



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, 11 February 2014 - 6:00 pm

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

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Graham Farrant
Chief Executive

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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)
Stephen Burgess	(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 - 10 December 2013 (Pages 1 - 7)

Business Items

4. CCG Commissioning Plans (Pages 9 - 17)

5. Better Care Fund Draft Plan (Pages 19 - 76)

6. Public Health Commissioning Plan 2014/15 (Pages 77 - 99)

7. End of Life Care Position Statement and Recommendations for Future Focus (Pages 101 - 120)

8. Summary of the New Ofsted Single Inspection of Services for Children (Pages 121 - 128)

9. CQC Inspection of BHRUT (Pages 129 - 131)

10. The Francis Report (Pages 133 - 140)

11. Progress on Winterbourne View Concordat (Pages 141 - 147)

12. Obesity Summit (Pages 149 - 151)

13. Waiver of Standing Orders for Public Health Contracts (Pages 153 - 162)

Standing Items

14. Sub-Group Reports (Pages 163 - 173)

15. Chair's Report (Pages 175 - 179)

16. **Forward Plan (Pages 181 - 184)**
17. **Any other public items which the Chair decides are urgent**
18. **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.***

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

MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 10 December 2013
(6:00 - 8:15 pm)

Present: Councillor M M Worby (Chair), Councillor J L Alexander, Matthew Cole, Councillor L A Reason, Anne Bristow, Frances Carroll, Martin Munro, Dr Waseem Mohi (Deputy Chair), Conor Burke and Chief Superintendant Andy Ewing

Also Present:

Apologies: Helen Jenner, John Atherton and Dr John

71. Declaration of Interests

Dr W Mohi declared a pecuniary interest in item 8 as he would be a beneficiary of the Public Health Service contracts being awarded to GPs.

72. Minutes - 5 November 2013

The minutes of the meeting held on 05 November 2013 were confirmed as correct.

73. Healthwatch: The First Six Months

Frances Carroll (Chair, Healthwatch Barking and Dagenham) introduced the report to the Board.

The Board asked if Healthwatch had enough volunteers to deliver its programme of Enter and View visits. Marie Kearns (Chief Executive, Harmony House) explained to the Board that recruiting volunteers is very difficult. It was suggested that Healthwatch try to attract volunteers from the workforces of NELFT, the CCG, and the Council. It was also suggested that Healthwatch uses the Team London volunteer website in search for Enter and View representatives. Martin Munro added that Nicholas Hurst and NELFT's body of governors would be another source of potential volunteers.

The Board noted the progress made by Healthwatch Barking and Dagenham to date.

74. Changes in the population of Older People in Barking and Dagenham

Matthew Cole (Director, Public Health) introduced the report to the Board.

The Board noted the significance of improving performance with regard to 30 day readmission into hospital and mortality that is amenable to health care as these areas are indicative of where the health and social care system is not working for the frail and elderly cohort of the population.

The H&WBB noted the report and in particular the future mid-term implications it may have for funding. The Board considered 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.

Further to the recommendations in the report the Board agreed to produce a concise analysis of the borough's demographics in terms of older people for use by partners in developing wider strategies and plans.

75. The Care Bill: Adult Social Care Funding

Anne Bristow (Corporate Director, Adult and Community Services) gave a presentation to the Board which:

- Set out the passage of the Bill through Parliament and timeline for implementing the reforms
- Recapped the provisions of Bill and explained the new system for funding
- Provided case studies to show how the capping system will work in practice
- Explored issues and challenges in delivering the reforms*

(*The presentation slides are published with the minutes to give further detail).

In response to the presentation, the Board raised the following issues/comments:

- A London-wide joint working party has been established to work through the challenges presented by the legislation. Guidance, information and resources/tool-kits are expected to support local authorities through implementation. Other boroughs are anticipating the same cost impacts and sharing the same concerns as LBBDD.
- Self-funders will have an interest in coming forward to be assessed. The Council estimates that an additional 5,600 assessments may need to take place in the period from 2015 to 2017 in order to assess hitherto un-assessed needs.
- Fundamental changes are needed for IT systems to manage records, assessments, and calculate care costs.
- If presented with legal challenges the established case law might be superseded by new interpretations of the legislation. Until new case law is established the Council's legal position on complex matters might be unclear.
- It is uncertain whether the public will realise they are liable for their costs or take suitable measures (personal savings or an insurance product) to plan for their care in later life.
- A large scale national communications campaign is needed to ensure good public understanding of changes and in particular the cost contributions of people to their care. Furthermore, the need to develop independent financial advice services is critical as currently the provision of such advice

is very limited.

- The changes have major workforce impacts in terms of training front line social care staff. It will be important that NHS staff have necessary training in order that they can give consistent messages on care options.
- 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. It would be more helpful if guidance and information related to the modern social care agenda and supporting people to remain in their homes for as long as possible.

The Board agreed to:

- 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.

76. CCG Commissioning Plans 2014/15

Conor Burke (Accountable Officer, B&D CCG) introduced the report to the Board.

The Board discussed the challenges of planning and setting priorities over a period of five years, especially at a time of major change in the health and social care sector. There is a danger that the five year strategic plan will not keep up with affairs and developments. The two year Delivery Plan will respond to such changes when it is refreshed and tie together short, medium and long term objectives for the CCG and its partners.

It was noted that the work of the Integrated Care Coalition has been useful in establishing a unified vision for health and social care locally. Further work is needed to ensure that the CCG's Commissioning Plans align with other local plans/strategies. The Board noted the priorities outlined in section 6.3 of the report which include: delivering more care in the community, raising standards within primary care, and improving performance in emergency and urgent care.

The Board agreed to:

- 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.

77. Delegated Authority Request for Public Health Service Contracts

Dr W Mohi declared a pecuniary interest in item 8 as he would be a beneficiary of the Public Health Service contracts being awarded to GPs.

The Board agreed to:

- Waive the requirement to tender the contracts for the health services noted in this report.

- 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.

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

Matthew Cole (Director, Public Health) introduced the report to the Board. The Board discussed the issues in relation to the performance indicators:

- It was noted that there are performance issues with the current provider for the Chlamydia screening programme in light of which the contract for this service will be reviewed.
- Emergency re-admissions within 30 days of discharge from hospital is a longstanding issue. More provision of recovery services and support from primary care to deliver care in the community setting will help to solve this multi-faceted problem.
- Despite the Council being tight with its enforcement and licensing controls alcohol related crime remains a problem locally. The Board believed that the borough was achieving the best results it could with the resources at the Partnership's disposal. The Board commented on the positive impact of banning drinking on the streets.
- Concern was raised about the numbers of women smoking during pregnancy. It was noted that the Family Nurse Partnership is taking action to engage with pregnant women on this issue.

The Board agreed to:

- 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.

79. Autism Self Assessment Framework and Autism Mapping Project

Bruce Morris (Divisional Director, Adult Social Care) introduced the report to the Board. Arising from the report the following issues or comments were raised:

- Due to better assessments and diagnostic tools the borough is catching up to the expected prevalence levels for the population, however there is much progress to be made in detecting people on the autism spectrum.

- Specific training for staff to carry out statutory assessments on how to make reasonable adjustments in their approach and communicate to people with autism was identified as a key area for improvement.
- Autism needs to be strongly reflected in the borough's Joint Strategic Needs Assessment and through the commissioning plans of partner organisations and the Council.
- The Board discussed the challenges of integrating services, commissioning support services for people with autism, and delivering training to professionals in the current economic climate.
- Cllr Reason (Cabinet Member for Adult Services and HR) questioned the Borough Commander about the training police officers are given to deal sensitively with people with autism. Chief Supt. Andy Ewing advised the Board that there is a specially appointed Mental Health Liaison Officer, and more generally Police Officers have good awareness/understanding of the needs of people on the autism spectrum.

The Board agreed to:

- Agree and validate the submitted Autism Self Assessment Framework ratings and task the Learning Disability Partnership Board to report back on an action plan for the improvement
- Note the findings from the recently completed independent Autism Mapping exercise.
- 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.

80. Urgent Care Board: Update

Conor Burke (Accountable Officer, B&D CCG) introduced this report to the Board. In updating the Board on the recent work of the Urgent Care Board the following issues or comments were raised:

- Queen's Hospital is struggling with patient flow through the hospital. This is a hospital-wide issue that impacts on the effectiveness of treating patients quickly in the Emergency Department. Queen's Hospital must improve how it deals with frail elderly patients and how it discharges patients to avoid delayed transfers of care.
- To address staffing shortages BHRUT has recruited 18 middle grade Doctors, 10 middle grade Anaesthetists, and 2 Consultants for the Emergency Department.
- £7 million of winter planning monies has been invested to help better manage demand for urgent and emergency care.

- The CCG was challenged over the provision of urgent care GP appointments being delivered through the pilot surge scheme and whether there would be analysis of the scheme in relation to reducing A&E attendances. Concerns were also raised about the lack of publicity to raise awareness of urgent care GP appointments among residents.

The Board noted the progress report and agreed to receive a further update at its meeting on 25 March 2014.

81. Engagement Strategy & Mechanisms: Update

Mark Tyson (Group Manager, Service Support and Improvement) introduced the report to the Board. Arising from the report the following issues or comments were raised:

- The web presence of the Board needs further work.
- There is variation between the H&WBB sub-groups in terms of the range and use of engagement mechanisms that exist within the Partnership. As the sub-groups develop/mature they will better understand how to interact and make use of those engagement opportunities.
- The Obesity Summit which is planned for 16 December will be a useful to see how the Board can engage with local stakeholders on an issue of strategic importance.
- Service users with learning disabilities would benefit from Board related materials being more accessible. It was also noted that the Service User Group (within the Learning Disability Partnership Board) is finding the nature of the business presented to it challenging. Simplifying the business and making it more relevant to the lives of service users would improve engagement.
- It was recommended that the Board's development day event on 13 January 2014 is used as an opportunity to develop the Board's engagement mechanisms. The outcomes of the development day will then feed into the Board's engagement strategy.

The Board agreed to follow the approach set out in section 5 of the report, which was as follows:

- To timetable a discussion at the next available meeting of each sub-group that explores the series of questions about mapping engagement across the Health and Wellbeing structure as set out in Appendix 1.

82. Sub-Group Reports

In response to the issue escalated by the Mental Health Sub-Group (Appendix 1), Dr Mohi (Chair, Barking and Dagenham CCG) confirmed that he will ensure GP attendance at that group's meetings going forward. Otherwise the Board noted the

content of the Sub-Group reports

83. Chair's Report

Cllr Worby drew the Board's attention to the new Care and Support Hub website and encouraged partners to visit the website and give feedback on the content of the pages.

The Board noted the Chair's Report.

84. Forward Plan

The Board noted the Forward Plan as set out in Appendix 1 of the report.

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	CCG Commissioning Plans		
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 (B&D CCG)	Contact Details: Tel: 020 3644 2370 E-mail: sharon.morrow@barkingdagenhamccg.nhs.uk		
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham CCG			
Summary: This reports provides the Health and Wellbeing Board with: <ul style="list-style-type: none"> • An overview of the NHS strategic and operational planning process following the release by NHS England on 20 December 2013 of <i>Everyone Counts: Planning for Patients 2014/15 to 2018/19</i> • A summary of the approach to strategic planning across the BHR system, building on existing collaborative arrangements • An overview of the issues that Barking and Dagenham CCG's operating plan will set out to address including the links to the Better Care Fund, on which there is a separate paper being presented to the Health and Wellbeing Board. 			
Recommendation(s) The Health and Wellbeing Board is asked to: <ul style="list-style-type: none"> • Note the briefing on the strategic and operational planning process for 2014/15 to 2018/19 • Comment on the issues being addressed within the Operating Plan and in particular the emerging priorities that have been identified • Receive the full draft of the Operating Plan at its meeting of 25 March. 			
Reason(s) The Health and Wellbeing Board will be required to sign off the Better Care Fund (BCF) to enable transfer of funds from health to social care. The CCG's Operating Plan sets out the overall plan for the CCG, incorporating the aims of the BCF. The CCG Operating plan will contribute to the delivery of the wider health economy's 5 year strategy which the Health and Wellbeing Board will also be involved in developing through the Integrated Care Coalition.			

1. Purpose of this report

1.1 Barking and Dagenham CCG is required to produce three key strategic documents:

- 5 year Strategic Plan as part of the Barking and Dagenham, Havering and Redbridge strategic planning unit
- 2 year Operating Plan for Barking and Dagenham
- 2 year Better Care Fund, a joint plan between the London Borough of Barking and Dagenham and the CCG.

1.2 These documents need to: respond to local needs and priorities; build on and align with current local strategies, particularly Health and Well-being Strategies; and respond to national requirements. The plans will set out the framework for the CCG's expenditure and activities during this period. This report provides an overview of the process for developing these plans and their content.

2. Background

2.1 Introduction

The CCG has been in operation since April 2013 and is responsible for commissioning hospital and community health services, including mental health services, for the local population. Each year it has to set out its plans for the future in line with its financial position.

2.2 National guidance

Everyone Counts: Planning for Patients 2014/15 – 2018/19 was released on 20 December 2013. It builds on the 2013/14 planning guidance and sets out a framework within which commissioners need to work with partners in local government and providers to develop strong, robust and ambitious 5 year plans to secure sustainable high quality care for all.

A full version of the guidance can be found at <http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf>

2.3 Stakeholder engagement

2.4 The CCG engages with stakeholders including patients and the public through its Patient Engagement Forum, through its relationship with Healthwatch and through other targeted activities. There has been ongoing discussion and engagement about the CCG's commissioning intentions at the sub-groups of the Health and Wellbeing Board (Mental Health, Children and Maternity and Integrated Care).

2.5 Healthwatch organised a stakeholder event on 16 January 2014 to engage with stakeholders on the CCG overall strategy with a particular focus on the joint work with the London Borough of Barking and Dagenham on the Better Care Fund and on changes to community and intermediate care services provided by North East London Foundation Trust that are currently being trialled as part of delivering more integrated care.

2.6 Financial Position

2.7 Barking and Dagenham CCG has driven a programme of efficiencies in 13/14 which has resulted in its current stable financial position. However there will be continuing pressures on the CCG budget which will require the CCG to maintain a similarly rigorous approach to expenditure in the period 14-19. The CCG will be seeking to maximise value through its contracted services and will continue with QIPP (Quality, Innovation, Productivity and Prevention) programmes. These will have a focus on providing services in the most planned, clinically and cost effective way possible to avoid use of non-elective care and to achieve the best outcomes for patients. The CCG financial allocations for 14/15 provides Barking and Dagenham CCG with a funding increase higher than the minimum agreed level, which is an improvement to the CCG's original funding expectation. However some of the planning assumptions (for example a 2.5% non recurrent spend requirement) may have a negative impact on the CCG's planning position. In addition the CCG's current year activity baseline has increased at month 7, and a significant overspend is being reported in acute contracts. This increase in activity will need to be reflected in financial plans. Emergency admissions investments which will need to be agreed with Acute Trusts through the Urgent Care Board and will need to be linked to the Better Care Fund.

3. 5 year Strategic Plan

3.1 Process for developing plan

A strategic planning unit of Barking and Dagenham, Havering and Redbridge, building on previous whole system working, will develop the 5 year strategic plan. The Integrated Care Coalition has been identified as the local vehicle for driving an ambitious five year plan forward. The need for stronger support from NHS England at Health and Well Being Boards, and for primary care contracting and development has been identified through that route.

The BHR-wide Integrated Care Steering Group has been used to take forward system wide discussions on the planning process, including the links to borough/CCG development of the local Better Care Fund Plans. This group will be extended to ensure appropriate input from NHS England to include primary care and specialised commissioning as well as engagement of public health.

3.2 Overview of content of plan

3.3 A draft BHR Strategic Headline plan on a page (see appendix 1) was co-produced with the Integrated Care Steering Group and NHS England in December prior to the formal release of the planning guidance. The following organisations have come together to agree the strategic plan:

- Barking and Dagenham CCG
- London Borough Barking and Dagenham
- Havering CCG
- London Borough Havering
- Redbridge CCG

- London Borough Redbridge
- Barking, Havering and Redbridge University Hospitals Trust
- North East London Foundation Trust.

3.4 The vision of this partnership is to improve health outcomes for local people through best value healthcare in partnership with the community.

3.5 The system objectives of the strategic plan will be to achieve the ambitions set out in *Everyone Counts*:

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

3.6 Work is underway to quantify the scale of the ambition locally.

3.7 These will be delivered through:

- *The BHR integrated care strategy and the Better Care Fund: developing seamless and integrated health and social care for local people, with continued implementation of the local strategy putting the person at the centre of care provided by integrated teams.*
- *The acute reconfiguration programme: Reconfiguring local A&E and maternity departments in order to improve the quality of urgent and emergency care and maternity services for local people; and the development of King George Hospital as a centre of excellence*
- *Specialised commissioning services: services that consistently deliver best outcomes and experience for patients, within available resources.*
- *Primary care improvement: primary care services that consistently provide excellent health outcomes to meet the individual needs of local people.*

- *Prevention and health promotion:* empowering and saving lives from vaccine preventable diseases, high quality, accessible screening programme for all, working together to achieve excellence in Health in Justice outcomes.

4. Operating Plan

4.1 Health and Wellbeing Strategy

The Operating Plan will align with the Health and Wellbeing Strategy, work is being undertaken to map the CCG contribution to delivering the Health and Wellbeing Strategy and to align this with the *Everyone Counts* ambitions.

4.2 Greater focus on outcomes

The strategic direction of Barking and Dagenham CCG's plans and the initial development of the Better Care Fund plans are consistent with the aims, framework and service characteristics set out in the planning guidance. It is clear, however, that further work is required to strengthen the improvement in outcomes expected as a result of the changes being made (work to date has focussed on the activity and financial impact). This will support the delivery of the Health and Wellbeing Strategy as noted above.

4.3 Stronger engagement

Further consideration will be given to stronger citizen engagement as the CCG moves into this next phase (taking into account initial feedback from local Call to Action responses).

4.4 New models of primary care

There is a national call for the development of new models of primary care, which are more proactive, holistic and responsive particularly for frail older people and those with complex health needs. There have been some initial local discussions on the development of a primary care improvement programme and within Barking and Dagenham there is a clearly identified need by stakeholders to improve access to primary care. The CCG's plans to address these issues will need to be reviewed to reflect proposed changes in the GP contract to secure specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. These plans will be complementary to the Better Care Fund plans.

4.5 Urgent care

Whilst the BHR Urgent Care Board operates largely as prescribed, review of membership in the New Year is proposed. The UCB will need to ensure there is a refresh of plans before summer 2014 and reach agreement on investment plans to be funded by the retained 70% from the application of the marginal rate rule. Procurement plans for urgent care will also need to take account of the national work to develop a new specification for NHS111.

4.6 Specialised commissioning

The CCG will need to work closely with Specialised Commissioning to understand the local implications of the developing national strategy.

4.7 Emerging Priorities

Taking into account the above factors, the emerging priorities for Barking and Dagenham CCG's 2 year operating plan are summarised below:

Priority	Proposed Changes
Integrated care	<ul style="list-style-type: none"> • Implement Integrated Care Strategy. Better care through - Joint Assessment and Discharge, Integrated Health and Social Care Teams, frail elders and falls prevention. Better care in nursing homes and at end of life. • Further focus on integrating mental and physical health services • Better Care Fund as key tool to support integration
Urgent care	<ul style="list-style-type: none"> • Implement urgent care strategy - people seen at the right place first time, improved access to primary care, changes to walk in centres and more effective hospital based urgent care/A&E services. • Improved access to mental health urgent care services
Planned care	<ul style="list-style-type: none"> • Improved productivity in elective care • Care as close to home as possible, better join up between primary care, community care and hospital care, getting the right tests/right care first time.
Primary care improvement	<ul style="list-style-type: none"> • Take forward a primary care improvement plan focused on setting quality standards and improving outcomes at practice, locality and CCG level • Support primary care provider development in line with NHSE England "Call to Action" transformation plans
Children and young people	<ul style="list-style-type: none"> • Joint planning and commissioning services for children with Special Educational Need and Disability including: Education, Health and Care Plan (EHCP) and personal budgets • Improving children's mental health through implementing Children's Improved Access to Psychological Therapies (IAPT) • Quality improvements to the maternity pathway and the care of women with complex social factors
Learning disabilities and mental health	<ul style="list-style-type: none"> • Implementation of the Winterbourne concordat and the development of a Section 75 for learning disabilities service with LBBD • Ongoing focus on meeting access and recovery rate

	<p>improvement for Improved Access to Psychological Therapies (IAPT)</p> <ul style="list-style-type: none"> • Implementation of the mental health tariff in shadow form • Improved dementia diagnosis rates and access to memory clinics
Cancer	<ul style="list-style-type: none"> • Early detection – particularly lung cancer in B&D • Improved screening • Improved primary care management at end of life (Macmillan GPs) • Better post-treatment pathways

The Health and Wellbeing Board is invited to comment on these priorities.

5. Better Care Fund

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better care and support to enable the achievement of health and social care outcomes and forms a key part of the CCG's Operating Plans. A separate report on the Better Care Fund is being made to the Health and Wellbeing Board from the Integrated Care Sub-Group.

6. Timelines

B&D CCG are required to submit a first draft of their 2 year Operating Plan and (with LBBD) the Better Care Fund plan on 14 February. Final submission for both of these is 4 April. The first draft of the 5 year strategic plan will need to be submitted on 4 April with the final document due on 20 June.

7. Appendices

- Appendix 1: The system narrative 'plan on the page' that was submitted on 18 December 2013

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The system narrative 'plan on the page' that was submitted on 18 December 2013

BHR strategic headline plan on a page

The BHR health economy is comprised of partners from Barking and Dagenham CCG, London borough of Barking and Dagenham, Havering CCG, London borough of Havering, Redbridge CCG, London borough of Redbridge, Barking, Havering and Redbridge University Hospitals Trust and North East London Foundation Trust; who have come together to agree, refine and implement the following vision:

Improving health outcomes for local people through best value health care in partnership with the community.

1 The BHR health economy is comprised of partners from Barking and Dagenham CCG, London borough of Barking and Dagenham, Havering CCG, London borough of Havering, Redbridge CCG, London borough of Redbridge, Barking, Havering and Redbridge University Hospitals Trust and North East London Foundation Trust; who have come together to agree, refine and implement the following vision:

2 **System Objective One**
To reduce the number of years of life lost by x%

System Objective Two
To improve health related quality of life for those with 1+ LTCs by x%

System Objective Three
To reduce avoidable time in hospital through integrated care by x%

System Objective Four
To increase the % of older people living independently following discharge by x%

System Objective Five
To reduce the % of people reporting a poor experience of inpatient care by x%

System Objective Six
To reduce the % of people reporting a poor experience of primary care by x%

System Objective Seven
To reduce hospital avoidable deaths by x%

4a **Delivered through the integrated care strategy**
Seamless and integrated health and social care for local people. Continued implementation of local strategy putting the person at the centre of care provided by integrated teams

Delivered through the acute re-configuration programme
Reconfiguring local A&E and maternity departments in order to improve the quality of urgent and emergency care and maternity services for local people; and the development of KGH as a centre of excellence for children's and women's services.

Delivered through specialised commissioned services
Specialised services commissioned that consistently deliver best outcomes and experience for patients, within available resources

Delivered through primary care improvement plan
Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Delivered through prevention and health promotion

- Empowering and saving the lives of Londoners from vaccine preventable diseases
- High quality, accessible screening programmes for all
- Working together to achieve excellence in Health in Justice outcomes for Londoners

5 **Overseen through the following governance arrangements**

- Health and Wellbeing Boards (HWBB) oversee the process for strategic planning in each borough
- Integrated Care Coalition (ICC): an advisory group to HWBBs - bringing senior leaders together to build a sustainable health and social care system
- The coalition has two subgroups:
 - Integrated care steering group: development and delivery of strategic plan
 - Urgent care board: improvement plan for urgent care
- All work streams have identified leads

3 **Measured using the following success criteria**

- All NHS organisations within the health economy report a financial surplus in 18/19 (under review)
- Local Authorities manage funding pressures
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns

6 **High level risks to be mitigated**

- BHRUT quality and performance issues
- Achieving financial balance / sustainable services
- Maximising impact with scarce resource

4b **Delivered through the Better Care Fund (BCF)**

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	Better Care Fund Draft Plan		
Report of the Integrated Care Sub-Group			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: YES	
Report Authors: Glynis Rogers, Divisional Director Community Safety & Public Protection Sharon Morrow, Chief Operating Office Barking and Dagenham Clinical Commissioning Group.		Contact Details: Tel: 020 8227 2749 Email: glynis.rogers@lbbd.gov.uk	
Sponsors: Anne Bristow, Corporate Director of Adult & Community Services Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group			
Summary: The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better care and support to enable the achievement of health and social care outcomes. Further Guidance was received in December 2013 including the allocations from current CCG and local authority funding to be included locally. The Health and Wellbeing Board (H&WBB) is required to agree and sign off a draft two year Plan proposed by the CCG and Council to be submitted to NHS England 14 February 2014. A final Plan, signed off by the H&WBB, is to be submitted by 4 April 2014. This report provides an overview with the required templates as appendices, which make up the Draft Plan for submission on 14 February 2014.			
Recommendation(s) i. Members of the Health and Well Being Board consider and agree the Better Care Fund Draft Plan contained in the Appendices of this Report, allowing Barking & Dagenham to meet the national deadline for submission on 14 th February 2014.			
Reason(s) It is a requirement of the transfer of money from health to the local authority that the Draft Plan be signed off by the Health and Wellbeing Board.			

1. Introduction

- 1.1. The Better Care Fund (BCF), previously referred to as the Integration Transformation Fund, provides an opportunity to transform local commissioning and services so that people are provided with improved integrated care and support to achieve their health and social care outcomes. The Fund is intended to support the scale and pace of integration between health and social care. It is a mechanism of promoting joint planning for the sustainability of local health and care economies against a background of significant savings targets right across the system
- 1.2. In addition to the overarching integration agenda, a number of national conditions and measures are attached to the Fund, designed to move resources across the system towards prevention and short term care interventions and away from high cost packages in acute or care home settings.
- 1.3. The Fund aims to provide local residents with the right care, in the right place, at the right time. The implication is that over time, care will increasingly be provided in community settings closer to home, and acute admissions will reduce where hospital care is not needed.
- 1.4. A proportion of the funding must be used to support adult social care services in each local authority, which also has a health benefit. A condition of the transfer is that the local authority agrees with local health partners how the funding is best used within social care and the outcomes expected from the investment. The Joint Strategic Needs Assessment and existing commissioning plans for both health and social care must be taken into account in how the funding is used.
- 1.5. The fund is made up of a number of existing funding streams to Clinical Commissioning Groups and Local Authorities, as well as recurrent capital allocations.
- 1.6. The Spending Round 2013 identified that, in addition to a planned £900m transfer nationally from the NHS to support adult social care, a further £200m would be transferred from the NHS in 2014/15 to assist localities in preparing for the BCF to comprise £1.1bn in total for 2014/15.
- 1.7. For 2015/16, the £3.8 BCF is made up of:
 - £1.9bn of NHS funding
 - £1.9bn based on existing funding in 2014/15 comprising £130m Carers Break Funding, £300m CCG Reablement Funding, £354m capital funding(including £220m Disabled Facilities Grant), £1.1bn existing transfer from health to social care.
- 1.8. The 2015/16 BCF is to be delivered through a Pooled Fund Agreement with a governance structure. The legislation for this is still to be agreed. The relevant amounts for Barking and Dagenham are cited in the financial implications section below. The only new money is the share of the £200m transfer in 2014/15 to prepare for the pooled budget arrangements in 2014/15, which for Barking and Dagenham is

£761K. The remainder of the fund is made up of existing expenditure for commissioned health and social care services. There is the option for local discretion to increase the Fund over the minimum allocation.

- 1.9 The Draft and Final Plans need to be submitted in prescribed template form and these are contained in the Appendices. These include the overall plan which for example, describes how the national conditions will be met, a financial summary, contingency plans, outcomes and metrics, list of schemes. There has been a delay in the availability of baseline metrics from NHSE which means that some of the outcomes metrics are yet to be fully developed for the final version of the plan. All of the metrics, targets and trajectories for improvement will require validation prior to the final submission.
- 1.10 The Draft Plan is to be signed off and submitted to NHS England by 14th February 2014 and the Final Plan is to be submitted by 4th April 2014. Both Plans need to be signed off by the Health and Wellbeing Board.
- 1.11 The development of the Draft BCF has been overseen by the Integrated Care Subgroup of the H&WBB.

2 National Conditions

- 2.1 The Spending Round established six national conditions for access to the Fund;
 - Plans to be jointly agreed by the constituent councils and CCG groups and signed off by the H&WBB. Local providers should be engaged in the process, so that the deployment of funds includes recognition of the service change consequences. Locally, the H&WBB Integrated Care Subgroup includes provider representatives. Local provider forums will be consulted on the use of the BCF.
 - Local areas must include an explanation of how local adult social care services will be protected within the plans
 - 7 day services in health and social care to prevent unnecessary admission at weekends and support patients being discharged should be agreed
 - Improved data sharing between health and social care, based on the NHS number as a primary identifier to achieve better seamless and safe care
 - Ensuring a joint approach to assessments and care planning and where funding is used for integrated packages of care, that there is an accountable professional
 - Agreement on the consequential impact of changes in the acute sector. Plans should not have a negative impact on the level and quality of mental health services

3 Outcomes and metrics

3.1 Local areas are expected to have a level of ambition for improvement against each of the national indicators to be included and a locally determined indicator.

3.2 Of the £3.8bn, £1bn will be linked to performance.

3.3 The national metrics underpinning the Fund are :

- Reducing admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Reducing avoidable emergency admissions
- A Patient /service user experience indicator
- An additional local metrics selected from the NHS, Adult Social Care and Public Health Frameworks.

The BCF Guidance provides a choice of nine metrics from which to choose a local metric. An evaluation exercise was undertaken to help decide which indicator will measure an improvement area relevant to Barking and Dagenham. On the basis of this, it is proposed that the metric measuring a reduction of injuries due to falls in people aged 65 and over, is prioritised. The number of admissions to hospital as a result of falls is increasing and an audit at BHR revealed that 25% of admissions to hospital are as a result of falls of those over 75 yrs. Work is in train under the auspices of the integrated care coalition to develop a joint falls strategy due to be completed in April 2014. The BCF will provide the mechanism to support and enable implementation of the strategy once agreed by partners.

3.4 For the patient / service user experience metric, a local measure can be used or the use of a national metric currently being developed may be put forward. An evaluation was carried out and it is recommended that the measure 'Proportion of people feeling supported to manage their (long term) condition', be used. It is thought to be strategically relevant because of the joint investment in this area and Long Term Condition management relating to a number of the schemes of the BCF. There is significant commitment locally to the six clusters supporting older people and those with complex needs to live independently in their own homes with support from the multi-disciplinary team where necessary. The indicator covers a range of different services, has remained the same for a number of years, so should be a stable indicator to measure.

3.5 As certain payments (£1bn nationally and approximately £3.7m locally) will be linked to performance it is important that contingencies exist where objectives are not met. Contingency Plans are being developed but it is hoped that the schemes will be robust enough to mitigate some risks. If the expected impact on the acute trust is not delivered, and acute hospital activity does not reduce as planned, this will have an

impact on CCG resources which will need to be considered alongside other pressures across the health and social care system. Demographic pressures will also need to be taken into consideration.

- 3.6 The Guidance states that for 2015/16 performance-related funding will not be withdrawn/reallocated if the level of ambition is not reached. However, if an area fails to deliver 70% of the levels of ambition set out in the plan, it may be required to produce a recovery plan.

4 Use of the BCF funding to support the implementation of the Care Bill

- 4.1 The Care Bill was announced in the Queens Speech May 3013 and is currently at Committee stage in the House of Commons. The Bill contains provisions covering adult social care reform, care standards, including the Government's response to the Francis Inquiry, health education and research. It is expected that it will be enacted during 2014.
- 4.2 The June Spending Round announced £335m in 2015/16 so that councils can prepare for the reforms to the system of social care funding. It includes Capital investment (£50m), including IT systems, which sits in the BCF. This money will contribute to the extra costs resulting from the Care Bill but there will be extra pressures which will need to be mitigated.
- 4.3 The Department of Health has identified £130m of other costs for 2015/16 relating to issues such as: putting carers on a par with users for assessment; implementing statutory Safeguarding Adults Board and setting national eligibility. The Department's position is that the Spending Round allocated funding to cover these costs as part of the BCF.
- 4.4 The implementation of the Care Bill in Barking and Dagenham is being overseen by a Council Programme Board and sponsored by the Corporate Director of Adult and Community Services. The BCF Plan thus provides an interface with the implementation of the Care Bill and new responsibilities.

5 Priorities

- 5.1 In November 2013 the H&WBB considered priorities put forward by commissioners;
- Delivery of the Integrated Care Strategy.
 - Integrated Health and Social Care working through delivery of the Joint Assessment and Discharge Service supporting 7 day working and improved arrangements for admission avoidance and discharge.
 - Exploring opportunities to utilise joint commissioning roles, notably in Learning Disability and Mental Health.
 - Supporting a joint and strengthened commissioning role with provider services.
 - Improvements in primary care improving access to support and interventions in people's own homes with less reliance upon acute services.

- Improvements in prevention, keeping people well and healthy for longer and protecting support for carers.
- Improving End of Life Care which enables greater numbers of people to be effectively cared for at home or in the place of their choice.
- Protecting Social Care Spending and services.
- Ensuring Integrated Service delivery to those families with the most complex needs.

5.2 The Integrated Care Subgroup has further considered priorities and also the Guidance for the BCF and is proposing additional priorities to reflect these ;

- Agreeing a joint Carers Strategy to give greater emphasis to the role family carers play to benefit them and those they support
- Early diagnosis for people living with Dementia and supporting their independence and carers
- Improving the sharing of information between health and social care using the NHS number as a patient identifier to facilitate more seamless, integrated and safe care and support
- Strengthening the outcomes and co-ordination of rehabilitation and reablement, and facilitating self management of conditions by service users/patients, through the various integrated services, to improve independence
- Supporting independence and recovery of people with mental health problems

6. Mandatory Implications

6.1. Joint Strategic Needs Assessment

Integration is one of the themes of the JSNA 2013 and this paper is well aligned to address and support the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and this paper identifies which areas can be addressed in more integrated way to shape future sustainable strategies for the borough.

Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular for:

- [Supported living for older people and people with physical disabilities](#)
- [Dementia](#)
- [Adult Social Care](#)
- [Learning Disabilities](#)
- [Mental health- Accommodation for People with Mental Illness](#)

- f) [End of Life Care](#)

6.2. Health & Wellbeing Strategy

The Better Care Fund reinforces the aims of the Health and Wellbeing Strategy and provides an excellent opportunity for alignment between the ambitious integration plans and the Strategy which are both as much about keeping people well and independent as about ensuring they receive the services they need if they become unwell. Our focus is on people's wants and needs rather than the organisations and structures that deliver care. We aim to prevent ill health and support people to stay well rather than only intervening in a crisis.

6.3. Integration

Integrated commissioning and provision is at the heart of the BCF. The Integrated Care Coalition (ICC) with the relevant CCGs and local authorities for Barking & Dagenham, Redbridge and Havering came together to agree the strategic commissioning case for integration and commissioning work accordingly. Barking and Dagenham have a strong history of integrated work and the Fund provides opportunity to strengthen this. Alongside this work, the Integrated Care Coalition is leading the work on the required 5 year Strategic Plan. This will set out our shared vision for fully integrated commissioning by year 5 of the Plan.

There is an agreed vision for integration confirmed at the Integrated Care Coalition in November 2012. This includes supporting and caring for people in their own homes or closer to home, shifting activity from acute to community services and particularly to locality settings. It places individuals at the centre of delivery, driving improvements to the quality of experience and outcomes. Examples of local integrated services and approaches include;

- Integrated multi-disciplinary teams across six clusters in Barking & Dagenham are well established aiming to achieve co-ordination of care across the health and social care economy with a focus on prevention and promotion of self management.
- Work is currently taking place, establishing the Joint Assessment & Discharge team based at Barking, Havering, Redbridge University Hospital Trust and working with North East London Foundation Trust and London Borough of Barking and Dagenham, and the CCG, from 1st April 2014. The aim is to ensure timely co-ordinated discharge from hospital and admission avoidance of unnecessary admission to hospital. Seven day working is part of this service.
- The promotion of physical activity through sports and leisure services using public health to improve health and well being

Further integrated approaches will develop as part of the BCF Plan which will be overseen by the Integrated Care Subgroup of the H&WBB. Integration of funds and commissioning for people with learning disabilities is the subject of a separate piece of work between the Local Authority and the CCG.

6.4. Financial Implications

- 6.4.1. Implications completed by: Roger Hampson, Group Manager (Finance) Adults and Community Services, Barking and Dagenham
- 6.4.2. The Better Care Fund (BCF) is expected to lead to the transformation of health and social care services for people in the community; this is to be achieved through the integration of services between health and social care using pooled budget arrangements. These pooled budget arrangements are expected to be in place from April 2015, and further guidance is to be issued. There will be significant financial implications for both the local authority and the CCG; and both organisations face significant financial challenges over the next three to five financial years. Cabinet will be asked to consider the Medium Term Financial Strategy for 2014/15 to 2018/19 at its meeting on 18 February 2014. The CCG's Governing Body will be reviewing financial plans on 25 March 2014.
- 6.4.3. 2014/15 will be the last year in which the local authority will receive a transfer from NHS resources direct from NHS England. From 2015/16, the resources will be included in resources allocated to the CCG and will be part of their minimum contribution to the local BCF pool.
- 6.4.4. The Social Care Grant in 2014/15 for Barking and Dagenham. will be £4.185m, including £761k dependent on the local authority and the CCG jointly agreeing and signing off a 2 year plan for the Better Care Fund for 2014/15 and 2015/16 (final Plan to be submitted by 4 April 2014).
- 6.4.5. The grant in 2013/14 was used to support a number of local services, including £450k for learning disability services. The Better Care Fund is not intended to cover services for people with learning difficulties as a separate national initiative has already been undertaken (the Winterbourne View concordat). It is therefore appropriate to realign the use of the Social Care Grant to cover those services to be included in the Better Care Fund; learning disability and other services that had been funded by the grant in 2013/14 will instead be funded from the base budget. The proposed allocation of the grant in 2014/15 is as follows:

	£000
Social Care Integrated Teams	1,475
Care Budgets for older people and people with a physical disability	573
Joint Assessment and Discharge Service	532
Workforce development – training	25
7 day working	100
Crisis Intervention Service	700

Care Budgets for people with mental health issues	500
LBBB Contribution to Development Officer for Joint Commissioning	40
Strengthening User and Carer Voice	50
Statutory costs of Safeguarding Adults	100
End of Life Services	90
Total	4,185

- 6.4.6. As stated above, from 2015/16 the Adult Social Care Grant will be included in the CCG revenue allocation of £13.055m and this amount is the CCG's minimum contribution to be made to the local BCF pool. The minimum contribution the local authority has to make to the BCF local pool is the total of capital grants for Disabled Facilities Grants and Adult Social Care Grants allocated by central government:

	£000
CCG revenue allocation	13,055
Disabled facility grant	672
Adult social care capital grant	508
Total	14,235

- 6.4.7. Approximately £3.7m will be dependent upon performance against a number of ambitious national and local measures as described elsewhere in this report (50% to be paid in April 2015 and 50% in October 2015). As indicated for 2015/16, performance related funding will not be withdrawn if the level of ambition is not reached; however, if an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan.
- 6.4.8. The delivery of integrated health and social care services at greater scale is expected to deliver improvements against national and local outcomes and release NHS savings. If planned improvements are not achieved, some of the BCF funding may be used to alleviate the pressure on other services and a contingency plan will need to be developed to address this risk.
- 6.4.9. The CCG revenue allocation is deemed by the Department of Health to include funding for some of the costs arising from the Care Bill, currently making progress through the House of Commons (eg putting carers on a par with users for assessment, implementing statutory Safeguarding Adults Boards, and setting national eligibility). The national allocation is £130m but the Department of Health

is not proposing to allocate sums to individual areas; however, an indicative allocation for Barking and Dagenham would be £500k based on the national allocation formulae of 0.38% to both the local authority and the CCG. Further work is to be undertaken to calculate these additional costs locally, and to identify how it is to be funded from within the BCF funding envelope. We are seeking further advice on this from the Department of Health, as both the CCG and the local authority wish to resolve this before the final BCF Plan is submitted in early April.

- 6.4.10. Proposals for the use of the adult social care capital grant will be presented at a later date, including any capital costs arising from implementation of the Care Bill, eg any necessary amendments to client record information systems.
- 6.4.11. The local authority will also receive a “new burdens” specific revenue grant in 2015/16 of £1.084 m to cover costs arising from reforms to the system of social care funding for early assessments and reviews, deferred payment, capacity building including recruitment and training of staff, and an information campaign. The total grant for Barking and Dagenham will be allocated out at a later date.
- 6.4.12. Legislation is needed to set up pooled budgets from 2015/16, and local authorities and CCGs are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy. In Barking and Dagenham, only the local authority wishes to pool more than the minimum although this has some risk (reduced flexibility to divert resources in-year to support overspending elsewhere, eg in the acute sector). The use of pooled budgets beyond 2015/16 may be tied to longer term budget plans, and both the local authority and the CCG will need to retain some flexibility to respond to the overall financial context in which we operate. The proposed additional contributions by the local authority to the pool in 2015/16 have generally been limited to 30% or less of existing social care budgets, which is broadly equivalent to the expected costs of new placements to be made in the year.
- 6.4.13. The proposed Better Care Fund in 2014/15 is £13.182m made up the following financial streams:

	£000
Social Care Grant	4,185
Public Health Grant	1,191
Local authority base budgets	5,100
Local authority capital grants	1,091
CCG – reablement	1,120
CCG - carers	495
Total	13,182

- 6.4.14. The Better Care Fund in 2015/16 is agreed as £21,610,000. Further discussions are taking place between the Council and the CCG, on the potential costs of implementation of the Care Bill, for those aspects deemed by the Department of Health to be included in national resources for the Better Care Fund, and agreement on how these are to be funded. Further work is also required to model the impact on acute care and develop contingency arrangements before the final submission in April
- 6.4.15. Further proposals on the operation of the pooled budget in 2015/16 will be prepared when the further guidance has been published.
- 6.4.16. One of the national conditions is protection for social care services (not spending). Local areas must include in the BCF plan an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally.
- 6.4.17. Joint Finance and Performance Monitoring arrangements will be put in place from 2014/15, overseen by the Integrated Care Subgroup of the H&WBB.

6.5. Legal Implications

There are no specific legal implications that arise from this report at this stage.

(Implications completed by: Chris Pickering, Principal Solicitor)

6.6. Non-Mandatory Implications

6.7. Staffing Implications

The integration agenda and schemes will result in new ways of working for staff who will be consulted accordingly. This will be supported by training and workforce development initiatives for which some extra funding has been included in the BCF Draft Plan. Further integration could lead to further restructures affecting staff. There is currently a staff consultation taking place on the implementation of the Joint Assessment and Discharge Service.

6.8. List of appendices:

- Appendix 1: Better Care Planning Template Parts 1 & 2

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Draft: Barking and Dagenham

Appendix 1



Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	London Borough of Barking and Dagenham
Clinical Commissioning Groups	Barking and Dagenham CCG
Boundary Differences	None
Date agreed at Health and Well-Being Board:	Plan – 11 February
Date submitted:	14 February
Minimum required value of ITF pooled budget: 2014/15	£761,000.00
2015/16	£14,235,000.00
Total agreed value of pooled budget: 2014/15	£13,182,000.00
2015/16	£21,610,000.00

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Barking and Dagenham CCG
By	Conor Burke
Position	Chief Accountable Officer
Date	<date>

Signed on behalf of the Council	London Borough of Barking and Dagenham
By	Anne Bristow
Position	Corporate Director Adult & Community Services
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Barking and Dagenham Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Maureen Worby
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Local Authority has developed a Market Position Statement where commissioning intentions and outcomes we are striving to achieve with service users and carers are made explicit for providers. Social care providers have been, and will continue to be provided with briefings on the Better Care Fund (BCF) so that they will work to common commissioning intentions and help shape service development. Provider Forums have been created in Barking and Dagenham to support a common approach. Besides the larger providers, micro providers who provide a very personalised approach are supported well through infrastructures in the Borough.

Health providers have engaged throughout the commissioning cycle, including

engagement via commissioning intentions, market events and contract negotiations.

The local community and mental health services provider, North East London Foundation Trust (NELFT) and the acute provider, Barking and Dagenham, Havering and Redbridge University NHS Hospitals Trust (BHRUT) are members of the Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Coalition (ICC). The ICC is the local health and social care vehicle for driving forward the 5 year strategic plan, so providers are engaged through this and in the BHR Integrated Care Steering Group in setting the overall strategic direction within which the BCF is being developed.

Within Barking and Dagenham, the Health and Wellbeing Board includes representatives from BHRUT and NEFLT, and so brings commissioners and providers together to address wider health and wellbeing improvements from the full range of perspectives. The Health and Wellbeing Board have reviewed the BCF as well as approve the final plan. The development of the BCF has been overseen by the H&WB Integrated Care sub-group which equally has membership across health and social care as well as from key providers.

Providers have been closely involved in developing the operational aspects of the BCF for example the development of the service model and implementation plan for the Joint Assessment and Discharge service and the developments in intermediate care and community services which are currently being tested.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Engagement around the BCF builds on work done in BHR over the period 2012-2013 to develop the local Case for Change for Integrated Care and the Integrated Care Commissioning Strategy which included wide stakeholder engagement, and which underpins many of the service developments that will be supported by the plan. There

have been ongoing discussions with patient and community representatives and groups around the BCF itself, most recently these include: the B&D CCG Patient Engagement Forum in November 2013; B&D CVS forum in December 2013 and a large (80 plus attendees) stakeholder event in January 2014 facilitated by Healthwatch. The latter event provided an opportunity for local stakeholders to review and comment on the plan and invited them to be part of its development in the future. The meeting had the opportunity to review implementation of the integrated care strategy to date and changes in intermediate care currently being tested. A full report from the event will be provided by Healthwatch (to follow) headline messages including a very positive response to the proposed integrated working of health and social care (to add once HW report available), with stakeholders feeling that broadly the services are needed and that more support to help people return / stay at home is welcomed.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

The documents that have been listed here are important in terms of background but do not give plans for each scheme or the national conditions.

Document or information title	Synopsis and links
BHR 5 year strategic plan	The headline transformation changes that are required across BHR to meet health outcomes and create a sustainable health and care economy. Attachment 1
Health and Wellbeing Strategy	The high level strategy that sets out the way in which partners will work together to address the needs of the diverse, growing population of Barking and Dagenham. Our Strategy is based on four priority themes that cover the breadth of the frameworks and in which the priorities under consideration are picked up within. One of the three outcomes of our Health and Wellbeing Strategy is to

	<p>improve health and social care outcomes through integrated services.</p> <p>http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf</p> <p>Integration is one of the themes of the JSNA 2013 and this paper is well aligned to address and follow up these priorities and the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.</p> <p>The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and this paper identifies which areas can be addressed in more integrated way to shape future sustainable strategies for the borough.</p> <p>Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular for:</p> <p>a) Supported living for older people and people with physical disabilities – see JSNA at http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-8.aspx</p> <p>b) Dementia – see JSNA at http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-28.aspx</p> <p>c) Adult Social Care http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-9.aspx</p> <p>d) Learning Disabilities – http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-3.aspx</p>
Joint Strategic Needs Assessment	

	<p>e) Mental health- Accommodation for People with Mental Illness http://www.barkinganddagenhamsna.org.uk/Section5/Pages/Section5-7.aspx</p> <p>f) End of Life Care http://www.barkinganddagenhamsna.org.uk/Section7/Pages/Section7-31.aspx</p> <p>The care of older people and end of life care including dementia, caring for the carers, discharge from hospital, and continuing care of patients with chronic conditions would be priorities for the BCF.</p> <p>The care of those with learning disability and mental health problems requires an integration of social care and health support, including health checks for both LD adults and mental health service users and help with employment as a priority.</p>
<p>Developing a commissioning Strategy for Integrated Health and Social Care services in Barking and Dagenham, Havering and Redbridge: Strategic outline case November 2012.</p>	<p>This established a vision for integration and services developed around people. This included:</p> <ul style="list-style-type: none"> • Enabling people to live well and independently for as long as possible and ensure services are designed to manage frailty and disability; • Deliver services closer to home rather than in a hospital or residential / nursing home; • Identified areas for development – such as commissioning for improved delivery of proactive care. <p>(Added as Attachment 2)</p>
<p>Integrated Care in Barking and Dagenham, Havering and Redbridge: the case for change</p>	<p>Established 'will dos' for our system which included:</p> <ul style="list-style-type: none"> • Promote and support independence, personal responsibility and self management and personalised choice; • Have a clear understanding of population need and inequalities, the opportunities and challenges of providing services to a

<p>August 2012</p> <p>diverse population</p> <ul style="list-style-type: none"> • Recognise that the user will be at the heart of developing our approach • Ensure health and social care resources are deployed as efficiently as possible to the most appropriate care setting at the lowest level of intervention • Ensure investment in community, social care and primary care capacity in order to shift activity and resources from hospitals and other institutions; • Not lose sight of the fact that prevention and early intervention strategies are needed to make changes in the longer term on the health and well-being of local people and support health and well-being strategies and commissioning strategy plans. <p>http://www2.redbridge.gov.uk/cms/care_and_health/adult_social_services/idoc.ashx?docid+06ccb1c9-6bd1-4ba-8efe-505a289c797a&version=-1.</p>	<p>Other identified documents:</p> <ul style="list-style-type: none"> • EOLC H&WB paper • JAD ICC paper • IRS ICC paper • H&WB Re-ablement Paper • ICM project plan and outcomes dashboard • Market Position Statement
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2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Commissioners and providers across health and social care in Barking and Dagenham are working together to look at how health and social care services can be made better for local people. With increased demand for our services, we need to:

- improve how people experience care and ensure the best possible quality to deliver the right care, in the right place, at the right time
- ensure the health and social care system is 'future proof' and able effectively to manage increasing demand and need, not only today, but in years to come
- ensure services are efficient and deliver value for money and are sustainable.

Barking and Dagenham CCG and Local Authority are committed to building responsive, integrated care designed around people's needs and delivered as close to home as possible. The development of the locality model – which aims to bring together clusters of General Practices with community health and social care professionals working together to assess, plan and coordinate the care of patients at high risk of admission to hospital – is at the heart of this approach. Six integrated health and social care localities have been established in B&D. We have built and developed this model over time both in terms of broadening the expertise and scope of the teams as well as ensuring these are operating at maximum efficiency. We are also working with NHSE to develop effective primary care development which underpins the effectiveness of the model.

Barking and Dagenham CCG and London Borough of Barking and Dagenham recognise that they need to work across a wider health and social care system to deliver some of the changes in service model and configuration they are seeking. As key partners in the Integrated Care Coalition they have worked with other partners in BHR to develop an Integrated Care strategy for health and social care. In it partners across health and social care are seeking to transform the relationship with individuals by placing them at the

centre of delivery, driving improvements to the quality of experience and outcomes. Where possible, local people want to be cared for and supported in their own homes, or closer to home, not in hospital. Family carers play a key role in supporting their loved ones, helping to promote their independence. We think, and evidence supports our thinking, that people spend too long in hospital, which can make it much harder for them to return home and live independently again.

The locality model in Barking and Dagenham fundamentally underpins the broader system wide integration work across BHR and focused on working with acute and community providers to enable better care and better outcomes for local people as we move away from bedded hospital care to locally delivered community based health and social care services with the focus on prevention, early intervention, focused rehabilitation/re-ablement and early intensive discharge. Service users, carers and providers contributed to the development of the model. We expect to see the benefits of this approach for patients and carers as well as ensuring the sustainability of health and social care services with reductions in acute activity and reductions in residential and nursing home placements.

The impact of this work over time will be that more and more care is provided to people either in their own home (for example Intensive Rehabilitation Service), or in community or locality settings through the Integrated Health and Social Care Teams – using bedded care as a ‘step – up’ rather than a ‘step down’ where needed and considering unplanned admissions as a marker of system weakness rather than a first port of call when things are going wrong for patients. Upstream work with patients and better discharge arrangements (through the Joint Assessment and Discharge Team) should also reduce the need for residential and nursing home placements as alternative options are explored including the provision of short term interventions. This will involve significant changes in terms of number of beds needed, building patient confidence in new models of service and developing local workforce to deliver more specialised care in locality/community based settings with a greater emphasis on the role of therapists in maintaining and returning people to independence.

These changes should deliver better outcomes for our patients and service users so that as well as changing the sort of care (from bed based and centralised to local and

ambulatory/home-based) and the focus of intervention (from unplanned and reactive to planned and preventative) and one which seeks to broaden choice in how on-going support needs might be met, we are able to improve how well supported patients feel in managing their LTCs.

This is in line with and a key enabler of the BHR system's overall acute A&E reconfiguration programme/modelling and the Long Term Financial Plan agreed across the system as well as changes in bedded intermediate care services aimed at providing more rehabilitation in the home setting reducing the number of rehabilitation beds needed as services in the community are developed. The commitment to develop King George Hospital as a centre of excellence for ambulatory care will be a key development in support of the overall strategic direction around the shift from bedded to community based/ambulatory care services and intensive rehabilitation.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The overall aim for integrated care is to strengthen the community response to people's needs by bringing together health and social care and so reduce the need for hospital care, maximise independence and improve outcomes.

The specific objectives are drawn from the Integrated Care Commissioning Strategy:

- Integrated Health and Social Care working that improves arrangements for admission avoidance and discharge and therefore, our usage of costly acute resources and improved experiences for service users and patients
- Supporting a joint and strengthened commissioning role with provider services
- Improvements in primary care improving access to support and interventions in people's own homes with less reliance upon acute services.

- Improvements in prevention, keeping people well and healthy for longer and protecting support for carers.
- Improving End of Life Care which enables greater numbers of people to be effectively cared for at home or in the place of their choice.
- Protecting Social Care services

These objectives will be measured by way of overall aspirations against the national outcome measures as set out in more detail below. In essence we expect to see from the planned changes the following;

To be completed following finalisation of trajectories for outcomes:

1. A reduction in delayed transfers of care from 302.2 to 226.5 and to 175.4 by 2016
2. A reduction in avoidable unplanned admissions by *(to be inserted into final plan)*.
3. Maintaining the effectiveness of our re-ablement services so that we continue to ensure upper quartile performance and 91.5 to 91.67%.
4. Reducing the number of people who need residential or nursing home placements by 170 to 144.
5. Improving the number of people who feel supported to manage their long term conditions by *(to be inserted into final plan)*.
6. Reducing the number of injuries due to falls in people aged 65 and over by 53.2 from 514.50 to 461.24 per 100,000.

There are also a number of specific measures which apply to specific change programmes detailed in c) below.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Scheme 1: Integrated Health and Social Care Teams

Integrated health and social care teams are in place. These build on the integrated case management structure that is in place for people most at risk of hospital admission and will incorporate a wider range of services including Community Treatment Services (providing acute care to people at home who would otherwise require hospital admission) integration of mental health social worker support and long term conditions services. In the coming year the proposed focus will be on:

- Improving the efficiency of team and ensuring focus on appropriate acuity of patients
- Developing COPD and IV and other condition specific pathways
- Implementing the nursing home support scheme
- Developing Occupational Therapy service around falls and fracture management
- Aligning End Of Life Care work
- Integrating Mental Health Social Work support with a focus on avoiding A & E attendances and emergency admissions
- Developing governance arrangements around the team
- Developing shared workforce skills and capacity.

For illustration, the model provides for the following tiers:

Tier 1: Community Nursing, generic therapies

Tier 2: Integrated Case Management- planned care & support for people with Long Term Conditions

Tier 3:Community Treatment Team/ IRS – urgent care and specialist intensive home support

Tier 4: Bed based support.

Our development work should support delivery of further reduction in avoidable admissions particularly around the identified top 10 ICD10 codes identified as being highest for unplanned admissions in the borough. The scheme will continue to be closely monitored in terms of delivery not only in respect of service access and capacity but also in respect of quality and effectiveness of the service delivered. This is against a range of outcome measures developed in 13/14. A full project plan will be provided for final submission.

Weekly performance dashboards are in place to capture service performance effectiveness and outcomes of the Community Treatment Team element of service – given that this was a service innovation implemented and refined in 13/14.

Scheme 2: Admissions avoidance and improved hospital discharge

A Joint Assessment and Discharge Service model has been developed to improve discharges from the acute hospital, supported by 7 day working and targeted care and support.

7 day working has been operationalised within our acute services providing an enhanced assessment and discharge capability across all days of the week and removing barriers that would ordinarily occur at weekends. This is already delivering improvements in user experience and in discharge flows across the week.

To strengthen our progress made in delivering 7 day working we are in the process of implementing the Joint Assessment and Discharge Service which will bring together in one team, discharge functions undertaken by acute trust staff and those undertaken by social care. Implementation is scheduled for the end of June 2014 (and approved by the Urgent Care Board on 10th December 2014). The service structure will be embedded into wards and Multi-disciplinary Discharge arrangements. We have now successfully recruited the Service Manager to assist in operationalising the service. The Local Authority will be the 'host' organisation for the service. The JAD team will have enhanced delegation and decision making, bringing this closer to individuals and their families and access to on-ward services.

In addition to having key service objectives - key measures (developed and having regard to the outcomes required within the JAD) will be:

- DTOC - number of people with a delayed discharge (days)

- Permanent admissions into residential/ nursing care placements for older people aged 65+
- numbers of assessments completed i.e. increase on current baseline
- number of discharges (over current baseline)
- number of continuing health care packages - broken down into community and placements
- the number of free nursing care cases
- numbers of referrals into community rehabilitation services
- improved user and patient experience

Service users assessed as having ongoing care needs and who are eligible for social care services are provided with personal budgets (wherever possible) or commissioned services. Wherever possible people are supported to direct their own care so that they have control over how their care is delivered and independence and choice are optimised.

Scheme 3: Rehabilitation

An Intensive Rehabilitation Service (IRS) is being trialled which provides intensive support to people at home, rather than in an acute or intermediate care bed. This is linked to a programme of productivity improvement for intermediate care beds that is also underway to allow more people to maximise their independence in their own home.

The Intensive Rehabilitation Service aims to provide an alternative to community bed rehabilitation to enable the support of people in their own homes as appropriate. Intensive, in home support is provided by the team with between one and four visits per day depending on the needs of the individual. The team works closely with Integrated health and social care locality teams and the community bed inpatient units to ensure a smooth and seamless patient journey to recovery. The service is open 8am-8pm, seven days a week and is accessed via Integrated health and social care teams.

Key milestones to implementation as follows:

<ul style="list-style-type: none"> • Paper to Gov Bodies including performance of trial to date and outcome from engagement work- Jan 14. • Assuming recommendation to extend trial is agreed we would be seeking to finalise the proposed model of intermediate care- June 14 • Formally consultation on any significant service changes- July-September 14 • Final decision paper to Gov Bodies- Nov/Dec 14 • Build changes in contracts 2015/16 <p>In 2014/15, it is anticipated this service would contribute to the Better Care funding ambitions to:</p> <ul style="list-style-type: none"> • reduce the amount of time people spend avoidably in hospital through better and more • integrated care in the community, outside of hospital, closer to home. • increasing the proportion of older people living independently at home following discharge from hospital. • increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and the community. <p>Weekly performance dashboards capture service performance effectiveness and outcomes.</p> <p>This scheme will also undertake further work to ensure that rehabilitation and re-ablement provided by social care are aligned so that outcomes are maximised.</p> <p>Scheme 4: Mental health support outside hospital</p> <p>This will bring together health and social care commissioned services that work to support people with mental health problems through talking therapies, primary care, social care, accommodation and employment and recovery services. The local authority approach fosters inclusion and access for service users to all community resources e.g. leisure and the Care and Support service directory for information and advice and</p>

Personal Assistant Finder.

People with mental health problems would benefit from and would prefer support outside of acute care settings and in planned ways at early stages and with a focus on recovery. Through our review 'frequent attenders' at A & E we identified issues with dual diagnosis and substance use as potential gaps in our current locality working and as such have agreed to deploy some of current year re-ablement funding for social work input to address these specific issues. *(Re-ablement metrics are subject to sub group discussion on 3rd February 2014).*

We are working with NELFT to ensure delivery of better access and recovery outcomes for people needing IAPT services (talking therapies). Although this is a challenging target steady progress is being made to deliver current year (13/14 targets). The RAID model has also been identified as a proposed approach to improving psychiatric liaison in acute hospital care and ensuring people with mental health needs are appropriately cared for.

The CCG is undertaking a review of mental health recovery services with a view to working with LBBD to ensure a coordinated approach to provision in the borough and to ensure focus is on prevention and recovery, employment and independent living. This is yet to go through appropriate governance procedures.

Key success measures currently focus on access/recovery rates for IAPT and overall avoidable admissions data. These will need to be refined in year to demonstrate success particularly around level of admission avoidance – potentially using some of the learning from the Community Treatment Team dashboard.

Scheme 5: Integrated commissioning

An integrated commissioning approach will be developed to deliver the commissioning changes required in the BCF. We have agreement to commence with a jointly funded post from our base budget to support our next steps in developing our integrated commissioning and working towards an integrated commissioning unit over a five year

period.

Integrated Commissioning which will commission on outcomes – we will review commissioning arrangements within year 1 of the BCF to :

- Further establish our approach to Joint commissioning, sharing resources and working across Local Authority and CCG to support the strategic implementation of integrated commissioning of health and social care.
- This shared approach could include older people, Long Term Conditions, urgent care community services, family carers, mental health and learning disability services. Also potentially covering joint nursing home, care home commissioning and domiciliary care and personal budgets.
- Arrangements will be put in place to oversee the day to day operation of the Better Care Fund Plan and support performance and outcomes required, alongside reporting requirements to the Fund's governance arrangements within our system.

We will develop success measures and timeframes once proposal agreed in principle.

Scheme 6: Support for family carers

We recognise that carers play a crucial role in supporting their loved ones to remain independent in their own home and also in supporting timely discharge from hospital. Carers are often the experts in a patients care and working closely with carers is crucial to achieving better outcomes.

An integrated carers strategy to be developed with a focus on aligning BCF funding to support carers locally and to take into account the requirements of the pending Care Bill. Further work is needed to develop approach, milestones and outcome measures which will be done in 14/15. Carers will be key to developing a joint approach.

This will support the increased emphasis on carers assessments that will be required as part of the implementation of the Care Bill.

Scheme 7: Care Bill Implementation

To include carers assessments, meeting national eligibility thresholds and statutory safeguarding board.

The Care Bill brings with it a range of new responsibilities and areas of focus, including those of deferred payments, revisions in financial thresholds and increased assessment activity. There will also be a specific emphasis on carers assessments, information and advice, advocacy and safeguarding boards becoming statutory with new responsibilities i.e. for reviews where lessons can be learnt from individual situations. These responsibilities align with most of the schemes putting service users/patients at the centre rather than the focus being upon the services themselves.

Our Strategic Needs Assessment has confirmed that Barking and Dagenham will see increased numbers of people aged 85 years of age and over. People over the age of 85 require at least 3 times as much social care support than 65 to 69 year olds we have also modelled a range of other factors including those of migration which will impact upon the need for support within the borough.

The Borough has a structured programme to prepare for the Care Bill in comparing current baseline with estimated costs of the care bill there is a cost pressure of £12.7 m with accuracy of our forecasting being a priority now that the legislation and its implications are better defined.

In ensuring an accurate understanding of the likely impact of the Bill we have identified steps within this plan that will positively impact upon demand. Further discussions are taking place between the Local Authority and CCG on the potential costs of implementation of the Care Bill, for these aspects deemed by the Department of Health to be included in national resources for the Better Care Fund and agreement on how these are to be funded.

Scheme 8: Prevention

The Local Authority invests in preventative services to promote health and wellbeing with an emphasis on physical activity and falls prevention. Further work will be undertaken to evaluate the effectiveness of the services and how they align with and support the various schemes.

Falls Project overview

The A&E audit showed that falls accounted for 25% of attendances in the over 75s. This project aims to reduce A&E attendances for falls by ensuring that the population has access to appropriate falls assessment and intervention.

This will be achieved by developing a shared vision/strategy for falls management for older people within BHR which will:

- Promote integration of falls services.
- Ensure appropriate and efficient utilisation of specialist falls services.
- Promote a whole systems approach, ensuring that falls assessment and intervention are seen as part of everyone's role.

Progress to date

- Scoping of current provision (Mapping of falls services and shadowing key teams).
- Project Team/ Frailty Academy members being recruited.
- Falls event planning in progress.

Key milestones

- Project plan agreed (December 2013).
- BHR falls event date and venue confirmed and invitation circulated (end January 2014).
- Mapping and analysis of current falls services conducted (end February 2014).
- BHR falls event (March 2014).
- Improvement initiatives identified (March 2014).
- Joint BHR falls strategy agreed (April 2014).

Outcome metrics to demonstrate success

- Reduce A&E attendance for falls among the over 75s in BHR
- Improved access to services and reduced waiting times for falls clinics
- Further metrics specific to improvement initiatives
- Targeted work with Care Homes in identifying risks for falls and in prevention.

Outcomes as per Care Homes project.

Scheme 9: End of life care

Supporting training and service improvements across agencies and services, and integrating into cluster teams.

A paper jointly prepared across health and social care is due for consideration at the H&WBB on February 11, 2014, which sets out a range of actions to develop EOLC services and through better integration support patients to die in their place of choice. This includes training and support to enable generic service providers to better support those with end of life care and support needs. The timeframes for this work will need to be determined once the proposed actions have been approved. The proposed success measures specifically for EOLC being proposed include:

Suggested Measures
Number of patients on the GP practice end of life register
% of deaths in hospital/ usual place of residence
Number/% of Service Users on practice / care home end of life registers benchmarked against prevalence in population generally or comparable practices (This can be benchmarked by list size for GP practice -& /or could just look for growth on current level of performance)
Number/% of Service Users who have been offered (advanced care plans) ACPs and number of ACPs in place
Number/% of people who died with a recognised end of life status
Number/%of Service Users dying in place of choice (as specified in ACP).
Reduction in emergency admissions which result in death is a measure of success in all settings.

Reduction in excess bed-days.	
Being pain free and having condition managed with medication.	
Loved ones / informal carers experiences to end of life care such as being near friends and family.	
Duration by condition and expected life expectancy against setting of care.	
Reductions in people dying in care homes who were not previously resident as such six months prior to death	

Priorities for our focus will be in relation to:

- Numbers of people with Advanced Care Plans in place
- Numbers of people who are able to die in the place of their choice
- Further work to consider the role of care homes
- Participation in GSF End of life Care training programme for generic service providers being rolled out across the borough.

This will play a key role in supporting overall outcome for the BCF of reducing unplanned admissions for people who can be better cared for in other care settings.

Scheme 10: Equipment and adaptations

Bringing together the commissioning and provision of equipment and adaptations that are required to support people in their homes.

Access to appropriate equipment to support care at home is a key element of patients and service users being able to manage independently at home with improved levels of self care. There are currently no integrated equipment facilities in Barking and Dagenham. Following agreement in principle to developing this together, this will provide a key underpinning ‘enabler’ to early and effective discharge, re-ablement, improved self care and rehabilitation and admission avoidance schemes outlined in this section. Timelines and key success measures will need to be developed but these will need to focus on timely access and link in with joint planning processes across health and social

care.

Scheme 11: Dementia support

Improving early diagnosis and support to people with dementia.

We need to build on current work supporting people with dementia and their carers in the borough. We want to ensure that we have a comprehensive approach across health and social care including prevention and delaying onset, early identification and coping with the later stages of the condition. The services currently in place (dementia resource centre, memory clinic and older people's mental health services) provide a starting point for developing and implementing a joined up dementia strategy locally. The CCG is making progress against the CCG indicator for dementia diagnosis with some improvement toward trajectory in 13/14 but with more work to do. Timelines and success factors will need to be agreed but clearly the focus needs to be on early identification and managing later stages of the condition in a planned and appropriate way rather than through unplanned emergency admissions and late stage diagnosis in acute setting. We will therefore develop a local dementia action plan.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

There are opportunities to make better use of acute resources. Nationally emergency admissions account for more than 70% of hospital bed days and those with higher length of stays are predominantly over 65 (Poteliakhoff and Thompson 2011). If all areas achieved the rate of admission and average length of stay of those in the lowest 25th per centile 7,000 fewer hospital beds would be needed across England.

Overall the planned changes will result in a reduction in the number of emergency

admissions, A&E attendances and length of stay. The impact on acute contracts will be aligned with BHRUT's long term financial model.

Detailed work is underway to quantify the impact of the schemes on emergency admissions and will be available for the final submission of the plan. This is a complex piece of work that requires alignment with contracts, with acute provider and other commissioners.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Governance and leadership shall be exercised by the CCG Governing Body and the Health and Wellbeing Board, supported by the Integrated Care Sub-group of the Health and Wellbeing Board and sub-group of senior CCG and local authority officers who are overseeing the detailed and day to day work. The Integrated Care Coalition provides oversees strategic plan development of which BCF if a key element oversight across Barking and Dagenham, Havering and Redbridge and therefore provides consistency in approach and in developmental opportunities across local authority boundaries. It will provide oversight of the operation of the BCF, our performance against required outcomes and additional steps which may be required.

An integrated commissioning approach, supported by agreement to jointly fund a shared post between the CCG and the Local Authority, will be further developed that will focus on commissioning for the BCF outcomes. We will review commissioning arrangements within year 1 of the BCF to :

- Further develop our integrated commissioning arrangements, sharing resources and working across LA and CCG to support the strategic implementation of integrated commissioning of health and social care.
- This shared approach will initially consider older people, LTC, urgent care community services, family carers mental health and learning disability services. It could be further extended to cover joint nursing home, care home commissioning

and domiciliary care and personal budgets.

- Arrangements will be put in place to oversee the day to day operation of the Better Care Fund Plan and support performance and outcomes required, alongside reporting requirements to the Fund's governance arrangements within our system.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The development of the BCF will seek to protect identified services that benefit health across the two year period and across the two budget setting years. Key priorities are ensuring people are safe and that those with critical and substantial needs have them met.

This will ensure funding is in place to the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management, review and commissioned services to people who have substantial or critical needs and effective information, signposting to those who are not eligible to FACs (Fair Access to Care services). Investment in integrated health and care teams (clustered around general practice) will provide earlier identification and intervention for those are likely to need future support. Social care support can be critical to keeping people with complex needs and frailty safe, independent and with quality of life.

Social care plays a significant role within our extension of 7 day working arrangements, providing improved access to assessment and support where required.

Alongside opportunities identified above and through utilisation of the fund and the schemes within it that will positively impact upon such areas as admissions to bed based services we also recognise that there are areas of new activity for example, the new Care Bill requires additional assessments to be undertaken for people who did not previously access social care.

Please explain how local social care services will be protected within your plans

The BCF provides an opportunity for LBB and B&D CCG to work together and in a

coordinated way to improve the way in which local services are used – focusing more on prevention and early intervention and improving outcomes for patients and pressures on services later in the care pathway – for example focusing on re-ablement and active rehabilitation which should reduce we think the net impact on residential and nursing home placements – as seen in other areas and release resources.

We will need to use the BCF in new and innovative ways to enable us to implement the Care Bill. A notional working sum for implementation has been identified but we will need to work through this together and also understand how other spend can be refocused to provide headroom for implementation.

We are also looking at how we can better support carers and maximise the way in which carers can work with health and social care services to improve outcomes and make the best use of our local resources. This will involve the development of a joint carers strategy as set out above.

The local Better Care Plan acknowledges within the schemes, financial allocations and priorities that will give us the best chance of sustaining local services that will best impact upon our system and current demand pressures

Modelling is underway in relation to the financial impact of the Care Bill and proposed re-investment by the CCG into key deliverables within the Better Care Fund.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

7 day working has been operationalised within our acute services providing an enhanced assessment and discharge capability across all days of the week and removing barriers that would ordinarily occur at weekends. This is already delivering improvements in user

experience and in discharge flows across the week.

In addition, and to strengthen our progress made in delivering 7 day working we are in the process of implementing a Joint Assessment and Discharge Service which will bring together in one team discharge functions undertaken by acute trust staff and those undertaken by social care. Implementation is scheduled for the end of June 2014 (and approved by the Urgent Care Board on 10th December 2014). The service structure will be embedded into wards and Multi-disciplinary Discharge arrangements. We have now successfully recruited the Service Manager to assist in operationalising the service. The team will have enhanced delegation and access to on-ward services.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

In 2010 the Local Authority and PCTs (CCG's) Commenced a data sharing programme using a single data repository for reporting. The linkage within the database is NHS number, over the subsequent years this repository has grown to provide access to health and social care personal involved in direct patient care. Today the repository provides the basis for information to be used by the Joint Assessment and Discharge service, Integrated case management service and Rapid response and urgent care teams along with crisis information for A&E consultants and general practice.

Collection of the NHS number is embedded into our social care business processes. Following a project in 2011 when social care records were matched to NHS numbers by the NHS Tracing Service, it is now routinely collected by the allocated social worker or support planner as part of the assessment or review process; use of the NHS Number forms part of our internal audit standards, and in 2013 a total of 241 further NHS Numbers were collected using this method. Of those clients being case managed by the Integrated Care Cluster Teams, 99.9% [1340 out of 1341 cases] have their NHS Number recorded.

The Council's IT Strategy, adopted in June 2013, committed the organisation to making use of open standards for data management and transparency. However, it also committed to making use of 'off the shelf' software, rather than excessively tailored 'bespoke' solutions. Therefore, we continue to exploit the excellent relationships between the Council, social care IT suppliers and NHS partner IT managers to look for improved ways of linking data management software

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by
NHS number is being used.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK).

In 2013 the PCT / CCG and local authority took part in a programme supported by the DoH to encourage the adoption of the interoperability toolkit standards. Currently the core system for sharing information is approved by the DoH to send and receive messages via ITK and this functionality is the basis for the Local Authority to share key elements of a patients social care record with Out of Hours, A & E and NHS 111 services.

As part of the Joint Assessment and Discharge work, an application programming interface (API) has been developed to enable Section 2 and section 5 information to be processed in the same format as the health service, Continuing Health Care process. This joining of systems and process all driven from a central combined health and social care repository (aligned by NHS number) is a key element of our strategy as we progress toward joined up working.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The Council already complies with the IG controls set out in the IG toolkit and the PSN CoCo (Code of Connection). The Council's most recent PSN CoCo was granted in

November 2013. The IG Toolkit was last submitted in March 2013 and we are working towards the submission for March 2014. The corporate Information Governance Board includes Caldicott Guardians, and oversees the Council's continued adherence to information governance requirements and best practice, reviews breaches of information security, and ensures required organisational development activity

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Integrated case management is in place in Barking and Dagenham. The population is risk stratified using the Combined Predictive Model. The top 1% of the population identified as being at highest risk of admission to hospital are targeted for integrated case management and provided with a joint care plan.

While the integrated care teams support coordinated care planning and an MDT approach to providing holistic patient care, the patient's registered GP is the 'lead primary care provider'. The patient's care co-ordinator is the first point of contact in the ICM model, but each patient has a named GP lead in their care plan. The coordinator role ensures continuity of care in all eventualities. This system will support the 'accountable GP for over 75s' initiative.

The risk stratification and care planning process is facilitated through the data repository described in section c above. This is a web based system that all providers (primary care, community care, social care, and secondary care) have access to allowing them to identify high risk patients. Targeting individuals at risk of acute admission and providing preventative interventions are key in reducing current usage of acute services and delivering savings in whole system costs. Multi-disciplinary care plans are also available on Health Analytics enabling all care providers real time access to care plans, which have the details of the accountable professional and opportunities for improved co-ordination.

As well as using the risk stratification tool to identify patients who could benefit from joint care planning to reduce risk of admission, we are also working with LTC services, EOLC services, and care homes to ensure that their patients can benefit from this where appropriate.

We are also promoting opportunities for improved levels of 'self care' through providing access through 'active aging', advice an information that may encourage lifestyle changes which promote improved health and wellbeing

As of 7th January 2014 ICM caseload is 1102, number of patients with an active care plan is 646.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
<p>BHRUT quality and performance issues- the local hospital trust faces substantial challenges to deliver quality care and financial sustainability. The intention to reduce expenditure on acute care will further impact upon the Trusts financial model.</p>	High	<p>Quality and performance contract management processes are key methods</p> <p>Special measures arrangements</p> <p>Urgent Care Board and system plan</p>
<p>Achieving financial balance and sustainable services through reconfiguration changes that will be challenging to implement and will require stakeholder, community and public / patient support.</p>	High	<p>QIPP and BCF key elements along with related assurance and progress monitoring processes which have matured over year. Developing more robust partnership communications and engagement on key issues.</p>
<p>The introduction of the Care Bill will result in significant increases in the costs of care provision that is at this point not fully quantifiable and will impact upon the sustainability of current social care funding and plans</p>	High	<p>We have undertaken an initial impact assessment of the effects of the care Bill and will continue to refine our assumptions around this as we develop our final response and begin to deliver upon the associated schemes</p>
<p>Maximising impact with scarce resources – given the population need in Barking and Dagenham</p>	High	<p>Close monitoring of outcomes and plan deliverables through established governance</p>

<p>and the particular challenges that the population has in improving health outcomes in an area of high deprivation, there is a risk that the efforts of health and social care services will have a limited impact upon outcomes</p>		<p>arrangements will establish progress and additional actions required. This remains however a significant challenge in our area.</p>
<p>Further cashable savings and efficiencies required from the Council and the pressures on CCG budgets due to over performance in other areas of health spend challenge planning assumptions and/or impinge on other areas of health and social care spend.</p>	<p>High</p>	<p>Activity within the plan reflects agreed local priorities and strategy for the Council and the CCG – including that of the Integrated care Strategy.</p> <p>The plan itself seeks to invest in preventative activity in order to reduce demand for higher cost services and seek similar benefits as those evidenced with LGA value cases 2013.</p>

Attachment 1: BHR five year strategic plan on a page (to be provided at final submission).
Attachment 2: Integrated care commissioning strategy November 2012 (to be provided at final submission).

Part 2

Better Care Planning Care template – Finance, outcomes and metrics

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
		£'000	£'000	£'000
Local Authority Barking and Dagenham		11,567	1,180	8,555
CCG Barking and Dagenham		1,655	13,055	13,055
BCF Total		13,182	14,235	21,610

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Barking and Dagenham has a clear strategy for integrated working aimed at bringing health and social care staff in the local primary and secondary sectors together, in order to provide more responsive patient centred care and to shift resources from the acute sector to the community. This is underpinned by an integrated care strategy which is overseen by the Integrated care Subgroup of the Health and Wellbeing Board. A programme of work is well underway, some initiatives already embedded locally. The programme consists of six established multi-disciplinary cluster teams organised around GP practices. The CCG has commissioned a community treatment team responding to emergencies in peoples homes and to encourage self care. There are targets against the provider contract which will be monitored by the CCG. The health provider trust, acute trust and local authority have jointly commissioned an assessment and discharge team comprising nurse and social workers which will support avoidance of admission where appropriate and timely discharge home. Seven day working across the acute trust has also been introduced. All new services are regularly monitored through an assurance system. It is hoped that some efficiencies will be made through service redesign and sharing of resources. The local acute trust is on special measures and quality and management of activity are risk factors locally. Performance is monitored by an Urgent Care Board chaired by the CCG Chief Officer. The BCF delivery will be monitored by the Integrated Care Subgroup of the Health and Wellbeing Board where progress, risks, performance and budget issues will be overseen. Further work is required before the final submission to develop a contingency plan to manage over performance on acute trust activity should the planned improvements

not be achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent £'000	Non- recurrent £'000	Recurrent £'000	Non- recurrent £'000	Recurrent £'000	Non- recurrent £'000	Recurrent £'000	Non recurrent £'000
Scheme 1; Integrated Case Management	CCG	5,245	0			9,864	0		
Scheme 2: Admission Avoidance and Discharge from Hospital	Local authority	2,047	0			2,047	0		
Scheme 3: Rehabilitation	Local authority	700	0			3,143	0		
Scheme 4; Mental health support outside hospital	Local authority	840	0			1,006	0		
Scheme 5: Joint Commissioning	Local authority	220	0			220	0		
Scheme 6: Support for Family Carers	Local authority	925	0			925	0		
Scheme 7: Care Bill implementation	Local authority	100	0			1,184	200		
Scheme 8: Prevention	Local authority	1,221	501			1,221	308		
Scheme 9: End of life	Local authority	105	0			105	0		
Scheme 10: Equipment and Adaptations	Local authority	350	590			377	672		
Scheme 11: Dementia support	Local authority	338	0			338	0		
Total		12,091	1,091			20,430	1,180		

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total BCF allocation

BCF Investment	2014/15 spend £'000	2014/15 benefits £'000	2015/16 spend £'000	2015/16 benefits
Scheme 1: Integrated Case Management	5,245	To be completed	9,864	To be completed
Scheme 2: Admission Avoidance and Discharge from Hospital	2,047	To be completed	2,047	To be completed
Scheme 3: Rehabilitation	700	To be completed	3,143	To be completed
Scheme 4: Mental health support outside hospital	840	To be completed	1,006	To be completed
Scheme 5: Joint Commissioning	220	To be completed	220	To be completed
Scheme 6: Support for Family Carers	925	To be completed	925	To be completed
Scheme 7: Care Bill implementation	100		1,384	To be completed
Scheme 8: Prevention	1,722	To be completed	1,529	To be completed
Scheme 9: End of life	105	To be completed	105	To be completed
Scheme 10: Equipment & Adaptations	940	To be completed	1,049	To be completed
Scheme 11: Dementia Support	338	To be completed	338	To be completed
Total	13,182		21,610	

Outcomes and metrics

For each metric other than the patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

For this indicator our 2012/13 baseline performance was 871 permanent admissions per 100,000 65+ population. This equates to 170 Barking and Dagenham residents aged 65 and over, admitted to residential care for that year. We have set what we feel is a realistic achievable target for the period underpinning the October 2015 payment of 738 admissions per 100,000 65+ population. Achieving this target would mean a reduction of 26 people being admitted throughout the financial year.

A number of schemes noted in the draft Plan will impact on this target.

Scheme 1

The integrated case management scheme is already an established way of working within Barking and Dagenham which involves a number of multi-disciplinary teams which are led by the locality GP. These teams have been set up to promote independence amongst the older population of the borough and those with complex conditions, by providing commissioned services and where possible services via a direct payment which in turn helps people to remain in their own homes for longer and maintain choice and control over the services they receive.

The Community Treatment Team(CTT) potentially helps to avoid unnecessary hospital admissions, It is provided by NELFT and works in an integrated way with health and social care staff to access emergency social care packages to keep people in their own home. Sustaining people at home by responding quickly to health crises can help to sustain them in their own homes for longer.

Scheme 6

The support for family carers scheme is being put in place to refresh the borough's carers strategy. This will encompass the requirements which have been identified in the upcoming Care Bill. In the borough we recognise the contribution of informal carers and that they are experts in caring for their loved ones which in turn enables them to remain living in their own home and to maintain independence. This can help to defer or avoid care home placement. The support for carers also helps to facilitate better pathways home from hospital, sometimes avoiding care home placement. We have proposed a scheme for dementia, to improve the co-ordination of health and social care and work with family carers and better support those with dementia, living at home. Improved co-ordination of community services can enable

people with dementia to live longer independently at home, thus avoiding for some, care home placements.

Scheme 3

The current changes being trialled in intermediate care where intensive rehabilitation in the home is being offered as an alternative to more traditional community bed-based care following hospital discharge, opens up the possibility of people being returned to independence more effectively after e.g. fractures following falls but has not been quantified in terms of nursing/residential homes admissions. A high proportion of care home placements nationally are known to be as a result of falls. .

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services

Our baseline (2012/13) performance for this indicator was strong, of the older clients discharged from hospital into re-ablement/ rehab services between October and December 2012 91.5% were still living in their own homes after 91 days. This performance placed us in the top quartile of our comparator group and above both the England and London average (81.4% and 85.3% respectively). With this performance in mind we have set the target for the October 2015 payment to maintain current performance, we are also aware that as this only looks at a three month period there is a possibility that results may fluctuate.

Scheme 3

The rehabilitation scheme will see services offered by the community health services provider trust (NELFT) moving towards providing intensive rehabilitation in the home setting reducing the number of rehabilitation beds needed as services in the community are developed. The scheme will also include the continuation of the Council's crisis intervention service which was introduced at the beginning of the 2012/13 financial year as a short term service to help people be assessed and receive the services they need as quickly as possible. We will also ensure that our local systems for rehabilitation and re-ablement join up well.

Delayed transfers of care from hospital per 100,000 population (average per month)

For this indicator we have used the 2012/13 financial year data as the current baseline for which a total 4,892 delayed days were reported for the London Borough of Barking and Dagenham. This is the equivalent of a monthly average of 407.7 delayed days which becomes 302.2 when converted to a rate per 100,000 residents (18+). This is higher than both the London average (177.9) and the England Average (280.1). Taking this into consideration we have set the targets for this indicator as 225 for the period underpinning the April 2015 payment and 175 for the period underpinning the October 2015

payment. We feel that these are challenging but realistic targets and if achieved will bring Barking and Dagenham in line with the current London average performance.

Scheme 2

The scheme which will have the most noticeable impact on the performance of this indicator will be the Admissions Avoidance and Discharge from Hospital Scheme. One aspect of this scheme will see the introduction of a Joint Assessment and Discharge Service in the acute setting which aims to improve how patients leave hospital and go back to their own homes safely and with dignity and respect. The Admissions Avoidance and Discharge from Hospital Scheme will also see the development of 7 day working of social care staff in hospital to enable weekend hospital discharges. There are huge benefits to 7 day working from a patient experience point of view as well as helping to reduce the number of days lost due to delayed transfers of care. As stated above the support for family carers scheme will also have a positive effect on this DTOC indicator.

The Intensive Rehabilitation Service, currently being trialled, will also support people to move more rapidly home from hospital.

Scheme 10

The Equipment scheme, ensuring that equipment is coordinated and available in a timely way, will support timely discharge.

Avoidable emergency admissions (composite measure)

Scheme 1

Barking and Dagenham CCG and LBBD have established joint working to provide Integrated Case Management (ICM), specifically targeted at people who are identified through predictive risk modelling as being at high risk of hospital admission. Teams of health and social care practitioners work together for a defined population, based on GP registration (localities of general practice). Health and social care are now working together to build on this well-established model in Barking and Dagenham by extending the approach which brings together a wider range of services into the localities, extending the opportunities for integration for service users. This range of services will include mental health workers and a wider range of long term conditions services.

Additional mental health social workers are being introduced to the integrated teams specifically to address the need to have improved mental health support for people identified as frequent attendees at A&E from our recent review.

The Community Treatment Team has been commissioned to specifically work with people requiring acute medical care who would otherwise require a hospital admission.

Scheme 8: Prevention activities including work to prevent falls and injuries following falls will reduce the number of admissions following falls.

Scheme 9: improvements in end of life care, combined with improved support for family carers (scheme 6) will help reduce the numbers of emergency admissions for people at the end of life, as they are provided with the support needed to die at home (according to their wishes).

Work is underway to quantify the impact of these schemes on emergency admissions and will be available for the final submission of the plan, This is a complex piece of work that requires alignment with contracts with acute provider and other commissioners.

Injuries due to falls for people aged 65 and over

One in three people over the age of 65, and one in two of those over 80, will fall each year¹. Falls and fractures among the over-65s take up four million hospital bed days each year in England, costing an estimated £2 billion. Injuries in the elderly due to falls can occur through inadequate assistance with personal care at home, particularly following discharge from inpatient hospital care for other health problems. Better social care support can reduce the number of hospital admissions due to injuries such as hip fractures and therefore the burden on the NHS.

It has been shown that implementing a falls prevention strategy can reduce the number of falls by between 15 and 30 per cent²; therefore, investing in social care could not only potentially reduce overall social and health care costs but also improve the lives of these vulnerable people and prevent avoidable suffering.

Barking and Dagenham hope to achieve the targeted reduction by developing a shared vision and strategy for falls management. The strategy will promote the integration of services for vulnerable people by promoting a whole systems approach, ensuring that falls assessment and intervention are seen as part of everyone's role. This will help to prevent falls

¹ NHS confederation: Ambulance Service Network Community Health Services Forum (April 2012), Falls Prevention: New approaches to integrated falls prevention services

² Department of Health (2009), Falls and fractures: developing a local joint strategic needs assessment.

occurring.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for the October 2015 payment. please see the technical guidance for further detail. If you are using a local indicator Please provide details of the expected outcomes and benefits and how these will be measured

Proportion of people feeling supported to manage their(long term) condition

For the patient experience metric we have decided to use the **Proportion of people feeling supported to manage their(long term) condition** indicator. The outcome of this indicator is calculated using responses to the GP Patient Survey (GPPS). The current GP Patient Survey (GPPS) questionnaire asks:

“Do you have any long-standing health problem, disability or infirmity? Please include anything that has troubled you over a period of time, or is likely to affect you over a period of time.”

Respondents who answer ‘Yes’ (rather than ‘No’ or ‘Don’t know / Can’t say’) are then asked:

“In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? (Please think about all services and organisations, not just health services)”

Respondents have a choice of 5 options:

- Yes, definitely
- Yes, to some extent
- No
- I have not needed such support
- Don’t know / can’t say

This indicator was chosen as we feel the integrated care management scheme and the mental health support outside hospital scheme will enable us to improve the way in which patients perceive the support they receive in managing their long term conditions. This is an indicator which encompasses health and social care and is the ultimate test of what we are trying to achieve. It is an indicator that was chosen in 13/14 by the CCG, with support from the local authority, and enables us to have some continuity of measurement. This is a holistic indicator that can include how well patient's clinical symptoms are managed, how they feel about the outcomes they are achieving and how services are affecting their lives, not just their health.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

All permanent admissions into residential or nursing placements must receive sign off from the group manager or above before they can be authorised. The number of older people admitted into permanent residential care is monitored on a monthly basis by senior management as part of regular performance monitoring. This indicator is also included in our health and Wellbeing Board performance framework. The number of older people admitted into external residential placements is also scrutinised on a monthly basis as part of rigorous financial monitoring.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services

Due to this indicator concentrating on a three month period this isn't something we can monitor on a monthly basis throughout the year. However the figures are thoroughly scrutinised before submission as part of the end of financial year statutory returns. In addition, outcomes of rehabilitation services offered via the provider trust are monitored by the CCG. The Local Authorities Crisis Intervention re-ablement service, provides up to 6 weeks intervention through the Integrated Care cluster model. These interventions can be clearly identified on the social care case management systems, so service users can be clearly identified and tracked, and performance of the Authorities crisis Intervention service is monitored monthly.

Delayed transfers of care from hospital per 100,000 population (average per month)

DTOC information is monitored in great detail throughout Adult Social Care. Any delayed days are discussed between the

main acute trust (BHRUT) and adult social care on a weekly basis, with necessary solutions and required steps and are agreed before any sign off takes place. Similar arrangements are being developed with our other principal neighbouring acute hospitals.

Both the number of people delayed (snapshot) and the total number of delayed days are monitored on a monthly basis at a senior level within social care and health.. The snap shot information is currently included in our Health and Wellbeing Board performance framework with plans to include this delayed days indicator from the start of the 2014/15 financial year. An in-depth look at DTOC performance is also presented at the borough's Urgent Care Board which is chaired by the Chief Accountable Officer for the three CCG's.

Avoidable emergency admissions (composite measure)

Performance arrangements still need to be worked through in detail but will be overseen by the B&D Integrated Care Group for locally delivered schemes and through the Integrated care Steering Group for BHR for system wide schemes. Some elements will be closely monitored through the UCB.

Injuries due to falls for people aged 65 and over

As this indicator is included in the Public Health Outcomes Framework this will be the subject of ongoing regular monitoring.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template for the multiple HWB combined.

Not Applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	871.0	N/A	738
	Numerator	170		144
	Denominator	19,517		19,517
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services		(April 2012 - March 2013)		(April 2014 - March 2015)
	Metric Value	91.50%		91.67%
	Numerator	110		165
Delayed transfers of care from hospital per 100,000 population (average per month)	Denominator	120		180
		(April 2012 - March 2013)		(April 2014 - March 2015)
	Metric Value	302.2	224.3	175.4
Avoidable emergency admissions (composite measure)	Numerator	4892	2875	1530
	Denominator	134913	142419	145342
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)
Proportion of people feeling supported to manage their(long term) condition – to be used for the patient/service user experience measure		(TBC)	(April - September 2014)	(October 2014 - March 2015)
		(insert time period)		(insert time period)
	Metric Value	tbc	N/A	tbc
Injuries due to falls for people aged 65 and over	Numerator	tbc	N/A - Annual Indicator * targets for the periods underpinning future payments have yet to be set for this performance indicator. Currently the only data for this measure is for 2011/11 & 2011/12 financial years. Historical data has been requested from the NE London	tbc
	Denominator	tbc		
		(April 2011 - March 2012)		

Commissioning Support Unit once this has been received work will be undertaken to set a realistic & achievable target which will be agreed by both Public Health and the CCG.

HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	Public Health Commissioning Plan 2014/15		
Report of the Director of Public Health			
Open Report	For Decision		
Wards Affected: ALL	Key Decision: YES		
Report Authors: Sarah Blair Interim Planning & Performance Manager Karen Fuller, Principal Accountant Public Health	Contact Details: Tel: 020 8227 3781 Email: sarah.blair@lbbd.gov.uk		
Sponsor: Matthew Cole, Director Public Health			
Summary: The following paper sets out the commissioning plan for the Public Health programme for the period 2014/15. It follows on from the "Public Health Commissioning Priorities 2014/15" paper, presented at the 5 November 2013 Health and Wellbeing Board. The Board agreed and prioritised the following:			
<ul style="list-style-type: none"> • Transformation of Health and Social Care • Improving premature mortality • Tackling obesity and increasing physical activity • Improving Sexual and Reproductive Health • Improving Child Health and Early Years • Improving Community Safety • Alcohol and Substance Misuse • Improving Mental Health • Reducing Injuries and Accidents 			
This paper sets out the funding proposals for these 9 priorities, together with the funding requirements for the mandated services and for a small number of other programmes.			

Recommendation(s)

1. To consider the resources allocated to the delivery of the 9 priorities agreed within the strategic framework for commissioning public health programmes for 2014/15 and 2015/16.
2. To endorse the commissioning intentions in this paper to ensure that service delivery continues to improve Public Health outcome indicators as outlined in the Public Health Outcome Framework and the Joint Health and Wellbeing Strategy.

Reason(s)

The Health and Social Care Act 2012 introduced the requirement for health and wellbeing boards to prepare joint health and wellbeing strategies for their local areas. The Joint Health and Wellbeing Strategy should provide an over-arching framework to ensuring a strategic response to the health and social care needs of the local population.

1. Background

Further to the commissioning priorities agreed by the Health and Wellbeing Board at its meeting on the 5th November 2013, this report sets out the Public Health commissioning intentions for 2014-2016 for improving health and wellbeing. The Director of Public Health has undertaken a review of the current resourced programmes against the 9 priorities identified.

This report is for discussion and agreement of the intentions contained within it for our resourced delivery programmes from the 1st April 2014.

2. The Public Health Grant

- 2.1 The Department of Health awarded the Council a £12.921m ring-fenced Public Health grant for 2013/14. We were also notified that a further £14.213m had been approved for 2014/15. The total confirmed Public Health grant awarded is £27.134m over the two financial years. See Appendix 1 – Grant breakdown by priorities.
- 2.2 Expenditure to 31st December 2013 was £6.8m, approximately 53% of the budget. The projected year-end position of the grant is currently projecting an underspend of £1.077m. This underspend is largely due to commissioned services not starting on time and the efficiency savings made on external commissioned services.
- 2.3 Once the final outturn position is known, a list of potential roll forwards will be scrutinised and a decision will be made as to whether the underspend should be rolled forward for the particular service in question, or whether it should be held in a separate budget line that may be used for redirection to other schemes on the reserve list.

2.4 The Department of Health (DH) expectation is that funds will be utilised in-year, but if at the end of the financial year there is any underspend, this can be carried over, as part of a public health reserve, into the next financial year. In utilising those funds in the next year, the grant conditions will still need to be complied with. However, where there are large repeated underspends the DH will consider whether allocations should be reduced in future years.

2.5 The 2014/15 budget allocation of £14.213m has been provisionally allocated as a result of a zero-based budgeting exercise. Requests for project funding have exceeded the £14.213m grant available, but the forecast underspend from 2013/14 could be used to meet this shortfall (£666,700), assuming all 2014/15 budgets are approved, as shown in the table below. This will be reviewed following the finalisation of the outturn position in May 2014. Until this point, some schemes will need to be placed on a reserve list.

2.6 Grant breakdown over three years is as follows:

Year	Total Grant	Total spend requests	Potential shortfall
2013/14	£12.921m	£12.921m	0
2014/15	£14.213m	£14.880m	£667k
2015/16	Potentially £14m	£17.700m	Potentially £3-£4m
Total	Circa £40m	£45.501m	Potentially £5m

2.7 Public Health England has also declared that the Public Health grant will be ring-fenced for a third year (2015/16), although specific amounts for each local authority have not yet been disclosed.

2.8 The Advisory Committee on Resource Allocation have commissioned research to develop a new formula for distributing the Public Health grant. The research is expected to be completed by summer 2014, and be used to inform Public Health allocations from 2015-16.

2.9 DH has said that the Public Health grant 2015/16 will be announced with the normal DH timetable of allocations (December 2014). If the new formula is not ready, the introduction of this could be delayed to the following year.

2.10 In 2015/16, the commissioning responsibilities for the Healthy Child Programme (0-5 years) and Child Health Records Service will be transferred to the Council from NHS England. The process of setting the baseline for transfer of funding to Local Authorities has not yet been decided. At this moment in time we are uncertain as to whether the allocation for 2015/16 will include sufficient additional funding to bring Health Visiting up to the numbers recommended in line with the Health Visitor Implementation Plan 2011-2015. This accounts for £2m of the £4m predicted short fall for 2015/16. See Appendix 1 – Grant breakdown by priorities.

2.11 While there may be additional funding for health visitors, this has not been confirmed at this stage. However, while there is no reason to assume the grant will be reduced in 2015/16 it is unlikely that the grant will increase, apart from provision

for transferred responsibilities. It is therefore prudent to plan on the basis that it will remain at around £13-14m. Even then, some of this funding may be connected with achieving the outcomes included in the Health Premium. Total spend requests of £17.7m therefore far exceed this assumed budget and decisions regarding priorities will need to be addressed once the final grant details are released in December 2014.

- 2.12 The sub groups of the Board will need to review and determine what programmes to deliver through the available financial envelope. A budget of £100k has been included in 2014/15 for a programme evaluation, which it had been hoped to do this financial year. However, with some schemes starting in line with the academic year, this will be carried out in September 2014. This will also inform the review of the Health and Wellbeing Strategy.
- 2.13 The Public Health grant contribution to the proposed two year Better Care Fund (BCF) plan totals £1.191m in 2014/15.
- 2.14 Additional schemes need to be considered in decision-making. The additional schemes are Care City of £300k and possible School Nursing pressures of £300k in 2015/16.

3. The Health Premium

- 3.1 The Health Premium Incentive Scheme will be introduced in 2015/16. It will be designed to reward communities for making progress against certain indicators identified from the Public Health Outcomes Framework. The selected health premium indicators will be communicated to local authorities by March 2014. The first incentive payment will be in the year 2015/16 to ensure local authorities are rewarded for the improvements they make.
- 3.2 When further details are released, an analysis will need to be undertaken to ascertain whether the premium is reflective of our local priorities and whether it is worth pursuing in financial terms. Priorities may need to be reviewed in light of the health premium, and programmes may need to be scaled up or down accordingly.

4 Commissioning Intentions

- 4.1 The commissioning intentions support the 9 priorities identified by the Board through the life course. A number of key documents have been published recently which impact on the current direction of the Public Health programmes and the desired impact the Health and Wellbeing Board needs to achieve if it is to reduce premature deaths from liver disease, cardiovascular disease, respiratory disease and cancer.
- 4.2 The tables below describe, by priority area, the current and proposed investments.

Table 1: Transformation of Health and Social Care

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Leisure offer over 60 years	130	130	130	390	Y	This cost is maintained ensuring the over-65s have improved access to leisure centres. Satisfaction survey results have proved very positive.
Active Age Centres	200	300	300	800	Y	Increase to reflect BCF and keeping older people healthy and active.
Eat well, Live an active life, Feel great (ELF)	70	70	70	210	Y	Specific intervention for people with learning disabilities. Currently level of investment maintained.
Volunteer drivers	48	48	48	144	Y	This project is designed to reduce social isolation in vulnerable people. Currently level of investment maintained.
Tenancy Support	40	110	110	260	Y	Part-year funding in 2013/14 and full year effect 2014/15 onwards. New investment targeted at keeping vulnerable residents in their tenancy to support the delivery of social care.
Winter warmth	10	50	50	110	Y	Part-year funding in 2013/14 and full year effect 2014/15 onwards. New investment targeted at reducing premature mortality.
Care City	0	300	0	300	N	Health and social care workforce development and research. A full report will be presented to the March Health and Wellbeing Board. Placed on hold until funding is established.
Total	498	1,008	708	2,215		Overall increase in investment to support the delivery of health and social care outcomes

Table 2: Improving Premature Mortality, including Smoking Cessation and Cancer Screening

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Smoking cessation support services inc. GP and Pharmacy and prescribing costs from 2014/15	620	824	1,520	2,964	N	Smoking budgets increasing due to more ambitious targets for the number of quitters. A significant increase in the cost of a specialist smoking cessation service (circa £700k) is anticipated over the next two years due to the cost of drugs used for nicotine replacement.
Smoking prevention – all ages	40	100	100	240	N	The increase in budget is reflective of a local policy shift in preventing young people from initiating smoking behaviour. There is a compelling case for reducing the number of people who take up smoking when the cost of education and brief intervention is weighted against the cost of treatment for smoking-related illnesses later in the life course. Smoking prevention work will increase to reflect the high incidence of smoking in the borough and the need for more preventative methods.
Tobacco Co-ordinator	17	60	60	137	N	Investment strengthened to maintain tobacco control initiatives.
Targeted health improvement projects	39	50	50	139	N	Investment maintained.
Pulmonary rehabilitation	100	100	100	300	N	A review is currently in place to determine how best to deliver this area of work.
Total	816	1,134	1,830	3,780		Overall increase in investment to address premature mortality.

Table 3: Tackling Obesity and increasing Physical Activity

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Healthier catering/ baby friendly feeding	70	0	0	70	N	Resources reinvested within this programme area.
From Seed to Plate	32	54	54	140	N	This scheme started in September and therefore the full-year effect will be evident in 2014/15. After initially being rolled out to half the schools in the borough, this initiative will be extended to every primary school as part of the industrial scale approach to reducing obesity in children and their families.
Healthy Heritage and Victory Gardens	20	50	50	120	N	The initial budget is for an audit and scoping exercise. The budget for 2014/15 will be placed on hold, pending the audit results. Investment for 2015/16 to be determined and money reinvested into the obesity programme if not needed.
Training and Skills – Disability Officer	47	47	47	141	N	Investment maintained.
Weight management 0-19	300	320	320	940	N	The budget has increased in 2014/15 due to the increased child population within the borough and the high prevalence of childhood obesity.
Young Persons Active for Life	150	150	150	450	N	This programme focuses on getting teenagers more active. This scheme started in September and therefore any underspend will be rolled into 2014/15 if approved.

Get Active!	100	151	151	402	N	This focuses on getting school children more active. This scheme started in September and therefore the full-year effect will be evident in 2014/15.
Youth Access Card	150	155	155	460	N	It is envisaged that this team will be utilised further to embed Public Health initiatives within the school-age group in the borough.
Summer Sorted	60	60	60	180	N	Investment maintained over the three year period.
Play in the Parks	55	55	0	110	N	Investment maintained over the three year period.
School swimming	78	78	78	234	N	Investment maintained over the three year period.
Cycle Clubs	60	60	60	180	N	Investment maintained over the three year period.
Exercise on referral	300	320	320	940	Y	An increase in investment is planned due to the focus on reducing obesity within the borough and the demand for the service.
Weight management - adults	50	55	55	160	Y	An increase is planned due to the focus on reducing obesity within the borough.
Leisure co-ordinator/ impact of new leisure centre	0	60	200	260	N	Increase in investment to deliver the new programmes.
Total	1,472	1,615	1,700	4,787		Overall investment increased to address lifestyle risk factors especially obesity.

Table 4: Improving Sexual and Reproductive Health (also a mandated service)

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Integrated services	1,112	1,200	1,200	3,512	N	Efficiencies were made within the contract in 2013/14; however, as a request will be made to extend this contract, additional resource may be required.
Targeted services	600	500	600	1,700	N	This is a demand-led service and hence difficult to predict due to a lack of historical information. While spend to date has been relatively low so far, more invoices are expected to be received during quarter 4. Demand for this service is also expected to increase longer term. Tariffs and charging mechanisms are being explored.
HIV Services	210	200	200	610	N	Efficiencies were made within these contracts and hence the budget has been reduced.
Chlamydia screening	300	300	300	900	N	Investment to continue at this level as this indicator is part of the Public health Outcomes framework (positive test in 15-24 year olds).
GP/Pharmacy services	200	220	220	640	N	Increased incentives have been agreed, hence the budget has increased.
Local access to primary prevention	60	60	60	180	N	Investment maintained in this condom distribution scheme for young people.
Pan-London HIV prevention	14	30	30	74	N	Investment will increase slightly in line with the Pan London agreement.
Improving the sexual health of sex workers	5	0	0	5	N	This has been decommissioned from this year's programme and picked up by the Health Intelligence resource.

Spread the Word project	35	35	0	70	N	This is a two year programme.
Sexual health, teenage pregnancy and HIV prevention	40	40	0	80	N	This is a two year programme.
Young People Friendly	30	30	0	60	N	This is a two year programme.
Integrated Youth Service	81	81	81	243	N	On-going programme for three youth workers to provide support.
Intrauterine devices (IUD) and contraceptive implants	0	60	60	120	N	This has been separated out from the GP/Pharmacy budget line.
LGBT Youth Support	20	20	20	60	N	Investment maintained.
Total	2,707	2,776	2,771	8,254		Overall investment maintained to deliver open access sexual health services.

Table 5: Improving Child Health and Early Years

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Family Nurse Partnership	150	300	300	750	N	The agreement for NHS England to contribute half of the costs is not expected to continue into 2014/15. Service review to begin in April 2014 but funding indicated for 2015/16 to remain within this programme area.
Baby Family Intervention Project (FIP)	60	140	200	400	N	The programme has been delayed, but is expected to cost £400k in total (2014/16).
Breastfeeding and early years nutrition	50	50	50	150	N	This contributes to the breastfeeding work carried out in Children's Centres and the breastfeeding needs assessment will influence the future direction of this programme area.
School Years Prevention	145	145	145	435	N	Investment maintained.
Health Visitor Transition	25	50	0	75	N	Investment maintained for the period of transition.
Healthy Child 5-19	1,206	1,200	1,200	3,606	N	Review required for additional school nursing posts.
School Nurses	0	0	300	300	N	Increase to match population increase.
Oral Health - children	30	30	60	120	N	Investment maintained.
Wellbeing curriculum skills	35	50	50	135	N	Investment maintained to support the delivery of health in schools.

Sexual relationships programme	30	0	0	30	N	This was a one-off project.
Administrative and project support	30	30	30	90	N	A budget has been created for this post from within the children's Public Health budget envelope.
Health Visitors	0	0	2,000	2,000	N	The responsibility for the commissioning of Health Visitors will transfer to Local Authorities in 2015/16 and this represents a significant cost pressure. Due to the number of staff delivering this function, it is anticipated that approximately £2m will be required to sustain this function. There are significant opportunities for integrating this service with other related functions such as FNP, Baby FIP and School Nursing and this may produce savings in the medium to long-term.
Total	1,761	1,995	4,335	8,091		Overall significant increase in resource for early years and delivery of the healthy schools programme.

Table 6: Improving Community Safety

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Youth Offending Boot camp	25	70	70	165	N	A discussion will take place to whether investment in this area is continued in 2015/16.
Children's Domestic Violence Service	40	160	160	360	N	Investment in line with Health and Wellbeing Board recommendation.
Public health and crime	275	275	275	825	N	Maintain level of investment to ensure achievement of shared Community Safety Partnership Public Health outcomes.
Total	340	505	505	1,350		Overall slight increase in investment.

Table 7: Alcohol and Substance Misuse

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Alcohol Co-ordinator	45	45	45	135	N	Investment maintained.
Joint Drug and Alcohol work	2,527	2,527	2,527	7,581	N	Investment maintained.
Joint Drug and Alcohol Commissioner	55	55	55	165	N	Investment maintained.
Alcohol and drug prevention	25	25	25	75	N	Investment maintained.
Action around alcohol hotspots	46	25	0	71	N	Investment maintained.
Increased alcohol treatment places	0	122	244	366	N	Alcohol treatment places will be increase to help prevent alcohol-related health issues.
Total	2,698	2,799	2,896	8,393		Overall year on year increase to reflect service demand and local need.

Table 8: Improving Mental Health across the life course

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Mental wellbeing – children and young people	40	0 (under spend from 2013/14 to be rolled into 2014/15)	40	80	N	Investment maintained.
Mental wellbeing – adults	45	45	45	135	Y	Investment maintained. Investment maintained.
Mental Health First Aid	66	63	0	129	Y	Two year training programme.
Total	151	108	85	344		Overall investment maintained in mental health.

Table 9: Reducing injuries and accidents

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Accident prevention	40	40	40	120	N	Investment maintained.
Total	40	40	40	120		Overall investment maintained.

In addition to these 9 areas spend within the programme also occurs within the following areas as outlined in tables 10, 11 and 12.

Table 10: Mandated Services (excluding sexual health)

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Emergency Planning	50	50	50	150	N	Investment maintained.
Local events and outbreaks	0	35	35	70	N	This is a contingency fund in the event of a flu outbreak or natural disaster. May also be used in times of extreme weather conditions such as providing water and sunscreen during a heat wave.
LBBB flu jabs	15	15	15	45	N	2014/15 budget to be placed on hold until underspends and roll forwards are established.
National Child Measurement Programme	50	50	70	170	N	This is a mandated national programme to monitor levels of childhood obesity. The increase in the child population is reflected in the budget increase.
NHS Health Check Programme	300	396	396	1,092	N	Increased incentives have increased the budget accordingly.
LBBB Health Check Programme	18	18	18	54	N	Health Checks are available to LBBB staff and increased promotion will increase uptake and as a result improve health outcomes.
Public Health Function – Intelligence	140	150	50	340	N	Investment maintained.
CCG projects	100	50	50	200	N	Work programme under review.
Total	673	764	684	2,121		Overall investment maintained.

Table 11: Wider priorities

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
	£000	£000	£000	£000		
Fire cadets	10	10	10	30	N	This scheme will be placed on hold in 2014/15 until underspends and roll forwards are established.
Targeted wellbeing interventions 0-19	45	0 (under spend from 2013/14 to be rolled into 2014/15)	45	90	N	Scheme was delayed; hence request to roll budget forward.
Oral health - adults	40	40	0	80	N	Two year programme to be developed. 2014/15 budget to be placed on hold until roll forwards and underspends are established.
Community health champions	107	0	0	107	N	Scheme likely to underspend and therefore may request to roll forward into 2014/15.
Creative referral	43	0	0	43	N	One-off project.
Healthy SMEs	0	176	176	352	N	New scheme – to be placed on hold until roll forwards and underspends are established.
Nurse-led staff absence	0	87	87	174	N	New scheme – to be placed on hold until roll forwards and underspends are established.
Total	245	313	318	876		Some schemes to be placed on hold until resources are established.

Table 12 – Corporate Costs

Project	Budget 2013/14	Proposed Budget 2014/15	Indicative 2015/16	Total 2013-2016	Included in BCF?	Explanatory Notes
Public Health Team	1,148	1,129	1,129	3,406	N	Costs of the team are expected to stabilise as reliance on agency staff reduces and permanent staff are recruited.
Corporate costs inc. Health and Wellbeing Board/Children's Trust, licences and data warehouse	374	694	699	1,767	N	Corporate costs have increased due to more accurate calculations of support costs, and stand at 12.83% of the grant for 2014/15.
Total	1,521	1,823	1,828	5,173		Investment maintained.

5. Mandatory Implications

5.1. Joint Strategic Needs Assessment

5.2. The priorities for consideration in this report align well with the strategic recommendations of the Joint Strategic Needs Assessment (JSNA). It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

5.3. Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The Strategy is based on four priority themes that cover the breadth of the frameworks and in which the priorities under consideration are picked up within. These are Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

5.4. Integration

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report makes several recommendations related to the need for effective integration of services and partnership working.

5.5. Financial Implications

Financial issues are addressed throughout this report. As stated above, proposals regarding 2015/16 will be considered after final grant details are released in December 2014.

A further report will be presented to the Health and Wellbeing Board at its March meeting on the "Care City" proposal.

(Implications completed by Roger Hampson, Group Manager, Finance)

5.6. Legal Implications

This report is seeking that the Health & Wellbeing Board (HWBB) consider the allocation of resources for commissioning of public health programmes for 2014/2015 and 2015/2016.

This report further seeks that the HWBB endorse the commissioning intentions noted in the report to ensure that service delivery continues to improve Public Health outcome indicators as outlined in the Public Health Outcome Framework and the Joint Health and Wellbeing Strategy.

To extent that the allocation of resources as noted in this report is in compliance with the conditions of the Public Health Grant awarded by the Department of Health to the Council, the Legal Practice is not aware of reasons why the HWBB should not give due consideration to the recommendations of this report.

The processes for procurement of specific items may require further consideration in

relation to compliance with the Public Contracts Regulations 2006; Legal Services and Procurement Services will provide specific advice and assistance as details as to the chosen routes for procurement on specific items are developed and emerge, so that relevant regulatory requirements are complied with.

(Implications to be completed by Daniel Toohey, Principal Corporate Solicitor)

5.7. Risk Management

Delivery of the commissioning intentions is a key dependency in the delivery of the Public Health, NHS and Adult Social Care Outcome Frameworks challenge as well as the delivery of the Children and Young People's Plan.

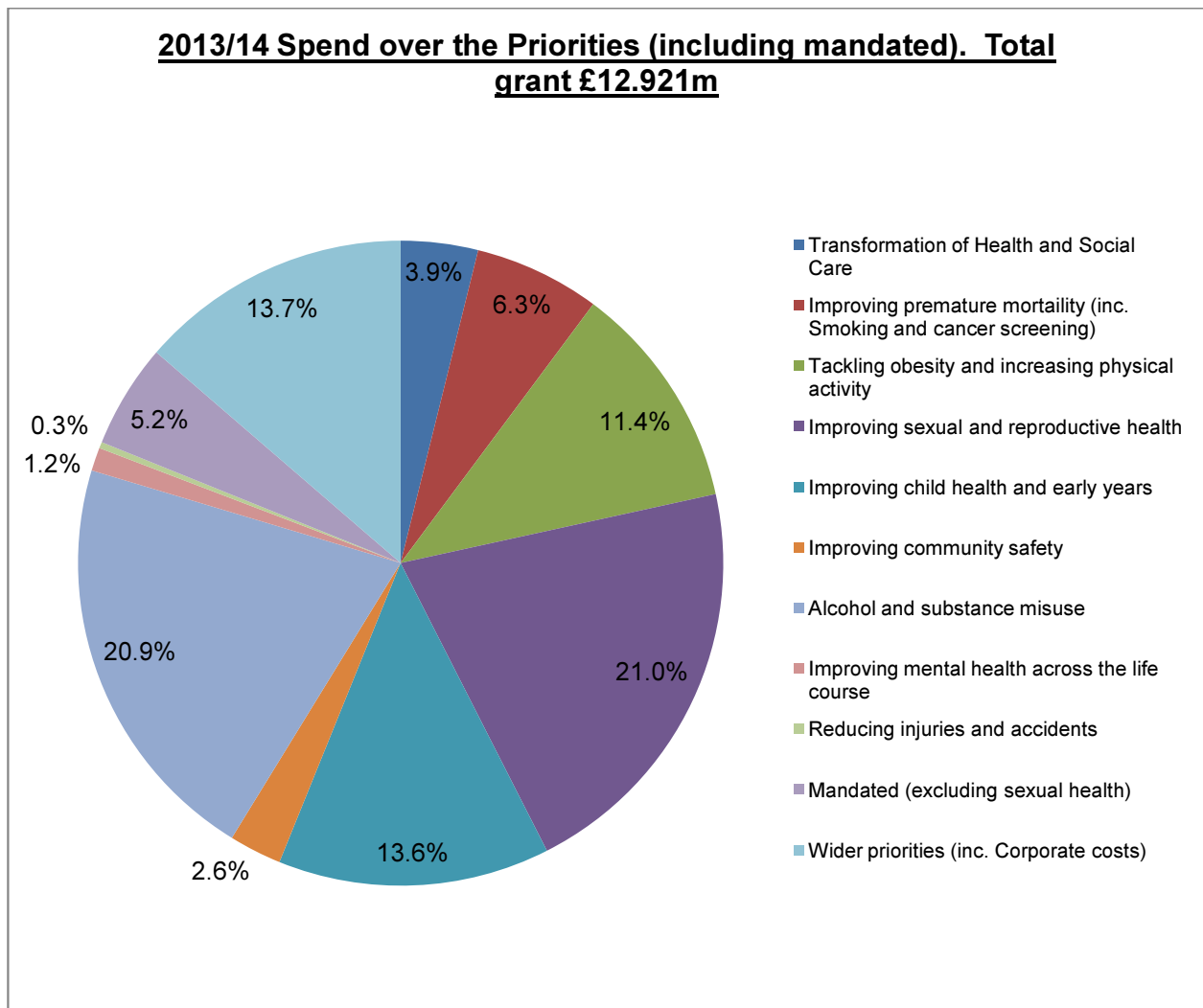
6. Background Papers used in the preparation of the Report

- [Barking and Dagenham's Community Strategy 2013-1016](#)
- [Joint Strategic Needs assessment](#)
- [Joint Health and Wellbeing Strategy](#)
- [Fair Society Healthy Lives \(The Marmot Review\)](#)
- [Longer Lives](#)
- [Independent Review on Poverty and Life Chances](#)
- <https://www.gov.uk/government/policy-advisory-groups/health-premium-incentive-advisory-group>

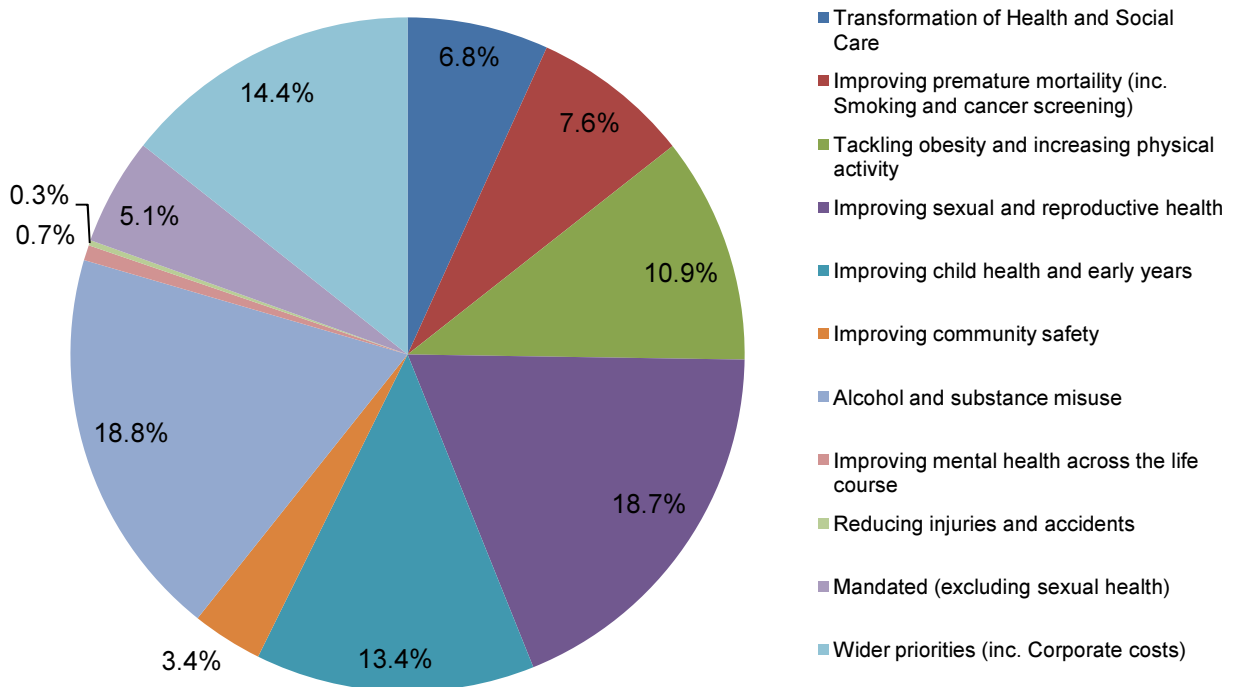
7. Appendices

- Appendix 1: Grant breakdown by Priorities

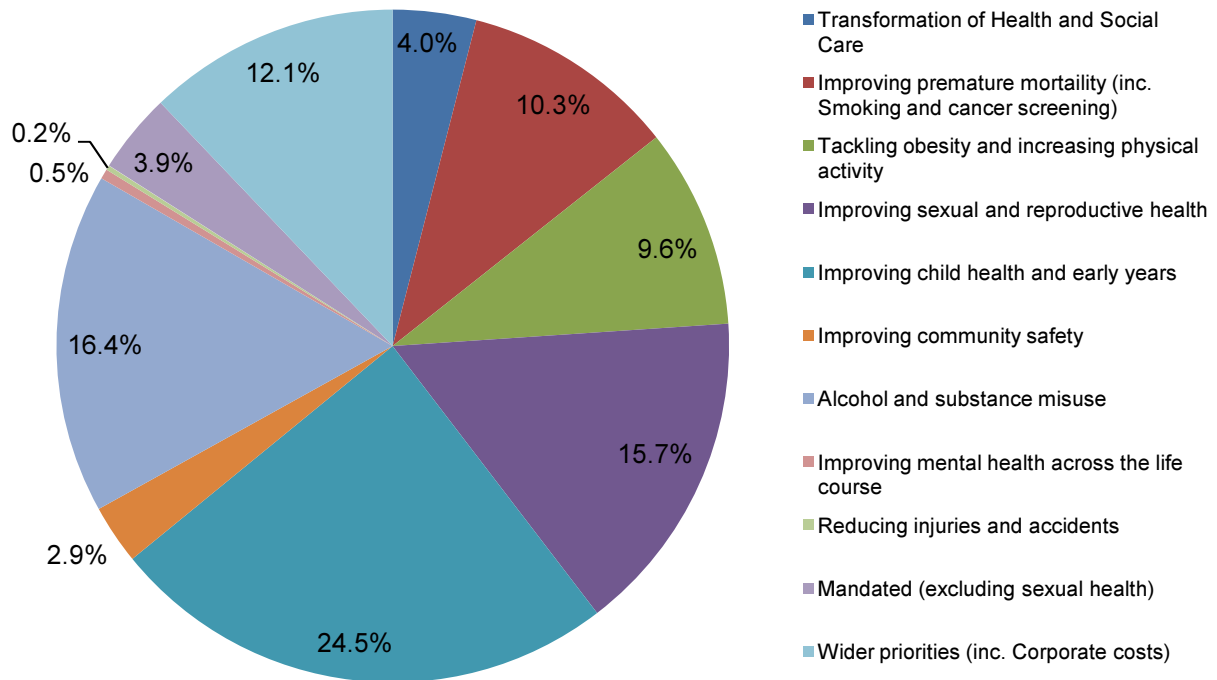
Grant breakdown by Priorities



2014/15 Spend over the Priorities (including mandated). Total grant £14.213m plus underspends from 2013/14



2015/16 Spend over the Priorities (including mandated). Grant unknown - spend requests total £17.7m



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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	End of Life Care Position Statement and Recommendations for Future Focus		
Report of the Integrated Care Sub-group			
Open	For Decision		
Wards Affected: ALL	Key Decision: NO		
Report Author: David Millen, Integrated Care Delivery Manager Carla Morgan, Strategic Delivery Project Manager (BHR CCGs)	Contact Details: Tel: 020 8227 2370 E-mail: david.millen@lbbd.gov.uk		
Sponsors: Dr Jagan John, Clinical Director, B&D CCG			
Summary: This paper has received consideration by the HWBB Sub-group 'Taking Integrated Care Forward in Barking and Dagenham' and provides a position statement update on Health and Social Care's provision of End of Life Care (EOLC) in Barking and Dagenham and considers future areas for focus within the coming planning cycle. This report provides an update on the end of life care (EOLC) services in place in Barking and Dagenham. By comparing the current services to the best practice standards set in the Department of Health End of Life strategy (2008), the report highlights the gaps in service provision. The Integrated Care Coalition has agreed that EOLC will be a priority. The Barking and Dagenham, Havering and Redbridge End of Life Subgroup of the Integrated Care Coalition (ICC) will develop proposals for addressing the identified gaps for consideration in the coming planning cycle. It is acknowledged that Redbridge are taking a different route through the Co-ordinate My Care (CMC) pilot. This report draws on both national and local work undertaken within Barking and Dagenham and across outer north east London (ONEL), including:			
<ul style="list-style-type: none"> • Department of Health, End of Life Strategy 2008 (DH 2008) • End of Life workshop hosted by Barking and Dagenham Partnership End of Life Care (EOLC) Steering Group 2010 • The People's Platform report on end of life care in September 2010 • Dr Sally Hearne End of Life review 2011 • ONEL End of Life Care Position Paper May 2012 			

- Barking and Dagenham Joint Health and Wellbeing Strategy 2012 – 2015
- BHR Integrated Care Strategic Outline Case November 2012

The People's Platform report on end of life care in September 2010 outlined core principles for end of life care:

'End of Life Care must be based on a few basic principles, which all care staff understand and accept... The main concerns were that people wanted to be treated with dignity and respect. Care should be sensitive to religion, culture and sexuality. Staff should make sure they know the patient's cultural background and personal history.'

The People's Platform also highlighted the importance of:

'Greater co-ordination between services is needed, for example having a lead person to join up the relevant services and work with the patient and their family to ensure that both the patient and the support network is given up-to-date information and appropriate services, from housing to medicines to respite care.'

Our primary assertion (and priority) is that people need to be able to choose to die in the setting of their choice and the role of services and support is to enable them to do so. Success in supporting people to remain at home is based upon a number of variables including the potential skill mix from Health and Social Care reducing our reliance upon bed based care- both in relation to acute hospital services and those provided within care homes.

This priority readily accords with one of our proposed priorities for the local plan for the Better Care Fund through the improvement in End of Life Care which enables greater numbers of people to be effectively cared for at home or in the place of their choice and the bringing together of diverse commissioning arrangements to support this. It is also clear that key areas of performance measurement within the Better Care Fund will relate to:

- Reduced usage of acute services
- Improvements in community support
- Reduced usage of care home beds

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- a) Note the position statement and approve the next steps for end of life care as identified throughout the body of the report (listed in Appendix 3 for ease of reference).
- b) Request that the Integrated Care Group develops an action plan to bring back to the Board in March 2014

1. Background

- 1.1. Work on improving EOLC services in Barking and Dagenham started in 2009 in response to the Department of Health National End of Life Care Strategy and an EOLC sub-group was established, reporting to the Health and Wellbeing Board. The aim of the group was to oversee the implementation of the National Strategy through coordinating delivery and promoting use of best practice tools and guidance.
- 1.2. Steady progress was made in rolling out key national end of life care tools such as the Gold Standard Framework and Preferred Priorities of Care. Enhancements were made to the district nursing service, community palliative care team. An out of hours service for palliative patients was put in place that allowed patients to continue to be cared for at home being able to receive appropriate interventions as required. This contributed to the objective of reducing the number of patients who die in hospital. In Barking and Dagenham the percentage of deaths at home improved from 17% of all deaths in 2005-06 to 20% of all deaths in 2010-11. Over the same period, the proportion of deaths in hospital fell from 72% to 62% Figure 1)

Fig. 1 - Barking and Dagenham place of death - summary % (Source: ONS PHMF)

	2005/06	2006/07	2007/08	2008/09	2009/10
Home	17.2%	18.3%	17.3%	18.5%	20.1%
Hospital	72.0%	69.4%	69.1%	66.7%	62.8%
Care home	6.4%	7.0%	8.0%	9.8%	13.3%
Hospice	3.4%	4.0%	3.9%	3.5%	2.7%
Other	1.1%	1.3%	1.6%	1.4%	0.9%

- 1.3. In noting the clear progress in the reduction in people dying in hospital we can see alongside this, that there have been some marked increased incidents (doubling) of place of death in care homes this suggests that care homes are increasingly managing the deaths of their residents effectively or conversely, that people are entering care homes and dying shortly after admission – this requires further investigation. We would therefore suggest that our priorities might benefit from being more fully drawn and may include:
 - Helping people to die at home should it be their wish to do so
 - Reductions in people dying in hospital

- Reductions in people dying in care homes who were not previously resident as such six months prior to death.

1.4. An Outer North East London (ONEL) wide steering group was formed in November 2011 consisted of end of life providers and commissioners from Barking and Dagenham, Waltham Forest, Redbridge and Havering health services. The early work of this group included a workshop, where the vision for end of life care was discussed. There was consensus of the vision for end of life care - to provide a co-ordinated and easily navigated end of life service. However at the time there was no clear picture of the EOLC services in place, and so the group commissioned an end of life position paper to summarise the EOLC services, with any gaps when mapped against the Department of health end of life care pathway highlighted.

2. Barking and Dagenham End of Life health services

2.1. There are various methods proposed to calculate the number of deaths which can be predicted and consequently managed - the estimated number for the borough varies between 1030 and 1979 per annum dependant on the prediction tool used.

2.2. Barking and Dagenham has services in place across the EOLC pathway, with specialist palliative care and hospice at home services provided by St Francis Hospice and a bereavement service provided by the third sector as described on the borough's end of life service map.

2.3. The Council commissions a range of services that are contributing to supporting people to remain in their own homes. It is often the case that support is provided to people solely by the Council (or in collaboration with health) where people may die within the first year of services and \ or support commencing. One of the key issues within the system as a whole is the extent to which end of life care is identified at service / support inception. Services commissioned by the Council will include:

- Support at home through the provision of funding for a Personal Assistant.
- Domiciliary or home care.
- Bed based placements.
- Respite services.

2.4. Our work on the Better Care Fund through the development of the two year plan, mapping key services as these are brought together is helping us identify and confirm inputs to End of Life care as a key part of the local service delivery landscape.

2.5. It is clearly the case that existing service providers will, given the nature of their role and the people they are supporting, be involved in caring for people in their end of life. Therefore, support needs to be given to these providers to help improve their capacity, capability and awareness of when to draw in appropriate specialist and / or clinical input where required.

3. Improvement Area for End of Life Care

The Barking and Dagenham end of life service map produced by the ONEL end of life care steering group is provided within Appendix 1: Further information on the gaps identified for improvement after mapping the borough's end of life services against the DH 2008 end of life strategy

This section identifies areas to improve end of life care in the community, care homes and through integrated care. Two funding transfer proposals from Health to Social Care, the Re-ablement allocation and NHS Social Care Section 256 transfer, are being used to improve EOLC, shown below in the next steps boxes.

3.1. End of life measures - options

Key metrics, local success measurements and local monitoring arrangements need to be considered for measuring our progress in delivering improvements to end of life care within Barking and Dagenham and to support further steps. There are a number of options which need to be balanced against alignment with other priorities, such as those within the Better Care Fund and that are proportionate. It is suggested that the following metrics could be considered:

Fig. 2 - Potential EOLC Measures

Suggested Measures	Data source
Number of patients on the GP practice end of life register	QOF codes
% of deaths in hospital/ usual place of residence	ONS statistics
Number/% of Service Users on practice / care home end of life registers benchmarked against prevalence in population generally or comparable practices (This can be benchmarked by list size for GP practice -and /or could just look for growth on current level of performance)	Care home registers (Adult Commissioning contract monitoring)
Number/% of Service Users who have been offered (advanced care plans) ACPs and number of ACPs in place	QOF codes / electronic palliative care registers (CMC)
Number/% of people who died with a recognised end of life status	QOF codes / electronic palliative care register compared to practice list size
Number/% of Service Users dying in place of choice (as specified in ACP).	Electronic palliative care register.
Reduction in emergency admissions which result in death is a measure of success in all settings.	SUS / acute data.
Reduction in excess bed-days.	SUS / acute data.
Being pain free and having condition	Survey of service users / the

managed with medication.	bereaved. Track rate of prescriptions issued.
Loved ones / informal carers experiences to end of life care such as being near friends and family.	Survey for the bereaved which identifies the extent to which people felt supported in their caring role, the cared for was worked with in a way which maximised dignity and respect etc.
Duration by condition and expected life expectancy against setting of care.	Measured against benchmarked stats.
Reductions in people dying in care homes who were not previously resident as such six months prior to death	Sample analysis of cessation of placements within 6 months of start

3.2. Proposed priority measures for 2014/15

Whilst the list of potential areas for measurement is wide it is proposed that for 14/15 we focus upon the following:

- Number of service users who have been offered (Advanced Care Plans) ACPs and the number of ACPs in place
- Number of service users dying in the place of their choice
- No of providers participating in EOLC training
- Acknowledging progress in reduced deaths in hospital, consider reductions in deaths of people in bed based services where there entry was less than 6 months prior.

In agreeing the areas of focus for the coming year it is proposed that further work be undertaken to establish baselines, comparative performance and that day to day progress be considered by the Sub-group of the Health and Wellbeing Board.

3.3. End of life training programme

Training and support for existing services has been identified as a gap and one where improvement in quality and skills would deliver significant benefits. Following submission of a successful bid, training provision has been secured to cover end of life identification and care planning including carer support and spiritual awareness. The Gold Standards Framework (GSF) is a nationally recognised as the model of best practice for end of life care and St Francis Hospice is an accredited training provider. The following areas have been identified for the provision of focused training support and which will provide optimum benefit across the system.

Securing funds for Gold Standards Framework training enables us to provide training across 80 care homes and 70 domiciliary care providers across Barking, Dagenham, Havering and Redbridge. GP practices in Barking and, Dagenham will benefit from a localised training programme. (Further details of the training approach are provided within Appendix 2).

Initial engagement took place with a range of service providers in Barking and Dagenham at the provider forum on 21 November which provided an opportunity to both brief providers on our objectives and the detail within the training programme; and also to ensure that this is further checked against providers experiences in caring for people, managing and supporting staff and in their interface with other organisations and services. Further engagement with providers is now being completed through various briefings and leafleting. Applications are still being received at the point of writing with those yet to respond with take up of the training places being subject to specific follow up to ensure opportunities and participation are maximised.

3.4. **General practice**

People can currently only access 'end of life services' if they are identified as end of life by a clinician; with earlier identification, greater numbers of people would benefit from end of life services and support. There is a clear need for people to be supported by health professionals to have conversations about their end of life preferences, and clinicians need to ensure information on these preferences are shared so they can be followed. GPs have the earliest opportunity to identify end of life patients and are uniquely placed to have a holistic view of the patient's history, aiding identification.

The funding secured to support end of life training for Barking and Dagenham GP practices, will be focused on local priorities. This bid proposes to fund a 6 month contract within Barking and Dagenham to support additional training delivery to GP practices. This training programme will include:

- Promotion of the prognostic indicators and use of the surprise question to increase the number of patients identified as end of life
- Promoting use of the RCGP end of life care charter and the patient charter
- a focus on building on the work of the existing integrated case management service and enhancing this service to delivery further end of life care

Next steps:

- To deliver the end of life training to GP practices.
- To provide a focus upon identified practices with lower levels of patients on end of life registers to target for support

3.5. **Care homes**

The GSF Programme for care homes, supported by the DH 2008 end of life strategy, is a very valuable training programme for care homes. Most care homes have started the training and additional funding will enable homes to be accredited.

Next steps:

- To utilise bid funding to provide GSF training to care homes. Successful bid details provided within Appendix 2
- Fund EOLC accreditation for care homes from Re-ablement allocations

3.6. **Home care agencies/personal assistants**

Increasing numbers of people nationally are receiving care and support in their homes and people using the services appreciate consistency of the people supporting them not least at end of life. With increased training, carers will be more comfortable and skilled in supporting people through end of life and continuity can be maintained. Personal budget holders are also increasingly purchasing personal assistants who may not ordinarily benefit from the training programme agency employed carers are able to access. The council have recruited a PA Coordinator who is developing a training programme linked to an accreditation scheme. A module of the training programme will be EOLC.

Next steps:

Develop EOLC training programme for home carers and PAs (NHS Social Care Transfer)

PAs offered opportunity to access places on the domiciliary care provider GSF training.

3.7. For informal carers

Carers of Barking and Dagenham (Carers BandD), the council funded carers' support service, offer EOLC training as part of their training programme. There are over 3,000 informal (unpaid) carers in the borough but take-up of EOL training is poor with less than 20 carers going on the training per year. Carers BandD have developed an Ageing Carers programme to support carers through the various challenges of growing old in a caring role. As part of this programme Carers of BandD have included an EOLC training session.

Next steps:

Reinvigorate EOL training programme for informal carers to improve the number of informal carers using it (NHS Social Care Transfer)

Encourage Carers in BandD to sign-up to the domiciliary care provider GSF training

3.8. Develop and embed end of life provision in Integrated Case Management (ICM) and community rapid response services (CTT)

Historically the Barking and Dagenham ICM service operated with exclusion for 'patients considered to be in the last 3 months of life'. Care co-ordination for end of life patients was undertaken by the patients GP Practice, with a high degree of support from the Community nursing service.

3.9. How ICM supports EOLC

Earlier this year it was agreed to expand the scope of Integrated Case Management. The ICM clinical lead agreed to support referrals into ICM for patients considered to be in the last three months of life. These referrals are to be non-disease specific, though this is not always feasible as it is more difficult for clinicians to effectively diagnose patients in the last 3 months of life without a cancer diagnosis.

The ICM multi-disciplinary meetings (MDT) mean clinicians benefit from joint working to support these often complex palliative patients. Where end of life patients are discussed in the ICM MDTs, invitations to meetings should be considered for St Francis hospice clinical staff and the practice nurse. The ICM lead nurse for Barking

and Dagenham has agreed to make use of the 'surprise question' to consider whether end of life care would be appropriate as a standard part of the ICM process. The 'surprise question' is 'whether you would be surprised if the person was to die in the next 12 months'?

Current processes need to be followed to ensure any patients identified as end of life as a part of the ICM service, are communicated to the GP practice for recording on the practice end of life register.

ICM has a vital role to ensure Advanced Care Plans are used. The care plan called 'Thinking Ahead' is based on the GSF guidance and has now been used for three years in the borough. They are completed by the individual if they have capacity. If not district nurses, nurse specialists and St Francis Hospice have supported their completion. Introducing these forms to social care staff can increase the number of plans in use. This is particularly useful for individuals in the early stages of dementia who can have their wishes recorded while they still have capacity. Given the dementia screening programme commencing for over 75s, more and more people will be diagnosed with dementia.

3.10. Rapid response - how CTT supports end of life care

The CTT service has been operating since January 2013 and operates a rapid response service from 8am – 8pm. This service could support end of life patients with any unplanned needs, which have not been planned for by community nursing services. This may include issues in the home such as administering IVs, and blocked catheters.

Next steps:

- CCG to work with the ICM delivery group to implement a plan which embeds the end of life support offered by the ICM service.
- Develop methods to see an increase in the number of advanced care plans in use in the community (NHS Social Care Transfer)

3.11. Electronic system to centralise storage of EOLC plans

Health Analytics is used by the Integrated Case Management (ICM) services within Barking and Dagenham, Havering and Redbridge as a care planning tool to support patients with multi co morbidities and complex needs. In the event an ICM patient attends BHRUT AandE, the ICM care plan can be viewed in order that clinical decision making is supported by a comprehensive view of the patients holistic ICM care plan. Health Analytics is also used for management of the continuing health care (CHC) fast track process.

Barking and Dagenham are planning to pilot an extension of the Health Analytics system to support end of life care planning.

Co-ordinate my care (CMC) is a system to provide an electronic way of sharing patient's end of life care plans. CMC was developed in west London by the Royal Marsden hospital. As part of the 111 implementation process in 2012, CMC training was provided to front-line staff in BHR however use of CMC has not progressed in Barking and Dagenham and use across London is variable. The London Borough of Redbridge and Redbridge CCG are planning to pilot CMC.

Next steps:

- Barking and Dagenham CCG to plan and implement a pilot of Health Analytics.
- Barking and Dagenham CCG to review the Health Analytics EOLC pilot alongside the Redbridge CMC pilot to decide the way forward.
- Develop methods to see an increase in the number of advanced care plans in use in the community (NHS Social Care Transfer)

3.12. Improvement to end of life standards within care home contracts

In addition to the training programme outlined above the following work can take place with care homes:

3.13. London-wide continuing healthcare procurement (AQP) process

A procurement process (AQP) is being initiated across London for patients placed into nursing homes as a part of the health fast track continuing healthcare process. As a part of the procurement documentation there is a clear service specification for the provision of end of life care, KPIs and payment arrangements.

The full procurement documentation can be found on the supply 2 health website: <https://www.supply2health.nhs.uk/CP9/Lists/AQPOffers/Attachments/3/Document%201%20AQP%20Qualification%20Information.pdf>

Next steps:

It is proposed that the AQP procurement process will be analysed to identify if any aspects of this wider procurement project could be applied to nursing/care home placements through spot purchase agreements

That we review current commissioning arrangements so that alongside training and support to service providers we consider the benefits or otherwise of an additional end of life care premium being paid to reflect the additional inputs required

3.14. Please don't admit cards

These cards are carried by residents in care homes to encourage Accident and Emergency staff to treat residents and return them to the care home rather than admit them to hospital, reflecting individual choices and preferences in how and where care is provided.

Next steps:

Complete roll out Please Don't Admit Cards in residential care homes and nursing homes (Re-ablement Allocation).

3.15. Community nursing levels (if GP education results in an increased identification rate)

As a part of Ernst Young's development of the integrated care strategy, the ONEL end of life steering group recommended district nursing levels be increased in order to support more people to die in their home environment rather than in a hospital.

The proposal outlined an investment (as an 'invest to save') of £440,815 and an expecting savings release from reduced admission rates of £400,000.

Next steps:

To be considered through the BCF process and integrated teams.

3.16. Acute response to the independent review of the Liverpool care pathway (LCP)

Following the release of the report, BHRUT have reviewed the recommendations, and are developing an action plan in response.

The full report can be accessed at this web address:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

Next steps:

This will be managed as a part of the acute trusts contracting process

4. Summary

The areas identified for improvement identified within this paper will be reviewed by Barking and Dagenham Clinical Commissioning Group and London Borough of Barking and Dagenham and considered for the coming planning cycle.

5. Mandatory Implications

5.1. Joint Strategic Needs Assessment

Barking and Dagenham's updated JSNA outlines:

In Barking and Dagenham the percentage of deaths at home improved from 17% in 2005-06 to 21% in 2009-10. In the same period, the deaths in hospital fell from 72% to 63%. (However deaths in a care home increased from 6% to 13%.) These modest improvements are below the England figures. In Barking and Dagenham around 60% of all deaths in 2007-2009 were the result of cancer, cardiovascular and respiratory diseases. Most deaths could be anticipated and the end of life adequately planned for.

The National Audit Office found that the NHS contracting with hospices on an annual basis, which leads to uncertainty in planning. They recommended that commissioners work with independent hospices to develop three year contracts. A locality wide electronic palliative care register would help with planning and coordination of care.

5.2. Health and Wellbeing Strategy

Barking and Dagenham Joint Health and Wellbeing strategy includes the following references to end of life care:

Page 7: The majority (around 7 out of 10) of predictable deaths occur in hospital but this is not what local residents want – with around two-thirds wishing to die in their own homes. Much more priority needs to be put into assisting people with severe illnesses to die with dignity and support in their place of choice and in unlocking the obstacles preventing this choice being met. Analysis of sample of people requiring

End of Life identifies that their care and support needs could readily be met in or closer to their own homes rather than in necessarily being admitted into hospital.

Page 8: In line with the Marmot's recommendations we cover the resident population across the life course from pre birth to end of life...

Page 23: There is no avoiding that old age is followed by death, and providing individuals support and dignity in dying is an important part of the health and social care agenda.

Page 24: Priority Area: Improvement and Integration of Services: more older adults who are terminally ill die with dignity in a planned and supported way.

5.3. Integration

End of life care is delivered by multiple providers, and as such effective integration between providers or collaboration, is key to the delivery of seamless end of life care and improved experience of support.

5.4. Financial Implications

There are potential financial implications relating to integrated teams. It is expected that the CCG allocation for 2014/15 will be published in December 2013, as part of the operating plan framework. Through the planning process, resources available to the CCG will be aligned to the areas of greatest strategic and local need. Given the current financial environment the CCG is not expecting that there will be new funding for investment

5.5. Legal Implications

This report contains suggested actions in appendix 3 which do not have legal implications to them. The rest of the report is for noting and does not contain matters for which legal implications arise.

(Implications completed by Chris Pickering, Principal Solicitor)

6. Background Papers Used in Preparation of the Report:

- Department of Health, End of Life Strategy 2008 (DH 2008)
- End of Life workshop hosted by Barking and Dagenham Partnership End of Life Care (EOLC) Steering Group 2010
- The People's Platform report on End of Life Care in September 2010
- Dr Sally Hearne ONEL End of Life Review 2011
- ONEL End of Life Care Position Paper May 2012
- Barking and Dagenham Joint Health and Wellbeing Strategy 2012 – 2015
- BHR Integrated Care Strategic Outline Case November 2012

7. List of Appendices

- APPENDIX 1: End of Life Care Pathway and Local Position

- APPENDIX 2: The Training Bid and Training Content
- APPENDIX 3: Areas for Improvement in End of Life Care - Next Steps

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DH End of life care pathway and local position

DH - end of life care pathway stages	Step 1 Discussions as the end of life approaches	Step 2 Assessment, care planning and review	Step 3 Coordination of care	Step 4 Delivery of high quality services in different settings	Step 5 Care in the last days of life	Step 6
Current end of life services	<ul style="list-style-type: none"> • Approx one third of deaths are identified on GP end of life registers 	<ul style="list-style-type: none"> • Approx one third of deaths are identified on GP end of life registers • Assessing needs of carers part is of end of life care planning 	<ul style="list-style-type: none"> • Strategic coordination: • Individual care co-ordination: provided by General Practice, District Nursing, with some patients receiving additional support from St Francis hospice specialist palliative care service • Rapid response: Community Treatment Team (CTT) • PELC (GP Out of hours) • 'Special patients notes' processes used to ensure PELC and LAS are aware of wishes 	<ul style="list-style-type: none"> • Acute: BHRUT • Community: NELFT - district nurses; Marie Curie – overnight respite service; St Francis Hospice – hospice at home; continuing health care – put comprehensive care packages into a person's home for the 'last 3 months of life • Hospice: St Francis Hospice – inpatient facility • Care Homes: could be considered a person's usual residence or a person could be placed in a nursing home by the continuing health care team • Ambulance: 'Special patients notes' processes used to ensure PELC and LAS are aware of wishes 	<ul style="list-style-type: none"> • Acute: BHRUT • Community: NELFT - district nurses; Marie Curie – overnight respite service; St Francis Hospice – hospice at home; continuing health care – put comprehensive care packages into a person's home for the 'last 3 months of life • Hospice: St Francis Hospice – inpatient facility • Care Homes: could be considered a person's usual residence or a person could be placed in a nursing home by the continuing health care team 	<ul style="list-style-type: none"> • St Francis hospice provide bereavement support where the deceased is known to the hospice • Bereavement service – provided by Hoe & Co (Hope)

<p>Gaps in end of life services when compared to DH best practice</p>	<ul style="list-style-type: none"> • End of life training programme for general practice • Clarify end of life metrics and measurement of success 	<ul style="list-style-type: none"> • End of life training programme for general practice • Clarify end of life metrics and measurement of success • Carer needs assessment and support would be supported by a GP practice training programme 	<ul style="list-style-type: none"> • Develop and embed end of life provision by ICM and CTT • Electronic system to centralise storage of EOL care plans 	<ul style="list-style-type: none"> • Improvement to end of life standards within care home contracts • If successful in increasing EOL identification community nursing provision would be insufficient to support patients in their home • Acute trust response to the independent review of the Liverpool care pathway (LCP) 	<ul style="list-style-type: none"> • Improvement to end of life standards within care home contracts • If successful in increasing EOL identification community nursing provision would be insufficient to support patients in their home • Acute trust response to the independent review of the Liverpool care pathway (LCP) 	
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The Training bid and training content

HE NCEL training bid – Barking and Dagenham overview

A bid for funding of end of life training was submitted to Health Education North Central and East London (HE NCEL) who hold the healthcare education budget. The successful outcome of the training bid was announced on the 27th September 2013.

A summary of the Barking and Dagenham training bid is below:

B&D localised GP Practice Programme

Within Barking and Dagenham a local training programme has been selected as their preferred training approach. This is in order that the training programme is focused on local priorities. This bid supports the funding of a 6 month contract within Barking and Dagenham to support additional training delivery to GP practices.

The training programme will include:

- Promotion of the prognostic indicators and use of the 'surprise question' to increase the number of patients identified as 'end of life'
- Promoting use of the RCGP end of life care charter and the patient charter
- a focus on building on the work of the existing integrated case management service and enhancing this service to delivery further end of life care

GSF Care Home Programme

The National Gold Standard Framework Centre in End of Life care are the leading providers of training in end of life care for generalist front line staff – GSF being one of the original models of best practice recognised by the Department of Health in 2005. GSF is widely used nationally with increasing levels of take up. This process saves money and improves quality of care and research demonstrates an improvement in quality and outcomes for patients, families and staff and cost savings through decreased hospital admissions and deaths.

GSF is evidence based both in its development and within the evaluation of the ongoing work – with in-built measurement tools. It is supported by policy - GSF is referred to in the NICE Supportive and Palliative Care Guidance, endorsed by the Royal Colleges of General Practitioners and Nursing, the House of Commons Health Select Committee, many National Service Frameworks, the End of Life Care Programme and DH End of Life Care Strategy (July 08) and Quality Markers. GSFCH is supported also by all major care homes organisations.

Most importantly, GSF is more than just education. Research suggests that education alone in care homes will not change practice and so there also needs to be a change in systems and processes and the culture of the home. This is the most comprehensive programme of service improvement for care homes currently available; bringing together many skills, tools and resources into one comprehensive approach that produces great lasting results. A train the trainer model was proposed for this training, so one person from each team attends the training and is supported to share learning with the rest of their team. Also support to supervisory staff to maintain approach and support application in

care staff alongside 'train the trainer' - so one person from each team attends the training and is supported to share learning with the rest of their team.

Saint Francis Hospice is a Gold Standards Framework (GSF) Regional Training Centre and will work in Partnership with the National GSF team to deliver this training and facilitation. Saint Francis Hospice is celebrating its 30th Anniversary next year and has a long successful history of providing training and support to care homes, GP's, district nurses and other health care professionals and community groups in Havering, Barking & Dagenham and Redbridge.

Care homes in Barking & Dagenham, who have not already commenced GSF training will be funded to complete the training.

Domiciliary Care Programme

The bid proposed that Saint Francis Hospice will also deliver GSF training programme for domiciliary care teams. If the full bid funding is allocated to the area, approximately 26 domiciliary care teams within Barking and Dagenham could be trained in a joint training approach across Barking & Dagenham, Havering and Redbridge. A train the trainer model was proposed for this training, so one person from each team attends the training and is supported to share learning with the rest of their team. This course is shorter than the care home programme and consists of three taught days and learning resources. This part of the project will be completed by March 2014.

As an example of the importance of training domiciliary care teams locally; in Barking and Dagenham, alongside training domiciliary care teams, personal assistants also need to access the training. This is because within Barking & Dagenham there is a large growth of people purchasing personal assistants (PAs) to support them at home. The borough has more people using PAs than using home care agencies. Alongside meeting the objectives with Putting People First, People with PAs having improved outcomes with greater independence and have forged positive working relationships with their PAs. They have found it gives them greater flexibility and control over their own life to do the things they want to do. Home carers can focus solely on personal care, whereas a PA supports a person to be independent through helping them do what the personal budget holder wants to do – meeting their desired outcomes -in and outside of the home. A PA register is now being developed in Barking and Dagenham so people can recruit from a wide range of PAs via the borough's website.

Areas for Improvement in End of Life Care - Next Steps

General Practice

- To deliver the end of life training to GP practices.
- To provide a focus upon identified practices with lower levels of patients on end of life registers to target for support

Care homes

- To utilise bid funding to provide GSF training to care homes. Successful bid details provided within Appendix 2
- Fund EOLC accreditation for care homes from Re-ablement allocations

Home care agencies/personal assistants

- Develop EOLC training programme for home carers and PAs (NHS Social Care Transfer)
- PAs offered opportunity to access places on the domiciliary care provider GSF training.

Informal Carers

- Reinvigorate EOL training programme for informal carers to improve the number of informal carers using it (NHS Social Care Transfer)
- Encourage Carers in B&D to sign-up to the domiciliary care provider GSF training

Rapid Response - how CTT supports end of life care

- CCG to work with the ICM delivery group to implement a plan which embeds the end of life support offered by the ICM service.
- Develop methods to see an increase in the number of advanced care plans in use in the community (NHS Social Care Transfer)

Electronic system to centralise storage of EOLC plans

- Barking and Dagenham CCG to plan and implement a pilot of Health Analytics.
- Barking and Dagenham CCG to review the Health Analytics EOLC pilot alongside the Redbridge CMC pilot to decide the way forward.
- Develop methods to see an increase in the number of advanced care plans in use in the community (NHS Social Care Transfer)

London-wide continuing healthcare procurement (AQP) process

- It is proposed that the AQP procurement process will be analysed to identify if any aspects of this wider procurement project could be applied to nursing/care home placements through spot purchase agreements
- That we review current commissioning arrangements so that alongside training and support to service providers we consider the benefits or otherwise of an additional end of life care premium being paid to reflect the additional inputs required

Please don't admit cards

- Complete roll out Please Don't Admit Cards in residential care homes and nursing homes (Re-ablement Allocation).

Community nursing levels (if GP education results in an increased identification rate)

- To be considered through the BCF process and integrated teams.

Acute response to the independent review of the Liverpool care pathway (LCP)

- This will be managed as a part of the acute trusts contracting process

HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	Summary of the New Ofsted Single Inspection of Services for Children		
Report of the Corporate Director of Children's Services			
Open Report		For Decision	
Wards Affected: NONE		Key Decision: NO	
Report Author: Vikki Rix, Performance and Strategy Manager, Children's Services		Contact Details: Tel: 020 8227 2564 E-mail: Vikki.Rix@lbbd.gov.uk	
Sponsor: Helen Jenner, Director of Children's Services			
Summary: This report summarises the new Ofsted single inspection framework for children's social care and LSCBs. The inspection covers children in need of help and protection, looked after children and care leavers. The summary report outlines the changes in the scope and judgements made in the single inspection framework, as well as providing an overview of inspection process. A presentation will accompany this report at the Health and Wellbeing Board to explore in detail some of the changes in the new framework. A brief overview of the current CQC programme of child safeguarding and looked after children reviews is also provided. A full report will come to a future meeting of the Health and Wellbeing Board.			
Recommendation(s) The Health and Wellbeing Board is recommended to:			
(i) Note the content and scope of Ofsted's new single inspection of services for children in need, looked after children, care leavers and the new Local Children's Safeguarding Board (LSCB) reviews and provide comments as appropriate.			
(ii) Note the CQC health programme of reviews on safeguarding and looked after children running from September 2013 and April 2015			

1. Background and Introduction

- 1.1 Ofsted's single inspection framework was published in October 2013 and came into effect in November 2013 on a universal three year cycle. The inspection brings together into one inspection: child protection; services for looked after children and care leavers, and local authority fostering and adoption services. Alongside the single inspection, there will also be a review of the work of the Local Safeguarding Children Board. This new Ofsted inspection framework has been introduced following a recommendation in the Munro Report, Protecting Children, 2011 that an inspection approach should take into account the 'child's journey'
- 1.2 The single inspection framework has now commenced and the first tranche of five LAs inspected (Derbyshire, Hartlepool, Slough, Sheffield and Hillingdon) under the framework was announced on 19 November, and inspections started on 20 November. The second tranche has commenced week beginning 13th January 2014 with a further 6 LAs currently being inspected (Bolton, East Sussex, Essex, Hounslow, Staffordshire and Coventry).

2. Content of the single inspection of services for children in need, looked after children and care leavers

- 2.1 The Ofsted single inspection focuses on the effectiveness of local authority services and arrangements to help and protect children, the experiences and progress of children looked after, including adoption, fostering, the use of residential care, and children who return home. The framework also focuses on the arrangements for permanence for children who are looked after and the experiences and progress of care leavers. In addition, the leadership, management and governance judgment addresses the effectiveness of leaders and managers and the impact they have on the lives of children and young people and the quality of professional practice locally.
- 2.2 The scope of the inspection, therefore, is very broad covering the following:
- Children and young people who are receiving or who need early help
 - Children and young people who are referred to us and are assessed (or not)
 - Children and young people who become the subject of a child protection plan or have been the subject of a plan and need continuing support
 - Children who are receiving support through a child in need plan
 - Children looked after (with a plan for adoption, to return home, special guardianship or residence order, living with a foster family) and children accommodated
 - Care leavers
- 2.3 Under the new framework, inspectors will make three key judgements in the single inspection:

- The experiences and progress of children who need help and protection;
- The experiences and progress of children looked after and achieving permanence (including contributory and graded judgements on adoption performance and the experiences and progress of care leavers); and
- Leadership, management and governance.

2.4 The overall effectiveness judgement will be a cumulative judgement based on those three key judgements listed in 2.3.

2.5 Judgements will be made on a four-point scale: outstanding, good, requires improvement (replacing the previous 'adequate' judgement) and inadequate. A judgement of 'inadequate' in any of the three key judgements will limit the overall effectiveness judgement to inadequate.

2.6 Where a Local Authority is judged to be inadequate for overall effectiveness, a full inspection will take place within 12 to 18 months (unless otherwise directed by the Secretary of State). Where a Director of Children's Services (DCS) holds the DCS statutory responsibility for more than one LA, the inspection of each LA will be concurrent wherever possible.

2.7 It is clear in the inspection framework that **only 'good' is now good enough**. Services judged as less than 'good' will now be judged as 'requires improvement' rather than adequate, as was the case in previous inspections. A key focus of the inspection is the extent to which children's experiences and progress are prioritised and the effectiveness of the help, protection and care that they receive.

2.8 For the first time Ofsted will also make discrete, graded judgments on the 'experiences and progress for care leavers' and adoption. Inspectors will evaluate the quality of plans for children's futures, the management and practice oversight of those plans to make them happen and the extent to which any delays are being swiftly reduced. They will also consider the quality of support and care for young people becoming independent and leaving the system, including the provision of safe and good housing, access to education, training and employment and the extent to which those individuals feel supported by their corporate parents.

3. Single inspection framework process

3.1 Inspections will be announced at short notice. The Local Authority will be notified that the lead inspector and a small team of inspectors will be arriving the following day to begin the inspection; the rest of the team will arrive at the start of the following week. Local Authorities will be informed on a Tuesday by 9.30am the day before the inspection commences.

3.2 The full inspection team will normally comprise seven suitably qualified HMI – six with experience in delivery and inspection of social care and one experienced in inspection of education provision. The inspection will take four weeks with a combination of on and off site time. The inspection team will normally be on site for 11 working days, and Ofsted will publish the report on its website within 30 working

days of the end of the on-site inspection. The LA is required to publish an action plan in response to the report within 70 working days of receiving the final report.

- 3.3 Where inspection evidence suggests that there are weaknesses in multi-agency practice, the relevant inspectorates will be notified, and may decide to inspect in accordance with their statutory powers.
- 3.4 As outlined in the single inspection Handbook, the LA will be asked to prepare and provide a large range of individual child level data in the first 2 weeks of the inspection as outlined in Annex A Ofsted guidance. The data requirements now span social care and education, as well as early help assessments, CAF and targeted intervention over a 6 month period mostly and cover children in and out of borough. The Children's Performance and Strategy team are currently undertaking a risk assessment on the new data requirements in order to identify key problems and solution to any data supply issues.
- 3.5 The LA will also be required to undertake an audit of 18 cases, selected by Ofsted, covering the experience and journey of the child, family, carer and the effectiveness of help and protection. The LA will be required to share the findings of those 18 audits with Ofsted inspectors once field work commences. The cases selected by Ofsted will comprise of: 6 children in need of help and protection, 10 looked after children including at least 2 out of borough and 2 care leavers.
- 3.6 Inspectors will also track the experiences and quality of practice in an additional 25-30 case files of children and young people during the onsite inspection across a range of criteria. Further cases may be selected for examination by inspectors if there is a particular theme the inspectors would like to examine in more detail. Inspectors will also evaluate thresholds and effectiveness of services through targeted sampling of at least 50 case files. In total, therefore around 100 children and young people will be looked at by inspectors.
- 3.7 As well as data and case file tracking, inspectors will also directly observe practice and interview staff and managers at all levels. A range of meetings will be directly observed by inspectors, for example, child protection and child in need meetings, legal planning meetings, looked after children reviews and early intervention meetings. The inspectors will also interview (face to face or by telephone) the Lead Member for children's services, the LSCB chair, business manager and LSCB partners, the corporate parenting group, the LA adoption panel chair and the fostering panel chair, family court representatives and Cafcass.
- 3.9 Views of children, young people and their families and foster carers will be sought by inspectors and form a significant part of the inspection. Supervision records and foster carer's records and reviews are also in the scope of the inspection.
- 3.10 Commissioned services will also be contacted by inspectors, including independent fostering agencies, children's homes, social work providers and voluntary adoption agencies.
- 3.11 The DCS will be updated on a daily basis on the progress of the inspection via brief face to face meetings. Any cases of safeguarding concern will be raised immediately for action.

3.12 A draft report is sent to the DCS within 15 working days of the end of fieldwork for a factual accuracy check. The DCS has five working days to respond. A pre-publication report is sent to the DCS, chair of the LSCB, local authority Chief Executive, lead member and Department for Education (within 25 working days of the end of fieldwork). The final inspection report is published on Ofsted's website (within 27 working days of the end of fieldwork).

Review of LSCBs

3.13 The Local Safeguarding Children Boards (Review) Regulations 2013 were published on the same day as Ofsted published the new single inspection framework. These regulations enable the Chief Inspector to conduct a review of the performance by a Local Safeguarding Children Board (LSCB), opening the way for Ofsted to review and report on the effectiveness of the LSCB at the same time as reporting on the inspection of the LA.

3.14 The LSCB review will usually take place in parallel with the single inspection of the LA. However, the review can be undertaken as a stand-alone review. The LSCB chair will be notified about the review at the same time as the Director of Children's Services (DCS). There will be an overall effectiveness judgement based on the same four point four point scale: outstanding, good, requires improvement and inadequate.

3.15 The judgement of the LSCB will be derived from an assessment of its compliance with statutory responsibilities in accordance with the Children Act 2004 and the Local Safeguarding Children Board regulations 2006. Inspectors will evaluate the LSCB's understanding of the strengths and weaknesses of multi-agency practice; the effectiveness of their monitoring and evaluation; and how well they have identified areas for improvement. The scope of the LSCB review is as follows:

- Assessment of evidence of coordination between statutory partners in work and mechanisms in place for helping, protecting and caring for children in the local area.
- Assessment the effectiveness of multi-agency training and the evaluation of its impact on management and practice.
- Ensuring that policies and procedures in respect of threshold for intervention are understood and effectively operated.
- Ensuring that Challenge of Practice and casework auditing are rigorous and used to identify areas for improvement.
- Ensuring that serious case reviews, management reviews and reviews of child deaths are used as opportunities for feedback and to drive improvement.
- Assessment of the LSCBs evaluation of local performance and its ability to influence and inform service delivery.

- 3.16 The LA is required to provide a range of information as part of the LSCB review and inspectors will interview a range of stakeholders including the LSCB chair, the LSCB business manager, the DCS, the Chief Executive and at least two other statutory LSCB partners. This would usually be a health and a police representative as a minimum. They will also, wherever possible, interview the lay members.
- 3.17 A draft report will be sent to the chair of the LSCB and board members within 15 working days of the end of the inspection. The Chair has 5 working days to report factual inaccuracies. The final report will be combined with the final report of the single inspection, and published together on Ofsted's website. In any instances where the review does not take place at the same time as the single inspection, the report will be published separately.

4. Consultation

- 4.1 Ofsted consulted on the new framework in the summer of 2013 and carried out pilot inspections. Following the outcomes of those consultations and pilots, Ofsted re-published the single inspection framework "Framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers (single inspection framework) and reviews of Local Safeguarding Children Boards" and the handbook, with new sections on the review of LSCBs in October 2013. Full details of those publication and reports can be accessed via the web links on page 8.

5. Legal Implications

- 5.1 Ofsted inspections are conducted under section 136 of the Education and Inspections Act 2006.
- 5.2 Ofsted regulates and inspects a range of children's services, including childcare, children's social care, the Children and Family Court Advisory Support Service (Cafcass), schools, colleges, adult and community learning, School Improvement Local authority arrangements and secure establishments.

6. Risk Management

- 6.1 The outcome of the single inspection and Ofsted judgements are highly significant in terms of the reputations of the Local authority. The Secretary of State for Education has the power to intervene if he considers that a Local authority is failing in its safeguarding duties toward children. The 2012 Ofsted inspection of safeguarding and looked after children (June 2012) judged the overall effectiveness of safeguarding to be good; outcomes for looked after children were judged as adequate overall.

7. Care Quality Commission (CQC) Child Safeguarding and Looked after Children Inspection Programme

- 7.1 Following deferment of the planned multi-agency inspections of child protection arrangements, the CQC announced its intentions to undertake reviews of how health services keep children safe and promote the health and wellbeing of looked after

children. The CQC implemented its programme of Children Looked After and Safeguarding Reviews on 30th September 2013, which will run until April 2015.

- 7.2 CQC will inspect health services within local authority areas in England and will case track individual children in each area. CQC will prioritise inspections based on the identified risk within the health services in those areas and visit at short notice. They will use their powers under Section 48 of the Health and Social Care Act 2008 to conduct this review.
- 7.3 The reviews will evaluate the quality and impact of local health arrangements for safeguarding children and improving healthcare for looked after children and care leavers. As with Ofsted's single inspection framework, there will be a focus upon the experiences of looked after children and children and families who receive safeguarding services.
- 7.4 The lines of enquiry have been identified as:
- The experiences and views of children and their families.
 - The quality and effectiveness of safeguarding arrangements in health.
 - The quality of health services and outcomes for children who are looked after.
 - Health leadership and assurance of local safeguarding and looked after children arrangements.
- 7.5 A full report and presentation on the CQC Children Looked After and Safeguarding Reviews will be reported to a future Health and Wellbeing Board meeting, including an update on preparation in health for this review in Barking and Dagenham.

8. Multi-agency child protection inspections update

- 8.1 The multi agency child protection inspection framework has been deferred. However, from April 2015 - with Ofsted's partner inspectorates (CQC, HMIP, HMIC and HMI Prisons), a framework that additionally evaluates the contribution of core statutory partners to the care and protection of children will commence. This will not replace the single inspection. Ofsted (together with colleague inspectorates) will select a sample of local authorities to visit for the multi-agency child protection inspection. The existing Ofsted framework will be the spine of that inspection with additional criteria to assess the contribution of partner agencies.

9. Background Papers Used in Preparation of the Report

- 9.1 A number of background papers were used in preparation for this report (see below links for more detail), including the framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers and reviews of LSCBs, Ofsted, November 2013 and the Ofsted handbook for single inspection; reports on responses to Ofsted consultation on the single inspection and LSCB reviews.

- [Ofsted single inspection framework and reviews of LSCBs](#)
- [Ofsted inspection handbook for single inspection](#)
- [Report on responses to Ofsted consultation on single inspection framework](#)
- [Report on responses to Ofsted's consultation on the review of the effectiveness of LSCBs](#)
- [Ofsted PowerPoint presentation on the single inspection \(PDF document\)](#)
- LGA/ADCS/SOLACE booklet, [Lessons from the single inspection framework pilots \(PDF document\)](#)

HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	CQC Inspection Report		
Report of the Chair of the Health and Wellbeing Board			
Open Report		For Discussion	
Wards Affected: ALL		Key Decision: NO	
Report Author: Glen Oldfield, Clerk of the Board, Democratic Services		Contact Details: Tel: 020 8227 5796 Email: glen.oldfield.@lbbd.gov.uk	
Sponsors: Cllr Maureen Worby, Chair of the Health and Wellbeing Board			
Summary: BHRUT was inspected 14 - 17 October 2013 as part of the first wave of the new hospital inspection regime undertaken by the CQC. BHRUT was selected as one of the first Trusts to undergo this new type of inspection because they were seen to be at 'high risk' - facing significant financial challenges and seriously underperforming on key indicators over the last few years. The findings of the CQC's inspection were published on 18 December. On the advice of the CQC, the NHS Trust Development Authority (NTDA) has placed BHRUT on 'special measures'. This meeting offers the first opportunity for the Board to consider and discuss the findings and judgements of the CQC and in particular the implications of BHRUT being placed on special measures by the NTDA. These recent developments will have no doubt raised anxiety amongst the community about the situation and future of their local hospitals. Cllr Worby, as Chair of the Board, has therefore convened this discussion between partner agencies as a matter of urgency.			
Recommendations			
1. Board Members are invited to raise and discuss any issues in relation to the CQC's inspection of BHRUT and the implications of the special measures regime.			

1. Introduction

- 1.1 Services at BHRUT have been under close scrutiny for some time, with a previous CQC report raising serious concerns (especially in Queen's A&E) in October 2011, which was followed by on-going monitoring of improvement.
- 1.2 BHRUT were inspected 14 – 17 October 2013 as part of the first wave of the new hospital inspection regime undertaken by the CQC. The changes to the CQC

regime ensure that it is a more robust assessment undertaken by a larger inspection team, who are selected for expertise in the services being reviewed.

- 1.3 BHRUT were selected as one of the first Trusts to undergo this new type of inspection because they were seen to be at 'high risk' - facing significant financial challenges and seriously underperforming on key indicators over the last few years.

2. Inspection headlines

- 2.1 The findings of the CQC's inspection were published on 18 December. BHRUT's ratings against the CQC's five key questions are summarised below:

i) **Are services safe?**

Services are, for the most part, safe, but at times they are unsafe - this is mainly around levels of medical staffing, particularly problematic in A&E. A&E remains the substantial concern, with long-standing problems around waiting times, particularly at Queen's Hospital.

ii) **Are services effective?**

The Trust had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in medicine, end of life care and outpatients. Effective care in the A&E departments is hampered by long waiting times for patients to be seen by a specialist.

iii) **Are services caring?**

Significant work has been undertaken to improve patient care and many patients and relatives were complimentary about the care they received and the way staff spoke with them. However, more work is required to improve care in the end of life service and ensure improvements in patient care in all services is reflected in national patient and family surveys.

iv) **Are services responsive to people's needs?**

Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments. BHRUT were also criticised for a lack of effective partnership working with other health and social care partners.

v) **Are services well-led?**

Examples were found of good clinical leadership at service level and staff were positive about their immediate line managers. However, it was felt that the Executive Team needed to be more visible and greater focus is needed at Board level to resolve longstanding quality and patient safety issues.

- 2.2 Some areas of good practice were also singled out by the CQC:

- Stroke services at BHRUT, hailed as one of the country's top performers;
- The development of a 'virtual ward' for care to follow the patient home;
- Sustained improvement in maternity services wards.

- 2.3 The full inspection report can be found by visiting the following link:

[http://www.cqc.org.uk/sites/default/files/media/reports/20131213 -
_cqc_quality_report_barking_havering_and_redbridge_university_hospitals_nhs_tru
st_final.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/20131213_-_cqc_quality_report_barking_havering_and_redbridge_university_hospitals_nhs_trust_final.pdf)

3. Special Measures

- 3.1 The Chief Inspector of Hospitals, Sir Mike Richards, stated that the scale of challenges faced by BHRUT were the highest that he had seen. Although it was acknowledged in the CQC report that the Trust Board were starting to work together as a team to address the longstanding issues at BHRUT, the report stated that the leadership was 'inadequate to address the scale of the challenges that the Trust is facing and additional support is required.'
- 3.2 The NTDA has therefore put the Trust into special measures on the advice of the CQC. In particular, this means:
- A focused regime to deliver improvement over a 12 month period, at which point there will be another inspection and the Chief Inspector will review whether 'special measures' continues;
 - Developing an improvement plan;
 - Reviewing leadership and governance of the Trust in the next month;
 - Linking with a high-performing trust as peer support; and
 - Appointing an Improvement Director to work with BHRUT executive team.
- 3.3 BHRUT have been asked to supply an improvement plan by the end of February and a newly seconded Improvement Director, Steve Russell, is leading this work for the Trust. In particular, the improvement plan is required to address the need to:
- Improve clinical and management support to deliver improvements to patient safety and quality, and improve ownership of improvement activity at every level of the Trust;
 - Resolve problems in A&E departments of King George and Queen's Hospitals, which are resulting in unsafe care;
 - Put a protocol in place for the transfer of patients between trust locations;
 - Address the Trust's discharge planning and patient flow problems, including improved working with local partners;
 - Implement infection control procedures consistently in every ward and theatre across the trust.
- 3.4 The Urgent Care Board has also discussed issues arising from the Inspection and special measures regime and the Integrated Care Coalition was due to meet on 10 February 2014 to discuss this and other issues. A verbal update from the Coalition will be provided to the Board.

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	The Francis Report		
Report of the Barking and Dagenham Clinical Commissioning Group			
Open Report		For Discussion	
Wards Affected: ALL		Key Decision: NO	
Report Author: Jacqui Himbury, Nurse Director, BHR CCG's		Contact Details: Tel: 020 8822 3152 E-mail: Jacqui.himbury@onel.nhs.uk	
Sponsor: Conor Burke, Accountable Officer, B&D CCG			
Summary: Further to an update report on the implementation of the Francis recommendations and the establishment of a designated task and finish group presented at the December meeting of the Health and Wellbeing Board, this report aims to appraise members of progress made to date.			
Recommendation(s) The Health and Wellbeing Board is asked to: <ul style="list-style-type: none"> i. Consider the report noting the progress made to date and the commitment of the task and finish group members to ensure recommendations are implemented and embedded ii. Discuss the implications for Barking and Dagenham and propose any further actions the Board agrees are required. 			
Reason(s): Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to review and comment on public inquiries into health and social care and make recommendations to improve the quality of care. The NHS Constitution should be the first reference point for all NHS patients and staff as it outlines the systems common values as well as patient rights, legitimate expectations and obligations of patients.			

1. Introduction

- 1.1 The purpose of this update report is to provide the Health and Wellbeing Board with a summary of the main issues and key recommendations raised in the second report from the public inquiry into the events at Mid Staffordshire Hospital carried out by Robert Francis QC
- 1.2 The report provides the Francis recommendation and action plan as developed by the task and finish group and details progress made to date with implementation of the actions across the Barking and Dagenham, Havering and Redbridge social care and health economy. The plan is attached at appendix 1.
- 1.3 The group is now established and this report details the preliminary progress made since the last update.

2. Background

- 2.1 The report of the Francis inquiry, tells first and foremost of the appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies were brought to the regulators attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus in reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.
- 2.2 The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. Francis states that Primary Care Trusts were not as effective as might have been expected in commissioning or monitoring delivery of care. The task and finish group considered the failings detailed above and in doing so agreed the actions in the implementation plan.
- 2.3 The task and finish group have been further influenced by the Keogh and Berwick reports, which both make explicit that service users and patients must be at the heart of all we do as system leaders, commissioners and providers of health and care services.
- 2.4 The Chairs of all safeguarding boards, Healthwatch representatives and the Lay members of the Clinical Commissioning Groups (CCGs) have provided input to the development of the Francis Implementation BHR System Wide Plan.
- 2.5 All three Local Authorities and CCGs report significant progress of actions in the plan. Progress against actions is detailed in Appendix 1.

3. Next steps

- 3.1 To hold a multi-agency commissioner and provider workshop in mid February to undertake a system wide quality gap analysis, and then building on what is in place

and working well develop a Quality Improvement Group that supports and enhances system wide quality improvement.

- 3.2 To continue to drive forward and implement the actions agreed in the plan. The task and finish group have now taken on a monitoring role and will meet monthly going forward.

4. Mandatory Implications

4.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall mortality analysis as well as a detailed safeguarding element within it. Integration and addressing issues presented by Francis are key themes of the JSNA 2013 and this paper is well aligned to address and follow up these priorities and the strategic recommendations of the JSNA. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

4.2. Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The strategy is based on four priority themes that cover the breadth of the frameworks and in which a large number of Francis's recommendations can be picked up within. These are: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

4.3 Integration

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services. Implementing the recommendations from the Francis Report will need to take account of integration and many of the actions will further support and strengthen integration, such as developing a joint mechanism for capturing service user/patient experience feedback to inform further integration.

4.4 Risk Management

Patient/service user care may be compromised if there is a failure to consider or implement relevant recommendations, which is in addition to organisational reputational risks. Agreement to establish the task and finish group and the consideration the Health and Wellbeing Board has already given to implementing the recommendations will mitigate this risk.

5. Non-mandatory Implications

5.1 Safeguarding

By its very nature the Francis Report has significant safeguarding implications and the overall report is aimed at making both the health and care system and the individual services within this more safe and driving continuous quality improvement. The CCGs are actively collaborating with the Children's and Adults Safeguarding Boards to lead and progress the implementation of the recommendations.

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**Francis Report
Task & Finish Group
System Wide Implementation Plan**

Week Commencing: 27 January 2014

RAG Key for monitoring progress

	Tasks and outcomes are completed
	Tasks and outcomes are on track, milestones met but not completed
	Tasks and outcomes have not been met or timescale slipped
	No update available

Goals	Francis Recommendation	Task	Due Date	Owner (s)	Status	RAG
All organisations must publish their response to the Report and Recommendations	1	Prepare and publish a response to the Francis report on organisational websites.	December	BDCCG HCCG RCCG	Response now on the CCG website Response now on the CCG website Response now on the CCG website	
Contracts for services must be clear on minimum standards and be Francis compliant	8, 13, 14, 124, 125, 127, 129, 130, 131, 132, 135, 136, 137, 205, 245	All organisations to prepare an annual report on the implementation of the Francis recommendations and to progress through internal governance mechanisms. Receive provider response to Francis Inquiry – BHRUT, NELFT, BH, PELC, Basildon University Hospital Trust. This should be included in the Quality Accounts Review all contracts & ensure Duty of Candour or an equivalent requirement is included. 2014/15 Duty of Candour strengthened in NHS Standard contract. Francis specifically referenced in the 14/15 contracts.	30 March 14 28 February 13 31 January 14	LBBB LBH LBR BDCCG HCCG RCCG LBBB LBH LBR	In progress Update report on progress going to HWB 11 February 13 In progress In progress Progress report is being presented to Health Scrutiny Committee on x January 14 Standard NHS contracts to be issued to all providers when new contracts issued. Contract negotiation process ongoing. New contracts will be issued for 14/15 CSU to be asked to do this Public Health Contracts to have included as appropriate on renewal This is a commissioning task and is in hand Contracts being reviewed	
		Ensure there is sufficient commissioning capacity to quality monitor and performance manage all contracts. Processes for identifying risks and emerging risks need to be clearly defined. This must include the appropriate escalation of risks	24 January 13	BDCCG HCCG RCCG	The larger contracts have a formal quality and performance framework in place. Medium size contracts are now quality assured. Smaller contracts are being reviewed, quality indicators are being developed that act as an early warning system. For Care homes joint quality assurance visits are being completed by LBH and CCG. Strong links with the CQC have also been developed. There is capacity to manage – the governance structure is in place for all major contract management. Capacity issues have been identified with medium and smaller value	

Francis Report System Wide Implementation Action Plan

Version 4.1

Author Jacqui Himbury

Updated date: 27 January 2014

								Reviewed and reported complete. Gaps identified and closed.	
				Collaborate on design of system-wide model to develop a Clinical Quality Board	28 February 14	All		Workshop to be organised to design model. This is now being progressed through the Urgent Care Board and the workshop is planned.	
				Consider other models and learn from best practice. Integrated social care and health models reviewed. Kings Fund and UCLP research also reviewed.					
				Monitor patients receiving acute treatment. Clinical insights on quality of services is captured from front line staff in general practice	28 March 14	BDCCG		A formal system is in place, although this requires a review which will be completed at end of February 14	
				Work with CSU on reporting framework to CCGs. To be monitored by the Quality and Safety Committee		HCCG		Plans are in place to implement a formal system of capturing real patient experience. The financial resourcing issues are in the process of being resolved.	
						RCCG		This is done through a CQUIN, monitored by the CQRM. Still to develop a systematic process for capturing feedback and patient stories.	
				Develop internal systems to allow GP's to track areas of concern	28 March 14	BDCCG		Process in place for capturing practice feedback is through locality meetings and localities issues log.	
						HCCG			
						RCCG		This takes place through the 4 Locality Committee meetings	
				Consider processes required to obtain adequate consent	28 February 14	BDCCG		CCG complaints policy in place. Review of consent policy in progress	
						HCCG			
						RCCG		This is detailed in contracts	
						LBBB		Public Health contracts where appropriate consent is built in i.e. sexual health, healthy adults etc	
						LBH		Normal practice	
						LBR		Currently being reviewed	
				Write to providers to formally enquire how they propose to implement these recommendations	12 February 14	BDCCG			
						HCCG			
						RCCG		Contracting are drafting a letter template to send to providers	
						LBBB		Public Health contracts been built in for future contracting discussions	
						LBH			
						LBR			
				Develop process for sharing upheld complaints when consent given	26 March 14	BDCCG			
						HCCG			
						RCCG			
						LBBB		Public Health being discussed locally and nationally	
						LBH			
						LBR			
				Revise and implement local scrutiny processes	12 February 14	LBBB		Complete	
						LBH		Via Quality and Suspension Board and Safeguarding	
						LBR		Need to review against recommendations	
				Clinical leaders to attend CQRM meetings to strengthen focus on clinical outcomes and triangulation of quality	29 January 14	BDCCG		Complete	
						HCCG		Complete	

Francis Report System Wide Implementation Action Plan

Version 4.1

Author Jacqui Himbury

Updated date: 27 January 2014

safety		indicators		RCCG	
All patients in acute settings to have an identified consultant who is responsible for their care and to be seen by consultants	236, 238	Ensure acute and mental contracts contain this provision and that this is monitored through the CQRM's	31 March 2014	RCCG BDCCG HCCG RCCG	Complete – Two Clinical Directors are members of the Quality and Safety Committee This is being discussed during the clinical contracting discussions and was discussed at the January CQRM. This is within the BHRUT contract and for A&E is monitored through the Emergency Care Standards Group. Barts Health contract is currently under discussion through the negotiation process Initial governing body away day held to build concept of behaviour charter that puts the patient at the heart of all we do. Output of governing body away day shared with all staff at organisational staff briefing Check with CSU HR staff Borough based workforce plans being developed Normal Practice
Culture and organisational development. Culture must be defined, understood and accepted by all staff who work within our organisations. This should then be continually reinforced by leadership, training, personal engagement and commitment. Have clear workforce plans for recruitment, retention and development of staff to create a positive culture	7, 126, 179, 180, 191, 194	Review existing workforce development plans and build on these plans in conjunction with Human Resources. Recruitment and retention must be specific actions	26 February 2014	BDCCG HCCG RCCG LBBB LBH LBR	The safeguarding assurance committee is reviewing this working with corporate services The safeguarding assurance committee is reviewing this working with corporate services The safeguarding assurance committee is reviewing this working with corporate services In progress In progress
Develop effective shared governance for quality and safety that demonstrates our commitment to quality	11, 244	Examine how new vetting system impacts on recruitment and retention	26 February 14	BDCCG HCCG RCCG LBBB LBH LBR	The safeguarding assurance committee is reviewing this working with corporate services The safeguarding assurance committee is reviewing this working with corporate services The safeguarding assurance committee is reviewing this working with corporate services In progress In progress
Patient and Public Involvement and insights to ensure service user and patient feedback drives quality improvement.		NHS England's QSG to invite representatives from local authorities and Health Watch Identify system wide issues through intelligence sharing		NHS England BHR GGS Nurse Director All	Complete Strategically and operationally systems have been reviewed and changes made. Formal intelligence sharing now common practice. Each agency to identify methods of communication working with communication leads
		Locally led conversations with patients, service users and their families and carers about "what matters to you"	Ongoing		
		Patient vignettes to go to every governing body meeting to present a patient perspective of receiving care	Ongoing	BHRCCG	This was discussed at all governing body meetings in January and is being progressed working with PPE lay members of the governing body's

Action Plan to be updated every fortnight after each meeting of the Task and Finish Group
New actions to be agreed at Task and Finish group and added as needed

HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	Progress on Winterbourne View Concordat		
Report of the Corporate Director of Adult & Community Services			
Open	For Decision		
Wards Affected: ALL	Key Decision: NO		
Report Author: Jackie Phillips, Interim LD Commissioning Manager	Contact Details: Tel: 020 8227 2295 E-mail: Jackie.phillips@lbbd.gov.uk		
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services			
Summary: In December 2012 the government published its final report into the events at Winterbourne View Hospital and set out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice. Following the report all relevant statutory and non-statutory (50 in total) agencies / organisations designed and signed up to a 'concordat' which outlines key actions and their commitments in response to Winterbourne which will have an impact on Barking and Dagenham. This report provides an update on the Borough's progress against the actions required since the July update to the Board.			
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the progress that the Borough has made in achieving the actions set out in the Winterbourne View Concordat since it last briefing. b) Note the Winterbourne View 'stocktake' document which has been produced for the Winterbourne View Joint Improvement Programme. c) Note the identified risks and mitigation plans.			
Reason(s) To ensure an appropriate and 'whole systems' approach is taken to addressing the findings of the Winterbourne View Concordat by the Health and Wellbeing Board			

1. Background and Introduction

- 1.1 This report provides an update on progress within the authority against the programme of actions set out in the Winterbourne View Concordat.

2. Progress

- 2.1 Since the last report to the Health and Wellbeing Board, the borough has continued to deliver against the milestones set out in the Concordat.

Local Register

- 2.2 The local register of all Health funded Barking and Dagenham Patients placed in inpatient services was handed over to the Clinical Commissioning Group on 01 April 2013 and is continually updated by the Community Learning Disability Team and reported to the CCG to ensure that the borough understands where individuals are placed, that they are receiving quality care and support proactive and effective discharge planning.

Numbers in Assessment & Treatment Units

- 2.3 The borough currently has seven people residing within a hospital/Assessment and Treatment Unit.
- 2.4 There has been one new admission within the last six months (two cases had previously been reported however one case was later identified as falling under Havering's responsibility).
- 2.5 The borough has recently accepted responsibility for a service user; this case was transferred by another local authority following a dispute relating to Section 117 responsibilities.
- 2.6 Of the other five, two service users have significant forensic histories; one service user is in a locked rehab unit and was recently made subject to Section 3 of the Mental Health Act following deterioration in behaviours. Following this, Section.117 after care responsibility will sit with another Local Authority with whom we are in discussions.
- 2.7 Of the remainder, one service user has been an informal patient in a local Assessment and Treatment Unit and is expected to be discharged within the next 4 weeks and the final service user is a patient in an out of borough Assessment and Treatment unit with significant challenging behaviours and subject to Section 3. The family of this latter individual is extremely resistant to a move, particularly if it means returning to the London area. The next CPA review is to be held in February and plans for the future will be discussed. The family has sought legal representation.

Discharge Planning

2.8 Comprehensive discharge plans have been put in place for the patients in the Assessment and Treatment Units for those deemed suitable for move on to local, less restrictive settings by 01 June 2014.

Joint Local Health and Social Care Self Assessment Framework

2.9 The borough completed its Joint Health and Social Care Self Assessment which was presented to the H&WBB in November 2013. This is in the process of being validated by Public Health England.

2.10 The borough will then put an action plan in place to improve the identified areas for improvement which will be delivered through the Learning Disability Partnership Board. The information from this is also being used to inform our Joint Strategic Plan on Challenging Behaviour.

Winterbourne View Stocktake

2.11 In 2013, the Council and the CCG undertook a 'Stocktake' of its progress against the Winterbourne View Concordat as part of a national exercise to establish progress and areas requiring assistance. This was reported to the Winterbourne View Joint Improvement Programme which is led by NHS England and ADASS and was established to help local areas fundamentally transform health and care services. A further 'stock take' was responded to in December 2013. There remains an issue of identification of NHS numbers of people in ATUs which is being worked on nationally. The report of the Stock take has now been made available.

2.12 In brief, the Stocktake found:

- All localities engaging and working on the Concordat commitments;
- Progress and leadership across the partners;
- H&WBBs being sighted on the Winterbourne priorities;
- Skilled and committed staff at commissioner, care management, community and provider levels and in leadership roles supporting change;
- Some service user and family carer engagement but this is not consistent;
- Safeguarding practices being followed consistently;
- Integrated/joint working evident in assessment, commissioning and service development although this is not evident everywhere;
- The engagement of newly formed CCGs is bringing fresh impetus and priority in some localities;
- Innovation and strategic planning in some localities to reduce reliance on distant, long term Assessment and Treatment placements;

- Over 340 examples of good policy/practice which are undergoing further analysis

But, the Stocktake highlights the following for development locally:

- An urgent need to resolve issues of definition raised in 'Transforming Care' and the Concordat and, in particular, a need to clarify and define the key individuals who need to be considered as part of the change programme both now and in the future;
- The development of whole life planning;
- The need rapidly to improve engagement, understanding and joint working across the various commissioning functions (specialist, forensic and health and social care);
- The need for localities to work together both within and across geographical boundaries to achieve longer term sustainable solutions;
- The need for a resolution to continuing difficulties in relation to Ordinary Residence;
- The need for consistent application at local level of Continuing Health Care criteria.
- There is a need for investment in behaviour support and community based accommodation options to enable safe and local support services;
- Integration, and use of, financial resources with medium and long term financial strategies;
- Collaborative work with providers at a national, regional and local level to develop alternatives to current provision;
- Expedition in work to improve quality and consistency of care through robust commissioning
- An increase in the development of, and investment in, service user, family carer and advocacy activity;
- An increase in the understanding and application of personalisation for all individuals, notwithstanding the complexity of their situation;
- Work to ensure the wider understanding and application of the Mental Capacity Act (MCA)
- A need for support to H&WBBs in their strategic role.

3. Ongoing Work

- 3.1 As part of the Winterbourne View Programme, the Council and the CCG are undertaking the following pieces of work by the required milestones set out in the Concordat:

Pooled Budget Arrangements and Lead Commissioning Responsibilities

- 3.2 The Council and the CCG are in the process of discussing pooled budgets and lead commissioner responsibilities. In view of the tight timescale required for this piece of work to be completed; the Council and the CCG are taking the approach that budgets will not be pooled at this stage for the commissioning function but that the budgets will be ring fenced and managed by the local authority. The integrated provision will be pooled. It is anticipated that pooling of budgets will occur on review. A high level project group is meeting monthly to ensure that there is agreement in place by the 1st April 2014 milestone and work has begun to agree formal arrangements between the Council and North east London Foundation Trust to consolidate the current integrated provision of the Community Learning Disability health and social care services.

Joint Challenging Behaviour Commissioning Plan

- 3.3 Adult commissioning has been working in collaboration with Children's Services on the Joint Strategic Plan to respond to the Winterbourne View Concordat. This is essentially a Commissioning Strategy for responding to the needs of children and adults with Challenging Behaviour (as per the agreed definition). Given the nature of the definition of challenging behaviour – and the inherent challenge that this poses - it is not a definition in itself readily identifiable through existing data collection systems. Children's Services have researched data to enable the authority to make some reasonable estimates as to likely numbers of children who are coming through and will be presenting with a need for services over the next five to six years. The plan has been drafted but will be undergoing revision over the next few weeks to make it more accessible; it is envisaged that the data collated by Children's Services will be included and the draft will be amended to incorporate the implications of the data.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall analysis of needs of people with a learning disability as well as a detailed safeguarding element within it. There is general agreement that cross-sector working in the borough with involvement from the NHS, employment, housing and other bodies, in addition to the Council's children's services and adult and community services is good.

4.2 Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, public health, and adult social care with the children and young people's plan. The strategy is based on eight strategic themes that cover the breadth of the frameworks in which learning disability is picked up as a key issue. These are Care and Support,

Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures for people with learning disabilities are mapped across the life course against the four priority areas.

4.3 Integration

Responsibility for ensuring the delivery of the things set out the concordat rests with both the NHS and the Local Authority and there is commitment on both sides to enable this to happen. The local action plan will be fully integrated and will include actions for both health and social care.

4.4 Financial

(Implications completed by Roger Hampson, Group Manager Finance)

There are no quantifiable costs attached to the programme of action identified in response to the Winterbourne View Concordat or the stock take. The delivery of the both programmes, including any subsequent additions, must be accommodated within the current resources of the accountable bodies identified within the plan.

4.5 Legal

(Implications completed by Lucinda Bell, Solicitor Social Care and Education)

The Health and Wellbeing Board is under a duty¹ to encourage integrated working. This includes:

- a duty to encourage those arranging for the provision of health or social care services in their area to work in an integrated manner; and
- a duty in particular to provide advice, assistance, and so on, to encourage the making of arrangements under section 75 of the NHTA 2006.

5 Risk Management

5.1 The following potential risks and mitigations have been identified:

Identified Potential Risk	Mitigation / Action
S75 / Pooled budget arrangements	Discussions are underway between the Local Authority and CCG Monitoring and progress will be reported to the LD sub-group and the H&WBB.
Move of people back to the local community by 01 June 2014 deadline	Comprehensive plans are already in place by the CLDT to support the patients identified to less restrictive settings The LD sub group will continue to monitor progress and report up to the H&WBB

6. Non-mandatory Implications

- 6.1 **Crime and disorder:** Some of the individuals in our AT&Us may present a risk of offending so risk management will need to be considered as part of the review process
- 6.2 **Safeguarding:** Barking and Dagenham will be bringing back to borough vulnerable service users who may have spent significant periods in patient services;
- 6.3 **Property/assets:** Barking and Dagenham will need to ensure suitable accommodation is in place as a form of prevention and for people who are coming back from out of borough.
- 6.4 **Service User and Carer impact:** Barking and Dagenham will have to work in close partnership with the carers and five service users in Assessment and Treatment Units (AT&U's) as part of the review process, in particular those who have been identified as suitable to return back to borough.
- 6.5 **Staffing issues:** Barking and Dagenham will need to ensure, in preparation for bringing individuals back into borough and as part of our local strategic plan, it has both a skilled and competent workforce in place to support and care for people with learning disabilities and who have behaviour which challenges.

7 Background Papers Used in the Preparation of the Report:

- Winterbourne View Joint Improvement Programme Stock take of Progress Report (September 2013)

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	Obesity Summit		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: NONE		Key Decision: NO	
Report Author: Monica Imbert, Health Improvement Advanced Practitioner		Contact Details: Tel: 020 8227 2223 Email: Monica.Imbert@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary: The Obesity Summit, held on 16 December 2013 concluded with five main recommendations for 'industrial scale' action to reduce overweight and obesity (and its impact on chronic disease and premature mortality) across the borough. These are summarised below.			
Recommendations			
<ol style="list-style-type: none"> 1. Engagement – Engage at least 4000 inactive residents physically active enough to meet the minimum recommended weekly physical activity target using the message that 'fit and overweight' is acceptable, rather than focusing on 'how to lose weight'. 2. Incentivisation – Offer incentives on an industrial scale to motivate groups of people to meet activity targets use incentives that focus on local charities or causes that will engage large numbers of people. 3. Early Identification and Intervention – Engage with all GP practices in developing chronic disease pathways that have a physical activity component that is integral to delivery of care, and in actively referring every patient who is overweight/obese and/or has a chronic illness to one of our lifestyles prevention programmes. 4. Marketing – Make use of more effective marketing, with borough straplines (eg 'Do it for Dagenham') and positive images that engage people, and to target specifically those communities that do not access our current programmes, e.g. men accessing weight loss programmes. 5. Environment and Planning – More assertive promotion aimed at increasing the communities use of green spaces, and continue our local planning regime to improve the health promoting environment. 			

Reason(s)

The Obesity Summit was as a result of a decision taken by the Health & Wellbeing Board in October 2013. The aim was to achieve a collaborative strategic response for effective industrial scale healthy weight programme to incentivise residents to adopt a healthier lifestyle.

1.0 Background

- 1.1 Barking and Dagenham the bottom 10% of local authorities in the national league tables on the prevalence of adult and child obesity as well as child and adult participation in physical activity.
- 1.2 28.7% of adults in Barking and Dagenham are obese (BMI of 30+) – Significantly higher than both national and regional rates, amounting to a total of 40192 of Barking and Dagenham’s adult population.
- 1.3 Nationally, Barking and Dagenham has the fifth highest proportion of overweight and obese children in Reception class (26.7%) and the fourth highest proportion in Year 6 (42.2%) when ranked by local authority.
- 1.4 Significant investment has been made in the borough, past and present, on a range of healthier eating and sport/leisure programmes but without a co-ordinated strategic approach to the delivery of these programmes the impact on reducing obesity levels has been minimal.
- 1.5 As a result a decision was taken by the Health and Wellbeing Board that a summit be held to advise the Board on concerted effective action.
- 1.6 The aims of the summit were to engage all local partners in revitalised action to reduce obesity over the next 18 months, and to agree a strategy for achieving that.

2.0 The Summit

- 2.1 The Summit took place on 16 December 2013 at The Technical Skills Academy in Barking and engaged participants in a combination of interactive workshops and collective discussion with approximately 54 delegates in attendance.
- 2.2 Dr William Bird, GP, reported on how other boroughs have motivated large proportions of residents to become more physically active through large-scale incentivised physical activity programmes, with ‘buy-in’ from most GPs and cooperation from schools and leisure services.
- 2.3 Four workshops/interactive events were held as follows:
 - i. Psychological insights into obesity.
 - ii. Planning, regeneration and saturation.
 - iii. Reinvigorating the specialist, clinical service offer.
 - iv. Tackling obesity – a whole systems approach.

- 2.4 Participants then engaged collectively in a plenary session making recommendations for the most effective action on obesity in the borough. The session asked participants four key questions:
- i. How we can get the borough more active and eating more healthily?
 - ii. How should we use incentives?
 - iii. Who should we target?
 - iv. How should we target them?
- 2.5 The information was collated and recommendations that ensued are summarised below.

3.0 Recommendations

- 3.1 Engagement – Engage at least 4000 inactive residents physically active enough to meet the minimum recommended weekly physical activity target using the message that ‘fit and overweight’ is acceptable, rather than focusing on ‘how to lose weight’.
- 3.2 Incentivisation – Offer incentives on an industrial scale to motivate groups of people to meet activity targets use incentives that focus on local charities or causes that will engage large numbers of people.
- 3.3 Early Identification and Intervention – Engage with all GP practices in developing chronic disease pathways that have a physical activity component that is integral to delivery of care, and in actively referring every patient who is overweight/obese and/or has a chronic illness to one of our lifestyles prevention programmes.
- 3.4 Marketing – Make use of more effective marketing, with borough straplines (eg ‘Do it for Dagenham’) and positive images that engage people, and to target specifically those communities that do not access our current programmes, e.g. men accessing weight loss programmes.
- 3.5 Environment and Planning – More assertive promotion aimed at increasing the communities use of green spaces, and continue our local planning regime to improve the health promoting environment..

4.0 Conclusion

- 4.1 Barking and Dagenham face significant challenges in tackling obesity in both adults and children. If we are to achieve really sustainable behaviour change, we need to develop integrated programmes that draw on the latest behavioural change research and motivate residents to live a more healthy and sustainable lifestyle in today’s environment. Both personal incentives and large scale actions have a role to play, with public and private sector partners working together for the benefit of the community.
- 4.2 The challenge to both commissioners and providers is the need to incorporate appropriate behaviour change approaches into service design and delivery in care and sickness services as well as health and wellbeing services, recognising that, for example, healthy eating and appropriate exercise may be as important to recovery as diligent adherence to taking recommended medicines.

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	Waiver of Standing Orders for Public Health Contracts		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: YES	
Report Author: Sarah Blair, Interim Planning & Performance Officer		Contact Details: Tel: 0208 227 3781 Email: sarah.blair@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary: <p>The purpose of this report is to seek a waiver of the requirement under the Council's contract rules to conduct a procurement exercise for contracts over £50,000.00.</p> <p>The transfer of the Public Health function to the Council from 1 April 2013 under the Health and Social Care Act 2012 resulted in the Council inheriting a range of contracts across different Public Health Service areas.</p> <p>The contracts novated or transferred to the local authority expire on March 2014. The services covered by these contracts each need to be reviewed in line with the Council's Public Health commissioning intentions and the priorities of the Health and Wellbeing Strategy. Following the review, the services the Council wishes or is required to retain need to be procured under new contracts.</p> <p>The re-commissioning of the new services will require an intensive procurement programme to ensure the process complies with both Contract Rules and where applicable, the Public Contracts Regulations 2006 (as amended). It will also be necessary for officers to comply with the Public Services (Social Value) Act 2012 requirements prior to commencing any procurement process.</p> <p>Following the transfer of Public Health functions to the Council we have been working to develop a procurement plan as attached in Appendix 1.</p> <p>The procurement programme will need to be conducted in stages so as to allow sufficient time and capacity to review the existing services and performance and engage with stakeholders to inform the new service provision. The staggered approach to procurement will also ensure continuity in service delivery and enable officers to stimulate the market and engage with key stakeholders as required.</p> <p>There is no provision for further extension of any of the contracts that have been novated to the Council. Hence further contracts need to be issued directly to the current providers under the same terms and conditions until such time as the procurement process for each contract has been completed and new competitively procured contracts for each service</p>			

can be awarded.

Recommendation(s)

The Health and Wellbeing Board is asked to:

1. Waive the requirement of the Council Contract Rules that requires us to conduct a procurement exercise for contract in the excess of £50,000.00. In accordance with contract rules 6.6.8 Public Health believe that there are exceptional circumstances why a procurement exercise cannot be undertaken at this stage.
2. Authorise the Corporate Director of Adult and Community Services to award the Public Health Contracts on the advice of the Director of Public Health listed in Appendix 1 to each of the current providers under the same terms and conditions as the current contract and for the duration detailed in Appendix 1.

Reason(s)

The contracts that were novated to the Council on 1st April 2013 cannot cease without alternative arrangements being in place. Equally, it is not possible in the limited time available prior to the cessation of the novated contracts for officers to assess the services required and conduct procurement processes in accordance with the relevant Contract Rules, and where applicable, the Public Contracts Regulations 2006 (as amended). Therefore in order for officers to directly award interim contracts to the current providers without undertaking any competitive process. The ground upon which a waiver is being sought is Contract Rules 6.6.8, which states "There are other circumstances which are genuinely exceptional.

1. Background/Scene Setting

- 1.1. On 1 April 2013 the delivery of Public Health services was transferred to local pursuant to the Health and Social Care Act 2012. At the same time Primary Care Trusts (PCTs) who until then managed contracts delivering public health outcomes ceased to exist.
- 1.2. The Statutory Transfer Scheme, enacted by the Secretary of State allowed public health contracts to legally "Novate" to the Council by a written Transfer Order from 1 April 2013. This included the transfer of all rights and liabilities existing under all clinical and non clinical arrangements
- 1.3. The majority of Public Health contracts were novated to the Council for 12 months from the point of transfer on 1 April 2013 on the NHS Standard terms and conditions. However, officers have come to the view that the novated contracts contained in Appendix 1 need to be continued in their current form for a further period of 12 to 18 months from their current expiration dates. This period will allow officers to undertake an informed assessment of future opportunities to increase quality and value for money and explore options to deliver these services in a more integrated and effective way. This will ensure that the needs identified in the Joint Strategic Needs Assessment and the key priorities within the Council's Health and Wellbeing Strategy are met by the newly procured contracts.
- 1.4. Re-commissioning of the contracts will include joint and integrated commissioning between the council, voluntary sector and NHS which in some cases will involve cross borough multilateral arrangements.

1.5. These arrangements have been informed by the Commissioning Priorities agreed at the Health and Wellbeing Board 5 November 2013. A procurement plan has been developed with a timeframe for each of the procurement exercises to allow for officers to implement the agreed proposals. This plan necessitates further issuing of contracts to current providers to allow for the procurement process to be completed and new contracts awarded.

2. Proposals and Issues

- 2.1. In order to allow sufficient time for completing the necessary process of obtaining approvals, undertaking consultation, running procurement processes in accordance with Contract Rules and the Public Contracts Regulations 2006 (as amended), the award of new contracts and the transfer of the new contracts to incoming provider/s, whilst also ensuring service continuity these projects will need to continue to 31 March 2015 with the exception of the Integrated Sexual Health Contract (it is proposed to extend this until September 2015). To facilitate this process it will require existing contracts to be extended to the incumbent provider until 31 March 2015. These extensions to contracts will be issued to each of the current providers on the same terms and conditions that presently exist. Contracts going forward from April 2015 will be issued on the Council's terms and conditions.
- 2.2. There are 7 sexual health contracts worth a total annual value of £2,479,000 and with a range of current expiration dates as detailed in Appendix 1. There are varying arrangements proposed for these contracts which are further detailed in Appendix 1. Sexual Health is a mandated service and must be provided; it is envisaged that the Integrated Services Universal Genitourinary medicine (GUM), Chlamydia and C-card will be procured as one contract. This will deliver an integrated sexual health service with one provider and ensure economies of scale and efficiency savings. The HIV Services currently provided will be evaluated during the financial year to determine the effectiveness of these current services.
- 2.3. Two of the sexual health contracts are complex contracts - the Integrated Sexual Health Contract delivered by Barking, Havering and Redbridge NHS University Hospital Trust (BHRUT) is delivered in conjunction with the London boroughs of Havering and Redbridge and the Chlamydia contract is delivered in conjunction with the London boroughs of Havering, Redbridge and Waltham Forest. Both of these contracts are due to expire on the 31 March 2014. In going forward officers across the three Councils are proposing to have one contract rather than two separate contracts to deliver a fully integrated sexually health service. Such a joint procurement of a complex service will take some time to complete and it is the intention of all parties to the current contracts to extend them for the period 1 April 2014 to 30 September 2015. The current exception to this is the Chlamydia contract; Barking and Dagenham are discussing with our neighbouring partners the option of having a one year contract with a break clause of six months.
- 2.4. With the BHRUT contract there is no advantage to be gained in expediting this procurement process as the current contract has been renegotiated with the provider by all the boroughs involved. This renegotiated contract is currently providing better value, has competitive rates and provides an enhanced service within the same contract value. If we commence tendering in April 2014, we will get a full year activity data including non-contracted activity and more knowledge about demand of these services across a range of providers.

- 2.5. The interim period of eighteen months will enable the three councils to focus on stabilising the sexual health services. In addition, officers anticipate obtaining greater clarity about the delivery of sexual health services across London and nationally by July 2014. Furthermore, the service includes highly specialist areas which can only be delivered from an acute trust setting, and includes linkages with primary care, thus the Council are keen to continue to support the development of these services and ensure best value without destabilising the delivery for people who need the service.
- 2.6. The values of the interim contracts will be frozen at current levels (or where appropriate price reductions sought) until the proposed end dates of the contracts.
- 2.7. The procurement process will ensure that the services provide value for money for the Council. Some of the contracts will be joined up and procured as a single contract to get maximum efficiency, some contracts will be procured jointly with other authorities, and where appropriate some contracts will have added service components.

3. Consultation

Consultation with partners and providers has taken place and a regular dialogue is ongoing.

4. Mandatory Implications

4.1 Joint Strategic Needs Assessment

The JSNA has highlighted sexual health (especially HIV and teenage pregnancy) and mental wellbeing as being areas in need of improvement. The oral health of the borough is conspicuously poor especially in children. In view of the measures in the Public Health Outcomes Framework it would be inadvisable to leave the borough with no provision, albeit temporary.

4.2 Health and Wellbeing Strategy

The Health and Wellbeing Strategy highlights the importance and actions required to improve sexual health and mental health or emotional wellbeing. Whilst oral health is not specifically identified in the Health and Wellbeing strategy – its presence in the Public Health Outcomes Framework and the conspicuously poor dental health in the borough makes it a priority.

4.3 Integration

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report's recommendations are underpinned for the need for effective integration of services and partnership working.

4.4 Financial Implications

There are no quantifiable financial implications to draw attention to. However, given the transition of contracts from NHS to LA this will mitigate against financial risks associated with a rushed procurement process and facilitate stability with respect to budget setting purposes. Value for money and future efficiencies can still be sought as reported in section 2.

[Completed by Faysal Maruf, Group Accountant – Finance]

4.5 Legal Implications

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.

This report states that the waiver is sought on the basis that there is currently not sufficient time to complete the necessary process of obtaining approvals, undertake appropriate consultation and run procurement processes in accordance with the Contract Rules.

Contract Rule 6.6.8 states that the Council can waive the requirement to tender contracts on the ground that there are genuinely exceptional reasons why a procurement exercise should not be conducted.

Furthermore, Contract Rule 6.3 provides that in instances where the value of a contract is over £500,000, a waiver of the Council’s tender requirements must be obtained from Cabinet/ HWB.

In agreeing the Recommendations of this report 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.

[Implications Completed by Bimpe Onafuwa, Solicitor]

4.6 Risk Management

The contracts listed in Appendix 1 are important to the continuing health of the residents of the London Borough of Barking and Dagenham. The provision of sexually health by the Council is a mandated service which must be provided and not having a number of these contracts in place would put the health of the population at risk.

5. Supporting Documentation

- [Barking and Dagenham’s Community Strategy 2013-1016](#)
- [Joint Strategic Needs assessment](#)
- [Joint Health and Wellbeing Strategy](#)
- Public Health Commissioning Priorities 2014/15

6. List of Appendices

- Appendix 1: Future Procurement of Public Health Projects

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Appendix 1: Future Procurement of Public Health Projects

Service Area	Contract Title	Service Provider	Current Contract end date	Start of new contract following procurement process	Annual value of the contract/s (£)	Comments	Next Steps	Recommendations for the Health and Wellbeing Board
Sexual Health	Integrated services Universal GUM and FP Services	BHRUT	March 2014	April 2015	1,200,000	Discussions taking place with Havering and Redbridge regarding joint procurement of this highly complex service, need time to look at activity data and prevalence before commissioning new service and join it with Terrence Higgins Trust.	To ask for waiver from the Health and Wellbeing Board. To issue an extension to the current provider from 1 April 2014 to 30 September 2015, for £1,800,000. To start the procurement process in February 2014.	To Waive Contract Standing Order 6.6.8.
Sexual Health	Chlamydia testing	Terrence Higgins Trust	March 2014	April 2015	300,000	To add this service to the Integrated Sexual Health Service and procure jointly with Havering and	To ask for waiver from the Health and Wellbeing Board to issue a contract to the current provider	To Waive Contract Standing Order 6.6.8.

Appendix 1: Future Procurement of Public Health Projects

							Redbridge.	for the period 1 April 2014 to March 2015, with a break clause at six months.	
Sexual Health	HIV/Rapid Testing	Terrence Higgins Trust	March 2014	April 2015	30,000		To examine these contracts over the next year to determine how best to deliver the services post April 2015.	To ask for waiver from the Health and Wellbeing Board to issue a contract to the current provider for the period 1 April 2014 to March 2015, with a break clause at six months.	To Waive Contract Standing Order 6.6.8.
Sexual Health	HIV Services	Positive East	March 2014	April 2015	89,000				To Waive Contract Standing Order 6.6.8.
Sexual Health	Primary prevention (C-Card)	Terrence Higgins Trust	March 2014	April 2015	60,000		To examine this contract over the next year to determine how best to deliver the services post April 2015.	To ask for waiver from the Health and Wellbeing Board to issue a contract to the current provider for the period 1 April 2014 to March 2015, with a break clause at six months.	To Waive Contract Standing Order 6.6.8.

Appendix 1: Future Procurement of Public Health Projects

Children	Oral health	North East London Foundation Trust	March 2014	April 2015	30,000	To examine this contract over the next year to determine how best to deliver the services post April 2015.	To ask for waiver from the Health and Wellbeing Board to issue a contract to the current provider for the period 1 April 2014 to March 2015, with a break clause at six months.	To Waive Contract Standing Order 6.6.8.
Obesity	Weight Watchers	Weight Watchers	March 2014	April 2015	50,000	To examine this contract over the next year to determine how best to deliver the services post April 2015.	To ask for waiver from the Health and Wellbeing Board to issue a contract to the current provider for the period 1 April 2014 to March 2015, with a break clause at six months.	To Waive Contract Standing Order 6.6.8.
Mental Health	Big White Wall	Big White Wall	March 2014	April 2015	30,000	To examine this contract over the next year to	To ask for waiver from the Health and	To Waive Contract Standing

Appendix 1: Future Procurement of Public Health Projects

					determine how best to deliver the services post April 2015.	Wellbeing Board to issue a contract to the current provider for the period 1 April 2014 to March 2015, with a break clause at six months.	Order 6.6.8.
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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

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, Clerk of the Board, 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.			
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: Children and Maternity Sub-group
- Appendix 5: Public Health Programmes Board

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Mental Health Sub-Group

Chair: Martin Munro, Executive Director of HR & Organisational Development, NELFT

<p>Items to be escalated to the Health & Wellbeing Board</p> <ul style="list-style-type: none"> a) There is no nominated NHS England or specialist commissioning representative and there has been no GP representative attendance to date b) It was reported that custody suites in the borough lack easy access to translators which makes it difficult to determine if someone has a possible mental health problem or is affected by drugs or alcohol. It was agreed this would be included in the exception report so that the Borough Commander is aware of these concerns.
<p>Meeting Attendance</p> <p>15 January, 2014: 53% (8 of 15)</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"> a) The Group made initial comments on a paper which had been circulated in respect of the BHR CCGs Joint Mental Health Commissioning Intentions b) Group members commented on the refresh of the Section 75 Annual Plan. A number of members volunteered their support to LBBB in refreshing the plan prior to the Steering Group meeting scheduled for 23 February.
<p>Action and Priorities for the coming period</p> <ul style="list-style-type: none"> a) Members supported the principles tabled previously by the interim Public Health Consultant member of the Group for a Barking & Dagenham Mental Health Wellbeing strategy which underpins commissioning plans. The Group requested that the new Public Health Consultant take this forward when once appointed.

Contact:

Anne Hine, PA to Martin Munro - Executive Director of HR & Organisational Development (NELFT)

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Integrated Care Group

Chairs:

Dr Jagan John, Clinical Lead, Barking and Dagenham Clinical Commissioning Group

Jane Gateley, Director of Strategic Delivery, Barking Havering and Redbridge Clinical Commissioning Groups

Items to be escalated to the Health & Wellbeing Board

- None

Meeting Attendance

25 November 2013: 59% (10 of 17)

23 December 2013: 38% (6 of 16)

Performance

Please note that no performance targets have been agreed as yet.

Action(s) since last report to the Health and Wellbeing Board

- The group receives a monthly update on the development of the Joint Assessment and Discharge Service (JAD) at BHRUT; the group was notified that following London Borough of Redbridge pulling out of the service at this stage, the service proposals have been reworked and the revised proposals were agreed at the Urgent Care Board in November 2013.
- The B&D Integrated Care Group discussed the EoL update paper at both the November and December meetings, developing the content to frame the discussion for the H&WBB in February 2014.
- The Group was updated on the funding awarded for end of life training within Barking & Dagenham. Gold Standards Framework training will be delivered by Saint Francis Hospice to care homes and domiciliary care providers; work to encourage care homes and domiciliary care providers to sign-up to the training programme has started. Within B&D a localised training plan has been developed for delivery to general practice.
- The group received its monthly update on the Community Services development. In September, B&D CCG Governing Body approved the trial of a new model of intermediate care. In the trial, to run Nov 13-Mar 14, the Community Treatment Team service extended its hours from 8am – 8pm to 8am – 10pm and has now 'gone live' in Redbridge with an Acute Hub at King George Hospital. The Intensive Rehabilitation Service which delivers rehabilitation services in patient's homes has gone live with a Dashboard developed to monitor weekly progress. NELFT continue to operate weekly project meetings to work up the operational detail of their proposals in partnership with health and social care colleagues. It was agreed this trial would 'double run' with the existing community bed based intermediate care services to provide opportunity to test the effectiveness of the new model. The approval was subject to the condition that intensive engagement with service users was be undertaken during trial period. An engagement plan has been developed in

B&D to maximise engagement both of potential service users, and those who have been supported by the Community Treatment Team and Intensive Rehabilitation Service. The engagement strategies seek to understand patient thoughts about the proposed model and their experience of using the new services to inform further development. Engagement strategies will be jointly undertaken by NELFT and the BHR CCGs and include:

- 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
- Richard Vann from Healthwatch presented a 'Enter and View' report which detailed the findings of patient and family experience from a visit to Sunrise A&B wards in August 2013 and the BHRUT action plan published in response to the recommendations.
- A paper was presented to update sub group members on progress developing the local approach to the Better Care Fund (previously ITF). Detail of the plans and metrics are being worked up and a final version will be shared for discussion at the HWBB meeting in February 2014.

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. Risks identified by the ICM ops group will be escalated to the Integrated Care Subgroup where appropriate.
- 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 in February 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 Better Care 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
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Learning Disability Partnership Board

Chair:

Glynis Rogers, Divisional Director Community Safety and Public Protection, LBBD

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>a) Issues have been raised around the support that Job Centre Plus are able to provide to people with learning disabilities. Some training opportunities have been shared between the Council and Job centre Plus and the issue will be raised through the Fulfilling Lives Working Group.</p>
<p>Meeting Attendance</p> <p>17 December 2013: 47% (8 of 17)</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>a) Two Learning Disability Partnership Board (LDPB) meetings have taken place since the last report in November 2013.</p> <p>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.</p> <p>c) Standing items on the LDPB forward plan include Winterbourne View and Children and Families Bill and Transitions.</p> <p>d) Topics that have been discussed recently include the Joint Strategic Plan, health and obesity and health projects.</p> <p>e) Unfortunately one of the service user representatives has stood down from the role. There will need to be an election at the Service Users forum to fill this place.</p>
<p>Action and Priorities for the coming period</p> <p>a) Future meetings are themed around the local offer, safeguarding and community safety, housing and education, training and employment.</p>

Contact:

Joanne Kitching, Business Support Officer

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Children and Maternity Group

Chair:

Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group

Items to be escalated to the Health & Wellbeing Board

- a) Clarification on the role of each of the Health and Wellbeing Board sub-committees in monitoring performance of the indicators included in the Health and Wellbeing Performance Framework
- b) NHS England have yet to respond to queries from commissioners and providers as they seek clarity about funding streams for health visiting in Barking and Dagenham.

Meeting Attendance

27 November 2013: 60% (9 out of 15)

Performance

A review of the performance indicators that are relevant to the group has been carried out and was discussed at the meeting. This set of indicators will be finalised and used by the group to plan their work, pending further discussions and alignment with the Public Health Children's Programme Board.

Action(s) since last report to the Board

The CMG at its meeting on 27 November:

- a) Reviewed the research report on the Common Assessment Framework and agreed to consider more detailed data and recommendations to support CAF processes
- b) Received a report on the implementation of the Children and Adolescent Mental Health Services Improving Access to Psychological Therapies programme in Barking and Dagenham and noted the progress of this programme
- c) Reviewed the final draft of the Children and Young People Programme review
- d) Reviewed the final draft of the CCG review of services for children with special physical and developmental needs
- e) Received an update on the SEND Transformation programme
- f) Noted feedback from discussions at the Health and Wellbeing Board in relation to health visiting

Action and Priorities for the coming period

- a) LBBD seeking clarification on Health Visiting funding from NHS England
- b) Review of children's public health programme (postponed from November meeting) to

be discussed at next meeting

- c) Finalising performance indicators
- d) Update on maternity services

Contact:

Mabel Sanni, Executive Assistant, Barking and Dagenham CCG

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Public Health Programmes Board

Chair:

Matthew Cole, Director of Public Health, LBBD

<p>Items to be escalated to the Health & Wellbeing Board</p> <ul style="list-style-type: none"> • None
<p>Meeting Attendance</p> <p>14 January 2014: 80%</p>
<p>Performance</p> <p>Quarter 3 performance data will be presented at the next Health and Wellbeing Board in March 2014.</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <ol style="list-style-type: none"> a) The Public Health commissioning Priorities Paper will be presented at the next Health and Wellbeing Board meeting in February 2014. b) The programme was unable to recruit a provider to deliver its level 3 Stop Smoking Service, in light of this the programme is now reviewing how best to deliver its smoking programme and where best to place investment whether in prevention or quitters. c) The Health Visiting contract is likely to move to the Council during 2015/16 the work to embed this will start now. d) The obesity summit was held in December and the report from the summit is contained within the main board report. e) The Public Health Campaigns programme will be evaluated and work on how to do this has begun.
<p>Action and Priorities for the coming period</p> <ol style="list-style-type: none"> a) The future direction of the Public Health sub group will be looked at the next meeting.

Contact:

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

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

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.		

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In this jam-packed edition of the Chair's Report, I discuss the challenges for the year ahead in my 'New Year message' and highlight the good work that is being done in the Borough on seven day working. I also share some useful websites on preventing attendances at A&E and review the work that local schools are doing on the Healthy Schools London Scheme.

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

Best wishes,

Cllr Maureen Worby, Chair of the Health and Wellbeing Board

'New Year message'

In my last Chair's Report I outlined our key successes from 2013 and the considerable amount that we have achieved together since 'going statutory' in April 2013. In my first Chair's Report of 2014 I just wanted to briefly focus on the challenges that we are going to face in the year ahead:

- Driving up the quality of services and responding to the Francis Report on Mid-Staffordshire NHS Trust. We have some real challenges in our local hospital services, particularly Queen's Hospital, and we need to continue to pull together as a local health and social care economy to help BHRUT to turn this around, particularly as they enter 'special measures'.
- Focusing on obesity and getting everyone behind this important cross-cutting issue that affects all of our services.
- Stepping up how the Board engages with the public, patients and service users, in partnership with our local Healthwatch.
- Continuing on our integration journey, particularly with the advent of the Better Care Fund.
- Implementing the Care Bill and the Children and Families Bill which will receive Royal Assent later this year.

I think our recent Development Day on 13 January 2013 was a fantastic way of focusing our attention on the year ahead and it showed us how far we have come since April 2013. Now that the Board's structures and machinery is embedded I hope we can continue to deliver positive outcomes on behalf of the health and social care economy and raise our profile and reach within the community.

Regarding the Development Day itself, I would like to thank all Board Members and colleagues from the sub-groups and wider Partnership for your attendance and contributions on the day. Ian Winter CBE and Jacqui White, our facilitators, have now finished their feedback report and the Board will receive the report, Ian's observations and the outcomes of the Development Day at its next meeting in March 2014.

BHR Collaborative Cancer Commissioning Group

The Board may wish to note that the BHR Collaborative Cancer Commissioning Group (BHR CCCG) held its first meeting on Friday 31 January 2014. The group has been set up to take a whole system, strategic approach to securing improvements in cancer for residents in Barking & Dagenham, Havering and Redbridge and leading on the development of a local strategy.

The meetings are being chaired by Matthew Cole, Director of Public Health. The first meeting was positive, resulting in a number of actions to drive forward the development of the group's workplan and the local strategy. Discussion items included an agreement of the scope and the Terms of Reference for the group, an update on commissioning intentions and screening, and a review of the Patient Experience Survey and local Macmillan bids.

For more information about the BHR CCCG, please contact Matthew Cole on 020 8227 3657 or email Matthew.Cole@lbbd.gov.uk

33 Borough schools in the Healthy Schools London Scheme

Healthy Schools London is a quality award scheme which recognises the good work schools do to support children's health and well-being. Healthy Schools London was launched by the Mayor of London in 2013 and replaces the National Healthy Schools programme which ended in 2010. The scheme was launched in Barking and Dagenham in November and we now have 33 schools registered.

There are three levels of Healthy Schools London award: Bronze, Silver and Gold. The tiered structure of the award is designed to help schools to progressively build on their policies and practice over a period of time. Currently all schools registered with the scheme in Barking and Dagenham are working towards the Bronze award. In order to gain the Bronze award schools have to review their provision for health and well-being and provide evidence of the work they are doing to provide high quality Personal Social Health Education (PSHE), encourage physical activity and healthy eating and support the emotional well-being of their pupil. Healthy Schools London is a whole school approach which ensures that schools embrace a health promoting culture.

It is an achievement to have 33 of our 58 schools enrolled in Healthy Schools London, particularly as I understand that we are the only London Borough with all Secondary Schools registered in the scheme. Well done to all schools and staff involved!

London Facilitation Development Fund

The London Health and Wellbeing Board Development programme, led jointly by London Councils, NHS London and London Social Care Partnership (formerly JIP) has announced a £7k development fund which London Health and Wellbeing Boards can apply for. Officers will be writing an application to bid for money which will aid our work in integration and engagement and I will report back in due course as to whether we were successful in our application.

Sharing of patient records

Although I am sure that you have seen the extensive media coverage, I would like to draw attention to recent announcements relating to the sharing of medical records.

In March, the Health and Social Care Information Centre (HSCIC) will be controlling a new database called care.data which will bring together medical data from GP and hospital records in one place for the first time. The extracted information will contain NHS numbers, dates of birth, postcodes, ethnicity and gender, although once different records have been linked, a new record will be created and will contain no information that identifies an individual.

Once live, organisations such as university research departments will be able to apply to gain access to the database, and advocates of the database have stated that the sharing of data will allow researchers to speed up medical advances, for example through investigating drug side effects or the performance of hospital surgical units by tracking the impact on patients. However, insurers and drug companies will also be able to apply to access the new database and privacy experts warn that there will be no way for the public to work out who has their medical records or to what use their data will be put.

Information is currently being distributed to residents in the Borough explaining the changes and information is available in local GP practices. If residents are happy for their information to be used then they do not need to do anything. However, if they do not wish for their information to be shared, they can contact their local GP practice who will make a note on their medical record. Additionally, residents can call the Patient Information line on 0300 456 3531. There is no deadline for the changes, as residents can register their wishes at any time, however the data extraction will begin next month.

For more information on care.data, please visit <http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/care-data.aspx>

Reviewing substructure

As the start of our second year of operation approaches, I would like to remind all Board Members to review their organisation's representation on the sub-groups of the Board. This is to ensure that membership is up to date and that the sub-groups are being attended by the right people. To make changes to membership, or to discuss the substructure in more detail, please contact Glen Oldfield, Clerk of the Health and Wellbeing Board on 020 8227 5796 or email Glen.Oldfield@lbbd.gov.uk.

Members are asked to submit any changes to subgroup membership by 28 February.

Integrated Care Open Day and Knowledge Hub Group

Members of the Board may be interested in an open invitation that I have recently received to attend the Islington Integrated Care Open Day on 6 March 2014 (exact timings to be confirmed). Islington are one of the 14 Integrated Care and Support Pioneer sites and their Open Day will review and share their learning so far as a Pioneer site and to discuss their experience of joint and value-based commissioning.

For more information, please contact Dr Jo Sauvage, Joint Vice Chair of Islington CCG on josephine.sauvage@nhs.net

I also wanted to highlight an online forum called the Health and Care Integration Group which has been set up on the Local Government Association's Knowledge Hub. The forum is a space for those who are responsible for shaping, delivering, commissioning or supporting integrated health and care locally to share good practice, learning and discuss live issues. The group can be found by logging on to <https://knowledgehub.local.gov.uk/group/healthandcareintegrationgroup>

Seven Day Working

Over the last few months we have discussed seven day working a great deal. We have put seven day working in place in our hospital social work team and acute services providing enhanced assessment and discharge capability and removing barriers for residents and their families that would ordinarily occur at weekends. We are getting a lot of great feedback from residents about this extra capability and we are seeing great results in discharge flows and our delayed transfers of care (DTC) figures.

On behalf of the Health and Wellbeing Board I would like to express my gratitude to those members of staff that are making 7 day working possible. I would also like to thank colleagues in the CCG for the initial steps that are being taken to extend opening hours in GP practices in order that our residents can attend surgeries at more flexible times. In particular, I would like to draw attention to the Tulasi Medical Centre in Dagenham, which is now opening 8am – 8pm seven days a week! This is fantastic news for residents who live in this area and I hope that this will become standard throughout GP practices in the Borough over the course of 2014.

Useful websites on preventing visits to A&E

I would urge Board Members to visit two useful websites about preventing visits to A&E:

- 1) The '**Not Always A&E**' website which is being heavily promoted by Barking and Dagenham CCG and was produced by the North and East London Commissioning Support Unit - <http://www.notalwaysaande.co.uk/>
- 2) **Dee's A&E Fail Tale** – a youtube video produced by the three CCGs across Coventry and Warwickshire in a bid to stop people using A&E services for minor illnesses and injuries - <http://www.youtube.com/watch?v=ffT1orYXdcl>

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HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

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. 			

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Meeting Date: 25 March 2014 (6pm, Barking Learning Centre)		Sponsoring Board Member/Report Author	
Scheduled Business	Evaluation of Public Health Campaigns	Matthew Cole/Monica Imbert	
	Joint Strategic Plan (Winterbourne View action)	Anne Bristow/Jackie Phillips	
	Q3 Performance	Matthew Cole	
	Poverty Profile	Matthew Cole/Karen Wheeler/Mark Adams	
	Longer Lives Update: Learning from comparator authorities	Matthew Cole	
	Director of Public Health Annual Report	Matthew Cole	
	Transfer of Health Visiting Commissioning	Helen Jenner and Matthew Cole	
	Urgent Care Board: Update	Conor Burke/Jane Gateley	
	Better Care Fund 2015/16	Conor Burke and Anne Bristow/David Millen	
	Outcomes of the Development Day	Cllr Worby/Glen Oldfield and Ian Winter	
	Care City Proposal	Martin Munro/Helen Oliver	
	CCG Draft Operating Plan	Conor Burke/Sharon Morrow	
	Autism Strategy	Anne Bristow/Jackie Phillips	
	Winterbourne View Challenging Behaviour Plan	Anne Bristow/Jackie Phillips	
	Diabetes Scrutiny: Update on Delivering the Recommendations	Matthew Cole/Dr Sue Levi	
Impact of the Recession and Welfare Reforms on Mental Health Scrutiny (Initial Response)	Anne Bristow/Louise Hider		

APPENDIX 1: Health and Wellbeing Board Forward Plan (2013/14)

Meeting Date:	25 March 2014 (6pm, Barking Learning Centre)	Sponsoring Board Member/Report Author
	Sub-Group Report: Public Health Programmes Board	Matthew Cole/Hanna King
	Sub-Group Report: Integrated Care	Dr John and Jane Gateley/Emily Plane
	Sub-Group Report: Children and Maternity	Sharon Morrow/Mary Pirie
	Sub-Group Report: Mental Health	Martin Munro/Anne Hine
	Sub-Group Report: Learning Disability Partnership Board	Glynis Rogers/Jo Kitching
	Chair's Report	Cllr Worby/Glen Oldfield
	Forward Plan	Cllr Worby/Glen Oldfield

Items to be considered in the new municipal year (2014/15)

- Winterbourne View Section 75 Agreement (Anne Bristow/Jackie Phillips)
- Mental Health Section 75 Agreement (Anne Bristow/Mark Tyson)
- Healthwatch Annual Report 2013/14 (Frances Carroll/Marie Kearns)
- The Care Bill (Anne Bristow/Mark Tyson)
- Health in Young Offender Institutions
- Impact of the Recession and Welfare Reforms on Mental Health Scrutiny (Action Plan)