Notice of Meeting

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, 17 June 2014 - 6:00 pm

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

Date of publication: 9 June 2014

Graham Farrant
Chief Executive

Contact:	Tina Robinson, Democratic Services Officer			
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Membership for 2013/14:

Cllr (Chair)	(LBBD) Subject to appointment by LBBD Annual Assembly
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr	(LBBD) Subject to appointment by LBBD Annual Assembly
Cllr	(LBBD) Subject to appointment by LBBD Annual Assembly
Cllr	(LBBD) Subject to appointment by LBBD Annual Assembly
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 - 11 February 2014 and 25 March 2014 (Pages 1 - 11)**

   To confirm as correct the minutes of the meeting held on 11 February 2014 and to note the 25 March 2014 meeting was inquorate.

BUSINESS ITEMS

4. **The Health & Wellbeing Board as a Committee of the Council (Page 13)**

5. **Healthwatch Barking and Dagenham Annual Report 2013/14 (Pages 15 - 72)**

6. **BHRUT Improvement Programme (Pages 73 - 135)**

7. **Joint Assessment and Discharge Service (Pages 137 - 140)**

8. **Addressing Variation in Primary Care Performance (Pages 141 - 171)**

9. **Mental Health Tariff (Pages 173 - 176)**

10. **Annual Health Protection Profile (Pages 177 - 186)**

11. **Transforming Services, Changing Lives in East London (Pages 187 - 192)**

12. **Developing the Health and Wellbeing Board (Pages 193 - 196)**

13. **Waiver of Contract Rules: Public Health Chlamydia Testing Contract Extension (Pages 197 - 200)**

14. **Urgent Action: Implementation of Matters Scheduled for Consideration by the Health and Wellbeing Board on 25 March 2014 (Pages 201 - 204)**

STANDING ITEMS

15. Sub-Groups Reports (Pages 205 - 212)

16. Chair's Report (Pages 213 - 217)

17. Forward Plan (Pages 219 - 229)

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

19. 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.***

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

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 11 February 2014
(6:00 - 8:30 pm)

Present: Councillor M M Worby (Chair), Councillor J L Alexander, Matthew Cole, Councillor L A Reason, Anne Bristow, Helen Jenner, Stephen Burgess, Martin Munro, Dr Waseem Mohi (Deputy Chair), Conor Burke and John Atherton

Apologies: Councillor J R White and Chief Superintendant Andy Ewing

85. Declaration of Interests

There were no declarations of interest.

86. Minutes - 10 December 2013

The minutes of the meeting held on 10 December 2013 were confirmed as correct.

87. CCG Commissioning Plans

Sharon Morrow (Chief Operating Officer, B&D CCG) introduced the report to the Board. It was noted that:

- The CCG's commissioning plans are intrinsically linked to the Better Care Fund plan. The CCG will submit its Operating Plan with the Better Care Fund Plan to NHS England on 4 April 2014.
- There has been discussion on the CCG's commissioning priorities across the Health and Wellbeing Board sub-groups
- The two year Operating Plan is being used as an opportunity to take forward primary care improvements
- Quality of care issues arising from the Francis Report are picked up in the commissioning plans.
- The Operating Plan reflects the CCG's financial position. The Board noted that the CCG must deliver savings of £10 million in 2014/15.

Cllr Worby (Chair of the Board) wanted to see more detail about the Operating Plan at this stage of the process and requested that the draft plan is shared with Board Members in advance of the 25 March meeting, or informal meetings between the CCG and partner organisations are arranged to give early sight of the content of the Plan. Having only been given the priorities to consider the CCG cannot expect Board Members to have confidence in the quality of the plan or that the detail within it has regard for the wider partnership's objectives.

John Atherton (Head of Assurance, NHS England) advised the Board that NHS England is working to bring together specialist, primary care, and CCG-led commissioning to make commissioning seamless and ensure that there are no gaps in care pathways or service provision.

Anne Bristow (Corporate Director, Adult and Community Services) commented that the planning process is very NHS-centric. It is challenging to develop truly

local plans when NHS England sets very rigid specifications for the CCG's Commissioning Plans. Anne Bristow was sympathetic to the timescales and process to which the CCG is bound. Anne Bristow asked that the CCG remembers to consult thoroughly with partners on its plans before submitting them to NHS England otherwise there is a risk that partners will feel unable to influence the content of the plans.

Conor Burke stated that the CCG is still in its infancy an organisation making it hard to develop its plans in a way that is fully aligned with those of the Council. This is compounded by having to operate in a complex commissioning framework where responsibilities for certain areas rest with different organisations or at different levels within the NHS. The CCG aims to get to a position where its plans will feel more local and aligned to the strategic objectives of the borough. As governance develops and the health and social care economy integrates further, shared decision-making and shared ownership of issues will follow.

Marie Kearns (Healthwatch) updated the Board on engagement work done by Healthwatch on the CCG's priorities. Residents highlighted access to GPs, access to urgent care, early detection of cancer, and developing pharmacy services as their priorities for the CCG.

The Board agreed to:

1. Note the briefing on the strategic and operational planning process for 2014/15 to 2018/19
2. Comment on the issues being addressed within the Operating Plan and in particular the emerging priorities that have been identified
3. Receive the full draft of the Operating Plan at its meeting of 25 March.

88. Better Care Fund Draft Plan

Further to the report, Bruce Morris (Divisional Director, Adult Social Care) and Sharon Morrow (Chief Operating Officer, B&D CCG) gave a presentation to the Board, following which the points or issues below were raised:

- The Better Care Fund (BCF) plan for Barking and Dagenham will be aligned to the BCF plans for Redbridge and Havering also. The three BCF plans will dovetail the CCG's broader strategic plans which itself will have regard to the plans and strategies of each of the local authorities.
- 25% of BCF funds are performance related. There is a lack of guidance on the performance related elements of the BCF so it is difficult to know what would happen if the borough failed to meet is performance targets. It is doubtful that BCF funding would be withheld, further action plans to bring up performance is a more likely intervention.
- The situation at BHRUT is a significant risk to meeting the performance targets attached to the BCF. Hospital admissions and delayed discharges of care will need to be reduced to mitigate risk. The BCF plan is reliant on BHRUT's improvement plan being successful and has been designed to support the recovery of BHRUT.
- The Board wished for commissioning organisations to consult early with partners on de-commissioning intentions and set out alternative plans for service provision at the earliest opportunity. Members of the Board from provider NHS trusts felt that the stability of a 24 month planning cycle would

help their medium and long term planning.

- Consideration needs to be given about how Disabled Facilities Grants and money from the Troubled Families agenda is included within the BCF. It will be necessary to give more thought about how children's health and wellbeing outcomes are incorporated as more funding streams are rolled into the BCF.
- A recent event hosted by Healthwatch gathered feedback from residents about the content of the BCF plan. Generally residents were supportive of the vision. There was consensus among the Board that further engagement is needed in the future.
- Board Members noted the scale of savings required of the CCG and the Council over the next five years and recognised the challenge of further integration and pooling of monies for partnership working in this context.

Cllr Worby (Chair of the Board) felt that the draft plan was a good submission putting the borough in a strong position to submit a high quality final plan. Cllr Worby felt that a lack of guidance from the Department of Health was problematic for developing BCF plans.

The Board agreed the Better Care Fund Draft Plan (Appendix 1), allowing Barking and Dagenham to meet the national deadline for submission on 14 February 2014.

89. Public Health Commissioning Plan 2014/15

Matthew Cole (Director, Public Health) introduced the report, in doing so the Board noted the following key points:

- Partner organisations commission public health initiatives too, therefore discussion is needed to align plans. Key to this will be more effective delivery of the prevention agenda through General Practice and Primary Care.
- A funding gap is forecast for 2015/16 as it not yet confirmed what the borough's Public Health Grant settlement will be. Furthermore, Public Health does not know what Health Premium the borough will receive or what funding is attached to health visiting responsibilities.
- Public Health is looking to experiment with different models of service delivery to create behaviour change among residents. There will also be greater emphasis on prevention especially with regard to smoking and obesity.

Conor Burke (Accountable Officer, B&D CCG) identified early intervention in cancer as an area not addressed by the Public Health Commissioning Plan. It was noted that there is a high level of cancer diagnosis in A&E which needs to be addressed.

The Board discussed Public Health Grant spend on children's health and early year interventions. Matthew Cole advised that public health spend on children's initiatives will go up in 2015/16 as more resource is invested in sexual health,

school nursing and health visiting. Because there is uncertainty over the funding arrangements for health visiting Public Health has been prudent to set aside monies should funding not come with commissioning responsibility.

Mr Nicholas Hurst (a member of the public) raised concern that sexual health services were not well signposted, as such service users are being referred incorrectly. Matthew Cole supported the view that there is a problem with access to sexual health services. Although the service is integrated across the three boroughs (Barking and Dagenham, Redbridge, and Havering) the information about the services and how they can be accessed needs to be improved; it was suggested a directory of some kind would be useful.

Ms Christine Brand (a member of the public) suggested that commissioning plans should give greater emphasis to wellbeing and to make it more meaningful and embedded within commissioning plans. Ms Brand also suggested that there should be more balance between health outcomes and wellbeing outcomes in those plans.

Cllr Worby (Chair of the Board) highlighted a correction to table 1 (page 81 of the agenda pack). It was confirmed that the leisure offer for older people is for ages 60 years and over. Board Members were asked to disregard the misprint on the explanatory notes for that entry in the table.
The Board agreed to:

1. 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. 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.

90. End of Life Care Position Statement and Recommendations for Future Focus

Sharon Morrow (Chief Operating Officer, B&D CCG) introduced the report to the Board.

Helen Jenner (Corporate Director, Children's Services) reminded the Board of the importance of end of life care (EoLC) provision for children and requested that children's needs are considered when developing the EoLC offer locally. It was suggested that demand for hospices is outstripping capacity. Sharon Morrow confirmed that the Integrated Care Group will include children's EoLC needs within its scope of work.

Cllr Alexander (Cabinet Member for Crime, Justice and Communities) asked if the EoLC pathway and advanced care plans are sensitive to cultural wishes and requests, and to what degree families are involved with developing end of life options.

Anne Bristow (Corporate Director,) advised the Board that EoLC needs to recognise the difference between unexpected deaths of younger adults and death in old age, as the reaction and needs of the family will depend on the

circumstances in which the person died.

Cllr Reason (Cabinet Member for Adult Services and HR) asked if the Personal Assistant and Carer training provided by West and Coe Funeral Directors would be delivered on a larger scale. Bruce Morris (Divisional Director, Adult Social Care) confirmed there are plans to roll out the training. Anne Bristow suggested that local undertakers and the community and voluntary sector are given a more prominent role in developing the local EoLC offer.

Dr Mohi (Chair, B&D CCG) highlighted that end of life plans are sometimes not followed and there is a need to address the practical reasons why this happens. Sharing the end of life plan with family members is a key issue as sometimes a person's wishes are forgotten in emotionally fraught situations or moments of crisis. The use of 'Do not admit' cards was suggested along with messages in bottles as ways to raise awareness that a person has an end of life plan.

It was noted that the NHS system can sometimes work against EoLC plans as by nature people tend to seek medical intervention to preserve life, overriding previously laid plans; cultural change is therefore needed.

The Board is agreed to:

1. 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).
2. Request that the Integrated Care Group develops an action plan to bring back to the Board in June 2014

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

3. Establish a working group, with participation from front line practitioners, to drive forward the EoLC agenda and address the practical issues that can affect EoLC plans not being followed.

91. Summary of the New Ofsted Single Inspection of Services for Children

Meena Kishinani (Divisional Director, Strategic Commissioning and Safeguarding) gave a presentation to the Board. The presentation covered:

- The inspection process and the areas that are under assessment
- How the new framework differs from previous frameworks and issues arising for Barking and Dagenham
- The scope of the inspections and who will required to participate or be interviewed
- The implications of the inspection framework for the Local Children's Safeguarding Board
- Risks within the new inspection framework

Arising from the report and presentation the following issues and comments were made by Board Members:

- A disproportionate number of children enter social services through police protection. This is potentially high risk for the Borough's inspection result as well as distressing for the child.
- It will be important that children get their health assessment within the

specified 28 day timescale
- The borough will need to improve educational attainment for looked after children
- Underlying problems which result in social services intervention such as poverty, security of housing tenure, and domestic violence will need to be addressed
- GP attendance at Child Protection Conferences is poor. This is a risk because under the new framework the borough will need to demonstrate its multi-agency approach.
- Record keeping will need to be tighter to show inspectors that decision-making and case management is robust.
- A peer review is scheduled for May 2014 to test the system and test the frontline of children's services. This will be a useful stocktake and identify issues to be addressed before Barking and Dagenham's first inspection under the new framework.
- The Health and Wellbeing Board will need to explore ways in which it can link with the Local Safeguarding Children's Board as the inspectors will expect to find a strong relationship and coherence around work. Joint planning between the H&WBB and LSCB might be worth consideration.
- Inspections will have a greater focus on observing social care practice.
- If an inspection reveals an issue of concern it could trigger a further inspection of that agency or area. Partners should therefore be mindful that at all times during the inspection all areas of the system are under scrutiny.
- Children's Services are under pressure due to rising demand. Health services will need to respond to this and in particular may need to put more resources into psychological therapies.
- Early intervention through Health Visiting or School Nurses will be integral to robustness of safeguarding. Uncertainty over Health Visiting arrangements which are in transition is a risk.
- Conor Burke (Accountable Officer, B&D CCG) suggested that it would be helpful for NHS colleagues to understand the profile of need for children known to social services. This will help GPs and other health professionals to support and take forward the agenda for looked after children and safeguarding as the responsibilities of the NHS become more embedded in these areas.
- Dr Mohi (Chair, B&D CCG) added that it would be helpful to know also the numbers of children within the social care system. Meena Kishinani advised that at any given time Children's Services is working with 2,200 children, of these roughly 450 are looked after and a further 250 are on a child protection plan.

The Board agreed to:

1. 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.

2. Note the CQC health programme of reviews on safeguarding and looked after children running from September 2013 and April 2015.

92. CQC Inspection of BHRUT

Stephen Burgess (Medical Director, BHRUT) updated the Board on actions taken by BHRUT since its inspection report was by the CQC. The Board noted the appointment of Steve Russell (Improvement Director), progress in developing an improvement plan, and some of the positive findings of the CQC.

Stephen Burgess drew the Board's attention to the difficulty the Trust faces in appointing clinical staff for the Emergency Department and how the special measures status has compounded this problem. To address this problem BHRUT is seeking to partner with Barts Health to attract applicants.

Helen Jenner (Corporate Director, Children's Services) offered support to BHRUT on behalf of the Local Children's Safeguarding Board. Objective scrutiny from partner agencies and bodies will assist with BHRUT's recovery programme. Helen Jenner felt it is important the Trust does not withdraw from partnership activities and keeps partner agencies involved throughout the recovery period, drawing in expertise and input where appropriate. It was noted that the Integrated Care Coalition has been involved in developing the Improvement Plan. The Trust welcomes support from partner agencies and views the plan as a shared document.

Cllr Worby (Chair of the Board) commented that the response from partners has been strong but wanted to see evidence of the Trust tackling its problems and sustaining improvement on longstanding quality issues. Cllr Worby also highlighted the finances of BHRUT as an intractable issue and suggested that BHRUT need to work closely with commissioners to provide its services in a way that supports the CCG to deliver system-wide changes to improve the health and social care economy.

The Board agreed to invite Steve Russell to present the Improvement Plan and progress against delivery.

93. The Francis Report

Conor Burke (Accountable Officer, B&D CCG) introduced the report to the Board. It was noted that the task and finish group's work is drawing to a close. The group will report its progress publicly and agree the next phases of taking forward the Francis Report recommendations. Key tasks include establishing how the partnership can develop assurance mechanisms to detect shortcomings in the quality of care, and deciding what will be the ongoing response to the Francis Report once the task and finish work is completed.

The Board asked if the Action Plan has been reviewed since BHRUT has been placed on special measures by the NHS Trust Development Authority. Conor Burke advised that the CCG has been well sighted on the findings of CQC and as such the special measures status and other judgments of the CQC has had little bearing on the content of the Action Plan which is comprehensive and takes account of BHRUT quality issues.

Anne Bristow (Corporate Director, Adult and Community Services) highlighted discussion which took place at the Health and Adult Services Select Committee about taking individual responsibility and positive action to challenge bad practice when encountered. Conor Burke agreed that the task and finish group will need to

reflect on how individuals can be empowered and how to create genuine collective responsibility in health and social care post-Francis.

Conor Burke asserted that BHRUT was not comparable to Mid-Staffordshire as the system as a whole is much stronger. BHRUT is distinct from Mid-Staffordshire because the collective governance of the health and social care economy is more robust and there is a greater level of focus and scrutiny on quality of care.

The Board agreed to:

1. 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
2. Discuss the implications for Barking and Dagenham and propose any further actions the Board agrees are required.

94. Progress on Winterbourne View Concordat

Stephan Brusch (NHS England) updated the Board on London-wide progress in implementing the Winterbourne View Concordat. The Board was given assurances that placements and care plans are being scrutinised and people are being moved into a community setting, where it is appropriate to do so without disruption or upheaval. Where people are being cared for in an inpatient setting those individuals are receiving support. This work is being overseen at a national level by an Enhanced Quality Team of NHS England.

The Board noted the establishment by NHS England of a Specialist Commissioning Unit to give support to London boroughs. An event has been held to tease out local barriers to implementing the Concordat and feedback from stakeholders is being used to inform the London action plan.

Stephan Brusch commented that Barking and Dagenham's response to Winterbourne View has been strong. When the self-assessment framework was reviewed by NHS England Barking and Dagenham showed a good focus on health outcomes. Stephan Brusch encouraged the borough to show progress against integration outcomes in order to take delivery of the Concordat to the next level.

Anne Bristow (Corporate Director Adult and Community Services) highlighted the challenge of meeting a large spectrum of need for roughly 160 people. Specialist need cannot be wholly met using borough resources; partnership working is therefore required within the sector and North East London region to deliver parts of the Concordat. Other challenges the Board noted were developing pooled budgets through section 75 agreements and that the Council has recently replaced its commissioning officer responsible for overseeing the Concordat.

Anne Bristow confirmed to the Board that the small number of inpatient placements for Barking and Dagenham have been reviewed by the Divisional Director of Adult Social Care and the Chief Operating Officer of the CCG. The Joint Strategic Plan, when presented to the Board in March, will give further detail and assurance as to the borough's position. It was noted that the timescales for delivering the Concordat are challenging but work is well advanced and it is expected that the local plan will be robust and credible having undergone a quality assurance process through NHS England.

The Board agreed to:

1. Note the progress that the Borough has made in achieving the actions set out in the Winterbourne View Concordat since it last briefing.
2. Note the Winterbourne View ‘stocktake’ document which has been produced for the Winterbourne View Joint Improvement Programme.
3. Note the identified risks and mitigation plans.

95. Obesity Summit

Matthew Cole (Director, Public Health) introduced the report to the Board and confirmed that the Public Health Team has commenced work to deliver the actions outlined in the report.

The Board commented on the success of the event, and following its outcomes agreed to:

1. 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. 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. 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. 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. More assertive promotion aimed at increasing the communities use of green spaces, and continue our local planning regime to improve the health promoting environment.

96. Waiver of Standing Orders for Public Health Contracts

The Board agreed to:

1. Waive the requirement of the Council Contract Rules that requires LBBD 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.

97. Sub-Group Reports

The Board noted that the Mental Health Sub-group now has ongoing participation from a GP. The group is now pursuing NHS England representation. John Atherton (Head of Assurance, NHS England) offered to assist with this process.

In response to the matter escalated by the Learning Disability Partnership Board, the Chair resolved to write to the Job Centre Plus about the support it gives to people with learning disabilities as it is likely that these issues are not uniquely local to Barking and Dagenham.

The Children and Maternity Sub-group highlighted that clarity is needed on the performance framework for the sub-groups. Also the group is confused as to the funding arrangements for Health Visitors having received conflicting information from different parts of the system. It was suggested that the Board writes to NHS England to have the funding arrangements explained.

The Board noted the Sub-group reports (Appendices 1 - 5).

98. Chair's Report

The Board noted the report.

99. Forward Plan

The Board noted the report.

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 25 March 2014
(6:00 - 6:02 pm)

Present: Councillor M M Worby (Chair), Stephen Burgess, Matthew Cole, Anne Bristow, Frances Carroll, Martin Munro, Dr Waseem Mohi (Deputy Chair) and Conor Burke

Apologies: Councillor J L Alexander, Councillor L A Reason, Councillor J R White, Helen Jenner, Dr John, Chief Superintendant Andy Ewing and John Atherton

100. Apologies for Absence

In accordance with the Council Constitution (Part B, Article 5, paragraph 4) the meeting was declared inquorate, at which point the meeting was closed.

Decisions required of this meeting, as listed in the reports, will be passed to the Chief Executive of the Council in order that the 'Urgent Action' provisions of the Council Constitution (Part B, Article 1, paragraph 17) can be enacted.

The Board Members in attendance discussed the agenda items informally.

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HEALTH AND WELLBEING BOARD

17 June 2014

Title:	The Health and Wellbeing Board as a Committee of the Council

Report of the Chief Executive

Open	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: John Dawe, Group Manager, Democratic Services	**Contact Details:** Telephone: 020 8227 2135 E-mail: john.dawe@lbbd.gov.uk

Sponsor:

Chair of the Health and Wellbeing Board

Summary:

The Health and Social Care Act 2012 conferred a range of statutory powers and functions on the Health and Wellbeing Board forming an integral part of the Council's overall political structure. This means that all Board meetings are conducted in accordance with the Council's Constitution and that, by and large, Board Members share a similar status with Councillors and Co-opted Members of the Authority, and are therefore bound by certain codes and protocols.

In order for Members of the Board to understand what that status means in practical terms and learn more about the governance arrangements and meetings procedure, John Dawe (Group Manager, Democratic Services) will give a brief introduction to the Council's political structure, the governance of the Board, and explain the standing orders that underpin the mechanics of Board meetings.

This presentation is supplemented by a welcome pack so that Board Members have this information for future reference. Much of the information being presented can be found in the Council's Constitution which can be found here.

http://www.lbbd.gov.uk/CouncilandDemocracy/EthicalGovernance/Documents/Const-full.pdf

Recommendation(s)

The Health and Wellbeing Board is asked to:

- note the status of the Board as a statutory Committee of the Council with the authority to take executive decisions
- note that meetings of the Board will be conducted in accordance with the Council's Constitution

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HEALTH AND WELLBEING BOARD

17 JUNE 2014

Title:	**Healthwatch Annual Report 2013/14**
Report of Healthwatch Barking and Dagenham	
Open Report	**For Information**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Marie Kearns, Chief Executive, Harmony House	**Contact Details:** Tel: 020 8526 8200 E-mail: mkearns@harmonyhousedagenham.org.uk

Sponsor:

Frances Carroll, Chair of Healthwatch Barking and Dagenham

Summary:

This report is for Members to see the progress of Healthwatch Barking and Dagenham.

This paper is a summary of Healthwatch Barking and Dagenham Annual Report. It outlines the work that has been undertaken by the Healthwatch team this year, highlighting achievements and challenges.

Recommendations

The Health and Wellbeing Board is recommended to:

(i) Consider the report noting the progress made in the last year.

(ii) Discuss the difficulties that Healthwatch have experienced in receiving feedback/communications from Member organisations as discussed in Section 4 of the report

Reason(s)

To bring to the attention of the Board trends in public opinion with regard to health and social care services of Barking and Dagenham. To advise the Board of any identified gaps in service provision and to be able to influence commissioning in a timely way.

1. Background and Introduction

1.1. Healthwatch Barking and Dagenham has been in place since the 1st April 2013. Although it is an independent organisation, it is delivered through the general governance arrangements of Harmony House Community Interest Company. This has allowed Healthwatch to develop faster than other local Healthwatch organisations.

1.2. One of the first local Healthwatch organisations in London to do so, Healthwatch Barking and Dagenham had its professional launch in May 2013 which was attended by Patrick Vernon OBE from Healthwatch England. Healthwatch have regularly taken our seat at the Health and Wellbeing Board and being represented at all of the Board sub-groups.

1.3. Healthwatch Barking and Dagenham has used a hub and spoke model as a way of engaging the community in the management and delivery processes. Local groups can become Healthwatch Associates. Currently there are 20 associate groups covering a wide range of interests.

1.4. Healthwatch Barking and Dagenham is governed by an Executive Board comprising of a chair, four executive directors and two associate directors.

1.5. Healthwatch has, throughout the year, set up opportunities to listen to views from local people and organisations by hosting public consultation events. As part of this Healthwatch has undertaken surveys around specific needs and service provision, as well as carrying out enter and view visits in both hospital and residential care settings. This has provided Healthwatch with invaluable intelligence and helped it to highlight local trends.

1.6. Positive outcomes from Healthwatch's representation have included carers being able to go into hospital to provide care, 0844 phone numbers no longer being used by GP surgeries and recommendations from Healthwatch's Dental Report regarding children's dental health being incorporated into the Health and Wellbeing Strategy. Healthwatch has also experienced several challenges throughout the year.

2. Public Consultation

2.1. Healthwatch had a public launch and two public events. All three were a success and over 600 people were engaged in total. We have had 20 outreach stands in various places across the borough including libraries, supermarkets, health centres, Children’s Centres and Youth Club provision. This has ensured that the local community’s views on the services they access have been captured.

2.2. From ‘your voice’ cards and other communication many people were keen to tell Healthwatch about their experiences of using local health and social care services. Over 50 % wanted to tell Healthwatch about their GP service. Over half of these had negative experiences. There was over 35% who shared their experience of hospital services. Over half of which were negative. We had a small number of individuals who shared their experiences of social services and the feedback also shows that over 60% of those had a negative experience.

2.3. Healthwatch has taken 105 calls and emails from the public requesting advice and signposting. The calls consisted of individuals wanting to know how to make a

complaint, where to go for benefit advice, issues relating to GP practices, and other signposting requests.

2.4. Healthwatch consulted with 200 people on the closure of Broad Street Walk-in Centre. The majority of patients said they would rather see their GP than visit a walk-in centre. However these patients attend walk-in centres because they are unable to get a timely appointment with their GP. The response from Healthwatch Barking and Dagenham and others to the Clinical Commissioning Group's (CCG) consultation on the proposed changes to urgent care services resulted in change. The CCG ran a pilot offering 25,000 extra urgent care appointments as part of a new way to provide urgent care by family doctors.

2.5. Healthwatch has a website and continues to use Facebook, Twitter and Streetlife as a means of communicating with the public.

3. Progress against workplan

3.1. This year Healthwatch has undertaken five Enter and View Visits and trained seven representatives.

3.2. The first visit was to Sunrise Wards A&B at Queen's Hospital, Romford. Our report made nine recommendations which were all accepted by the hospital. Examples; patients have emergency call buzzers positioned where they can be reached. Patients with personal budgets are now able to use their home care staff in the hospital setting.

3.3. Three social care visits were undertaken. One was announced and two were unannounced. These were at Darcy House, Cloud House and Look Ahead. One of the visits resulted in a safeguarding alert being made. Healthwatch is continuing to have discussions with one provider about their catering service as they feel that food is not part of health or social care but as part of tenancy agreement.

3.4. Healthwatch undertook a project on the experiences of young people accessing dental services. The dental report found that there is still much work to be done in getting the 40% of all of the borough's young people, who do not attend the dentist, to understand the importance of regular dental care. The report was presented to the Public Health Programmes Board who accepted the recommendations which are included in the next iteration of the Public Health Commissioning Strategy.

3.5. At the request of the Health and Adult Social Services Select Committee, Healthwatch looked at the support needs of young diabetics. Overall the findings showed that the experience of services was generally good, however changes need to be made so that information on diabetes is tailored appropriately to that age group. The findings also showed that 38% of the respondents never had their weight checked.

3.6. Healthwatch also looked at the how young adults with type 2 diabetes could be supported in the borough. Overall the responses showed that the experience of services was good. However areas of improvement included the promotion of available courses to diabetic patients. There is also the need to revisit the Council's exercise programme and reconsider the times sessions are held to enable individuals to fit the programme around their working life.

3.7. Healthwatch Barking and Dagenham undertook a survey at two care homes and a health care department to find how easy it is for staff to raise concerns and "whistle blow" when the behaviour of colleagues is observed to be inappropriate and where the basic principles of care do not conform to an acceptable standard. This project is

still ongoing as there has been difficulty getting surveys back from the 200 employees who were invited to respond.

3.8. The Special Educational Need project did not go ahead as this would have duplicated the consultation that the Council were undertaking on the local offer.

3.9. The personal budget survey was undertaken due to public consultation. The findings, in the format of a final report, will be going to the Learning Disability Partnership Board for the September 2014 meeting.

3.10. Due to Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) placing new discharge policies and processes in place, the Healthwatch Board felt the project on elderly discharge should discontinue as it would not be possible to see the real impact of the new service until it has had time to settle.

3.11. Healthwatch wanted to find out the views and experiences of local people who had been discharged from the stroke service. Information gathered so far shows a wide disparity in the service provided. This work will continue in 2014/15.

3.12. In addition to the work plan we undertook three further areas of work.

3.13. Healthwatch organised workshops focused on the Community Treatment Teams and the Better Care Fund. Over 70 people attended the event. North East London Foundation Trust (NELFT) and the CCG have taken into account the issues raised during the workshops. One aspect was the publicity of the new services. Information leaflets have been developed for patients explaining the new services and how they work.

3.14. It came to our attention that at least 9 GP practices were still using 0844 numbers. The cost of using the 0844 numbers is high compared to using local telephone numbers and disadvantaged many low income patients. Healthwatch Barking and Dagenham highlighted the issue to the CCG. This has resulted in GP practices dropping the 0844 number in favour of the cheaper local telephone numbers.

3.15. The pilot surge appointments were designed to offer 25,000 extra urgent appointments through local GP practices. Information gathered so far shows that 16,548 appointments have been offered so far. However Healthwatch requested information under Freedom of Information Act and only 17 GP practices have complied with our request for information. This has been one of Healthwatch's challenges.

4. Challenges

4.1. Originally Healthwatch wrote to the 39 GP practices who were part of the surge urgent care appointments system. Only two replied. All practices were contacted again but the response was still poor. A Freedom of Information request was then sent to all the 41 practices, the response was still extremely slow and to date we have only received 17 responses. Healthwatch is now pursuing this matter further.

4.2. In order to identify patients being discharged through the stroke service, Healthwatch asked NELFT and BHRUT to contact patients on our behalf. This has resulted in NELFT saying it would have to be referred to their governance committee. The last communication with them was on the 20 November 2013, there has been no correspondence since. BHRUT were waiting for a new member of staff to be recruited and could not help at the time. Healthwatch has had no communication with BHRUT since then. This has resulted in writing to Matthew Hopkins, the newly appointed Chief Executive, for his help in this matter.

Healthwatch will continue to pursue this matter further.

4.3. There have been challenges with the care providers, in particular Darcy House, where it has been difficult to find out who is responsible for providing the residents with food. It transpired that it was part of the resident's tenancy agreement. As a result neither the social care provider or the landlord felt it was their responsibility and therefore thought it should not be part of the enter and view report. Despite this, Healthwatch have pursued the matter as not all residents were happy with the standard of food.

5. Networks and Partnerships

5.1. During the year Healthwatch staff and volunteers have represented local people's voices on various statutory committees as well as the Health and Wellbeing Board and have facilitated events supporting the CCG and NELFT.

5.2. We have a seat on the Safeguarding Adults Board and have been asked to work in partnership with the Board next year to engage with the local community to find out if residents know how to recognise and raise a safeguarding concern.

5.3. The team has attended over 300 meetings between them.

6. Mandatory Implications

6.1. **Joint Strategic Needs Assessment**

When developing our work stream Healthwatch Barking and Dagenham has been mindful of the content and data in the Joint Strategic Needs Assessment (JSNA). In particular the work to be completed on the care of Stroke sufferers reflects the high priority and inequalities associated with this condition for people in Barking and Dagenham. The findings of the dental report have also been similar to the JSNA findings.

6.2. **Health and Wellbeing Strategy**

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

6.3. **Integration**

Healthwatch Barking and Dagenham is particularly interested in helping to promote integrated working between health and social care services. This is reflected in many of the topics which were chosen for the 2013/14work plan such as stroke services and diabetes services for children and younger adults.

6.4. **Financial Implications**

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

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

6.5. **Legal Implications**

Under the Health and Social Care Act 2012 Healthwatch Barking and Dagenham has the power to undertake announced or unannounced 'enter and view' visits to health and social care services.

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

6.6. **Risk Management**

All those undertaking Enter and View visits are approved representatives who have undertaken training.

6.7. **Patient/Service User Impact**

The Healthwatch work programme is designed to reflect the views of service user experience of the health and social care services in Barking and Dagenham. By reporting back the views of the public to this and other relevant Boards Healthwatch can ensure that the consumer is at the heart of all decisions that are made about their health and wellbeing.

7. Non-mandatory Implications

7.1. **Safeguarding**

All staff and volunteers of the Healthwatch team are given awareness training on safeguarding issues. A Healthwatch representative sits on the Safeguarding Adults Board. Through one of the enter and view Visits a safeguarding alert was made.

7.2. **Property/Assets**

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

7.3. **Contractual Issues**

Healthwatch Barking and Dagenham is commissioned by the Local Authority and is funded until March 2015.

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

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

None

7.5. **List of Appendices**

- Appendix 1: Healthwatch Annual Report 2013/14

healthwatch

Barking and Dagenham

Our Achievements

Broad Street Walk in Centre

200 people consulted on the closure of Broad Street Walk In Centre.

Majority of patients said they would rather go to their GP then a Walk In Centre but are unable to get an appointment.

The response from Healthwatch Barking and Dagenham and others to the CCG consultation on the proposed changes to urgent care services resulted in change.

The CCG offered to make a minimum of 25,000 extra urgent appointments available later in the year, as part of a new way to provide urgent care by family doctors.

5 Enter and View visits conducted this year!

Sunrise A and B Frail and Elderly Enter and View Visit:
As a result of the recommendations patients have emergency call buzzers positioned where they can be reached, be consulted on who helps them with their personal hygiene needs and have changes to their health and treatment explained to them more clearly by medical staff.

Patients with personal budgets that provide staff to assist them at home will now be able to have those staff more closely involved in their hospital care.

Dental Report

Our dental report found that there is still much work to be done in getting the 40% of all of the borough's young people, who do not attend the dentist, to understand the importance of regular dental care.

From the findings 3, recommendations were made. One of the recommendations was *"To encourage regular brushing of teeth at an early age, all B&D Children aged between 3 and 5years are given a free toothbrush, with a written reminder to parents to take their children to the dentist every 6 months whether they need it or not."*

The report and findings were presented to the Public Health Programmes Board. The Public Health Programmes Board agreed that the recommendations would be included as part of the Public Health Strategy.

Our Achievements

Workshops on the Community Treatment Teams and the Better Care Fund.

Over 70 people attend event commissioned the CCG .

Workshops took place at the event which gave local people a chance to understand what the Better Care Fund is and what the Community Treatment Teams mean for the local community. NELFT and the CCG have taken into account the issues raised during the workshops and now have taken steps to improve some of the aspects that were discussed.

One of aspects was marketing and communication of the new services. Information leaflets have been developed for patients explaining the new services and how they work. These are available at community rehabilitation units, hospitals and are handed to patients.

084 GP telephone numbers

Healthwatch Barking and Dagenham was alerted by a number of concerns raised by local people about the cost of using 084 pre-fixed telephone numbers when needing to contact their GP practices.

The concerns raised by local people about this issue have been addressed by Healthwatch Barking and Dagenham through working with the Clinical Commissioning Group to bring about change in the way this service is delivered by some local GP practices.

Providers of GP telephone systems have moved GPs to geographic-rate 01, 02 or 03 numbers.

Barking & Dagenham Clinical Commissioning Group (B & D CCG) acknowledged patients' concerns in response to Healthwatch raising this issue with them.

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You can download this publication from www.healthwatchbarkinganddagenham.co.uk

Contents

Setting the scene

Foreword 2

About us

Healthwatch Network 5

Healthwatch Barking and Dagenham 6

Healthwatch powers 7

Our structure 8

Our projects

Children's dental health 13

Diabetes project 14

Consultation on closure of Broad Street and the Surge Scheme 16

GP Practices Use of 084 Telephone Numbers 18

NELFT Quality Accounts 19

Barking Havering Redbridge Trust Quality Accounts 20

Care Closer to Home 22

CCG priorities and The Better Care Fund 23

Duty of Candour 24

Stroke Discharge 25

Personal Budget Project 26

Reports and Recommendations 26

Freedom of Information Requests 27

Enter and View

What is Enter and View 29

Authorised Representatives 30

Visits undertaken 31

Volunteering 35

Out and About, Communication and Engagement

Communication 37

Out and about in Barking and Dagenham 38

Networks and Partnerships 42

Income and Expenditure 44

Looking forward 45

Foreword

Frances Carroll
Chair
Healthwatch
Barking and Dagenham

Welcome to the first annual report of Healthwatch Barking and Dagenham .

We are pleased to be able to highlight both the successes and challenges Healthwatch has experienced in its first year here in Barking and Dagenham.

A vital part of Healthwatch's role is representing the views of people who use health and social care services to commissioners and service providers.

Healthwatch has, throughout the year, set up opportunities to listen to views from local people and organisations by hosting public consultation events, undertaking surveys regarding specific needs and service provision, as well as carrying out enter and view visits in both hospital and residential care.

This has provided Healthwatch with local intelligence highlighting trends and evidence gained from local people and organisations. The information has enabled us to focus our work plans on the issues of concern, which are referred to in this report.

This intelligence also enables Healthwatch to present feedback to commissioners of local services and influence future planning, giving local people a voice in their futures, particularly at a time of rapid change within the NHS and social care.

During the year Healthwatch staff and volunteers have represented local people's voices on various statutory committees as well as the Health and Wellbeing Board and have facilitated events supporting the Barking and Dagenham Clinical Commissioning Group (CCG) and North East London Foundation Trust (NELFT).

This has given Healthwatch the opportunity to become established as representing local people's voice and influencing statutory decision making.

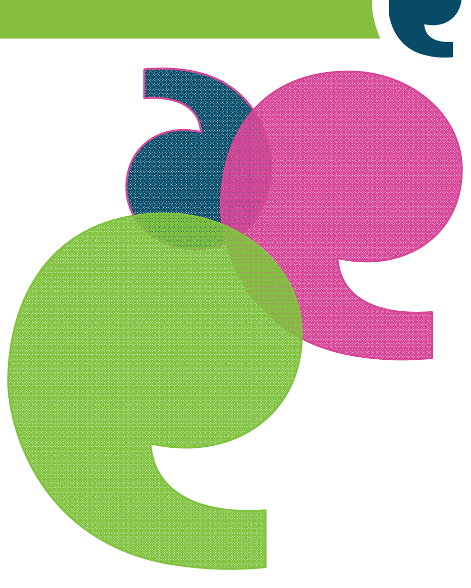
Positive outcomes from Healthwatch's representation have included carers being able to go into hospital to provide care, 0844 phone numbers no longer being used by GP surgeries and recommendations from Healthwatch's Dental Report regarding children's dental health being accepted.

Healthwatch has also experienced its challenges throughout the year which are referred to in the report, not withstanding difficulties with accessing information and there remains barriers to overcome in the coming year.

Barking and Dagenham Healthwatch's engagement throughout the year with local service users, as well as local organisations, has helped us to focus our work plans for the coming year.

We look forward to continuing with these work plans in the year ahead and working with the local community, commissioners and service providers to ensure responsive and effective health and social care for our community in Barking and Dagenham.

About Us



Healthwatch Network

Healthwatch Barking and Dagenham is a local organisation within a national Healthwatch England framework. We champion the views of local people on health and social care services.

Healthwatch England is nationally focused. There are 152 community focused local Healthwatch organisations. Barking and Dagenham is one of these.

Together we form the Healthwatch network, working closely to ensure consumers' views are represented nationally and locally.

Healthwatch England

Healthwatch England gives a national voice to the key issues that affect children, young people and adults who use health and social care services.

Healthwatch England gathers intelligence of trends and consumer experiences at a national level, based on evidence gained from people who use the services nationally and locally, information shared by local Healthwatch and evidence gathered from other partners.

All of this evidence is used to highlight major issues and seek change in the policy, regulation and delivery of health and social care services.

Where very important issues arise, they are raised with the Secretary of State for Health, the Care Quality Commission, the NHS Commissioning Board, Monitor or local authorities in England. By law they have to respond to what Healthwatch England has to say.

Healthwatch Barking and Dagenham

Healthwatch Barking and Dagenham is all about local voices being able to influence the delivery, quality and standard of local health and social care services. We believe that every voice counts when it comes to Shaping services for today and improving them for the future.

We:

Are inclusive and reflect the diversity of the community it serves.

Alert Healthwatch England to concerns about specific care providers, who can recommend further action from the Care Quality Commission (CQC).

Listen to people who have concerns or who want to complain about NHS services or other health and social care provision.

Provide authoritative, evidence based feedback to organisations responsible for commissioning or delivering local health and social care services.

Have a seat on the Barking and Dagenham Health and Wellbeing Board, ensuring that the views and experiences of patients, carers and other people, who access services, are taken into account when local needs assessments and strategies are prepared.

(Health and Wellbeing Boards bring together the NHS, Public Health, Clinical Commissioning Group (CCGs) Adult and Children's Services, councillors and local Healthwatch, to improve and plan how to best meet the health and wellbeing needs of the local community and reduce inequalities.

Provide people with information about their choices and what to do when things go wrong.

Enable people to share their views and concerns about local health and social care services such as GPs, dentists, hospitals, day care services and care homes.

Provide Barking and Dagenham Clinical Commissioning Group with information and recommendations about services.

WE believe that people using the services are best placed to tell us and share

Healthwatch Powers

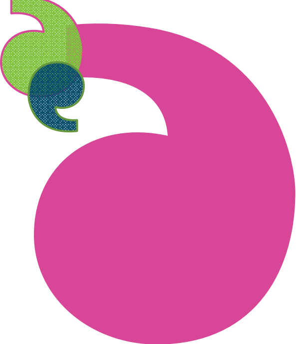
Under the Health and Social Care Act 2012
Healthwatch Barking and Dagenham have the powers and functions below :

By law service providers and commissioners must respond to requests of information in 20 working days.

By law service providers and commissioners must respond to any recommendations we make within 20 working days.

Service providers must allow entry to Authorised Healthwatch Representatives to conduct announced or unannounced 'enter and view' visits to assess services.

A seat on the Health and Wellbeing Board, to promote health improvements and tackle health inequalities.



Overview

Harmony House CIC, won the tender for Healthwath Barking and Dagenham.The policies and procedures of Harmony House have been adopted by Healthwatch Barking and Dagenham. This includes the confidentiality policy,equal opportunities and volunteering policy.

Our Structure

Hub and spoke model

One of the requirements within the tender process was to have a Hub and Spoke Model.

Healthwatch is the HUB and the associates and local community are the spokes, telling us their views on health and social care services.

Associates

To ensure that the voices of the local community are heard we have Healthwatch Associates.

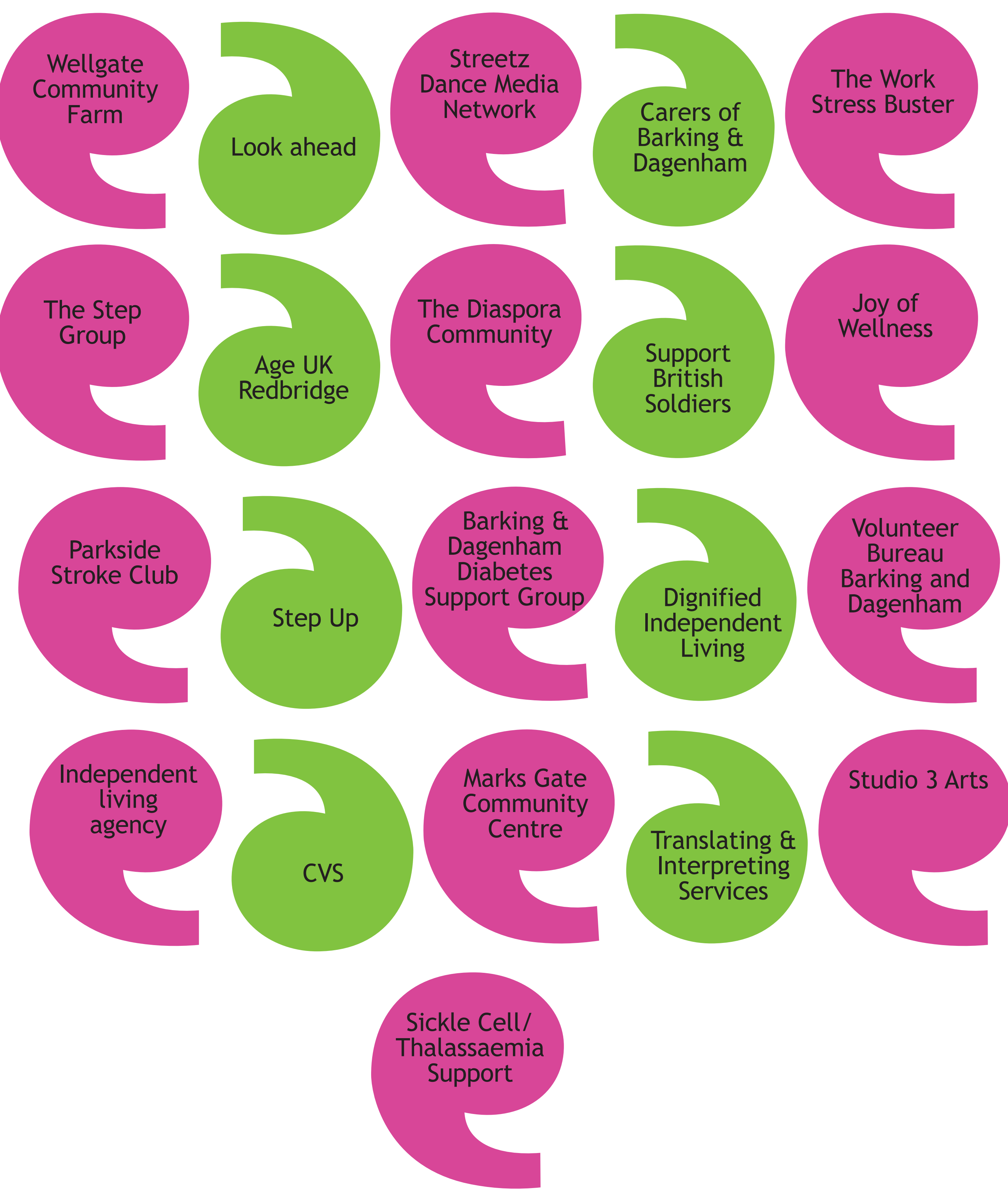
Associates are well established interest groups that have formed around their member's common bond as service users of either health or social care services. We keep our associates up to date with local and national news who then disseminate this information to their service users.

Some of our Associates hold databases on other organisations and service users. This enables Healthwatch to reach a good diversity of the community.

Participants

We do not have a membership for individuals, however we do have a participants list. This is a database of the local people who have attended a Healthwatch event, spoke to us at one of our stands or contacted us in one way or another. We send them regular emails with updates and information on forthcoming events if they choose to stay involved.

Our Associates



Executive Board,staff and volunteers

Our structure looks to ensure that local residents and stakeholders can influence how decisions are made and what priorities are taken forward.

The Board takes the strategic lead in developing priorities of Healthwatch Barking and Dagenham ensuring the views of the community are listened to.

The Executive Board is set up with 8 seats. Membership is broken down into two main areas to ensure broad representation. This includes the Chair, Executive Directors and Associates.

Executive Directors

There are 4 seats for Executive Directors. These seats are open only to individuals and not organisations or groups.

Each Director represents one of the areas below:

- Health
- Social Care
- Children and Young People
- Older people

Associates

There are 3 seats for Associates. These seats are for organisations or groups representing a particular health/social care issue.

Staff

The Chief Executive of Harmony House is the Contract Manager for Healthwatch.

We have two staff members who are Healthwatch Officers.

The Board

Frances Carroll Chair	Barbara Sawyer Executive Director Adults and Older Peoples Representative	Grace Kuku Associate	Lorraine Goldberg Associate

Becoming a Board member .
We are currently recruiting for Executive Board Members .
Contact us for more information.

Meet the Staff

Marie Kearns
Contract Manager

Manisha Modhvadia
Healthwatch Officer

Richard Vann
Healthwatch Officer

Our Projects

Children & young peoples Dental Health

Our recommendations were taken into account and are now part of the Public Health Strategy!

We found that statistics reflected there was a constant 60% of children and young people who access dental services in Barking and Dagenham.

We undertook a survey of 157 local young people to discover their views on going to the dentist and better understand why 40% do not attend at all. We looked at the general dental health of children and young people in the borough and what their views are of the dental services available. Young people who went to the dentist found the service to be easy to access and the practitioners friendly and reassuring.

We found however, that there is still much work to be done in getting the 40% of all of the borough's young people, who do not attend the dentist, to understand the importance of regular dental care.

From the findings 3, recommendations were made.

One of the recommendations was

"To encourage regular brushing of teeth at an early age, all B&D Children aged between 3 and 5years are given a free toothbrush, with a written reminder to parents to take their children to the dentist every 6 months whether they need it or not."

The report and findings were presented to the Public Health Programmes Board.

The Public Health Programmes Board agreed that the recommendations would be included as part of the Public Health Strategy.

Diabetes Project

At the request of the Health and Adult Social Services Select Committee, Healthwatch undertook two projects.

The first project was to look at how young people with diabetes could be supported in the borough.

The second project was to look at how young adults with type 2 diabetes could be supported in the borough.

Children and young people

Healthwatch Barking and Dagenham has undertaken a survey of children up to the ages of 16 to find out what their experience has been like whilst accessing diabetes services and what their support needs are.

Healthwatch worked with the Diabetes Paediatric Service at BHRUT and sent out the questionnaire to the 90 registered service users. All 90 live in Barking and Dagenham.

Overall the findings showed that the experience of services was generally good.

However there are some areas which could be improved to meet the needs of young people and children.

Young people felt that information about diabetes needed to be tailored around their age group.

The findings showed that 38% of the respondents never had their weight checked. Services for children need to ensure that all checks are carried out. If patients are not checked, complications will be difficult to prevent.

Young adults

Healthwatch Barking and Dagenham undertook this project to provide information about the support needs of younger adults and their experiences of diabetic services.

Overall, the responses showed that the experience of services was pretty good.

However there were areas of improvement around the support needs of diabetic patients.

Taking into account the feedback from respondents, Healthwatch made the following points to be considered:

Promotion of available courses needs to reach all diabetic patients and they need to be given the opportunity to attend.

Individuals would like an online forum where they can share their issues, exchange information, provide advice, receive advice and meet others who also suffer from type 2 diabetes.

Commissioners need to relook at the council's exercise programme and reconsider the times to enable individuals to fit the programme around their working life.

The findings have been incorporated within the Health and Adult Social Services Select Committee summary which will be presented to the Health and Wellbeing Board. Decisions will be made on the necessary actions that need to be taken. At the time of writing this report, no decisions had been taken.

Challenges

This project was specific to a target audience, for this reason we tried a number of times to get GP practices on board so that Healthwatch could send the surveys to their diabetic patients, however the GPs did not respond.

Healthwatch had asked GP practices via the CCG, to send surveys out to diabetic patients. Stamps and envelopes were being provided, and a member of staff would have been available to assist if GP practices did not have the staff to undertake the mail out.

However only 2 GPs responded and worked with Healthwatch to send the surveys out to their diabetic patients.

Healthwatch had asked the CCG to send out reminders to other GP practices and still we had no response from the GP practices.

We hope that GP practices will consider and look into why this happened and work with Healthwatch Barking and Dagenham in the future, to ensure that patients can have their say on health and social care services.

Consultation on the Closure of Broad Street Walk In Centre

Healthwatch undertook a survey with 200 members of the public to seek public opinion on the proposed closure of Broad Street Walk In Centre.

The majority of the 200 people consulted said they would rather see their own doctor for urgent care if they could get an appointment in a timely way. As most believed this was not going to happen, they wanted Broad Street to remain open.

There was also a clear message that the public is confused about the variety of terminology used to describe urgent care settings and when it is appropriate to attend which setting. This report was sent directly to the CCG and copies given to the Health and Well Being Board and the Health and Adult Services Select Committee (HASSC).

The response from Healthwatch Barking and Dagenham and others to the CCG consultation on the proposed changes to urgent care services resulted in change.

The CCG offered to make a minimum of 25,000 extra urgent appointments available later in the year, as part of a new way to provide urgent care by family doctors.

GP Urgent Care - SURGE Scheme

From October 2013 To March 2014, the clinical commissioning group commissioned GP practices in the borough to undertake a pilot scheme to provide **25,000** urgent care appointments **in addition** to the services they already provide.

Healthwatch Barking and Dagenham first wrote to participating GP services on the 9th December 2013, asking for responses to specific questions relating to the scheme referred to as 'surge'. Healthwatch received 2 responses to this request.

The Healthwatch Board decided that this was not an adequate response and so a formal request under the Freedom of Information Act (FOIA) was sent to all GP practices in the borough on the 17th March 2014 - whether participating in the scheme or not. GP practices were set the date for information to be returned by 21st April 2014.

Healthwatch asked for the following information:

- How many additional urgent care appointments is your surgery providing on average each day?
- Is your practice providing urgent care appointments in the evenings and at weekends?
- Who at your surgery decides what an urgent appointment is?
- What other services do you refer patients to as part of your urgent care pathway?
- Has your practice set waiting times for urgent care appointments and if so, how long are patients expected to wait to get an appointment?
- Can patients drop in at any time to your surgery and be seen as an urgent care patient?
- Is there an established Patient Participation Group at your surgery – if so, who is the lead person at your practice for this?

In response, Healthwatch received 17 written replies from the 41 Freedom of Information requests that were sent out. The level of response is not satisfactory.

From the responses received so far and based on the information provided by practices, Healthwatch Barking and Dagenham estimates that the pilot scheme has yielded **16,548** appointments. It is not clear whether these appointments are in addition to the usual appointments the practices provide.

The pilot scheme has been extended until the 30th June 2014.

Healthwatch Barking and Dagenham will continue to work with the Clinical Commissioning Group and the General Practices to obtain the information that represents and informs the public interest through the changes to urgent care services being provided at GP surgeries.

GP Practices in Barking & Dagenham Use of 084 Patient Contact Telephone Numbers

Healthwatch Barking and Dagenham was alerted by a number of concerns raised by local people about the cost of using 084 pre-fixed telephone numbers when needing to contact their GP practices.

The concerns raised by local people about this issue have been addressed by Healthwatch Barking and Dagenham through working with the Clinical Commissioning Group to bring about change in the way this service is delivered by some local GP practices.

In Barking and Dagenham, local Healthwatch found that 9 of the 40 GP practices in the borough (22.5%) were using 084 numbers for patients to contact them.

NHS England advised that they would contact the GP practices still using 084 numbers (8% Nationally) - via their Local Area Teams - to remind them that they would be in breach of contract if they 'do not take all reasonable steps' to stop using premium rate telephone numbers.

Providers of GP telephone systems have agreed to move GPs to geographic-rate 01, 02 or 03 numbers.

Barking & Dagenham Clinical Commissioning Group (B & D CCG) acknowledged patients' concerns in response to Healthwatch raising this issue with them.

North East London Foundation Trust Quality Accounts

Healthwatch Barking and Dagenham sent a response on 15th May 2013.

As Healthwatch was a new organisation, we were not in a position to respond to the request for a retrospective view ; however we raised the following:

"Looking forward, we are particularly interested to know what the Trust's strategy is concerning the engagement of the public and local community in Barking & Dagenham.

The single paragraph in the report about engagement doesn't give us much to go on; it would be very useful to have a 'bigger picture' on the Trust's commitment to this and how this will be achieved. Working with patients and other stakeholders; what are the Trust's proposals to ensure that processes are fully inclusive to everyone in the community?"

Healthwatch Barking and Dagenham are represented on the mental health sub- group of the Health and Wellbeing Board. Going forward, Healthwatch will be looking for opportunities where individuals who have experience of using local mental health services can represent and influence future mental health strategies and policies that could affect services for local people.

Healthwatch Barking and Dagenham were not provided with any response to the points raised about the trusts forward plan.

Barking Havering Redbridge Trust Quality Accounts

Healthwatch Barking and Dagenham were asked to feed into and provide a response to the trust quality account 2012/13. As a new organisation, Healthwatch could not provide a retrospective view on the services provided, however on the trust proposals for their forward plan, the following observations and comments were put forward:

Emergency and Urgent Care

“Does the 4 hour target for A&E include both sites across the Trust as they are presently, or is this only applied to Queens Hospital?”

“What steps will the Trust take to publicise the increase in use of the Urgent Care Centre? How will this information reach the community from Barking and Dagenham?”

“Does this include collaborating with the local Clinical Commissioning Group on proposals they may have for local urgent care pathways?”

“The proposal to reduce the length of stay in hospital beds; does this include commissioned bed services in local areas too e.g. Grays Court in Barking & Dagenham? If so, is there likely to be an estimate of how this will affect local social care services in Barking & Dagenham?”

“Does the discharge policy include weekends and if so, would more patient transport services be available at these times? How will this change in services be communicated in a way that patients will understand?”

Quality, Effectiveness and Safety Trigger Tool

“This is a positive move towards measuring and monitoring the quality of services; will this include measuring standards as well and how will this be communicated to patients so that they can understand?”

Friends and Family Test

"How is the Trust intending to communicate the outcomes from this to patients so that they will know how the test is working for them?"

Emergency Surgical Access

"The move towards 7 day working rotas for Doctors and Consultants; will the staff providing the extra time for services be employed by the Trust or will the Trust have to consider using bank or agency staff to cover this?"

Infection Prevention and Control

"The Trust target of MRSA zero tolerance against the backdrop of 95% control for elective and emergency patients; what measures and steps would the Trust intend to take to deal with the 5% that are not screened and could present a risk?"

"ANTT – what does this mean to patients and how will the Trust communicate what this means? Is it a measure that would be included in their care plan?"

"We look forward to your comments concerning the issues raised and that you give them due consideration when finalising your report."

Healthwatch Barking and Dagenham were not provided with any response to the points raised about the trusts forward plan.

Care Closer to Home

We were commissioned by Barking and Dagenham Clinical Commissioning Group to run two workshops, which were on :

1. The two new pilot services. The Community Treatment Team and The Intensive Rehabilitation Service.

2. CCG commissioning priorities for the next two years and the Better Care Fund.

The first workshop gave local people and organisations a chance to understand the new services that are being piloted, share their views and any concerns.

The event was well attended by over 70 local residents and organisations.

A presentation was delivered by Caroline White (Director of Adult services for NELFT). This was followed by a question and answer session allowing participants to ask specific questions.

Healthwatch then facilitated workshops to discuss specific questions.

From the discussions many valuable comments were received.

Some of the themes that emerged are listed below:

- The importance of team working and the good communication between stakeholders including the voluntary sector.

- Quick response times for service users.

- a greater emphasis on effective and clear communication and involvement with informal and formal carers.

NELFT have responded to some of the queries that were asked at the event, they have produced a “you said and we did sheet”, which highlights the steps they have taken, Some of these included:

- Developed information leaflets for patients explaining the new services and how they work. These are available at community rehabilitation units, hospitals and are handed to patients.

- Patients are triaged through the community treatment team, which makes sure patients go to the service that best meets their needs.

- Working with social care staff to trial different approaches to make sure social care needs, as well as physical and mental health needs, are met.

CCG priorities and The Better Care Fund

The second workshop gave the CCG an opportunity to:

- Update participants on progress the CCG have made in their first year
- Set out the key commissioning priorities for the next 2 years
- Get feedback on their plans and areas where the CCG need to improve services.
- Explain about the Better Care Fund and the views of this.

A presentation was delivered by Doctor John, on the priorities that have been set by the CCG.

Glynis Joffe from London Borough Barking and Dagenham also delivered a presentation on what the Better Care Fund is and the update so far.

A question and answer session took place after each presentation allowing the participants to ask questions to Sharon Morrow, Doctor John and Glynis.

Healthwatch also facilitated workshops and from these we found that the majority of participants did not have issues with the priorities that have been set. There were concerns about the implementation of these.

A number of themes occurred from the discussions these included:

Difficulty in booking GP appointments having an impact on diagnosis certain health and issues and referrals to services.

The need of services to work together including community and voluntary groups to ensure that patients are signposted to support services to enable them to take more responsibility of their health.

More information as to how funds are going to be spent and what services will be cut or reduced.

The findings from this event supported the CCG to better understand the concerns of the local community. Furthermore it was an opportunity to explain what the Better Care Fund is and how it will be funded.

Duty of Candour

The Francis report into Mid-Staffordshire Foundation Trust and investigation into abuse at Winterbourne View raised many concerns from service users and their families, relating to systemic failures in some health and social care services.

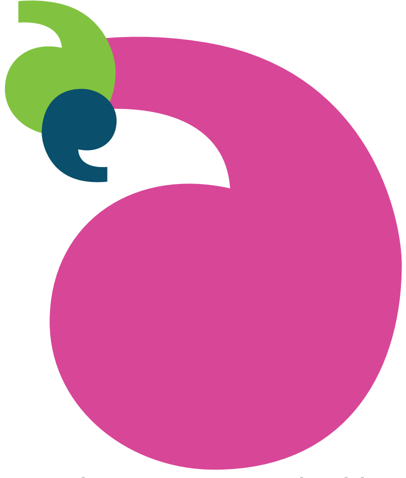
As part of a wider enquiry for work being undertaken by Healthwatch Barking and Dagenham, a survey was undertaken at two care homes and a health care department to find out and begin to understand how easy and open it is for staff to raise concerns and "whistle blow" when the behaviour of colleagues is observed to be inappropriate and where the basic principles of care are not being performed to an acceptable standard.

The following summary refers to feedback that Healthwatch has received so far:

5 (14%) of the respondents said there were no policies for staff to complain about bad practice or unacceptable behaviour by a colleague at work.

Of those that said they knew about their employer's "whistle blowing" policy; 20 (57%) said they found out about it either through face to face or computer based training.

6 (17%) people said they had used their work's policy - of these, 4



(11.5%) said investigations had been carried out and followed up; 1 (3%)

said it was confidential and 1 (3%) wasn't told what the outcome was.

2 (6%) people said they wished they had used the policy but didn't due to concerns and fears of being penalised or sacked at work.

When asked about ways to raise difficult matters with their managers, 18 (51%) said that their managers had an "open door" policy – other responses included using a suggestion box; staff questionnaire and feedback via email.

Of the responses Healthwatch received, 10 (28.5%) said that their manager had spoken with them about the questionnaire, before they completed it.

Healthwatch will continue to work with various Health and Social Care providers during 2014/15 to find out more about the extent of "whistle blowing" policies across services and providers that serve the borough.

Stroke Discharge

Healthwatch wanted to find out the views and experiences of people from Barking and Dagenham who had used the stroke service discharging process.

With input from the Stroke Association, Healthwatch developed a questionnaire to gather peoples' experiences of the service.

Healthwatch visited the stroke service at Grays Court in Dagenham and Parkside Stroke Club in Barking. We met with 30 patients and some of their carers.

Healthwatch received 6 responses to the survey.

Barriers to achieving more responses from other stroke patients have occurred due to accessing patient contact information from North East London Foundation Trust (NELFT) and Barking, Havering and Redbridge University Trust (BHRUT) under the terms of the Data Protection Act. Some key points that have emerged so far:

Working with health service partners to reach greater numbers of stroke patients from the borough to participate in the survey, is an ongoing challenge.

Barking and Dagenham has no funded presence in the borough that gives ongoing support and information to stroke patients and their carers, once discharged from services.

Patient experience of the discharge processes vary from a comprehensive care plan to none at all.

Healthwatch Barking and Dagenham will continue to develop the work undertaken with this project over the next year.

Personal Budget Projects

One of the last pieces of work that Healthwatch undertook this year was on personal budgets.

A survey has been produced and distributed out to find out the experiences of individuals who have a personal budget. The project is still ongoing and will continue next year, however So far the feedback we have received shows:

50% of respondents felt that having a personal budget has improved their relationship with friends and family, that they are able to go out more, they can choose where they want to go.

60% of respondents felt that their personal budget gives them choice and more power about how they want to receive their care and from who.

Respondents feel that their needs to more information about what services they can access using their personal budget.

Reports and Recommendations

Reports and recommendations made during this year to commissioners are listed below:

Dental Report: This report went to the Public Health Programmes Board and The Health and Wellbeing Board as part of the Public Health Strategy.

Report on 0844 GP telephone lines: This report was sent to the CCG.

Diabetes report: This project was requested by HASSAC. The report has been sent to the HASSAC and is due to go the Health and Wellbeing Board and the CCG for consideration as part of the summary produced by the HASSAC.

Sunrise A and B Ward Enter and View report: This report was presented at the Integrated Care Sub Group and the HASSAC.

Freedom of Information Requests

	Reason	Response	Outcome
Date: 22nd August 2013			
Healthwatch requested information regarding young people and the access to dental services.	Healthwatch were undergoing a Dental project and needed to know how many children and young people were accessing dental services within Barking and Dagenham.	A response was received within the timeframe.	The information was used to compare data to see if there has been a change in the number of children accessing dental services.
Date: 17th March 2014			
Healthwatch requested information regarding GP urgent care appointments from 41 GPs in the borough.	Service users informed the Healthwatch that they were unable to access their GP for urgent appointments. Healthwatch wanted to find out what appointments systems are in place at the practices within the borough.	Not all GPs had responded at the time of writing this report.	This project will continue next year, there are no outcomes to report on as of yet.

Enter and Views

What is Enter and View

Healthwatch can enter certain health and social care premises to view the care being provided. This includes premises such as hospitals, care homes and doctors surgeries etc.

Healthwatch compiles a report from what service users have said at the visits and make recommendations or suggestions for improvements and also highlight what is working well.

The Enter and View programme is an important part of the Healthwatch activity and the law enables Healthwatch to undertake these visits.

Visits can be unannounced or announced.

Healthwatch recruited and trained 7 Authorised Enter and View Representatives this year. However one left due other commitments.

At the time of writing this report another four volunteers were recruited and booked to have their training.

Healthwatch Barking and Dagenham trained all the individuals according to guidelines provided by Healthwatch England.

The training programme ensured that representatives were given a full understanding of the process and their duties in carrying out this role.

Five visits were undertaken over the course of the year. The visits undertaken were

1)Queens Hospital
2)(follow up visit) to Queens Hospital
3)Cloud House
4)Look Ahead
5)Darcy House

Reports on the visits were sent to the service providers for comments .Once a response had been received from the service provider the reports were then made public documents.

The reports were then sent to the commissioners of the services, Care Quality Commission and other relevant stakeholders. Copies of the reports are also available on our website.

Meet our Authorised Enter and View Representatives

Barbara Sawyer

Frances Carroll

Val Shaw

Our staff have also undertaken the Enter and View Training

Want to be an Authorised Enter and View Representative Please call us on 020 8526 8200

Director of Nursing Flo Panel -Coates commented,
"I feel that the report is a fair reflection of activity and patient care on the wards and would like to thank you and your team for their time and helpful comments"

Visit to Sunrise Wards A & B

Visit to Sunshine Wards A&B at the Queen's Hospital Romford. On the wards, which care for frail and elderly patients, our volunteers asked patients and their visitors for their experiences of hospital life.

Healthwatch choose three topics to ask patients from Barking and Dagenham about.

•Meal times: was their food tasty, were they given time and help to eat it.

•How were they helped to wash and bathe: was there sufficient help and was it offered in a dignified manner.

•How did the staff interact with them: were they friendly, professional and did they have time for them.

There were nine recommendations made and BHRUT fully accepted all the recommendations for improving the stay of patients in their care.

As a result of the recommendations patients will have emergency call buzzers positioned where they can be reached, be consulted on who helps them with their personal hygiene needs and have changes to their health and treatment explained to them more clearly by medical staff.

Patients with personal budgets that provide staff to assist them at home will now be able to have those staff more closely involved in their hospital care.

These are among the nine recommendations fully accepted by the hospital.

An action plan was developed by the trust in response to the recommendations made.

A follow up visit was undertaken to gather the views and experiences about the services being provided to them after the implementation of changes made by the Trust in response to recommendations made from Healthwatch Barking and Dagenham.

A follow up visit has been conducted. However at the time of producing this report an official response has not been received and therefore Healthwatch is unable to comment on this.

The three social care Enter and Views were done in a series.

Representatives from Healthwatch Barking and Dagenham wanted to speak with residents from the borough that were using the services at Darcy House, Cloud House and Look Ahead to gather and record their views on 6 areas of enquiry. These were:

- Nutrition
- Personal Hygiene
- Social Activities and Hobbies
- Family Contact
- Clothing
- Staff interaction

A summary of the findings can be found on the following pages.

Darcy House

Darcy House extra care housing is provided through the council and in partnership with Hanover Housing Association.

The extra care scheme is staffed 24 hours in shifts: 7.30am to 1 pm, 4 staff are on duty including the Manager. From 1pm to 7.30am there are two members of staff who are on duty. There is a buzzer system available in all the flats and bungalows.

There is a site manager who is on duty from 9 -5, employed by Hanover Housing.

49 residents are currently resident at Darcy House. 31 of these receive care.

Overall from the visit and from what residents told us, it has come across that Darcy House is a comfortable home where individuals are receiving a good standard of care.

The residents seem to be generally happy with the services that are being provided and are very much aware that this is a independent living setting and they are happy to be independent but with the staff there if they need to call upon them.

Healthwatches Enter and view report highlighted that although patients were happy with the staff and the service they receive, there were concerns relating to the temperature of food when served and residents feeling that they are having to wait for longer then they should for carers when buzzed. There were also some concerns raised about the repairs of showers when they were out of order.

TLC care services did respond and are working with the resident to explain not only how the buzzer system works but have recently TLC had recently in March taken the action to minimise the concern over the buzzer issue by providing additional care staff in the morning because this is usually when the demand is really high (7.30 – 13.30 now making it 5 care staffs in the morning).

Cloud House

Cloud House is a small care home that has been open for 2 years; it is owned by Delrose House Limited. It is situated on a residential estate and is near to some local shops and a GP practice.

The home provides residential support and care for male individuals with Mental Health conditions and/or Learning Disabilities. The Lead Representative was advised that residents currently living in the home are settled and stable in the home; any new referrals are carefully assessed prior to being accepted.

The home is advertised as providing services for 10 residents, each with access to their own rooms with en-suite WC facilities.

Mary Chander, the care home manager, oversees the running of another care home in Ilford. Mary advised that she works up to 5pm at Cloud House, although she is on call out of hours when needed.

The home is staffed 24 hours in shifts: 7.30am to 5 pm, 3 staff are on duty including the Manager; 5pm to 9pm, 2 staff on duty; 9pm to 7.30am there is 1 'awakening' member of staff on duty.

Healthwatch representatives felt this was a positive visit and that the standard and quality of care observed was meeting the needs of residents, based on the feedback received.

There were four areas raised by Healthwatch representatives, of these two of the recommendations were:

- The care home staff should ask each resident if they have had enough to eat at mealtimes and to ensure that they each have an equal say in the choice of the food on the menu for the following week.
- The home has a no smoking policy; residents are allowed to smoke in the garden. Consideration should be given for the provision of a shelter outside, for residents that smoke.

Look Ahead

Look Ahead (Ford Road) is supported living accommodation for individuals who have Learning Disabilities.

This service is commissioned by. London Borough of Barking and Dagenham (LBBD).

Look Ahead (Ford Road) accommodates seven residents in single occupancy bedrooms and has a communal kitchen and dining room. The units are not ensuite but have basins in rooms with shared bathroom.

Residents have personal budgets that they use to pay for toiletries, activities, food, clothing etc

Overall from the visit and from what residents told us, it has come across that Look Ahead supported living is a comfortable place where individuals are receiving a good standard of support that they need to live independent lives.

The residents seemed to be happy with the services that are being provided; however for Healthwatch Representatives felt that more could be done to encourage group outings if the residents wanted this.

Volunteer for Healthwatch!

Healthwatch is keen to recruit volunteers who have an interest in health and social care. The work of our volunteers will be essential in developing the work of Healthwatch Barking and Dagenham.

There are a number of different ways in which you can get involved:

Enter and View Representative: These volunteers will be authorised representatives. Their role will be to observe how local health and social care services are being provided. Representatives will need to interact with service users and providers. They will need to identify examples of both good practice and where improvements need to be made. The information will be collated in a report and sent to the service provider for a response.

Outreach Volunteers: Helping to man information stalls at community events and various health and social care settings. This area consists of a variety of roles including promoting Healthwatch, having stands at events, consulting with people, having a display at health and social care settings. Advising individuals of certain health and social care services, including advocacy services

All volunteers will be given the necessary training, support and expenses!

If you are interested please contact

Healthwatch Barking and Dagenham

on 0208 526 8200 or

email us Info@healthwatchbarkinganddagenham.co.uk

Out and About Communication & Engagement

Communication

We want to ensure that we are communicating widely with the local community to ensure their voices are captured and heard, keep them up to date with what is happening nationally and locally with health and social care services and inform them of opportunities to influence services.

There are are number of ways we do this:

Website
A website has been developed to promote the work that we do.

National and local health and social care news and events are uploaded on the website giving people the option of keeping up to date and get involved.

There is also a section on local services that individuals can access.

Social Networking Sites
We have a Facebook and Twitter account to promote the activities of Healthwatch Barking and Dagenham and a Streetlife account. The networking sites enable us to inform a number of individuals from all walks of life.

Leaflets

We have produced a leaflet which has been distributed out to all the GPs,Care homes, Pharmacies, the leaflets are also available in easy read.

Media
We have promoted news through Barking and Dagenham Post, sharing the outcomes of the work that has been undertaken, we advertise events and keep local people involved in health and social care issues.

Associates
We distributes information via our associates to their service users, this gives us the opportunity to connect with some individuals who we not be able to speak with.

Out and About In Barking and Dagenham

Healthwatch Barking and Dagenham carry out outreach stands across the borough to ensure that we capture the local communities views on the services they access.

By finding out and understanding the needs of services users, we are able to work with services and commissioners to towards designing services which met the needs of local people.

This year we have had 20 stands in various places across the borough including libraries, supermarkets, health centres, Children's Centres and Youth Club provision.

The outreach stands also gives volunteers and staff the chance to approach a wide range of individuals to let them know who we are what and we do. The stands also gives service users the chance to share their experience directly with us.

We have also attended various events across the Borough.

We also had a public launch: an all day event at Vicarage field. Over 300 people were spoken to and given information about Healthwatch.

On this occasion the majority of people were concerned about the closure of Broad Street Walk in Centre.

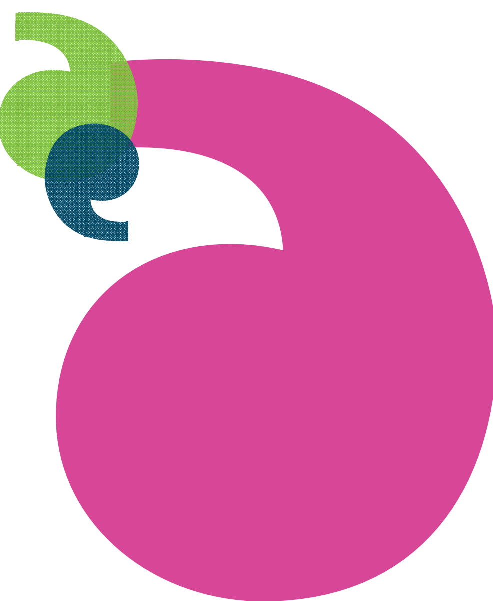
A local pharmacist provided health checks for 100 people that included BMI assessments and blood pressure checks. Examples of other locally available activities, which boost health and wellbeing, were available such as a Yoga and Belly dancing demonstrations and head and hand massages.

Another two public events took place one in Barking one in Dagenham. The event in Dagenham took place in Kingsley Hall and was focused particularly for older people. There were local organisations who attended such as DABD Uk and Carers of Barking and Dagenham. Demonstrations and head and hand massages and nail painting were also available.

All three were a success and we engaged with over 600 people in total.

Healthwatch has taken 105 calls and emails from the public requesting advice and signposting. The calls consisted of individuals wanting to know how to make a complaint about, where to go for benefit advice, issues at the GP practice and other signposting requests.

Comments from local people

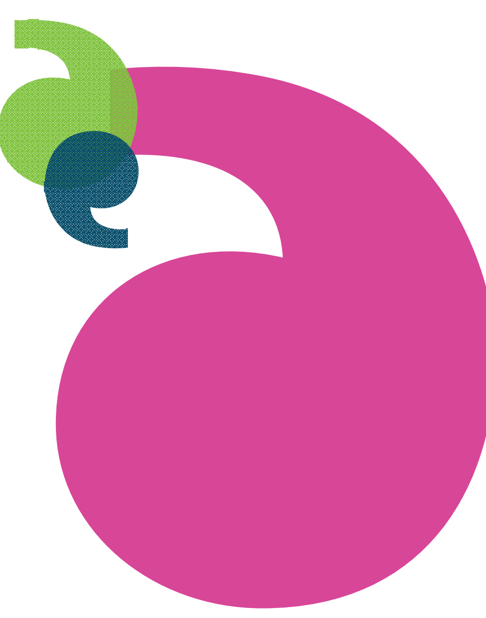


"GP is good, quite like them but long wait for blood test."

"Waited 4 weeks and 4 days for an appointment – there were none any earlier. I'm worried that no service will be provided over a weekend."

"BHRUT - General lack of nurses, they are overworked. Not good for patients' health."

"Mother needs social care but cannot get it. Has heart problems."



"I pay for care out of my personal budget money. I have a live in carer but feel my life is being dictated by the Social Worker and the carers they want to provide my care. I feel bullied and harassed that my wishes are not respected."

"My experience of the service is fine but waiting to see a paediatrician takes too long - 4 month waiting list."

Out and About In Barking and Dagenham - what the public told us

Throughout the year Healthwatch Barking and Dagenham has engaged with the public through a number of public events and site visits to various locations around the borough including at the premises of some of the providers from outside the borough, that serve local people.

From meeting people, 189 were keen to tell us about their experiences of using local Health and social care services... These are the issues that mattered most to people

101 people (53.4%) wanted to tell us about their GP service. Of these, 47 (46.5%) told us their experience of using their GP services was a positive one. 54 (53.5%) had negative experiences with their GP service.

Some examples of feed back we received about GP services:

- "My GP is very good with my children, but for myself he doesn't really seem that interested in my health needs"
- "Need more GP appointments to be available at weekends and bank holidays; I don't just get unwell during week days"

There were 69 people (36.4%) who told us about the hospital services they had experienced. Of those people, 47 (68.1%) said that their experience of using the service had been a negative one and 22 (31.9%) told us their experience of the service was positive.

Some examples of feedback we received about local hospital services:

- "King Georges and Queens have a general lack of nurses and too many patients to deal with. It worries me that patients, including members of my family, could be put in danger"
- "When I go to Queens Hospital Anti-Coagulant Clinic I'm always greeted by my first name and seen within 20 minutes"
- "I had a good experience at King Georges Hospital; quick appointment; quickly investigated –couldn't fault them "

15 people (8%) told us about their experiences of social care services in Barking and Dagenham.

Of those individuals; 10 (66.6%) had negative experience and 5 (33.4%) had positive experience of services.

Examples of feedback we received about social care services:

- “The carers that come to assist me are there for ten minutes when it should be for half an hour. They do what they think I need and when I tell them this, they argue with me”

- “I have had social care support for many years and have always been satisfied with the service”

- “I feel my life is being dictated by the social care staff who tell tales about me that are not true. I feel harassed and bullied”

4 people (2.2%) wanted to tell us about other services they had experience of using. Some feedback of other services:

- “People don’t tend to use the gym which is free for the over 60’s – they should make the most of the activities; it will help keep them healthy”

- “The community dental service is very good, but where I have to contribute to the cost because I work, I find it difficult to pay the contribution as I only get low wages”

Over the next year, Healthwatch Barking and Dagenham want to encourage more people to come forward and tell us about their experience of using local health and social care services.

Networks and Partnerships

Healthwatch is committed to working in partnership to ensure local peoples experiences both positive and negative are heard and taken into account. We have outlined below the partnerships and networks that we have been involved in.

Health and Wellbeing Board

London Borough of Barking and Dagenham Health and Wellbeing Board includes Barking and Dagenham Council, Barking and Dagenham Clinical Commissioning Group (B&D CCG), Healthwatch Barking and Dagenham, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), North East London Foundation Trust (NELFT) and The Metropolitan Police.

The Health and Wellbeing Board have the following sub groups

Children and Maternity Sub Group
Public Health Programmes Board
Learning Disabilities Partnership Board.
Integrated Care Sub Group

Each sub group has a representative from Healthwatch who attends and contributes to discussions ensuring the voice of the local community is heard.

Healthwatch share evidence based reports to the sub groups, decisions about who could take the recommendations forward are discussed and these are then presented to the Health and Wellbeing Board.

Healthwatch have a seat on the Board to represent the local voice, comment and challenge decisions that are being made.

We reported on a 6 monthly review to the Board and our annual report will also be presented.

North East London Healthwatches

Barking & Dagenham, Havering, Redbridge, Waltham Forest and Newham Healthwatch have began to meet to ensure that common themes and issues where necessary can be taken forward. Two meetings were held this year with the vision that these will become more regularly in the coming year.

London Healthwatch Network

The London Healthwatch Network gives a perspective on issues that Healthwatches are facing across London. It is an opportunity to share information and tackle issues as a London Healthwatch Network where needed.

B&D Health & Adult Services Select Committee (HASSC)

We worked on the diabetes project, which was requested by HASSAC. Healthwatch have attended scrutiny meetings and given input at these meetings.

Joint Overview Scrutiny Committee (JOSC) - North East London

Healthwatch have attended JOSC meetings and given input at these

CQC

We ensure that CQC are up to date with our findings from Enter and View visits and findings that we come across in regards to the services they monitored.

Safeguarding Adults Board

We have a seat on the Safeguarding Adults Board and have been asked to work in partnership with the Board next year to engage with the local community to find out if they know how to raise a safeguarding concern , if they feel there is enough information about the matter and what would stop them from raising an alert. This piece of work will be taken forward early next year.

CCG

We have meet with the CCG chair a number of times and also have a non voting seat on the Clinical Commissioning Group Patient Engagement Forum which we regularly attend.

We were also commissioned by the CCG to deliver a workshop on the Community Treatment Teams, Better Care Fund and CCG priorities.

North East London Foundation Trust (NELFT)

NELFT are the providers for Community Health Services and Mental Health Services in the borough. We are involved in the mental health sub group to ensure that the patient voice is taken into account. We have also worked with Community Health Services in delivering workshops on the new Community Treatment Teams.

Barking Havering Redbridge Hospital Trust (BHRUT)

Both King George Hospital and Queens Hospital come under BHRUT. We undertaken a visit to the frail and elderly ward at Queens Hospital. We made nine recommendations.

The trust accepted all the recommendations. A follow up visit was undertaken where Enter and View Representatives found that our recommendations were implemented.

London Borough of Barking and Dagenham (LBBD)

We have attended the Care Providers forum, informing care providers of the role we play. We are also working with LBBD alongside the CCG to keep the public updated about the Better Care Fund.

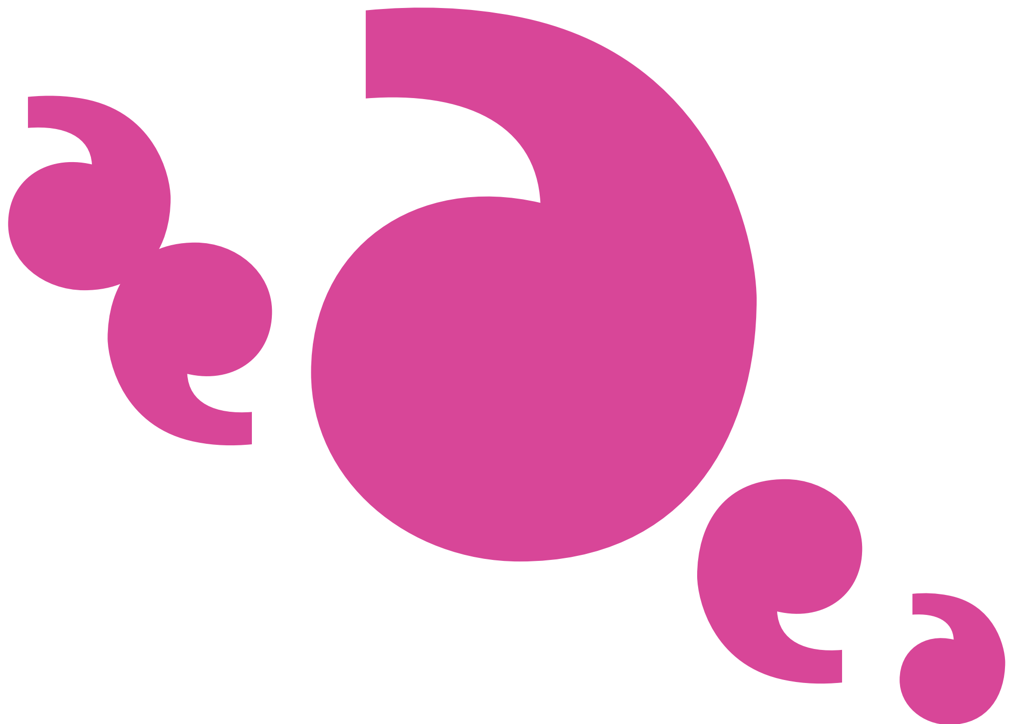
We have undertaken 3 enter and view visits. After one of the visits we raised a safeguarding alert to the LBBD safeguarding team .

In total we have attended over 300 meetings, this includes forums and presentations that have been undertaken.

Income and Expenditure

These figures are a breakdown / overview for this report and audited accounts will be contained in the Harmony Houses annual accounts.

Description	Annual Cost
Staffing salary with job titles: Health Watch Manager. Outreach Worker. 2x Admin Support	75,442
Training and supervision	12,000
Recruitment (staff, volunteers, experts etc)	1,800
Other (Please Specify) (travel)	2,100
Accommodation (lease/rental etc)	9,000
Equipment & stationery	5,650
Consumable/Administration	5,150
Other Overheads (specify) general administration	2,725
Materials	2,000
Social media	2,610
Events	3,400
Consultation	3,125
TOTAL COST	125,002



Looking Forward

A work programme for next year will be developed once a consultation event is held with the public.

This will ensure that the areas of work that will be taken forward will be from feedback received from the local community.

Some areas of work that may be taken forward have been highlighted below, these have been determined by the findings from the various consultation and engagement events held this year.

Please note this is a list of the possible projects and a final decision will be made after asking the community what they would like us to take forward and they will also have the opportunity to raise other areas they may feel we could look at.

- Children's Orthotics
- Children's Accident and Emergency Services
- Relocation of Cardiovascular and Cancer Services
- Duty of Candour (continuation):
- Children's Mental Health
- Adults Mental Health
- Maxillofacial Service
- Stroke project (continuation)
- Accident and Emergency Children
- Personal budgets (continuation)

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HEALTH AND WELLBEING BOARD

17 JUNE 2014

Title:	**BHRUT Improvement Programme**
Report of the Barking Havering and Redbridge University Hospitals NHS Trust	
Open	**For Discussion**
Wards Affected: ALL	**Key Decision:** No
Report Author: Steve Russell, Improvement Director, BHRUT	**Contact Details:** Telephone: 01708 435000 E-mail: Steve.Russell@bhrhospitals.nhs.uk
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Summary: The Care Quality Commission (CQC) inspection of Barking Havering and Redbridge University Hospitals NHS Trust took place from the 14 – 17 October 2013 and the Trust was the second in London to be scrutinised under the new inspection model. The final CQC report was published in December 2013. Following their inspection, the CQC recommended that the Trust be placed into special measures, publicly recognising and reinforcing that the Trust must make significant improvements. Particular areas of focus centred on the emergency pathway and overall organisational structures and processes to oversee and drive improvement in the quality of services. The attached Improvement Plan sets out what the Trust will do to meet these challenges.	
Recommendation(s) The Health and Wellbeing Board is asked to: • Note the Improvement Plan and presentation submitted to the Health and Wellbeing Board	

1. List of Appendices

Appendix 1: Unlocking our potential our improvement plan for 2014/15 (Summary)

Appendix 2: Unlocking our potential our improvement plan for 2014/15 (Presentation slides)

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APPENDIX 1

unlocking our potential

our improvement plan for 2014/15

taking **pride**
in **improving** the
care we provide to
local **people**

FINAL

Contents

Introduction **3**

Executive Summary **5**

Section 1: Workforce **7**

Section 2: Patient Flow **12**
Strategic fit with the health economy **13**
ED and Acute Assessment **15**
Discharge **18**
End of life care **20**

Section 3: Patient care and clinical governance **24**
Sepsis **25**
Documentation **26**
Quality Governance **27**
Patient Experience **28**

Section 4: Outpatients **32**
Outpatients **33**
Day surgery **35**

Section 5: Leadership and organisational development **38**

Section 6: Delivering the improvement plan **40**

Appendix 1 – detailed action plans

Introduction

Unlocking our potential: our improvement plan

The 6,000 people that make up BHRT, have a very simple purpose – to provide high quality, compassionate care and treatment for our local communities.

We have a clear picture of how we want our services to run in the future for the 700,000 local people who rely on us for care, treatment and support, whether this is planned or in an emergency.

We want to provide high quality care as standard across our two sites. We want high performing maternity and emergency services that can be relied on 24/7. We want patients to receive prompt surgery when they need it, with the best possible outcomes and returning home as soon as possible.

In many cases we do this well, and there are many positive things about the services that our staff provide which should be celebrated. We are, however, alert to the enormous challenge that we face to achieve this on a consistent basis across all our services, at all hours of the day and all days of the week.

The recent inspection by the Care Quality Commission (CQC) has given us cause to pause, reflect and refocus. We are determined to work with our staff to deliver the change that we all so passionately want to see for the people we serve, and to become a more credible and effective partner in our local health and social care economy.

To do this, we need services to be provided where they have the best impact, whether at Queen's, King George or in peoples' own homes in the community. And, reinforced by the Francis report into Mid-Staffordshire Hospital and the Keogh reviews into mortality, emergency care and seven day working, there is a need to make sure our services are of a consistently high standard for patients.

This means working closely with local GPs and councils to play our part in coordinating home care. We also need to work closely with hospitals across London so our patients have rapid access to additional specialist skills, expertise and technology should they need it.

At this point in time, we are some way off achieving this vision. The Trust has a number of significant barriers, some clinical, some financial and some organisational, to overcome first.

Whilst some of these are long-standing and complex, and some cannot be solved by us alone, we can and must make significant progress ourselves. These challenges come on top of the need to meet increased demand for our services and make more of limited national NHS resources.

Following their inspection, the CQC recommended that the Trust be placed into special measures, publicly recognising and reinforcing that the Trust must make significant improvements. Particular areas of focus centred on our emergency pathway and our overall organisational structures and processes to oversee and drive improvement in the quality of services.

This plan sets out what we will do to meet these challenges. Importantly, the special measures regime gives us the opportunity, and the support from across the NHS and with partners, to address these issues once and for all.

We are grateful to our partners for the support they are providing to us. Our plan reinforces and supports the strategic objectives of our coalition of partners, especially our objectives of transforming emergency care and developing our workforce. This plan, and its implementation, will play a major

role in achieving the aims of our local GPs and local authorities to improve healthcare for our local communities.

Delivering our plan will not only see immediate improvements in our services, but they help us take the longer term steps needed to truly unlock our potential. For example, improving our emergency department will benefit patients in the short and medium term, and will allow us to move forward with the confidence of our staff and partners to make the larger strategic changes already agreed but delayed by our current performance. Progress will help us to secure more investment and attract the permanent staff we need. This will be difficult but only by doing so, will other benefits flow. This plan sets out what must be done, how, by whom and by when.

Executive Summary

The Care Quality Commission (CQC) inspection took place from the 14th – 17th October 2013 and the Trust was the second in London to be scrutinised under the new inspection model. The final CQC report was published in December 2013.

The CQC have five themes against which they assess services – safe, effective, caring, responsive and well led. The full reports are available on the CQC website (http://www.cqc.org.uk/directory/rf4). This section provides a summary of their findings about services at Queen's Hospital and King George Hospital.

1. Ensuring services are safe

The CQC said: Many of the services are safe but require some improvements to maintain the safety of patient care. The A&E department at Queen's Hospital is at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with long waiting times for patients to be assessed by specialist doctors. Other services such as medicine and surgery require improvement.

2. Ensuring services are effective

The CQC said: 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 emergency department is hampered by long waiting times for patients to be seen by a specialist.

3. Ensuring services are caring

The CQC said: National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. 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. We observed that staff treated patients with dignity and respect. However, more work is required to improve care in the end of life service and ensure improvement in patient care in all services is reflected in national patient surveys.

4. Ensuring services are responsive

The CQC said: The longstanding problem of waiting times in the emergency department at Queen's Hospital has not been addressed. Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments. A lack of effective partnership working with other health and social care partners has contributed to the problems.

5. Ensuring services are well led

The CQC said: We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. The trust Executive Team need to be more visible and greater focus is needed at Board level to resolve longstanding quality and patient safety issues.

Our Improvement Plan approach and structure

We have focused on five improvement themes to strengthen the safety, effectiveness, care and responsiveness of our services whilst improving how we lead and develop our organisation.

Here is a summary of the themes and the main objectives we will be focusing on:

Workforce: recruiting, retaining, developing and deploying the right numbers of permanent staff we need to provide high quality care 24/7

Our objectives are to increase the number of A&E senior medical staff , attract more permanent staff to work here and keep them for longer.

Patient flow and emergency pathway: making sure our patients are assessed and treated promptly and are supported to return home as soon as they are medically fit to leave hospital, and to ensure that patients having planned care are treated in an appropriate environment and have the right follow up care

Our objectives are to improve the way we assess people when they come to hospital, and to work with our community services to significantly improve the pathway for frail older people. We will reduce admissions, and ensure people do not spend avoidable time in hospital by changing processes, behaving as one team across organisations and making better use of community services to provide care and assessment that currently takes place in an acute bed. We will support this with a new model of clinical care for patients who do need to be in acute beds, being seen daily by a consultant 5 days a week and moving to 7 days a week across more wards when we concentrate care on one site.

Patient care and clinical governance: supporting all our care with effective management of patient notes, information and with systems which alert us quickly to problems.

Our objectives are overhaul our clinical governance arrangements and the way in which we ensure services are effective through better use of information and increased visibility in frontline departments. We will also improve outcomes for patients by giving training to our staff to diagnose and treat sepsis.

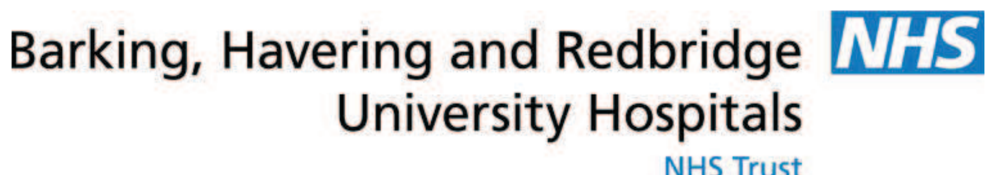
Outpatients: ensuring effective management of our outpatient services so they run on time, every time

Our objectives are to overhaul the way we plan and manage outpatient appointments to make them more effective. For day care surgery, we will improve the environment, reduce the number of cancelled operations and improve care for patients after surgery.

Leadership and organisational development: putting the right systems, structures, checks and balances in place to make sure our Trust is properly managed from Board to ward.

Our main objectives will be agreed shortly by the new Chief Executive who takes up their position in April 2014.

Many of the improvements that need to be made are the responsibility of the Trust. However, one of the major areas for improvement is the emergency care pathway. For this area, successful improvement needs our actions to fit into the health economy strategy and also needs the support of partners. The relationship between the improvement plan and the health economy strategy is described in the patient flow section, and the support required from partners is summarised in section 6 – 'delivering the improvement plan'.



unlocking our potential

section one – workforce

our improvement plan for 2014/15

Improving our permanent workforce

Why this is important

Providing high quality services requires us to have the right number of staff with the right skills in each of our departments. A stable, largely permanent workforce drives up quality because people working in our hospitals understand our ways of working, build positive relationships with the local communities and share a stake in our future success.

The CQC found that:

- Morale amongst our 6,000 staff has improved and their inspectors received positive feedback on the care our staff provides to patients
- Long-standing difficulties in recruiting permanent staff are having an impact on the effectiveness and safety of our services across both sites. There is an over-reliance on locum and temporary staff that impacts on patient care. This is particularly the case in A&E where there are not enough consultant or middle grade doctors, but is also a problem in some other specialties too.
- Ineffective compliance and shift rota management systems are leading to a poor deployment of permanent staff and there is no central oversight for management of ward staffing levels and the use of temporary or locum staff.

Our assessment of the key issues:

The workforce challenges we face are driven by a number of issues:

- The Trust's long-standing challenges have led to a reputation that does not encourage enough people to choose it as their preferred place of work. This is particularly the case for junior and senior medical roles within the Trust, but also applies to nurses and some therapy roles.
- Doctors in training do not always have a positive experience, usually because of perceived high workloads, and a lack of consistent clinical supervision and training from senior medical staff. This can discourage doctors from choosing to work here. However, many trainees who have worked at our hospitals speak very positively about the level of pathology that they are exposed to at the Trust and the learning opportunity this provides.
- The challenges facing the organisation (in particular those arising from the emergency pathway) result in high turnover which negates the impact of recruitment. This is compounded by other local hospitals paying their staff inner London weighting which we are not able to provide because of our location. For example, exit interviews showed 20% of nurses leave for the same grade job in another Trust because they receive higher pay and believe they will have a better experience
- There has been a lack of coordinated oversight of workforce levels and the mix of temporary and permanent staff. Some systems are in place, e.g. eRostering & eJobPlanning but are not fully utilised.
- Job planning for medical staff has been less effective and has not been implemented in a way that reflects the Trust's needs and priorities and desired working models.

Our improvement objectives are to:

1. Increase the number of A&E senior medical staff through improved recruitment, training and job design
2. Strengthen and diversify our workforce model by developing our non-medical A&E workforce
3. Improve the oversight and deployment of our workforce on both a strategic and shift by shift basis
4. Improve our overall recruitment processes to reduce our reliance on locum, bank and agency staff
5. Ensure clinical directorates and HR have a shared objective to improve recruitment and retention.

Our priority actions that will deliver the biggest impact are:

Objective one: Increase the number of A&E senior medical staff through improved recruitment, training and job design

1.1 Through improving the patient flow (which is described in section two) we will seek to make the A&E department a more attractive place to work, and we will reduce the requirement for A&E senior staff through consultants in Elderly Medicine and Acute Medicine undertaking the initial assessment and treatment of a group of patients who are currently the responsibility of A&E
1.2 We will aim to improve recruitment to A&E consultant posts by creating rotations with other Trusts, such as Barts Health, to make the posts more attractive, and will assess the feasibility of creating an academic post at BHRT.
1.3 Our local education and training organisation (LETB), health education north central and east London, will implement new rotations for specialist registrars with our hospitals forming part of 5 out of 9 rotations, and with rotations redesigned to link the significant training opportunity at Queen's with more sub-specialist opportunities in other hospitals. More senior trainees will be placed at Queen's.
1.4 We will create a local parallel training programme for the 18 non-training grade posts that we have filled to maximise retention. We will evaluate the success of this and consider further overseas recruitment.
1.5 We will, with the LETB, create 4 new training posts in A&E and acute medicine by establishing an acute care common stem training programme at Queen's Hospital.

Objective two: Strengthen and diversify our workforce model by developing our non-medical A&E workforce

2.1 We will train 4 advanced nurse practitioners and 7 emergency nurse practitioners to develop an alternative and more consistent workforce to A&E doctors, as part of the overall A&E senior clinical decision making workforce.

Objective three: Improve our recruitment processes and attract more people to work at BHRT

4.1 We will engage specialist support and will work with partner organisations to better promote the opportunities at the Trust, and the local area.
4.2 We will run targeted national and international recruitment campaigns, will regularly recruit to take account of turnover and will guarantee our local student nurses who achieve their competencies jobs within the Trust.

Objective four: Improve our retention of people who join BHRT

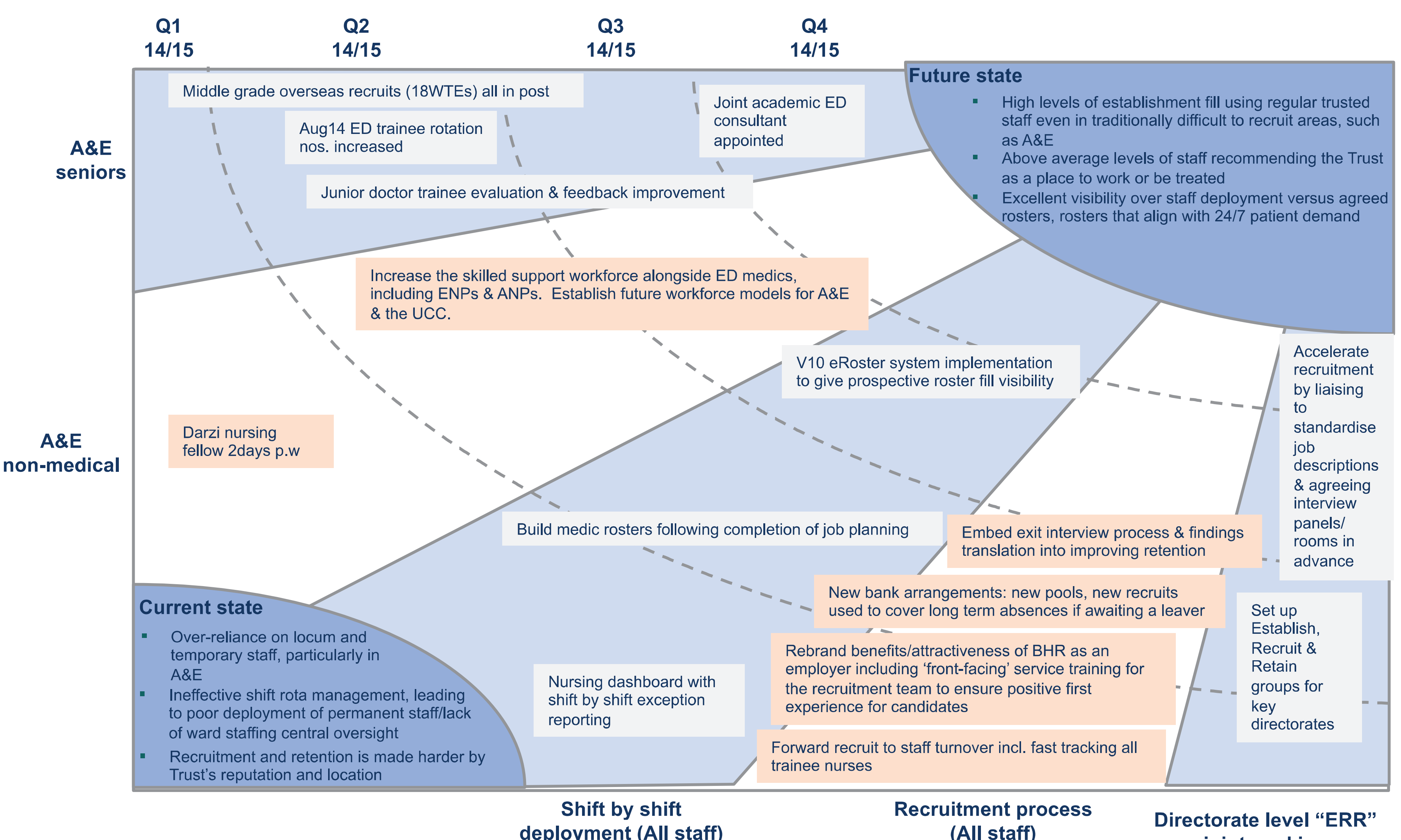
5.1 We will improve our exit interview process and will work with staff side partners to reduce the number of people who leave the Trust.

We will know we have been successful if:

1. Vacancies in permanent doctors or doctors in training fall from 13 Consultant posts and 18 middle grade posts to 5 and 5.
2. We have 4 ANP and 7 ENP nursing staff in post, working independently.
3. We increase the number of appointable applicants for posts we recruit to.
4. The proportion of our posts filled by permanent staff rises from 87% to 89%.
5. Staff turnover across the Trust falls to no more than 10%, particularly within the Emergency Department and amongst qualified nurses, which experience rates of 20%.
6. Staff recommending the Trust as a place to work or be treated, as reported in the staff survey, improves from 3.55 out of 5 to at least 3.7 out of 5 (i.e. from a below average to an above average score).

A summary of the actions we are taking to move towards achieving our future state is shown on the following page and the detailed actions are shown in Appendix 1.

Workforce improvement plan on a page



unlocking our potential

section two – patient flow

our improvement plan for 2014/15

2.1 A&E department and acute assessment
2.2 Discharge from hospital
2.3 End of life care

Introduction: There is a health economy strategy in to which the improvement plan fits, and can accelerate delivery of the strategic objectives

The BHR economy is made up of partners from Barking and Dagenham CCG, the London Borough of Barking and Dagenham, Redbridge CCG, the London Borough of Redbridge, Havering CCG, the London Borough of Havering and Barking, Havering and Redbridge University Hospitals NHS Trust and North East London NHS Foundation Trust.

The integrated care coalition, which is made up of all these organisations, is the vehicle for collectively building a sustainable health and social care system.

The coalition is placing a particular priority on driving improvements in the pathway for frailty and long term conditions, as people in this pathway have the most health and social care needs and are consequently are the greatest users of health and social care from an emergency care perspective.

Transforming the emergency care pathway and transforming our workforce, are the major priorities for the coalition, and there are clear strategic objectives that describe the future vision for emergency care across BHR, in which the improvement plan actions sit.

This section describes how the improvement actions associated with the emergency care pathway fit into and accelerate delivery of these strategic objectives.

Our improvement objectives	Which will result in
1. People at risk of an unplanned admission to hospital will be identified and care plans put in place proactively to prevent their condition deteriorating.	Fewer emergency admissons to hospital and fewer acute bed days
2. For people who do need urgent care, there will be alternatives to admission to a hospital bed to maximise the likelihood of them being treated in an ambulatory or home setting.	Fewer emergency admissons to hospital and fewer acute bed days
3. For people who do need admission to hospital, avoidable time in an acute hospital bed will be eliminated.	Fewer acute bed days
4. For people who have ongoing care needs at the time they leave hospital these will be delivered in their own homes as the default to reduce avoidable admissions to community beds and nursing and residential care.	Fewer admissions to nursing and residential homes, fewer community bed days
5. For people who have been admitted to hospital there will be interventions put in place to support them after discharge to prevent avoidable readmissions	Fewer emergency readmissions to hospital and fewer acute bed days
6. For people who are at the end of life, they will have advanced care plans put in place and they will be cared for in their preferred place.	Fewer emergency admissons to hospital and fewer acute bed days

Delivering these objectives will result in an emergency care system in which the default is care at home, rather than care in a hospital bed and will ensure that the acute hospital capacity is only used for patients who need that level of care.

Building blocks have been put in place in the community

In 2013/14 a number of community based services were put in place as the building blocks for the out of hospital enablers to support the new model.

1. Intensive Case Management (ICM), built around groups of GP practices – system objective 1
2. Community Treatment Team (CTT) – system objective 2 and 3
3. Intensive Rehabilitation Service (IRS) – system objective 4

The Trust's and partner organisation improvement actions fit into the health economy strategy, build on the interventions to date and will accelerate delivery of the strategic objectives

The improvement plan will support the delivery of the health economy future model of care in a stepped way.

1. By stabilising the current emergency care pathway, putting in place significant changes to the clinical operating model at the 'front end' of the pathway

2. Through the new clinical model joining up with the community based schemes and operating as 'one team' to start the more radical shift of services to the new model of care.

3. Through responding to the reduced demand, driven by a concerted hospital and community effort, by consolidating and reducing the current acute bed base onto the Queen's site and rebalancing the organisation to one in which there is a greater focus on specialist out-reach and support to manage patients in alternative care settings.

The improvement plan has actions for the Trust and partner organisations which fit with each of the 6 key objectives and provide the opportunity to create a fully integrated 'end to end' frailty pathway.

The three areas of focus – A&E and acute assessment, discharge and end of life care describe the improvements that will be made, and the relationship to the strategic objectives is shown on page 23.

Improving patient flow – Accident and Emergency Department and Acute Assessment

Why this is important

Last year, there were over 220,000 attendances at our Accident & Emergency (A&E) departments and we admitted 59,000 patients to hospital. The NHS constitution sets a standard that 95% of people should be seen, treated and admitted or discharged within four hours of entering our emergency departments.

There is evidence that shows that people who wait longer than four hours in A&E have a higher risk of mortality and have higher lengths of stay in hospital. Overcrowded departments can result in the risk of treatment being delayed with patients being managed in the wrong clinical area.

The CQC found that:

- Patients were not always receiving timely and proper care because of major delays in their assessment and treatment
- Patients were waiting too long to see a specialist doctor when they had been referred by an A&E clinician, and were waiting too long to move to a hospital bed
- The pathway for children un-necessarily delays their initial assessment.

Our assessment of the key issues:

- Whilst there are some challenges at King George Hospital, the major issues are at Queen's Hospital, and the improvement actions largely relate to Queen's Hospital.
- We currently admit around 65 to 75 patients to General Medicine at Queen's Hospital each day, for which there should be a total of just over 110 of our beds that we dedicate to assessment and short stay. We currently run 64 of our beds in this way. This means that short stay patients are admitted into the main hospital bed base, and may stay in hospital longer as a consequence
- The current pathway is 'serial' in nature and patients have a review from a senior physician only at the very end, after the patients have already often spent a large amount of time in A&E being clerked by A&E doctors and then referred to medicine, to then be reviewed by another junior doctor
- Patients are often not seen by a consultant on the day that they are admitted to hospital because of the length of the process leading up to consultant review and the length of time that consultants are present on the assessment unit
- There are insufficient alternatives to admission, such as 'hot clinics' and ambulatory care which are not available on a daily basis.
- A recent audit showed that around 35 of the patients we admit each day met a frailty score indicating they would benefit from specialist assessment and treatment by geriatricians. We currently have 10 frailty beds within the MAU. This means the right clinicians are not assessing many frail patients.
- 40% of patients who spend more than 4 hours in our departments are discharged from A&E. Many of these are out-of-hours. This is in part because the A&E workforce is overloaded, and is devoting considerable time to patients who are admitted to another specialty, and partly because of a lack of senior presence out of hours.
- There are community services in place which could be utilised for more patients to care for them in their own homes.

Our improvement objectives are to:

1. Improve the assessment and treatment within A&E
2. Create a new pathway for frail older patients so they are assessed by a specialist team outside of A&E so patients are discharged sooner
3. Strengthen the links between the new frailty service and community services to prevent patients being admitted, and to support more care being delivered at home
4. Increase the number of patients treated in an alternative care setting rather than being brought to A&E by working with London Ambulance Service and our Community Service partners
5. Create a new initial assessment and short stay pathway for adult medical patients so they are first seen by a Consultant or Specialist Registrar outside of A&E and are discharged sooner
6. Improve the paediatric A&E pathway.

Our priority actions that will deliver the biggest impact are:

Objective 1: Improve the assessment and treatment within A&E

1. We will create an observation unit at Queen's Hospital to treat patients who need observation and treatment for up to 6-8 hours
2. Develop the Urgent Care Centre to function as a distinct service 24/7 to reduce the pressure on the main department, staffed by a dedicated team of emergency nurse practitioners to create a more consistent workforce
3. We will provide more dedicated paediatric consultant support and leadership to the children's A&E.

Objective 2: Improve the pathway for frail older patients, and reduce the volume of activity in A&E

4. We will change one of our current admission wards into a frailty unit and patients will be assessed in the unit, rather than in A&E, by a Senior Clinician as they present (known as an 'on take model')
5. Community services (CTT, IRS and ICM) will support this and the elderly short stay ward to discharge more people home
6. We will implement daily ambulatory clinics as an alternative to acute admission, and to support discharge
7. We will run a pilot to assess patients in their own homes rather than at hospital with remote support provided by the specialist consultant team.

Objective 3: Improve acute assessment for adults, and reduce the volume of activity in A&E

1. We will create a 'medical receiving stream' so that stable medical patients are transferred directly to the unit, and assessed by an Acute Medicine specialist, removing the step of assessment by the A&E medical staff
2. The consultant presence will be extended to 10pm, to ensure that more patients are seen by a consultant on the day of their presentation
3. We will implement daily ambulatory clinics as an alternative to acute admission, and to support discharge.

We will know we have been successful if:

1. The median time to assessment by an appropriate decision maker is 60 minutes or less
2. 95% of medical patients have their initial assessment by a senior physician within 30 minutes of referral from A&E
3. 95% of patients stay in the assessment area for 12 hours or less
4. 50% empty capacity at 8am in 18 trolleyed Medical Assessment Space (95% achievement over rolling 7 days) and capacity of at least 9 assessment trolleys at 8am
5. 50% of patients are discharged within 24 hours of arrival to MAU short stay and 85% are discharged within 48 hours of arrival to MAU short stay short stay beds
6. 95% of patients who meet the frailty threshold are admitted to the frailty assessment unit within 30 minutes of referral
7. There is improved patient experience measured through the Friends & Family Test and staff survey results within ERU and Short Stay MAU.

The next section sets out the changes that we are making to improve discharge and reduce occupancy in the hospital which is critical to improving the overall emergency pathway. A summary of all the actions we are taking to improve patient flow is shown at the end of this section on page 22 and the detailed actions are shown in Appendix 1.

Improving in-patient care and discharge from hospital

Why this is important

We know that patients want to go back to their usual place of residence as soon as they are well enough to do so. A well-managed discharge from hospital supports patients to recover and regain their independence more quickly.

Patients want to be supported once they are at home to check they are coping and to allay any concerns that might lead to readmission to hospital on an unplanned basis. In turn, this enables us to admit patients who are medically unwell to the hospital by ensuring that beds are not occupied by patients who are able to have their care needs met outside of an acute hospital.

Ensuring that only patients who need to be in an acute hospital bed are cared for in those beds means that the hospital will need fewer beds overall, which in the medium term will allow in-patient care for emergency admissions to be focused on a single site and will mean that we can provide better quality with a smaller permanent workforce, meaning that we will no longer have big gaps in our workforce filled by temporary bank and agency staff.

The CQC found that:

- There were delays in patients being discharged, because of hold-ups in doctors completing discharge summaries, long waits for medication to take home and delays in putting care packages in place
- There were patients who were assessed as fit for discharge but were delayed because of a lack of community capacity or delays in arranging support for them
- Occupancy in the hospital was too high, and the discharge arrangements need a whole system review
- Some patients were not discharged from ITU when they could be stepped down to a ward because of a shortage of available beds, which sometimes resulted in patients who needed ITU being nursed elsewhere
- Patients were being nursed in recovery because of bed shortages, which is an inappropriate environment and led to operations being cancelled
- There was not clear monitoring of length of stay to identify specific blockages and when and why they occur
- Improvements were needed in ensuring patients are cared for on the appropriate ward
- Seven day working was not embedded as job planning had not taken place to enable consultants to be on the ward seven days a week.

Our assessment of the key issues:

- Patients remain in hospital beds despite being medically fit for discharge due to delays in completing the appropriate paperwork correctly first time - this includes social service referrals for packages of care, fast-track for end of life care and electronic discharge summaries
- The processes on the wards for prioritising discharges earlier in the day and ensuring that appropriate actions are being taken to expedite discharge are not consistent; therefore very few patients are discharged before midday. Productive Ward Round best practice is not rolled out or embedded across the medical wards to support timely and earlier discharges to improve patient flow.

Our improvement objectives are:

1. To reduce avoidable time in hospital
2. To improve capacity planning

Our priority actions that will deliver the biggest impact are:

Objective 1 – reduce avoidable time in hospital

1.1 Implement a new medical model for in-patient wards and roll out the Productive Ward Round model to all multidisciplinary teams with a consultant review of all patients each day, consistent junior doctor cover and tasks associated with discharge completed in real time rather than batched
1.2 Implementing a 'trusted assessor' model so that patients are only assessed once, and only when required
1.3 Move to a model of 'discharge to assess' through the community based services (IRS and CTT) and streamline and prioritise the paperwork requirements to support discharge
1.4 Broaden the criteria for rehabilitation beds, moving them to sub-acute beds, with the intensive rehabilitation service working to support these patients at home more rapidly
1.5 Improving the effectiveness of our discharge and transfer processes through the Joint Assessment & Discharge (JAD) Team
1.6 Eliminating delays for in-patient diagnostic tests
1.7 Implement LACE scoring to identify patients at risk of readmission and implement the evidence based community and primary care interventions to ensure people are supported in their own homes 30 days after discharge.

Objective 2 – improve capacity planning

2.1 Undertaking regular evidence based audits to show our effectiveness of reducing avoidable time in hospital and using the results to drive change across the health and social care economy.

We will know we have been successful if:

1. There are at least two discharges per medical ward before midday across both sites i.e. 10% of daily discharges before midday, and hospital occupancy drops to 95%
2. Length of Stay (LOS) for medical wards reduces by at least one day
3. Re-admissions reduce from current position of c6.8% towards the improvement trajectory of 4%.
4. The number of avoidable days in hospital identified in the utilisation review reduces to 5-10%

The next section sets out the changes that we are making to improve end of life care which is important to improving the overall emergency pathway because at the present time too many people are not effectively supported to die at home.

A summary of all the actions we are taking to improve patient flow is shown at the end of this section on page X and the detailed actions are shown in Appendix 1.

Improving end of life care

Why this is important

Our primary goal is to help people recover from illness or injury, but when someone reaches the end of their life we want to ensure that people are made comfortable, treated with kindness and respect and that they are supported to die in their preferred place. The majority of people (75%) say that they would prefer to die at home.

The CQC found that:

- Some patients and families at KGH felt they were not fully involved in end of life arrangements, with not enough support and guidance from the palliative care team
- the ease of attending palliative care training, and the numbers of staff doing so, raised the possibility of variability of care across wards
- there were delays in supporting patients through the fast-track process. There were weekend referrals to the palliative care team which could not be completed until Monday because the team was only available Monday to Friday. Care packages are not always delivered on time due to the length of time it took to complete the referral form and information sharing, particularly over weekends.

Our assessment of the key issues:

- Too many people die in hospital in BHRUT. The latest SHMI data shows that 76% of people die in hospital. This shows that we are in the bottom third for supporting people to die at home who are admitted to hospital and die within 30 days of that admission
- An audit showed that 85% of patients who are considered for 'fast-track' discharge are supported by the specialist palliative care team, with the remaining 15% managed by ward teams. The average time to complete the fast-track paperwork was seven days for those managed by the specialist team and 12 days for those managed by the ward teams. The completion of the paperwork is therefore taking too long
- The national standards for rapid discharge of end of life patients are within 24 hours. The current process requires paperwork to be completed and sent to the Brokerage Team for ratification which takes up to 48 hours, making it difficult to meet national rapid discharge standards. Paperwork required currently consists of four components; National Tool, Care Plan (this is part of the tool, however a London Wide initiative requires the Care Plan as an additional document), medical report and signed consent form. We will work with our partners to streamline requirements whilst meeting statutory requirements for fast track paperwork
- An audit of 32 fast-track applications for January showed that 63% were approved by the CCG the same day, and 10% within 24 hours. 21% were ratified after 48 hours – and these all related to applications submitted on Fridays or over the weekends as there is no cover from the CCG Brokerage team over the weekend.

Our improvement objectives are:

1. To reduce the number of people who are admitted to hospital at the end of their life
2. Improving the care for people when they are in hospital and at the end of their life
3. To eliminate avoidable time in hospital for patients who are admitted to hospital and want to be cared for at home.

Our key priority actions that will deliver the biggest impact are:

Objective 1: Reduce the number of people admitted to hospital and the end of their life

1.1 Working with partners to implement advanced care planning and the gold standards framework to support more patients to die at home.

Objective 2: Improving the care for patients in hospital

2.1 Raising staff awareness through relevant training in more accessible formats
2.2 Providing specialist palliative care cover 7 days a week.

Objective 3: Avoiding time in hospital when patients want to cared for at home

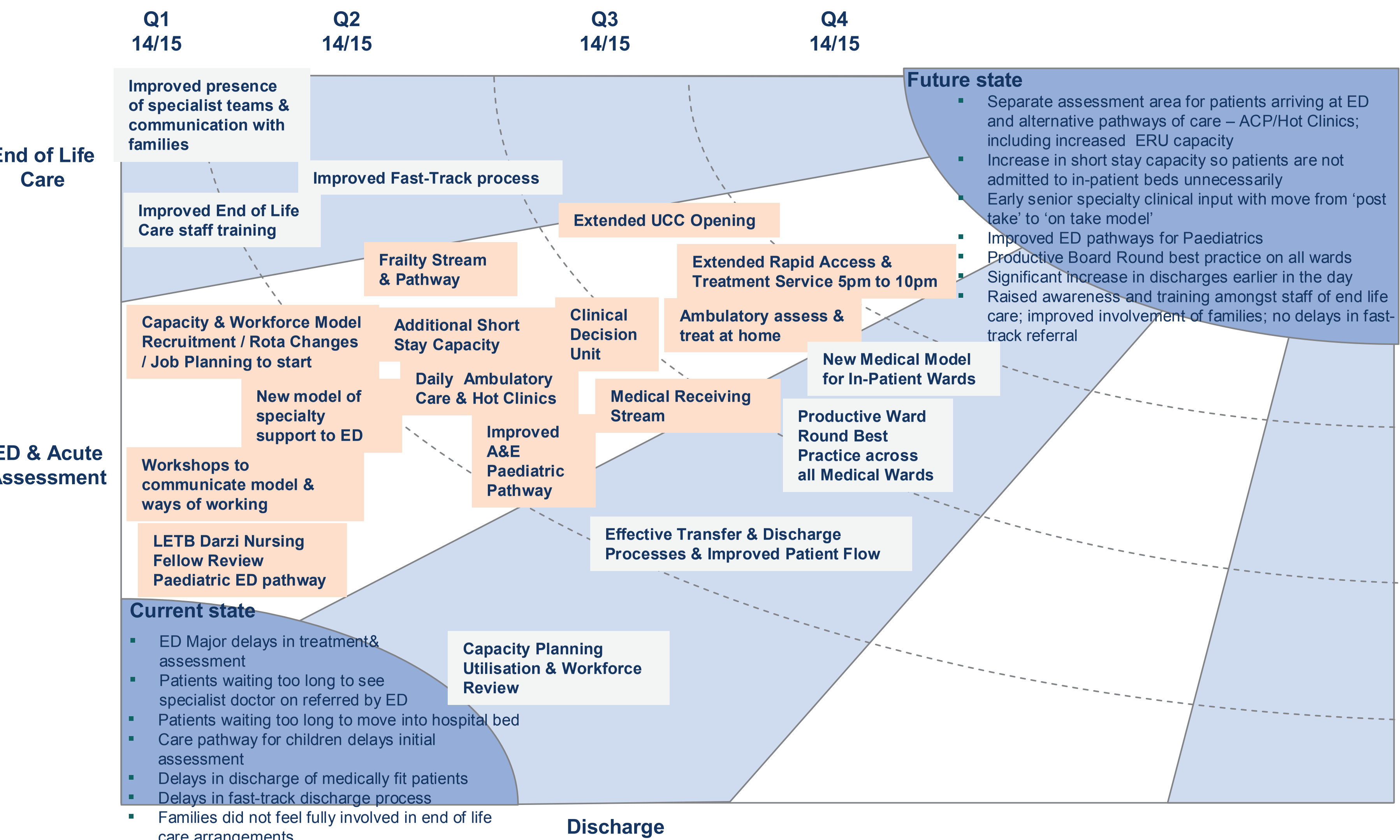
3.1 Providing specialist palliative care team input across the Trust seven days a week and providing patients and their families with a named contact who will manage their pathway at end of their life so patients die in their preferred location
3.2 Streamlining requirements whilst meeting statutory requirements for fast track paperwork through work with our partners
3.3 Implementing a brokerage system at weekends.

We will know we have been successful if:

1. Staff have the appropriate skills and support to effectively care for patients at the end of their life with 25% of staff trained by April 2014 and 50% by July 2014.
2. Families speak positively about end of life care within the Trust, measured through the bereavement survey.
3. Patients are supported to return home more rapidly with paperwork completed within 48 hours and discharge achieved within 72 hours.
4. More people have advanced care plans in place which support them to die in their preferred place of care.

A summary of all the actions we are taking to improve patient flow is on the following page and the detailed actions are shown in Appendix 1.

Patient Flow Improvement Plan On A Page



unlocking our potential

section three – patient care and clinical governance

our improvement plan for 2014/15

3.1 Sepsis
3.2 Documentation
3.3 Quality governance
3.4 Patient experience

Improving the way we treat people with sepsis

Why this is important

Sepsis is a serious illness which is caused by severe infection and is sometimes called septicaemia, or blood poisoning. There are different stages of sepsis and as it becomes more severe it can be very dangerous. It is therefore important to recognise signs of sepsis, screen for sepsis and to rapidly give patients with sepsis or septic shock a defined set of treatment.

The CQC found that:

- Staff they spoke to had not been trained in BHRUT to recognise and manage sepsis, were not able to define what sepsis was and did not know if there was a guideline available to follow
- the Trust did not use a best practice tool such as the Sepsis Six which is a series of life saving interventions and that the observation charts did not prompt staff to consider sepsis.

Our assessment of the key issues:

The Trust has carried out an audit of a sample of around 80 patients who had sepsis to see whether the best-practice standards were achieved. The audit showed that improvements could be made in:

- the awareness of clinical staff about sepsis and the Sepsis Six care bundle
- the time between patients presenting to hospital and receiving antibiotics
- the consistent delivery of the 3 tests and 3 treatments (known as the Sepsis Six) to patients who are identified as having sepsis.

Our improvement objectives:

1. Improve the awareness and recognition of sepsis
2. improve the number of patients who have evidence based care to reduce mortality

Our priority actions that will deliver the biggest impact are:

Objective one: Improve the awareness and recognition of sepsis

1.1 Raise awareness of sepsis and deliver training for our clinical staff.

Objective two: Improve the number of patients who have evidence based care to reduce mortality

2.1 Implement a screening tool for sepsis and the Sepsis Six care bundle
2.2 audit our compliance with the College of Emergency Medicine standards for A&E, and the sepsis six care bundles, to ensure that our actions are effective.

We will know we have been successful if:

1. Sepsis is identified promptly through use of the sepsis screening tool
2. patients have the three investigations and three treatments (the Sepsis Six) within the first hour
3. mortality from Sepsis reduces.

Our detailed action plan is shown in Appendix 1.

Improving documentation

Why this is important

Good record keeping is an integral part of nursing, midwifery and medical practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow. Good record keeping, whether at an individual, team or organisational level, has many important functions including:

- Showing how decisions related to patient care were made
- helping to identify risks, and enabling early detection of complications
- promoting better communication and sharing of information between members of the multi-professional healthcare team and making continuity of care easier
- supporting effective clinical judgements and decisions
- providing documentary evidence of care and treatment provided.

The CQC found that:

- Many records, including discharge plans, are not consistently kept-up-to-date and do not include the care patients either need or have received
- documents did not include the more personal aspects of care, which can impact on experience and dignity
- patients are transferred across our sites without proper records.

Our assessment of the key issues:

The Trust has not placed sufficient emphasis historically on the importance of documentation and good record keeping; this is partly a result of a perception of insufficient time being available to front line staff.

Past audits have also identified concerns around the quality of documentation, however this has not been effectively addressed.

Our improvement objective is:

1. **To ensure that patients are being regularly reviewed and assessed, evidenced by complete documentation.**

Our priority actions that will have the biggest impact are:

1.1 Reinforce and communicate the standards required in respect of documentation
1.2 regularly review patient notes to ensure nursing documentation is of agreed standard
1.3 review all of our documentation to identify changes to streamline it and improve integration with other healthcare professional records.

We will know we have been successful if:

1. A minimum of 95% of records meet all the documentation standards by October 2014
2. 100% of patients transferred between sites have a completed checklist in place by April 2014.

Our detailed action plan is shown in Appendix 1.

Ensuring effective systems to monitor and improve quality of services

Why this is important

The NHS Constitution commits all NHS organisations to a series of values including a 'commitment to quality of care' which states:

"We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes."

Currently we are not able to consistently demonstrate that we have the systems, processes and culture in place to achieve this commitment.

The CQC found that:

- Incident reporting systems did make clear how the trust was learning from incidents and making necessary changes
- key safety and quality data is not aggregated into one place to allow for the recognition of themes
- there are not effective systems in place to monitor the quality of the services provided
- there was variation in how national guidelines (eg NICE) are being implemented and monitored
- some staff were unaware of the link between changes in practice as a result of learning from incidents.

Our assessment of the key issues:

The challenges we face are driven by a number of issues:

- Significant focus has been on responding to operational quality and safety challenges which has diverted attention away from developing systematic solutions
- high turnover of staff (including large number of temporary staff) leading to limited organisational memory and a need for significant ongoing induction and training of new staff in trust systems and processes
- limited organisational capacity and capability around clinical governance
- the Trust has not yet undertaken Quality Governance Assurance Framework (QGAF) in readiness for any future Foundation trust application.

Our improvement priorities are:

1. Improve our systems for overseeing quality of services and ensuring that care is effective
2. improve our risk management systems and processes
3. improve how lessons are learned and changes made.

Our priority actions that will have the biggest impact are:

Objective one – improve systems for ensuring care is effective

1.1 We will implement a standardised clinical governance infrastructure across all directorates and review the clinical governance self assessment and address any gaps
1.2 we will strengthen the corporate clinical governance department with staff who will be centrally managed but will work with directorates to provide expertise and support
1.3 we will expand the quality metrics that are monitored within the Trust through the implementation of board to ward reporting
1.4 we will implement a peer review process in which each directorate will have a peer review of quality and safety twice a year
1.5 we will review our compliance against all NICE guidelines and implement a new system for considering new guidance that is published.

Objective two – improving our risk management systems

2.1 We will put in place a dedicated risk manager and review all of the risk registers to ensure they are up to date.
2.2 we will incorporate a monthly review of risk registers into the strengthened clinical governance process
2.3 we will implement an audit programme of completed actions
2.4 we will strengthen the QIA process to include key metrics that will be tracked to ensure that potential risks are monitored as CIP schemes are implemented.

Objective three – improve how we learn and make changes

3.1 We will audit the action plans for all incidents which result in severe or moderate harm to ensure the actions taken have been effective
3.2 we will review the top three lessons learned from incidents, complaints and claims and run targeted campaigns to raise awareness and promote change on a quarterly basis.

We will know we have been successful if:

1. 100% of directorates have had an internal assurance review by November 2014
2. there is a standard clinical governance system in place across all Directorates
3. all wards have a ward quality dashboard within a 'ward to board' reporting framework
4. 100% of areas have an up to date and accurate risk register which is driving decision making and improvement actions to mitigate risk
5. staff report that they have confidence that if identifying risks, action will then be taken
6. the Trust is compliant with NICE guidance or has assessed and managed the risk where it is not
7. staff are aware of the lessons from incidents and there are clear records of improvements that have been made, and audits to show they are effective.

Improving patient experience

Why this is important

Patients have a right to be treated with compassion, dignity and respect within a clean, safe and well managed environment, a right which is enshrined in the NHS constitution.

We want our patients to not only be treated well clinically, but also in a way which makes them feel safe and cared for. We want people who use our services to speak positively about their experience, as an important marker of quality.

The CQC found that:

- Many patients and relatives were complementary about the care they received and the way staff spoke with them
- more work is required to ensure the improvements are reflected in future national inpatient surveys.

Our assessment of the key issues:

- As a result of the challenges that the Trust has faced it does not have a strong reputation within the local community and has not been able to address this in recent years. We need to use the experience of other Trusts who have improved their patients experience to address this issue
- although the results of the Friends and Family Test have improved, these results have not been reflected in the national surveys. We think that this is partly because the surveys cover patients who were treated some time ago, and partly because the underlying reputation of the Trust has an influence on how people respond to the national surveys.

Our improvement objectives are:

1. To improve the reported level of satisfaction with the services we provide by responding to patient feedback
2. ro positively improve the reputation of the services amongst the local population

Our priority actions that will deliver the biggest impact are:

Objective one – to improve the reported level of satisfaction by responding to feedback

1.1 We will increase our reporting of the Friends and Family Test to weekly, and will broaden the scope to include outpatients
1.2 we will implement a programme of non-executive director visits to departments
1.3 patient stories will be the first item on the Board agenda
1.4 we will work with other Trusts to learn from other Trusts who have improved their patients experience, as measured by the national surveys, and incorporate their learning into our actions.

Objective two – to positively promote the Trust to improve the reputation of its services

2.1 We will introduce a 'you said we did' campaign on a monthly basis with proactive communication inside and outside the Trust
2.2 we will commission an independent assessment of the views of key opinion formers about the quality of services and develop a plan to address any areas of weakness

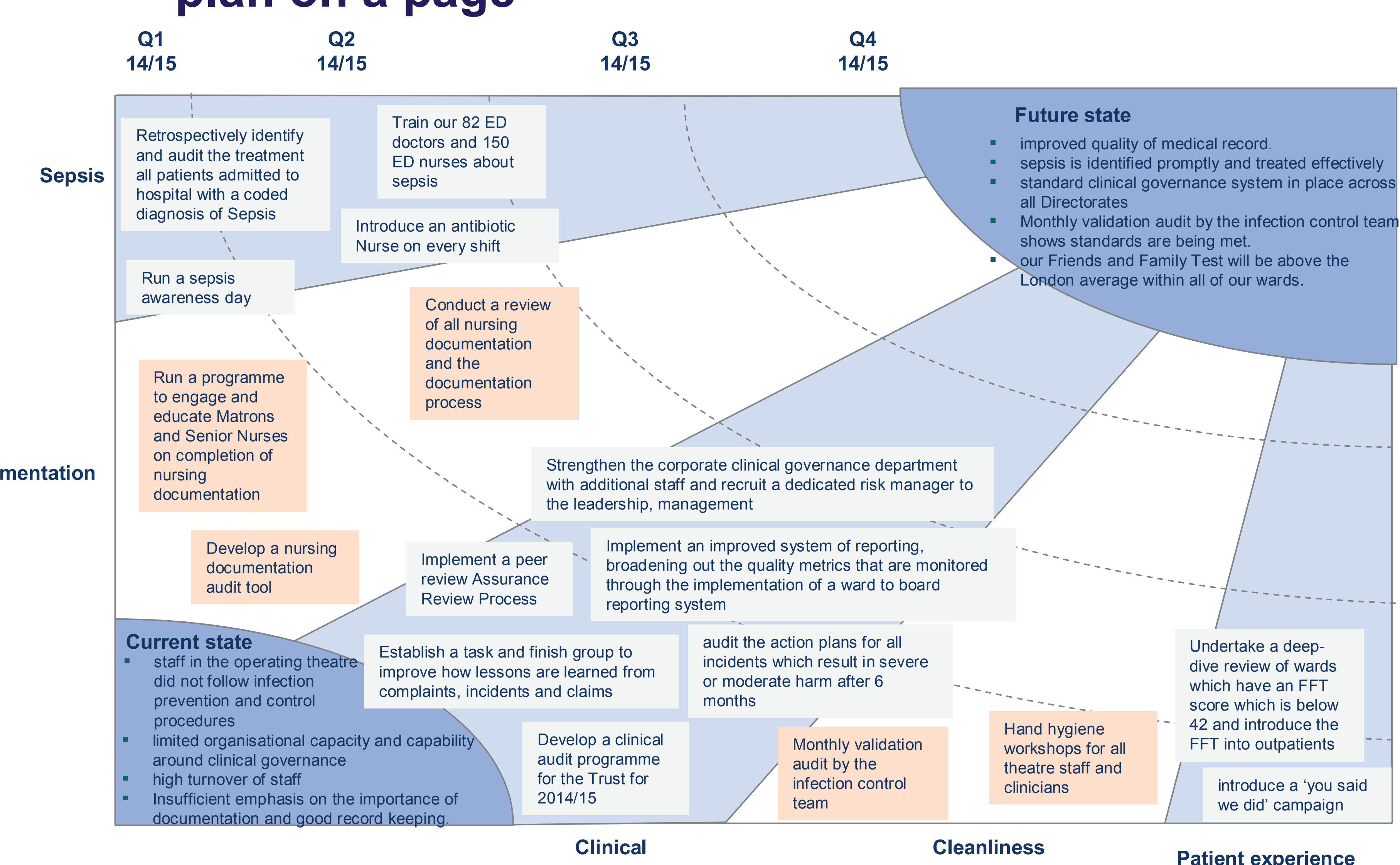
2.3 we will improve the way in which we promote positive news about the Trust to the local community.

We will know we have been successful if:

1. Our in-patient Friends and Family Test is consistently above the London average within all of our wards.
2. our ED Friends and Family Test is answered by 20% of patients and improves from its current position to the London average or better
3. 0ur 'you said, we did' campaign can evidence on a monthly basis our reaction to patient's experiences.

A summary of all the actions we are taking to improve clinical governance and patient experience is shown on the following page and the detailed action plans are shown in Appendix 1.

Patient care and clinical governance improvement plan on a page



unlocking our potential

section four – outpatients

our improvement plan for 2014/15

4.1 Outpatients
4.2 Day care surgery

Improving our outpatient services

Why this is important

There are 670,000 outpatient appointments at our hospitals each year. Many people therefore rely on us to provide them with a high quality service in which they are seen promptly, at a time convenient to them and by the right doctor.

The CQC found that:

- Appointments are not being booked properly, with poor communication to patients about the time, date and venue of their appointment leading to confusion, and patients not being booked to see the right doctor for their condition
- scheduled appointments are delayed or cancelled for a number of reasons including missing notes, consultants being double booked and staff arriving late
- the environment in which the sexual health service was located was not fit for purpose.

Our assessment of the key issues:

Since the CQC report we have undertaken an initial review of our outpatient service. It is clear that major improvements are needed. There are a number of issues that have been unresolved for some time, and these have been further exacerbated by the introduction of our new PAS system, although this will help us improve our service once fully implemented.

We have found that:

- Patients are not being booked into the correct clinics because our directory of services is out of date, and our consultants are not reviewing referrals quickly enough to make sure patients are seen in the right clinic
- patients are not able to get through to the contact centre if they want to make or change an appointment
- our staff are not tracking medical records when they are moved between departments which means we are unable to easily locate the notes to make sure they are available for the appointment. We found that approximately 15 – 20% of notes are missing based on a snapshot audit that we completed over a two week period
- our clinic schedules need to be completely reviewed and changed because we are booking too many patients at the same time and at short notice
- we are cancelling appointments because of poor coordination with doctors annual leave and are not able to re-arrange the appointments in a reasonable timeframe
- our IT systems for communicating appointments or changes is ineffective and means patients receive multiple letters and have delays in getting appointment confirmed
- systems were not used to check the impact on service quality of moving our sexual health clinic.

Our improvement objectives are:

1. To improve the environment of the sexual health clinic
2. to re-build all of our clinic appointment slots so that patients are seen on time in the right clinic
3. to improve the information we collect about how effective the outpatient service is, monitoring it more closely and taking prompt action where improvements are needed.
4. to improve our administrative and customer service arrangements.

Our priority actions which will have the greatest impact are:

Objective one – restructure our outpatient clinic slots

2.1 We will re-profile all the clinics that we run to create the right number of slots at the right time intervals and will make sure that clinics are only scheduled when doctors are available
2.2 we will rebuild the directory of services so patients are referred to the correct clinics
2.3 we will leave some clinics vacant so that if we need to rearrange an appointment a patient does not wait too long for a new appointment
2.4 we will ensure that clinicians are job planned in a way that enables them to attend clinic on time.

Objective two– improve the information we use to oversee, monitor and improve the effectiveness of our outpatient service

3.1 We will introduce weekly monitoring and then we implement the functionality of the new PAS system which will enable us to have better information to monitor the services
3.2 we will introduce the Friends and Family Test into outpatients and report by consultant
3.3 we will implement regular senior manager visits to outpatients to seek feedback from patients and staff.

Objective three – improve our administrative and customer service arrangements

4.1 We will review and monitor the printing workflows to ensure they are correctly set up
4.2 we will create a dedicated team of staff who are focused solely on call handling
4.3 we will ensure that the improvement actions are joined up with the work which is taking place to ensure our newly implemented computer system is fit for purpose.

We will know if we have been successful if:

1. Patients are seen in appropriate environments and speak positively about their experience
2. 80% of patients are seen within 15 minutes of their appointment time
3. their medical records are available to the doctor or specialist nurse who is seeing the patient
4. patients are seen by the right clinician in the right clinic first time
5. appointments are not rescheduled un-necessarily
6. the average 'did not attend (DNA) rate drops from 12% to 10% in the first six months from implementation
7. the DNA rate is sustained for a period of three months thereafter and shows a declining trend.

A summary of the actions we are taking is shown at the end of this section and our detailed action plan is shown in Appendix 1.

Day care surgery

Why this is important

Each year, over 65,000 patients have day surgery across our two hospital sites. The CQC found that too many of our operations are cancelled and too often patients have to recover from their operation in areas which do not provide a good experience.

The CQC found that:

- Patients recovery after day surgery was not properly managed in order to provide a good experience
- too many operations were cancelled, with some being cancelled two or three times.

Our assessment of the key issues:

- Day surgery environment means patients often undergo recovery in the wrong environment
- poor processes and lack of escalation and oversight leads to too many cancelled operations.

Our improvement objectives are:

1. To improve the environment in recovery as a short term measure
2. reduce the number of patients whose operation is cancelled
3. improve the arrangements for patients after they go home if they have any concerns or queries

Our priority actions which will have the greatest impact are:

Objective one – improve the environment

1.1 We will create toilet and shower facilities and ensure that a nurse is specifically identified to care for patients who stay in recovery

1.2 our improvements in patient flow should mean that in the medium term patients will be able to move to a ward more quickly, and in the longer term we are creating a dedicated elective centre at King George Hospital, separated from the emergency care pathway.

Objective two – reduce the number of cancelled operations

2.1 We will introduce additional flexible lists on demand to provide additional capacity for urgent cases so that routine surgery is not cancelled.

Objective three – improve our aftercare for patients

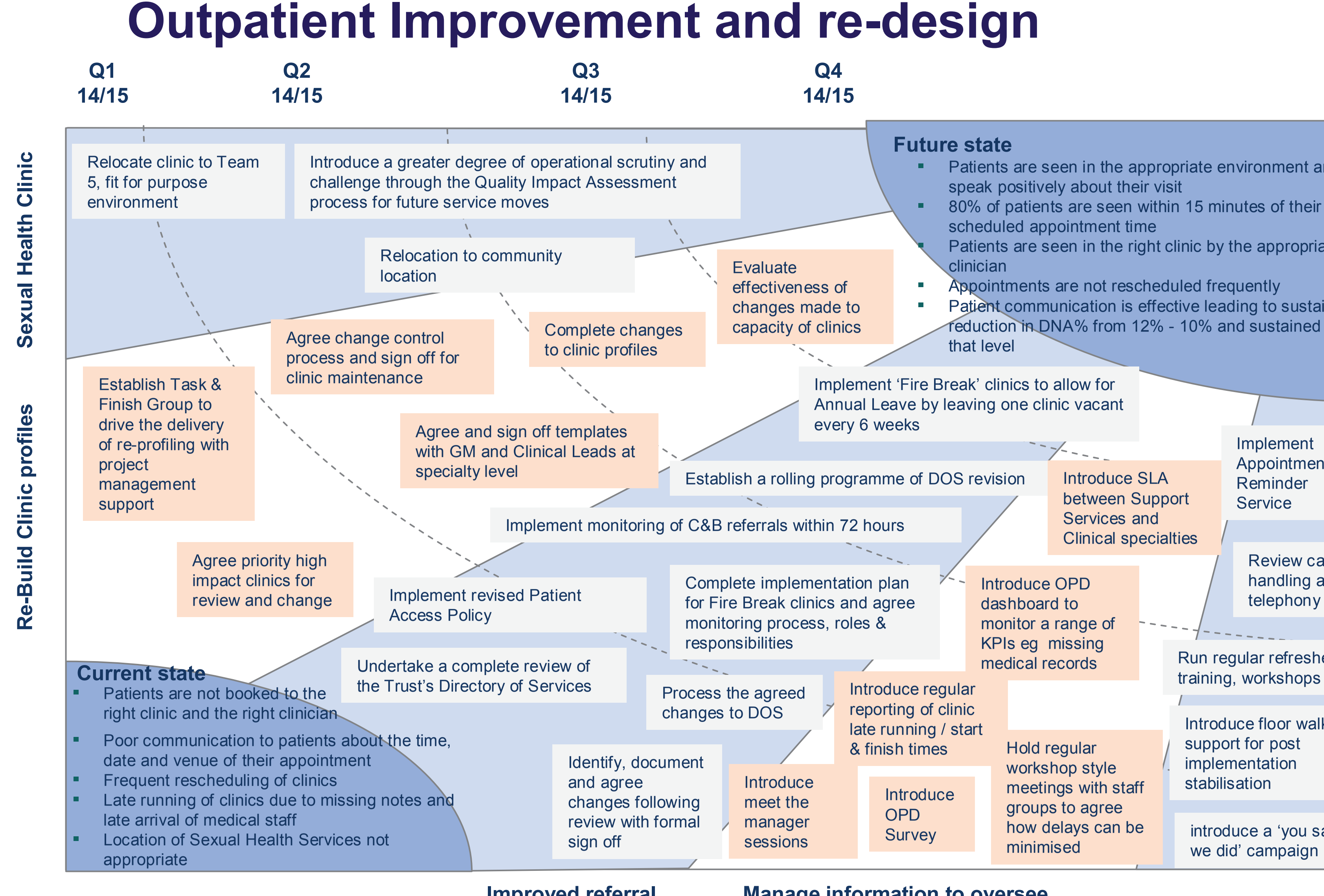
3.1 We will provide patients with be given a dedicated contact number to call if they are experiencing any pain or have post-operative queries.

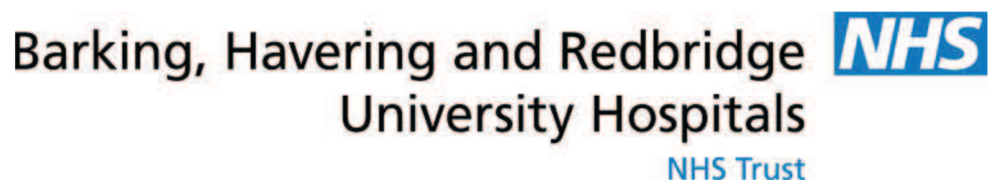
We will know we have been successful if:

1. The patient's experience of day surgery is improved through the availability of toilet and shower facilities. The provision of cold food during the day will improve the environment for patients recovering from anaesthetic.

2. the number of cancellations for day surgery procedures is reduced. In particular the number of patients experiencing cancellation for a second or third time will be significantly decreased through the improved use of flexible capacity
3. patients report greater satisfaction with their day case surgery and the support they receive after going home.

Outpatient Improvement and re-design





unlocking our potential

section five – leadership and organisational development

our improvement plan for 2014/15

Leadership and organisational development

The Trust was placed in special measures because of the scale of the improvements that needed to be made.

A new Chief Executive takes up post in April 2014 and the Trust will also receive feedback from the capability review that was undertaken.

As such, the improvement objectives associated with leadership,management and organisational development will be agreed once the new Chief Executive starts in post.

The priorities for development are likely to include:

1. Developing a clear, concise strategy for the Trust
2. Stabilising the senior leadership team and developing a strengthened unitary board and executive team
3. Ensuring there is an effective structure and operating model in place to support effective execution and delivery
4. Ensuring the executive team have appropriate portfolios to support aligned and effective delivery
5. Ensuring there is adequate capacity in the non-executive director team, and strengthen the arrangements for holding the executive to account
6. Strengthening clinical leadership, and strengthening the collective medical, nursing and managerial leadership arrangements at a service level
7. Improving the responsibility for external relationships and developing better and stronger partnerships
8. Improving the management and clinical information within the Trust, and how it is used to become a more data driven organisation with better board to ward reporting
9. Improving the focus on follow through, follow up and supporting development whilst strengthening holding people to account
10. Strengthening the communications function
11. Improving our staff and partner engagement

unlocking our potential

section six – delivering the improvement plan

our improvement plan for 2014/15

Delivering improvement: Introduction

We recognise that in the past we have developed detailed plans that have not been fully implemented, and that delivery of the scale of change that is required is a risk to the achievement of our improvement objectives.

Approach

The Trust has identified an executive director, who supported by the TDA Improvement Director will oversee the implementation of the changes we have identified. We will appoint a dedicated programme director and a clinician to lead the implementation.

The delivery of change will be integrated into our 'business as usual' arrangements because it is important that improvement becomes a more structured part of our day to day work. However, we recognise that additional dedicated resource embedded within our business as usual arrangements will be required to achieve the level of change we have identified.

Where improvement work identified in the plan can be integrated with or drive delivery of existing programmes of work, such as that of the integrated care coalition on frailty and long term conditions we will do so.

Each of our key improvement themes is led by an Executive Director who acts as SRO, and will be supported by additional dedicated project management resource embedded within the directorates, but managed by the central programme director and a project management office which will monitor delivery.

Recognising that the success of other organisations and BHRT are interdependent in many ways, the Trust will identify the most effective way of securing the additional implementation support in partnership with local stakeholders, and will ensure that this is used to build capacity and capability in change and improvement within the Trust's operational and clinical staff.

Resource implications

There are four types of resource required to effectively implement the changes we have identified:

1. Additional recurrent expenditure in the short term, which should lead to efficiencies in future years
2. Non-recurrent expenditure to support the implementation of the plan through additional clinical and management capacity, PMO support and additional external expertise
3. Transitional expenditure in which additional capacity may be required to provide stability and headroom whilst the changes are implemented
4. Additional capacity in out of hospital settings

Support from partners

The Trust has been well supported by partner organisations during the development of the improvement plan, for which we are very grateful. The improvement plan contains changes that can only be implemented with support from partners and these are summarised below.

Workforce:

1. Positively promoting the Trust and the local area as a great place to live, train and work
2. Creating workforce rotations that maximise the fill rate of doctors in training – in particular in medical specialities and emergency care
3. Support the creation of joint consultant posts, or rotational posts.
4. Supporting the development of Queen's Hospital as a site for future training programmes

Patient flow:

1. Implementing advanced care planning to prevent people needing emergency care
2. Piloting the deployment of specialist assessment in peoples homes as a response to some calls to the ambulance service
3. Streamlining the paperwork requirements to support discharge (such as CHC and fasttrack)
4. Broaden the criteria for intermediate care beds and implement a trusted assessor model
5. Implement the discharge to assess model
6. Implement the evidence based interventions to reduce readmissions to hospital
7. Increase the support of CTT and IRS to 'pull' patients out of sub-acute hospital beds

Leadership and organisational development:

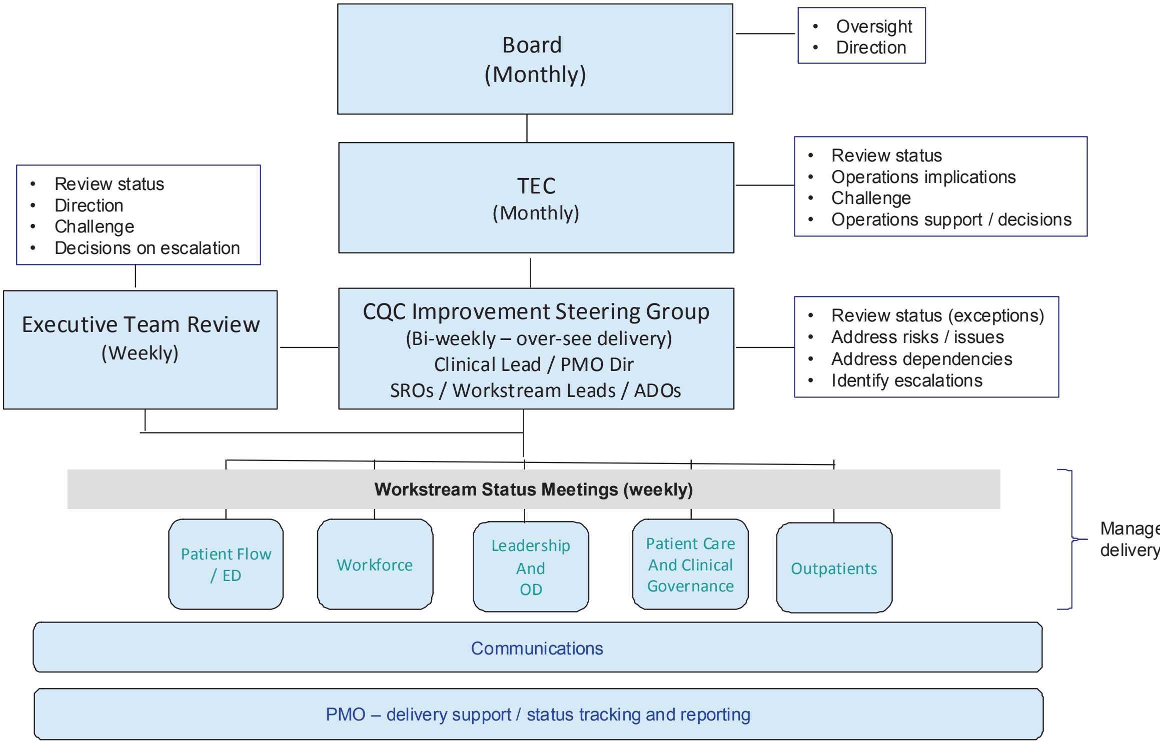
1. Supporting the positive promotion of the Trust and its services where appropriate
2. Implementing joint leadership and development programmes for clinicians and managers across health and social care
3. Supporting the development of stronger and more effective joint working arrangements
4. Supporting the development of an outward facing organisation and bringing an external view inside the Trust

Key risks to delivery

1. Capacity and capability within BHRT is inadequate to implement and embed the changes identified
2. There is insufficient focus on the delivery of the changes required due to competing priorities
3. The changes required cannot be effectively implemented because there is insufficient capacity to provide adequate stability in the emergency pathway from which change can be made
4. The Trust is unable to recruit to key clinical and managerial posts that are required to achieve the improvements
5. The support from partner organisations is insufficient to achieve the changes identified
6. The agreements reached at a senior level in organisations does not translate effectively into new ways of working at the shop-floor clinical interface.

Governance arrangements

The internal governance arrangements are summarised below



The delivery of the improvement plan will be overseen by the Board of Directors on a monthly basis, and two key sub-committees of the Board (Workforce Committee and Safety and Quality Committee) will provide further in-depth scrutiny and hold the Executive Team to account for delivery.

As has been described the improvement plan requires health economy oversight, particularly in relation to the emergency care pathway, and the Integrated Care Coalition will ensure collective delivery across all member organisations.

Conclusion – beyond the improvement plan

The improvement plan represents the start of a journey of improvement, putting in place the building blocks that will create the foundation for future change and improvement. It aims to stabilise the Trust, whilst taking the first steps to change the clinical, operational and governance models.

More strategic and transformational change can and will then follow on from this, allowing the Trust to take further steps with partner organisations to further transform services.

This is particularly the case for the emergency pathway in which the improvement objectives in this plan are aligned with delivery of a smaller emergency care workload and the acute reconfiguration which will consolidate acute services onto a single site.

A smaller, more efficient and more effective set of services, concentrated in fewer areas will support the Trust and the health economy move towards the goal of clinically excellent and financially sustainable services delivering care for local people in the right setting.

1. There will be a lower workforce requirement, which will mean that the Trust will be able to operate with a lower core staff base. This will improve quality as currently the Trust relies on high levels of expensive temporary staffing to run the current number of wards that are required.

2. Acute care will be concentrated on the Queen's Hospital site, allowing the release of acute estate at King George Hospital to be developed for step down and then ambulatory care as the full impact of the shift to home based care is achieved.

3. The senior medical workforce will be concentrated on a single site (for emergency care) allowing quality standards to be achieved.

This improvement plan therefore sets the stage for future and ongoing improvement and transformation of services for our local community towards the local health economies vision.

Barking, Havering & Redbridge University Hospitals NHS Trust
March 2014

Barking, Havering and Redbridge University Hospitals **NHS**
NHS Trust

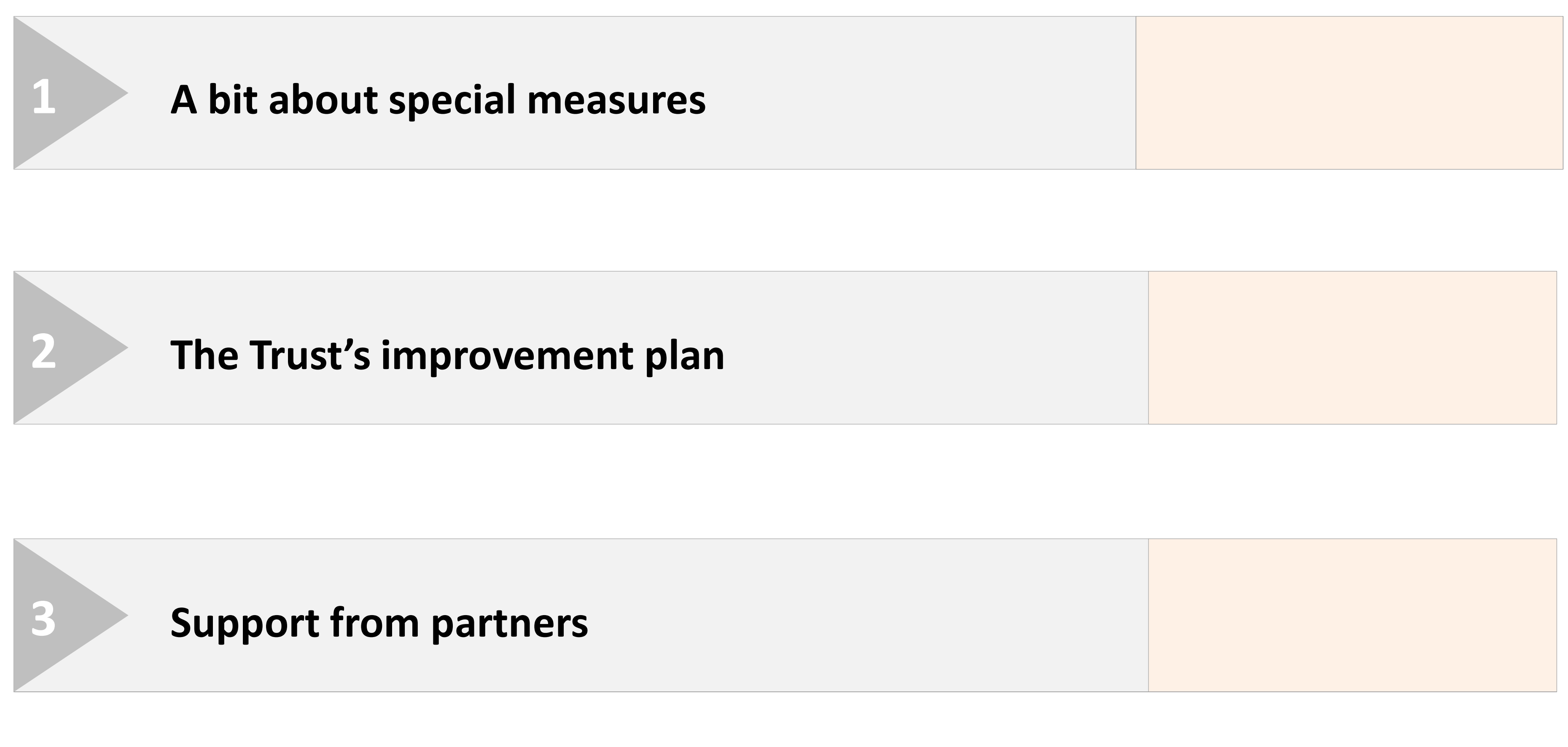
Unlocking our potential

a summary of our improvement plan for 2014/15

In partnership with

NHS
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Contents



1 A bit about special measures

2 The Trust’s improvement plan

3 Support from partners

A brief overview of special measures

- An intervention intended to create focus and support where organisations face significant challenges

- BHRT followed the Chief Inspector of Hospitals findings and in view of the scale of the leadership task given the deteriorating financial position

- Trusts in special measures
  - Have a TDA Improvement Director allocated to oversee and support the Trust's improvement plan
  - Have to produce a plan and deliver improvements over a period of time
  - Receive support to make improvements
  - Have to report progress monthly which is overseen by the TDA
  - Will have a re-inspection from the Chief Inspector of Hospitals

This is one component of our four pronged quality and cost improvement plan for 2014/15 to move us out of special measures and on to a more stable footing

Quality improvement

- **Five key areas of targeted improvement** to address the findings of the Chief Inspector of Hospital's review of the domains of safety, effectiveness, caring, responsiveness and well led in key services
- **Improvements in national operating standards** in the domains of cancer and referral to treatment
- **Local quality improvement priorities such as CQUINS and** harm reduction, falls, avoidable mortality, radiology and use of ICT

Cost improvement

- **Delivering a 'stand still' position with a deficit of £38m** through cost reduction of £20m, preparing to reduce the deficit in future years and rebalancing the elective and emergency workload

Our improvement plan has been developed over a period of time

Findings of the Chief inspector of hospital's review published

Compliance actions developed and submitted on 4th February 2014

First draft of the improvement plan shared with partners on 9th March 2014 following internal development

Second draft of the improvement plan shared with partners

Endorsed by Quality & Safety Committee

Discussed and endorsed **vision, principles and key intervention** at Urgent Care Board, recognising alignment with the system strategic plan.

Discussed and endorsed **vision, principles and key intervention** with caveats on delivery risk at Integrated Care Coalition, recognising alignment with the system strategic plan.

Our improvement plan contains 5 key themes to address the findings of the Chief Inspector of Hospital's review. Each theme has improvement objectives and supporting improvement actions

1. Workforce
2. The emergency care pathway
3. Clinical Governance
4. Outpatients
5. Leadership & OD

We have identified the priority improvement objectives and actions that will have the biggest impact . There are 26 priority objectives, of which 12 relate to must do actions. The objectives will be delivered by 67 priority improvement actions

Theme	Number of priority objectives	Safe 7	Effective 7	Caring 2	Responsive 10
Workforce	4 (1)	4 (1)			
Emergency Pathway	8 (4)		3 (1)		5 (3)
Quality Governance	8 (5)	3 (3)	3 (2)	2	
Outpatients	6 (2)		1		5 (2)

(n) Number of objectives relating to 'must do's'

Our 4 priority actions to recruit the best, retain the best, and develop our teams to be the best together

	BHRT actions	'Asks of partners'
1. Improve the senior A&E medical staffing	1.1 Improve the working environment 1.2 Create a parallel training programme for NCCG and improve the training of junior doctors in A&E and Acute Medicine 1.3 Establish an ACCS stem	1.1 Create rotational posts, academic posts and a CEM time limited programme 1.2 Restructure rotations
2. Diversify the workforce	2.1 Train ENP and ANPs	2.1 Develop consolidated training programmes at BHRT (PA and NP)
3. Improve recruitment and attract more people	3.1 Better promote the opportunities in the Trust 3.2 Run targeted campaigns, and recruit for turnover	3.1 Promote the area as a place to live, train and work
4. Retain more people who join BHRT	4.1 Improve our awareness of the reasons that people leave and take actions 4.2 Improve staff engagement	

Patient flow: some context

- Emergency admission rates relative to population around national average
- A&E conversion rate higher than national average
- 40% of patients who spend more than 4 hours in the department are discharged home, and time to see an A&E doctor rises significantly out of hours
- Average medical admissions of 65 at QH per day, of which 50% meet the frailty criteria
- Very high ambulance arrivals, with over one third being for >75 year olds
- Length of stay higher than national average with an opportunity of c140 by moving to peer average in medicine
- Largest bed use appears to be for 65-85 with 1-3 LTCs followed by 86+ with 1-2 LTCs and then 86+ with 3 LTCs
- Wrong beds in the wrong place, and too many beds relative to what **should** be needed, but occupancy at 98%+
- 32% of medical admissions (45% of all) discharged before 2 midnights (against IST recommendation 50-65%)
- Readmissions above national average. 45% readmitted within 7 days, 23% in second week, 33% in week 3 or 4, consuming 204 beds
- 76% of people admitted to hospital who die, die in hospital

The improvement plan aims to align actions with the health economy strategic vision

1. Prevent people having an emergency episode, with home the default place of care
2. Providing alternatives to admission when people do have an urgent need
3. Reducing avoidable **time** in hospital
4. Home being the default place of care on discharge, with people remaining at home 90 days after discharge
5. Supporting more people at the end of their lives to be cared for in their preferred place of care

- Fewer emergency admissions
- Less time in a bed, and acute beds only used for patients with an acute need
- Fewer admissions to nursing and residential care
- Fewer emergency readmissions – more people staying at home
- Fewer patients receiving end of life care in hospital

Home is the default at every stage of the pathway, because we behave as one team, and have the right systems and services in place all the time. This should result in a smaller, higher quality acute hospital base with acute care consolidated on one site.

There are 8 priority actions to improve flow, which have been grouped into 5 pathway improvements

	BHRT actions	'Asks of partners'
1. Improved A&E assessment	1.1 Create an ED observation unit 1.2 Develop a standalone UCC service 1.3 Improve paediatric ED 1.4 Improve diagnostic access	
2. Improved Frailty Pathway	2.1 Create a frailty unit 2.2 Daily ambulatory clinics 2.3 Pre-hospital interventions 2.4 Implement LACE scoring	2.1 Trusted assessor model 2.2 Discharge to assess 2.3 Restarts and simple care packages 2.4 Implement 7 evidence based interventions 2.5 IRS to support acute elderly beds 2.6 CTT model to extend to ERU and MRU
3. Improved Acute assessment	3.1 Create MRU 3.2 Extend AAU consultant presence to 10pm 3.3 Daily ambulatory clinics 3.4 Eliminate delays for in-patient diagnostics	
4. Improved in-patient model	4.1 'On-off' model and roll out productive ward 4.2 Improve capacity planning using level of care audits	
5. Improved end of life care	5.1 Implement liaison palliative care into MAU and acute wards 5.2 Provide SPC as part of complex care hubs	5.1 Streamline paperwork and implement brokerage at weekends 5.2 Implement structured ACP

This will need to be supported by a significant programme of development, and an aligned 'focus' to deliver

The urgent care board and integrated care coalition have endorsed the approach and the 'interventions' and have raised the need to:

1. Implement clinical leadership across organisations
2. Align our collective efforts on frailty with support from UCLP
3. Ensure the governance arrangements between organisation support a 'many organisations one team' approach
4. Implement a programme of training and development to support front line staff move to this way of working

There are 8 priority objectives to improve our quality governance arrangements

	BHRT actions
1. Improve awareness of sepsis	1.1 Delivery mandatory training
2. Increase the number of patients receiving evidence based care	2.1 Implement sepsis six care bundle 2.2 Regular audit of compliance
3. Improve documentation of care	3.1 Communicate and reinforce required standards 3.2 Regularly audit notes 3.3 Review and streamline documentation
4. Improve systems for monitoring effectiveness of care	4.1 Implement standardised clinical governance framework 4.2 Strengthen the clinical governance department 4.3 Expand the range of quality metrics 4.4 Implement peer review of services 4.5 Review compliance against NICE standards
5. Improve risk management systemts	5.1 Put in place risk manager and review all risk registers 5.2 Implement regular review of risk registers 5.3 Audit completed actions 5.4 Strengthen QIA process
6. Improve learning	6.1 Audit all action plans for severe or moderate harm 6.2 Communicate the top 3 lessons in targeted campaigns
7. Improve satisfaction by responding to feedback	7.1 Increase range and frequency of FFT 7.2 NED visits to departments 7.3 Patient stories on Board agenda 7.4 Learn from other Trusts
8. Positively promote the Trust’s services to enhance reputation	8.1 ‘You said we did’ campaign 8.2 Understand the views of key opinion formers

There are 6 priority objectives to improve our outpatient and day case surgery services

	BHRT actions
1. Restructure our outpatient clinics	1.1 Reprofile all clinics 1.2 Rebuild DOS 1.3 Implement firebreak clinics 1.4 Ensure clinicians attend on time
2. Improve our oversight of outpatients	2.1 Weekly monitoring of % patients seen in 15minutes of appointment time 2.2 Implement FFT by consultant 2.3 Improve senior management engagement in OPD
3. Improve our admin and customer service	3.1 Review letter and printing content and workflow 3.2 Improve call handling 3.3 Implement the Medway PAS improvement plan
4. Improve the recovery environment	4.1 Create toilet and shower facilities at QH 4.2 Create a dedicated elective centre at KGH
5. Reduce cancelled operations	5.1 Additional flexible lists to reduce short notice cancellations
6. Improve our aftercare	6.1 provide a dedicated point of contact

We have identified 3 key risks to the delivery of our improvement objectives, and these are consistent with the views of our partners

1. What is different this time? - our capacity, capability and focus to deliver

2. The support we need from others being implemented

3. Implementing significant change whilst we are still running in the old model, with no headroom and a lack of transitional support

Support from partners

Frailty / Care of the elderly	
IRS to support acute elderly beds	
CTT model to extend to ERU and MRU	
Implement 7 evidence based interventions	

End of Life care services	
Streamline paperwork and implement brokerage at weekends	
Implement structured ACP	

Discharge arrangements	
Trusted assessor model	
Discharge to assess	
Restarts and simple care packages	

'One team' governance and behaviours. Consistent translation of intent to operational practice at the patient interface

Next steps and questions

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HEALTH AND WELLBEING BOARD

17 JUNE 2014

Title:	**The Joint Assessment and Discharge Service**
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: No**
Report Author: Bruce Morris Divisional Director, Adult Social Care	**Contact Details:** Tel: 020 8227 2749 E-mail: bruce.morris@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director Adult and Community Services	
Summary: The Board previously considered detailed proposals for the development of a Joint Assessment and Discharge Service in August 2013. The statutory partners in the BHR health and social care economy, London Borough of Havering, London Borough of Barking & Dagenham, London Borough of Redbridge, BHRUT, NELFT and the 3 CCGs have been working together through an “Integrated Care Coalition” to finalise service development and begin steps towards implementation. This report provides an update on progress for the new service which became operational from 2 June, and continuing work to resolve remaining outstanding issues.	
Recommendation(s) The Health and Wellbeing Board is recommended to agree: (i) To note the progress of the Joint Assessment and Discharge Service (ii) To note that a further report will be brought back to the Board considering future hosting arrangements for the service.	

1. Background and Introduction

1.1 The Joint Assessment and Discharge Service (JAD) Service will consist of around 50 health and social care staff, with a staffing budget of c.£2m. The Service Manager was appointed in February - employed by LBBD as the ‘host’ organisation. Remaining appointments were made at the end of May following the formal staff consultation process.

1.2 The JAD is the single point of contact for all referrals of people who may require health and/or social care support at the point of discharge from the hospital, in the form of care and support at home or in residential and nursing care with a dedicated

member of staff, either social worker or nurse, for each ward. The service has been made up of a number of teams employed by both NHS and local authorities brought together in one service and operates 7 days a week to both facilitate discharges at weekends and meet with family members who may visit relatives at weekends.

2. Governance

2.1 The development and implementation of the JAD has been overseen by the Integrated Care Coalition and the Urgent Care Board with regular Executive Steering Group meetings with senior representation from each participating organisation led by LBBD.

2.2 Partnership arrangements are formalised through a s.75 agreement which gives delegated authority for staffing matters, commitment of care budgets and decision making for Continuing Health Care expenditure. The aim is that, as far as possible, decisions can be made as close to and with the patients and families concerned, rather than decisions being referred back to “panels”.

2.3 The implementation of the JAD is intended to positively impact upon broader system improvement and particularly assist the performance and quality improvements required at BHRUT. The developments dovetail with the Improvement for BHRUT and the service works at both a strategic and operational level with BHRUT.

3. Staffing

3.1 A formal consultation process with affected staff from 4 employing organisations was led by LBBD following the relevant policies and procedures and concluded on 8th May. A small number of staff who have been displaced who are being managed through their respective organisations’ policies and procedures.

3.2 Recruitment for the small number of vacant posts is underway led by LBBD and staff who will be employed by partners depending upon where the vacancy arises.

4. Accommodation

4.1 At the point of writing this report, BHRUT have not been able to identify appropriate accommodation for the service which is disappointing. A number of solutions are being pursued by BHRUT and the partners and the service look forward to a satisfactory solution.

5. Processes

5.1 The main objective for the service was to improve the effectiveness of discharge arrangements from BHRUT. The service has hosted and led a number of pilots with 3 elderly wards with a view to developing consistent processes and behaviours that can be modelled throughout the hospital. The engagement of staff at all levels on the wards has been encouraging and BHRUT have played and a full and effective part in the development of the service.

6. Consultation

6.1 Healthwatch have facilitated two consultative events bringing together the schemes within our joint Better Care Fund plan – of which the JAD is a specific scheme.

7. Mandatory Implications

7.1 Joint Strategic Needs Assessment

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

a) Supported living for older people and people with physical disabilities – see JSNA at
http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-8.aspx
b) Dementia – see JSNA at
http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-28.aspx
c) Adult Social Care
http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-9.aspx
d) Learning Disabilities –
http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-3.aspx
e) Mental health- Accommodation for People with Mental Illness
http://www.barkinganddagenhamjsna.org.uk/Section5/Pages/Section5-7.aspx
f) End of Life Care
http://www.barkinganddagenhamjsna.org.uk/Section7/Pages/Section7-31.aspx
g) 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

7.2 Health and Wellbeing Strategy

The service has been developed to positively impact upon the health and well being of people who have received acute care and require support, information and advice to leave hospital in a timely and safe way. This is a key service in helping to deliver improvements in health and social care outcomes through integrated services.

We have developed a range of performance outcomes for the service which both align to existing measures – such as the number of people remaining at home after 91 days of discharge, number of discharges and numbers entering long term bed based care. We are also critically developing a measure that will provide the service with direct feedback from service users and their families determining both their experience of support and the extent to which they consider that their individual outcomes have been met.

7.3 Integration

The delivery of the Joint Assessment and Discharge Service will deliver a single, integrated discharge function across BHRUT involving hospital discharge staff, LBBD SW staff, LB Havering hospital SW team and staffing resources from NELFT.

7.4 **Financial Implications**

At this stage the service has been modelled on existing staffing budgets and final job evaluations; there are no financial issues. The pooled implementation pot is considered sufficient at this stage, and partners are continuing to manage additional one-off implementation costs from within their own budgets.

The S.75 provides for delegated authority to the service in respect to social care budgets and Continuing Health Care. Further work is being completed from finance teams to ensure there are simplified approaches to funding flowing between organisations and satisfactory reporting mechanisms and draft monitoring and reporting arrangements are currently receiving consideration by the Steering Group.

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

7.5 **Legal Implications**

Section 75 of the National Health Service Act 2006 and the Local Authorities Partnership Arrangements Regulations (2000) (SI 617) (as amended) provide the statutory foundation allowing certain Local Authorities and NHS Bodies to form partnering arrangements for the provision of health and social services to communities they serve.

These statutory requirements set out the circumstances when and type of information that must be included with what is known as a S.75 agreement.

The delivery of the JAD required a formal S.75 to be in place to address the arrangements which would allow staffing and resources to be managed within the service. We have developed a final draft of a S.75 which has been subject to support from the Councils legal services and in turn partner organisations contributing to the JAD seeking parallel input from their legal representatives.

Legal Services continue to work with the instructing client department in progressing the final S.75 agreement and are available to provide further advice and assistance as required.

Implications completed by: Allan Donovan, Interim Corporate Lawyer

7.6 **Risk Management:**

The S.75 provides for the management of risk between the partners to the JAD and includes provisions in the event of exit from the service by the partners.

7.7 **Customer/ Patient/service user impact**

The provision of the JAD will support improvements in collaborative working with decisions moved closer to the service user and their families as planning for discharge is begun within the wards at the point of admission.

Alongside a range of performance measures the conclusion of our approach to gaining direct feedback from individuals and their families will provide further steer in the development of the service as this beds down.

HEALTH AND WELLBEING BOARD

17 June 2014

Title:	Addressing Variation in Primary Care – A Report for Barking & Dagenham H&WB Board

Report of the NHS England London Region	
Open Report Yes	**For Information**
Wards Affected: All wards	**Key Decision:** No
Report Author: Neil Roberts, Head of Primary Care NHS England (London Region, North, Central & East)	**Contact Details:** Tel: 0207 932 3888 E-mail: neilroberts@nhs.net
Sponsor: John Atherton, Head of Assurance North Central and East London	
Summary: The paper sets out how the variation in primary care performance is identified and handled. The appendices provide some background on the GP outcome standards and some key data relating to primary care contracts and contractors. It makes reference where the Board might like to consider its due diligence of contracts offered to GP and pharmacies for the services the Local Authority commissions.	
Recommendation(s) The Health and Wellbeing Board is recommended: (i) To note the content of the report (ii) To determine how it might want to consider its "due diligence" on those services the Public Health team choose to commission from GP practices and pharmacies	
Reason(s) Variations in the quality of primary care will result in variations to the standard of service provided to our local population.	

1. Background and Introduction

1.1 GPs are independent contractors, not employees of the NHS. Mostly GPs work to national contracts. The process for handling poor individual performance is defined in Performer List Regulations (community pharmacy has no contract but is bound to deliver services to a set of statutory regulations). Once variation is identified, handling mechanisms are put in place that may relate to developmental, contractual or formal performer list action (or a combination of all three).

2. Proposal and Issues

2.1 Systematic scrutiny of delivery of GP standards and their improvement is getting underway with the CCG. All practices have access to the web tool where these data are maintained – practices had to validate their data. New primary care strategy and some new London standards are emerging.

3. Consultation

3.1 Much of this is national contract matter negotiated at the time between the NHS and the professions centrally.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

H&WB supporting improvement programmes

4.2. Health and Wellbeing Strategy

Not applicable to H&WB Board

4.3. Integration

Not applicable to H&WB Board

4.4. Financial Implications

Not applicable to H&WB Board

4.5. Legal Implications

Legal implications relate mainly to the NHS. Ramifications for the LA if it commissions services from a practitioner/contractor not able to work because of Regulatory Body action.

Implications completed by: Neil Roberts, Head of Primary Care NHS England (London Region, North, Central & East)

4.6. Risk Management

Not applicable to H&WB Board

4.7. Patient/Service User Impact

Not applicable to H&WB Board

The purpose of the work is to improve services to patients

5. Non-mandatory Implications

5.1. Contractual Issues

Contracts held and managed by NHS England. Local Authority may have some contracts with some GP practices and community pharmacies

6. Background Papers Used in Preparation of the Report:

None

7. List of Appendices:

- Addressing Variation in Primary Care (Powerpoint Presentation) – May 2014

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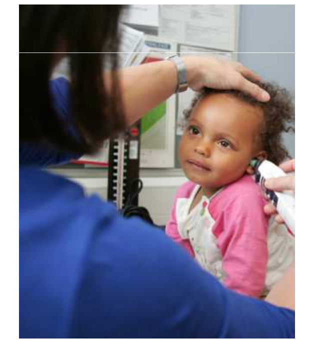
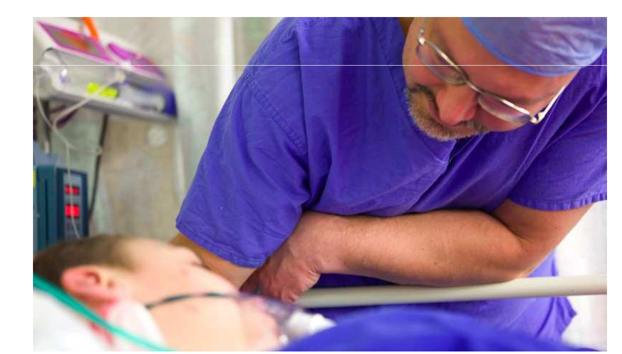
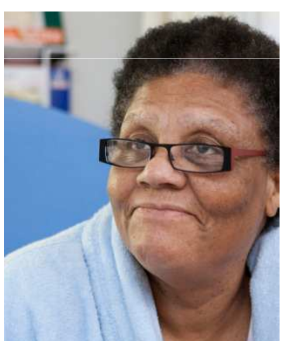
Primary Care Commissioning

Addressing Variation in Primary Care – A Report for Barking & Dagenham H&WB Board







May 2014
V Final

How NHS England addresses the variation in primary care performance and suggestions where NHS England thinks the Board can support improvement programmes for primary care performance

Background

- GPs are independent contractors, <u>not</u> employees of the NHS
- They must be included in the Performers' List to deliver services
- Performer List Regulations set out a regulatory framework for applying conditions to a GP's inclusion or continued inclusion
- NHSE decisions can be (and often are) appealed via the First Tier Tribunal
- Important to differentiate practice Vs individual, but these can be blurred

How we identify poor performance 1)

We continue to make use of a range of information from different sources:

- National, London and local data to inform, compare and challenge (GP High Level Indicators and GP Outcome Standards)
- Local intelligence from peers, other contractors/performers
- Information from Regulators, Regulatory Bodies and other statutory/non statutory organisations, including MPs, Councillors, Overview & Scrutiny Committees
- Information from complaints, other providers, surveys, press/TV, on line posts
- Direct patient feedback
- Whistleblowers
- Commissioned reviews
- …and we consider individual performer matters via a performance "Decision Making Group" (DMG)

How we identify poor performance 2)

Main source is systematic use of GP High Level Indicators and GP Outcome Standards

NHS England focus on practices with 5 or more outliers on the latest data available

Practices thus identified; call “case review” of interested parties

Gather other intelligence

Build a full picture of the practice/issues – important to note that the data needs to be understood before decision taken to proceed

NB Just because a practice is an outlier, this doesn’t necessarily mean there is poor performance

Managing GP Performance

Two aspects of **performance management** in primary care for which NHS England is responsible:

- Contractual – managed by the Head of Primary Care
- Individual Performer – managed by the Medical Director. The two will often overlap and so close working relationships are essential

CCGs have a responsibility to support NHSE **improve** the quality of primary care

New national arrangements developed …

Contractual –

- The range of national standards practices will be expected to meet ✓
- The weighting/tolerances/triggers etc. to be applied ✓
- The national process for handling poor contractual performance

Individual performer –

- The new National Performer List and associated regulations ✓
- The national process for handling poor individual performance, including arrangements for Panel consideration etc.

✓ = produced and in use

Where national policies are not yet in place we have developed and apply a consistent policy across London

Contractual or practice matter

- Issue raised
- Consider significance and share with CCG re improvement
- Practitioner responds / Practice provides development/improvement plan to CCG if requested
- NHSE monitor practice remediation
- NHSE prepare and issue contract breach notice and remediation where appropriate
- Repeat “offences” could lead to repeat breach and ultimately contract termination (rare)

Individual Performance

- Issue identified – serious case, could consider suspension
- Referred to Screening Committee/DMG for next steps
- Raise matter with the practitioner
- External review (for some cases)
- Practitioner responds
- Back to DMG for next steps which could include:
- Practitioner referred to Panel for Performer List action
    - Removal
    - Conditions
    - No action
- Right of appeal
- DMG keeps watching brief

Shortcomings in current arrangements

- Commissioning of primary care split across 4 organisations
- Confusing arena – NHS England, CQC, Regulatory Bodies
- Funding availability for development
- NHS England staffing really stretched; no capacity to deliver an improvement agenda systematically; NHS England more remote from local provision
- NHS England “Serious Issues Team” only recently recruited
- NHS England focus has had to be on areas where performance is worst
- Linkage with CCGs not always joined up; not always joint fora in place to have a discussion about improvement

Intentions for moving forward…

Under the 5 year Strategy, B&D CCG is currently establishing a Primary Care Transformation Programme. 3 main projects…

- Primary Care Improvement
- Prime Minister's Challenge Fund, and
- GP Provider Development

During the next 4 weeks CCG will establish the Primary Care Improvement project – this will also include representation from the wider primary care family (e.g. community pharmacy)

The Quality Improvement workstream of the PC Improvement project will be the forum to work with NHSE to support the quality improvement agenda, by …

- reviewing performance and triangulating more current, local data against GPOS and GPHIL
- having the input of the local Public Health team to support this piece of work
- agreeing a local dashboard and get the engagement of the local professional comms and the emerging GP federations
- developing a local plan to support the federations and individual practices to works towards achievement of the GP developmental standards
- NHS England expects to field a senior presence to work with the CCG

H&WB supporting improvement programmes

- Link commissioning decisions with CCG/NHS England - allows some “due diligence”
- Ensure JSNA and PNA robust and useful for commissioners’ use
- If pathway design is needed to resolve service improvement, ensure colleagues connected and contribute
- Construct of Local Quality Board (see previous slide). H&WB to be engaged
- How to use the connections to support / enable premises infrastructure improvements
- Full linkage with the public health team

Some background information and data ….

The GP Outcome Standards (GPOS)

The General Practice Outcome Standards are a pan London set of standards that provide practice data on agreed standards of care that all patients should receive from general practice. They are part of a programme designed to support and improve primary care in London.

- A set of 24+ indicators first developed in London
- Now a national tool, available publicly
- Triggers and thresholds agreed with the profession

It is important to note that the system provides the NHS with the data to enable more in depth local discussion to be had with a practice where appropriate; so for example low uptake on immunisations could be for a variety reasons – it doesn't necessarily mean that clinical performance is wanting.

The data is available publicly on the myhealthlondon website…
http://www.myhealth.london.nhs.uk/london-living/features/gps-london/what-are-london-outcome-standards

Developing the GP Outcome Standards

The underpinning principles for the standards are as follows:

- should focus on the basics that patients should expect to receive from general practice
- need to be outcomes-focussed, which concentrate on the immediate outcomes related to service delivery, which will lead to longer-term health outcomes
- should focus on areas where general practice have direct control and accountability
- short-term outcomes need to be areas of delivery where there is a strong evidence pathway between the service/intervention delivery and longer-term health outcomes
- They need to align with the emerging domains in the National NHS Outcomes Framework
- The standards will need to evolve over time as quality improves and more data becomes available
- The outcome standards draw on existing data sources to avoid creating any additional burden on practitioners to report new data.
- New standards will be considered on an annual basis to ensure that the standards remain valid, robust and highly relevant to patients, the public, general practice and wider health policy.

How are the Outcome Standards measured?

The tool measures a practice's achievement against thresholds that have been agreed by the General Practice Outcome Standards and Framework Programme Board. The standards highlight excellence and identify risks to quality and safety.

The thresholds, which have been set to assess how far away a practice's achievement is from either nationally-agreed thresholds or averages in London, are the measurements that identify how a practice is performing to the standards. These measurements are called "triggers". Triggers are grouped into three categories:

1. Those which already have nationally-agreed or expected levels of achievement S2
2. Reported vs. expected disease prevalence
3. Those which are assessed against the London average

Each indicator threshold has an upper and lower limit. The indicator thresholds are therefore grouped into the following categories:

Level One Trigger
Level Two Trigger

A practice's achievement within these standards determines the overall practice and borough rating. The standards group practices into categories dependant on the number or combination of Level One and Level Two Triggers that are identified by the General Practice Outcomes Standard tool. The categories are:

Achievement Category	Level 1	Level 2
Higher Achieving Practice	0 – 4 triggers	0 triggers
London Achieving Practice	5 – 7 triggers	1 trigger
Approaching Review Practice	8 – 10 triggers	2 triggers
Review Identified Practice	11 or more triggers	3 or more triggers

Slide 16

S2 I think this is too much detail and should be simplified and combined with slide 17?
See, 03/06/14

GPOS Summary (data drawn from https://www.primarycare.nhs.uk)

Q61 - NORTH EAST LONDON LOCAL AREA TEAM OVERVIEW – mostly Dec 2012 data

Total No. of Practices: **601**
Higher Achieving Practices: **13** (2.16%)
Achieving Practices: **136** (22.63%)
Practices Approaching Review: **184** (30.62%)
Practices with Review Identified: **268** (44.59%)

CCG OVERVIEW FOR NHS Barking & Dagenham CCG
Total No. of Practices: **41**
Higher Achieving Practice: **1**
Achieving Practice: **8**
Practice Approaching Review: **19**
Practice with Review Identified: **13**

S5

On GPHLI….5 or more outliers… Biggest number is in NECL

- A national (bigger) set of indicators for commissioners
- Builds on GPOS

Q61 - NORTH EAST LONDON LOCAL AREA TEAM OVERVIEW

Total No. of Practices: **601** (London 1516)
Practices with 5 or more outliers: **67** (London 149)

Q63 - SOUTH LONDON LOCAL AREA TEAM

Total No. of Practices:**498**
Practices with 5 or more outliers:**41**

Q62 - NORTH WEST LONDON LOCAL AREA TEAM

Total No. of Practices:**417**
Practices with 5 or more outliers:**41**

CCG: NHS Barking & Dagenham CCG
Total No. of Practices: **41**
Practices with 5 or more outliers: **2**

NHS England attention thus far focussed on areas with performance worse than B&D

Slide 18

S5 Think you clearly need to differentiate between GPOS and GHIL - could be confusing
See, 03/06/14

5 or more outliers by CCG…

CCG: NHS Barking & Dagenham CCG
Total No. of Practices: **41**
Practices with 5 or more outliers: **2**

CCG: NHS Redbridge CCG
Total No. of Practices: **48**
Practices with 5 or more outliers: **10**

CCG: NHS Newham CCG
Total No. of Practices: **64**
Practices with 5 or more outliers: **11**

CCG: NHS City and Hackney CCG
Total No. of Practices: **46**
Practices with 5 or more outliers: **3**

CCG: NHS Barnet CCG
Total No. of Practices: **69**
Practices with 5 or more outliers: **2**

CCG: NHS Enfield CCG
Total No. of Practices: **63**
Practices with 5 or more outliers: **3**

CCG: NHS Havering CCG
Total No. of Practices: **53**
Practices with 5 or more outliers: **3**

CCG: NHS Waltham Forest CCG
Total No. of Practices: **47**
Practices with 5 or more outliers: **10**

CCG: NHS Tower Hamlets CCG
Total No. of Practices: **36**
Practices with 5 or more outliers: **7**

CCG: NHS Islington CCG
Total No. of Practices: **38**
Practices with 5 or more outliers: **0**

CCG: NHS Camden CCG
Total No. of Practices: **40**
Practices with 5 or more outliers: **5**

CCG: NHS Haringey CCG
Total No. of Practices: **56**
Practices with 5 or more outliers: **11**

Complaints

- High volume
- Common themes…
  - Questioning clinical care/clinical competence
  - Attitude
  - Behaviour
  - Poor access
  - Removal from list – often inappropriately

Complaint Cases: London Area Team Vs Bark & Dag

S3

AREA	Performer	Clinical Competence	Inappropriate claims / Financial probity	Manner / Attitude	False Declaration/ Failure To Declare	Criminal investigation	Coroners Investigations	Domestic Homicide Review	Child Safeguarding	Adult Safeguarding	Total
SOUTH	GP	40	3	7	2	2	1	1	1	2	59
	Dentist	8	2	4	2	0	0	0	1	0	17
	Pharmacist	3	0	1	2	0	0	0	0	0	6
	Optometrists	1	2	0	0	0	0	0	0	0	3
South Total	All Performers	52	7	12	6	2	1	1	2	2	85
NORTH WEST	GP	65	3	3	0	0	0	0	1	1	73
	Dentist	8	2	2	1	0	0	0	0	0	13
	Pharmacist	0	0	0	0	0	0	0	0	0	0
	Optometrists	2	1	2	0	0	0	0	0	0	5
North West Total	All Performers	75	6	7	1	0	0	0	1	1	91
NORTH EAST	GP	162	11	33	1	19	0	0	2	0	90
	Dentist	74	12	1	2	1	0	0	0	0	23
	Pharmacist	14	3	0	0	4	0	0	0	2	18
	Optometrists	13	2	1	1	1	0	0	0	0	18
North East Total	All Performers	263	28	35	4	25	0	0	2	2	359
Barking & Dagenham	GP	20	0	2	0	2	0	0	0	0	24
	Dentist	4	1	0	1	0	0	0	0	0	6
	Pharmacist	1	0	0	0	0	0	0	0	0	1
	Optometrists	0	0	0	0	0	0	0	0	0	0
	All	25	1	2	1	2	0	0	0	0	31

Slide 21

S3 You will be asked if these have been resolved or the outcome of them?
See, 03/06/14

Performer Cases… some numbers 1)

Use of Performers List Regulations (Medical, Dental, Optometry)

	Subject to Conditions	Subject to Conditions % of Total	Suspended		Suspended % of Total	Removed	Removed % of Total	Barking & Dagenham only
North East	21	0.41%	3		0.06%	1	0.02%	
South	14	0.23%	0		0.00%	0	0.00%	
North West	15	0.41%	2		0.05%	0	0.00%	
Total for London	50	0.33%	5		0.03%	1	0.01%	0

Regulator's action (incl. GMC, GDC etc.)

	Subject to conditions	Subject to Conditions % of Total	Suspended		Suspended % of Total	Removed	Removed % of Total	Barking & Dagenham only
North East	23	0.44%	4		0.08%	6	0.12%	
South	7	0.11%	6		0.10%	0	0.00%	
North West	15	0.41%	5		0.14%		0.00%	
Total for London	45	0.30%	15		0.10%	0.10%	0.00%	1 undertaking

Panel, Tribunal Crown Court Cases

Area Team	Number of Panel Hearings	Number of Tribunal Hearings	Number of Ccrown Court Cases	Barking & Dagenham only
North East	3	0	0	
South	1	0	0	
North West	3	0	0	
Total for London	7	0	0	0

Performer Cases… some numbers 2)

Cases of Poor Practitioner Performance by Contractor Group and Area Team

AREA	Performer	Number of Performers	Number of Cases of Poor Practitioner Performance or Misconduct	Cases As a % of the Number of Performers	1	2	3	Current number of Live Cases	Closed
SOUTH	GP	3173	62	2%	9	50	3	62	124
	Dentist	1681	12	1%	2	8	2	12	13
	Pharmacist	650	5	1%	1	3	1	5	15
	Optometrists	1301	6	0%	0	6	0	6	10
South Total	All Performers	6805	85	1%	12	67	6	85	162
NORTH WEST	GP	1979	61	3%	22	34	0	56	42
	Dentist	1103	29	3%	9	20	5	34	29
	Pharmacist	514	0	0%	0	0	0	0	5
	Optometrists	612	1	0%	0	1	0	1	0
North West Total	All Performers	4208	91	2%	31	55	5	91	76
NORTH EAST	GP	2707	228	8%	24	62	54	140	88
	Dentist	1727	90	5%	8	11	42	61	32
	Pharmacist	701	23	3%	1	2	12	15	5
	Optometrists	735	18	2%	1	2	8	11	7
North East Total	All Performers	5870	359	6%	34	77	116	227	132
Barking & Dagenham	GP	Unknown	24	Unknown	1	14	4	19	5
	Dentist	Unknown	6	Unknown	0	2	3	5	1
	Pharmacist	Unknown	1	Unknown	0	0	1	1	0
	Optometrists	Unknown	0	Unknown	0	0	0	0	0
	Total	Unknown	31	Unknown	1	16	8	25	6

Slide 23

S4 See, 03/06/14

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HEALTH AND WELLBEING BOARD

17 JUNE 2014

Title:	**Mental Health Tariff**
Report of the Clinical Commissioning Group	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG	**Contact Details:** Tel: 020 3644 2370 E-mail: Sharon.morrow@barkingdagenhamccg.nhs.uk
Sponsor: Conor Burke, Chief Officer Barking and Dagenham CCG	

Summary:

The paper provides a briefing on the national tariff payment system 2014/15 and the tariff deflator of -1.8% that has been applied to mental health service contracts. NHS England and Monitor are responsible for setting the NHS payment system and published the 2014/15 national tariff payment system in December 2013 following a period of consultation with commissioners and providers.

The payment guidance recognises the challenge faced by providers and commissioners to improve productivity and operational efficiency and to transform patterns of care. Monitor believes that there are opportunities for improving care and safety by using resources more efficiently and is requiring providers to make productivity improvements of 4% in 2014/15. It is expected that productivity improvements will be made through operational efficiencies and not impact on the quality of patient services.

Concerns have been expressed nationally by mental health leaders and some politicians that that mental health services will lose resources at a time when there is a focus on improving mental health standards and ensuring parity of esteem.

Recommendation(s)

The Health and Wellbeing Board is recommended to

(i) Consider what the implications are for the borough and to what extend parity of esteem between mental and physical health is damaged by this policy.

1. Background and Introduction

1.1 The purpose of the paper is to brief the Health and Wellbeing Board on the national tariff payment system and how this has been applied to mental health providers in 2014/15. The report outlines how the risk of productivity improvements impacting on the quality of patient services is being monitored.

2. Operating Plan guidance

2.1 National guidance [Everyone Counts: Planning for Patients 2014/15 to 2018/19] was published in December 2013 alongside CCG and NHS England direct commissioning allocations for 2014-2016.

2.2 This included guidance on financial planning, outlining the assumptions that NHS commissioners should make in setting budgets and agreeing contracts with providers. Financial planning assumes that commissioners will be required to make efficiency savings of around 9% in 2014/15, which includes a provider efficiency savings.

3. 2014/15 national tariff payment system

3.1 NHS England and Monitor took on responsibility for the NHS payment system from the Department of Health under the provisions of the Heath and Social Care Act 2012.

3.2 Monitor and NHS England consulted on proposals for the 2014/15 national tariff between October and November 2013 and published the 2014/15 national tariff payment guidance on 17 December 2013. There were no substantial changes to the original proposals as a result of the consultation process.

3.3 The scope of the tariff payment guidance includes acute, community and mental health providers. Monitor is responsible for ensuring that licensed providers comply with the national tariff and also has powers for ensuring that commissioners comply with the national tariff.

3.4 The 2014/15 payment guidance recognises the substantial challenge faced by providers and commissioners to improve productivity and operational efficiency and also to transform patterns of care. Monitor believes that there are further opportunities for improving care and safety by using resources more efficiently and is requiring providers to make productivity improvements of 4% in 2014/15. An impact assessment, published by Monitor in October 2013, supported the conclusion that this was a reasonable, if stretching, efficiency requirement that balanced the need for providers to remain stable and commissioners to manage rising demand.

3.5 Provider contracts in 2014/15 have been uplifted for inflationary costs that average 2.5%. Some cost uplifts reflect costs that apply only to acute services and not to community or mental health services. An uplift of an estimated £150 million nationally which was identified for acute trusts, relating to service developments required following the recommendations of the Francis and Keogh reports, has not been applied to non-acute services. The net tariff reduction in 2014/15 has therefore been adjusted to - 1.5% for acute services and to - 1.8% for non-acute services.

3.6 The differential tariff reduction across acute and non-acute services has raised concerns that mental health services will lose out at a time when there is a focus on improving mental health standards and ensuring parity of esteem.

3.7 There are mechanisms in place to provide assurance that productivity improvements do not impact on the quality of patient services. Foundation Trusts are required to submit a two year operational plan 2014/15 – 2015/16 to Monitor that includes cost improvement plans to deliver the 1.8% efficiency requirements. Cost improvement schemes should improve or maintain quality whilst driving up productivity and will include a combination of efficiency schemes and schemes which are more transformational.

3.8 The CCG also has an established process through the Clinical Quality Review Meetings to review provider cost improvement plans and this is a commissioner requirement that is set out in the operating plan.

4. Mental health services

4.1 Mental health services have historically been funded through block payment arrangements with the level of block payment generally based on historic levels of funding. Aligning payment to patient outcomes has historically not been part of the payment approach in mental health.

4.2 The introduction of a mental health tariff from 2015/16 will identify currencies for 21 care clusters for adult mental health services that group patients based on common characteristics, such as level of need and similar resources being required to meet those needs. Commissioners and providers will set local prices for each care cluster operating under the rules set by Monitor.

4.3 For services that are not covered by the adult cluster currencies, local providers and commissioners will need to agree local prices based on the principles of the mental health tariff guidance.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment

Section 7 of the JSNA recommends that, given the anticipated population increases and the high levels of deprivation in the borough, there is likely to be a much greater demand on services to improve the mental health and wellbeing of Barking and Dagenham residents.

5.2 Health and Wellbeing Strategy

The Health and Wellbeing Strategy reflects mental health and wellbeing as a theme across the life course and acknowledges the impact of income poverty on people's mental health.

5.3 Integration

The scope of the tariff payment guidance includes the commissioning of NHS health care services are commissioned under joint commissioning arrangements even if commissioned by the Local Authority. The CCG and Local Authority will be entering into a range of joint commissioning arrangements through the Better Care Fund in 2015/16.

5.4 Financial Implications

All providers are required to deliver 4% efficiency savings in 2014/15. In addition to the NHS Deflator they also need to fund pay and price increases, which means that for NELFT as a provider organisation the annual cost improvement requirement is 4% (the level of annual efficiency indicated by Monitor).

Implications completed by: Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG

5.5 Legal Implications

None.

5.6 Risk Management

Trust cost improvement plans are reviewed by the CCG to provide assurance that they are deliverable without impacting on the quality and safety of patient care. Foundation trusts are required to submit cost improvement plans to Monitor as part of their two year operational plan.

5.7 Patient/Service User Impact

Efficiencies from the tariff deflator are delivered by operational efficiencies and not through cuts to services.

HEALTH AND WELLBEING BOARD

17th JUNE 2014

Title:	**Annual Health Protection Profiles 2013 - North East and North Central London**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: None**
Report Author: Dr Tania Misra, Consultant in Communicable Disease North East and North Central London Health Protection Team Matthew Cole, Director of Public Health	**Contact Details:** Tel: 020 7811 7100 E-mail: necl.team@phe.gov.uk Email: matthew.cole@lbbd.gov.uk
Sponsor: **Matthew Cole, Director of Public Health**	

Summary:

This report summarises infectious disease notifications, outbreaks and health protection incidents that were managed by the North East and North Central London Health Protection Team in 2013. There is also a summary of important infections including Sexually Transmitted Infections and Healthcare Associated Infections in North East and North Central London, and their implications for Barking and Dagenham.

The report provides the Board with a level of assurance that the programmes and measures to prevent and manage communicable disease continue to be effective.

Recommendation(s)

The Health and Wellbeing Board is asked to note :

(i) The continued importance of Health Protection issues within the Borough, especially in relation to Sexually Transmitted Infections and HIV, Healthcare Associated Infections and vaccine preventable diseases (VPDs) such as Measles, Mumps and Pertussis.

(ii) The Director of Public Health advice that NHS England be asked to provide further information to the Board on the arrangements being put in place to improve performance in achieving the optimum uptake of immunisation programmes by the eligible population of Barking and Dagenham.

(iii) The provision of appropriate HIV testing services needs to be considered. National advice is that, when the diagnosed HIV prevalence is greater than 2 per 1,000, routine HIV testing for all general medical admissions and for all new registrants in primary care should be undertaken. Borough prevalence is at this level and therefore routine testing should be implemented.

(iv) The need to increase effort to prevent Health Care Associated Infections through key initiatives such as the appropriate use of antimicrobials, appropriate insertion and care of invasive devices and lines, and training in infection prevention and control for all care providers be included in the refresh of the Joint Health and Wellbeing Strategy.

Reason(s)

Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to protect the health of the population. This includes assuring that steps are taken to protect the health of their population from hazards, ranging from relatively minor outbreaks of infectious disease and contaminations, to full-scale emergencies, and to prevent as far as possible those threats arising in the first place.

Barking and Dagenham's Director of Public Health (DPH) has a duty to 'provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local health protection arrangements'. In order to undertake this duty, and to provide appropriate advice as to the adequacy of local health protection arrangements, the DPH needs to be assured and satisfied that there are adequate health protection immunisation and screening plans in place in the Borough.

1. Background and Introduction

1.1 Public Health England (PHE) is the expert national public health agency which fulfils the Secretary of State for Health's statutory duty to protect health and address inequalities, and executes his power to promote the health and wellbeing of the nation.

1.2 PHE ensures there are effective arrangements in place nationally and locally for preparing, planning and responding to health protection concerns and emergencies, including the future impact of climate change. PHE provides specialist health protection, epidemiology and microbiology services across England. For Barking and Dagenham these arrangements are managed by the North East and North Central Health Protection Team based in Victoria.

1.3 Improvement in the public's health has to be led from within communities, rather than directed centrally. This is why every upper tier and unitary local authority now has a legal duty to improve the public's health. Local health and wellbeing boards bring together key local partners (including NHS clinical commissioning groups who have a duty to address health inequalities) to agree local priorities.

1.4 PHE will support local authorities, and through them clinical commissioning groups, by providing evidence and knowledge on local health needs, alongside practical and professional advice on what to do to improve health, and by taking action nationally where it makes sense to do so. PHE in turn is the public health adviser to NHS England.

1.5 PHE works in partnership with the Chief Medical Officer for England and with colleagues in Scotland, Wales and Northern Ireland to protect and improve the public's health, as well as internationally through a wide-ranging global health programme.

1.6 NHS England has the responsibility for commissioning immunisation programmes for Barking and Dagenham residents.

1.7 Health Protection Profiles are prepared annually by the North East & North Central London Health Protection Team to provide a summary of the health protection issues affecting each borough in the sector.

2. Legislative Framework

2.1 Under Section 2A of the NHS 2006 Act (as inserted by Section 11 of the Health and Social Care Act 2012), the Secretary of State for Health has a duty to "take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health". In practice, Public Health England will carry out much of this health protection duty on behalf of the Secretary of State.

2.2 Under a new Section 252A of the NHS Act 2006, the NHS Commissioning Board (NHS England) will be responsible for (a) ensuring that clinical commissioning groups and providers of NHS services are prepared for emergencies, (b) monitoring their compliance with their duties in relation to emergency preparedness and (c) facilitating coordinated responses to such emergencies by clinical commissioning groups and providers.

2.3 The Health and Social Care Act 2012 also amends Section 253 of the NHS Act 2006 (as amended by Section 47 of the 2012 Act), so as to extend the Secretary of State's powers of direction in the event of an emergency to cover an NHS body other than a local health board (this will include the NHS Commissioning Board and clinical commissioning groups); the National Institute for Health and Care Excellence; the Health and Social Care Information Centre; any body or person, and any provider of NHS or public health services under the Act.

2.4 The Council has statutory duties for controlling risks to public health arising from communicable diseases and other public health threats and must appoint a Proper Officer to undertake key functions. PHE provides the expertise to support local authorities in these functions and Consultants in Communicable Disease Control are generally appointed as the Proper Officer.

2.5 The Proper Officer appointed under the Public Health (Control of Disease) Act 1984 should be medically qualified. The main responsibility of the Proper Officer is to require information or action in relation to people, premises or objects which may be infected, contaminated or could otherwise affect health.

3 Local Health Protection Arrangements

3.1 The Director of Public Health (DPH) is responsible for exercising the new public health functions on behalf of the Council. The DPH has the responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health".

3.2 The delivery of Health Protection needs strong working relationships and the legislative framework that underpins this objective ensures that organisations do

what is required. At the local level NHS Barking and Dagenham Clinical Commissioning Group and NHS England have a duty to cooperate with the Council in respect of health and wellbeing.

3.3 Unitary and upper tier local authorities have a new statutory duty to carry out the Secretary of State's health protection role under regulations to be made under Section 6C of the NHS Act 2006 (as inserted by Section 18 of the Health and Social Care Act 2012) to take steps to protect the health of their populations from all hazards, ranging from relatively minor outbreaks and contaminations, to full-scale emergencies, and to prevent as far as possible those threats arising in the first place.

3.4 Within this context, the Council has established a Health Protection Committee which supports the DPH in their role of leading the response, planning and preparedness to Health Protection challenges. The Committee reports through to the Health and Wellbeing Board.

3.5 The purpose of the Committee is to put this into practice through facilitating, reviewing and instigating actions to protect the health of the local population.

4. Health Protection Profile

This report highlights the following health protection issues for the London Borough of Barking and Dagenham (LBBD). The management, prevention and control of communicable disease has been effectively delivered last financial year by the partners. The key issues to note around the notifications of infectious diseases are:

4.1 The infectious diseases and / or agents that constituted the highest rates of notifications from LBBD in 2013 include:

- Campylobacter, which is a type of bacterium that causes food poisoning and is the commonest cause of gastrointestinal infections in the UK. There was a significant increase in these infections reported from LBBD in 2013 in comparison with previous years. Local acute trusts have moved to a lab-based surveillance system from one dependant on clinicians' verbal reporting, and the increase in reported campylobacter infections is considered to be due to this new system of reporting which was initiated in 2013.

- Mumps, which is a viral illness and is a vaccine preventable disease (VPD). Mumps is now more common, particularly in young adults who were not fully vaccinated against mumps in childhood and who have not been exposed to naturally occurring illness.

- Salmonella, which is another common cause of gastrointestinal infections, largely causing food poisoning. Salmonella infections are also related to travel and can be acquired from close contact with pets as well.

- There has been no confirmed of Measles reported from LBBD in 2013. Measles is a viral illness that can lead to serious complications, and this is also a vaccine preventable disease (VPD). The confirmed cases of Measles have been seen unvaccinated children or adults.

- There is a national outbreak of Pertussis (whooping cough), and this has also been reflected in an increase in cases reported from LBBD. We took part in the national campaign and programme to increase uptake amongst pregnant women. The Pertussis campaign hasn't been fully evaluated yet. The end-result being an non-event (that is, mums don't get Pertussis, and so they don't pass it on to their newborns) hence this will be difficult to evaluate, but a favourable outcome already is a reduction in the number of Pertussis deaths in neonates compared to 2012.

- Group A streptococci cause a range of infections from sore throat and scarlet fever to life threatening septicaemia. The current national rise in scarlet fever cases is also reflected locally, and some of these infections have been invasive.

- There were 11 outbreaks reported from LBBD in 2013. These related mainly to gastroenteritis outbreaks in care homes and schools. Compared to other boroughs in North East London (largest number reported = 22), this does not place LBBD as an outlier.

The Health Protection Team in Public Health England provides outbreak management advice and guidance to care homes and schools, working closely with the Environmental Health team from LBBD, the NHS, and the Directorate of Public Health. If an outbreak is protracted or there are concerns about food safety related to a food outlet or restaurant, or there are concerns regarding hygiene practices in a care home, environmental health officers are able to use legal powers under public health legislation to serve improvement notices, or even enforce the closure of premises that pose a significant public health risk.

4.2 Tuberculosis

There were 76 Tuberculosis (TB) cases reported from LBBD in 2013, out of 905 TB notifications from North East London, and 3020 TB notifications overall in London. The rate of TB in LBBD was 40.5/100,000 population in 2009, and following a low in 2012 of 35.2/100000 population, it was at 39.9/100,000 population in 2013.

The Director of Public Health introduced a universal BCG vaccination policy in 2009. At the time when this policy was introduced, the known TB rates in LBBD were just below 40/100,000. There was a TB incident in a local primary school in late 2008, where an unusually large number of children were found to be exposed to TB when screened. The Director of Public Health, with advice from the former Health Protection Agency (now part of Public Health England) introduced universal BCG vaccination in LBBD. Since April 2009, all babies born in LBBD are given the BCG vaccination at birth. This is in line with the policy in the neighbouring boroughs of Newham, Redbridge and Waltham Forest, and an example of an informed public health decision making based on epidemiological data and population needs.

45% of the patients diagnosed with TB in North East London in 2013 had pulmonary involvement. A small number of TB cases in LBBD were infectious and there were public health implications in three instances, where contact tracing exercises were undertaken in order to offer screening tests to those who were exposed. When TB notification exercises are undertaken, these are planned and

implemented collaboratively with the Directors responsible for Public Health, Housing, and of Environmental Protection at LBBD, the TB specialist team at Barking, Havering and Redbridge University Hospitals NHS Trust, and the Health Protection Team in Public Health England. As there are identified resources for dealing with outbreaks and incidents, there can be a prompt and efficient response. Media statements are prepared with comments from the Director of Public Health and the communication teams from PHE and LBBD which work collaboratively to field media enquiries. Public Health England have a 24/7 service that is able to respond to calls from those who are being offered screening, as well as worried members of the public.

4.3 Sexually Transmitted Infections (STIs) and HIV

Our picture of sexual ill health has seen a steady worsening. The key issues are:

- Like all boroughs in North East London, LBBD has seen a rise in the number of people living with HIV over the last five years. The number of people living with HIV and known to NHS and Social Care services has increased from 508 in 2008 to 706 in 2012. This represents a 39% increase. The two main groups with the highest levels of HIV infection are Black African heterosexual women and men who have sex with men (MSM) and we have invested in both local and pan London programmes that include education, support and rapid HIV testing. In 2012, among GUM clinic patients from Barking and Dagenham who were eligible to be tested for HIV, 73% were tested.

- LBBD is ranked 42 (out of 326 local authorities, first in the rank has highest rates) in England for rates of acute STIs in 2012. A total of 1996 acute STIs were diagnosed in residents of LBBD, (1077 in males and 918 in females), a rate of 1067.2 per 100,000 residents (males 1185.2 and females 954.7). 56% of diagnoses of acute STIs were in young people aged 15-24 years.

- The rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in LBBD was 2331.3. LBBD has commissioned a Chlamydia Screening Programme that is working towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 in the 15 to 24 year old age group and this is an indicator in the Public Health Outcome Framework. All young people aged 15 to 24 years should be screened for chlamydia at least annually or with every change of partner.

4.4 The Health and Social Care Act 2012 directs local authorities to commission appropriate access to comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention). To support universal and consistent provision of contraception there have been long standing legislative requirements to ensure access to, and free supply of, contraception.

The present Integrated Sexual Health Service contract and the Chlamydia Screening contract expired at the end of March 2014. The Health and Wellbeing Board extended these contracts at its February 2014 meeting for a further period of 18 months before commencing a procurement process which allows us to consider the following in respect of the services we wish to commission:

- Prevention efforts, such as greater STI screening coverage and HIV testing, and easier access to sexual health services, should be sustained and continue to focus on groups at highest risk, particularly Black African women, MSM and young people.

- Health promotion and education, which remain the cornerstone of STI and HIV prevention through improving public awareness of STIs and HIV and encouraging safer sexual behaviour such as consistent condom use and reductions in both the numbers and concurrency of sexual partnerships.

- Given the high rates of poor sexual health due to STIs, including HIV, in North East and North Central London it is clear that sexual health should remain a public health priority

- The Public Health Outcomes Framework includes an indicator to assess progress in achieving earlier HIV diagnoses. The provision of appropriate HIV testing services, to deliver against this indicator needs to be considered. As LBBD has a diagnosed HIV prevalence greater than 2 per 1,000, implementation of routine HIV testing for all general medical admissions and for all new registrants in primary care is recommended

- The changes to the NHS sexual health commissioning arrangements have led to fragmentation of STI and HIV services, which will inevitably dilute emphasis on prevention. Ensuring the provision of comprehensive sexual health services is a challenge which the new Sexual Health Commissioning arrangements will be required to address.

- Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

- Increased access to STI and HIV testing and treatment, chlamydia testing, contraception and abortion services and HIV prevention and sexual health promotion work in schools would be the key components of a comprehensive and young people friendly service.

4.5 Health Care Associated Infections

The prevention of healthcare associated infections (HCAI) due to MRSA and Clostridium difficile (Cdiff) is a national priority and these infections are also included in the Public Health Outcomes Framework. NHS Barking and Dagenham Clinical Commissioning Group has the third highest rates of Cdiff infection in people aged over 2 years amongst North East London clinical commissioning groups at 17.5/100,000 population. Although this is below the England average of 27.3/100,000 population, it is among the higher rates in North East London. This indicates that there is substantial work to be done around antimicrobial use and prevention of Cdiff infection in the community.

The Barking and Dagenham rate for MRSA bacteraemias in the community is 2.1/100,000 population. This is higher than the national average of 1.7/100,000 and provides an important indicator of infections in the community. Work is

needed to improve training in the care of IV lines and catheters in the community to ensure that they are inserted safely and managed properly, so that MRSA bacteraemia can be prevented.

The Director of Public Health recommends that HCAI prevention through key initiatives – e.g. appropriate use of antimicrobials, appropriate insertion and care of invasive devices and lines, and all providers of care being trained in infection prevention and control is included in the refresh of the Joint Health and wellbeing Strategy.

4.6 **Immunisation coverage**

The 2013/14 Quarter 4 data for immunisation coverage is not due to be published by Public Health England until June 2014. In 2013/14 Quarter 3, and throughout the year prior to Quarter 3, LBBD had performed below the national average for uptake of two doses of MMR, and for DTaP/IPV at five years old. Two doses of MMR coverage is also below the London average, with 80.9% coverage, although DTaP/IPV is above the London average at 82.4% coverage. Both of these figures are the lowest quarterly uptake levels seen in the last two years.

The target for immunisation coverage at 5 years of age is 90%. Immunisation coverage in Barking and Dagenham is therefore lower than the national target, and lower than the regional average as well. Apart from not meeting targets, low immunisation coverage is a risk to the unimmunised children who are at risk of infection from the vaccine preventable diseases against which they are not protected.

For seasonal influenza immunisations in those aged 65 and over, LBBD performed better than the London average between September 2013 and January 2014 with 71.2% coverage compared to 70.0%, although this was 2.0% below the national average. The target for coverage was 75% so this was not achieved.

Provisional figures for HPV uptake from September 2013 to December 2013 show that LBBD has higher coverage than the regional average for both the first and second doses. Coverage for the first dose is just below the level for England as a whole, and second dose coverage is higher than the England average, at 79.2% compared to 69.8%.

Increasing immunisation uptake for both children and older people is a priority for the Council, local GPs and NHS partners. The Director of Public Health advises that NHS England provides further information to the Board on the arrangements being put in place to improve performance in achieving the optimum uptake of immunisation programmes by the eligible population of Barking and Dagenham.

5. Consultation

Performance discussed at the Health Protection Committee.

6. Mandatory Implications

6.1 **Joint Strategic Needs Assessment**

The Joint Strategic Needs Assessment has a strong health protection analysis including detailed immunisation, screening and communicable disease sections

within it. There is general agreement that cross-sector working in the borough with involvement from the NHS, employment, housing, police and other bodies, in addition to the Council's children's services and adult and community services is good.

6.2 **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 health protection 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 immunisation, screening and communicable disease control are mapped across the life course against the four priority areas

6.3 **Integration**

Currently, health protection at the local level is delivered by a partnership of the NHS, the Public Health England and local authorities. Public Health England leads and delivers the specialist health protection functions to the public and in support of the NHS, local authorities and others through local health protection units a network of microbiological laboratories and its national specialist centres.

The Public Health Outcomes Framework includes a health protection domain. Within this domain there is a placeholder indicator, "Comprehensive, agreed inter-agency plans for responding to public health incidents". The Department of Health is taking forward work to ensure that it can effectively measure progress against this indicator.

6.4 **Financial Implications**

There are no direct financial implications for Barking and Dagenham as a result of the 2013 Health Protection Profile. It is recommended the report is used to inform the Joint Strategic Needs Assessment (JSNA). Any actions from the JSNA that require resources from the Local Authority are most likely to be funded from the Public Health Grant, however there are competing demands on this cash limited funding.

In 2013/14 to support the management of outbreaks and communicable disease control, the Director of Public Health allocated a budget of £50,000 for responding to large outbreaks or an incident that could have wider public health impact. Part of this budget was utilised effectively in the management of a TB incident where Interferon Gamma Release Assay (also known as IGRA – this is a simple blood test) tests could be offered to screen identified contacts, thereby making screening efficient and easier to implement.

This budget has also been utilised to secure accommodation where recommendation has been made to the Director of Public Health that this is essential for the protection of the public and the management of the infection.

Implications completed by: Roger Hampson Group Manager, Finance

6.5 **Legal Implications**

There are no legal implications in relation to this report.

Implications completed by: Chris Pickering, Principal Solicitor

6.6 **Risk Management**

Health protection needs constant appraisal and will always be in need of strengthening. Complacency is the greatest danger – the notion that we have the issue ‘sorted out’ is always going to be dangerous. There is great value in joint exercises, which have worked well in the past, to maintain and/or heighten awareness, identify issues and provide for a more robust and effective response to problems. One of the main functions of Public Health England is to collate information; provide linkage between organisations; increase research capacity, co-ordination and utility; and provide education and training (principally for frontline staff but always with an eye to the needs of the public).

HEALTH AND WELLBEING BOARD

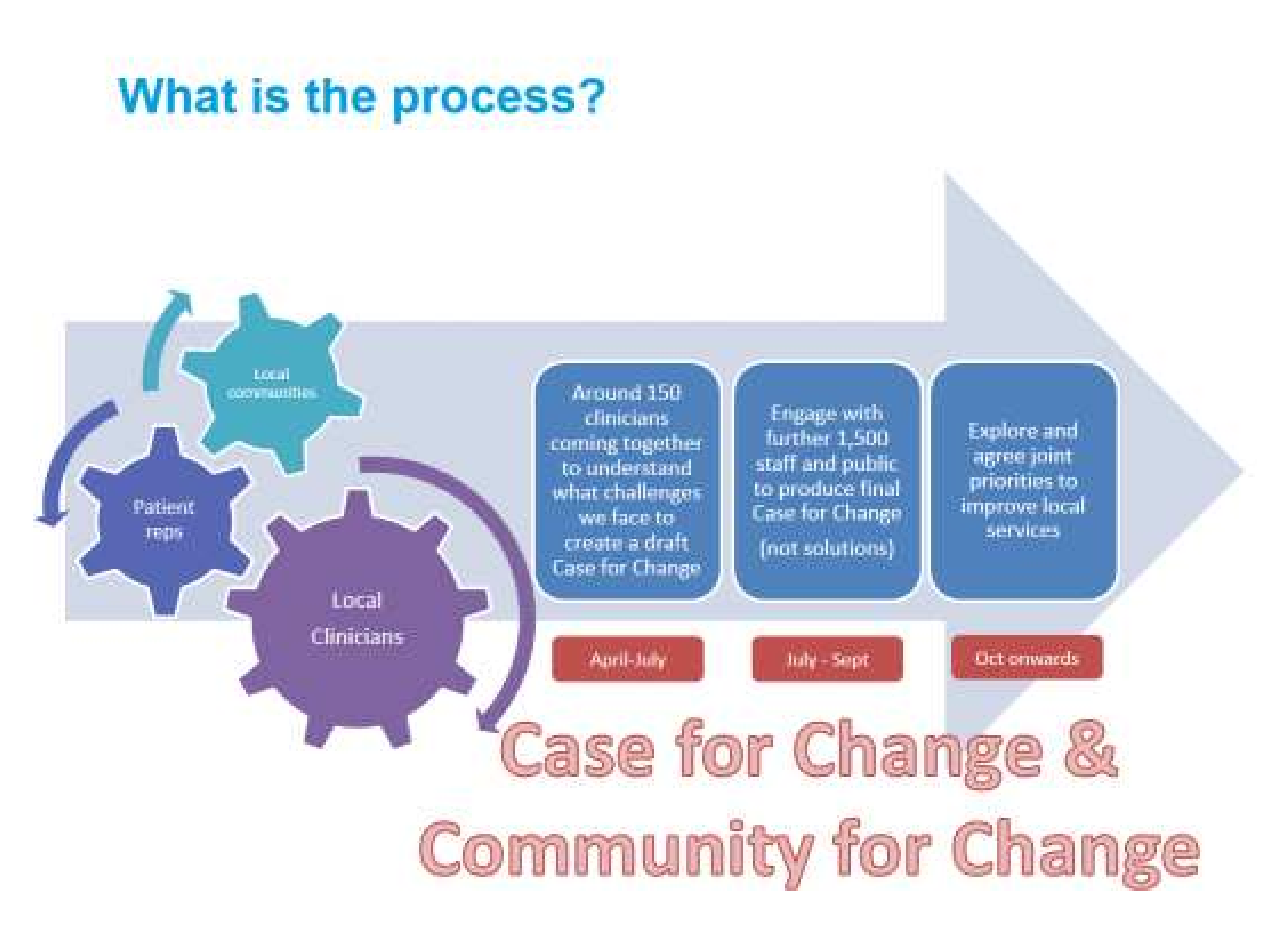
17 JUNE 2014

Title:	**Transforming Services, Changing Lives in East London**
Report of the North East London Commissioning Support Unit	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Zoe Hooper, Communications Manager	**Contact Details:** Tel: 020 688 1678 E-mail: zoe.hooper@nelcsu.nhs.uk
Sponsor: Conor Burke, Accountable Officer, B&D CCG	

Summary:
Local CCGs (Waltham Forest CCG, Tower Hamlets CCG, Newham CCG, Barking and Dagenham CCG, and Redbridge CCG), NHS England, Barts Health and other local providers have established a clinical transformation programme called Transforming Services, Changing Lives, which will consider how services need to change to provide the best possible health and health care for local residents. A key element of the programme will be to consider how best to ensure safe, effective and sustainable hospital services at Bart's Health and Homerton hospitals, set in the context of local plans to further develop and improve primary, community and integrated care services.

The work, which was launched in February 2014 and is expected to run until September 2014, will develop a baseline assessment of the drivers for change in the local health economy and support further discussions about the scope, scale and pace of change needed. Key outputs from this work are:

- a detailed 'case for change', delivered through a clinically led, comprehensive clinical engagement process
- establishing the appropriate foundations for a longer term joint transformation programme should partner organisations conclude that this is necessary in order to bring forward whole system, health economy-wide improvements in the clinical and financial viability of local services in East London.



Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Schedule a substantive business item for a future meeting of the Board to discuss the case for change.

1. Background and Introduction

1.1. The NHS in East London faces the very real challenge of providing care for a growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK. Providing for today while planning for a tomorrow which is unlikely to see budgets rising to the same extent as demand, will require us to think differently about how we provide care, and make changes to where and how care is provided if we are to meet the growing needs of local people.

1.2. Local CCGs (Waltham Forest CCG, Tower Hamlets CCG, Newham CCG, Barking and Dagenham CCG, and Redbridge CCG), NHS England, Barts Health and other local providers have established a clinical transformation programme called Transforming Services, Changing Lives, which will consider how services need to change to provide the best possible health and health care for local residents. A key element of the programme will be to consider how best to ensure safe, effective and sustainable hospital services at Bart's Health and Homerton hospitals, set in the context of local plans to further develop and improve primary, community and integrated care services.

1.3. The work, which was launched in February 2014 and is expected to run until September 2014, aims to understand the current demands on the NHS and analyse the local health economy.

1.4. Local clinicians have been asked to use their own knowledge of national and international best practice to review the quality and performance of East London health and social care services, highlight areas of good practice that should be maintained and developed, and set out if, why, and in what specialties they think there may be a case for change to ensure the very best care for local residents. It will not, at this stage, set out any recommendations for change.

1.5. CCGs, together with the other partnership organisations, are engaging with key stakeholders such as local councils, Health and Well Being Boards and other local providers to develop and test ideas.

1.6. Between July and September the initial thoughts and ideas being developed by clinicians will be tested out with a wider group of stakeholders before publishing a Case for Change in autumn 2014.

Key outputs during this phase of work:

- a detailed 'case for change', delivered through a clinically led, comprehensive clinical engagement process
- dialogue to determine joint priorities for improvement where by working together we can get more impact more quickly

Key dates during this phase of work:

- **April 4 2014:** launch event to outline plans, gather initial feedback and begin the engagement process. Around 150 stakeholders were invited, including Health and Wellbeing Board representatives.
- **June 6 2014:** 'The emerging case for change' seminar to gather initial feedback on draft principles of the case for change. Around 200 stakeholders have been invited, including Health and Wellbeing Board representatives.
- **June – July 2014:** Engagement events to develop and refine the draft case for change. Approximately 1,500 staff and local stakeholders will be invited.
- **September:** Publication of case for change.

2. Governance and engagement

2.1. The governance arrangements for the programme have been established and include:

— A **Programme Board** as a key element of the structure – tasked with providing the strategic oversight for the Programme. To reflect the external decision making requirements, the Programme Board reports to the relevant statutory bodies of CCGs, providers and the NHS England. CCGs will ensure a clear link through to HWBBs. Additionally WF, TH and Newham Councils have been invited to sit on the Programme Board. Local Council is welcome to be represented on the Programme Board if they would like to be and / or can be

briefed through CCG representatives / regular updates provided to HWBB meetings.

- A **Clinical Reference Group and clinical working groups** reflecting the key clinical leadership role in exploring and shaping a 'Case for Change'. CCGs, Barts Health, Homerton Hospital, community and mental health service providers and the London Ambulance service have been invited to nominate clinicians and other front-line staff to join clinical working groups. Links are also being established with academic partners. The clinical working groups will focus on:
  - unplanned care (urgent and emergency care, acute medicine, non-elective surgery)
  - planned care (long-term conditions)
  - planned care (surgery)
  - maternity and neonatal care
  - children and young people, and;
  - clinical support services
- A **Public and Patient Reference Group** to provide ideas and feedback to clinicians leading the TSCL programme and support and advise on public engagement activities. The group is made up of representatives from three broad groups:
  - local branches of Healthwatch
  - patient representatives from the CCGs involved in the programme
  - patient representatives from the providers involved in the programme
- A **Communications and Engagement work stream** that recognises the importance of engaging local stakeholders in our work at an early stage. This group is supporting the public and patient reference group, coordinating a series of engagement events, launching a microsite (www.transformingservices.org, live from July) and ensuring stakeholders, such as Health and Wellbeing Boards, are briefed.

3. Why have we taken this step?

3.1. The five CCGs have a duty to promote a comprehensive health service for their population of around 1.3 million people.

3.2. Today, local NHS services face the very real challenge of providing care for a rapidly growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.

3.3. The health economy is never static. Change is happening all around the system. In the last year, since the establishment of CCGs, we have seen the introduction of NHS 111, the development of integrated care and soon the launch of personal health budgets. We need to respond to these changes to ensure that benefits are realised and unintended consequences are avoided.

3.4. However, we also know that some services simply need to improve to meet local needs. We need to address the areas where we are not so good. We know that the quality of care we provide is inconsistent. We need to work better with providers and

with social care to address the challenges we face and decide how we can introduce new and different ways of providing care.

3.5. Collectively commissioners have agreed with providers to look at the challenges we face, to ensure we can continue to provide the care our patients need, at the best possible place for them. Organisation boundaries must not and cannot impede the commitment to deliver improvements at scale across the partnership.

3.6. We also need to make sure that any changes in the future happen safely and effectively.

3.7. In developing their case for change, clinicians will be guided by the principles of the Francis Report to ensure delivering first class care for patients and local populations is the driver for change.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

The priorities for consideration in this report align well with the strategic recommendations of the Joint Strategic Needs Assessment. However, it needs to be noted that the vast majority of our patient flows go to Barking Havering & Redbridge University Hospitals NHS Trust. Barts Health NHS Trust is an important tertiary site for our residents to access for specialist services. Also there are areas where further investigation and analysis have been recommended as a result of this year's JSNA for the BHR health and social care economy which map across to Barts Health. 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.

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 the priorities under consideration are picked up within focused on the challenges of the Barking Havering and Redbridge health and social care economy. 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 would apply to paper. However, it needs to be noted that the vast majority of our patient flows go to Barking Havering & Redbridge University Hospitals NHS Trust. Barts Health NHS Trust is an important tertiary site for our residents to access for specialist services.

4.3. Integration

None at the present time

4.4. Financial Implications

None at the present time

4.5. Legal Implications

None at the present time

4.6. Risk Management

None at the present time

4.7. **Patient/Service User Impact**

5. Barts Health NHS Trust provides a range of general and specialist services to Barking and Dagenham residents. Any future changes to services could have an impact on local residents.

6. Background Papers Used in Preparation of the Report:

None.

7. List of Appendices:

None.

HEALTH AND WELLBEING BOARD

17 JUNE 2014

Title:	**Developing the Health and Wellbeing Board**
Report of the Executive Planning Group	
Open Report	**For Decision**
Wards Affected: NONE	**Key Decision: NO**
Report Author: Louise Hider, Health and Social Care Integration Manager	**Contact Details:** Tel: 020 8227 2861 E-mail: louise.hider@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services	

Summary:
The Health and Wellbeing Board has been operational since April 2013 and has completed its inaugural year as a statutory committee. The Board held a Development Day in January 2014 to review the progress of the Board's work and operation to date and to discuss the development of its activity, particularly in the areas of engagement and integrated working.

The Board are asked to note the headline findings of the January Development Day and note that the Executive Planning Group will be reviewing the full Feedback Report from the day to inform future development activity.

Recommendation(s)

The Health and Wellbeing Board is recommended:

(i) To note the headline findings of the January Development Day;

(ii) To note that the Executive Planning Group are working through the detailed findings;

(iii) To forward any further ideas or suggestions that they may have to the Executive Planning Group (via Anne Bristow) to inform ongoing planning;

(iv) To note the proposal for two further Development Days in 2014/15 (October 2014 and February 2015) to continue the Board's development.

Reason(s)

Priority three of the Corporate Plan is to improve the health and wellbeing through all stages of life for residents of the borough. The H&WBB is the focal point of the local health and social care economy where its member organisations come together to make strategic plans for the provision of health and social care services and to ensure that commissioning decisions (collective or sovereign) result in the delivery of the borough's overall Health and Wellbeing Strategy. To fulfil its role it is important the H&WBB understands its remit and is able to make good, well-informed decisions on behalf of the Borough.

1. The January Development Day

1.1. The Board commissioned Ian Winter CBE as an external facilitator for the Board's first development day which was held on 13 January 2014. The programme for the day was divided into four parts (how are we doing; what could change; making a difference; engaging, understanding, and impact) and particularly focused on the areas of engagement and integrated working.

1.2. 34 delegates attended the event with each sub-group and member organisation represented, and 11 out of 15 Board Members in attendance.

1.3. Listed below are the important headline observations from the sessions:

- Discussions on tricky issues need to start earlier to prevent problems downstream
- Sub-groups need more clarity about what is required from them
- Partners to set the agenda of the Board, otherwise it will be Council-driven.
- The Board needs to promote itself better both within the health and social care system and externally to other stakeholders and residents
- Not all Board members are active participants in all discussions
- The Board needs to pare back its work programme being more selective about where it focuses its attention and delegating issues that it cannot deal with to sub-groups for them to work through/lead on.

1.4. Despite these issues the views expressed by delegates at the Development Day were largely positive and confirmed that the Board was indeed well-advanced and working effectively. For example, the survey conducted in advance of the development day showed that:

- 82% felt that Board agenda items were relevant to their organisation
- 50% felt that Board had made good progress
- 71% felt that the work of the Board was aligned with their organisation's priorities
- 43% felt the work of the Board was making a difference
- 70% saw an impact on improving effectiveness and efficiency of service delivery
- 57% think that the work of the Board helps discussions and decision taken outside of board meetings.

1.5. The full Feedback Report has been provided to the Executive Planning Group who are working through the issues raised. Board Members have also been provided with a full copy of the Development Day report and are asked to provide any comments, ideas or suggestions to the Executive Planning Group via Anne Bristow.

2. Future Development Days

2.1. Board Members stated that they found the January Development Day useful and it is proposed that two further Development Days will be held in the next financial year to assess how it is performing, what it has achieved and where it will need to prioritise improvement in 2014/15 to continue moving forward and improve its effectiveness as a strategic decision-making body. The Executive Planning Group will be discussing the next Development Day in October at their June meeting and will ensure that the feedback from the January development session informs this planning.

3. Consultation

In preparation for the Development Day a questionnaire was sent to all invitees. The findings of which were used to inform the programme of the Development Day and were the basis of the stock take that was presented to delegates. The Development Day evaluation form also surveyed delegates to see if their perceptions had changed as a result of the workshops.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

The content of this report has no direct implications for the JSNA, though Board Members might wish to reflect on how the outcomes of the Board meetings improves the JSNA process and influences new iterations.

4.2. Health and Wellbeing Strategy

Producing the H&WB Strategy is a statutory requirement for the Board. It is important that the Strategy has shared ownership and buy-in from all stakeholders on the priorities. How other local strategies align with the H&WB Strategy, establishing if the borough has a coherent shared vision for health and social care, and developing a more inclusive approach to drafting the Strategy are all issues that might be worth exploring in future development activities.

4.3. Integration

Clause 195 of the HSCA 2012 places a duty on H&WBBs to encourage integrated working building strong and mature relationships between the member organisations will facilitate discussions around sharing resources and delivering services in partnership, informally or through section 75 agreements. The Sub-groups of the H&WBB will play a crucial role in identifying opportunities for integration and testing feasibility of any proposals.

4.4. Financial Implications

The Board has set up a contributory development fund for use in year two and with the expectation that this will be replenished at the start of each year. BHRUT, NELFT, B&D CCG and the Council have pooled £2,000 each to be used for development activities, public engagement work, and by the sub-groups of the Board to expedite their development. Sub-groups are asked to submit proposals to access this fund through the Executive Planning Group.

In addition the Borough has successfully bid for £7,000 of funding from London Councils. The Board therefore has a total of £15,000 at its disposal to help it achieve its development objectives for the next municipal year.

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

4.5. **Legal Implications**

The Board must ensure that it fulfils its purpose and responsibilities as described in the HSCA 2012. It is therefore prudent to have a plan for developing the Board and to periodically assess the Board's performance and progress.

(Implications completed by: Chris Pickering, Principal Solicitor)

4.6. **Patient/Service User Impact**

Increasing the public profile and visibility of the Board with residents was a prominent theme of the Development Day. The Board may wish to focus on this development area and give particular thought to how existing engagement mechanisms relate to the Board and how communications can be ramped up to raise awareness about the Board and to solicit the views of residents on health and social care issues. The role and activities of Healthwatch will be important to moving forward in this area.

It should be noted that the Board has had regular attendance from members of the public at its meetings and that the Board uses Twitter to broadcast meeting proceedings. Since February 2014 the Chair of the Board has also sent out monthly newsletters to staff in Member organisations after each Health and Wellbeing Board meeting in order that they are aware of the discussions, decisions and issues arising from each meeting. These initial attempts at engagement need building on with a greater emphasis on engaging with patients and service users.

5. Background Papers Used in Preparation of the Report:

- Feedback Report Development Event, Ian Winter Consultancy (January 2014)

6. List of Appendices:

- None

HEALTH AND WELLBEING BOARD

17 June 2014

Title:	**Waiver of Contract Rules: Public Health Chlamydia Testing Contract Extension**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Author: Zoë Garbett, Head of Public Health Commissioning, LBBD	**Contact Details:** Tel: 020 227 2311 E-mail: zoe.garbett@lbbd.gov.uk

Sponsor:

Matthew Cole, Director of Public Health LBBD

Summary:

A report was presented to the Health and Wellbeing Board on 11 February 2014 asking for eight public health contracts to be extended. (Minute 96, 11 February 2014 refers)

This report asks for the Board to extend one contract for a further six months to end 30 September 2015 with break clauses at six and twelve months.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

The Board is recommended to:

1. Agree to the extension of the Chlamydia Testing Contract for a further six months by a Waiver under Contract Rules 6.6.8, to permit the extension of the Chlamydia Testing contract with the current provider, Terrence Higgins Trust, for an additional six months to 30 September 2015, with a break clause at six and twelve months.

2. Authorise the Corporate Director of Adult and Community Services, on the advice of the Director of Public Health, and in consultation with the Head of Legal and Democratic Services to extend the contract with Terrence Higgins Trust.

Reason(s)

The Health and Social Care Act 2012 directs local authorities to commission appropriate access to sexual health services (ie. comprehensive sexual health services including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention). To support universal and consistent provision of contraception there have been long standing legislative requirements to ensure access to, and free supply of, contraception. The NHS Act 2006 makes the following provisions (contraception and Sexually Transmitted Infections (STI's)

are dealt with separately):

"The Secretary of State for Health must arrange, to such extent as he considers necessary to meet all reasonable requirements, for:

(a) the giving of advice on contraception,

(b) the medical examination of persons seeking advice on contraception,

(c) the treatment of such persons, and

(d) the supply of contraceptive substances and appliances".

The Secretary of State has delegated this power in order for it to be properly enacted. The Regulations outlined in the Health and Social Care Act 2012 state that most functions must be exercised on behalf of those registered with a local GP, however some functions including the services which the Secretary of State has a duty to provide relating to contraception must be for the benefit of "all persons present in the area" i.e. must be open-access and not limited to the residents of the local authority.

1. Background and Introduction

1.1 A report was presented to the Health and Wellbeing Board on 11 February 2014 (Minute 96 refers) asking for eight public health contracts to be extended.

1.2 This report asks for the Board to extend one of those eight contracts (listed in table 1) for a further six months to end 30 September 2015 (total extension 18 months from April 2014). The extension will allow for:

- Chlamydia testing to be included in the Integrated Sexual Health tender
- An understanding of the sexual health services market place that operates on a tariff basis which varies across London.
- A more in depth analysis of the budget as the 2013/2014 contract was based on outturn figures provided by the PCT for the period April 2010 to March 2011.
- The procurement process to be carried out in collaboration with the London boroughs of Havering and Redbridge. Havering leads on the procurement process.

Table 1: Public Health Contracts requiring extension

Contract	Service provider	Previously approved end date	Revised end date
Chlamydia testing	Terrence Higgins Trust	April 2015	30 September 2015

2. Consultation

Consultation with partners and providers has taken place and a regular dialogue is ongoing. A paper detailing the Integrated Sexual Health (including Chlamydia testing) procurement is going to the Procurement Board on the 16th June.

3. Mandatory Implications

3.1 Joint Strategic Needs Assessment (JSNA)

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

3.2 Health and Wellbeing Strategy

The Health and Wellbeing Strategy highlights the importance and actions required to improve sexual health. This extension is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy. The future procurement should further enhance the quality and access of services as well as user and patient experiences.

3.3 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 extensions allow for effective integration of services and partnership working.

3.4 Financial Implications

This report requests extensions to a public health contract by a further six months to September 2015 for the reasons set out in the report. The annual value for Chlamydia testing is £300,000, to be funded from the Public Health budget.

Completed by Roger Hampson (Group Manager – Finance, Adult & Community Services).

3.5 Legal Implications

3.5.1 As an amendment to the report which was presented to the Health and Wellbeing Board (the “HWB”) on 11 February 2014, the Board is being asked to authorise the extension of the above contract for a period of 18 months from April 2014 until September 2015. This report advises that the existing contract received authority for an extension of 1 year until 31 March 2015.

3.5.2 It is noted that this extension is requested so that the existing contract expires at the same time as the Integrated Sexual Health Services Contract delivered by Barking, Havering and Redbridge NHS University Hospitals Trust (BHRUT) when the intention is to procure one contract to deliver a fully integrated sexual health service.

3.5.3 Rule 54.1.4 of the Council’s Contract Rules states that extensions can only be made where an exemption request (waiver) is made where no specific provision exists in the contract.

3.5.4 It is anticipated that extending the contract for an extra 6 months will bring the total spend for the extension to approximately £450,000. In accordance with rule 54.4 of the Council's Contract Rules, the HWB can indicate whether it is content for the contract to be extended for a total of 18 months.

Completed by Daniel Toohey (Principal Corporate Solicitor, Legal and Democratic Services)

3.6 Risk Management

The contract listed in Table 1 is important to the continuing health of the residents of the London Borough of Barking and Dagenham. The provision of Chlamydia testing by the Council, as Integrated Sexual Health services, is a mandated service which must be provided and not having these contracts in place would put the health of the population at risk.

4. Background Papers

- Barking and Dagenham's Community Strategy 2013-1016
- Joint Strategic Needs Assessment
- Joint Health and Wellbeing Strategy
- Public Health Commissioning Priorities 2014/15

Health and Wellbeing Board

17 June 2014

Title: Urgent Action: Implementation of Matters Scheduled for Consideration by the Health and Wellbeing Board on 25 March 2014	
Report of the Chief Executive	
Open Report	**For Information**
Wards Affected: All	**Key Decision:** No
Report Author: Alan Dawson, Democratic Services Manager	**Contact Details:** Tel: 020 8227 2348 E-mail: alan.dawson@lbbd.gov.uk
Accountable Divisional Director: Fiona Taylor, Head of Legal and Democratic Services	
Accountable Director: Graham Farrant, Chief Executive	

Summary

The meeting of the Health and Wellbeing Board on 25 March 2014 was inquorate. As a consequence, the Board was not in a position to make any decisions on matters on the agenda for that meeting. However, as allowed under the Council's Constitution, the Board Members in attendance chose to discuss the agenda items in an informal setting once the meeting had been officially closed.

Several items of business on the agenda for that meeting required decisions to be made which were of significance and which could not wait until the next scheduled meeting (17 June 2014). The Chief Executive therefore agreed to deal with those matters, set out in the schedule at **Appendix 1** to this report, under the Council's Urgent Action provisions (paragraph 17, Article 1, Part B of the Constitution at that time). The matters were formally approved on Wednesday 26 March 2014.

The reports to which those matters relate are available to view on the Council's website at http://moderngov.barking-dagenham.gov.uk/documents/g7091/Public%20reports%20pack%20Tuesday%2025-Mar-2014%2018.00%20Health%20and%20Wellbeing%20Board.pdf?T=10

Recommendation

The Health and Wellbeing Board is asked to note the action taken by the Council's Chief Executive under the Urgent Action procedures (paragraph 17 of Article 1, Part B of the Council's Constitution) as detailed in Appendix 1 to this report.

Background Papers Used in the Preparation of the Report:

- Chief Executive's letter dated 26 March 2014 entitled "Urgent Action under Paragraph 17, Article1, Part B of the Constitution – Decisions of the Health and Wellbeing Board".

List of appendices:

- **Appendix 1** - Schedule of decisions taken by the Chief Executive that were due to be taken by the Health and Wellbeing Board on 25 March 2014

Appendix 1

Urgent Action: Schedule of decisions taken by the Chief Executive that were due to be taken by the Health and Wellbeing Board on 25 March 2014

Better Care Fund Final Plan	**Key decision**
To: a) Agree the Final Plan as set out at Appendix 2 to the report, in the context of the remaining issues that are discussed in Section 4 of the report. b) Delegate authority to the Corporate Director of Adult and Community Services, acting on behalf of the Council, and the Accountable Officer acting on behalf of Barking and Dagenham CCG to approve the Final Plan in the light of any outstanding matters arising from the Board's discussions.	
CCG Strategic Plan/Operating Plan	**Key decision**
To: a) Agree, on advice of the Corporate Director of Adult and Community Services, to the proposed outcomes and related trajectories as set out in the CCG's strategic plan and operating plan b) Delegate authority for final approval of the trajectory relating to the years of life indicator to the Director of Public Health for LBBD and the Chief Operating Officer for the CCG c) Agree the proposed increase in medication errors reporting in the Operating Plan (see paragraph 5.5)	
Transfer of Health Visiting Commissioning	Non-key decision
To: a) Agree the initial transition programme (see paragraph 3.1)	
Care City Proposal	**Key decision**
To: a) Support the development of the Care City concept in Barking and Dagenham; b) Delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Head of Legal and Democratic Services and the Chief Financial Officer, to negotiate and enter into a partnership arrangement between the Council and NELFT in accordance with Section 75 of the NHS Act 2006; c) Delegate authority to the Corporate Director of Adult and Community Services to finalise the related arrangements for the interim "collaboration lab" in 2014/15, including up to £300k of funding from the Public Health grant for set up costs, and £72k from the Adults and Community Services reserve, if needed for funding the first year of rent.	

Learning Disability Section 75 Agreement and Challenging Behaviour Plan	Key decision

To:

1. For the Section 75 commissioning agreement:
   a. Approve the proposed partnership arrangement between the Council and the CCG in accordance with Section 75 of the NHS Act 2006, and the proposed arrangements in respect of the associated contracts with service providers on the integrated service provision as detailed in this report;
   b. Approve the extension of the Section 75 agreement and associated service provider agreements following the initial three year term by agreement between the Council and the CCG;
   c. Delegate authority to the Corporate Director of Adult and Community Services in consultation with the Head of Legal and Democratic Services, the Chief Finance Officer and the Cabinet Member for Health as necessary, to conclude the negotiation and execution of the Section 75 agreement and other contracts associated with this agreement.
2. For the Challenging Behaviour Joint Strategic Plan:
   a. Approve its adoption and implementation

Mental Health Section 75 Agreement	Key decision

To:

a) Approve the proposed partnership arrangement between the Council and NELFT in accordance with Section 75 of the NHS Act 2006;

b) Delegate authority to the Corporate Director of Adult and Community Services in consultation with the Head of Legal and Democratic Services and the Chief Finance Officer, on the Council's behalf, to conclude the negotiation and execute the Section 75 agreement, in consultation with the Cabinet Member for Health as necessary.

Supported Living Tender	Key decision

To:

a) Approve to waive contract rules to extend existing contracts with Look Ahead and MCCH for a further period of four months (to 31 January 2015) based on the tender timetable set out in this report, and to authorise the Corporate Director of Adult and Community Services to make the necessary arrangements;

b) Delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer and Head of Legal and Democratic Services, to proceed to tender in line with the process described in outline and on conclusion of the necessary modelling.

HEALTH AND WELLBEING BOARD

17 JUNE 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: Louise Hider, Health and Social Care Integration Manager	**Contact Details:** Telephone: 020 8227 2861 E-mail: Louise.Hider@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.
Board Members should note that the Children and Maternity Sub-Group and the Public Health Programmes Board have not met since the last meeting and therefore a sub-group report has not been attached for these two groups. However updates for these sub-groups are as follows:

Children and Maternity sub-group
The Board should note that a Children and Maternity workshop was scheduled to be held on 28 May 2014 but this was cancelled due to the unannounced inspection by OFSTED and the timing of the meeting coinciding with Elected Member briefings following the local elections. The workshop has been rescheduled for 2 July 2014 and a report on the workshop will be provided in the next Children and Maternity sub-group report.

Public Health Programmes Board
The Public Health Programme Board has been reviewed to ensure that it is fit for purpose. The key areas the Board will look at over the coming weeks includes Health Protection, Obesity and Sexual Health which reflect the Local Authorities statutory duties and areas of concern. The next meeting will be held on 27 June 2014.

Recommendations:

The Health and Wellbeing Board is asked to:

- Note the contents of sub-group reports set out in the Appendices 1-3 and comment on the items that have been escalated to the Board by the Sub-groups.

List of Appendices

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

APPENDIX 1

Integrated Care Group

Chairs:
Dr Jagan John, Clinical Lead, NHS 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

- The Health and Wellbeing Board is asked to note progress of the integrated care sub group

Meeting Attendance

24 February 2014: 56% (9 of 16)
24 March 2014: 50% (8 of 16)
28 April 2014: 67% (10 of 15)

Performance

Please note that no performance targets have been agreed as yet; going forward the group will review progress against Barking and Dagenham targets delivered through achievement of milestones in Better Care Fund schemes.

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

- The previous three meetings of the Integrated Care Group (February – April 2014) have been dedicated to the development of Better Care Fund (BCF) proposals and detailed project plans to support these.
- The group has strengthened governance arrangements around the BCF plan; the local operational group has been reframed to oversee Better Care Fund projects. This group will be accountable to the Integrated Care Sub Group who will monitor progress against target. The Integrated Care Sub Group will report progress to the Health and Wellbeing Board.
- BCF plans include the following schemes around which the Sub group agenda will be framed going forward:
  - Scheme 1: Integrated Health and Social Care Teams
  - Scheme 2: Discharge from Hospital
  - Scheme 3: Intermediate Care/Reablement
  - Scheme 4: Mental health support outside hospital
  - Scheme 5: Joint Commissioning
  - Scheme 6: Support for Family Carers
  - Scheme 7: Care Bill implementation
  - Scheme 8: Prevention/Falls
  - Scheme 9: End of life
  - Scheme 10: Equipment and Adaptations
  - Scheme 11: Dementia support

Action and Priorities for the coming period

- The group will now focus on finalising of the Better Care Fund scheme project plans, monitoring delivery, and addressing any issues arising from BCF implementation; regular updates will be provided to the Health and Wellbeing Board.

- The group is in the process of developing reablement metrics; the Health and Wellbeing Board will be updated on progress.

- The group will develop an end of life care update paper which will go to the Health and Wellbeing Board in June 2014.

Contact: Emily Plane, Project Officer, Strategic Delivery, BHR CCGs
Tel: 0208 822 3052; Email: Emily.Plane@onel.nhs.uk

APPENDIX 2

Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Commissioning and Partnerships, London Borough of Barking and Dagenham

Meeting Attendance

29 April 2014: 65% (13 out of 20)

18 March 2014: 60% (12 out of 20)

3 February 2014: 58% (10 of 17 attendees)

17 December 2013: 47% (8 of 17 attendees)

4 November 2013: 71% (12 of 17 attendees)

23 September 2013: 71% (12 of 17 attendees)

12 August 2013: 88% (15 of 18 attendees)

Items to be escalated to the Health & Wellbeing Board

(a) None

Action(s) since last report to the Board

(a) Two Learning Disability Partnership Board (LDPB) meetings have taken place since the last report in January 2014.
(b) The Service User, Carer and Professionals and Provider Forums are meeting regularly. The Forum representatives have an opportunity to give feedback and raise any issues at every LDPB meeting.
(c) Standing items on the LDPB forward plan include Winterbourne View and Children and Families Bill and Transitions.
(d) Topics that have been discussed recently include the housing, Learning Disability Section 75 Agreement, the Behaviour That Challenges Plan, the Autism Plan and Learning Disability Week.

Action and Priorities for the coming period

(a) At future meetings the following will be discussed: Market Position Statement Update, ELF Project Update, Autism Plan, Supported Living, Transport Forum, Children and Families Bill, Care Bill, Healthwatch Consultation on Personal Budgets, Fulfilling Lives, Update on the Joint Assessment and Discharge Service, Care City, Community Safety and Learning Disabilities.

Contact: *Joanne Kitching, Health Integration Support Officer, London Borough of Barking and Dagenham*
Tel: *020 8227 3216* / E-mail: *joanne.kitching@lbbd.gov.uk*

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Mental Health sub-group

Chair: Gillian Mills, Integrated Care Director (Barking and Dagenham), NELFT

Items to be escalated to the Health & Wellbeing Board

(a) None to note.

Performance

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

Meeting Attendance

16 April, 2014: 60% (9 of 15)

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

(a) The Terms of Reference and membership of the group were reviewed. The issue of NHS England representation on the Group has been resolved. John Atherton will act as the point of contact for the Group and organise attendance of relevant NHS England expert colleagues.

(b) Sub-group discussion regarding voluntary sector and service user membership of the group. Agreed to add ‘Engagement Strategy’ as a duty and responsibility to the Terms of Reference.

(c) The Group made initial comments on a paper which had been circulated in respect of the Mental Health Needs Assessment undertaken in September 2013. Agreement that further work is required to undertake epidemiological assessment of mental health and wellbeing of the B&D population. LBBD Public Health leading on commissioning a 4 month project. Interim and final report will be presented to the MH Sub-Group, and will inform future service commissioning intentions and service improvement.

(d) The group considered the 25 areas noted within the DH document ‘Closing the Gap: Priorities for essential change in mental health’ published in January 2015. Agreement that service commissioners and providers should undertake benchmarking audit to establish where organisations are against the recommendations.

Action and Priorities for the coming period

(a) On behalf of the Board, the sub-group agreed to take forward the recommendations of the Health and Adult Services Select Committee’s scrutiny review on the impact of the recession and welfare reforms on people’s mental wellbeing. An action plan is being developed for review at the June sub group meeting and to provide a report to the July Board meeting.

Contact:

Julie Allen, PA to Integrated Care Director (NELFT)

Tel: 0300 555 1201 ext 65067; **E-mail:** Julie.allen@nelft.nhs.uk

HEALTH AND WELLBEING BOARD

17 JUNE 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, Health and Social Care Integration 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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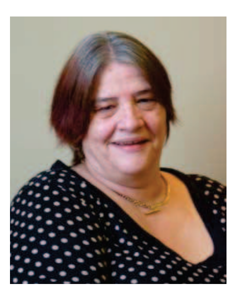


Welcome to our second statutory year as a Board!

In this edition of my Chair's Report I discuss the Care Act receiving Royal Assent and update the Board on the Better Care Fund and the progress of Care City. I also congratulate the CCG on their success in the Prime Minister's Challenge Fund as well as Matthew Hopkins on his appointment as Chief Executive at BHRUT. 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

Care Act

The Care Bill went through its final stages of the parliamentary process and on 14 May 2014 it was given Royal Assent. We are now waiting for the consultation on the draft regulations and guidance to begin.

For an overview of the Act please see Norman Lamb's ministerial statement which followed Royal Assent. As Members of the Board will remember, the majority of the Care Act will come into force in April 2015 which is a very challenging timetable for such major reform. The Board will be receiving a report at the July meeting which summarises the Act, unpicks the detail in the secondary legislation, and explains in depth the local approach to implementing the Act's provisions. As discussed at previous Health and Wellbeing Board meetings, the Act also has provisions that have implications for partner organisations, and this will also be discussed in the July report.

For the moment the Board are reminded that Anne Bristow has set up an adult social care reform programme which has within it six workstreams to deliver the various elements of the Care Act. The Programme Board has been meeting since November 2013 and has now reached the point where the implementation programme will 'move up a gear', particularly now that the regulations will be imminently published.

Prime Minister's Challenge Fund

In the March Chair's Report I discussed the bid that BHR CCGs put into the Prime Minister's Challenge Fund, supported by myself and the other Health and Wellbeing Board Chairs in Havering and Redbridge. I am delighted to report that the joint application to the Challenge Fund was successful and that BHR CCGs have been awarded £5.6M to implement their plans, which focus on two strands of work:

- **Improved Access** - for patients through better access to appointments within and outside of core hours, with a simpler point of entry. This will include more urgent week day appointments between 6.30pm and 10pm, with extra urgent appointments at the weekend – all in addition to normal GP opening hours
- **Complex Care** - focussing on complex patients with increased need for specialist skills. Local GPs will support people with complex health problems with a dedicated team of clinicians including a GP, practice nurse and consultant.

I will look forward to the Board receiving updates on the progress of these important changes to primary care services over the coming months.

New Chief Executive at BHRUT

In the last Chair's Report I discussed the new appointment of Steve Russell as the Improvement Director at BHRUT as well as Dr Maureen Dalziel's appointment as interim Chair.

I would now like to welcome Matthew Hopkins as the new Chief Executive at BHRUT following his appointment in April 2014. Prior to this, Matthew was the Chief Executive of Epsom and St Helier University Hospitals NHS Trust for three years and has also worked at a number of other London teaching hospitals. I hope that the Board joins me in wishing Matthew success in this challenging role.

Board Members can follow Matthew on Twitter @M_J_Hopkins.

Carers' Strategy

The Borough's current Carers' Strategy is due to draw to a close in 2015 having been in existence since it was adopted in 2011. It is felt that the current Strategy is out of date as it doesn't take into account developments such as those relating to the Care Bill, Better Care and progress towards improved integration between health and social care. We also know that carers have a significant impact upon demand for health and social care, notably upon emergency admissions, and are integral to helping people to remain healthy and independent for as long as possible. Supporting the health and wellbeing of carers is therefore essential and should also be reflected in our Borough-wide strategy.

We have therefore sought to engage with an expert partner – Carers UK – to develop and refresh our Carers' Strategy. Carers UK have achieved positive outcomes in other areas of the country and will be undertaking engagement with carers, voluntary organisations and staff, as well as other stakeholders to review and renew the Strategy. They will also be drawing upon national best practice and outcomes to determine local priorities and needs, and will look at the engagement and effectiveness of current services in order to make recommendations of ways in which commissioners in the Borough can make best use of their resources for the benefit of carers in Barking and Dagenham. I will look forward to following the refresh of the Strategy over the next few months and receiving updates to the Board in due course.

CCG Board Appointments

I wanted to alert Board Members to the results of the CCG Governing Body election which was held recently. From 1 April 2014, the following Clinical Directors will form the Governing Body:

Dr Arun Sharma

Dr Ravaili Goriparthi

Dr Ramneek Hara

Dr Jagan John

Dr Gurkirit Kalkat

Dr Chandra Mohan

Dr Waseem Mohi

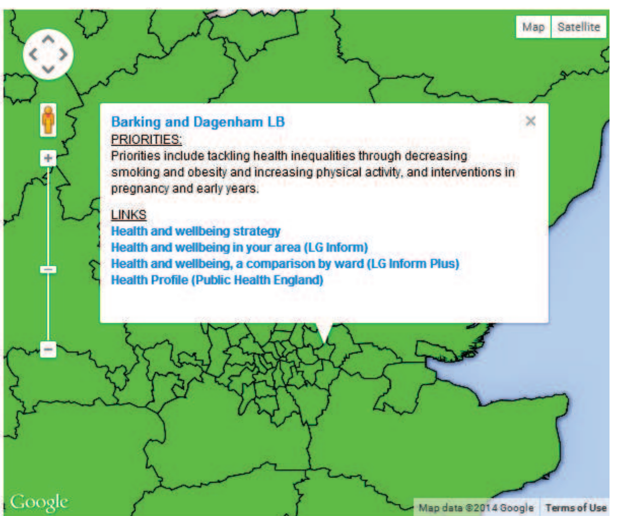
Dr Mohi and Dr John will remain as the Clinical Director representatives at the Health and Wellbeing Board. For more information about the Governing Body, please contact Anne-Marie Keliris, Company Secretary by emailing AnneMarie.Keliris@onel.nhs.uk

Chair's Report

17 June 2014

Mapping Health and Wellbeing Board priorities

Members of the Health and Wellbeing Board may be interested in a new interactive map highlighting the priorities of all Health and Wellbeing Boards across England. By selecting a theme, for example smoking or healthy living, the map highlights all areas citing it as one of their health and wellbeing priorities.



You can also select a single area on the map and view a summary of the local priorities, access links to the local Health and Wellbeing Strategy, view data reports produced through LG Inform and LG Inform Plus highlighting measures of health and wellbeing for the area and also see the latest Health Profile for the area produced by Public Health England.

The interactive map can be found by visiting:

http://www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE

Better Care Fund Update

I wanted to ensure that I gave Members of the Board an update on our Better Care Fund Plan, particularly following recent media coverage. Following positive feedback from NHS England we have developed a detailed stakeholder engagement plan and detailed implementation plans for each of the 11 schemes within our Better Care Fund plan with work commencing to deliver each of the schemes from June. Oversight of progress is maintained through the Integrated Care sub-group, with monthly updates provided. We have identified the likely impact upon the hospital trust and the required reductions in emergency admissions and have worked closely with the hospital to ensure alignment with both their improvement plan and the steps to implement the new Joint Assessment and Discharge Service. We are linked into NHS England, the Local Government Association and London Councils to ensure that we can make ready use of emerging best practice and guidance in our delivery of the required changes to services.

Regular updates will be brought to the Board over the coming months, including a report to the Board in September.

Current Status of Care City

The Care City programme is continuing to gather momentum and to date has attracted over £2.5 million worth of investment. This includes a £1.8million NELFT contribution for the purchase of an interim show home for care city.

The search for a new interim site has resumed following news that we were not able to secure the initial preferred option. However, this turn of events has presented us with an opportunity to increase our ambition - to seek a space which will also support us to accommodate our growing number of researchers.

We are currently exploring a number of Barking sites. We continue to work towards developing the Care City Business Plan by July which will determine the next phase of the programme. A paper detailing the proposed governance of Care City will also be presented to Cabinet and the Health and Wellbeing Board in July.

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HEALTH AND WELLBEING BOARD

17 JUNE 2014

Title:	**Forward Plan**
Report of the Chief Executive	
Open	**For Comment**
Wards Affected: NONE	**Key Decision: NO**
Report Authors: Tina Robinson, Democratic Services	**Contact Details:** Telephone: 020 8227 3285 E-mail: tina.robinson@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 for the 2014/15 municipal year and 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:

a) 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;

b) To consider whether the proposed report leads are appropriate;

c) 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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HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT - July 2014 Edition

Publication Date: 30 June 2014

DRAFT

THE FORWARD PLAN

DRAFT

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).
In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk.

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2014 / 2015 Council year, in accordance with the statutory 28-day publication period:

Edition	Publication date
June 2014 edition	19 May 2014
July 2014 edition	30 June 2014
September 2014 edition	11 August 2014
October 2014 edition	29 September 2014
December 2014 edition	10 November 2014
February 2015 edition	12 January 2015
March 2015 edition	16 February 2015

DRAFT

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed. It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting Alan Dawson on 020 8227 2348 or alan.dawson@lbbd.gov.uk .

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and or Board Member who is the sponsor for that item.

DRAFT

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: Tuesday, 29.7.14	The Care Act : Framework The Board is following the passage of the Care Bill into the statute book. This report will be the third in a series of reports that considers the local implications and readiness of the Borough to meet provisions of the legislation once it is given Royal Assent. • Wards Directly Affected: All Wards	Open	Bruce Morris, Divisional Director, Adult Social Care (Tel: 020 8227 2749) (bruce.morris@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Diabetes Scrutiny: Update on Delivering the Recommendations After giving an initial response to the recommendations on 04 June 2013, it was agreed that the Public Health Programmes Board would be the body responsible for delivering the HASSC's recommendations following its review of diabetes care locally. This report will be the second six-monthly report that tracks implementation of the recommendations. • Wards Directly Affected: Not Applicable	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	**Autism Strategy** : Framework The Board is asked to review and approve the refreshed edition of the Autism Strategy which picks up improvements identified in the Autism Self Assessment Framework and independent mapping exercises. • Wards Directly Affected: All Wards	Open	Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)

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Health and Wellbeing Board: Tuesday, 29.7.14	Impact of the Recession Scrutiny (Action Plan) The Health and Wellbeing Board will receive and give comments on an Action Plan which will be produced in response to the findings and recommendations of the Health and Adult Services Select Committee's scrutiny review. The review investigated the impact of the recession on residents' mental health and wellbeing. The findings of the review were originally presented to the Board on 25 March for discussion. • Wards Directly Affected: All Wards	Open	Gillian Mills, Integrated Care Director, NELFT (gillian.mills@nelft.nhs.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Health and Young Offenders The Board will receive a report that outlines the health needs and challenges for young offenders as a cohort. The Board will discuss gaps in service provision and how health inequalities can be addressed for this group. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	The Children and Families Act : Framework The Board will receive an update on the passage of the legislation and relevant issues arising for Barking and Dagenham in terms of implementing the provisions of the Act. • Wards Directly Affected: All Wards	Open	Meena Kishinani, Divisional Director of Commissioning and Safeguarding (Tel: 020 8227 2786) (meena.kishinani@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Urgent Care Board Update The Board is receiving regular updates from the CCG-led Urgent Care Board. This report will be the fourth update following that of 25 March 2014. • Wards Directly Affected: All Wards	Open	Jane Gateley, Director of Strategic Delivery (Jane.Gateley@onel.nhs.uk)

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Health and Wellbeing Board: Tuesday, 29.7.14	Dementia Needs Assessment The Office of Public Management were commissioned by Public Health to complete a Dementia Needs Assessment for the borough. The key objectives include providing epidemiological information on the prevalence of dementia, consultation with key stakeholders and exploring current services and market gaps. OPM's report will propose a number of recommendations to be considered by the Board. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Child Death Overview Panel Annual Report The Board will receive and discuss the Child Death Overview Panel Annual Report of 2013/14. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Improvements to the Breastfeeding Pathway : Community The Breastfeeding Needs Assessment looked at current services within the Borough and the key areas for improvement. Public Health received the completed report in May 2014. The Board will be asked to look at the actions from the Breastfeeding Needs Assessment and in doing so identify necessary changes and improvements and decide the most appropriate owners of these actions • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Public Health Review : Community The report will present the use and impact of the Public Health Grant in 2013/14 including lessons learnt to inform the use going forward and to enable resource decision into 2014/15. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

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Health and Wellbeing Board: Tuesday, 29.7.14	**Joint Strategic Needs Assessment** : Framework This Board will be asked to agree key strategic recommendations arising from the refresh of the Joint Strategic Needs Assessment (JSNA) for 2014. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 29.7.14	Care City: Update : Community Care City is a regional initiative that will facilitate greater collaboration and integration between the NHS, social care sector, academic institutions and small and medium enterprises operating in North East London. As well as bring integration to health and social care, the Care City project will stimulate regeneration, attract investment, and create jobs in the borough. The Board will be presented with an update on the plans for Care City following the last presentation of the initial Care City proposals to the Board in March 2014. • Wards Directly Affected: All Wards	Open	Helen Oliver, Adult Safeguarding (Tel: 0208 724 8857) (helen.oliver@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 9.9.14	End of Life Care: Progress on Actions Following the meeting of 11 February 2014 at which the Board was presented with a position statement and next steps to take forward the end of life care agenda, the Board will receive and consider an action plan produced by the Integrated Care Sub-group to deliver those next steps. • Wards Directly Affected: All Wards	Open	David Millen, Integrated Care Delivery Manager (david.millen@lbbd.gov.uk)
Health and Wellbeing Board: Tuesday, 9.9.14	Life Study - new UK birth cohort study : Community The report will set out the aims of the Life Study which will investigate a wide range of influences operating in early life, that have implications for children's health, wellbeing and development. • Wards Directly Affected: All Wards	Open	Conor Burke, Accountable Officer (Designate) (conor.burke@onel.nhs.uk)

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APPENDIX 1

Membership of Health and Wellbeing Board:

4 LBBD Councillors (to be appointed by Annual Assembly)
Anne Bristow, Corporate Director for Adult and Community Services
Helen Jenner, Corporate Director for Children's Services
Matthew Cole, Director of Public Health
Frances Carroll, Chair of Healthwatch Barking and Dagenham
Dr Waseem Mohi, Chair of Barking and Dagenham Clinical Commissioning Group (Deputy Chair of the H&WBB)
Dr Jagan John, Clinical Director (Barking and Dagenham Clinical Commissioning Group)
Conor Burke, Accountable Officer (Barking and Dagenham Clinical Commissioning Group)
Martin Munro, Executive Director of Human Resources & Organisational Development (North East London NHS Foundation Trust)
Stephen Burgess, Interim Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Chief Superintendant Andrew Ewing, Borough Commander (Met Police)
John Atherton, Head of Assurance (NHS England) (non-voting board member)

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