



HEALTH & WELLBEING BOARD

The legal status, role and detail about the governance of the Health & Wellbeing Board can be found in [Part B, Article 5](#) of the Council Constitution. Full terms of reference for the Board can be found in [Part C, Section D](#). More information about the work of the Board is listed on the Council's website www.lbbd.gov.uk

Tuesday, 10 December 2013 - 6:00 pm

**Venue: Conference Room, Barking Learning Centre
2 Town Square, Barking, IG11 7NB**

Date of publication: 02 December 2013

Graham Farrant
Chief Executive

Contact: Glen Oldfield, Clerk of the Board, Democratic Services

Telephone: 020 8227 5796 | E-mail: glen.oldfield@lbbd.gov.uk

Membership for 2013/14:

Councillor M Worby (Chair)	(LBBD)
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Councillor J Alexander	(LBBD)
Councillor L Reason	(LBBD)
Councillor J White	(LBBD)
Anne Bristow	(LBBD)
Helen Jenner	(LBBD)
Matthew Cole	(LBBD)
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Martin Munro	(North East London NHS Foundation Trust)
Dr Mike Gill	(Barking Havering & Redbridge University NHS Hospitals Trust)
Chief Supt. Andy Ewing	(Metropolitan Police)
John Atherton (Non-voting member)	(NHS England)

Barking and Dagenham's Vision

Encourage growth and unlock the potential of Barking and Dagenham and its residents.



Priorities

To achieve the vision for Barking and Dagenham there are five priorities that underpin its delivery:

1. Ensure every child is valued so that they can succeed

- Ensure children and young people are safe, healthy and well educated
- Improve support and fully integrate services for vulnerable children, young people and families
- Challenge child poverty and narrow the gap in attainment and aspiration

2. Reduce crime and the fear of crime

- Tackle crime priorities set via engagement and the annual strategic assessment
- Build community cohesion
- Increase confidence in the community safety services provided

3. Improve health and wellbeing through all stages of life

- Improving care and support for local people including acute services
- Protecting and safeguarding local people from ill health and disease
- Preventing future disease and ill health

4. Create thriving communities by maintaining and investing in new and high quality homes

- Invest in Council housing to meet need
- Widen the housing choice
- Invest in new and innovative ways to deliver affordable housing

5. Maximise growth opportunities and increase the household income of borough residents

- Attract Investment
- Build business
- Create a higher skilled workforce

AGENDA

1. Apologies for Absence

2. Declaration of 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 - 5 November 2013 (Pages 1 - 8)

Business Items

4. Healthwatch: The First Six Months (Pages 9 - 14)

5. Changes in the population of Older People in Barking and Dagenham (Pages 15 - 30)

6. The Care Bill: Adult Social Care Funding (Pages 31 - 40)

7. CCG Commissioning Plans 2014/15 (Pages 41 - 46)

8. Delegated Authority Request for Public Health Service Contracts (Pages 47 - 57)

9. Health & Wellbeing Outcomes Framework Performance Report - Quarter 2 (2013/14) (Pages 59 - 78)

10. Autism Self Assessment Framework and Autism Mapping Project (Pages 79 - 101)

11. Urgent Care Board: Update (Pages 103 - 106)

12. Engagement Strategy & Mechanisms: Update (Pages 107 - 115)

Standing Items

13. Sub-Group Reports (Pages 117 - 127)

14. Chair's Report (Pages 129 - 135)

15. Forward Plan (Pages 137 - 140)

16. **Any other public items which the Chair decides are urgent**
17. **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.***

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

MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 5 November 2013
(4:05 - 6:15 pm)

Present: Councillor M M Worby (Chair), Councillor J L Alexander, Councillor L A Reason, Anne Bristow, Helen Jenner, Frances Carroll, Martin Munro, Conor Burke and Chief Superintendent Andy Ewing, and John Atherton

Also Present: Cllr C Geddes

Apologies: Councillor J R White, Dr Waseem Mohi, Dr John and Dr Mike Gill

56. Declaration of Interests

There were no declarations of interest.

57. Minutes - 17 September 2013

The minutes of the meeting held on 17 September 2013 were confirmed as correct.

58. Commissioning GP Premises

Neil Roberts (Head of Primary Care, NHS England) introduced the report to the Board. Neil Roberts explained the process by which requests for GP premises are dealt with. It was noted that the Primary Care Commissioning Team receives GP premises requests, once initial research has been undertaken the request is tested against NHS England's criteria and a Project Initiation Document (PID) is drafted. The PID is assessed by an internal screening group and if the request is endorsed the PID is passed to the Finance Investment Procurement and Audit Committee for approval, upon which a full business is developed.

The Board noted that NHS England is in the process of developing a national operating model similar to the framework described in the report which is being used by the London region in the interim.

The Board asked if NHS England took account of the need to prioritise access to GP services as in Barking and Dagenham there is a high number of single-handed practice or some premises that are in poor physical condition. The Board was advised that accessibility is part of the fuller list of criteria that will be used once the national operating model is in place. Furthermore, NHS England will try to deliver the strategic aims for a local area and take account of CQC ratings of practices, therefore issues around access to GPs would be taken into consideration.

The Board asked what role the Primary Care Commissioning Team plays when leases for GP premises are coming to an end. Although responsibility for re-procuring premises rests with the contractor NHS England is able to influence the process and make suggestions.

The Board asked whether local regeneration plans are used as an evidence base from which to make decisions or ensure provision of services in a community. Neil Roberts advised the Board that when NHS England took over responsibility for commissioning GP services local regeneration plans were not handed over. The Board was very disappointed that NHS England was not briefed on local regeneration plans and that there is little clarity as to how NHS England engages with stakeholders in its current procedures. Neil Roberts encouraged local authorities to approach NHS England to make them aware of key regeneration plans in their area. Again the Board was disappointed as they would have expected NHS England to be more pro-active in their approach and to make use of information that was already in the NHS' possession.

Conor Burke (Accountable Officer, B&D CCG) commented that the development of the CCG's five year commissioning strategy is a good opportunity to join up the borough's regeneration plans with the planning of local health services so that in future the commissioning of GP services, and their premises, is dovetailed with local plans and strategies.

The H&WBB agreed to:

- Note the current approach to premises investments and consider how this approach applies locally.
- Note the position of NHS England in developing an overarching Premises Policy.

59. The 0-5 year Healthy Child Programme (Health Visiting) Service

Nicky Brown (Commissioning Manager, NHS England) introduced the report to the Board.

The Board asked if funding for the Health Visitor (HV) posts was guaranteed. It was explained that the cost pressure of recruiting additional Health Visitors is guaranteed. However, if HV posts are unfilled after the transition process finishes in April 2015 then funding for those posts will be lost. The Board sought clarity on this issue as it would be problematic for local authorities to assume responsibility for commissioning HVs without the necessary funding to recruit the workforce needed to deliver the service.

It was noted that NHS England is trying to reduce provider's dependency on agency HVs as these are more expensive than permanent staff. The commissioning arrangements encourage providers to reduce their vacancy rates by releasing funding once its use of agency staff is below a target percentage.

The Board raised concerns with regard to safeguarding as a minority of children do not receive a health visit within the first 2 years of life. It was confirmed that 6% (roughly 3,000) of children in Barking and Dagenham were not in receipt of a health visit within the 14 day target. The Board stressed the importance of reaching families early to give support and to ensure that children get the best start in life. Safeguarding and performance issues related to the HV programme will be discussed at the Children and Maternity Group.

The Board noted that the MESCH programme (described in Appendix 2) will be

taken forward by a dedicated officer within the CCG. Nicky Brown confirmed that funding is in place to give to the CCG to make the appointment.

The H&WBB agreed to:

- Note the progress against the Health Visitor Implementation Plan is on track to deliver the required outcomes and outputs and that in order to do so the service is undergoing significant service redesign.
- Note the progress being made to deliver the national programme, which will considerably increase Barking and Dagenham's health visiting workforce by 2015, enabling NELFT to develop the capacity to deliver the Healthy Child Programme within the context of an integrated model with a view to improving children's health outcomes and reducing demand for targeted services.

Further to the recommendations in the report, the Board agreed to:

- Receive a report at its meeting of 25 March 2014 to explore the transition arrangements for the handover of commissioning from NHS England to the Council.

60. Public Health Commissioning Priorities 2014/15

John Currie (Commissioning Manager) presented the report to the Board. It was noted that a final commissioning plan will be submitted to the Board in February for approval.

Anne Bristow (Corporate Director, Adult and Community Services) advised Board Members to be aware that a large portion of Public Health Grant will be used to fund mandated services. Therefore, Board Members should give particular consideration to the non-mandated services/programmes that can be funded through the grant to fulfil the Health and Wellbeing Strategy priorities and deliver the JSNA recommendations. Anne Bristow requested that Public Health's commissioning plan for 2014/15 reflects the Board's objective to tackle obesity. Cllr Worby (Chair of the Board) wanted Public Health to develop industrial scale interventions in response to the borough's health profile.

The Board was asked to think about how difficult decisions will be reached with regard to disinvestment and be ready to decommission services that do not deliver the desired outcomes for residents. Also there is a balance to be struck between maintaining funding levels in areas where performance has markedly improved and that re-allocating funding to other areas.

Conor Burke (Accountable Officer, B&D CCG) asked that partners are mindful of health and wellbeing priorities when conducting service reviews to find efficiencies. While value for money is important, commissioners should understand the relationships between services/programmes and the impacts of any re-modelling or disinvestment on wider service provision.

The H&WBB agreed to:

- Consider the priorities and set the strategic framework for commissioning public health programmes for 2014/15.
- Note that the next stage is to look at resourced delivery programmes, in respect of what is being done now, what could be stopped or done differently, and what else is needed to make a difference.

Further to the recommendations in the report, the Board agreed to:

- Task the Public Health Programmes Board to evaluate the success/impact of public health communications campaigns to see whether target audiences have been reached.

61. Children and Families Bill

Helen Jenner (Corporate Director, Children's Services) gave a presentation to the Board. The Board raised the following comments or issues in response to the report and presentation slides:

- Mediation is strengthened by the Bill. This should result in fewer Special Educational Need (SEN) tribunals which can be a difficult process for families to go through.
- The Council currently provides more than the statutory minimum in terms of transport assistance for young people. It may be difficult to maintain this offer as budgets shrink and responsibilities grow.
- The Bill is contradictory in that it encourages young people to have personal budgets but at the same time Health and Care Plans will have very specific requirements.
- The Bill does not marry well with some provisions of the Care Bill. The Children and Families Bill puts emphasis on a local offer of services whereas the Care Bill puts emphasis on national standards. Furthermore, the Care Bill tightens eligibility criteria for adult social care meaning that when a young person moves from children's social care into adult social care there is a possibility that the overall care package will be a smaller offer. This will naturally undermine the transition elements of the Children and Families Bill.
- During the transition process the wishes of the young person and their parent/carer may be at odds. This could be a challenge for agreeing a Health and Care Plan.
- Where schools are not under the control of the local authority it will be harder to achieve consistency in terms of the SEN offer.

The H&WBB agreed to:

- Support the integrated project team
- Endorse the direction of travel

- Receive regular updates on progress against the Project Plan, particularly through the Children and Maternity Sub-Group.
- Support the input from across the partnership to a Local Offer

Further to the recommendations in the report, the Board agreed to:

- Develop a Local Offer on a page to make the document more accessible to a wider readership.
- Circulate the Local Offer consultation documents to Board Members prior to the start of the formal consultation with members of the public.

62. The Care Bill

Anne Bristow (Corporate Director, Adult and Community Services) gave a presentation to the Board. The Board raised the following comments or issues in response to the report and presentation slides:

- The nurturing of social enterprises will be important to create a vibrant market for users of personal budgets.
- Much of the political debate around the funding reform has focussed on elderly people and the protection of their assets. There has been less consideration given to how the new funding system will work for younger working age adults.
- The borough will need to develop independent financial advice services to help people who need to contribute to their care package and explain options such as deferred payments.
- It is anticipated that in April 2016 there will be a major surge in demand for care assessments. It will be important that the assessments are thorough and attention is paid to the eligibility criteria to ensure that the Council can afford to meet the needs of those who require a care package.
- Portable Care Accounts will prove challenging as it will be difficult to keep accurate records for people who have been in the system for a long time or have moved home to become the responsibility of another local authority.
- Healthwatch will have an important role to play in helping residents to understand the Bill and its impacts on their care and support.

The H&WBB agreed to:

- Note the wide ranging implications of the Care Bill and the steps being taken to prepare for the Bill by the local authority.
- Agree on how the Health and Wellbeing Board might respond to the Bill and prepare for its implementation over the coming year.

- Note the opportunity to attend a workshop on the legal implications of the Care Bill (para 5.1).

63. Integration Transformation Fund 2015/16

Conor Burke (Accountable Officer, B&D CCG) introduced the report to the Board. The Board raised the following comments or issues in response to the report.

- Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. This plan will need to be agreed by the Health and Wellbeing Board before March 2014.
- Integration must improve patient outcomes. Pooling resources and working jointly is the mechanism for integration but the borough must not lose focus on making a difference to the patient experience. Bureaucracy and getting lost in planning should not get in the way of service re-design and system change.
- Although health and social care services for 18 to 25 year olds are not an explicit priority listed in the report there is a priority to integrate service delivery for families with complex needs which would include this age group.
- The CCG is on a journey towards personal health budgets. This will take time to become embedded.
- Year-on-year budget cuts and the redeployment of funds is a big challenge. Bringing together commissioners will undoubtedly bring improvements to integration but because the ITF is made up of existing funding streams (not new ones) there will be difficult choices ahead and perhaps sacrifices in some areas. It is important that when budgets are pooled the result is better efficiency rather than a loss of overall funds.
- 25% of the ITF is tied to performance against outcomes set out in the local joint plan.

The H&WBB agreed to:

- ask relevant officers within the CCG and local authority to draft and prepare the plans for discussion at a future Board and submission to the Department of Health.
- Task the Integrated Care Sub-Group to lead on both the development of the plan and any subsequent monitoring and reporting to the Board, together with any implications.
- Note the opportunities alongside the implications for disinvestment
- Note that a further report will come to the Board with the draft two year plan in February 2014.

- Consider the draft shared priorities in (2.2) that will form the basis for concrete proposals to be considered at a future meeting.

64. Learning Disability Joint Health and Social Care Self Assessment Framework

The H&WBB agreed to:

- Note the initial findings from the Joint Health and Social Care Self-Assessment Framework (JHSCSAF);
- Note there are areas that have been self-assessed as 'less effective' at this stage, and require the Learning Disability Partnership Board to report back with an improvement plan to tackle these areas to a future meeting.

65. The Francis Report

The Board noted the report. Further to the recommendations in the report, the Board agreed to:

- Conduct a peer review exercise with another London Borough to get external validation of the borough's response to the Francis Report recommendations.
- Receive the full implementation plan for the Francis recommendations at a future meeting of the Board.

66. Tender of Specialist Domestic Violence Services

The H&WBB agreed to:

- Approve the procurement of IDSVA community based provision and supported Accommodation, on the terms detailed in the report; and
- Delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer, LBBD to award the contract to the successful contractor upon conclusion of the procurement process.

67. Diabetes Scrutiny: Update on Delivering the Recommendations

The H&WBB agreed to:

- Indicate timescales for completion or progression against recommendations/actions for the benefit of those monitoring of the action plan.
- Schedule a further progress report to the 25 March meeting of the Board so that a fuller end of year summary of progress can be presented to the HASSC in the new municipal year.

68. Sub-Group Reports

The H&WBB noted the reports of the Sub-Groups. The Children and Maternity Group asked for clarity on the criteria for escalating performance issues to the Board.

The Board agreed that issues should be escalated when the Sub-Group believes it can no longer make a difference to performance in an area or when improvement has stagnated or declined over the period of two reporting quarters.

69. Chair's Report

The H&WBB noted the Chair's Report.

70. Forward Plan

The H&WBB agreed to:

- Note the content of the Forward Plan
- Circulate the most up-to-date version of the Forward Plan to Board Members in light of changes arising since the publication of the Plan in the agenda pack.

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Healthwatch: The First Six Months		
Report of the Healthwatch Barking and Dagenham Board			
Open Report	For Information		
Wards Affected: NONE	Key Decision: NO		
Report Author: Marie Kearns, Chief Executive, Harmony House	Contact Details: Tel: 0208 526 8200 E-mail: mkearns@harmonyhousedagenham.org.uk		
Sponsor: Frances Carroll: Chair of Healthwatch Barking and Dagenham.			
Summary: Further to the setting up of the Healthwatch Barking and Dagenham team and Board and the presentation of their work plan for the year, this report is for Members to appraise the progress made so far. It identifies the changes made to service delivery as a result of planned work undertaken by the local Healthwatch team. The topics which people most frequently and freely comment on are G.P. appointments and both urgent and non-urgent care at Queen's Hospital.			
Recommendation(s) The Health and Wellbeing Board is recommended to agree: (i) Consider the report noting the progress made to date			
Reason(s) To bring to the attention of the Board trends in public opinion with regard to health and social care services of Barking and Dagenham. To advise the Board of any identified gaps in service provision and to be able to influence commissioning in a timely way.			

1. Background and Introduction

- 1.1. Healthwatch is an independent consumer champion for both health and social care. It exists in two distinct forms—Healthwatch England, at the national level and local Healthwatch, at a local level. Healthwatch England is a committee of the Care Quality Commission.
- 1.2. The aim of our local Healthwatch in Barking and Dagenham is to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided in the borough.
- 1.3. Healthwatch Barking and Dagenham has been in place since the 1st April 2013. Although an independent organisation, it is delivered through the general governance arrangements of Harmony House Community Interest Company. This has allowed us to develop more quickly than other Healthwatches that have first had to form themselves into charities or social enterprises. We began by transferring the staff from the Local Involvement Networks (LINKs), as they had employment rights under TUPE legislation, and we were pleased to have the benefit of their experience.
- 1.4. As required by the commissioners we have used the hub and spoke model as a way of engaging the community in our management and delivery processes. Local groups can become Healthwatch Associates. It is through this network that we feed out information such as the latest updates on the Care Bill and the Children and Families Bill. We now have 19 associate groups that cover a wide range of interests. These include Carers, the Alzheimer Society, the Diabetes network and the Translating and Interpreting services. Our associates also provide us with information from their members around their experiences of health and social care services.
- 1.5. In the first month we advertised for our new Board, and were able to attract a good cross section of the community. We have a chair and four executive directors with three further associate directors. The associate directors represent our associate groups whilst our executive directors are individuals who take responsibility for one of four areas on the board: older people, children and young people, health issues and social care issues.
- 1.6. One of the first Healthwatches in London to do so, Healthwatch Barking and Dagenham had its professional launch in May, attended by Patrick Vernon OBE from Healthwatch England. We have regularly taken our seat at the Health and Wellbeing Board and being represented at all of the Board sub-groups.

2. Public Consultation

- 2.1. In September Healthwatch had a public launch: an all day event at Vicarage field. Over 300 people were spoken to and given information about Healthwatch. On this occasion the majority of people were concerned about the closure of Broad Street Walk in Centre. A local pharmacist provided health checks for 100 people that included BMI assessments and blood pressure checks. Examples of other locally available activities, which boost health and wellbeing, were available such as a Yoga and Belly dancing demonstrations and head and hand massages. Further events are

booked to take place in the Heathway Shopping Mall and the Becontree Leisure Centre.

- 2.2. For our first year we have planned to have 19 Healthwatch stands in a variety of places across the borough. We have had 13 so far in libraries, supermarkets, medical centres, Children's Centres and Youth Club provision. In this way our volunteers and staff can approach a wide variety of people to give them information about Healthwatch and ask people for their experiences of services.
- 2.3. The majority of the 120 people consulted in this way have chosen to comment on G.P. services. Experiences reported are almost evenly split between positive and negative views. Just over half commented that services were generally alright with the remainder complaining of waiting too long for an appointment and even being told to go to A & E. There were individual reports of rudeness and an unidentified miscarriage.
- 2.4. Healthwatch Barking and Dagenham keeps in regular contact with people through an online chat site called Street life. Through this source people have mostly chosen to comment on services in Queen's Hospital. There have been 10 recent posts commenting on waiting times for both urgent and non-urgent care. One man reported waiting seven hours to be discharged from a ward. There are also several complaints about the signage in Queen's hospital suggesting that it is difficult to find wards or where patients have been taken to.
- 2.5. Healthwatch undertook a large survey to ascertain public opinion on the proposed closure of Broad Street. The majority of the 200 people consulted said they would rather see their own doctor for urgent care if they could get an appointment in a timely way. As most believed this was not going to happen they wanted Broad Street to remain open. There was also a clear message that the public is confused about the variety of terminology used to describe urgent care settings and when it is appropriate to attend which setting. This report was sent directly to the CCG and copies given to the HWB and the Health and Adult Services Select Committee (HASSC). The response from Healthwatch Barking and Dagenham and others to the CCG consultation on the proposed changes to urgent care services resulted in change. The CCG has offered to make a minimum of 25,000 extra urgent appointments available later in the year, as part of new ways to provide care by family doctors.
- 2.6. Healthwatch has taken 75 calls from the public requesting advice and signposting. Almost a third of these calls have been people seeking benefit advice with the remainder asking advice with regards to complaints and other signposting requests.
- 2.7. Healthwatch Barking and Dagenham have developed a website which we use to provide the public with information. We also have a Facebook page and a twitter account.

3. Progress against the Annual Work Plan.

- 3.1. Healthwatch presented its annual work plan to the Health and Wellbeing Board in September. As well as our public consultation and signposting, we have completed three of our larger pieces of work, one of which was an Enter and View visit.
- 3.2. Having trained five of our volunteers to be Enter and View Authorised Representatives we undertook an Enter and View visit to the wards for Frail and Elderly patients in Queen's hospital. This was a planned visit; with the hospital have prior warning as to what areas we were interested in, and 20 days to feedback on the report. The Director of Nursing replied to our findings by saying that the hospital thought it to be a balanced and fair report and that the recommendations would be taken up in full. Some recommendations were minor including how food was served or the frequency with which patients were helped to clean their teeth, whilst others were larger and more radical. We have proposed and, it has been accepted, that patients who have personal carers at home can have those carers play a larger role during an inpatient episode. We feel this will be doubly beneficial as it will relieve a time pressure on the nursing staff and allow the patients with the most complex care needs to be supported by carers who understand their needs well. The hospital has forwarded an action plan showing how the recommendations have been put in place. We will follow up with an unannounced visit in the New Year. The full report will go to the Integrated Care Board. The Healthwatch Team and board believe this to be an example of best practice in showing how Healthwatch can bring users views to bear on how services are delivered.
- 3.3. Healthwatch has looked at the general dental health of children and young people in the borough and what their views are of the dental services available. Our findings here are broadly in line with the borough's JSNA for the numbers of young people accessing dental services. Of those that went they found the service to be easy to access and the practitioners friendly and reassuring. We found however, that there is still much work to be done in getting the 40% of all of the borough's young people, who do not attend the dentist, to understand the importance of regular dental care. The full report and recommendations will be going to the Children and Maternity and Public Health sub-groups.
- 3.4. At the request of the Health and Adult Social Services Select Committee Healthwatch has undertaken work on Diabetes care for children and younger adults. This has made slower progress as it has been difficult to identify and get feedback from service users of this age group. The Select Committee has been kept informed of our progress and challenges and the full report will be sent to them as well as the Integrated Care and Children and Maternity sub-groups.
- 3.5. The remainder of the work plan will go ahead as scheduled in the New Year.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

In developing our work stream Healthwatch Barking and Dagenham has been mindful of the content and data in the Joint Strategic Needs Assessment. In particular the work to be completed on the care of Stroke sufferers reflects the high priority and inequalities associated with this condition for people in Barking and Dagenham.

4.2. Health and Wellbeing Strategy

The topics chosen for the Healthwatch work plan all fall within the four priority themes of the Health and Wellbeing Strategy as highlighted when the work plan was first presented to the Board.

4.3. Integration

Healthwatch Barking and Dagenham is particularly interested in helping to promote integrated working between health and social care services. This is reflected in many of the topics we have chosen for our work plan such as Stroke Services, discharge of elderly patients from hospital and Diabetes services for children and younger adults. Our Enter and View of the hospital wards for the frail and elderly has resulted in carers, employed through personal budgets, being considered as an integrated part of the patients care from the time of admission.

4.4. Financial Implications

Healthwatch Barking and Dagenham is commissioned by the Local Authority and is funded until March 1015.

(Implications completed by: Marie Kearns Contract Manager for Healthwatch Barking and Dagenham)

Legal Implications

None at present

(Implications completed by Marie Kearns, Contract Manager for Healthwatch Barking and Dagenham)

5. Non-mandatory Implications

5.1. Safeguarding

All staff and volunteers of the Healthwatch team are given awareness training on safeguarding issues. A Healthwatch representative sits on the Adult Safeguarding Board.

5.2. Property/Assets

The board of Healthwatch Barking and Dagenham has chosen not to take on a permanent property from which to deliver the service. It was felt that having roving Healthwatch stands would allow more flexibility in the way we access all sections of the community.

5.3. Customer Impact

The entire Healthwatch programme is designed to have the maximum impact on the customers' experience of the health and social care services in Barking and Dagenham. By reporting back the views of the public to this and other relevant Boards we can ensure that consumer is at the heart of all decisions made about their health and wellbeing.

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Changes in the population of Older People in Barking and Dagenham		
Report of the Corporate Director of Adult and Community Services			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: NO	
Report Author: Dr Sue Levi, Consultant in Public Health Medicine		Contact Details: Tel: 0208 227 5343 E-mail: sue.levi@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary: The numbers and projected changes in numbers of older people in Barking and Dagenham have come under scrutiny for a number of reasons: <ul style="list-style-type: none"> • New and challenging resource allocations are being examined to see if they are consistent with demographic changes. • Integration of care for older people requires collaboration and sharing of knowledge concerning older people and their illnesses and needs. The number of people aged 65 or over will remain relatively static until 2018 when it will begin to rise. It is predicted that the number of women between 75 and 84 will fall and the number of men over 90 will rise.			
Recommendation(s) The Health and Wellbeing Board is asked to discuss and note the report, in particular, the future mid-term implications it may have for funding. To consider the impact of the numbers of older people and projected changes within the strategic framework for commissioning health and social care services over the next three years.			
Reason(s) Most other populations in London and England have expanding populations of people aged 65 and older because of improved life expectancies and ageing of the post war 'baby boomer' generation, born between 1943 and 1960, when more children were born than preceding or subsequent years. Somewhat unexpectedly, the number of women aged between 75 and 84 is expected to fall slightly in the next 5 years in Barking and Dagenham. National resources are frequently allocated on a 'per person' basis with a weighting, or increase, for increasing			

age. Consequently, funding may be expected to remain static if population change predictions are accepted.

1. Background

The numbers and relative proportions of older people in the London Borough of Barking and Dagenham appear to be changing. These changes are expected to have implications for the planning and provision of health and social care for older people. They could also result in changes in financial allocations by central government. Public Health were asked to examine those population movements and changes in detail, and to provide a briefing for local partners, structured so as to assist planning of future care and to help predict financial planning. This paper presents a range of analyses of the population, informed by analyses of local data by the Adult and Community Services Directorate, together with data and projections and migration data from the national Census, from the national Projecting Older People Population Information System (POPPI), and data on population flows, internal and external migration and community mapping from the Council's strategy team.

2. Financial allocations to the borough

The partners are currently reviewing health and social care resource allocations to ensure that planned future provision takes note of population changes and projections, and is equitable, while also continuing to respond rapidly to changing deprivation and the often poor health outcomes that are found locally.

2.1 Health Care Funding

The funding of health care in the borough is decided by NHS England, using a planned allocation formula based on weighted capitation. This involves:

- Each Clinical Commissioning Group's population;
- A weight, or adjustment, for need for health care services related to age (all else being equal, areas with older populations have a higher need per head);
- A weight, or adjustment for need over and above that due to age (all else being equal areas with poorer health have a higher need per head);
- A weight, or adjustment, for unavoidable costs due to location (e.g. higher unit staff costs and higher costs of land and equipment) plus the emergency ambulance cost adjustment (EACA).

Since the need for different types of health services varies, separate formulae are used by NHS England for general and acute, mental health, maternity and prescribing. These are combined to form their overall 'Need-Weighted Capitation Formula'.

2.2 Social Care Funding

In 2013/14 the Council's gross revenue budget requirement for general fund services totals £391m, including £58m for Adult Social Care. In addition, the Council receives substantial ring-fenced funding through the Dedicated Schools Grant (£216m) and the Housing Revenue Account (£107m).

The Council has a net budget requirement for 2013/14 of £178m (£48m for Adult Social Care); this is funded by a mixture of formula grant, specific grant, Council Tax and National Non-Domestic Rates.

Formula grant includes a relative needs formula which in the case of Older People has the following components:

- A basic amount per person aged over 65, either in households or supported by the authority in a care home
- An age top-up, including a factor for people aged 90 years and over
- A deprivation top-up
- A low income top-up
- A sparsity top-up
- An area cost adjustment.

Relative Needs Formulae are designed to reflect the relative needs of individual authorities in providing services. They are not intended to measure the actual amount needed by any authority to provide local services, but to recognise the various factors which affect local authorities' costs locally.

The Council is still under considerable financial constraints following the last Comprehensive Spending Review, which announced spending cuts of 30% over the four year period between 2011/12 to 2014/15. Further funding reductions and changes in the way local authorities are funded provide even greater challenges for the future.

Due to the constraints on funding the Council has had to make a number of very challenging decisions to deliver its priorities within a significantly reduced funding settlement. In 2012/13 approved savings of £2.2 million were achieved within Adult Social Care services, and a further £1.7m in 2013/14. Pre-agreed savings of £1.3 million are built into the social care budget for 2014/15.

The Integration Transformation Fund was announced in June 2013 within the Government's spending review. It was described as creating a national £3.8 billion pool for 2015/16 of NHS and Local Authority monies, and is intended to support an increase in the scale and pace of integration and to promote joint planning for the sustainability of local health and care economies. It should be stressed that these national resources are currently committed to existing core activity, and that changing services and spending patterns will take time. The Fund itself does not therefore address the financial pressures faced by local authorities and CCGs; nonetheless, the Government believes it can act as a catalyst for developing a new shared approach to delivering services and setting priorities. Details of how the scheme will work at national and local level have yet to be finalised. However, access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. It is anticipated that this plan will need to be agreed by the Health and Wellbeing Board before March 2014.

The 2015/16 formula for allocating the national pool is subject to ministerial decisions in the coming weeks. For indicative purposes it is however estimated that around

£14m would be included in the Integration Transformation Fund in Barking and Dagenham. This includes:

- Carers' breaks funding.
- CCG re-ablement funding.
- Capital grant funding (including the Disabled Facilities Grant).
- The existing transfer from health to social care.
- Additional monies from NHS allocations – this includes funding to cover demographic pressures in Adult Social Care and some of the costs associated with the Care Bill.

Based on the draft assumptions, in this borough approximately £3.7m of the £14m would be tied to performance against outcomes set out in the local joint plan. Further detailed work is needed to assess the full impact of the Social Care funding reforms for the Council in 2015/16 and beyond. This work will be overseen by the Care Bill Working Group.

This paper aims to help local partners with their planning and prediction of services, priorities and financial planning, by examining the borough's predicted population changes in detail and considering their implications for health and social care demand.

2. Population Measures

3.1 How the Population is Measured and Predicted

The population used for NHS resource allocation is the Clinical Commissioning Group registered population (CCG RP) which is currently around 203,000 (2012) and is inflated due to mobile London populations, and moved-out patients not re-registering with out-of-borough GP practices until they are ill. CCG RP is around 17,000 higher than accepted estimates of the resident population of 186,000. The GP registered population is then 'scaled back' to the Greater London Authority (GLA) and Office for National Statistics figures so that accurate population changes and projections can be made.

Council resource allocation is determined by the Office for National Statistics (ONS) population size counts. The most recent product includes:

- 2011 Census counts
- Death predictions – using age and sex standardised mortality calculations
- Inward and outward migration trends and predictions
- Fertility predictions and birth rates

Whilst these data will be reasonably accurate for 2012 and 2014 their accuracy will deteriorate with time and by 2020 there is a 4% discrepancy between ONS and GLA estimates of the over 65s and around a 13% discrepancy for the over 90s. For men, over 90, the GLA figure is higher but for women the ONS figure is higher. Hence there is minimal sum discrepancy.

The population predictions are intended as a guide and, it is for this reason, that they are updated nationally every year. The GLA population predictions, including the Strategic Housing Land Availability Assessment, have merit but the methodology is not used nationally for resource allocation.

3.2 What the Whole Population of Barking and Dagenham Looks Like

Figure 1 – Population Pyramid – comparison to London

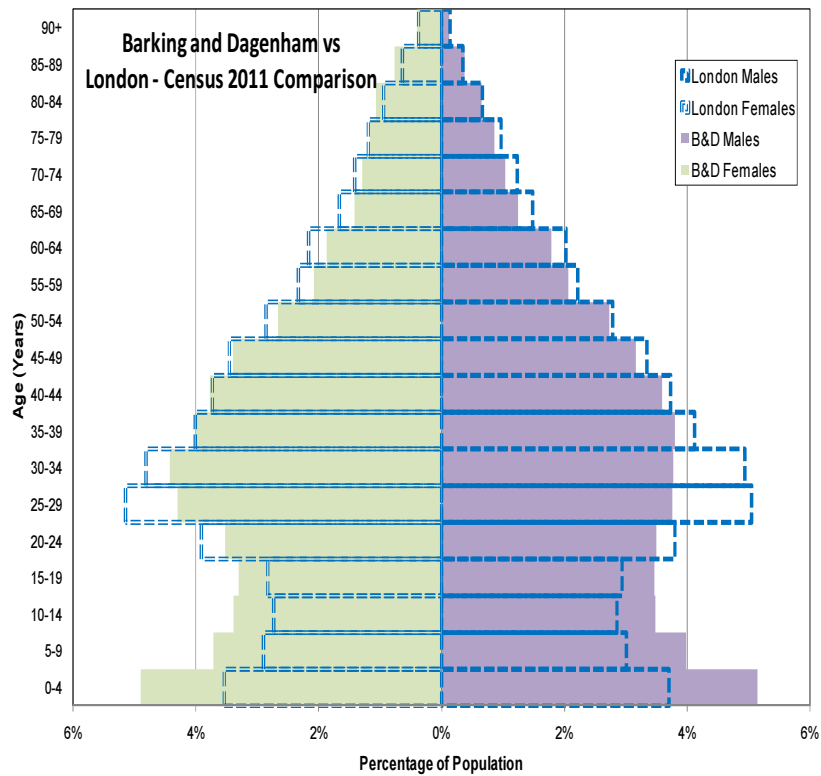
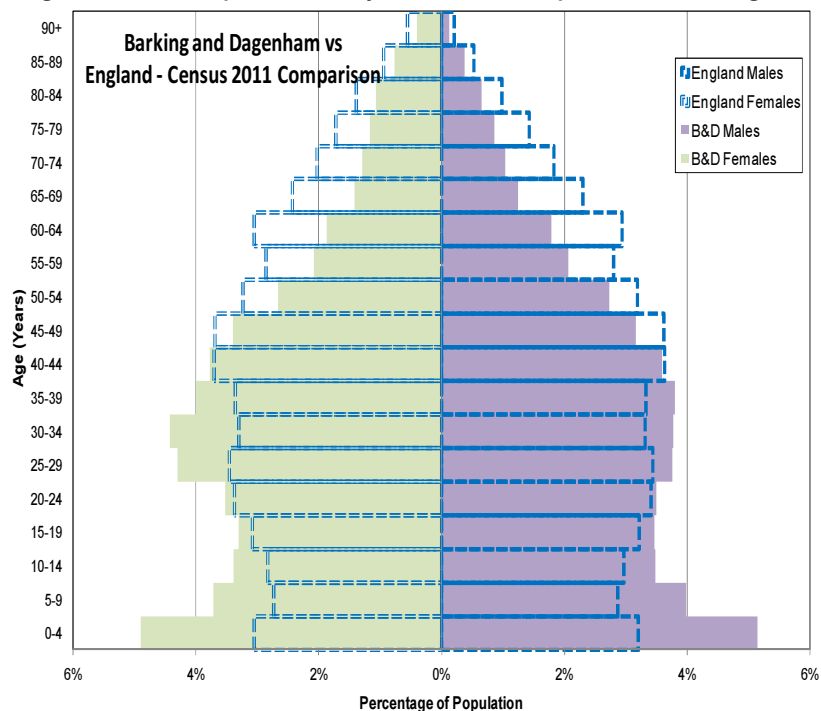


Figure 1a – Population Pyramid – comparison to England



Source: ONS Census 2011

The population distribution pyramids show that Barking and Dagenham has a lower proportion of people in each age band in the 65 year olds and over compared with London and very markedly so when compared with England.

This is a reflection of the high number of children and young families.

3.3 Numbers of 65 Year Olds and Over

This document and its analyses concentrate on 65 year olds and older. Choosing this age range is somewhat arbitrary as the difference between ‘Older People’ and people with Long Term Conditions and age related needs can become blurred and there is no clear threshold as:

- 50 year olds and over are eligible for Barking and Dagenham Active Ageing opportunities.
- 60 year olds and over are eligible for the free leisure offer including free swimming.
- 60 year olds and over are eligible for Oyster card free travel.
- The age for receipt of State Pension is currently 62 for women and 65 for men (as at November 2013) but will be 66 for both sexes by the end of 2020.

The board may wish to choose a different age range for future analyses.

Table 1: Over 65 population projections for Barking and Dagenham

	Census	2012 ONS projections					
AGE GROUP	2011	2012	2014	2016	2018	2020	Change %
MALES							
65-69	2,324	2600	2700	2800	2700	2700	6%
70-74	1,925	1900	1900	2000	2200	2300	23%
75-79	1,601	1600	1500	1500	1400	1500	-3%
80-84	1,204	1200	1200	1100	1100	1100	-4%
85-89	684	700	700	700	700	700	2%
90+	223	300	400	500	600	600	115%
Total	7,961	8200	8300	8500	8700	9000	10.0%

FEMALES	2011	2012	2014	2016	2018	2020	Change %
65-69	2,626	2800	3000	3000	3000	3000	7%
70-74	2,401	2300	2200	2300	2500	2600	12%
75-79	2,178	2100	2100	1900	1900	1900	-11%
80-84	1,999	2000	1800	1700	1600	1600	-19%
85-89	1,418	1300	1300	1300	1300	1200	-12%
90+	738	800	800	800	900	900	13%
Total	11,360	11300	11200	11100	11100	11200	-2%
Total	19,321	19500	19500	19600	19800	20100	3%

(Source – ONS 2012 Projections - numbers rounded to nearest 100 % change calculated from original figures at <http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/index.html>)

Projections suggest that the number of older people (65 years and older) will rise over the next 6 years, though this will happen slowly. The numbers of older men will increase year on year, while those of older women will remain fairly static, or fall very slightly. That slight fall in numbers of women is expected primarily in 75 to 84 year olds. The number of women aged between 65 and 74, and the over 90s is projected to increase slightly. The number of men aged over 90 is projected to double.

Information is presented in the section ‘The Effect of Aging on Needs’ (below) that shows that the over 85 year olds need at least 3 times as much social care support than 65 to 69 year olds. The borough social care needs are modelled in the section

‘People Needing Help with Self Care’ (below) to include this expansion of the number of over 85 year olds.

The decrease in the number of 75 to 84 year old women is not easily explained and may be due to a combination of anticipated life expectancies, population cohorts ageing and small scale geographical movements e.g. nursing homes slightly outside the borough etc. The aspect of premature mortality is being looked at in the Longer Lives work.

It is worth exploring issues around social care needs of those over the age of 90 as the literature suggests that this is one of the big concerns around the high need of people in this age group, whilst those in the 65-74 age group have a lower likelihood of need especially as access criteria may tighten.

3.4 Older People as a Proportion of the Overall Population

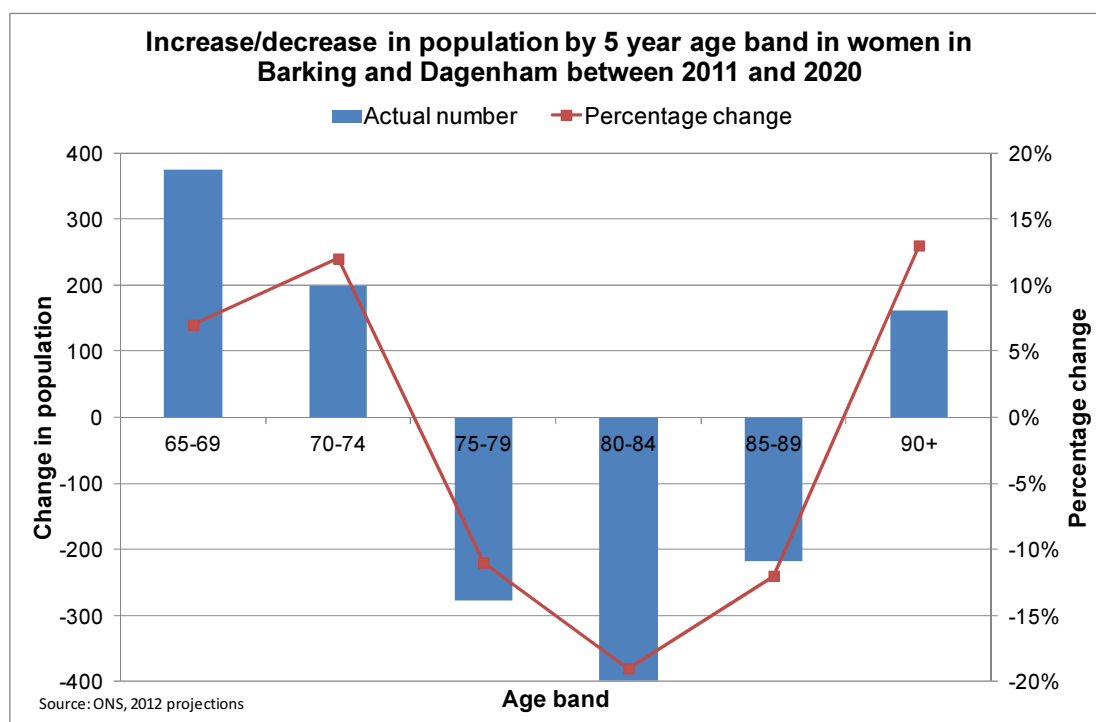
The proportion of the population over 65 years of age is projected to decrease progressively over the next 6 years, whilst the proportion composed of people aged over 85 looks set to remain the same.

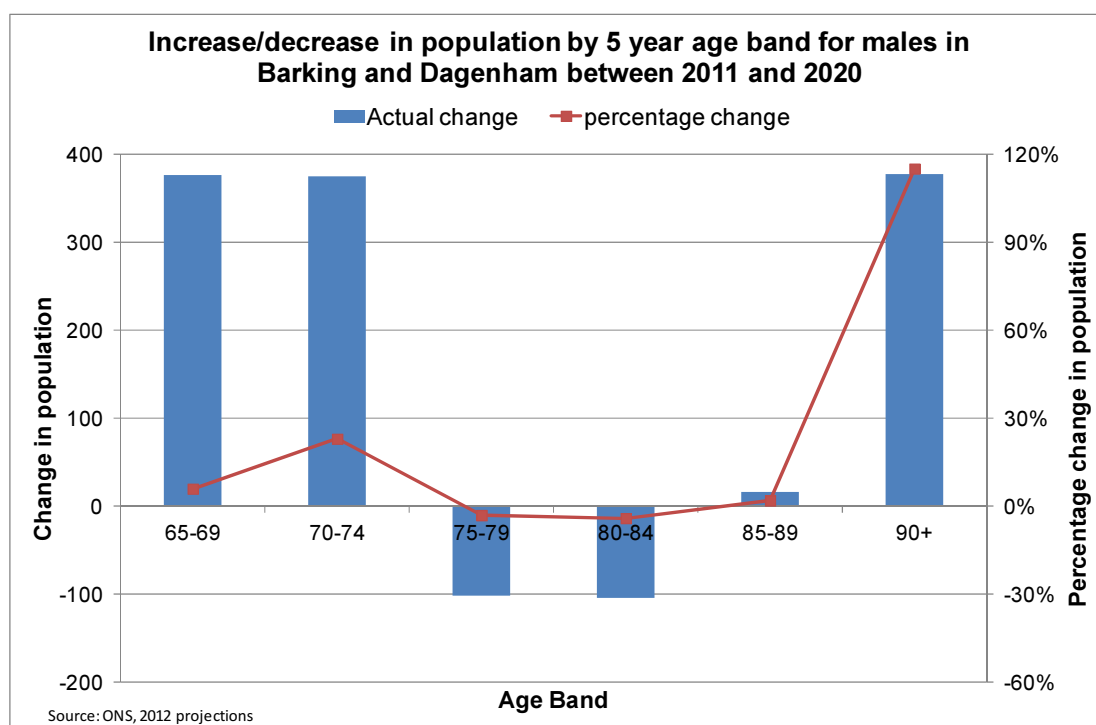
Table 2: Proportion of the Population in Age Bands

	2012	2014	2016	2018	2020
Total population	191,600	200,600	209,400	217,700	225,600
Population aged 65 and over	19,500	19,700	19,600	19,700	20,100
Population aged 85 and over	3,100	3,200	3,300	3,400	3,400
Population aged 65 and over as a proportion of the total population	10.2%	9.8%	9.4%	9.1%	8.9%
Population aged 85 and over as a proportion of the total population	1.6%	1.6%	1.6%	1.6%	1.5%

Source: POPPI (Projecting Older People Population Information)

Figure 2 – Changes in each age group





3.5 Black and Ethnic Minority Older People

There will be a substantial increase in the numbers and proportion of the 65 year old and older population from Black and Minority Ethnic groups. A number of conditions are more common among people from some of those groups e.g. diabetes, stroke, prostate cancer and sickle cell disease. These conditions may therefore become slightly more common as the population changes in relative ethnic composition. However, the use of resources is hard to predict.

Table 3: Change of Ethnicity ratios – 2012-2020 by Age/Sex band

Change in Percentage of Ethnicity of all over 65s 2012-2020

	Year 2012	Year 2014	Year 2016	Year 2018	Year 2020
BAME Males - number	1300	1500	1700	1900	2200
BAME Females - number	1300	1600	1900	2200	2500
Population over 65	19600	20000	20500	21000	21600
BAME Males (% of all persons over 65)	6%	7%	8%	9%	10%
BAME Females (% of all persons over (65)	7%	8%	9%	11%	12%

BAME Persons % of all persons over 65)	13%	15%	17%	20%	22%
--	-----	-----	-----	-----	-----

(BAME = Black and Minority Ethnicities)

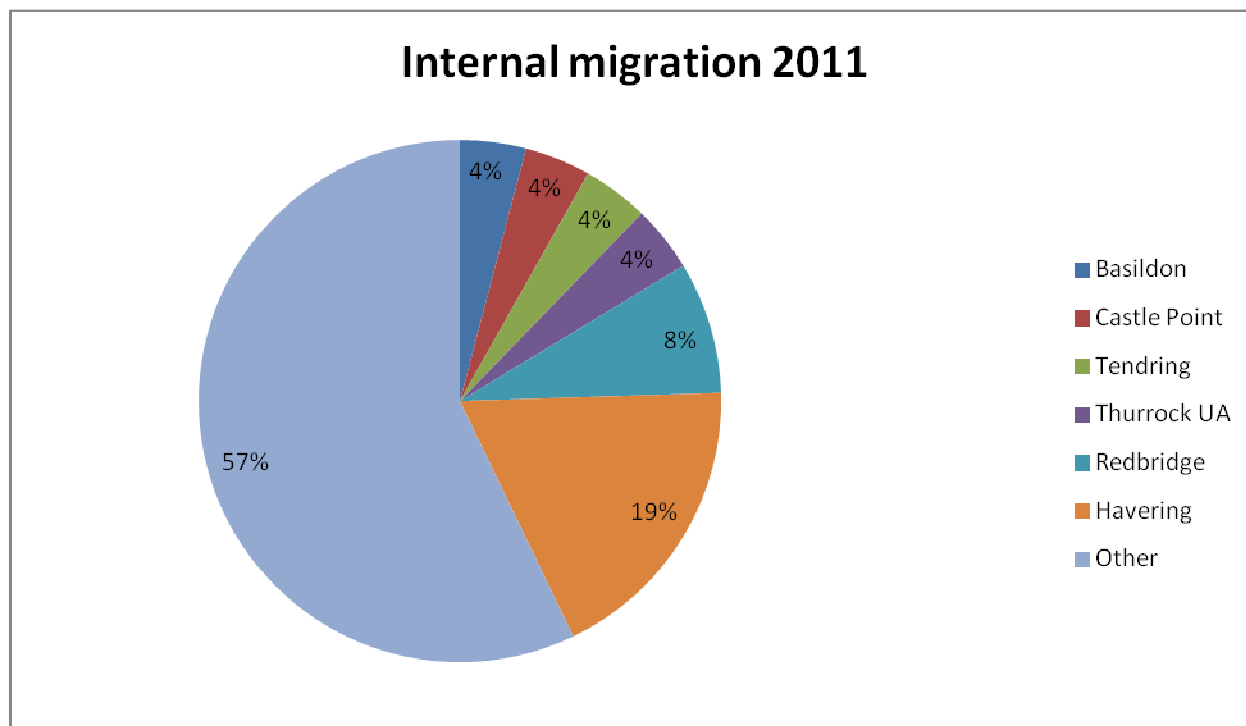
Source GLA 2012 Ethnic Group Population Projections – population figures rounded to nearest 100

3. Migration

According to the Office for National Statistics, in 2011, of the 11,400 people who moved out of the borough to other parts of England, only about 500 were over 65. In the same year, about 200 people aged 65 years and over moved into the borough, with the highest proportion of them coming from neighbouring boroughs. The chart below (Figure 3) shows the ‘destination’ boroughs with the highest numbers of ‘outflow’.

Hence, it would appear that internal migration of older people is small with a net change of 300 in-year leaving, out of a total over 65 population of 19,000 in 2011. This number might become important if it was consistent and in a discrete age band rather than across the ages over 65 years. It might be possible to examine migration by age at a future date.

Figure 3



4. Modelling care services that will be used by the Older Population

5.1 The Effect of Aging on Needs

A person’s requirement for formal support generally increases with age but is obviously influenced by other factors as well including informal support networks and cumulative health problems. For example, for older people needing assistance with at least one aspect of self care (bathing, washing, cutting toenails etc) the need is

almost 3 times as high in men older than 84 compared with those of 65 to 69. For women, the same figure is 3.5 times higher. For assistance with domestic tasks, over 85 year men need 4 times more support than 65 to 69 year old men. For women, 3 times more domestic support is required for the over 85s than the 65 to 69 year olds,

Age range	% males	% females
Needing assistance with self care		
65 to 69	18	21
85+	51	74
Needing assistance with domestic tasks e.g. shopping, changing light bulbs etc		
65 to 69	16	28
85+	68	82

The figures for self care requirements are generally higher in women than men for the same age groups and one of the suggested reasons is that women live longer than men so are more commonly living alone and have no partner to provide support.

5.2 People Needing Help with Self Care

The Adult and Community Services directorate provided data on service use to inform this paper. Recent levels of service utilisation within social care (see Table 4, below) show a fluctuating picture. However, no clear pattern of increase in needs for services could be discerned. There is a perception of increased demand for services which might be related to population ageing and higher needs per person after adjusting for the expectation of need for their age.

Table 4: Number of Episodes* of Service Receipt in a Financial Year

		Community Based Services	Residential Care Home Placements	Nursing Care Residential Placements	Total
2010/11	Age 65 and over	2795	465	235	3495
	2010/11 Total	3910	590	250	4750
2011/12	Age 65 and over	3445	475	240	4155
	2011/12 Total	5045	640	250	5935
2012/13	Age 65 and over	2920	400	255	3360
	2012/13 Total	4370	495	270	4890

Source: Local Social Care Data Collection

*this table represents episodes of care so a nursing home may have twice the number of episodes annually than it has beds.

The number of people in the borough needing care support e.g. with dressing, bathing etc is predicted to remain fairly static over the next 5 years. It is, however, projected to begin to rise around 2020. It might have been expected that requirements would increase progressively, but does not in fact appear to do so, because of the predicted reduction in the numbers of women aged between 75 and 84 years of age (see Table 5 below).

Table 5: People aged 65 and over unable to manage at least one self-care activity on their own, by age and gender, projected to 2020

	2012	2014	2016	2018	2020
Males aged 65-69	468	486	504	486	486
Males aged 70-74	361	361	380	418	437
Males aged 75-79	464	435	435	406	435
Males aged 80-84	396	396	363	363	363
Males aged 85 and over	510	561	612	663	663
Females aged 65-69	588	630	630	630	630
Females aged 70-74	690	660	690	750	780
Females aged 75-79	819	819	741	741	741
Females aged 80-84	1,060	954	901	848	848
Females aged 85 and over	1,554	1,554	1,554	1,554	1,554
Total population aged 65 and over unable to manage at least one self-care activity on their own	6,910	6,856	6,810	6,859	6,937

Source: Figures are taken from Living in Britain Survey (2001), table 35.

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the self-care activities listed, to 2020.

5.3 People Living in a Care Home

Data from the Office of National Statistics was analysed and predicts that there will in the future be a small increase in people living in care homes. This is mainly attributable to more of the people aged 85 years and over needing residential care

(see Table 6). Whilst these rises are expected to be small, they will nevertheless be likely to have considerable cost implications, since a high proportion of the local population will be needing assistance to fund their own care.

Table 6: People aged 65 and over living in a care home with or without nursing by local authority / non-local authority, by age, projected to 2020*

	2012	2014	2016	2018	2020
People aged 65-74 living in a LA care home with or without nursing	11	11	12	12	12
People aged 75-84 living in a LA care home with or without nursing	48	47	43	43	43
People aged 85 and over living in a LA care home with or without nursing	71	73	75	77	77
People aged 65-74 living in a non LA care home with or without nursing	29	30	31	31	32
People aged 75-84 living in a non LA care home with or without nursing	108	106	98	97	97
People aged 85 and over living in a non LA care home with or without nursing	162	167	172	178	178
Total population aged 65 and over living in a care home with or without nursing	428	434	432	438	439

Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S126 Type of communal establishment and sex by resident type and age.

*these are based on a single day snapshot so are lower figures than total year figures i.e. table 4

5. Healthcare Service Requirements

Most medical conditions become more frequent with age. For example dementia is more than 20 times more common in 90 year olds than in 65 to 69 year olds:

Age Range	% males	% females with dementia
65 to 69	1.5	1.0
90+	28	31

Because dementia incidence rises inexorably with age, there is very likely to be a progressive rise after 2018 in people in our borough suffering from dementia (see Table 7). Prior to 2018, the projected figures are likely to be fairly static. Again this is

highly influenced by the predicted decrease in the numbers of women aged between 75 and 84 years old.

Table 7: People aged 65 and over predicted to have dementia, by age, projected to 2020

	2012	2014	2016	2018	2020
65-69	67	71	72	71	71
70-74	114	112	117	128	134
75-79	218	213	200	195	200
80-84	388	362	338	325	325
85-89	406	406	406	383	383
90 and over	329	357	385	444	444
Total population aged 65 and over predicted to have dementia	1,522	1,520	1,518	1,546	1,556

Source: POPPI (Projecting Older People Population Information)

For most of the major life-limiting medical conditions e.g. Chronic Obstructive Pulmonary Disease (COPD), diabetes and heart disease – the number of sufferers over 65 is predicted to remain fairly static, and thus their use of health care is predicted to remain fairly constant. Even hospitalisations from falls - which is more directly related to age - is predicted to remain fairly constant (see Table 8 below).

The local picture is very different than the national picture where the number of people of 65 and over with diseases will increase dramatically. For example nationally the number of people with diabetes, over 65 years of age, will increase by almost 200,000 or 15% in 8 years whereas in this borough there will be only 80 more people or a 3% rise in prevalence in this age group.

Table 8: People aged 65 and over predicted to be admitted to hospital as a result of falls, by age, projected to 2020

	2012	2014	2016	2018	2020
People aged 65-69 predicted to be admitted to hospital as a result of falls	28	30	30	29	30
People aged 70-74 predicted to be admitted to hospital as a result of falls	39	38	40	43	45
People aged 75 and over admitted to hospital as a result of falls	364	364	350	350	350
Total population aged 65 and over predicted to be admitted to hospital as a result of falls	431	432	419	422	424

Source: POPPI (Projecting Older People Population Information) 2013

6. Ability of local residents to contribute financially to their own care

The relative proportion of more deprived households in the borough is much higher than in most boroughs in England and many other London boroughs. The proportion of our residents from the two lowest income quintiles makes up a large proportion of our borough's population. Thus the economic situation of a great many Barking and Dagenham residents is known to be worse than that of a number of other London boroughs, and quite a lot worse than much of England. Hence, when their income and assets are assessed against their care charges, our older residents can be expected or predicted to have to rely disproportionately on Council resources, relative to their own contribution. There also likely to be less income for the Council from people partially or completely self funding. This is likely to magnify the financial effect of increasing dependence among our borough's older population.

7. Conclusions

We predict that the total number of 65 year olds and over living in Barking and Dagenham will remain fairly static until 2018, at or around which point it is likely to show a small increase. This overall picture conceals changes in certain age groups. For example, the number of women aged between 75 and 84 in our borough is projected to decrease, whilst men over 90 are likely to double in number.

The need for services – for example, assistance with self care, dementia care, and hospital care for falls appears likely to be relative static until around 2018, at which point it appears likely to start to rise modestly.

A few health needs and related social care needs for life-limiting conditions may become more common, especially those related to the changing proportions of older people from Black and Minority Ethnic groups, for example prostate cancer and sickle cell disease are likely to increase in frequency in the over-65 year olds.

8. Mandatory Implications

8.1. Joint Strategic Needs Assessment

This document augments the demographic analyses in the JSNA and will be used in the next iteration of it.

8.2. Health and Wellbeing Strategy

The Health and Wellbeing Strategy emphasises the expansion of the child and youth population. Little attention was given to changes in the older people's population. This document expands on the demographic changes

8.3. Integration

Increasing integration of health and social care will require careful planning around numbers. With the release of details of the new Integration Transformation Fund there may be more necessity for very close attention of changing patterns of older people's health and social care usage.

8.4. Financial Implications

This report indicates that the number of older people living in Barking and Dagenham will remain fairly static until 2018. However, the increasing number of people aged 90 and over will need to be kept under review as this may have implications for adult social care in the longer term.

The report also sets some of the challenges facing the authority in delivering its priorities within a significantly reduced funding settlement, together with funding changes such as the announcement on the Integration Transformation Fund for 2015/16, and the potential impact of the Social Care funding reforms in 2015/16 and beyond.

(Implications completed by Roger Hampson, Group Manager Finance, Adults and Community Services)

8.5. Legal Implications

This report asks for the demographics to be noted and asks for contributions from partners. There are no legal implications arising from this report

(Implications completed by Chris Pickering, Principal Solicitor)

8.6. Risk Management

The danger is that resource allocation will not closely conform with population and disease level changes. This can be ameliorated by close attention to twice yearly population change figures.

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	The Care Bill: Adult Social Care Funding	
Report of the Corporate Director of Adult & Community Services		
Open Report	For Information	
Wards Affected: ALL	Key Decision: No	
Report Author: Anne Bristow, Corporate Director of Adult & Community Services	Contact Details: 020 8227 2300 Anne.Bristow@lbbd.gov.uk	
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services		
Summary: At its meeting in November 2013, the Health and Wellbeing Board received an overview of the changes outlined in the Care Bill and the perceived impact that they will have locally. The Board agreed to devote a substantial amount of time over the coming year to the Care Bill, particularly as more details become available and the detailed implications are worked through. The Board also agreed to receive reports on aspects of the Care Bill at alternate meetings over the next year. This report details the huge changes that will affect individuals, their families and partners in relation to social care contributions. These changes include a proposed £72,000 cap on care costs, financial support for those under substantially increased thresholds of assets, a universal deferred payment scheme and a standard contribution that individuals will be expected to pay towards their living costs (of around £12,000 a year). Section three of this paper discusses some of the issues that have been put forward locally in response to the proposals and it is suggested that these form the basis for a discussion at the Health and Wellbeing Board. A presentation will also be given at the meeting to build upon some of the details in this report and to show examples and case studies of how the funding reforms will affect people in Barking and Dagenham from 2015/16.		
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Note the wide ranging implications of the social care funding reforms put forward in the Care Bill for individuals, their families, the local authority and other partners; • Discuss some of the issues that have been identified locally in response to the funding reforms and think through how the Health and Wellbeing Board may help prepare for the changes, not only in constituent organisations, but also readying individuals and families in the Borough. 		

1. Background

- 1.1. The Care Bill is a far reaching piece of legislation, which whilst primarily introducing changes to the provision of adult social care will have significant implications for the local health economy as a whole, both financially and operationally. The Bill is currently moving through the parliamentary process, awaiting a date for its second reading in the House of Commons, and is expected to receive Royal Assent in mid-2014. However, key guidance on aspects of the legislation may not be available until much later in 2014.
- 1.2. A summary of the Bill and the expected implementation dates of key aspects of the Bill were discussed at the last Health and Wellbeing Board meeting in November, along with a first look at the impact that the Bill will have in Barking and Dagenham. The Board agreed to devote a substantial amount of time over the coming year to the Care Bill and to receive reports on aspects of the Bill at alternate meetings over the next year. The link to the initial Care Bill report in November and the minutes of the meeting can be found here:
<http://moderngov.barkingdagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7077&Ver=4>.
- 1.3. The focus for this report is that of the new arrangements proposed in the Care Bill for the contributions that Adults will be asked to make to their social care costs. This is arguably one of the largest changes put forward in the Bill and will have a significant impact both on local residents and their families, but also on the local authority and other partners.
- 1.4. The equitable and sustainable funding of social care has been a hotly debated topic; there have been many attempts to review the way in which social care is funded and how the costs of these services are shared between the individual and the state. This has included the review of adult social care legislation carried out by the Law Commission in May 2011 and the Dilnot Commission on Social Care report published in July 2011, which found that social care funding was unfair and unsustainable. The Care Bill is a response to the findings of the Dilnot Commission and many of Dilnot's proposals are being implemented in the new Bill. Please see **Appendix 1** for the government's response to the recommendations put forward by the Dilnot Commission.
- 1.5. This report will review the changes to Adult Social Care funding and contributions as well as the initial local response to these proposals which formed the Borough's response to a recent Department of Health consultation on the topic. These issues, which will be teased out further by an accompanying presentation at the December Health and Wellbeing Board meeting, will form the basis for a wider discussion about the funding reforms, their perceived impact and the preparations that the Board and its partners will need to take prior to implementation of the Bill in 2015/16.

2. Overview of the changes proposed

- 2.1. The following is a summary of the changes that are proposed in the Care Bill relating to social care funding:
- 2.2. **A cap will be introduced on the costs that people have to pay to meet their eligible needs (from April 2016).** The most significant of the changes relate to Dilnot's findings, with the aim of trying to make the cost of paying for care fairer. This

includes the introduction of a £72,000 cap on lifetime costs in respect of care, although this is less generous than commonly believed as individuals must first meet new national eligibility criteria. The cap is expected to be set at £72,000 in April 2016 for people of state pension age and over, and lower for working age adults. The cap will be reached based on the contributions of both the local authority and the individual.

- 2.3. **A 'Care Account' will be an up-to-date record of a person's accrued total care costs** and local authorities will be required to keep a care account for adults whose care costs are counted towards the costs cap. Once the cap is met, the local authority will be responsible for meeting the costs of care, excluding £12,000 in living costs per year (see para 2.4 below).
 - 2.4. It should be noted that free care will be given to people who turn 18 with eligible needs, however we do not yet know how the 'sliding scale' between 18 and 65 will be set for those developing eligible care needs well before their older age.
 - 2.5. **Financial support will be provided to more people to help them with their care costs (from April 2016).** This will help people with their care home costs if they have up to £118,000 in assets (including their home); the current threshold is £23,250. Where the value of someone's home is not counted as they continue to live at home, it is intended that financial support will be provided with care costs to people who have up to £27,000 in assets. As a result, all local authorities are likely to be asked to provide care support for increased numbers of individuals with eligible needs.
 - 2.6. **A standard contribution to living costs of around £12,000 a year will be set (from April 2016).** People in care homes will remain responsible for their living costs or 'hotel costs' when they reach the cap if they can afford to pay them, equivalent to £12,000 from April 2016. The hotel costs will not count towards the care cap.
 - 2.7. **A universal deferred payment scheme may be implemented (from April 2015).** This means that from April 2015 individuals will be given the option of deferring payments for their care until death to avoid selling their home. However, if individuals hold liquid assets in excess of an amount (to be determined), they may not be allowed to enter a deferred payment arrangement. Local authorities will be able to charge interest on these deferred payments.
 - 2.8. **A duty for local authorities to provide information and advice, particularly how to access independent financial advice (from April 2015).** Local authorities will be under a duty to provide care and support information from April 2015, including information on how residents can access independent financial advice to support financial planning.
- 3. Issues with the proposed funding reforms for the Board's consideration**
- 3.1. The Department of Health undertook a consultation to seek views on the funding reforms set out above to ascertain how changes to the funding system should be organised locally, with a view to informing the development of detailed policy and regulations and guidance (subject to the successful passage of the Care Bill through Parliament). The consultation asked many questions, particularly focusing on policy design, the technical implementation of deferred payment agreements and the new

charging rules, and asked for local opinions regarding the care cap and access to financial support. Responses were asked to be submitted by 25 October 2013.

- 3.2. The local authority submitted a response, informed by a consultation event in October that was held with social care managers and third sector partners and providers in October. The event clarified some of the thoughts on how the proposals may impact upon the Borough locally, and posed a number of questions which the Department of Health will need to work through in drawing up guidance.
- 3.3. The local response to the consultation can be summarised under the headings below and are useful in teasing out some of the issues posed by the proposals in the Care Bill. A presentation at the Board will build upon this response, using case studies and real life examples, to precede a discussion at the meeting.
- 3.4. The Health and Wellbeing Board are asked to consider the issues below and particularly think about how the Board can help to prepare local residents and their families for the changes and what partner organisations will need to do to support their implementation.

3.5. Information, advice and communication

- The public need to understand that these new changes have not made care free at the point of use, in the same way as the NHS. Thought needs to be given as to the way that the message is given nationally and locally, particularly relating to the costs and the contributions involved in social care. The Health and Wellbeing Board may play a focal part in how these messages are promoted in Barking and Dagenham.
- Some form of 'care cost calculators' (similar to the mortgage calculators available on banks' websites) would be helpful in order that residents can work out the level of contributions that they would be likely to pay. However, these tools should not replace face-to-face advice. ADASS and other sector leaders have been pressing Government for some form of standard 'tool' for the public to use to estimate their liability for the cost of care, along with some very clear messages about standard expectations of the new care system.
- The current availability of independent financial advice around social care options is limited and local authorities and by extension Health and Wellbeing Boards will need to work with national government, voluntary sector organisations and financial services organisations to ensure that people have access to the information and advice they need to make the right choices about their care and support.

3.6. Financial planning implications

- There are huge concerns that with many people not enrolled in a pension until auto-enrolment forced the issue, and with many understandable pressures on their income, residents will be unlikely to prioritise saving for their social care costs. There are issues here relating to how this will be communicated and what insurance products or auto-enrolment options will be put forward. One element put forward in our local response was whether tax incentives, much like pension tax relief, could be used as a good

incentive to take up recognised insurance products from the financial services market.

- It is also thought that more people will sign their properties over to their children in order to avoid care costs and it is not clear how the local authority would work through this issue if the universal deferred payment scheme was put in place.
- Finally, it has to be presumed that some legislative safeguards, similar to the existing deprivation of assets rules (which govern how local authorities treat people's 'running down' of their means-testable assets), would continue to apply.

3.7. Too much focus on residential care?

- There are concerns that the Bill places too much strength on residential care as a care option and that this may not facilitate a balanced approach when individuals and their families are making difficult decisions on care. This is also likely to run counter to the prevailing policy on increasing personalisation, choice and control, and moving care 'closer to home'.
- It is important that all partners in the local health economy are thinking carefully about their role in supporting good, sensible long-term care decisions and that they too are not encouraging individuals towards entering residential care when that may not be in their best interest. The Health & Wellbeing Board may have a key role in fostering the debates and discussions around professional practice and advice to respond to this, backed up by analysis of changing flows of people into residential care from, for example, hospitals.
- Overall, the funding reform debate is too focused on finance and charging and protecting assets and should also focus on care standards, quality and people choosing the 'right' care.

3.8. Regional variations in costs and assessment

- There are concerns that thresholds will be applied on a national basis and this may be based on national costs that might not apply to the cost of care provision in London. This also applies to the level of the 'daily living' allowance, which may differ across the country in terms of what seems reasonable. Issues such as the London Living Wage, the level of rents in London and the impact of welfare reform (including the 'bedroom tax') should be taken into account.

3.9. Implementation issues

- There is a very real concern about the provision of adequate resources to meet the expected spike in assessment activity. Current self-funders will now have an interest in coming forward for assessment in order that they begin to contribute towards the care cap from 1 April 2016. The Council has estimated an additional 5,600 assessments may need to take place in the period from 2015 to 2017 in order to assess hitherto unassessed needs. This will put pressure on resources for assessment activity and responding to identified need and will require a fundamental change in IT management systems.

- The changes will also have real resourcing issues for those in the third sector and in welfare benefits advisory roles as residents understand the funding reforms and consider how they impact upon them. It is also not clear how care contributions will link to other benefits. As an example, currently someone can be in receipt of attendance allowance but not meet local authority care thresholds and it is not clear whether there will be alignment on this in the future. It is similarly unclear how the contribution to living costs (maximum £12k) will be means-tested, bearing in mind that the basic state pension would be considerably less than this sum.

3.10. Queries regarding deferred payments

- Debates are currently taking place in parliament which has led to concerns that the deferred payment option will not be universal, but instead be available just for those with less than £27,000 in assets. The debate is focused on whether deferral would only be available to those whose assets to be protected are property-based, rather than cash savings for example.
- There are also lots of questions remaining on whether the living cost can be made deferrable as well as the care costs and how a charge on a property that underpins a care debt stands in relation to other debts and claims against the estate or the property. The local authority also has concerns that with mortgages being a 'first charge', and the care debt increasing over time, it would be concerning if there was a possibility of being unable to reclaim the full debt because the property has been remortgaged (or burdened with other secured debts) after care debts became secured against it.
- There will also be a risk that, should a property deteriorate in the years that the owner is in care, in some parts of the country the value of the property could drop below the outstanding debt.

3.11. The management of the Care Account

- The Care Account poses a number of challenges for local authorities, and tracking people's progress towards the cap will be a significant endeavour. For example, the question arises as to how the local authority will know of self-funders, and changes to their circumstances or care purchasing decisions, in order to keep the Care Account updated. Whereas those self-funding residential or nursing care can be relatively easily identified, in the community it will be more challenging. If there is no need of local authority support, they may well not proactively approach the council until a point at which their affairs take some time and work to clarify.
- The voluntary sector may prove to be a valuable source of information about self-funders, and some guidance to promote proactivity in sharing records may well yield valuable information that can allow the Council to act promptly to begin people's Care Accounts. Again, the Health & Wellbeing Board may have a facilitative role in this regard.
- There will need to be clear processes for taking the Care Account between different authorities. This raises the concern about where the Care Account is stored, and any national standards about record-keeping for the Account, which we would expect to see in regulations or statutory guidance.

4. Next Steps

- 4.1. As discussed at the last Health and Wellbeing Board meeting, the Council has set up a Adult Social Care Reform Programme Board to work through the implications of the Bill and prepare for its implementation. The Programme Board is meeting regularly and regularly reviewing communications that are coming from the Department of Health as well as the current debates that are taking place in the Houses of Parliament as the Bill moves through the process to Royal Assent.
- 4.2. It is hoped that the response from Barking and Dagenham to the Department of Health, along with similar responses from the Association of Directors of Adult Social Services, the Local Government Association, London Councils and other professional bodies will help shape the continued development of the funding reforms and the subsequent regulations and guidance. The local authority will continue to consult and work with partners, the third sector and other providers as further communications are made relating to the funding reforms and the wider Care Bill and these will be brought to the Health and Wellbeing Board for consideration.

5. Mandatory Implications

Joint Strategic Needs assessment

- 5.1. The Joint Strategic Needs Assessment currently describes demand for social care services based on current systems of provision and understanding of the future demography of the borough. New demographic projections have recently emerged and, together with the radical changes to the delivery mechanisms for social care which are set out in the Bill, substantial revision of the JSNA's analysis will be required as the implications are better understood.

Health & Wellbeing Strategy

- 5.2. The Health & Wellbeing Strategy sets out the Board's strategic intentions to 2015, which is when the majority of the Care Bill's implementation is due to commence. The next iteration of the Strategy will therefore need to deal in some detail with the future direction of social care services as part of an overall health and social care system. In parallel to this legislative development, there are significant moves towards greater integration of services which will also drive changes in the wider health and social care economy, and which will need to be core to the revised Health & Wellbeing Strategy.

Integration

- 5.3. Whilst integration is a significant policy driver around health and adult social care at present, the Care Bill is less clear on the contribution it will make to promoting integration. The underlying principle remains that social care services are chargeable and provided subject to a separate eligibility assessment, while the NHS is free at the point of delivery funded from general taxation. At its last meeting, the Health & Wellbeing Board also commented on the issues at the interface between the Care Bill and the Children & Families Bill, where young people with disabilities transfer into adult services.

Financial Implications

Completed by: Roger Hampson, Group Manager, Finance (Adults)

- 5.4. From April 2015, there will be a universal requirement for local authorities to offer deferred payment agreements to care users who meet certain criteria; and although the increased financial threshold and the cap on care costs do not come into force until April 2016, local authorities will face transitional costs in 2015/16. To meet these costs in 2015/16 the Government will be providing a £285m revenue grant. Of this, £110m is to cover the cost of deferred payments, and £175m is to cover the capacity building and early assessments required for transition to the capped cost model. In addition the Community Capacity Capital Grant, which will form part of the pooled Integration Transformation Fund in 2015/16, will include £50m for IT changes necessary for integration and funding reform. The amounts to be allocated to Barking and Dagenham from these national funds are not yet known.

Other policies in the Care Bill will also lead to additional costs, including new duties for the assessment and support of carers, better provision of information and advice, and a national minimum eligibility framework. Further detailed work is needed to assess the full impact of the Social care funding reform for the Council in 2015/16 and beyond, but preliminary estimates indicate a potential cost of £10m to £12m in 2016/17. This further work will be overseen at officer level by the Adult Social Care Reform Programme Board.

Legal Implications

Completed by: Dawn Pelle, Adult Social Care Lawyer

- 5.5. There are no further legal implications that have not been identified in the body of the report.

APPENDIX 1

Main recommendations of the Dilnot Commission and the government's response as detailed in the Care Bill 2013

Source: *The King's Fund, 'Paying for Social Care: Beyond Dilnot'*

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/social-care-funding-paper-may13.pdf

	Recommendation in Dilnot	Government response in the Care Bill
1	To protect people from extreme care costs, there should be a cap on the lifetime contribution to adult social care costs that any individual needs to make at between £25,000 and £50,000. Where an individual's care costs exceed the cap, they would be eligible for full support from the state.	Accepted – cap to be set at £72,000 from 2016, with a lower cap (to be decided) for working-age people.
2	To extend protection to people falling just outside of the means test, the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000.	Accepted – the upper capital threshold for means-tested support will rise to £118,000 from 2016/17 (equivalent to £100,000 in 2010/11 prices) and the lower threshold to £17,000 (equivalent to £14,250 in 2010/11 prices).
3	Those who enter adulthood already having a care and support need should immediately be eligible for free state support to meet their care needs, rather than being subjected to a means test.	Accepted – there will be a zero cap for people who turn 18 with eligible care and support needs.
4	Universal disability benefits for people of all ages should continue as now. The government should consider how better to align benefits with the reformed social care funding system, and attendance allowance should be re-branded to clarify its purpose.	The government has not commented on this recommendation.
5	People should contribute a standard amount – £7,000 to £10,000 yearly to cover their general living costs, such as food and accommodation, in residential care.	Accepted – from 2016 people in residential care should pay a contribution of around £12,000 yearly towards general living expenses (£10,000 in 2010/11 prices).
6	Eligibility criteria for service entitlement should be set on a standardised national basis – in the short term at substantial – to improve consistency and fairness across England, and there should be portability of assessment.	Accepted – the Care Bill makes provision for a national minimum eligibility threshold, to be in place from 2015 and the level to be determined through regulations.
7	The government should also urgently develop a more objective eligibility and assessment framework.	The government has said it will 'develop and test options for a potential new eligibility and assessment framework'.
8	To encourage people to plan ahead for their later life, the government should invest in an awareness campaign to inform people of the new system and the importance of planning ahead.	See below.

	Recommendation in Dilnot	Government response in the Care Bill
9	The government should develop a major new information and advice strategy to help when care needs arise, in partnership with charities, local government and the financial services sector. As proposed by the Law Commission, a statutory duty should be placed on local authorities to provide information, advice and assistance services in their areas, irrespective of how people's care is funded or provided.	Accepted – the government has committed to providing a 'clear, universal and authoritative source of national information about the health, care and support system'. The Care Bill places a new duty on local authorities to ensure that information and advice is provided locally, and the government is setting up an expert working group with financial services, local authorities and the care sector to support the development of an information offer.
10	Carers should be supported by improved assessments and have new legal rights as recommended by the Law Commission.	Accepted – the Care Bill contains new provision to strengthen the rights of carers.
11	The government should make a clear statement that disability-linked annuities are permissible under current pension taxation rules.	The government has said it will clarify the tax treatment of disability-linked annuities.
12	The current deferred payment scheme should be extended so that it is a full universal offer across the country.	Accepted – deferred payments will be available in all local authorities from April 2015, as reflected in the Care Bill.
13	In reforming the funding of social care, the government should review the scope for improving the integration of adult social care with other services in the wider care and support system – in order to deliver better outcomes for individuals and value for money from the state.	Accepted – taken forward through new powers and duties in the Health and Social Care Act 2012, through the Care Bill and through the forthcoming Common Purpose Framework.

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	CCG Commissioning Plans 2014/15		
Report of the Barking and Dagenham Clinical Commissioning Group			
Open Report	For Decision		
Wards Affected: ALL	Key Decision: NO		
Report Authors: Sharon Morrow, Chief Operating Officer	Contact Details: Tel: 020 3644 2370 E-mail: sharon.morrow@barkingdagenhamccg.nhs.uk		
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham CCG			
Summary: The following paper provides an overview of the strategic and operational planning process for Barking and Dagenham CCG for 2014/15 including a summary of the guidance provided to date, the key deliverables and timeline, and current information about the way the Integrated Transformation Fund will operate. It also includes the progress made in developing commissioning strategy and plans, in particular with the public and key stakeholders such as member practices.			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Note guidance and progress to date • Consider the commissioning plans of the CCG including the Integrated Transformation Fund at meetings in February and March 2014. 			

1. Background and Introduction

- 1.1. Each year NHS commissioners are required to refresh their strategic and operational plans to take into account changes in local needs, central planning guidance on requirements and annual financial allocations. The planning process and planning period develops year on year to reflect national policy. The first CCG commissioning strategy plan "Plan on a Page" was developed as a one year plan and signed off in March 2013.
- 1.2. The forthcoming planning cycle will be informed by central planning guidance and the CCG financial allocations are expected to be provided during the week commencing 16th December 2013. In advance of this being published, a number of guidance documents have been provided from NHS England setting out the

strategic direction and key areas that CCGs should take into account as they start to develop their plans.

- 1.3. At the heart of the planning process is the need to respond effectively to the Call to Action (NHSE) and Closing the Gap (Monitor) documents which make the case for developing ambitious and transformative plans that address the substantial financial challenges that the NHS will face over the next seven years. Involving patients and the public in key questions around sustainability and strategic transformation and working in partnership around a clear integration agenda will be crucial to delivering change.
- 1.4. The development of joint plans with the Local Authority for the further development of integrated services, funded through the Integration Transformation Fund, also form part of the CCG planning process.

2. The NHS belongs to the people - call to action

- 2.1. In July NHS England initiated a national campaign to engage with the public, NHS staff and politicians on the future shape of the NHS in order to meet rising demand, the introduction of new technology and meet the expectations of its patients. This is set against a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a funding gap which could grow to £30bn between 2013/14 to 2020/21.
- 2.2. The report summarises a number of future pressures identified that threaten to overwhelm the NHS including:
 - Ageing and growing population
 - Increasing number of people with long-term conditions
 - Lifestyle risk factors affecting younger people
- 2.3. The aim is to engage in an honest and realistic debate with the public about the future of the NHS and to use the output of that dialogue to drive the development of provider and commissioner strategic plans. The key questions in the debate include the balance between funding prevention services and acute care, the use of new technologies, 7 day working, improving patient experience and control of their own care and improving value.

3. National Guidance on planning process

- 3.1. For the forthcoming planning round commissioners are required to develop a five year strategic plan and two year operating plan that sets out in more detail the delivery plan for 2014-2016. The five year strategic plan is expected to cover an area (planning unit) that is based on existing health economies. The planning unit should have sufficient scale to deliver geography wide clinical improvements, enable the pooling of resources to reduce risk associated with large investments and not cut across existing collaborative agreements.
- 3.2. The planning unit for Barking and Dagenham CCG is the Barking and Dagenham Havering and Redbridge health economy. The establishment of the BHR Integrated

Care Coalition places the CCGs and boroughs in a strong position to take forward the development of a five year strategic plan. The local approach will be to use the existing BHR Integrated Care Steering Group as the Strategic Planning Group. There will also be a close alliance with the Waltham Forest, East London and the City (WELC) CCGs because of the contracting relationship with Barts Healthcare (who, for example, provide some of the maternity services for Barking and Dagenham).

- 3.3. Each CCG will develop its own two year operating plan that will reflect the delivery of the wider strategic plan. The strategic and operational planning process is expected to focus on improving outcomes with commissioners and providers working together to determine local levels of ambition for improvement against each domain of the NHS outcomes framework.

4. Integration Transformation Fund

- 4.1. The Local Government Association and NHS England published guidance on 17 October 2013 on how CCGs and councils should work together to develop their plans for the pooling of £3.8 billion of funding, announced by the Government in the June spending round, to ensure a transformation in integrated health and social care. Formal planning guidance on how the fund will operate will be published in December.
- 4.2. The arrangements for the Integration Transformation Fund (ITF) will be an integral part of the development of CCG strategic and operating plans and are considered to be a catalyst for developing an integrated approach to planning across health and social care. The Health and Wellbeing Board has received a separate report on the Integration Transformation Fund.

5. Key planning milestones

- 5.1. The planning timelines are set out below:

Milestone	Date
Planning Units identified	12 November
Final planning guidance	w/c 16 December
Allocations	w/c 16 December
1st submission	14 February
Contracts signed	28 February
Refresh of plan post contract sign off	5 March
Plans approved by Board	31 March
Submission of final 2 year plans and draft 5 year plan	4 April
Submission of final 5 year plan	20 June

- 5.2. Further reports will be made to the Health and Wellbeing Board at the meetings in February and March.

6. CCG commissioning intentions

- 6.1. The publication of CCG commissioning intentions forms part of the annual planning process and is aligned to the refresh of the CCG strategic commissioning plan. Commissioning intentions signal to providers and stakeholders the impact of plans to take forward CCG commissioning priorities on the following year contracts and the CCG operating plan
- 6.2. In advance of national planning guidance being published, the CCG has started to refresh the operating plan for 14/15, taking into account the refresh of the Joint Strategic Needs Assessment and local initiatives that have been developed over the last twelve months. Plans will be updated over the next few months and will include London and national operating framework priorities as these are made available.
- 6.3. Barking and Dagenham CCG maintains a continued commitment to improve the care and quality of health services that they commission for their residents, promoting care closer to home and service development in the community as reflected in their local and corporate objectives:

Local:

1. Improve health outcomes for children and young people in our borough
2. Improve access to and experience of primary care
3. Continue to focus on the development of our new organisation – our members, governing body and staff

Collaborative:

4. Improve the quality of care from all the services we commission
 5. Improve the performance of urgent and emergency care, with a particular focus at BHRUT
 6. Strengthen community services, bringing more services to people closer to home
- 6.4. High level commissioning intentions were approved by the CCG governing body in September and the CCG is in the process of engaging with stakeholders, patients and the public on their further development.
- 6.5. Further joint planning is taking place with the Local Authority to identify the range of services that will be commissioned through the Integration Transformation Fund in 2014- 2016. In addition discussions are taking place regarding the joint commissioning of other services including for learning disability services.

7. Stakeholder engagement

- 7.1. CCG draft commissioning intentions have been discussed at the following subgroups of the Health and Wellbeing Board:

- The Children and Maternity Group
- The Integrated Care Subgroup
- The Mental Health Subgroup.

7.2. Further engagement work is planned including a broader stakeholder event in January to be planned jointly with LBBD and other partners. This will build on ongoing engagement across a range of priority areas where strategies are in place or in development. This includes acute reconfiguration plans, integrated care strategy and associated delivery plans this year and 14/15 and a draft B&D urgent care strategy linked to the wider BHR system plans. Further work is needed to develop a planned care strategy, joint children's commissioning approach with LBBD, primary care strategy and to develop a clear view on a local strategy for cancer and CVD.

8. **Mandatory Implications**

8.1. **Joint Strategic Needs Assessment**

In developing commissioning intentions for 2014 -16 the CCG has taken into account the recommendations of the JSNA, with a particular focus on: commissioning high quality children and maternity services and improving integrated care for people with chronic conditions.

8.2. **Health and Wellbeing Strategy**

The CCG will ensure that the commissioning strategy supports the delivery of the Health and Wellbeing Strategy through the services it commissions and through partnership working with LBBD and other key stakeholders.

8.3. **Integration**

Integration is an important approach for the CCG. The CCG is building on the integrated health and social care cluster arrangements already in place in B&D by commissioning more integrated health services to provide better experience and outcomes for patients. The creation of the Integrated Transformation Fund will provide further opportunities for integrated care and strengthened commissioning arrangements.

8.4. **Financial Implications**

CCGs will receive two year financial allocations in December which will be allocated using a new national formula. It is expected that Barking and Dagenham CCG will lose funding as a result of the new formula.

The financial settlement for 15-16 will include the creation of the Integrated Transformation Fund (ITF) a ring-fenced pooled budget of £3.8 billion nationally to be committed locally with agreement of H&WB for investment in out of hospital care on the basis of £2 billion savings from current acute spending.

8.5. **Legal implications**

There are no legal implications at this stage. The Department of Health is considering what legislation may be necessary to establish the Integrated

Transformation Fund, including arrangements to create the pooled budgets. Government officials are exploring the options for laying any required legislation in the Care Bill. Further details will be available in due course. The wider powers to use Health Act Flexibilities to pool funds, share information and staff are unaffected.

8.6. **Contractual Issues**

The CCG operating plan will form the basis of contractual arrangements with the providers of health services for Barking and Dagenham.

9. **Background Papers Used in Preparation of the Report:**

- [Barking and Dagenham Joint Strategic Needs Assessment](#)
- [Barking and Dagenham Health and Wellbeing Strategy](#)
- [David Nicholson letter 10 October 2013](#)
- Anne Rainsberry letter 14 October to CCGs
- [LGA and NHSE letter 17 October on Integrated Transformation Fund](#)

HEALTH AND WELLBEING BOARD

12 DECEMBER 2013

Title:	Delegated Authority Request for Public Health Service Contracts		
Report of the Director of Public Health			
Open Report	For Decision		
Wards Affected: ALL	Key Decision: YES		
Report Author: Ross Kenny, Principal Public Health Specialist Health Care	Contact Details: Tel: 0208 227 2799 Email: Ross.Kenny@lbbd.gov.uk		
Sponsor: Matthew Cole, Director of Public Health			
Summary: Approval is sought from the Health and Wellbeing Board to delegate authority to the Corporate Director of Adult and Community Services, on the advice of Director of Public Health and the Chief Finance Officer to award the Public Health service contracts to the chosen General Practice and Pharmacy providers. Due to the unique position of General Practice and Pharmacy to delivery these programmes more cost and clinically effectively than alternative providers, a request will be made to waive the council tender process. As part of the transition of Public Health to the Local Authority, a number of programmes delivered through General Practice and Pharmacy (formally referred to as Locally Enhanced Services) were rolled over for 2013/14 under existing terms and conditions. These contracts have been refreshed to incorporate updated guidelines, best practice and to enhance local delivery models to be offered to providers for 2014/15. It is not intended or envisaged that one provider will be able to provide services up to £400,000 in value, however due to the aggregate value of the contracts (over £1million) and the request to waive the tender process, approval is being sought from the Health and Wellbeing Board.			
Recommendation(s) The Health and Wellbeing Board is recommended to: 1) Waive the requirement to tender the contracts for the health services noted in this report. 2) Agree that the Corporate Director of Adult and Community Services, on the advice of the Director of Public Health and the Chief Finance Officer awards the contracts to the providers identified, and in accordance with the procurement strategy outlined, in this report.			

Reason(s)

The services outlined below are currently not compulsory for General Practice and Pharmacy to deliver under their core contracts. It is therefore essential that these important preventative and early intervention programmes continue to be commissioned by the Council in order for the population of Barking and Dagenham to access the services from their primary sources of health care provision (General Practice and Pharmacy).

1. Background and Introduction

Prior to the transition of Public Health in April 2013, Public Health teams in Primary Care Trusts (PCTs) would commission General Practice and Pharmacy to deliver programmes beyond their mandatory 'core' functions. The contracts were commonly known as Locally Enhanced Services (LES) and covered a broad spectrum of programmes determined by the need and health outcomes of the population. These contracts have been refreshed (now referred to as Public Health Service Contracts) to incorporate updated guidelines, best practice and to enhance local delivery models to be offered to providers for 2014/15. The Council intends to continue to commission in 2014/15 the Health Check Programme, Chlamydia Screening, Smoking Cessation, contraceptive Intrauterine Devices (IUDs) and Contraceptive Implants, drugs shared care, supervised consumption and Pharmacy sexual health.

It is not intended or envisaged that one provider will be able to provide services up to £400,000 in value, however due to the aggregate value of the contracts (over £1million) and the request to waive the tender process, approval is being sought from the Health and Wellbeing Board.

2. Proposal and Issues

2.1. Rationale for tender waiver request

General Practice and Pharmacy are the preferred providers for the programmes due to the availability of patient data (for targeting and invitation), clinical expertise, patient trust and relationship and following up and management of any subsequently diagnosed conditions. These are all key requirements of the programmes which render alternative (non primary care) providers unsuitable.

Current legislation prevents any other provider viewing the patient's clinical record and inviting them for activities except for the national screening programmes or when the patient's explicit consent has been obtained. Hence, other providers could offer opportunistic testing of patients in libraries, shops, supermarkets etc but only GPs can use the patient's record to risk assess them and invite them for testing. Furthermore, alternative providers would have to return patient outcomes back to their respective GP which can (and historically has) resulted in delays in patient follow up and potential loss of information.

To replace the non GP-list based services a number of providers would need to be recruited to replicate the spread across borough. Each would be of relatively low volume and value which may prove difficult to attract alternative providers. Alternatively, larger volumes could be commissioned through non primary care providers but ensuring sufficient uptake is difficult due to securing suitable venues across the borough as well as gaining population trust in the provider. It is anticipated

that coverage would drop should alternative providers be commissioned while they became established in different configurations and venues. It is also important to note that the commercial rate for some of these interventions if delivered through an alternative provider may be 25 to 100% higher with no guarantee of greater population coverage.

It is therefore recommended that the contracts are offered to Barking and Dagenham primary care providers uncontested, waiving a full tender process.

2.2. Programmes 2014/15

Total Public Health Service contract value for 2014/15 = **£1,051,000 per annum.**

2.2.1. Health Check Programme (mandatory council function from April 2013)

- General Practice contract amount (should target be met) = £306,000 per annum.

Across the anticipated 40 providers, the payment per provider will range between £3,000 – £19,000 based on the number of checks provided with the median cost per provider being £6,800. Please note – these amounts are based on the expected number of providers choosing to deliver the service – should fewer providers take part then the those delivering will be set higher targets and therefore have increased earning potential. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

- Pharmacy contract amount (should target be met) including required testing kits = £50,000 per annum

Across the anticipated 8 providers, the earning potential per provider is expected to be circa £6,250 (including payment for consumables). Please note – these amounts are based on the expected number of providers choosing to deliver the service – should fewer providers take part then the those delivering will be set higher targets and therefore have increased earning potential. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

Total Health Check Programme contract cost = **£356,000 per annum**

2.2.2. Primary Care Level 2 Smoking Cessation (in addition to the smoking cessation service)

- 1000 validated quitters to be achieved through Primary Care (General Practice and Pharmacy) = £83,000
- Associate prescribing costs (responsibility of LBBDD from April 2014) = £231,000

Across the anticipated 62 providers (pharmacy and general practice), the average earning potential (including remuneration and reimbursement for prescribing costs) is expected to be circa £5065. Please note – these amounts are based on the expected number of providers choosing to deliver the service – should fewer providers take part

then the those delivering will be set higher targets and therefore have increased earning potential. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

- Total Primary Care Smoking Cessation cost = **£314,000 per annum**

2.2.3. Intrauterine Devices (IUDs) and Contraceptive Implants (General Practice only)

- Long Acting Reversible Contraception (LARC), which includes IUDs and Contraceptive Implants, provides an alternative to barrier and oral contraception which is less dependent on daily compliance. While LARCs can be accessed through sexual health clinics, it is most cost effective and better for patient access for the service to be delivered through General Practice.
- Anticipated contract cost based on 2012/13 and modelling data from 2013/14 = **£60,000 per annum**

Across the anticipated 29 providers (based on 2012/13) the average earning potential will range from £100 to £15,000. Please note – these amounts are based on the expected number of providers choosing to deliver the service – should fewer providers take part then the those delivering will undertake more procedures and therefore have increased earning potential. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

2.2.4. Shared Care (Drugs)

- The purpose of this programme is to deliver integrated care involving primary care teams, community pharmacists, dedicated clinical staff, and other health professionals to manage people with ongoing drug misuse problems. The implementation of this scheme will ensure that patients with drug misuse problems are effectively managed within the community setting and that they will have greater choice of and access to treatment services.
- Anticipated contract cost based on 2012/13 = **£77,000 per annum**

Across the anticipated 17 providers (based on 2013/14), the average earning potential is expected to be circa £4500. Please note – these amounts are based on the expected number of providers choosing to deliver the service as well as the number of patients requiring the service. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

- While this service is part of the Public Health service contract, the management and payment is overseen by the Adult Commissioning team and not directly by the Public Health team.

2.2.5. Chlamydia Screening

- The programme aims to increase the number of 15-24 year olds screened for Chlamydia through General Practice to promote early identification and treatment.
- Anticipated contract cost based on 2012/13 delivery = **£20,000 per annum**

Across the anticipated 47 providers (GP and Pharmacy based on 2013/14), the average earning potential is expected to be circa £400. Please note – these amounts are based on the expected number of providers choosing to deliver the service as well as the number of patients requiring the service. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

2.2.6. Pharmacy Sexual Health Service

- The objective of the service is to improve the sexual health of young people by integrating Emergency Hormonal Contraception (EHC), Chlamydia screening and provision of free condoms. This approach provides a bundle of complimentary services, with each component reinforcing a sexual health message that aims to prevent unplanned conceptions and subsequent abortions, screen for Chlamydia and provide free condoms.
- Anticipated contract cost based on 2012/13 = **£200,000 per annum**

Across the anticipated 17 providers (based on 2013/14), the average earning potential is expected to be circa £11,800. Please note – these amounts are based on the expected number of providers choosing to deliver the service as well as the number of patients requiring the service. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

2.2.7. Pharmacy supervised consumption (Methadone and Buprenorphine)

- The aim of service is to provide a supervised environment (pharmacy) for those receiving treatment for drug addiction to have managed doses of Methadone and Buprenorphine.
- Anticipated contract cost based on budget and delivery in 2012/13 and 2013/14 = **£24,000 per annum**

Across the anticipated 16 providers (based on 2013/14), the average earning potential is expected to be circa £1500. Please note – these amounts are based on the expected number of providers choosing to deliver the service as well as the number of patients requiring the service. Furthermore, should a model be adopted whereby one provider delivers the service on behalf of other potential providers, the earning potential will be substantially higher than the figure quoted above. Until the contracts are offered to providers and provider capacity to deliver is established, more accurate figures cannot be provided.

3. Consultation

The Director of Public Health has consulted with both the Local Medical Committee and the Local Pharmaceutical Committee during the process of establishing the commissioning intentions.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

The health topics addressed by the programmes above (Cardiovascular disease/diabetes detection, smoking, sexual health and contraception and substance misuse) are all outlined in the JSNA as areas where improvements can be made in Barking and Dagenham in terms of early detection and reducing prevalence. The above programmes play a significant role in improving outcomes across these key population health topics.

4.2. Health and Wellbeing Strategy

All of the programmes discussed in this paper for commissioning through Primary Care for 2014/15 and 2015/16 contribute to achieving the priorities of the Health and Wellbeing Strategy: Health Check programme (Prevention Theme priority 5), Smoking Cessation (Prevention Theme priority 1), Sexual Health (Protection Theme priority 5) and Substance Misuse (Prevention Theme priority 3).

4.3. Integration

The General Practice and Pharmacy prevention programmes are key elements of an integrated health care approach to tackling key health and wellbeing issues within Barking and Dagenham and provide wider access to services.

4.4. Financial Implications

(Implications completed by Roger Hampson Group Manager Finance, Adults and Community Services)

The total of anticipated contract costs is £1,051,000 in 2014/15 as set out in the table below and is within the available budget.

Contract	Anticipated Cost (£)
Health Check Programme	356,000
Primary Care Level 2 Smoking Cessation	314,000
IUDs and Contraceptive Implants	60,000
Shared Care (Drugs)	77,000
Chlamydia Screening	20,000

Pharmacy Sexual Health Service	200,000
Pharmacy supervised consumption	24,000
Total	1,051,000

4.5. Legal Implications

(Implications completed by Eldred Taylor-Camara, Legal Group Manager)

This report is seeking that the Health and Wellbeing Board (the “HWB”) waive the requirement, under the Council’s Contract Rules, to tender contracts noted in this report.

Under the Public Contract Regulations (the “Regulations”) health care services are classified as Part B services and therefore are not subject to the strict tendering regime set out in the Regulations. The Council however still has a legal obligation to comply with the relevant provisions of the Council’s Contract Rules and with the EU Treaty principles of transparency, equal treatment of bidders and non-discrimination.

Paragraph 4.7 of this report states that the waiver is sought on the grounds that the services to be procured are specialist services and that due to the current immaturity of the market limited alternative providers are available.

Contract Rule 4.2.1 states that the Council can waive the requirement to tender contracts, while Contract Rule 4.2.2.1 provides that a waiver may be granted where the services to be procured are of a specialist nature, and the Chief Officer considers that no satisfactory alternative is available. Furthermore, Contract Rule 4.2.2.3 provides that a waiver of the Council’s tender requirements can be granted on the direction of Cabinet/the HWB.

In deciding the geographic remit within which a contract should be tendered, guidance under the EU Treaty Principles require that procuring authorities consider whether the value of the procurement is likely to attract cross border interest from potential bidders. Officers have suggested in paragraph 2 of the Report that there would be no cross border interest due to the relatively low volume and value of the contracts and the need for the services to be delivered by local GPs and Pharmacies.

Information provided also in paragraph 2 of this report indicates that the projected aggregate values of each of the services range from £20,000 to over £300,000. These are the aggregate values available to all prospective providers. Contracts with individual providers will be in the region of £100 to £19,000, therefore the likelihood of cross border interest is minimal. The fact that the contracts are to be offered to all GPs and Pharmacies in the borough addresses the issues of transparency and equal treatment and therefore minimises the likelihood of a challenge by a potential bidder.

In agreeing the Recommendations the HWB needs to satisfy itself that reasons and grounds stated by officers in this Report satisfy the requirement for the issuing of a waiver.

4.6. Risk Management

There is a risk that should the programmes not be delivered through General Practice and Pharmacy this will effect delivery and subsequently the Health Premium

payments in 15/16 due to the reduced clinical effectiveness of delivery through an alternative provider as well as the limited number of alternative providers available.

4.7. Procurement Implications

4.7.1. Health Check Programme

(Implications completed by Martin Storrs, Strategic Procurement Manager)

Health check programme will be procured from the Boroughs GPs and Pharmacies on a voluntary take up basis. GPs will be offered Contracts via the Local Medical Committee and Local Pharmaceutical Committee and will be contractually committed to deliver an agreed number of Health Checks on a monthly basis.

GP's and Pharmacies will be contracted with utilising the Departmental of Health Contract that has been reviewed by LBBB Legal

This series of contracts is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a formal invitation to tender including an advert would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract rules.

A Waiver would be sought on the following grounds:

- a) Boroughs GP's and Pharmacies are best placed to deliver these specialist services
- b) GP's and Pharmacies have the advantage of holding the necessary patients records
- c) GPs and Pharmacies are best placed to collect and share the necessary patient information
- d) Currently an immature market with limited private and voluntary sector providers exists

4.7.2. Primary Care Level 2 Smoking

Primary Care Level 2 smoking will be procured from the Boroughs GPs and Pharmacies on a voluntary take up basis. GPs and Pharmacies will be offered Contracts via the Local Medical Committee and Local Pharmaceutical Committee and will be contractually committed to deliver an agreed number of smoking quitters on a monthly basis.

GP's and Pharmacies will be contracted with utilising the Departmental of Health Contract that has been reviewed and agreed by LBBB Legal

This contract is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a formal invitation to tender including an advert would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract rules.

A Waiver would be sought on the following grounds:

- a) Boroughs GP's and Pharmacies are best placed to deliver these specialist services
- b) GP's and Pharmacies have the advantage of holding the necessary patients records
- c) GPs and Pharmacies are best placed to collect and share the necessary patient information
- d) Currently an immature market with limited private and voluntary sector providers exists

4.7.3. Intrauterine Devices (IUDs) and Contraceptive Implants

Intrauterine Devices and Contraceptive Implants will be procured from the Boroughs GPs on a voluntary take up basis. GPs will be offered Contracts via the Local Medical Committee and will be contractually committed to deliver to an agreed service level.

GP's will be contracted with utilising the Departmental of Health Contract that has been reviewed and agreed by LBBB Legal

This contract is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a formal invitation to tender including an advert would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract rules.

A Waiver would be sought on the following grounds:

- a) Boroughs GP's are best placed to deliver these specialist services
- b) GP's have the advantage of holding the necessary patients records
- c) GPs are best placed to collect and share the necessary patient information
- d) Currently an immature market with limited private and voluntary sector providers exists

4.7.4. Shared Care (Drugs)

Shared Care (Drugs) will be procured from the Boroughs GPs on a voluntary take up basis. GPs will be offered Contracts via the Local Medical Committee and will be contractually committed to deliver to an agreed service level.

GP's will be contracted with utilising the Departmental of Health Contract that has been reviewed and agreed by LBBB Legal

This contract is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a formal invitation to tender including an advert would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract rules.

A Waiver would be sought on the following grounds:

- a) Boroughs GP's are best placed to deliver these specialist services
- b) GP's have the advantage of holding the necessary patients records
- c) GPs are best placed to collect and share the necessary patient information
- d) Currently an immature market with limited private and voluntary sector providers exists

4.7.5. **Chlamydia Screening**

Chlamydia Screening will be procured from the Boroughs GPs on a voluntary take up basis. GPs will be offered Contracts via the Local Medical Committee and will be contractually committed to deliver to an agreed service level.

GP's will be contracted with utilising the Departmental of Health Contract that has been reviewed and agreed by LBBB Legal

This contract is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a three documented quote process would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract Rules.

A Waiver would be sought on the following grounds:

- a) Boroughs GP's are best placed to deliver these specialist services
- b) GP's have the advantage of holding the necessary patients records
- c) GPs are best placed to collect and share the necessary patient information
- d) Currently an immature market with limited private and voluntary sector providers exists

4.7.6. **Pharmacy Sexual Health Service**

Pharmacy Sexual Health will be procured from the Boroughs Pharmacy's on a voluntary take up basis. Pharmacy's will be offered Contracts via the Local Pharmacy Committee and will be contractually committed to deliver to an agreed service level.

Pharmacies will be contracted with utilising the Departmental of Health Contract that has been reviewed and agreed by LBBB Legal.

This contract is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a three documented quote process would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract rules.

A Waiver would be sought on the following grounds:

- a) Boroughs Pharmacy's are best placed to deliver these specialist services

- b) Currently an immature market with limited private and voluntary sector providers exists

4.7.7. Pharmacy supervised consumption

Supervised Consumption will be procured from the Boroughs Pharmacy's on a voluntary take up basis. Pharmacy's will be offered Contracts via the Local Pharmacy Committee and will be contractually committed to deliver to an agreed service level.

Pharmacies will be contracted with utilising the Departmental of Health Contract that has been reviewed and agreed by LBBD Legal.

This contract is being let for a period of one year in order for Public Health to review the market place and consider alternative options e.g. Public and Private blend.

Due to the value and Part B nature of this contract a three documented quote process would be required however due to the nature of the service being procured a Waiver will be sought to waive the required Contract rules.

A Waiver would be sought on the following grounds:

- a) Boroughs Pharmacy's are best placed to deliver these specialist services
- b) Currently an immature market with limited private and voluntary sector providers exists

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Health & Wellbeing Outcomes Framework Performance Report - Quarter 2 (2013/14)		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: NO	
Report Author: Mark Tyson, Group Manager, Service Support & Improvement, Adult & Community Services		Contact Details: Tel: 020 8227 2875 E-mail: mark.tyson@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary: At its meeting of 16 July 2013, the Health & Wellbeing Board agreed the subset of performance measures that would form its regular Board reporting, from within the extensive set of measures agreed in the Outcomes Framework whilst the Board was in shadow form. The Board also agreed a dashboard format, and a format for reporting further detail on those indicators that required escalation, whether due to noteworthy success, failure to meet targets, or because they were deemed to be of particular policy significance. This report provides the performance update in line with that system for Quarter 2 (to September 2013). It also contains a summary of reports issued by the Care Quality Commission on Barking & Dagenham providers during the period.			
Recommendation(s) Members of the Board are recommended to: <ul style="list-style-type: none"> • Review the overarching dashboard, and raise any questions to lead officers, lead agencies or the chairs of subgroups as Board members see fit; • Note the further detail provided on specific indicators, and to raise any further questions on remedial actions or actions being taken to sustain good performance; • Note the information provided about Urgent Care and CQC activity in the period. 			
Reason(s): The dashboard was chosen to represent the wide remit of the Board, but to remain manageable. It is important, therefore, that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking further monitoring across the wider range of indicators in the Outcomes Framework.			

1. Background/Introduction

- 1.1. The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity. The performance framework is designed to provide this overview, and to provide on-going monitoring of areas of concern.
- 1.2. In July 2013, the Board agreed a process and format for performance reporting, including a selection of indicators from within the more exhaustive Outcomes Framework agreed in 2012. Quarter 1 was reported in September.

2. Overview of Performance in Quarter 2

- 2.1. Appendix A contains the dashboard that summarises performance against the measures selected by the Board in July 2013.

3. Data availability and timeliness of indicators chosen

- 3.1. There continue to be substantial gaps in monitoring information due to indicators being on annual cycles or having significant delays in the data becoming available. The matter has been discussed at the Executive Planning Group, and the suggestion made to continue for the remainder of this year on the indicators proposed, and to review the position in time to report on quarter 1 in 2014/15. Where there remain difficulties in data flows to Public Health from parts of the NHS, it is anticipated that these would have been resolved. In other areas, interim or proxy measures will have been worked up to give some approximate indication of progress towards targets set.
- 3.2. Additionally, work is underway to agree the measures that will support monitoring of the Integration Transformation Fund, which should be reflected in future Board monitoring reports for 2014/15. This can be picked up when agreements have been finalised in February 2014.

4. Areas of concern

- 4.1. Appendix B contains detail sheets for seven areas of concerning performance highlighted this quarter, as below.

4.2. Indicator 6: Prevalence of obesity in children in Reception Year Indicator 7: Prevalence of obesity in children in Year 6

The prevalence rate in both reception year and year six is well above the national and regional averages, with Barking ranking the fifth and fourth highest respectively across the country. Childhood obesity is acknowledged as a key priority locally and regionally. The target for participation in the national child measurement programme has been achieved in 2011/12. Obesity in reception (age 4 -5 years) has decreased in 2011/12 as compared to the previous year, and the target has been achieved for this age group, whilst for year 6 a significant increase has been seen. Funding has been allocated from the Public Health Grant for a range of healthy eating proposals which will give an industrial scale healthy eating programme across the borough,

and an ambitious programme to promote participation in regular physical activity in schools. The Board's Obesity Summit will seek to address these long-term trends.

4.3. Indicator 16: Number of positive Chlamydia screening tests

Performance has been below target for this indicator over the course of the past year. A recovery plan was constructed by Terrence Higgins Trust (THT) for 2013/14 Q2 which aimed to improve both coverage and numbers of positives at Chlamydia testing sites. The original discussion with our parties was to extend this contract with a similar time line and with similar reasons as outlined above. However since the reporting mechanisms for this project changed at the beginning of April 2013 (previously the provider was measured on the number of people tested; now it is on the number of people who test positive) the current provider THT has been unable to hit the targets set and is not likely to hit the target for this year despite all the efforts being made.

4.4. Indicator 20. Percentage of women who are smoking at time of delivery

Barking & Dagenham is, and has, historically, been performing far worse than both the London and England averages. Rates for the last two quarters have risen from 12.1% to 15.0%.

4.5. Indicator 30: Alcohol-related recorded crimes

Barking & Dagenham's performance is worse than both national and regional averages, with rates being almost twice as high as England as a whole. However, this indicator has shown a slight downward trend over the last two reported financial years, mirroring national and regional trends.

4.6. Indicator 32: Emergency readmissions within 30 days of discharge from hospital

Barking & Dagenham has a higher percentage of readmission than both national and regional averages. The rate has also shown an increasing trend since 2006/07. However, 2010/11 is the most recent data available and was released by HSCIC in March 2013. It is not possible to calculate local rates as Public health do not currently have access to HES data; applications for access to HES data are currently in process.

4.7. Indicator 33: Rate of premature mortality of people under the age of 75 from all causes amenable to healthcare

Barking & Dagenham has consistently been above the regional and national rates over the last 17 years. The rate for Barking & Dagenham does show a downward trend though, with rates falling by 28.2 per 100,000 in the last four years, a trend that is also observed in national and regional rates.

5. Areas of good performance to highlight

5.1. Appendix C contains a detail sheet on the healthcheck target, highlighting improved performance in this quarter's report.

5.2. Indicator 21: Percentage of eligible population that received a health check in last five years

Whilst the indicator remains below target, progress between quarter 1 and quarter 2 is deserving of mention. At 3.5%, whilst below the expected 3.75%, is the nearest to target that this indicator has been over the last six quarters. This is a result of

work undertaken with primary care by Public Health, including the incentive payments that were introduced in order to drive up performance.

6. Inspection activity of the Care Quality Commission with Barking & Dagenham registered providers, published between 1 July 2013 and 30 September 2013

- 6.1. Appendix D contains an overview of investigation reports published during the period on providers in the London Borough of Barking & Dagenham, or who provide services to residents in the Borough. The report lists the position at the time of publication of the inspection report, as well as the current status of the service (as at 27 November 2013).
- 6.2. During the second quarter, 19 organisations were inspected across the Borough. Of these, 15 met all required standards set by CQC. The remaining 4 did not meet all requirements. Notably during this time Queen's Hospital Emergency Department was inspected and failed to meet 3 of the required standards, and there has been considerable separate briefing and discussion on the matters raised by the Care Quality Commission. In addition, the following providers failed to meet one or more of CQC's standards:
- Abbey Care Home Ltd;
 - Anytime Recruitment Ltd / Anytime Care 2020;
 - Elora House (learning disability residential care);
 - Dr Mohan & Associates, Urswick Medical Practice.
- 6.3. The organisations that did not meet standards were given deadlines to comply with actions set down by CQC in order to implement improvements to meet requirements. These improvements will be reviewed by CQC as part of their ongoing inspection cycle. As at 29 November 2013, improvements continue to be required at these providers; Anytime Care has ceased to offer services.

7. Mandatory Implications

Joint Strategic Needs Assessment

- 7.1. The Joint Strategic Needs Assessment provides an overview of the health and care needs of the local population, against which the Health & Wellbeing Board sets its priority actions for the coming years. By ensuring regular performance monitoring, the Health & Wellbeing Board can track progress against the health priorities of the JSNA, the impact of which should be visible in the annual refreshes of the JSNA.

Health and Wellbeing Strategy

- 7.2. The Outcomes Framework, of which this report presents a subset, sets out how the Health & Wellbeing Board intends to address the health and social care priorities for the local population. The indicators chosen are grouped by the 'life course' themes of the Strategy, and reflect core priorities.

Integration

- 7.3. The indicators chosen include some which identify performance of the whole health and social care system, including in particular those indicators selected from the Urgent Care Board's dashboard.

8. List of Appendices:

Appendix A: Performance Dashboard

Appendix B: Detailed overviews for indicators highlighted in the report as being in need of improvement

Appendix C: Detailed overviews for indicators highlighted in the report as performing particularly well

Appendix D: Details of inspection activity undertaken by the Care Quality Commission on Barking & Dagenham registered providers

This page is intentionally left blank

Appendix 1: Indicators for HWBB - 2013/14 Q2

Key

Data unavailable due to irrelevance, reporting frequency or the performance indicator being new for the period
Data unavailable as not yet due to be released
Data missing and requires updating
Provisional end of year figure
DoT
NC
No colour

The direction of travel for each indicator is denoted with an arrow, which has been colour coded to show whether performance has improved (green) or worsened (red)

Lifecourse Stage	Title	2011/12				2012/13				2013/14				BENCHMARKING		HWBB No.		
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	DoT	RAG Rating		England Average	London Average
Early Years	Percentage of children achieving national standard for school readiness aged 5 years. Large decrease in both local, regional and national figures is due to the method of reporting changing since 2011/12.	61.0%				46.0%								↘	A	52.0%	53.0%	1
Early Years	Rate of infant mortality under the age of 1 year Crude rate of infant death per 1,000 live births. Data is released annually by ONS - next release is due Jan-Feb 2014. Local rates could also be calculated once access is gained to PCMD database from ONS. Public Health is currently in the process of acquiring these data.	3.8*												→	G	4.3	4.1	2
Early Years	Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 1 year old Provisional publication date for Q2 data: 20 December 2013.	89.4%	91.2%	91.0%	90.9%	92.1%	90.0%	90.0%						→	A	94.7%	90.4%	3
Early Years	Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old Provisional publication date for Q2 data: 20 December 2013.	77.9%	85.5%	83.8%	85.5%	85.0%	83.8%	83.8%						→	A	88.4%	80.4%	4
Early Years	Prevalence of Breastfeeding at 6-8 Week Check Next quarterly release will be in March 2014 when 2013/14 Q1, Q2 and Q3 data will all be released together by Department of Health. London figure unavailable for 2012/13 Q4 due to a number of boroughs failing data validation.	53.5%	55.4%	54.2%	54.8%	48.3%								↘	A	46.6%		5
Primary School	Prevalence of children in reception year that are obese or overweight 2012/13 data due to be published December 2013.	26.7%												↘	R	22.6%	23.3%	6
Primary School	Prevalence of children in year 6 that are obese or overweight 2012/13 data due to be published December 2013.	42.2%												↘	R	33.9%	37.2%	7
Primary School	Percentage of primary school children eligible for Free School Meals This is an annual indicator submitted to DiE in the January Census each year - benchmark data is available annually - it is not quarterly.	28.8%				28.4%								↘	NC	18.1%	23.8%	8
Primary School	Of those eligible, the percentage of primary school children who take up Free School Meals This is an annual indicator submitted to DiE in the January Census each year - benchmark data is available annually - it is not quarterly.	76.1%				78.6%								↘	NC	84.7%	89.5%	9
Adolescence	Alcohol specific admissions aged under 18 Under 18s admitted to hospital with alcohol specific conditions: Persons, crude rate per 100,000 population. The estimated date of the refresh of alcohol statistics is March 2014.	28.5#												↘	G	55.8	35.7	10

* Data from 2010/11

** Data from 2009/11

Data from 2008/09-2010/11

Appendix 1: Indicators for HWBB - 2013/14 Q2

Key

..
Data missing and requires updating
Provisional end of year figure
DoT
NC
No colour

Data unavailable due to irrelevance, reporting frequency or the performance indicator being new for the period

Data unavailable as not yet due to be released

Data missing and requires updating

Provisional end of year figure

The direction of travel for each indicator is denoted with an arrow, which has been colour coded to show whether performance has improved (green) or worsened (red)

No colour

Lifecourse Stage	Title	2012/13								2013/14				BENCHMARKING				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	DoT	RAG Rating	England Average	London Average	HWBB No.
Adolescence	Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	46.3	34.2	..	..	..	..	..	..	..	..	..	..	→	A	28.3	25.9	11
	2012/13 Q2 data due to be published by ONS on 26th November - Data relates to calendar year 2012 Q2 - 32 females conceptions aged 15-17, representing a rate of 34.2 and a % decline on the 1998 baseline of -37.4. Lowest teenage conception rate since 1998.	-15.2%	-37.4%	..	..	..	..	..	..	..	..	..	..		-38.3%	-49.3%		
Adolescence	Under 18 rate of terminations of pregnancy	23.8	..	..	..	..	..	..	..	..	..	..	..	→	NC	12.8	14.8	12
	Rate per 1,000 women aged under 18	..	..	..	..	..	..	..	..	..	..	..	..
Adolescence	Annual health check Looked After Children	94.2%	81.5%	78.3%	64.6%	71.2%	71.2%	62.9%	69.2%	..	..	..	..	→	A	84.3%	88.1%	13
	Percentage of children in care for a year or more with up to date health checks improved to 69.2% in Q2 and has increased further to 81.0% as at the end of October 2013. Performance is much improved and RAG rated amber, having been rated red last quarter. We predict to be over 85% by the end of November and performance will be RAG rated green.	..	..	..	..	..	..	..	..	..	..	..	..
Adolescence	Emotional Wellbeing of Looked after children	18.4%	..	..	..	13.5%	..	..	..	..	..	..	..	→	G	13.8%	13.5%	14
	Please note a lower figure indicates better performance. This is an annual indicator based on an SDQ score of looked after children - It is a questionnaire and is not published quarterly.	..	..	..	..	..	..	..	..	..	..	..	..
Adolescence	Number of children and young people accessing Tier 3/4 CAMHS services	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	15
	Data source has been identified. Merrisha Gordon Service Manager Barking & Dagenham CAMHS has passed it to the Performance Informatics Team for approval. Data should be available at the end of November 2013.	..	..	..	..	..	..	..	..	..	..	..	..
Early Adulthood	Number of positive Chlamydia screening results	182	140	128	135	585	126	131	..	..	..	..	..	→	R	..	..	16
	Please note that a higher number is considered to be good performance as the goal is to find an increased number of people with an under-reported condition.	..	..	..	..	..	..	..	..	..	..	..	..
Early Adulthood	Number of four week smoking quitters	426	295	323	436	1480	390	262	..	..	..	..	..	→	A	..	..	17
Early Adulthood	Cervical Screening - Coverage of women aged 25-64 years	75.0%	..	..	..	74.9%	..	..	..	..	..	..	..	↘	A	78.3%	74.1%	18
	Percentage of women who have been adequately tested within the last five years - 2013/14 due to be released October 2014	..	..	..	..	..	..	..	..	..	..	..	..
Maternity	Percentage of Women seen by a maternity professional by 12 weeks and 6 days of pregnancy	..	76.8%	77.5%	82.3%	..	..	..	..	..	..	..	..	→	NC	..	..	19
Maternity	Percentage of women who are smoking at time of delivery	12.8%	13.7%	12.1%	16.4%	15.0%	..	..	..	..	..	..	..	→	R	12.8%	5.6%	20
	HSC/C: Statistics on Women's Smoking Status at Time of Delivery - Q1 2013-14 will not be published, due to operational reasons the data for this report will be included in the Quarter 2 report on the 27 November.	..	..	..	..	..	..	..	..	..	..	..	..

* Data from 2010/11

** Data from 2009/11

Data from 2008/09-2010/11

Appendix 1: Indicators for HWBB - 2013/14 Q2

Key

	Data unavailable due to irrelevance, reporting frequency or the performance indicator being new for the period
	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional end of year figure
	The direction of travel for each indicator is denoted with an arrow, which has been colour coded to show whether performance has improved (green) or worsened (red)
	No colour

Lifecourse Stage	Title	2011/12				2012/13				2013/14				BENCHMARKING		HWBB No.	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	DoT	RAG Rating		England Average	London Average
Established Adults	Percentage of eligible population that received a health check in last five years	12.4%	2.1%	2.0%	2.9%	3.0%	10.0%	1.9%	3.5%	..	..	..	↗	G	1.9%	2.1%	21
	Please note that annual figures are a cumulative figure accounting for all four previous quarters.																
Established Adults	Breast Screening - Coverage of women aged 53-70 years	66.6%					..						↘	A	77.0%	69.3%	22
	Percentage of women whose last test was less than three years ago - 2012/13 due to be released February 2014.																
Older Adults	The percentage of people receiving care and support in the home via a direct payment	39.1%	40.1%	42.2%	47.3%	54.0%	42.1%	59.2%	66.6%	..	..	..	↗	G	N/A	N/A	23
Older Adults	Older people in residential/nursing care admissions/discharges	132/125	32/41	40/49	50/46	36/44	158/180	30/28	42/32	..	..	..	↗	G	N/A	N/A	24
Older Adults	Rate of emergency admissions for COPD per 100,000 population	238.5*	..	..	..	..	..	..	..	..	..	..	N/A	NC			25
	Directly Standardised Rate - due to a lack of access to Hospital Episode Statistics it is not possible to obtain a more up-to-date figure. Nationally released data is due January 2014. Applications to access HES data are in progress.																
Older Adults	Percentage of people who die at home														21.0%	21.8%	26
	Due to the Public Health Mortality file no longer being provided by ONS since the move from the NHS to the LA we are not currently able to calculate this. The data sharing agreements have been approved. The dispatch of the data is now being awaited, upon which the figure will be able to be calculated again. Until then the only figures available are nationally released figures that are not broken down to LA level.																
Vulnerable	Number of cases discussed at MARAC meetings per quarter	315	101	94	106	81	382	80	194	..	..	..	↗	G	N/A	N/A	27
Vulnerable	Percentage households in temporary accommodation	1.6%	1.6%	1.7%	1.7%	1.7%	1.7%	1.8%	..	..	..	..	↘	NC	0.2%		28
All Ages	Alcohol related recorded crimes	13.0	..	..	..	..	..	..	..	..	..	..	↗	R	11.1	7.0	30
	Persons, all ages, crude rate per 1000 population.																
All Ages	KT31 contraceptive services - statutory return - LARCS	35.0%					41.0%						↗	G	27.0%	28.0%	31
	As a percentage of total first contacts for contraception reasons only. Figure is for Barking, Havering and Redbridge University Hospitals NHS Trust.																

* Data from 2010/11

** Data from 2009/11

Data from 2008/09-2010/11

Appendix 1: Indicators for HWBB - 2013/14 Q2

Key

	Data unavailable due to irrelevance, reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional end of year figure
DoT	The direction of travel for each indicator is denoted with an arrow, which has been colour coded to show whether performance has improved (green) or worsened (red)
NC	No colour

Lifecourse Stage	Title	2011/12				2012/13				2013/14				BENCHMARKING		HWBB No.	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	DoT	RAG Rating		England Average
All Ages	Emergency readmissions within 30 days of discharge from hospital	..	..	..	..	..	..	..	..	..	..	..	→	R	12.0%	11.8%	32
Percentage of emergency admissions occurring within 30 days of the last, previous discharge after admission. Indirectly standardised rate - 2010/11 is the most recent data published and was released by HSCIC in March 2013.																	
All Ages	Rate of premature mortality under the age of 75 from all causes	182.9**	..	..	..	..	..	..	..	..	..	..	N/A	R	146.1	137.6	33
Age-standardised mortality rate from causes considered preventable per 100,000 population - 2009/11 is most recent data published and was released by ONS in March 2013.																	
All Ages	Percentage successful completion of drug treatment - all drug users	63.0%	70.0%	76.0%	73.0%	71.0%	71.0%	71.0%	71.0%	57.0%	66.0%	..	↗	A	45.0%	41.0%	34
All Ages	Rate of emergency admissions due to ambulatory care sensitive conditions	1136.2	..	..	..	..	..	..	..	..	..	..	↗	NC	..	..	35
Rate per 100,000 population.																	
All Ages	Improving Access to Psychological Therapies	1.5%	1.5%	1.9%	1.9%	1.9%	2.3%	..	..	..	..	..	↗	A	2.5%	2.3%	37
People who have entered treatment as a proportion of people with anxiety or depression (Percentage).																	
All Ages	Percentage of eligible diabetic population receiving screening for early detection of diabetic retinopathy	82.8%	80.4%	88.5%	83.6%	85.6%	85.6%	85.6%	85.6%	..	..	..	↗	G	80.5%	79.3%	38
All Ages	Delayed Transfers of Care, including those that are due to the local authority	9.5	6.0	6.0	4.5	1.5	4.5	4.5	0.75	1.1	..	..	↗	G	3.3	2.7	39
Directly standardised rate per 100,000 population.																	

* Data from 2010/11

** Data from 2009/11

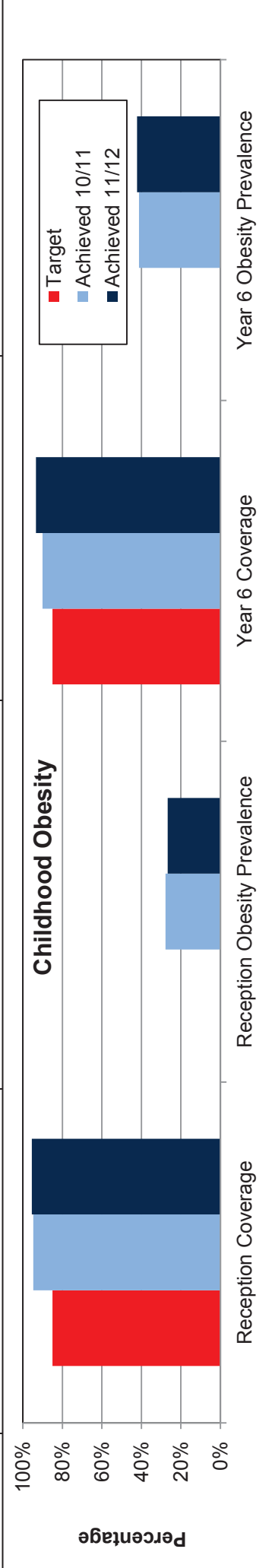
Data from 2008/09-2010/11

Definition
 Coverage – Percentage of children in either reception or year 6 that have had their height and weight measured during the school year.
 Prevalence – Percentage of children in either reception or year 6 whose weight is above the 95th centile of the population.

What good looks like
 Coverage figures should be above the target figure of 85% and as close to 100% as possible. Prevalence figures should be as low as possible.

Why this indicator is important
 The NCMP is an important element of the Government's work in addressing childhood obesity, and is operated jointly by the Department of Health (DH) and the Department for Education (DfE).

History with this indicator	Reception Obesity Prevalence	Year 6 Obesity Prevalence
2011/12: Reception – 26.7% prevalence; 94.7% coverage. Year 6 – 42.2% prevalence; 90.0% coverage.		
Target	85.0%	85.0%
Achieved 10/11	94.7%	90.0%
Achieved 11/12	95.4%	93.4%



Performance Overview
 Coverage for both Reception and Year 6 is over target by 10.4% and 8.4% respectively.
 Reception and Year 6 prevalence rates are both well above national and regional averages.

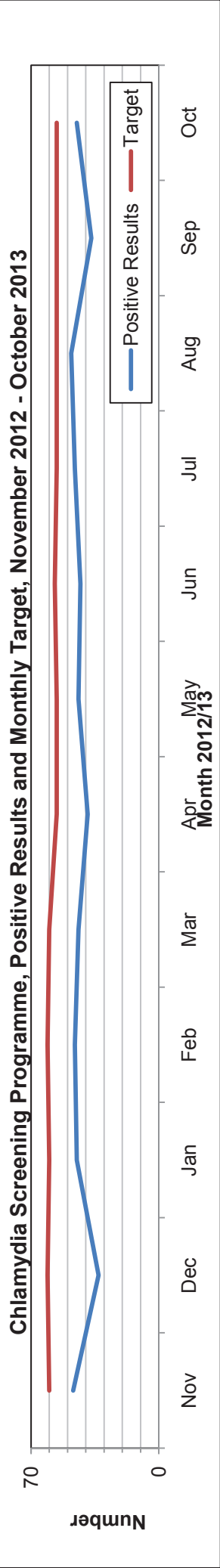
Further Actions & comments
 • Prevalence of obesity is far greater than the percentage for both London and England.

RAG Rating

Benchmarking

2010/11 – Reception: 27.8% Year 6: 41.2%

Definition	Number of positive tests for Chlamydia.												How this indicator works	This indicator is reported quarterly via the National Chlamydia Screening Programme and covers screening uptake and positivity rates among young people aged 15-24 years.		
What good looks like	The number of positive results to be greater than target levels on a monthly basis. A higher number of positives show that the correct people are being targeted for screening for an under-reported condition.												Why this indicator is important	Chlamydia is the most commonly diagnosed sexually transmitted bacterial infection among young people under the age of 25. The infection is often symptomless but if left untreated can lead to serious health problems including infertility in women.		
History with this indicator	2011/12: 587 positive results. 2012/13: 585 positive results (target: 726).															
Positive Results	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13				
Target	47	33	45	46	44	39	44	43	46	48	37	45				
Quarterly	Quarter 3	128/182	Quarter 4	135/181	Quarter 1	126/169	Quarter 2	131/168								

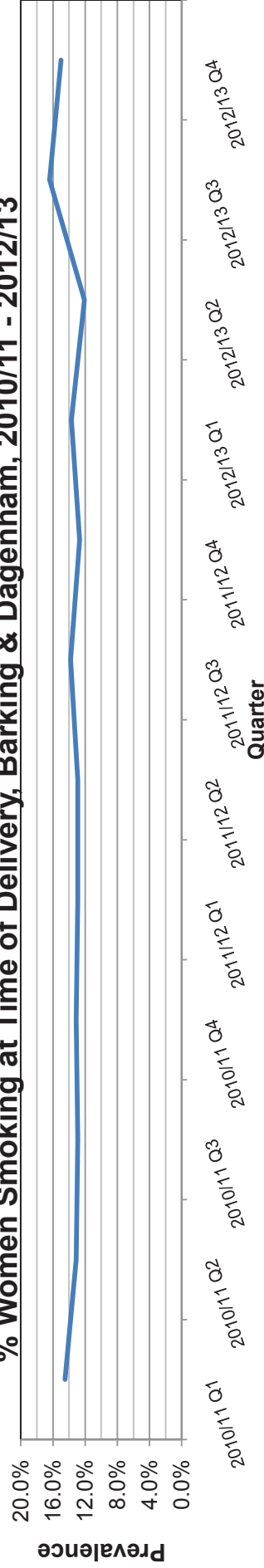


Performance Overview	Barking and Dagenham has not met the monthly target for positive tests for any of the last twelve months. There has been a drop-off in positive tests since July 2012, with monthly numbers being below 50 every month since.												Performance has been below target for this indicator over the course of the past year. A recovery plan was constructed by Terrence Higgins Trust (THT) for 2013/14 Q2 which aimed to improve both coverage and numbers of positives at Chlamydia testing sites. The original discussion with our parties was to extend this contract with a similar time line with the similar reasons as outlined above. However since the reporting mechanisms for this project changed at the beginning of April 2013 (previously the provider was measured on the number of people tested; now it is on the number of people who test positive) the current provider THT has been unable to hit the targets set and is not likely to hit the target for this year despite all the efforts being made.		
RAG Rating	Barking and Dagenham has not met the monthly target for positive tests for any of the last twelve months. There has been a drop-off in positive tests since July 2012, with monthly numbers being below 50 every month since.														

Benchmarking	The annual positivity rate was 2,395 per 100,000 people in 2011/12 whilst the 2012/13 rate for positivity was 2,966 per 100,000 people. Number of Eligible Young People aged 15-24 years in the population is 24491 in Barking and Dagenham.														
---------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Definition	Percentage of women who are smoking at time of delivery.	How this indicator works	This data collection is designed to provide a measure of the prevalence of smoking among women at the time of giving birth at a local level.
What good looks like	For the percentage of women smoking at time of delivery to be as low as possible.	Why this indicator is important	Babies from deprived backgrounds are more likely to be born to mothers who smoke and to have much greater exposure to secondhand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.
History with this indicator	2009/10: 13.7% 2008/09: 11.3%		
	Q1	Q2	Q3
2010/11	14.5%	13.1%	12.9%
2011/12	12.9%	12.9%	13.8%
2012/13	13.7%	12.1%	16.4%
			Q4
			13.1%
			12.7%
			15.0%

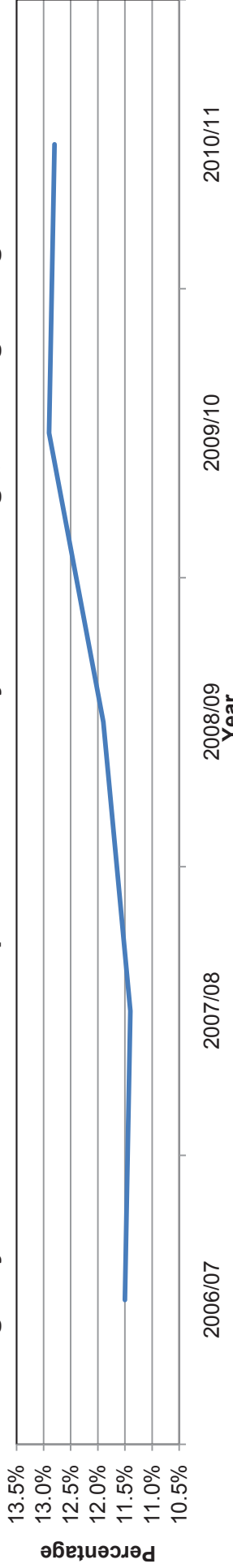
% Women Smoking at Time of Delivery, Barking & Dagenham, 2010/11 - 2012/13



Performance Overview	Barking & Dagenham is, and has historically been, performing far worse than both the London and England averages. Rates for the last two quarters have risen sharply from 12.1% to 15.0%.
RAG Rating	
Benchmarking	In England, the percentage of mothers smoking at delivery was 12.7% in 2012/13, for London it was 5.7%.

Definition	Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the previous discharge from hospital after admission.	How this indicator works	The number of finished and unfinished continuous inpatient (CIP) spells that are emergency admissions within 0-29 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies.
What good looks like	For the percentage to be as low as possible, indicating that fewer people are readmitted soon after discharge.	Why this indicator is important	Health interventions and social care can play roles in putting in place the right re-ablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short-term.
History with this indicator	2006/07: 11.5%		
	2007/08 11.4%	2008/09 11.9%	2009/10 12.9%
B&D			2010/11 12.8%

Emergency Readmission to Hospital Within 30 Days of Discharge, Barking & Dagenham

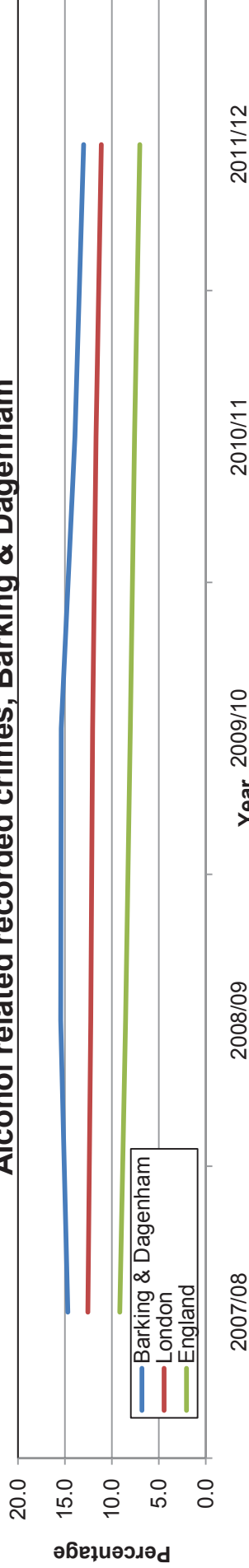


Performance Overview	Barking & Dagenham has a higher percentage than both national and regional averages. The rate has also shown a generally increasing trend since 2006/07.	Please Note	2010/11 data was released by HSCIC in March 2013 due to large lags in processing the data.
RAG Rating			
Benchmarking	England 2010/11: 12.0% London 2010/11: 11.8%		

Definition	Alcohol-attributable recorded crimes, alcohol-attributable violent crimes, alcohol-attributable sexual offences, crude rate per 1,000 population, all ages, persons.	How this indicator works	Crimes are recorded using the practice governed by Home Office counting Rules for Recorded Crime and the National Crime Recording Standard.
What good looks like	The rate per 1,000 population should be as low as possible.	Why this indicator is important	It has been estimated that in a community of 100,000 people, each year 1,000 people will be a victim of alcohol-related violent crime. The Government lists a reduction in alcohol-fuelled violent crime among its core priorities in its Alcohol Strategy.

	2008/09	2009/10	2010/11	2011/12
B&D	15.4	15.4	13.9	13.0
London	12.2	12.0	11.7	11.1
England	8.5	8.0	7.6	7.0

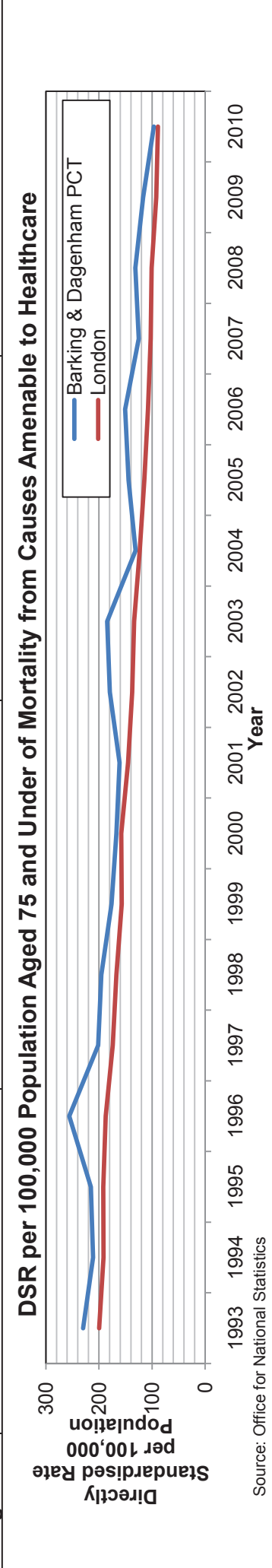
Alcohol related recorded crimes, Barking & Dagenham



Performance Overview	Barking & Dagenham has had a higher rate of alcohol-related crimes for all of the past five years data was recorded. The borough has seen a slight downward trend between 2010 and 2012, mirroring both national and regional averages.
RAG Rating	

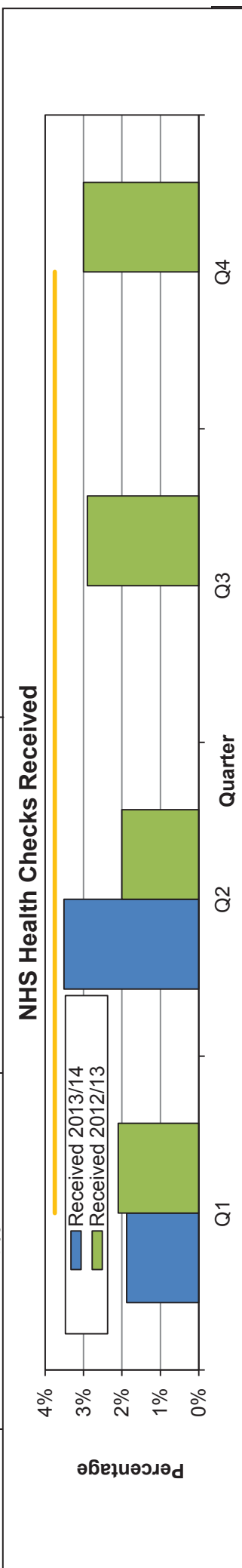
Benchmarking	England 2011/12: 7.0 per 1,000 population London 2011/12: 11.1 per 1,000 population
---------------------	--

Definition	Numerator: Number of deaths that are considered preventable (classified by underlying cause of death recorded as ICD10 codes, and for the age groups shown) registered in the respective calendar years. Denominator: ONS mid-year population estimates aggregated across three years.	How this indicator works	The indicator is based on the preventable mortality component of avoidable mortality as defined by the Office for National Statistics (ONS).	
What good looks like	Rate per 100,000 should be as low as possible, indicating fewer deaths amenable to healthcare.	Why this indicator is important	Preventable mortality can be defined in terms of causes that are considered to be preventable through individual behaviour or public health measures limiting individual exposure to harmful substances or conditions. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases.	
B & D	2007 125.1	2008 131.6	2009 116.8	2010 96.9
London	102.8	100.8	92.1	88.9
England	100.8	97.2	91.1	88.1



Performance Overview	Please Note	2009/11 data was released by ONS in March 2013 due to large lags in processing the data.
RAG Rating		
Benchmarking	London 2010: 88.9 England 2010: 88.1	

Definition	Percentage of the eligible population (those between the ages of 40 and 74, who have not already been diagnosed with heart disease, stroke, diabetes, kidney disease and certain types of dementia) receiving an NHS Health Check in the relevant time period.	How this indicator works	Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions is invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and afterwards given support and advice to help them reduce or manage that risk. The national targets are 20% of eligible population should be offered a health check and 75% of those offered should receive a check.
What good looks like	For the received percentage to be as high as possible and to be above target.	Why this indicator is important	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, and kidney disease.
History with this indicator	2011/12: 12.4% received. 2012/13: 10.0% received		
Target	Q1 3.75%	Q2 3.75%	Q3 3.75%
Received 12/13	2.1%	2.0%	2.9%
Received 13/14	1.9%	3.5%	3.0%



Performance Overview	10 practices have met their quarterly targets in total and 6 practices have performed more health checks than in previous months since the payment increase from £20 per health check to £35, this may increase during October due to practices not being completely aware of the payment increase until late September.	Actions to sustain or improve performance	Seven practices are under performing and steps are in place to assist them. The remaining practices are performing health checks but are falling slightly below their quarterly quotas.
RAG Rating			
Benchmarking	In 2011/12, only 12.4% received health checks, which was less than the set target of 15%. In 2012/13, only 10.0% received health checks against the target of 15%.		

This page is intentionally left blank

Provider Name	Location Name	Weblinks	Location Organisation Type	Report Date	Inspection Date	Result	Comments/Summary
London Borough of Barking & Dagenham	Ted Hennem House Jacobs Close, Dagenham, Essex, RM10 7NH	http://www.cqc.org.uk/directory/1-454834572	Social Care Org	Inspection Report published 02 July 2013	22 May 2013	All standards met	Report details the following standards not met: 1 Care and welfare of people who use services; 2 Staffing 10/07 Warning was issued by CQC regarding failing standards in A&E. Urgent improvements were requested as key national standards were not being met. Patient outcomes were below standards. There are not enough full time consultants or junior doctors to provide medical care for the number of people who attend Queens A&E. Improvements had been made in Majors. They included better provision of food and drink including hot meals. Patients are accommodated on beds instead of trolleys. The Trust has recently funded two agency health care assistants (HCAs) to provide cover twenty four hours seven days per week. In addition there is an extra housekeeper on duty for every shift. Provider to implement improvements by 02/08 and provide evidence of this to CQC.
Barking, Havering & Redbridge University Hospitals NHS Trust	Queen's Hospital, Romford	http://www.cqc.org.uk/directory/144	NHS Healthcare	Inspection Report published 6 July 2013	21 & 22 May 2013	The service met 1 out of 3 standards inspected	Current status (29/11/13) 3 standards required improvement: 1 Standards of treating people with respect and involving them in their care; 2 Standards of providing care, treatment and support that meets people's needs; 4 Standards of Staffing CQC undertook an investigation at Queen's Hospital using their new way of inspecting hospitals. The report is expected imminently.
Dr Israr Moghal	Dr Israr Moghal Parsloes Ave, Dagenham	http://www.cqc.org.uk/directory/1-496542640	Primary Medical Services	Inspection Report published 06 July 2013	11 June 2013	All standards met	Standard not met: 2 Standards of treating people with respect and involving them in their care. The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them.
Abbey Care Home Limited	Abbey Care Home	http://www.cqc.org.uk/directory/1-362678647	Social Care Org	Inspection Report published 12 July 2013	11 June 2013	The service met 4 out of 5 standards inspected	The manager and all the care staff had completed Mental Capacity Act 2005 and Deprivation of Liberty safeguards training but there was no evidence that the learning had been incorporated into their practice. Current status (29/11/13): improvements required around treating people with respect and involving them in their care.
Mr Nasser Kassouri	Faircross Care Home	http://www.cqc.org.uk/directory/1-128184546	Social Care Org	Inspection Report published 18 July 2013	21 June 2013	All standards met	
Orchard Road (OS) Limited	1-5 Orchard Road	http://www.cqc.org.uk/directory/1-257523992	Primary Dental Care	Inspection Report published 01 August	03 July 2013	All Standards met	
Wideway Care Limited	Wideway Care Limited - 10a Station Parade	http://www.cqc.org.uk/directory/1-126620169	Social Care Org	Inspection Report published 01 August	27 June 2013	All standards met	
Barcheater Healthcare Homes Limited	Park View Care Home	http://www.cqc.org.uk/directory/1-125861732	Social Care Org	Inspection Report published 02 August	26 June 2013	All standards met	
Deirose House Limited	Cloud House	http://www.cqc.org.uk/directory/1-320058309	Social Care Org	Inspection Report published 14 August	10 July 2013	All standards met	
M N S Care plc	Hanbury Court Care Home	http://www.cqc.org.uk/directory/1-119099319	Social Care Org	Inspection Report published 15 August	31 July 2013	All standards met	

Provider Name	Location Name	Weblinks	Location Organisation Type	Report Date	Inspection Date	Result	Comments/Summary
Anytime Recruitment Limited	Anytime Care 2020	http://www.cqc.org.uk/directory/1-325346003	Social Care Org	Inspection Report published 16 August 2013	18 July 2013	The service met 4 out of 5 standards inspected	Standard not met: 1 Standards of treating people with respect and involving them in their care People did not have a choice of carer of their preferred gender, even when this was important to them. In general users of the service were happy with the care provided. There are robust recruitment process, various monitoring systems and a complaints process in place. Provider to implement improvements by 12/09 and provide evidence of this to CQC
Dia Tilakasiri	Elora House	http://www.cqc.org.uk/directory/1-146917848	Social Care Org	Inspection Report published 16 August 2013	04 June 2013	The service met 5 out of 6 standards inspected	Report Standard not met: 6 Assessing and monitoring the quality of service provision The provider was collecting information about the service and told us he was checking the quality of care records. However, he was not recording the outcome of such audits or the resulting improvements he had made to the service. Provider to implement improvements by 22/08 and provide evidence of this to CQC.
CRI (Crime Reduction Initiatives)	Barking and Dagenham Recovery Service (Opiate dependency service)	http://www.cqc.org.uk/directory/1-433405078	Social Care Org	Inspection Report published 23 August 2013	23 July 2013	All standards met	Current status (29/11/13): Improvements required: 5 Standards of quality and suitability of management (systems for monitoring care quality)
Bupa Care Homes (CFHCare) Limited	Chaseview Residential and Nursing Home	http://www.cqc.org.uk/directory/1-127903453	Social Care Org	Inspection Report published 23 August 2013	22 July 2013 & 19 July 2013	All standards met	
TLC Care Services	Fred Tibble Court	http://www.cqc.org.uk/directory/1-189037049	Social Care Org	Inspection Report published 29 August 2013	02 August 2013	All standards met	
Bennetts Castle Limited	Bennetts Castle Care Home	http://www.cqc.org.uk/directory/1-117294310	Social Care Org	Inspection Report published 05 September 2013	07 August 2013	All standards met	
Chinite Resourcing Limited	Chinite Resourcing Limited (Dementia, LD, MH, 65+ care services)	http://www.cqc.org.uk/directory/1-326243330	Social Care Org	Inspection Report published 13 September 2014	29 July 2013	All standards met	
Dr Mohan and Associates	Dr Mohan and Associates Urswick Medical Centre, Urswick Road, Dagenham, RM9 6EA	http://www.cqc.org.uk/directory/1-569632930	Primary Medical Services	Inspection Report published 14 September 2013	20 August 2013	The service met 5 out of 6 standards inspected	Report Standard not met: 4 Management of medicines People were not protected against the potential risks associated with the unsafe management of medicines. This was because the processes and procedures for ensuring that emergency medicines were available and safe to use were not always followed. People said treatment choices were explained to them and they were able to make choices. Provider to implement improvements by 27/09 and provide evidence of this to CQC.
Whalebone Lane Limited	Whalebone Lane Dental Clinic	http://www.cqc.org.uk/directory/1-197288246	Primary Dental Care	Inspection Report published 14 September 2014	13 August 2013	All standards met	Current status (29/11/13): Improvements required: 3 Standards of caring for people and protecting them from harm (medicines management)

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Autism Self Assessment Framework and Autism Mapping Project		
Report of the Corporate Director of Adult and Community Services			
Open Report	For Decision		
Wards Affected: ALL	Key Decision: NO		
Report Author: Pete Ellis Strategic Commissioner, Adult Commissioning	Contact Details: Tel: 020 8227 2492 E-mail: pete.ellis@lbbd.gov.uk		
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services			
Summary: This report provides: <ul style="list-style-type: none"> • An overview of the areas for improvement identified in the Autism Self Assessment Framework which assesses compliance and progress against the National Autism Strategy: <i>Fulfilling and Rewarding Lives</i>; • Key findings from the recently completed independent Autism Mapping project. 			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ol style="list-style-type: none"> (i) Agree and validate the submitted Autism Self Assessment Framework ratings and ask the Learning Disability Partnership Board to report back on an action plan for the improvement (ii) Note the findings from the recently completed independent Autism Mapping exercise. (iii) Note the Clinical Commissioning Group and local authority will be working together through the Learning Disability Partnership Board to develop an integrated Health and Social Care Autism Strategy which will be reported back to the Board in 2014. 			
Reason(s) Since the release of the National Autism Strategy in 2009, every Council with Adult Social Services Responsibilities has been required to complete an annual Autism Self Assessment Framework (SAF) to demonstrate progress towards meeting the objectives outlined in the national strategy. The Minister for Care and Support wrote to each Local Authority area in August requesting that the SAF is taken to their Health and Wellbeing Board for validation and approval. Both the National Autism Strategy: <i>Fulfilling and Rewarding Lives: the Strategy for Adults with Autism</i> and the Council's Autism Action Plan is due to be refreshed at the end of			

1. Background and Introduction

- 1.1 Autism, or Autism Spectrum Disorder (ASD) is not one condition but a spectrum of disorders within which there are common traits but wide variations in levels of functioning, with some people able to lead relatively independent lives and others requiring life-long support.
- 1.2 The National Autism Society defines Autism as, “A lifelong developmental disability that affects how a person communicates with, and relates to, other people and the world around them. It is a spectrum condition, which means that, while all people with autism share certain areas of difficulty, their condition will affect them in different ways. Asperger syndrome is a form of autism¹.”
- 1.3 People with autism, including those with Asperger syndrome, share a difficulty in making sense of the world around them. A person with autism will have three main areas of difficulty which is sometimes called the ‘triad of impairments’. They are:
- (1) Difficulty with social communication;
 - (2) Difficulty with social interaction;
 - (3) Difficulty with social imagination.
- 1.4 In 2010 the government implemented the Autism Act and published ‘*Fulfilling and rewarding lives: the strategy for adults with autism*’, developed under the last government and which has been retained as the national strategy by the current coalition government.
- 1.5 The strategy resulted from the Autism Act, which set out governmental commitment to inclusion and full participation by adults with autism in society. A key plank of the legislation was to give people with autism who did not have a learning disability the right to an assessment for adult social care services. There was evidence that those people were being excluded from services and that it was difficult for them to get the right help, treatment and support.
- 1.6 The strategy sets out a vision for adults with autistic spectrum disorders which aspires to ensure that ‘all adults with autism are able to lead fulfilling and rewarding lives within a society that accepts and understands them. It sets out a number of rights and entitlements, which people with Autistic Spectrum Disorder should have and sets its priorities which are to achieve:
- Increasing understanding and awareness of autism;
 - A clear consistent pathway to diagnosis;
 - Improving access for adults to services and support that they need to live independently;
 - Helping adults with autism into work;
 - Enabling local partners (social care, mental health, health, voluntary groups and mainstream services) to develop relevant services for adults with autism.

¹ <http://www.autism.org.uk/about-autism/autism-and-asperger-syndrome-an-introduction.aspx>

1.7 Additional funding was not made available for the implementation of '*Fulfilling and Rewarding Lives*' and the focus was on adapting and making existing services more accessible and responsive, and reallocating existing resources and funding bids in areas such as employment and social support.

1.8 In response to this strategy Barking and Dagenham Council put in place a multi-agency implementation plan. The Self Assessment Framework measures how we are progressing in terms of delivering against the strategy's key priorities.

2. Estimated Prevalence of People with Autism in Barking and Dagenham

2.1 There is consistent evidence from epidemiological surveys in the UK and the rest of the world that the prevalence of autistic spectrum disorder is somewhere between 60 and 100 people per 10,000 of the general population. The most recent British surveys suggest that prevalence is at the higher end of this estimate.

2.2 Prior to the introduction of a specialist diagnostic pathway led by NHS North East London Foundation Trust, assessments for adults who presented was undertaken by clinicians in the Community Learning Disability team. This had identified limited numbers who met the diagnostic criteria. In the longer term, with improved identification of children in the borough with the condition, together with the development of greater expertise amongst clinicians in identification, numbers are expected to rise.

2.3 Research indicates that there is a higher prevalence amongst males than females, but this gap is narrowing. From early estimates based on national prevalence and applying these rates to our local population, there could be predicted to be approximately 1,300 men and 140 women² with autism in Barking and Dagenham (1.8% of adult men, 0.2% of women)³.

2.4 Local authorities were asked to undertake a mapping exercise in 2012/13 in order to form a view about the numbers and needs of people in the area, and gaps in services. For most authorities this was a largely desktop exercise. In Barking & Dagenham an independent review was commissioned that involved a number of focus groups with families and people with autism themselves to hear local views about where change was required, as well as providing information about current and future need. The results of the exercise were used to supply evidence for the SAF and more detail is provided elsewhere in the report.

2.5 While the JSNA does not currently capture the numbers of children with autism, using the national prevalence range of 60-100 people with autistic spectrum disorder per 10,000 population in Barking and Dagenham there could be between 351 and 583 children and young people aged nineteen or under with ASD.

3. The Self-Assessment Framework and the Autism Mapping Project

3.1 This is the third Autism Self Assessment Framework completed by the borough and focussed on the Autism strategies priorities. There was a requirement in the

² Brugha, T. et al (2009). Autism spectrum disorders in adults living in households throughout England - Report from the Adult Psychiatric Morbidity Survey.

³ Data taken from Barking and Dagenham's Joint Strategic Needs Assessment (2012).

Self Assessment Framework to 'RAG' rate (Red, Amber or Green) progress against 37 questions set against the following domains:

- (1) Local authority area
- (2) Planning
- (3) Training
- (4) Diagnosis led by the local NHS Commissioner
- (5) Care and support
- (6) Housing & Accommodation
- (7) Employment
- (8) Criminal Justice System (CJS)
- (9) Optional Self-advocate stories
- (10) Administration questions

3.2 In this year's SAF the CCG was also required to complete a section (section 4) and the Local Authority were asked to validate it with both people with autism and the Health and Wellbeing Board. To assess progress, the Local Authority were required to either answer 'Yes' or 'No' to some questions or to RAG (red, amber or green) rate performance against a defined set criteria for each question.

Autism Mapping Project

3.3 Completion on the Autism Self-Assessment Framework follows work already undertaken as part of the Council's Autism Action Plan. A key aim of the plan, arising from the National Autism Strategy, is to "...enable local partners in developing appropriate services for adults with autism". To achieve this the Council recently completed an independent mapping project on its adult autism services which involved focus groups and interviews with professionals, stakeholders, carers and people with autism in identifying how we can improve services for people with autism.

3.4 The key findings from this project also mirrored areas in the ASAF, and have informed completion of the Framework. These included:

- Under-developed reporting of the numbers of adults with a diagnosis of autism that are receiving a service from the Council.
- An expectation as the population of the borough increases in size, together with an increase in numbers diagnosed with autism there will be an anticipated increase in demand for services.
- A need to continue to raise awareness and 'mainstream' autism in universal services so they are accessible.
- The project highlighted that the borough has a good infrastructure in place for mainstream volunteering, employment and social opportunities which should be capitalised on. There is a need to ensure that these services are adapted for adults with autism to improve accessibility.
- There are some high cost care packages for adults and children placed out of area with autism. These have been reviewed as part of the

Winterbourne View reviews and will link into the Joint Local Strategic Plan that is due to be presented to the Board in February 2014.

- Underdeveloped service planning for people with a diagnosis of autism who do not meet the clinical or eligibility criteria for either Mental Health or Learning Disability services.
- Better and improved access for adults with autism to access the mental health system / services.

4. Areas for improvement

4.1 Through completion of the ASAF, as detailed in Appendix 1, the following areas were particularly identified as requiring improvement.

4.2 **Data on the number of people with a diagnosis of autism meeting eligibility criteria for social care** – The local authority began collecting data on adults meeting the eligibility criteria in September 2012 and our data tells us that the numbers on the adult case management system (AIS) is lower than would be expected based on the national prevalence figures. We will improve the data on the number of adults with a diagnosis of autism meeting the eligibility criteria through data cleansing and through the annual review process where social workers will update the system.

4.3 **Planning for the particular needs of older people with autism.** The Council recently reviewed its older people services and identified there is a gap in identifying the needs of older people with autism in the borough. As part of our Autism Action Plan in 2014 best practice on planning and delivering services for older people with autism will be researched to learn lessons from elsewhere and see whether these can be usefully applied locally.

4.4 **Specific training for staff to carry out statutory assessments on how to make reasonable adjustments** in their approach and communicate to people with autism. Statutory assessments are completed by a registered and qualified social worker who has the relevant skills and competence to make adjustments in their approach to people with a range of communication difficulties including autism. The local authority is in the process of commissioning specific autism training for relevant staff.

4.5 In addition to the 'red' areas, the following were assessed as 'amber' and identified as areas for improvement. These are:

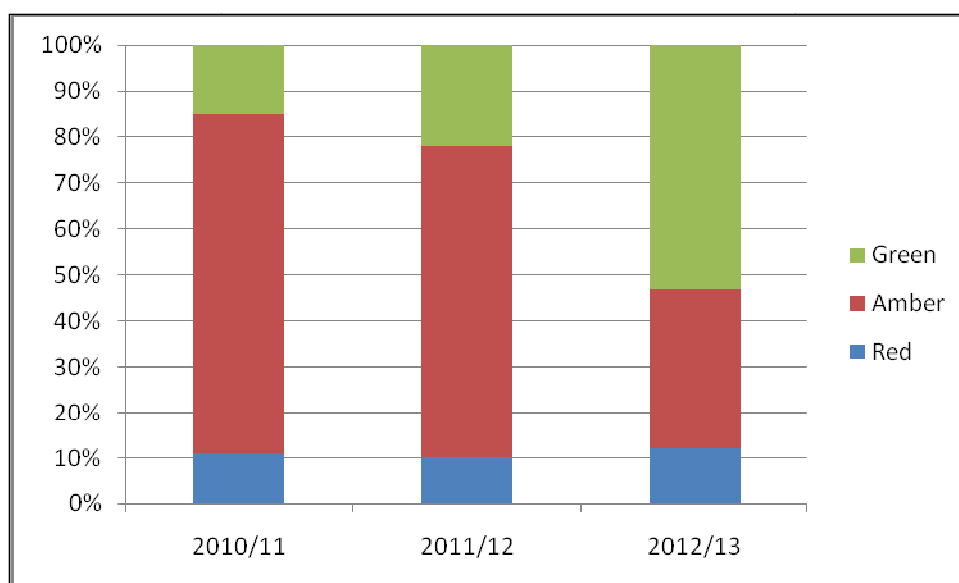
- To improve the reasonable adjustments we make to every day services;
- Autism awareness training. In addition to its e-learning package the borough is in the process of organising autism awareness training (advanced and intermediate) and NHS North East London Foundation Trust will be providing training on the diagnostic pathway. This will be targeted towards the local social care workforce as well as staff in the community and mainstream provision;
- Ensuring information about local support is accessible to people with autism;
- The consideration of the housing needs of people with autism in the Council's Housing Strategy. A commitment has been made by the Housing

Department to include a specific focus on autism when the strategy is refreshed;

- Improve the promotion to local employers around employing people with autism;
- Clinical Commissioning Group engagement- The Barking and Dagenham Autism Action Plan is due to be refreshed in 2014. This will be developed jointly by all key partners including commissioners of health services. The Local Authority will continue to work closely with the Clinical Commissioning Group to increase awareness and understanding of the needs of people with autism. Key members of the CCG are core members of the Learning Disability Partnership Board, which is the currently responsible for overseeing and implementing our Autism plan, and recently commissioned NHS NELFT to implement the ASD diagnostic pathway.

5. Progress against the Autism Action Plan

5.1 The borough continues to make progress in delivering the priorities set out in the local autism action plan.



5.2 Progress was widely attributed to the Council's detailed oversight of autism services in the borough through the mapping project together with the development in 2013 of a clear, consistent diagnostic pathway led by NHS NELFT. In addition, there has been increased awareness amongst frontline professionals with the introduction of a comprehensive autism e-learning package.

6. Consultation

6.1 In completing this year's ASAF the Council consulted people with autism on its submission to see whether they agreed with the ratings given. The ASAF has also been presented at the Learning Disability Partnership Board, and its forums (service user, carer and provider), for discussion. Additionally, as part of the ASAF four self advocacy stories from people with autism were included.

7. Mandatory Implications

Joint Strategic Needs Assessment

- 7.1 The JSNA draws on data from many sources, including national statistics and surveys. Local data is also available from many services, but in some cases this is very limited because of national data confidentiality regulations. In the case of autism, local data is in short supply, and estimating local numbers of people affected by drawing on national estimates may be unhelpful because of the small numbers involved. Section Three of the JSNA shows numbers of children with autistic spectrum disorder referred to the portage service, and these are very small. Likewise, the numbers of Barking & Dagenham pupils with statements or At School Action Plans in the borough are also fairly small, though not out of line with national prevalence estimates

Health and Wellbeing Strategy

- 7.2 In order to have good mental and physical wellbeing, all of us need a reasonable income, employment where we have some feeling of control over our work, a feeling of safety and not being discriminated against, and decent housing. This applies equally to people with autism, who may need extra support in terms of housing, employment, education and social support so that they can live independently within the community. They will also need access to sensitive helpful and actively preventive primary health care.
- 7.3 In delivering these our Health and Wellbeing Strategy Priority Area's on Care and Support is to provide children with the best start in life applies to children with autistic spectrum disorder, and sets the following goals:
- (i). 'More children identified with special needs should have their needs met and demonstrate improved health and mental health outcomes'
 - (ii). 'More children with chronic and/or complex health and social care needs are supported in an integrated way at home... And supported to continue their education'
 - (iii). 'More children with special education needs have their needs met and demonstrate improved educational and health outcomes'

In addition to Children and Young People, other priority areas in the strategy which are relevant to adults with autism include:

- (iv). 'by affirming the need to take account of the needs of the most vulnerable and excluded groups'.
 - (v). 'to promote choice, control and independence'.
 - (vi). 'supporting people to make lifestyle choices... Which will positively improve the quality and length of their lives...'
 - (vii). '...being able to take part in the design and delivery of services that are suitable for their needs.'
- 7.4 Public Health is represented on the Learning Disability Partnership Board and have contributed population and other data. Public Health have in turn gained knowledge from the Board especially about unmet needs and priorities expressed

by people with autism and learning disabilities, which have in turn been used to plan to make the JSNA more helpful and informative.

- 7.5 These critical factors are also outlined in our 'Autism Mapping Project' and will be taken into account when refreshing our autism action plan in 2014.

Integration

- 7.6 Integration between Health and Social Care is a key component in delivering the actions set out in the National Autism Strategy and progress has been made in this process through the introduction of NHS North East London Foundation Trusts Autistic Spectrum Disorder Diagnostic Pathway. Additionally, as part of the training and raising awareness of autism the borough, NELFT are planning to deliver autism awareness training for clinicians and practitioners on the new diagnostic pathway. Members of the CCG are core members of the Learning Disability Partnership Board, which is responsible for delivering the local autism plan, and have recently commissioned NHS NELFT to implement a local ASD diagnostic pathway
- 7.7 There are opportunities to joint planning and delivery of support for people with autism in an integrated way in the future. The plan is due to be refreshed in 2014, this presents an excellent opportunity for the Council and CCG to work on a joint approach to autism locally.

Financial Implications

- 7.8 As stated in the main body of the report, specific funding was not made available for the implementation of 'Fulfilling Lives' and the focus therefore is around adapting and making accessible what already exists, and reallocating existing resources and funding bids in areas such as employment and social support. However, £10k has been set aside in this year's training budget to deliver autism training to relevant staff in the coming months; quotes are currently being received to enable a training provider to be selected.

Legal Implications

- 7.9 There are no legal implications arising from this report.
- (Implications completed by Michael Henson-Webb, Solicitor, Adult Social Services)

Risk Management

- 7.10 A recent analysis of data from SEN, the Children's with Disabilities Team and numbers gathered from the local special school Trinity shows large numbers of diagnosed, known children with autism (323) who are now coming through the system which will create a demand pressure for the borough, particularly in five years time. From 2018 between 15 and 30 young people with autism are anticipated to be coming through transition from children to adult services each year.
- 7.11 If we are to engage operationally with key stakeholders in the Criminal Justice System we must also be mindful that National Offender Management Service is undergoing major reform and change which could impact this work.

8. Non-mandatory Implications

Crime and Disorder

- 8.1 As part of the Self Assessment Framework we were asked whether the Criminal Justice System were engaging in planning for adults with autism. We rated ourselves 'green' due to the boroughs excellent relationships with its CJS partners in the Community Safety Partnership, Safeguarding Adults Board and our Learning Disability Partnership Board. The borough will continue to work closely with its CJS partners around autism and they have been invited to attend the planned autism awareness training.

Safeguarding

- 8.2 Like all adults at risk people with autism are more vulnerable to criminal acts against them due to their social difficulties and may be taken advantage or become unwitting accomplices to criminal activity. The Council will continue to work closely with colleagues in safeguarding children and adults and will ensure input from these teams in the refresh of the local autism action plan in 2014.

Customer Impact

- 8.3 The SAF and Autism Mapping Project has given a clear idea on the gaps in provision and the needs of adults diagnosed with Autism in the borough. The outcomes from both pieces of work will be used as part of the Autism Action Plan refresh in 2014 which, once completed, will have a positive impact on the lives people with Autism in the borough.

Staffing issues

- 8.4 The need for specific training for staff has been identified elsewhere in the report and is now being delivered. We are exploring jointly with Havering whether it would be helpful to consider a specialist post or a low level preventative service.

9. List of Appendices:

Appendix 1: 2012 /13 Barking and Dagenham Autism Self Assessment Framework

Appendix 2: Autism Mapping Project Executive Summary

This page is intentionally left blank



Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

1

Comment

NHS Barking and Dagenham Clinical Commissioning Group.

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- Yes
- No

If yes, how are you doing this?

the London Borough of Barking and Dagenham (hereby known as the 'council') is currently working closely with its neighbouring local authorities (Havering, Redbridge and Waltham Forest) around potentially delivering joint ASD training across the boroughs. We are also working closely with the London Borough of Havering around reviewing the outcomes from both boroughs' recently completed mapping projects and discussing any potential joint commissioning opportunities which have emerged from these.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- Yes
- No

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Both the council and NHS Barking and Dagenham CCG have a named commissioner responsible for ASD in the borough and both sit and report to the Learning Disability Partnership Board (LDPB), a sub-group to the Health & Wellbeing Board, which has responsibility for delivering and monitoring progress against the boroughs ASD action plan.

Their contact details are:

LBBB, email:pete.ellis@lbbd.gov.uk.

jamilahmed@barkinganddagenhamccg.nhs.uk.

Local Authority: Pete Ellis, Strategic Commissioner,

CCG: Jamil Ahmed, Commissioning Support Manager, email:

4. Is Autism included in the local JSNA?

- Red
- Amber
- Green

Comment

Yes, the borough collates data on the number of Adults with JSNA in the borough.

5. Have you started to collect data on people with a diagnosis of autism?

- Red
 Amber
 Green

Comment

Yes, since 2012 the council has started to collate data on the number of adults who have a diagnosis of ASD and are eligible to receive a service from the council. NHS NELFT, who deliver the local diagnostic assessments in the borough, also collects data on the number of adults that have been diagnosed by the service. In addition, Education (Special Educational Needs) and Children's Services collates comprehensive data on the numbers of children and young people (CYP) who have either a identified special educational need and/or diagnosis of ASD. This data is also shared across health & social care and children's, adult and education services for strategic purposes.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- Yes
 No

If yes, what is

the total number of people?

11

the number who are also identified as having a learning disability?

0

the number who are identified as also having mental health problems?

0

Comment

These numbers show the additional people that have been identified as having Autism since the council began collecting data in 2012 and the number of adults with a diagnosis of autism and meet the councils eligibility criteria. Prior to 2012 these individuals were unlikely to have been known to the council. We recognise, however, that the prevalence data in our JSNA suggests there could be a significantly higher number of autistic adults who should be known to the council and we will be completing a data cleansing exercise over the next two years to successfully identify more individuals.

7. Does your commissioning plan reflect local data and needs of people with autism?

- Yes
 No

If yes, how is this demonstrated?

Yes, the councils current Autism action plan (2010-2013) has commissioning intentions which are themed around the key outcomes in the National Autism Strategy 'Fulfilling and Rewarding Lives'. These commissioning intentions were designed through analysing local need and prevalence data contained in our JSNA.

8. What data collection sources do you use?

- Red
 Red/Amber
 Amber
 Amber/Green
 Green

Comment

Our Adult, Children and Education services all have in place a number of robust case management and recording systems (called AIS / Swift / ICS / e-star) for people who receive a council service and/or have SEN. In addition, we have a number of processes in place to capture qualitative data such as through our Learning Disability Partnership Board (LDPB); service user and carer consultations and our six weekly service user, carer and provider forums which are part of our LDPB.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- Red
 Amber
 Green

Comment

Yes, since the CCG's inception on the 1st April, 2013 they have not yet been able to fully engage with the council on our Autism action plan. With this plan due to be refreshed in 2014 it presents an excellent opportunity for both the council and the CCG to design this jointly. Key members of the CCG are also core members of the LPDB, which is the currently responsible for overseeing and implementing our Autism plan, and recently commissioned NHS NELFT to implement the ASD diagnostic pathway.

10. How have you and your partners engaged people with autism and their carers in planning?

- Red
 Amber
 Green

Please give an example to demonstrate your score.

Yes, both our family carers and adults on the autistic spectrum were consulted, through 1:1 interviews and focus groups, when designing our Autism action plan and as part of our recently completed autism mapping project. Finally, both family carers and people with ASD are core members of our LDPB, where the Autism action plan is delivered and monitored, and we have a service user & carer forums which meet every six weeks.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- Red
 Amber
 Green

Please give an example.

Although the council does not have a dedicated policy on making reasonable adjustments specifically for people with Autism it does have a comprehensive Equality Policy framework which ensures we meet our statutory requirements. To ensure we continually meet our high standards on equality we also have a single equality scheme and complete the Local Governments Equality Framework. Some examples of how we have done this are outlined below:

Example 1:

Our dedicated disabled sports team working with local disability community groups we have been able to organise and run inclusive sessions. Inclusive sessions currently running are athletics, cycling, and two multi sports sessions, one for young people and one for adults. There are also a number of other sessions that are currently in the first stage of organisation. These include Wheelchair Basketball, and Sitting Volleyball.

Example 2: At Dagenham Library staff invited a group of people with Autism to come in and talk to them about their condition. Our staff arranged the visit when the library was closed as they said prior to this meeting that they do not like the noise and bustle of this busy library. Since then reasonable adjustments have been made where we have a separate quiet room which enables them to feel more comfortable at the library.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- Yes
 No

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

Yes, the council has an agreed transition pathway in place to help support our young disabled people prepare for adulthood. Transition plans are designed during Year 9 and this process is led and arranged by the pupils Head teacher. The pathway applies to all children with either a identified special educational, social care or health care need with the only potential restriction that applies is whether a young person meets the councils eligibility criteria for Adult services.

13. Does your planning consider the particular needs of older people with Autism?

- Red
 Amber
 Green

Comment

No. However, during the summer of 2013 the council undertook a review of its older people services and are now putting in place comprehensive plans which includes reviewing how we can better meet the needs of older people with complex needs, such as those with Autism. Since Autism was added to the adult services case management system (AIS) in 2012 the council now has the ability to record data on our older population who have a diagnosis of ASD. As stated in question 6 we recognise that we need to better identify adults with autism known to the council and we will be carrying out an exercise over the next two years that will enable us to better identify these individuals.

Training

14. Have you got a multi-agency autism training plan?

- Yes
 No

15. Is autism awareness training being/been made available to all staff working in health and social care?

- Red
 Amber
 Green

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

Yes, the council has in place a comprehensive Autism awareness e-learning package that is available to all health and social care practitioners in the borough. The councils learning and development team have robust systems in place that enable us to collate and monitor data on training take up which is then reviewed periodically. In addition, as part of our recent mapping exercise, we independently reviewed our Autism training plan against the skills for care and NICE guidelines which confirmed that it was compliant.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- Red
 Amber
 Green

Comments

No. However following a recent restructure of its Adult Social Care workforce it ensures that all statutory assessments are completed by a registered and qualified social worker. As a result, staff completing statutory assessments have both the relevant skills and competence to make any reasonable adjustments in their approach and communication for people with Autism. The council also has a comprehensive training plan in place for its social care workforce that includes Autism.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- Yes
 No

Please comment further on any developments and challenges.

No, since its inception on the 1st April 2013 the CCG has not yet been able to fully engage in the workforce development planning around Autism. The CCG are, however, key members to the Health and Wellbeing Board and its five sub groups including the LDPB where the Autism plan is monitored and reviewed. Our Autism plan is due to be reviewed in 2014 and the CCG will be key partners in this process.

18. Have local Criminal Justice services engaged in the training agenda?

- Yes
 No

Please comment further on any developments and challenges.

Yes, local police have attended training events in the past around Learning Disability and Autism awareness and all local CJS partners are able to access the councils Autism e-learning also. As part of our training plan on Autism we will also take into account any training needs of local CJS partners also.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- Red
 Amber
 Green

Please provide further comment.

Yes, in June 2013 NHS NELFT implemented a local diagnostic ASD pathway for the borough. This can be accessed through referrals made by either local GP's, Social Care teams, Adult Mental Health services, CAMHS or local voluntary / private organisations. We can confirm that the pathway was designed using the NICE Autism guidance G142.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

1

Year (Four figures, e.g. 2013)

2013

Comment

N/A

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

8

Comment

The local pathway has only just started so the referral for assessment is yet unknown but NHS NELFT have stated that they expect the average wait will be no more than 2 months.

22. How many people have completed the pathway in the last year?

60

Comment

60 and 25 of these then went onto a full diagnosis assessment.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- Yes
 No

Comment

Yes, the CCG has commissioned NHS NELFT to implement a local Autism diagnostic pathway.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis
 b. Specialist autism specific service

Please comment further

NELFT recently implemented local diagnostic pathway across its four boroughs (Barking & Dagenham, Havering, Redbridge and Waltham Forest). The main functions of this pathway is to provide:

1. An assessment and immediate post diagnostic support. The team will not be able to offer long term therapeutic or support function.
2. Provide consultation to Wards and local Community Teams
3. Signposting to other NHS NELFT services
4. Signposting to local authority services

It is not integrated with the social care assessment and this is something NELFT, CCG and the council will be working on.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

- Yes
 No

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

NHS NELFT have recently implemented a pilot diagnostic ASD pathway across their four London boroughs (Barking & Dagenham, Havering, Waltham Forest and Redbridge). If during a diagnostic assessment an adult is identified as potentially having a social care need they are then referred to the councils access and intake team for a community care assessment. As this pathway is reviewed during the pilot period we are confident that it will become better integrated with our local social care services.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

The council has some post diagnostic support services available in the borough which can be accessed by adults with Autism and their carers (see question 33 also). For example, we have a number of information & advice services such as the councils 'one stop' shops, our Intake team and our easy access social care website 'living the life you want'. In addition, we also have local voluntary organisations that provide support in a 'wider personalisation perspective' by offering services such as brokerage and independent peer support brokers. The council also has a dedicated personal assistant coordinator to support services find a PA. Additionally, our preferred option now is to offer everyone deemed eligible to receive a service from the council a personal budget. However, it must be noted that as a result of the current austerity programme the number of services available in the borough has unfortunately decreased and people, if eligible, are increasingly being asked to contribute towards their social care costs.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

1920

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

2

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

2

Comment

N/A

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

Yes
 No

If yes, please give details

Yes, Adults with a diagnosis of Autism and who have following this assessment been referred for a community care assessment will go through the council's 'Intake' team who can provide information , advice or signposting to other support services. If following a diagnosis assessment an individual does not either have any identified social care needs they can be signposted or provided information as part of the service offered by NHS NELFTS diagnostic pathway.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

Yes
 No

If yes, please give details

Yes, NHS NELFT has recently implemented a local ASD diagnostic pathway in the borough. If during a diagnostic assessment an individual has a potential social care need they are then referred to the councils 'access and intake' team for a community care assessment irrespective of whether they have a learning disability.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

Red
 Amber
 Green

Comment

Yes, our providers on the council's 'specialist advocacy and social care complaints framework' are required to meet the requirements of the National Autism Act Adherence to this is monitored through the councils contract monitoring and annual review processes. Our IMCA, IMHA and DoLS providers are also required to ensure all advocates have or are working towards Level 3 Certificate in Independent Advocacy and/or Diploma in Independent Mental Capacity Advocacy - Deprivation of Liberty Safeguards (IMCA - DoLS). All our local advocacy providers have confirmed that they can deliver their own in-house Autism training and can also access for free the councils Autism awareness e-learning.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- Red
 Amber
 Green

Comment

Yes, the borough has in place IMHA, IMCA and DoLS which can provide access to a specialist advocate for adults with autism who may not otherwise be able to meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes. All providers have confirmed that they deliver Autism training to their staff and can access the councils Autism e-learning

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- Yes
 No

Provide an example of the type of support that is available in your area.

The council has a number support services that can be accessed by people with Autism who are eligible or not for statutory services. Some examples are,

<i>Barking & Dagenham and PACT;</i>	<i>Information, Advice and Guidance: Citizens Advice Bureau</i>
<i>and the councils one stop shops; Employment: council Job Shops, Job Centre Plus and work programme providers;</i>	<i>Carer support: Carers of</i>
<i>Welfare advice: DABD (UK);</i>	<i>Education: Havering</i>

College offers there Realistic Opportunities for Supported Employment (ROSE) programme for people with Autism and/or a learning disability. Specialist Support for people eligible to receive a council service: this is delivered through our Access and Intake team and Community Learning Disability Team which is a multi disciplinary team of health and social care professionals which includes Social workers, Nurses, Physiotherapists, Occupational Therapists, Psychologists, Psychiatry and Art Therapists.

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- Red
 Amber
 Green

Comment

The borough aims to make all information accessible to ensure we meet our statutory requirements in Equality law. The council has in place a easy access webpage called 'living the life you want' for people with disabilities and their carers to access which contains a wide arrange of information on local services. We have recently completed our draft 'local offer', aimed towards children & young people and their carers, as part of our requirements in the proposed Children and Families Bill. This contains a wide range of education, health and care services, including those that provide support to children young people and cares for people with Autism, available in the borough.

The borough does have some generic preventative services available to people with Autism or their family carers.

For example:

Ambassadors' who offer training, advice and peer advocacy.

Social groups: We have Ab-phab, Gateway and Spartans social clubs that are available to people with Learning Disabilities and Autism which are also run by people with disabilities.

Carer support: We have Carers of Barking & Dagenham, who also deliver the incredible years training to carers to children and young people with ASD, and Parents of Autistic Children Together (PACT) in the borough who offer low level support to both family carers and people with Autism.

Early intervention /preventative mental health services: NHS NELFT delivers IAPT and primary care mental health services.

Peer advocacy: we have the 'Autism

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- Red
 Amber
 Green

Comment

The council has a comprehensive five year generic Housing Strategy which includes the housing needs of disabled people, including groups such as Learning Disability and Strategy for Disabled Adaptations, but has no specific section on Autism. This Strategy will be refreshed during 2015 and will include a specific action plan for people with autism. In the meantime we will build upon and extend the work of the Learning Disability Housing Group to implement specific actions around autism and housing including supporting people with autism (and their carers) to understand the housing options available to them; embedding the needs of people living with autism into the strategic objectives of the LBBB regeneration strategy; undertaking a specific needs analysis; providing up to 25 units of accommodation to support young people living with autism.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

- Red
 Amber
 Green

Comment

Yes. During 2013 we delivered a one off British Institute of Learning Disability accredited training event to local mainstream employment services (e.g. work programme providers, Disability Employment Advisors and local Job Clubs) on how to better support adults with Autism either find or in their place of employment. The Autism Ambassadors also work with local employers and have a joint-agency promotion pack to help demonstrate the benefits of employing someone with Autism. We know that, through our recently completed mapping project, we need to better promote to our local employers employing the skills and benefits of employing people on the autistic spectrum. We aim to address this through the council's autism action plan, which will be reviewed next year, and the council's Fulfilling Lives programme which is designed to modernise day opportunities for people with a learning disability or autism in the borough.

36. Do transition processes to adult services have an employment focus?

- Red
 Amber
 Green

Comment

Yes, as part of the our transition planning, which starts in Year 9, a career PA will explore with the young person their individual goals and aspirations around employment. The transition plan is then reviewed during each academic year and until the young person leaves education. We know, however, that supporting young people into employment is an area of development and this was fed back to us by our carers and people with Autism during the recently completed mapping project. We hope this area will be addressed through the refresh of our Autism action plan next year and the councils Fulfilling Lives, Winterbourne View and Children and Families Bill programmes which will all include improving how we better support young people who come through transition.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- Red
 Amber
 Green

Comment

The council has excellent relationships with our CJS partners through our Community Safety Partnership, Safeguarding Adults Board and our Learning Disability Partnership Board where the Autism action plan is reviewed and monitored. In addition, local Health and Social Care practitioners work in partnership on a daily basis with Criminal Justice practitioners via a number of routes such as by acting as appropriate adults and working with the Public Protection Unit, MAPPA and local probation services to support the management of vulnerable people who present a risk to the public. The borough's safer places scheme was also designed through our partnership work with carers, service users and the Police. CJS partners have also attended previous Autism training and have access the to the councils Autism awareness e-learning.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one). In the comment box provide the story.

Self-advocate story one

Question number

25262829

Comment

We gathered feedback during our recent mapping exercise from carers and people with Autism. The following five stories were from this exercise. *The council received positive feedback from people with Autism on the number of mainstream opportunities for voluntary and work based opportunities that can offer a valuable first step into employment for many people with ASD.*

Self-advocate story two

Question number

112833

Comment

"...Support for people with ASD could be improved by adapting what already exists or small investments in community development and support".

Self-advocate story three

Question number

12

Comment

Carers gave positive feedback that children and younger people services were getting better at identifying young people with Autism and services to support them. It was expressed that awareness generally is much higher than it used to be.

Self-advocate story four

Question number

11263335

Comment

"...People, even if diagnosed, have a real problem gaining any sort of support if they have an IQ over 70 and no presenting mental health issue. Early intervention and support are needed before mental health problems kick in further down the line".

Self-advocate story five

Question number

42

Comment

"...Local primary care health services are unable or unwilling to adapt, resulting in distressing episodes when people were attending appointments."

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

Yes

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the [ministerial letter](#) of 5th August 2013?

Yes

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

Month

Year

Appendix 2: Section 1 Introduction and summary

Summary

This report is a mapping exercise, and therefore its chief function is to describe things as they currently stand in relation to autistic spectrum disorder in Barking and Dagenham. However it also views this in the context of what is happening elsewhere – particularly models and examples of good practice and demographic trends – and what needs to happen in the future. It is not a strategy but its intention is to provide the information and actions necessary to create a strategy which meets the needs of people with ASD in the borough and moves towards achieving the vision of ‘Fulfilling and Rewarding Lives’.

In summary the report has found that there is only a very small number of specialist services focused on autistic spectrum disorder and these are almost exclusively focused on people who have ASD and severe/complex learning disabilities. Only small numbers of the 750-1275 adults we would expect there to be in the borough are known to services. However, far larger numbers of children and young people with ASD are known to the borough, particularly in the early years up to year 9. This does not appear to reflect a rise in the incidence of autism – the numbers still fall well within the expected prevalence range - but improvements in diagnosis and awareness. For adult services it represents an acute demand pressure in the medium term, reinforced by evidence of growing numbers of adults coming forward for diagnosis.

Feedback gathered from people with ASD, their families and professionals reveal strong concerns about the transition process and a pattern of young people moving into adulthood and finding it difficult to gain support. There is a consensus that an employment strategy across the spectrum of autism will be critical in the future both in mainstream and specialist services – ranging from meaningful occupation in a social enterprise setting for people with complex needs to support into mainstream employment for people who are ‘high-functioning’. Access to housing and social activity will also be key.

Also critical will be a protocol and partnership between learning disability and mental health services (and between social care and health) to ensure that there is a meaningful, appropriately supported pathway for adults with ASD post-diagnosis or post-transition. This may involve a specialist social care and health team brought together by re-allocating existing resources. It must link a social care pathway to the current diagnostic pathway.

The final element of creating an effective response to autistic spectrum disorder will be the engagement of mainstream services. Housing, employment, leisure, volunteering, libraries, colleges, regeneration and others can all make a contribution by adapting and adjusting their offer so that they can accommodate and support people with ASD. All of this will require a strategic focus built on real partnerships to drive through the necessary changes.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Urgent Care Board Update		
Report of the Barking and Dagenham Clinical Commissioning Group			
Open Report	For Decision		
Wards Affected: NONE	Key Decision: NO		
Report Author: Jane Gateley, Director of Strategic Delivery, BHR CCGs	Contact Details: Tel: 020 8926 5219 E-mail: jane.gateley@onel.nhs.uk		
Sponsor:	Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group		
Summary:	This purpose of this report is to update the Health & Wellbeing Board on the work of the Urgent Care Board.		
Recommendation(s)	The Board is asked to note the progress report and agree to receive a further update at its meeting on 25 March 2014.		
Reason(s):	There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.		

1. Background/Introduction

- 1.1 Following the CQC visit at BHRUT and the continued failure to hit the 4 hour target (A&E performance is calculated as the percentage of A&E attendances where the patient spent 4 hours or less in A&E, from arrival to transfer, admission or discharge. The standard is 95% for all types of patents), CCGs proposed to the Integrated Care Coalition that an Urgent Care Board (UCB) be established to support system wide improvements in care.
- 1.2 Following a work shop in May 2013 senior leaders supported this proposal.
- 1.3 The establishment of the UCB does not impact on the formal contractual governance arrangements in place to performance manage individual providers.
- 1.4 Meetings have been held on a monthly basis since June 2013.

2 Progress Update

- 2.1 The role and priorities of the Urgent Care Board were reported to the Health and Well Being Board in September. This paper provides an update on progress.
- 2.2 The last meeting of the Urgent Care Board was held on 24 October 2013. The meeting is well attended by all local health and social care organisations and there continues to be a clear commitment from all parties to work together to improve performance.
- 2.3 The Health and Well Being Board have been separately advised of the outcome of the BHRUT A&E Clinical Review. The UCB have received the report and at its last meeting considered the recommendations and proposed actions. This was agreed in principle and will now be monitored by the UCB going forward.
- 2.4 Performance data reported shows BHRUT continue to fail to meet the 95% target (The latest trajectory submitted by the Trust since the meeting shows the Trust projecting achievement of the 95% target in March 2014).
- 2.5 A&E recruitment continues to be a risk and whilst the Trust reported benefits to patients from the introduction of 7 day working, length of stay metrics indicated a rise rather than increase.
- 2.6 Local Authorities advised they were all ready to implement 7 day working from the beginning of November, and it was agreed to review progress at the November meeting. An update was provided by LBB on the Joint Assessment and Discharge proposals. It was agreed that a revised/final proposal would come back to the UCB in November.
- 2.7 Commissioners advised that across all three boroughs CCGs were introducing GP surge schemes across the winter period to provide additional access to general practice.
- 2.8 Commissioners reported that discussions were taking place with Urgent Care Centre providers at Queens and KGH to increase the level of utilisation ahead of the winter period.

- 2.9 The Board received a report from commissioners outlining the next steps for the Frailty project following the audit of circa 300 patients at Queens A&E and the service mapping exercise. Colleagues agreed the cross system workshop held in October had been extremely beneficial, identifying a number of quick wins that should be progressed immediately e.g. London Ambulance Service (LAS) to refer direct to the Community Treatment Team where agreed protocol requirements met. A progress report on this work stream will come back to the next UCB.
- 2.10 Conor Burke updated the UCB on a meeting between commissioners, LAS and BHRUT. The action plan arising from the meeting was shared with the UCB and will be monitored via the UCB going forward. The plan includes closer working between LAS and the Trust on a daily basis to support the management of flow of patients through the hospital. LAS also outlined their winter initiatives including an alcohol diversion scheme an additional training for staff to ensure they utilise all appropriate alternatives to A&E.
- 2.11 The UCB were advised that £7m of winter monies has been earmarked for the BHR health and social care system. As previously reported these monies are being targeted to UCB priority areas and will be monitored via the UCB. Winter plans in general have been submitted and weekly system wide winter escalation teleconferences have begun.

3 Mandatory Implications

3.1 Joint Strategic Needs Assessment

The priorities of the Urgent Care Board are consistent with the Joint Strategic Needs Assessment.

3.2 Health and Wellbeing Strategy

The priorities of the Urgent Care Board are consistent with the Health and Wellbeing Strategy.

3.3 Integration

The priorities of the Urgent Care Board are consistent with the integration agenda.

3.4 Financial Implications

(Implications completed by Martin Sheldon, Chief Financial officer, B&D CCG)

The UCB will make recommendations for the use of the A&E threshold and winter pressures monies.

3.5 Legal Implications

There are no legal implications arising directly from the UCB.

3.6 Risk Management

Urgent and emergency care risks are already reported in the risk register and board assurance framework.

4 Non-mandatory Implications

5 Customer Impact

5.1 There are no equalities implications arising from this report.

5.2 Contractual Issues

The Terms of Reference have been written to ensure that the work of the Board does not impact on the integrity of the formal contracted arrangements in place for urgent care services.

5.3 Staffing issues

Any staffing implications arising will be taken back through the statutory organisations own processes for decision.

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Engagement Strategy & Mechanisms: Update	
Report of the Corporate Director of Adult & Community Services		
Open Report	For information	
Wards Affected: ALL	Key Decision: No	
Report Author: Mark Tyson Group Manager, Service Support & Improvement	Contact Details: mark.tyson@lbbd.gov.uk 020 8227 2875	
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services		
Summary: At its meeting in June 2013, the Board agreed an approach to developing an Engagement Strategy. The approach centred on the subgroups of the Board, and requested each group to schedule appropriate discussions with a view to setting out their approach to engagement, the mechanisms they would use, and priorities for engaging with the public, service users and carers. The subgroups of the Board are all at different stages of development and have made different inroads into establishing their engagement mechanisms and priorities. This report summarises progress and invites Health & Wellbeing Board comment. It proposes a simple next step to support the proposed mapping of connections and activity across the work of the health and social care partnership.		
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Note the progress on engagement to date; • Provide feedback to the subgroups on areas to be developed; and • Agree the recommended approach to moving the discussion forward, set out in Section 5. 		

1. Background

- 1.1 As noted in the June report to the Health & Wellbeing Board, the Health & Wellbeing Board has a critical role in ensuring that plans for the development of health and social care services are “founded on the views and experiences of service users, carers and the general public”.
- 1.2 The report noted Healthwatch’s position as a statutory core member of the Board reflects this role, but went on to observe that “Healthwatch cannot be the sole conduit for information and views on the future direction of services and the Board must ensure that it is engaging with the views of a wide cross-section of service users, residents, carers and frontline health and care workers.
- 1.3 It was therefore proposed that the Board develop an engagement strategy to inform this work, and in discussion it was felt that this was best undertaken by the sub-groups. Amongst actions arising from the discussion were:
 - Subgroups to have engagement as a discussion item in order to review how they link to existing forums, what gaps they have, and what tools and techniques they intend to deploy to ensure their work is grounded in the views of those affected.
 - This work was then to be collated into an engagement strategy ‘map’ showing the connections, information flows, and early specific plans for events, consultations and web developments.
 - Healthwatch, the Health & Wellbeing Board support team and the CCG Operations team join together - with others who may be keen to contribute - review the strategy map and to shape how the Board itself can use information being gathered through the emerging strategy, including online, written and face-to-face methods, and the expectations on how reports are crafted to include reference to feedback from residents and service users.
 - The Health & Wellbeing Board support team to pull together an overview of how the Council’s social media channels and the website may be used by the Health & Wellbeing Board, with input from the Corporate Communications team, in order to feed this into the developing strategy.

2. Board Approach

- 2.1 The Health & Wellbeing Board itself has made some steps towards improving its engagement with service users, the public and providers, although there remains much to be done. The Council’s corporate approach to publicising health campaigns, and to soliciting feedback from the community on relevant matters, is also of support to the Board.
- 2.2 The Twitter feed (@BarDagHWBB) went live on 8 July 2013, since when 179 tweets have been published to (currently) 74 followers. These include professional and user representative organisations, think tanks and local individuals. In terms of opening up access to the Board meetings, around 47 tweets were sent during the course of November’s Board meeting, as well as pre- and post- links to the minutes and agenda pack.
- 2.3 The Council’s webpages have been reviewed to improve the clarity of information that they contain about the work of the Health & Wellbeing Board and the Council’s

general responsibilities for the improvement of the health of the population following the transfer of public health. It is recognised that there is still some work to be done to improve the online information offer in this regard.

- 2.4 The Council has initiated a substantial work programme to meet the new responsibilities expected from the Care Bill, which include new duties for the provision of information and advice on social care. As a first step, a new social care website - Care & Support Hub (careandsupport.lbbd.gov.uk) - has been created. The site includes information pages, a service directory and a Personal Assistant Finder, which allows PAs to promote their services and service users to browse and contact them. As part of the development of the website, Healthwatch supported the Council in convening a group of service users to advise on the initial designs and content.
- 2.5 On 13 November 2013, under the Board's banner, a workshop at the Barking & Dagenham Partnership focused on engaging local professionals and members of the Partnership in the issues around mental health, linking into the work of the Health & Adult Services Select Committee on mental health and austerity. A range of local services and projects, including mental health service user groups and self-help systems such as 'Big White Wall', were provided with the opportunity to explore the services that they offered, and feedback was sought from delegates to the conference.

3. Health & Adult Services Select Committee

- 3.1 The Health & Adult Service Select Committee have undertaken in-depth scrutiny reviews of diabetes services (published early 2013) and the impact of austerity and the recession (currently underway). The Board received the diabetes report, and planned actions in response to its recommendations.
- 3.2 The scrutiny review had engaged with a wide range of professionals and service user groups, with the Chair of the local Diabetes Support Group co-opted to the Committee, leading to review conclusions that are soundly based on the views of local users of services.

4. Sub-group activity

- 4.1 The request for sub-groups to give consideration to their approach to engagement was made at a point when, in the case of some sub-groups, they were still establishing themselves, agreeing priorities and clarifying membership. There has been some progress in all cases, although it is, for the most part, less formal than was originally intended.

Mental Health Sub-Group

- 4.2 At their meeting on 14 August, the group agreed to organise an event to capture public voice regarding mental and physical health conditions. A task and finish group was established to deliver the event, which is planned for the first quarter of next year. The group consists of Healthwatch, Public Health, NELFT, the Mental Health service user engagement group, and the Council's Children's Participation team, and they have begun to agree an outline for what will happen at the event. The focus will be on the experience of residents with long-term conditions and their

access to mental health support, looking to improve the complex interactions in services.

- 4.3 An event took place at the Broadway Theatre on World Mental Health Day, with a good representation from service users meeting members of the Health & Adult Services Select Committee and senior officers to shape the findings of the report being prepared by the Select Committee on mental health and austerity. The service users took the opportunity to highlight a number of concerns, including anxiety around Universal Credit and Benefits Assessments; supporting people who have experienced mental ill health to up-skill for work; and feelings of victimisation in the workplace.

Older People and Integrated Care Sub-Group

- 4.4 The Older People & Integrated Care Sub-Group has been principally focused on local co-ordination of the work of the Integrated Care Coalition and Urgent Care Board, and scoping further work on End of Life Care and frequent attenders at A&E. As such, opportunities have not yet arisen for detailed engagement activity.
- 4.5 However, the group has considered how information about patients' preferences is transferred when care is transferred, reviewing the Integrated Case Management assessments to confirm that they are adequate for maintaining patient/service user voice during transfers of care.
- 4.6 In September, B&D CCG Governing Body approved the trial of a new model of intermediate care. The trial, to run from November 2013 to March 2014, includes the establishment of a new home-based intensive rehabilitation service (IRS) and expansion of Community Treatment Team (CTT) to operate from 8am to 10pm. It was agreed that the trial would 'double run' with the existing community bed-based intermediate care services to provide an opportunity to test the effectiveness of the new model. These developments form part of the Integrated Care work programme.
- 4.7 The approval of the trial was subject to the condition that intensive engagement with service users was to be undertaken during trial period to understand their experience of the new services and thoughts on the proposed model.
- 4.8 A multiple strategy engagement plan has been developed for Barking & Dagenham to maximise engagement of both potential service users and those who have been supported by the Community Treatment Team and Intensive Rehabilitation Service. The engagement strategies sought to understand patient thoughts about the proposed model and their experience of using the new services to inform further development. Engagement activities will be jointly undertaken by NELFT and the Barking & Dagenham, Havering and Redbridge CCGs between November 2013 and January 2014.
- 4.9 Engagement strategies are summarised as follows:
- NELFT Patient Engagement Forum;
 - Exit surveys completed by patients who have been through IRS and CTT services;
 - Patient satisfaction survey;

- Follow up phone calls to patients post discharge from IRS/CTT- a standardised 'script' has been developed to illicit information regarding patients experience of the new services;
- CCG Patient Engagement Forum;
- Healthwatch focus group.

4.10 Progress and outputs from the engagement activity will continue to be reported through to the Older People and Integrated Care Sub-Group.

Learning Disability Partnership Board

- 4.11 In many respects, the Learning Disability Partnership Board (LDPB) has the most established and active engagement programme to support its work. When established, the LDPB was accompanied by the establishment of a Service User Forum, Family Carer Forum and Professionals and Providers Forum. These have been meeting regularly and there have been reports between those and the LDPB itself. The LDPB has held 5 meetings and the themes have included health, community safety, quality assurance and autism. Future themes include housing, community safety and safeguarding and employment, skills and training. The LDPB has produced a newsletter to share information. These will be produced on a quarterly basis.
- 4.12 The first meeting of the Service User Forum was very well attended, with over 80 people present. There have been five meetings since it has been established. Due to the high numbers attending the first meeting a decision was taken to limit attendance to three representatives per organisation to ensure effective and engaging discussions can take place. It is to be noted that, whilst historic engagement activities were successful with those with learning disability not eligible for local authority services, the new arrangements are much more inclusive, with service users from a range of care settings and types of care delivery alongside the continued involvement of those without eligible care needs.
- 4.13 Three service users have been voted to represent the Forum at the LDPB. Unfortunately one Service User representative has recently stood down from the role. This arrangement is under on-going review to confirm that it delivers the representation and involvement that was intended, whilst the LDPB also works through the business that it is required to deliver for the Board.
- 4.14 As part of collecting 'people's stories' for the Self Assessment Framework (SAF) an art activity was facilitated with service users to collect positive and negative stories and gain feedback on improvements for the future. In order for the forum to hold meaningful discussions it is felt that the meetings should be held quarterly in a more conference style setting using facilitators and engaging participants in activities. Discussions at other meetings have centred around Winterbourne View, the Children and Families Bill and Learning Disability Week.
- 4.15 The Family Carer Forum has held five meetings. Attendance has been fairly low averaging around eight attendees. The Forums are working with local carer organisations to disseminate information and encourage people to attend. They have recently mailed 87 and emailed 19 carers to invite them to the meeting. A Chair and Family Carer representative has been appointed.

- 4.16 Some of the issues that have been discussed at the Family Carer Forum meetings include the Self Assessment Framework (SAF), the Francis Report, Fulfilling Lives, Learning Disability Week, Winterbourne View, the Children and Families Bill, Fairer Charging and invoicing, welfare benefits changes and the role of Job Centre Plus.
- 4.17 The Professional and Providers Forum meet quarterly and have held two meetings so far. Two representatives have been elected to sit on the LDPB. Discussions have taken place around closer partnership working and a model of support for people with complex needs.

Children & Maternity Sub-Group

- 4.18 At the meeting on 29 May a discussion was held on representation of children and young people through Healthwatch. A paper about the Clinical Commissioning Group's engagement with children and young people formed the basis of the discussion. It was agreed that the CCG would invest £10k in commissioning work through the Children's Services Engagement Team.
- 4.19 The delivery plan, to be agreed, will include use of a range of mechanisms including Young People's Development Forum, focus groups with the specific parent groups, the BAD Youth Forum, and work with the Young Inspectors and in schools.
- 4.20 Work has started with the Young Inspectors. The Young Inspectors are visiting General Practice Patient Participation Groups to support improved engagement of young people in these groups, with the aim of supporting general practices to develop their service delivery for young people.

Public Health Programmes Board

- 4.21 The Public Health Programmes Board covers many of the areas about which campaign information would be disseminated to the public. At the meeting on 16 July, there was a discussion about forthcoming campaigns which included International Day Against Violence Against Women (White Ribbon Day), Movember, Stoptober and World AIDS Day.
- 4.22 Actions have been agreed around outreach work with teenagers regarding Chlamydia testing and prevention, in response to reviews of the data regarding testing uptake.
- 4.23 Planning is underway for the Board's agreed Obesity Summit, with the intention of widening the professional and public influence on work to reduce obesity. This will take place on 16 December, and the Public Health Programmes Board will assimilate the outputs from the event and consider the impact on current plans and commissioned activity around obesity.

5. Recommendations

- 5.1 To move this work forward, it is recommended that a discussion be timetabled at the next available meeting of each sub-group, to a series of questions as set out in Appendix 1. They are intended as a guide, to structure discussions, and are relatively self-explanatory. The Learning Disability Partnership Board may not need to undertake this exercise, but may find a 'refresher' discussion useful.

6. Mandatory Implications

Joint Strategic Needs Assessment

- 6.1 Considerable work was undertaken to engage a wider cohort of people in the development of the last Joint Strategic Needs Assessment. However, it remained an acknowledged deficiency that there was not more service user, carer, patient and public 'voice' in the findings of the JSNA. This should be made easier if the Partnership can embed engagement activity, aligned to its priorities, in the work to deliver the Strategy.

Health and Wellbeing Strategy

- 6.2 As above, the Health & Wellbeing Strategy responds to the identified priorities and issues in local health and social care services and the health of the population. Ensuring that it is shaped by the views of local people will be greatly facilitated by an approach to engagement which is 'everyday business'. This will not replace the need to consult specifically on future iterations of the Strategy, but if the mechanisms can be mapped across the main subgroups and Board priorities, then they will be readily available to support strategy development activities.

Integration

- 6.3 By focusing engagement activity on the subgroups, it is intended that 'holistic' views will be obtained, shared across all relevant partners and minimising consultation fatigue, and better aligned to the increasingly integrated approach to service planning and delivery.

Legal Implications

- 6.4 There are no legal implications as such but in terms of engagement with service users, carers and the wider public it is always good practice to bear in mind the principles of consultation laid down in case law known as the 'Gunning Principles'¹. These principles will be helpful in relation to the engagement strategy proposed in the report. Any failure to properly consult, especially if changes are to be made to particular services, could lead to judicial review.

(Implications completed by Dawn Pelle, Adult Care Lawyer)

¹

- (i) Consultation must take place when the proposal is still at a formative stage;
- (ii) Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
- (iii) Adequate time must be given for consideration and response; and
- (iv) The product of consultation must be conscientiously taken into account.

This page is intentionally left blank

Discussion Framework: Creating an Engagement Map

The following questions are intended to guide discussion, the results of which will inform a mapping of principal engagement routes and mechanisms. Sub-Groups of the Health & Wellbeing Board are asked to timetable a discussion at their next available meeting, to record the results and return them to the Health & Wellbeing Board support team at glen.oldfield@lbbd.gov.uk.

1. Existing mechanisms: What existing engagement mechanisms exist for engaging the following, and have connections already been established?
 - a. Existing service users and carers relating to the work of the sub-group;
 - b. Potential new service users or carers relating to the work of the sub-group;
 - c. The general public (focusing on which engagement mechanisms are deemed particularly helpful for the work of this sub-group);
2. Individual agency approaches: What mechanisms or projects are the sub-group aware of that may be of particular benefit for the client groups and programmes that the sub-group is overseeing, and what connections have already been established?
3. Are there specific examples for each of the above?
4. Priorities for engagement
 - a. What areas of the Health & Wellbeing Strategy have the group established as needing further engagement with service users, carers or the general public?
 - b. On which projects or programmes does the sub-group anticipate requiring formal engagement with service users, carers or the general public and what approaches (including timetables) have been suggested/agreed?
 - c. What service user groups or equalities strands does the group consider need particular attention over the coming year-to-18-months in order to ensure that their voice is more appropriately and adequately reflected in service planning?

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Sub-Group Reports		
Report of the Chair of the Health and Wellbeing Board			
Open Report	For Information		
Wards Affected: NONE	Key Decision: NO		
Report Authors: Glen Oldfield, Democratic Services	Contact Details: Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk		
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board			
Summary: At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board. The Children and Maternity Group met last on 27 November 2013, the update from that group will be given verbally at the meeting.			
Recommendations: The Health and Wellbeing Board is asked to: <ul style="list-style-type: none"> • Note the contents of sub-group reports set out in the Appendices 1-5 and comment on the items that have been escalated to the Board by the Sub-groups. 			

List of Appendices

- Appendix 1: Mental Health Sub-group
- Appendix 2: Integrated Care Sub-group
- Appendix 3: Learning Disability Partnership Board
- Appendix 4: Public Health Programmes Board

This page is intentionally left blank

Mental Health Sub-Group

Chair:

Martin Munro, Executive Director, Human Resources & Organisational Development, NELFT

<p>Items to be escalated to the Health & Wellbeing Board</p> <ul style="list-style-type: none"> • Lack of NHS England and specialist commissioning representation was mentioned in the H&WBB exception report. As this is unchanged it is now escalated to the H&WBB. • Members also noted there had been no attendance by GPs to date.
<p>Meeting Attendance</p> <p>30 October 2013: 40% (6 of 15 members) plus 1 guest speaker</p>
<p>Performance</p> <p>Please note that no performance targets have been agreed as yet.</p>
<p>Action(s) since last report to the Board</p> <p>BHR CCGs Joint Mental Health Commissioning Intentions were tabled and considered at the meeting on 30 October.</p> <p>A paper was considered about the NEL Recovery College for mental health service users. The purpose was to promote and raise the profile of NEL Recovery College to the Mental Health Sub Group and in turn the H&WBB and to be considered for commissioning intentions cycle. This local initiative is based on national evidence but will be subject to local evaluation. Although NELFT are hosting, it is not owned by NELFT.</p> <p>Mental Health Service Information in GP surgeries was raised on behalf of the LBBD Patient Experience Partnership (PEP) in September when service users asked about provision of information regarding NELFT Services at GP Practices. No GP representative was present however it was confirmed the CCG can arrange to support the distribution of materials.</p> <p>An initial proposal was tabled by Public Health to develop a Health and Wellbeing Strategy for Barking and Dagenham. Members will consider and comment on the proposed strategy.</p>
<p>Action and Priorities for the coming period</p> <p>Members of the MH Sub Group will attend the Children's Health Board to hear presentation about Children and Adolescent Mental Health on 27 November 2013.</p>

Contact: Fran Hayward, PA to Executive Director of Human Resources & Organisational Development, NELFT

Tel: 0300 555 1047 / Internal Ext: 4292 **E-mail:** Francesca.Hayward@nelft.nhs.uk

This page is intentionally left blank

Integrated Care Sub-Group

Chairs:

Dr Jagan John, Clinical Lead, NHS Barking and Dagenham Clinical Commissioning Group
Jane Gateley, Director of Strategic Delivery, BHR Clinical Commissioning Groups

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>None</p>
<p>Meeting Attendance</p> <p>28 October 2013: 53% (8 of 15)</p> <p>Note: Severe adverse weather conditions resulted in lower than average attendance at this meeting</p>
<p>Performance</p> <p>Please note that no performance targets have been agreed as yet.</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <ul style="list-style-type: none"> ▪ Integrated Case Management leads continue to develop an Integrated Case Management scorecard detailing monthly Integrated Case Management performance against targets which the Integrated Care Group will review at each meeting. The ICM scorecard should be finalised in November. ▪ The group received its monthly update on the Community Services development. NELFT continue to operate weekly project meetings to work up the operational detail of the proposals in partnership with health and social care colleagues. The Community Treatment Team service will be extending its hours from 8am – 8pm to 8am – 10pm from November 2013. The Intensive Rehabilitation Service which delivers rehabilitation services in patient's homes is planned to go live from November 2013. ▪ The group receives a monthly update on the development of the Joint Assessment and Discharge Service (JAD) at BHRUT; the group was notified this week that the London Borough of Redbridge has pulled out of the service at this stage. This is an unexpected development, however Barking and Dagenham and Havering Adult social care, along with BHRUT and NELFT stakeholders have reiterated their commitment to the JAD service which is still anticipated to go live in April 2014. ▪ The end of life update paper for the Health and Wellbeing Board will now be going to the meeting in February. The Integrated Care Group will discuss and develop this paper at their next meeting in November. ▪ The group were updated on the success of a bid for £535,000 funding of end of life training across Barking & Dagenham, Havering and Redbridge. Gold Standards Framework training will be delivered by Saint Francis Hospice to care homes and domiciliary care providers. Within B&D a localised training plan will be developed and delivered to general practice. ▪ An analysis of the audit of frequent attendees was presented to the group highlighting that the 260 patients reviewed accounted for 5% of total A&E attendances during the

period covered. This report was supported by a Nursing Home patient review and recommendations based on the findings will be taken forward to close gaps in service/improve care for these patients.

- Dr Sue Levi from B&D Public Health presented an 'Older People Report' which analysed and profiled 'need' and forecast population demographic change to 2018.
- The BHR Urgent Care Board recently signed off 6 priority work programmes, one of these being a 18-24 month programme focussed on frail elders being led by UCLP and the Innovation Unit, and overseen by the CCG Strategic Delivery team. The aim of this work is to provide the foundation for targeted interventions, in the short term to prepare for winter, and in the longer term to ensure a coordinated approach for better supporting frail and older populations across BHR. The project has undertaken an audit in A&E at Queens Hospital, interviewing 293 frail elders in order to understand their journey to hospital and to identify interventions which might have provided an alternative to hospital attendance; a copy of the outcome report was circulated to the group. In addition the team have mapped patient demand and current services, and interviewed key stakeholders from health, social care and the voluntary sector. A Strategic steering group will be in place to oversee progress of the above and progress will be reported back via the Integrated Care group.

Action and Priorities for the coming period

- The group will continue to monitor Integrated Case Management performance, reporting progress to the Health and Wellbeing Board and escalating issues as required.
- An End of Life paper outlining current provision in Barking and Dagenham and identifying gaps in service is being sent to the Health and Wellbeing Board from the Integrated Care Sub Group, to frame End of Life discussion.
- The Integrated Care subgroup will receive a regular update on the delivery of the end of life training programme for general practice, care home and domiciliary care providers.
- The integrated care subgroup will continue to discuss Community Services developments and update the Health and Wellbeing Board on progress.
- The Integrated Transformation Fund is now a standing item on the agenda of the Integrated Care group; the group will discuss ITF developments and update the Health and Wellbeing Board on progress going forward.
- The integrated care subgroup will continue to discuss Frail Elder developments and update the Health and Wellbeing Board on progress.

Contact: Emily Plane, Project Officer, Strategic Delivery, BHR CCGs

Tel: 0208 822 3052 **E-mail:** Emily.Plane@onel.nhs.uk

Learning Disability Partnership Board

Interim Chair:

Jenny Beasley, Group Manager, Adult Commissioning

Items to be escalated to the Health & Wellbeing Board

None

Performance

Indicator	Lead	Delivery Plan	Outcome/ Activity Indicator	Lifecourse	Suggested Sub Group	HWBB Dashboard	Performance
LDD children under 5years with annual health plan in place	NCB London	Healthy Child Programme 0-5yrs	Activity	Pre-Birth and Early Years	LDPB		
% of individuals with LDD with annual health check	CCG	TBC	Activity	Vulnerable and Minority Groups	LDPB	Yes	81% have had a Annual Health Check
% of individuals with LDD with health and wellbeing plan	CCG	TBC	Activity	Vulnerable and Minority Groups	LDPB		66% have a Health Action Plan.
% of individuals with Learning Difficulties and Disabilities (LDD) with a named key worker	LBBD	TBC	Activity	Vulnerable and Minority Groups	LDPB		100% children 32% adults (* this is usual practice as cases are closed on

							AIS following either an annual review or assessment with all enquiries / requests going through the CLDT intake team)
Learning Disability/Difficulty (LDD) children under 5years with annual health check complete.	NCB London	Healthy Child Programme 0-5yrs	Activity	Pre-Birth and Early Years	LDPB		Q1 2013/14 - 62.9%. Q1 2012/13- 81.5% London average: 88.1% England average: 84.3%

Action(s) since last report to the Board

- (a) Two Learning Disability Partnership Board (LDPB) meetings have taken place since the last report in September.
- (b) The Service User, Carer and Professionals and Provider Forums are meeting regularly and have set up programme of future meeting dates. The Forum representatives have an opportunity to give feedback and raise any issues at every LDPB meeting.
- (c) Standing items on the LDPB forward plan include Winterbourne View and Children and Families Bill and Transitions.
- (d) Topics that have been discussed are the role of Healthwatch, the Winterbourne View Joint Strategic Plan and Self Assessment Framework, autism and quality assurance.
- (e) The first LDPB newsletter was produced and distributed and included information about Learning Disability week.

Forums Feedback

Service User Forum

Service user forum met on the 14th October and feedback was that:

- The Board needs to ensure the information given at the forum is accessible.
- The agenda can be overwhelming and complex which results in a lot of service users not understanding the discussion.
- A feeling amongst the service users that the agenda is not service user or carer led and instead is an agenda set by the Council / CCG.
- Suggestions of reviewing the frequency of when the service user forum meets and having one item to be discussed per forum.

Carer Forum

The Family Carer forum met at Heathlands on the 15 October. The Forum discussed the following:

- Children and families bill, in particular a draft version of the Local Offer for disabled adults which received immediate feedback.
- The Autism Mapping Project was presented and the development of a local diagnostic pathway was well received.
- There was feedback on Healthwatch and carers were provided with information and contact details
- The Self Assessment Framework was discussed in detail and where carers had not yet completed shared stories they were encouraged to do so.
- Carers had previously raised the issue of the invoices received for services for their children and this has been taken up with Elevate. A meeting has been organised with Elevate and they have been invited to attend the next forum.
- Looked at the agenda items they would like, as carers, to put on the agenda for safeguarding and community safety themed meeting in December.
- There was concern expressed by carers about the reasonable adjustments and training needed for Job Centre Plus staff when benefit changes are being made for people with Learning Difficulties.

Provider and Professional Forum

The provider and professional forum met at Maples Resource Centre on the 16th October and discussed the themes from Augusts (Health) and Septembers (Autism) and the forthcoming LDPB themes (Community Safety & Safeguarding and Quality Assurance) in order to give suggestions that they would like to discuss as part of the agenda.

In this forum the Providers and Professionals discussed:

- Presented the Adult Safeguarding alert process and given information on the Hate Crime service and how to make referrals.
- Providers and professionals discussed what they felt the priorities should be for the Joint Local Strategic Plan.
- Providers and professionals asked for information from our CCG on the new health commissioning structures.
- The forum fed back on the requirements set out in the Children and Families bill and the need to involve providers and professionals in its implementation.
- Presented and discussed the outcomes from a recent Autism Mapping Project in the borough and the NHS NELFT's autism diagnostic pathway.
- Discussed what agenda items they would like, as providers and professionals, to put on the agenda for safeguarding and community safety themed meeting in December.

Action and Priorities for the coming period

1. Continue working on the Section 75;
2. Sign off the Joint Local Strategic Plan on Challenging Behaviour;
3. Discuss how we can implement the areas identified in the SAF as areas for improvement;
4. Continue to work and discuss the key actions outlined in the Programme set out in the Children and Families Bill and link into the SEND Programme board.
5. Future meetings are themed around health, safeguarding and community safety, housing and education, training and employment.

Contact: Joanne Kitching, Business Support Officer, LBBD

Tel: 020 8227 3216 **E-mail:** joanne.kitching@lbbd.gov.uk

Public Health Programmes Board

Chair:

Matthew Cole, Director of Public Health

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>None</p>
<p>Meeting Attendance</p> <p>29 October 2013: 66%</p>
<p>Performance</p> <p>Quarter 2 Performance on the Public Health grant was presented at the meeting.</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <p>a) Public Health Commissioning Priorities paper was approved at the last Health and Wellbeing Board.</p>
<p>Action and Priorities for the coming period</p> <p>a) An obesity summit will take place on the 16 December 2013.</p> <p>b) A draft Project Plan for the Commissioning Programme for the period 2014/15 will be presented at the next Programme Board in January.</p> <p>c) The future direction of the Public Health Programme Board will be determined over the coming months.</p> <p>d) Public Health will be supporting World AIDS Day.</p>

Contact: Pauline Corsan, PA to Matthew Cole, Director of Public Health, LBBD

Tel: 020 8227 3953 **E-mail:** Pauline.corsan@lbbd.gov.uk

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Chair's Report	
Report of the Chair of the Health and Wellbeing Board		
Open Report	For Information	
Wards Affected: NONE	Key Decision: NO	
Report Author: Louise Hider, Business Services Unit Manager	Contact Details: Tel: 020 8227 2861 Email: louise.hider@lbbd.gov.uk	
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
Summary: Please see the Chair's Report attached at Appendix 1.		
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.		

This page is intentionally left blank



In the last edition of my Chair's Report for 2013, I begin with an overview of our achievements since the Board became statutory as part of my 'Christmas message'. The report then goes on to give a summary of three events/meetings that I have recently attended - the Barking and Dagenham Partnership Conference, the November Health and Adult Services Select Committee and the Alcohol Strategy launch. I then draw the Board's attention to some recent announcements, as well as the launch of the Council's new Adult Social Care website – the Care and Support Hub.

I would welcome Board Members to comment on any item covered should they wish to do so.

Christmas Message

As 2013 draws to a close, I wanted to reflect on the year, and particularly the months since the Board officially became an Executive Committee of the Council in April. Since 'becoming statutory' we have achieved a great deal together, including:

- Continuing to strengthen our focus on integrated service delivery, agreeing priorities for joint funding and designing new joint services to improve people's discharge from hospital.
- Commissioning a range of new public health prevention programmes through our new Public Health Grant, investing across the age range, from healthy child services, through to our Active Age programme for older people.
- Responding to the Government's reports on Winterbourne View and Mid-Staffordshire NHS Trust, ensuring that our services are as safe as people have a right to expect.
- Starting the preparations for the implementation of new legislation, particularly the Care Bill and the Children and Families Bill.

Our five subgroups are also now meeting regularly and have good and relevant representation from member organisations. I see the subgroups as the 'driving force' behind the Health and Wellbeing Board and I look forward to continuing to hear about the progress of their work programmes as they take forward various priorities on the Board's behalf over the next year.

I thank you all for your hard work and dedication over the last year and I wish you all a very Happy Christmas with family and friends. I look forward to seeing you at our Development Day on 13 January 2014 to discuss our key challenges and aims for the year ahead.

Winter Plans kick-in

Since 1 November, partners in the local health economy, including the Council's Social Care team have been implementing 7 day working to ensure that patients receive a joined up service in hospital. We have been working with residential, nursing and domiciliary care providers to ensure that patients can be discharged quickly from hospital on any day of the week and that the right care and support is in place for them when they leave hospital. Gearing up for this challenging time of year is always a huge demand on our time: it's always a partnership effort, but this year it has been more so than ever.

New Adult Social Care Website

A new website for Adult Social Care in Barking and Dagenham, called the 'Care and Support Hub', has now gone live. The website can be found by clicking on the 'Care and Support Hub' link on the Council's homepage or by visiting <http://careandsupport.lbbd.gov.uk/>

The Care and Support Hub aims to be colourful and engaging, simple to use and facilitates service users to have more choice and control in their social care. The website includes general information and advice pages but also two new functions which we hope will help our local residents.

One is a service directory that contains an interactive directory of Social Care related services and providers in the Borough, including care and residential homes. Helpfully, this directory also includes CQC inspection information about the service where it is available.

The second new function is our new Personal Assistant Finder. This is a tool which service users can use to view the Council's register of accredited Personal Assistants (PAs), look at individual PA profiles and help them to find a PA who matches their requirements and personal preference.

We would be grateful to receive any feedback about the new website and also any information that members of the Health and Wellbeing Board may wish to see included on there. Please contact Louise Hider, Business Services Unit Manager on 020 8227 2861 or email Louise.Hider@lbbd.gov.uk with your ideas!



Partnership Conference

At the beginning of November I attended the Annual Barking and Dagenham Partnership Conference. This year the conference covered two main themes. Firstly, reviewing the Community Strategy and hearing from the theme boards (including the H&WBB) and secondly, focusing on civic engagement in the Borough. As part of the first theme, I was pleased to be asked to give a presentation at the Conference about the Health and Wellbeing Board and I discussed our membership, our progress since 'going statutory' in April and our work going into 2014.

As part of the second theme of 'civic engagement', four interactive workshops were hosted by each of the theme Boards, with our own Board hosting a workshop on civic engagement and emotional wellbeing. Our workshop promoted the work already going on in the Borough to support residents in their emotional wellbeing and the workshop was set up in a series of stalls to showcase some of the services and support available, including the Recovery College, Starlight (a local mental health service user-led support group) and the Older People's Mental Health team.

Other stalls also offered 'taster sessions' to allow delegates to sample support in the workplace, online and in the community including Mental Health First Aid staff training, the Big White Wall and self-help books available in our libraries through the 'Books on Prescription' scheme. Importantly, we also asked delegates to put forward ideas on the workshop's 'Improvement Wall' on how they could improve their own emotional wellbeing and how services could help individuals to do this, as well as where gaps in current service provision may lie.

The workshop was really well-received and the ideas from the 'Improvement Wall' will be given to the Mental Health sub-group to discuss over the coming months.

Mental Health scrutiny review

Over the past five months the Health and Adult Services Select Committee (HASSC), led by Councillor Alasia, has conducted a scrutiny review on the impact of the current recession and the welfare reforms on the mental health and wellbeing of residents in Barking and Dagenham. As part of its investigation, the Committee has undertaken three sessions and two site visits with representatives from various statutory Council services, voluntary organisations, Job Centre Plus, the CCG, NELFT and the NELFT Service User Reference Group. The Committee has also hosted a focus group with service users to coincide with World Mental Health Day on the 10 October 2013.

I was invited along to talk to the Committee about what the Health and Wellbeing Board does to support residents with existing mental health problems and initiatives that are in place to support those that may be experiencing depression, stress and anxiety, particularly as a result of the recession and welfare reforms. It was good to discuss the work of the Board with the Committee and to hear about their initial findings and recommendations, some of which they will propose to put forward to the Health and Wellbeing Board for further exploration and action.

The draft of the Mental Health Scrutiny Review is currently being written - look out for the report when it is published for agreement at the HASSC meeting on 14 January 2013. I'll ensure that the report and recommendations are brought to a future Health and Wellbeing Board for discussion.

Alcohol Awareness Week Launch

I was privileged to open the launch event for the Barking and Dagenham Alcohol Strategy 2013-2016 on 22 November as part of Alcohol Awareness Week. The delivery of the Alcohol Strategy is being led by the Community Safety Partnership's Alcohol Alliance Group. It is envisaged that the key outcomes from the delivery of the strategy in 2016 will be:

- Better health outcomes for people misusing alcohol.
- A safer community with a reduction of victims of alcohol related crime.
- Preventing young people from misusing alcohol.
- Strong and resilient families that are able to meet their individual needs.

The launch event was attended by GPs, Council staff, Police, NHS, pharmacists and other professionals from the local health economy and was an opportunity for everyone to talk about the work that they do on the alcohol agenda and how the Alcohol Strategy is being delivered. The event was a success and I would urge all members of the Health and Wellbeing Board to familiarise themselves with this important document if they haven't done so already. The Strategy can be found at: <http://modern.gov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=180&MId=6400&Ver=4>

Specialist Cancer and Cardiovascular Services

Engagement has begun on a suite of proposals that will change the way cancer and cardiovascular services are delivered in North East London. The recently published [Case for Change](#) sets out the vision, rationale, and recommendations which seek to develop two world-class specialist centres in North and East London, one for cardiovascular services at St Bartholomew's Hospital and one for cancer services at University College Hospital. The purpose of the change is to improve clinical outcomes which are currently below regional, national and international averages.

The proposals will be scrutinised by the four-borough Outer North East London Joint Health Overview and Scrutiny Committee once the consultation is launched by NHS England in the New Year. To inform the scrutiny process the Council welcomes the views of local commissioners, providers and Board Members on the impact of the re-configuration on Barking and Dagenham residents who will be travelling to different sites for their specialist treatment. Views can be given through Glen Oldfield, Scrutiny Officer (glen.oldfield@lbbd.gov.uk // 020 8227 5796).

New ASCOF reports

ASCOF stands for Adult Social Care Outcomes Framework and it measures the performance of the adult social care system as a whole and its success in delivering high quality, personalised care and support. ASCOF has always been important for internal planning by Councils, Ministers and Parliament but has now been made available to the public via the website below;

<http://ascof.hscic.gov.uk>

This website allows members of the public to access the ASCOF data for their local authority and compare this with the performance of other areas and I thought it would be useful for Members of the Health and Wellbeing Board to be aware of this for their future work and analysis. The performance report contains some highlights from the data.

Announcements

Empowering GPs: Changes to the GP Contract

Changes to the GP (General Medical Services) Contract will come into effect from April 2014. The changes put emphasis on GPs providing proactive care, reducing hospital admissions, and increasing access to consultations. Furthermore, patients will benefit from extended opening hours, improved online services, and the freedom to choose which GP practice best meets their needs. Full detail of the contract changes can be found in [NHS England's letter to Area Team Directors](#).

Monitor's Walk-in Centre Review: Preliminary Report

Monitor has reviewed the provision of Walk-in Centres, analysed how and by whom they are used, and studied the drivers behind the trend of Walk-in Centre closures which include duplication of service, funding pressures, and the failure to reduce A&E attendances. When considering the Barking and Dagenham context, section 7 of the report states that closures of Walk-in Centres have an adverse affect in areas where it is difficult to access a GP. The report urges commissioners to be cautious when closing Walk-in Centres and take steps to ensure that primary care access is able to meet patient needs before Walk-in Centre provision is withdrawn.

A final report from Monitor is expected in January 2014 with recommendations for commissioners and responses to feedback from the review's findings. It will be important that the findings from this report are used alongside the evaluation of the Surge Scheme pilot to inform the new model of urgent care being developed locally.

Failure of London A&Es on Waiting Targets

The London Assembly's Health Committee has analysed data that shows that over the past year many London A&E departments consistently missed the Government target of 95 per cent of patients being dealt with within four hours. The report singled out Barking, Havering and Redbridge University Hospitals Trust for missing the 4 hour target every week – averaging a rate of just 84.8 per cent over the past 52 week period. The Health Committee has put pressure on NHS England (London) to demonstrate strategic leadership and develop a coherent plan for the capital's A&E services.

A New Blueprint for Urgent and Emergency Care

Following the completion of phase one of the national Urgent and Emergency Care Review, Sir Bruce Keogh, Medical Director of NHS England, has proposed a fundamental shift in provision of urgent care, with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment.

Keogh envisages that it will take 3 to 5 years to enact the major transformational change set out within the report as commissioning is overhauled and new payment mechanisms are developed. Phase two of the review will engage services, organisations, professionals and patient representatives in the practical design of a new system. Reports from Keogh's Delivery Group will be published on an ongoing basis.

CQC State of Care Report 2012/13

The findings from more than 35,000 inspections underpin CQC's fourth annual State of Care report, which considers how care is delivered in hospitals, care homes, dental surgeries and in the community. The report highlights that:

- 10% of people received poor quality care.
- 'Avoidable' emergency admissions among the elderly increasing
- People with dementia continue to have poorer outcomes in hospital

The key findings of the report can be viewed as an infographic by following this link: http://www.cqc.org.uk/sites/default/files/media/documents/stateofcare_infographic.pdf

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

10 DECEMBER 2013

Title:	Forward Plan (2013/14)		
Report of the Chief Executive			
Open	For Comment		
Wards Affected: NONE	Key Decision: NO		
Report Authors: Glen Oldfield, Democratic Services	Contact Details: Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk		
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board			
Summary: Attached at Appendix 1 is the Forward Plan for the Health and Wellbeing Board. The Forward Plan lists all known business items for meetings scheduled in the 2013/14 municipal year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that we publish the key decisions (within at least 28 days notice of the meeting) in order that local people know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.			
Recommendation(s) The Health and Wellbeing Board is asked to: <ul style="list-style-type: none"> • Make suggestions for business items so that decisions can be listed publicly in the Council's Forward Plan with at least 28 days notice of the meeting; • To consider whether the proposed report leads are appropriate; • To consider whether the Board requires some items (and if so which) to be considered in the first instance by a Sub-Group of the Board. 			

This page is intentionally left blank

Health and Wellbeing Board Forward Plan (2013/14)

Meeting Date: 11 February 2014 (6pm, Barking Learning Centre)		Sponsoring Board Member/Report Author
	Public Health Commissioning Plan 2014/15	Matthew Cole/John Currie
	End of Life Care	Conor Burke/Sharon Morrow and Bruce Morris
	Inspection Frameworks for Children's Services	Helen Jenner/Meena Kishinani
	Integration Transformation Fund 2015/16	Anne Bristow/David Millen
	The Francis Report	Conor Burke/Jacqui Himbury
	Supported Living Tender	Cllr L Reason/Pete Ellis
	Joint Strategic Plan (Winterbourne View)	Cllr L Reason/Glynis Rogers
	Q3 Performance	Matthew Cole
	Working Age Adults	Matthew Cole
	Work Programmes of H&WBB Sub-groups	Cllr M Worby/Glen Oldfield
	Sub-Group Report: Children and Maternity	Sharon Morrow/Mary Pirie
	Sub-group Report: Integrated Care	Dr J John, Jane Gateley/Emily Plane
	Sub-Group Report: Learning Disability Partnership Board	Glynis Rogers/Jenny Beasley
	Sub-Group Report: Mental Health	Martin Munro/Fran Hayward

	Sub-group Report: Public Health Programmes Board	Matthew Cole/Hanna King
	Chair's Report	Cllr M Worby/Mark Tyson
	Forward Plan	Cllr M Worby/Glen Oldfield
Meeting Date:	25 March 2014 (6pm, Barking Learning Centre)	Sponsoring Board Member/Report Author
	Longer Lives Update: Learning from comparator authorities	Matthew Cole/Andy Beckingham
	Director of Public Health Annual Report	Matthew Cole
	Impact of the Recession Scrutiny	TBC
	Transfer of Health Visiting Commissioning	Helen Jenner/Matthew Cole
	Healthwatch Barking and Dagenham Annual Report 2013/14	Frances Carroll/Marie Kearns
	Sub-Group Report: Children and Maternity	Sharon Morrow/Mary Pirie
	Sub-group Report: Integrated Care	Dr J John, Jane Gateley/Emily Plane
	Sub-Group Report: Learning Disability Partnership Board	Jenny Beasley/Joanne Kitching
	Sub-Group Report: Mental Health	Martin Munro/Fran Hayward
	Sub-group Report: Public Health Programmes Board	Matthew Cole/Hanna King
	Chair's Report	Cllr M Worby/Mark Tyson
	Forward Plan	Cllr M Worby/Glen Oldfield
Scheduled Business		