellbeing Outcomes Framework

Vision: By 2023, as Barking and Dagenham continues to grow, our residents will have improved health and wellbeing, with less health inequalities between Barking and Dagenham residents and the rest of London: no-one will be left behind.

Priority themes	Outcomes
Best Start in Life	**1.** Increase the percentage of children who are best prepared to start school by the age of 5
Early Diagnosis and Intervention	**2.** Increase healthy life expectancy by removing barriers to early diagnosis and intervention
Building Resilience	**3.** Improved multi-agency support for those with Adverse Childhood Experiences **4.** Aspiration: Increase the level of educational attainment, skills and employment **5.** Improve physical and mental wellbeing **6.** Ageing Well: increased level of residents who age well **7.** A borough with zero tolerance to Domestic Abuse that tackles underlying causes, challenges perpetrators, and empowers survivors

The nature of health means that it could take years or even decades to see marked improvements.

How will we know that our interventions are having the desired effect?

Supporting measures

Supporting measures demonstrate, year by year, the impact and effectiveness of the work being carried out and the progress made towards the desired outcomes.

They should be:

- Person centred
- Outcome focused (wherever possible, focusing on the impact to residents)
- Routinely measurable
- Comparable to national and local performance

Measures have been suggested for each of the seven outcomes. We need you to tell us:

- Are these the right measures?
- Will they demonstrate progress towards the relevant outcomes?
- If not, what can they be replaced with?
- Do they represent the work of all involved parties?
- For each measure, which organisation will lead on providing data and narrative?

Best Start in Life

Outcome 1: Increase the percentage of children who are best prepared to start school by the age of 5

#	Suggested supporting measure	Frequency	Data source	Lead organisation
1	Percentage of children who received two doses of MMR before their fifth birthday	Annual	PHE / NHS Digital	BHR CCG
2	Percentage of children in Reception classified as obese	Annual	National Child Measurement Programme	LBBD
3	Percentage of children achieving a good level of development by the age of 5	Annual	Early Years Foundation Stage Profile return, DfE	LBBD

Questions:

- Are these the right measures?
- Will they demonstrate progress towards the desired outcome?
- If not, what can they be replaced with and which organisation will lead on providing data and narrative?

Early Diagnosis and Intervention

Outcome 2: Increase healthy life expectancy by removing barriers to early diagnosis and intervention

#	Supporting measure	Frequency	Data source	Lead organisation
4	Proportion of cancers diagnosed at an early stage (stage 1 & 2)	Annual	National Cancer Registration and Analysis Service	LBBD
5	Percentage of people receiving an HIV diagnosis at a late stage of infection	Annual	HIV and AIDS Reporting System (HARS), PHE	LBBD
6	Proportion of eligible people receiving an NHS Health Check	Quarterly	Health Checks data collection, PHE	BHR CCG

Questions:

- Are these the right measures? Will they demonstrate progress towards the outcome?
- Is there a pre-diabetes or NHS Diabetes Prevention Programme measure that should be included?
- Is there a composite measure which sums up early detection?

Building Resilience

Outcome 3: Improved multi-agency support for those with Adverse Childhood Experiences

#	Supporting measure	Frequency	Data source	Lead organisation
7	First time entrants into the youth justice system (rate per 100,000 population aged 10-17 years)	Quarterly	LBBD	Youth Offending Service
8	*Placeholder*			
9	*Placeholder*			

Questions:

- What else can be measured that will demonstrate improvements in the multi-agency support provided for those with ACEs?
- Measures from Health, NELFT, 3rd Sector?

Building Resilience

Outcome 4: Increase the level of educational attainment, skills and employment

#	Supporting measure	Frequency	Data source	Lead organisation
10	Average Attainment 8 score of pupils at the end of key stage 4	Annual	GCSE Results, DfE	LBBD
11	*Placeholder*			
12	*Placeholder*			

Questions:

- What else can be measured that will demonstrate improved education, increased skill levels and higher employment rates?

Building Resilience

Outcome 5: Improve physical and mental wellbeing

#	Supporting measure	Frequency	Data source	Lead organisation
13	Percentage of physically inactive adults	Annual	Active Lives Adult Survey, Sport England	?
14	Suicide mortality rate per 100,000 population (directly age standardised)	Annual	PHE	?
15	Proportion of patients who felt that the healthcare professional recognised and/or understood any mental health needs during their last general practice appointment	Annual	GP Patient Survey	BHR CCG

Questions:

- Are these the right measures? Will they demonstrate progress towards improved physical and mental wellbeing?
- If not, what can they be replaced with and which organisation will lead on providing data and narrative?

Building Resilience

Outcome 6: Ageing Well - Increased level of residents who age well

#	Supporting measure	Frequency	Data source	Lead organisation
16	Rate of emergency admissions to hospital per 100,000 population aged 65 and over	Quarterly	Hospital Episodes Statistics (HES)	BHR CCG
17	Emergency hospital admissions due to falls in people per 100,000 population aged 65 and over (directly age standardised rate) OR Hip fractures per 100,000 population aged 65 and over (directly age standardised rate)	Annual	PHE (using HES from NHS Digital)	BHR CCG
18	Percentage of patients aged 17 years and over with diabetes	Annual	Quality and Outcomes Framework, NHS Digital	BHR CCG

Questions:

- Are these the right measures? Will they demonstrate that services are enabling people to age well?
- Should an obesity measure be included?

Building Resilience

Outcome 7: A borough with zero tolerance to Domestic Abuse that tackles underlying causes, challenges perpetrators, and empowers survivors

#	Supporting measure	Frequency	Data source	Lead organisation
19	Domestic abuse-related incidents and crimes recorded by the police, crude rates per 1,000 people	Annual	ONS	?
20	Percentage of secondary pupils who state that hitting a partner is acceptable (Schools Survey)	Every 2 years	School Survey	?
21	*Placeholder – awaiting Autumn report from the Domestic Abuse Commission*			

Questions:

- Are these the right measures?
- Should number/rate of referrals to Refuge charity be included?
- Will they demonstrate progress towards tackling the underlying causes of domestic abuse, challenging perpetrators and empowering survivors?
- If not, what can they be replaced with and which organisation will lead on providing data and narrative?

Next steps

- Do the agreed measures represent all parties and do they meet the expectations of the Board?
- How frequently should supporting measures be reported to HWB?
- Who within your organisation will provide the data and narrative for reporting to HWB?

The measures will be reviewed at the end of the 2020/21 reporting year to ensure they are fulfilling their purpose.

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Health and Wellbeing Board

10 March 2020

Title: Development of Appt-Health product; digitally transforming preventative healthcare for local GPs.	
Report of: Councillor Maureen Worby Cabinet Member for Social Care and Health Integration.	
Open	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Pye Nyunt, Head of Insight & Innovation	**Contact details:** pye.nyunt@lbbd.gov.uk
Accountable Director: Mark Tyson, Director of Policy and Participation.	
Accountable Strategic Leadership Director: Elaine Allegretti, Director of People and Resilience.	

Summary

An update around the work of App health's Innovation UK funded pilot in Barking & Dagenham which focuses on a text booking service for Health checks.

Recommendation(s)

The Health and Wellbeing Board is asked to note the report.

1. Background

1.1. The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of largely preventable conditions including stroke, kidney disease, heart disease, type 2 diabetes and dementia. It is also intended to reduce the administrative pressure on, and cost to Primary Care providers.

1.2. The NHS Health Check Programme locally is underperforming. The Public Health England target for uptake of Health Checks is 66%, LBBD has a current uptake rate of 60.1%. Despite this being lower than the national target, LBBD is still higher than the England average which currently sits at 48.1%.

1.3. During the summer of 2018 a small prototype pilot was trialled with Appt Heath, a small start-up company, in two of the borough's GP surgeries. Although only at a small scale, the pilot showed promising results by increasing the uptake of Health checks in the two surgeries it worked in.

1.4. As a result, LBBD's Insight Hub and Appt-Health jointly bid for funding from Innovate UK to develop an automated two-way booking system for NHS Health Checks. It was announced in March 2019, that we were successful in securing **£142k** to commence an 18-month project in LBBD from April 2019.

1.5. The project is being delivered with the support of Together First – the consortium of GPs in the borough - as well as the Clinical Commissioning Group and LBBD Public Health colleagues.

1.6. The Insight Hub's new Behavioural Science Lead, Tim Pearse, joined the team on the 3rd June and has been working with the Appt Team to design messages and the evaluation of the project.

2. The benefits of increased uptake

2.1 Higher uptake in LBBD would lead to a range of long-term population health benefits. A University of Cambridge study from 2018[1] found that for every million people aged 40-74, increasing the uptake of the Health Check by 30% would lead to:

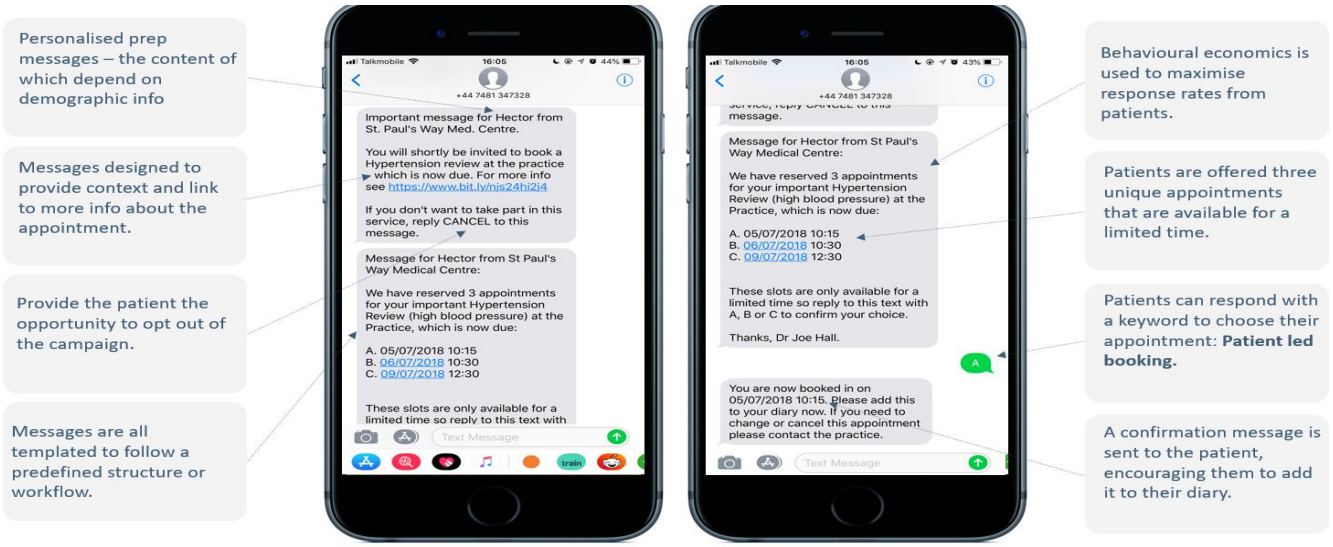
- 980 fewer preventable deaths
- 3,700 more people free of disease, and
- 27,000 additional Quality Adjusted Life Years (QALY) over the lifetime of the participating cohort.

2.2 This represents a public benefit of £8.1 billion (based on the estimate of 15 million eligible individuals in England).

1 https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002517

3. How the Appt Health Product Works

3.1 Appt-Health works by matching data on eligible patients and availability of appointments in GP surgeries. The product then sends a personalised text message to your phone to allow you to book an appointment.



4. Trial Approach

4.1 Selection of practices

All practices in Barking and Dagenham were sent a letter about participating in the trial, from the Clinical Commissioning Group (CCG), co-signed by Dr Jagen John (the Head of Barking and Dagenham CCG) and Cllr Worby (Health and Wellbeing portfolio lead for LBBD). As a result, seventeen GP surgeries volunteered to take part in the trial and offer a balanced spread according to the practice list size, historical NHS Health Check uptake rates and geographic location.

4.2 Selection of cohort and randomisation

To test the efficacy of the product we will run a randomised controlled trial. This means that in each surgery the eligible cohort will be randomly split, and one half will receive Appt and the other will receive business as usual i.e. letters/call and re-call. The trial started on 01/08/2019 and will end on 31/03/2020.

4.3 We estimate that 4,000 patients will be part of this trial over this time.

5. Future commercial model

5.1. The company Appt-Health will retain all intellectual property for the development of the product for the lifecycle of this project (which is funded by Innovate UK).

5.2. The LBBD GPs that signed up to the trial will be able to use the product for free for the duration of the trial. IF they want to continue to use it after this there will be a subscription fee payable to Appt Health.

6. Next steps

6.1 The randomised control trial will continue to run until the end of the financial year, following a predetermined sequence of rounds.

October 2019 – January 2020: Appt SMS round 2 and round 3.

- Any patient that does not attend an NHS Health Check in round 1 (i.e. they do not book or they book and do not attend the booked appointment) will be included in a follow up in round 2 (and so on for round 3).
- This approach ensures that every resident has the opportunity to book a health check at a time is convenient for them and will allow us to target specific messaging at different groups to (we hypothesise) improve engagement and maximise health check uptake rates.
- Data analysis to be carried out by the Insight Hub to better understand the demographic groups that engaged/didn't engage in round 1 of SMS invitations.
- Report quarter 2 progress to Innovate UK (funder).

November 2019:

- Apply insights from analysis of round 1 to design round 2 SMS workflow to better target groups that didn't engage in round one. For example, this could include targeting demographic groups with anomalously low uptake rates with a more assertive message about the risks of cardiovascular disease – which may improve uptake routes in that group.

December to January 2019:

- Carry out service design project for multi-media approach in round 3+ (e.g. paper letters and automated voice calls)
- Run a GP and Practice Manager engagement event.
- Conduct a more general discussion with the community regarding access to primary healthcare and appointment booking using the council's One Borough Voice platform.

February 2020 – follow up letters

- Not every patient will be able to book by SMS, so we will be following up to ensure access is maximised.

February - March 2020: Automated voice calls

- A final round of automated voice calls that will follow the letter invitations as a final opportunity for patients to book as part of the trial.

7. Results as of Jan 2020

Appt's cohort data	Round 1	Round 2	ESTIMATE: Round 3,4 & 5	Total
Booking rate achieved (of SMS's delivered)	46.70%	15.20%	50%	N/A
Booking rate of total cohort (n=2554)	24.16%	5.76%	38%	67.54%
Number of patients booked	617	147	961	1725.00
Estimated QALYs	6.17	1.47	9.61	17.25
Estimated additional years of life	5.55	1.32	8.65	15.52
Estimated new detections of disease	31.47	7.5	49.01	87.98

LBBD data	#	Description
Borough average uptake rate	54.80%	(Source: PHE FingerTips 15/16-19/20 data)
Range (Best performing practice - Worst performer)	133.00%	(Best had 136% uptake, worst had 3% 18/19 data)
Total number eligible	50477	(Source: PHE data)

Projections (if Appt used in all GP practices)(Over 5 years)	#
Number of patients booked	34092
QALYS	341
Extra years of healthy life	307

8. Next stages

8.1 Based on lessons learned from success to explore other areas where the Appt-Health tool could improve take up rates.

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

List of appendices - None

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