

HEALTH & WELLBEING BOARD
Tuesday, 29 July 2014 - 6:00 pm

Conference Room, Barking Learning Centre2 Town Square, Barking, IG11 7NB

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

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Graham Farrant
Chief Executive

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Membership for 2013/14:

Cllr Maureen Worby (Chair)	(LBBB) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Laila Butt	(LBBB) Cabinet Member for Crime and Enforcement
Cllr Evelyn Carpenter	(LBBB) Cabinet Member for Education and Schools
Cllr Bill Turner	(LBBB) Cabinet Member for Children's Social Care
Anne Bristow	(LBBB) Corporate Director of Adult and Community
Helen Jenner	(LBBB) Corporate Director of Children's Services
Matthew Cole	(LBBB) Divisional Director of Public Health
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Jacqui Van Rossum	(North East London NHS Foundation Trust)
Dr 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 - To confirm as correct the minutes of the meeting held on 17 June 2014 (Pages 1 - 12)

CHILDREN AND YOUNG PEOPLE

4. The Children and Families Act (Pages 13 - 35)

5. OFSTED Children's Social Care Inspection Feedback (Pages 37 - 40)

6. Breastfeeding Pathway Review (Pages 41 - 46)

7. Child Death Overview Panel Annual Report (Pages 47 - 56)

8. Contract: Extending the Contract for Public Health Healthy Child Programme 5 - 19 Years Old (Pages 57 - 63)

THE CARE ACT

9. The Care Act (Pages 65 - 100)

MENTAL HEALTH

10. Mental Health Tariff (Pages 101 - 104)

11. Impact of the Recession Scrutiny (Action Plan) (Pages 105 - 128)

12. 'Closing the Gap': Priorities for Essential Change in Mental Health (Pages 129 - 140)

LOCAL HEALTH ECONOMY UPDATES

13. Urgent Care Board Update (Pages 141 - 151)

14. Care City: Update (Pages 153 - 161)

15. Better Care Fund - Update (Pages 163 - 166)

16. Progress on the Diabetes Actions from the Health and Adult Services Select Committee Scrutiny Review (Pages 167 - 177)

17. **Sub-Group Reports (Pages 179 - 189)**
18. **Chair's Report (Pages 191 - 243)**
19. **Forward Plan (Pages 245 - 263)**
20. **Any other public items which the Chair decides are urgent**
21. **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.***

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

MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 17 June 2014
(6:00 - 8:31 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), Cllr Evelyn Carpenter, John Atherton, Anne Bristow, Stephen Burgess, Frances Carroll, Matthew Cole, Chief Superintendent Andy Ewing and Helen Jenner

Also Present: John Dawe, Steve Russell, Neil Roberts, Dr Tania Misra, Sharon Morrow

Apologies: Cllr Laila Butt, Cllr Bill Turner, Conor Burke and Dr John

1. Declaration of Interests

There were no declarations of interest.

2. Minutes - 11 February 2014 and 25 March 2014

The minutes of the meeting held on 11 February were confirmed as correct. It was noted that the meeting on 25 March was inquorate.

3. The Health & Wellbeing Board as a Committee of the Council

The Board received a presentation from John Dawe, Group Manager Democratic Services, who outlined the role and integral position of the Health and Wellbeing Board in the Council's overall political structure, how all Board meetings should be conducted in accordance with the Council's Constitution and how Board Members share a similar status with Councillors and Co-opted Members of the Authority, and were therefore are bound by certain codes and protocols. The presentation covered governance arrangements and meeting procedures, including scrutiny of Board decision making, codes of conduct, the role of the Monitoring Officer and declaration of interests in the context of the Register of Members and Co-Opted Members' interests. Board Members were reminded of the requirement to register relevant interests within 28 days of the meeting on a prescribed form, to be circulated.

The Board members were also provide with a welcome pack for future reference and were reminded that much of the information could also be found in the Council's Constitution.

The Board noted:

- (i) The status of the Board as a statutory Committee of the Council with the authority to take executive decisions; and
- (ii) That meetings of the Board will be conducted in accordance with the Council's Constitution.

4. Healthwatch Barking and Dagenham Annual Report 2013/14

Frances Carroll, Chair of Healthwatch Barking and Dagenham, presented the first annual report of Healthwatch which provided details of the work that had been undertaken during 2013/14. The achievements, progress against the work plan and challenges had included:

- Public Consultation
- Consultation on the Closure of Broad Street Walk-in Centre, which had resulted in the CCG pilot of 25,000 extra urgent care appointments by GPs.
- Progress against the work plan in regards to visits to Queen's Hospital.
- Social care visits to Darcy House, Cloud House and Look Ahead.
- Survey to ascertain how easy it was for staff to raise concerns or to 'whistle-blow' in regards to inappropriate behaviour or care that was not to an acceptable standard.
- Survey of young people's dental experiences and provision of toothbrush for all 3 to 5 year olds project.
- Children and Young Adults with Diabetes issues and actions.
- Discharge from the stroke service survey.
- Community Care Teams and Better Care Fund workshops held.
- The cessation of 0844 telephone numbers by GPs in the Borough.
- Issues that Healthwatch they were facing in regards to obtaining responses from GPs, including through Freedom of information requests.
- Difficulties in getting NELFT and BHRUT to contact patients discharged through the stroke service.

Frances Carroll explained that Healthwatch recommendations were sometimes met with a non helpful response, such as a solicitor's letter. This might be due to a lack of understanding of the role of Healthwatch within some organisations in the sector. Sharon Marrow advised that the CCG have and will continue to share information with Healthwatch. A number of Board Members suggested that should Healthwatch have difficulties they should contact the appropriate Board Member who would be able to assist in facilitating responses from the appropriate part(s) of their organisation.

Helen Jenner, Corporate Director of Children's Services indicated that she felt more work could be done with the Barking and Dagenham Youth Forum (B.A.D Forum) on young people's health issues and felt that the engagement programme details would assist.

The Chair said that she needed some clarity on how concerns identified by

Healthwatch are escalated to the Board. The Chair also queried whether the same participants regularly take part in Healthwatch events or whether there were different organisations or people depending on the topic. Francis Carroll advised that 'voice cards' were a way of gathering intelligence from a wider group and the cards use open questions to pick up trends. Anne Bristow, Corporate Director of Adult and Community Services said that she was disappointed that the hub and spoke communication method had so far not resulted in more active involvement by the community.

Councillor Carpenter raised concerns about the size of Healthwatch as an organisation and its ability to deliver in view of the large brief and area Healthwatch covered. Francis Carroll advised that they now had two full time staff and a number of good quality volunteers. Cllr Carpenter indicated that she felt Healthwatch would need to ensure they prioritise and focus on both what could and needed to be delivered within timescales. Francis Carroll advised that Healthwatch do not pick broad subjects, but pick specific issues that they can hone into but are sometimes dependant upon the responses or assistance of member organisations.

The Board:

- (i) Noted the progress made in the last year;
- (ii) Noted the difficulties that Healthwatch had experienced in receiving feedback / communications from Member organisations and that communications needed to be improved between both partners and contributors;
- (iii) Noted that Helen Jenner, Corporate Director of Children's Services, would provide details of the Barking and Dagenham (BAD) Youth Forum to Healthwatch in order that young people's views can be part of the Healthwatch engagement process; and,
- (iv) Asked Healthwatch to provide further clarification, at a future meeting, into the mix and number of individuals and cohort(s) they consult and how they can improve on the 'hub and spoke' method of working.

5. BHRUT Improvement Programme

Steve Russell, Improvement Director of Barking Havering and Redbridge University Trust (BHRUT), presented a report on the Care Quality Commission (CQC) Inspection of the BHRUT Hospitals in October 2013 and the CQC report which was published in December 2013. As a result of the Inspection, the CQC had recommended that the BHRUT be placed into special measures and that significant improvements were required; particularly around the emergency care pathways, governance, organisation / structures and processes to drive improvements in the quality of services.

The Board were apprised of the Improvement Plan which BHRUT had drawn up and the five key areas of ensuring the services are safe, effective, caring, responsive and well lead and the progress that had been made and work that was ongoing. Mr Russell made particular comment in regards to:

- Consultants would now be part of the patient process much earlier in emergency treatment.
- 600 people had been trained / retrained in sepsis management and treatments.
- The ethos of the organisation is being changed to be more outward facing and staff are realising the need for joined up working with partner organisations and services.

Mr Russell stressed that special measures had allowed extra support and expertise to be levered-in to progress the required improvements. There was now strong clinical and managerial leadership and changes were being made organisationally for success. The most potent factor was that the attitude of staff had changed and they were now much more open and receptive to innovation and the development of the Action / Improvement Plan with the wider health sector.

Matthew Cole, Director of Public Health LBBB, said that the Improvement Plan seemed to be very medical based and asked if were BHRUT satisfied that the organisation had enough support and services for mental health issues. Mr Russell responded that the BHRUT is keen to develop mental health provision and with NELFT, and would welcome input from partners.

Helen Jenner, Corporate Director of Children's Services LBBB, said that the work that was being undertaken on the Improvement Plan was to fix the problems found by the CQC inspection at that time, however, there would be a massive change in demographics in the next few years and she asked if the improvement plan would be the only way of moving things forward or if emerging issues could also be given resources. Mr Russell indicated that they were more aware of such pressures and would work on these issues as well as the response to the Inspection.

Councillor Carpenter, Cabinet Member for Education and Schools LBBB, indicated that she felt that the Improvement Plan was better presented but was still concerned that in the past organisational culture issues had caused blockages to improvement at BHRUT and asked Mr Russell why it would be different this time.

Mr Russell responded that the clinical directors, senior clinicians, operational managers and matrons were now talking about the Improvement Plan as their Plan. The Plan had been compiled in a different way, with much more ground up consultation and suggestions. There was still work to do in rolling out the changes, but cultures and attitudes were beginning to change.

The Chair commented that budgets had been top sliced by NHS London but the benefits had not seemed to materialise in the east of London. John Atherton, NHS England, said that he felt broadly the Improvement Plan was right, it was linked with the right partners and there was a good timescale for change and pace for improvement, bearing in mind the Government agenda and funding issues.

The Chair said felt there were two bits missing, the problems with the building itself at Queen's Hospital and how we would change the behaviour of the public choosing to go to Accident and Emergency (A&E) because other services are not easily available.

Mr Russell accepted that the building was not optimal at present and that they will

be looking at the redesign of A&E in the future. Work also needed to be done in regards to transporting people to hospitals, and the mindset of being within hospital walls to get treatment when a paramedic /mobile doctor 'in home' service could reduce the number of people taken to hospital.

Dr Steven Burgess, Interim Medical Director BHRUT, stressed that they know they have much more to do but the development of the plan had been at the shop floor and there was a definite culture change taking place following the introduction of the 'PRIDE' Programme.

Frances Carroll, Healthwatch, commented that the over use of A&E at both Queen's and King George Hospitals clearly indicated that there was a need to look at the primary care sector first and GP services and appointment availability, as well as provision at weekends when GP surgeries were not open. Steve Russell advised that even if the primary care was better it would still not solve all the issues as there was still a need to change the public's perceptions and expectations.

Sharon Morrow, Chief Operating Officer B&D CCG, said that it was important that the various partners were aligning plans so that they were all working towards common goals and service provision and this had begun to happen.

The Board

- (i) Noted the Improvement Plan; and,
- (ii) Requested BHRUT to report back to the 28 October on the progress being made against the Improvement Plan and any further actions being taken.

6. Joint Assessment and Discharge Service

Bruce Morris, Divisional Director Adult Social Care LBBB, reported on the work that had been undertaken in regards to the development of a Joint Assessment and Discharge (JAD) Service by the partners. The new service had become operational on the 2 June 2014 and was now a single point of contact for all referrals of people who may require health and / or social care support at the point of discharge from hospital, whether that be at home or in residential or nursing care. The service structure was in place, with one qualified worker per ward. Mr Morris advised that ICT issues for the service still needed to be resolved, but were being worked upon, and the service needed to be co-located to improve communication between staff and other services.

The Board noted:

- (i) The progress that had been made on the Joint Assessment and Discharge Service; and,
- (ii) It was anticipated that BHRUT would make the necessary arrangements for a co-location site for the Joint Assessment and Discharge Service staff to be available shortly.

7. Addressing Variation in Primary Care Performance

Neil Roberts, Head of Primary Care NHS England (London Region, North Central and East), presented the report on the variation of primary care performance, and how it is identified and handled, together with details of the GP standards outcome and other key data.

The details set out in the report also provided areas for consideration in relation to the Board's due diligence role, particularly in regards to contracts offered to GPs and pharmacies that the local authority commissioned. The value of the contract was £8bn and that GPs were independent contractors and not employees of the NHS. Funding had been targeted at areas where performance has been poor and that had recently been other areas of London. There was also a five year strategy, which included the establishment of a Primary Care Transformation Programme, and they were also looking at co-commissioning projects between the three CCG.

Mr Roberts went on to inform the Board it had not proved possible to have a national standard, therefore, a London-wide standard had been developed. They were also looking to further develop 17 aspirational standards at the moment.

Matthew Cole asked how this work responds to the Francis recommendations and in regards to individual performance if they felt they had included the 'Francis' recommendations in relation to safeguarding and was advised that they had not done so as the GP contract is limited on safeguarding and there is more in CQC registration. Mr Cole and Councillor Carpenter both asked if it was not more appropriate to suspend somebody accused of a serious allegation whilst they were being investigated. Mr Roberts explained how they would investigate and if necessary suspend a specific person and how the statutory process is then followed.

Dr Mohi, Barking and Dagenham CCG, advised that there had been difficulties in regards to communication in the past but this had improved as of late. The ability to obtain a GP surgery appointment was known to reduce the likelihood of a hospital A&E attendance so it was important that issues such as appointments and later opening need to be considered by NHS England when drawing up contracts or co-commissioning as this could have both a serious and long-term effect on the overall standards being provided.

Anne Bristow, said there seemed to be little in the way of patients voice in the process. Mrs Bristow indicated she had particular concern that NHS England had not taken the Francis recommendation to the core of their operation and stressed that investigation systems need to be in place, especially for vulnerable adults. Mrs Bristow added that this may be an issue that the Board might wish to lobby on in future.

The Board:

- (i) Noted the report from NHS England;
- (ii) Expressed concern that the issues relating to GPs in the Francis Report had not been addressed by NHS England;

- (iii) Asked NHS England to revisit the arrangements with GPs in relation to Safeguarding issues as problems with accountability were still being encountered; and,
- (iv) Recognised the resource limitations for effective oversight of work done by GPs, but asked that NHS England consider what positive action might be taken to embed good practice as part of future commissioning and monitoring of contracts and report back to the Board in due course.

8. Mental Health Tariff

Deferred to the 29 July meeting.

9. Annual Health Protection Profile

Dr Tania Misra, Consultant in Communicable Disease North East and North Central London Health Protection Teams, gave a presentation on the Annual Health Protection Profiles for the area. The report provided information on the legislative framework, local health protections arrangements and the local profile in regards to infectious disease notifications, outbreaks and health protection incidents during 2013. The highest rates of notification had been in campylobacter (which causes gastro intestinal infection / food poisoning), Mumps, Salmonella (gastro intestinal / food poisoning), Measles, Whooping Cough, Streptococci infections (sore throats / scarlet fever / septicaemia). The report also provided details on Tuberculosis, sexually transmitted infections, HIV and other healthcare associated infections and the implications of those for the area.

Dr Misra advised the Board that there had been some difficulty in obtaining up to date data in regards to immunisations and in some instances the report contained details that were currently two quarters behind. The immunisation rates for the Borough had indicated a general decline in take-up for children under 5, resulting in the Borough being both below local and national average. The seasonal influenza immunisations for those over 65 (or with an underlying medical condition) had improved and were at 71.2%, but this was still short of the national average. However, the HPV uptake had been good with higher coverage than the region for both the first and second doses.

The Board :

- (i) Noted 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) Accepted the Director of Public Health's advice and agreed 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) Noted 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) Noted 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.
- (v) Requested the 15 to 20 age group statistics to be broken down in regard to sexually transmitted infections (STIs) and for this information to be provided to the Corporate Director of Children's Services and brought specifically to the attention of secondary schools and colleges.

10. Transforming Services, Changing Lives in East London

The Board received the report from Barking and Dagenham CCG on the real challenges of providing care for a growing local population, whilst continuing to meet the health needs of some of the most deprived areas in the country. Resource restrictions will require both different and innovative ways to ensure care is provided to meet the needs of Waltham Forest, Tower Hamlets, Newham Redbridge and Barking and Dagenham CCGs and NHS England. As a result a clinical transformation programme called Transforming Services, Changing Lives, was established. A key element of the programme was to consider how best to ensure safe, effective and sustainable hospital services at Bart's Health and Homerton hospitals and how this would fit in the context of local plans to further develop and improve primary, community and integrated care services. The work started in February 2014, had its public launch in April and is expected to run until September 2014.

The Board:

- (i) Noted the report and expressed concern that the lessons from earlier consultation on such changes do not appear to have been learned; and,
- (ii) Requested that in future the Board is part of the consultation earlier in the process as this would enable the Board, and its wider partner organisations, to influence the business case in regards to any service or provision changes.
- (iii) Noted that an update report will be presented in September.

11. Developing the Health and Wellbeing Board

The Board:

- (i) Noted the headline findings of the January Development Day;
- (ii) Noted that the Executive Planning Group are working through the detailed findings;
- (iii) Agreed that Board Members should forward any further ideas or

suggestions that they may have to the Executive Planning Group (via Anne Bristow) to inform ongoing planning;

- (iv) Noted the proposal for two further Development Days in 2014/15 (provisionally 6 October 2014 and February 2015) to continue the Board's development; and,
- (v) Noted the need to return their survey on Peer Review.

12. Waiver of Contract Rules: Public Health Chlamydia Testing Contract Extension

Further to Minute 96, 11 February 2014, the Board received the report from Matthew Cole, Director of Public Health LBBB, which requested a further extension of one of the contracts to enable the effective integration of services and partnership working. The Board's approval was required under the Council's Contract Rules, as set out in the report.

Accordingly the Board:

- (i) Agreed 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.
- (ii) Authorised 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.

13. Urgent Action: Implementation of Matters Scheduled for Consideration by the Health and Wellbeing Board on 25 March 2014

The meeting of the Health and Wellbeing Board on 25 March 2014 had been inquorate and 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 on 17 June 2014.

The Board noted that under the Council's Urgent Action provisions the following matters were formally approved by Chief Executive on Wednesday 26 March 2014.

(i) Better Care Fund Final Plan

- (a) Agreed the Final Plan as set out at Appendix 2 to the report on the 25 March agenda, in the context of the remaining issues that are discussed in Section 4 of the report.
- (b) Delegated 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 Clinical Commissioning Group (CCG) to approve the Final Plan in the light of any outstanding matters

arising from the Board's discussions.

(ii) CCG Strategic Plan / Operating Plan

- (a) Agreed, 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) Delegated 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) Agreed the proposed increase in medication errors reporting in the Operating Plan (as set out in paragraph 5.5 of the 25 March agenda item)

(iii) Transfer of Health Visiting Commissioning

- (a) Agreed the initial transition programme

(iv) Care City Proposal

- (a) Supported the development of the Care City concept in Barking and Dagenham;
- (b) Delegated 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) Delegated 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 £300,000 of funding from the Public Health grant for set up costs, and £72,000 from the Adults and Community Services reserve, if needed for funding the first year of rent.

(iv) Learning Disability Section 75 Agreement and Challenging Behaviour Plan

- (a) For the Section 75 commissioning agreement:

Approved 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;

Approved 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;

Delegated 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.

- (b) For the Challenging Behaviour Joint Strategic Plan:

Approved its adoption and implementation

(v) Mental Health Section 75 Agreement

- (a) Approved the proposed partnership arrangement between the Council and NELFT in accordance with Section 75 of the NHS Act 2006;
- (b) Delegated 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.

(vi) Supporting Living Tender

- (a) Approved a waiver of 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 the report on the 25 March agenda, and to authorise the Corporate Director of Adult and Community Services to make the necessary arrangements;
- (b) Delegated 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.

14. Sub-Groups Reports

At each meeting each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Health and Wellbeing Board.

The Board noted the update provided in the report in regard to the Children and Maternity Sub-Group and the Public Health Programmes and also the reports attached as Appendices for the:

- Integrated Care Sub-group
- Learning Disability Partnership Board
- Mental Health Sub-group.

15. Chair's Report

The Board received and noted the Chair's report, which included updates on:

- Care Act
- Prime Ministers Challenge Fund
- New Chief Executive Appointment at BHRUT

- Carers' Strategy
- Clinical Commissioning Group Board Appointments
- Mapping Health and Wellbeing Board priorities
- Better Care Fund Update
- Current Status of Care City

16. Forward Plan

The Board

- (i) Noted the draft Forward Plan for July and that items had been added since publication of the agenda and that the deadline for changes or additions for any items to be considered at the 29 July meeting or later was 27 June 2014.
- (ii) In view of the Board concerns over the number of items for the 29 July meeting Anne Bristow, Corporate Director of Adult and Community Services advised that she would review the Forward Plan with partners to see if it was possible to defer any items to a later date in order to even out the workloads for the next couple of meetings.

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Children and Families Act Briefing		
Report of the Corporate Director of Children's Services			
Open Report	For Information		
Wards Affected: All	Key Decision: No		
Report Author: Jackie Ross, SEN Consultant	Contact Details: Tel: 020 8227 3352 Email: Jackie.ross@lbbd.gov.uk		
Sponsor: Helen Jenner, Corporate Director of Children's Services			
Summary: <p>The Children and Families Act became law in March of this year. The Act, and the code which is statutory guidance, has significant service delivery implications for all partners - health, education, social care and adult services.</p> <p>The Act introduces the new 'Special educational needs and disability code of practice 0-25 years' replacing the existing SEN Code of Practice as from 1 September of this year. This has the status of statutory guidance.</p> <p>Work on the Local Offer and Education Health and Care Planning is on course and ready for 1 September. Our community engagement for the Local Offer has become an exemplar of good practice, on the recommendation of the DfE.</p> <p>Our Education, Health and Care Plans have been developed in partnership with parents and are being trialled. A training programme to support staff with implementation is underway. Work in relation to transition to adulthood and joint commissioning is still to be taken further forward.</p> <p>This report provides Health & Wellbeing Board members with an overview of progress on implementation and further detail on the implications of the Act and its supporting statutory guidance.</p>			
Recommendation(s) <p>The Health and Wellbeing Board is recommended to:</p> <ul style="list-style-type: none"> (i) Agree support for compliance with the Children and Families Act and the current draft version of the 'special educational needs and disability code of practice 0-25 years' which we are directed by the DfE to use as statutory guidance. (ii) Note the statutory duties which require full implementation by 1 September 2014 and consider their implications for strategic and commissioning decisions. (iii) Note that the statutory guidance requires that: "Joint commissioning should be informed by a clear assessment of local 			

needs. Health and Wellbeing Boards are required to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, to support prevention, identification, assessment and early intervention and a joined-up approach”

And to further note that the refresh of the Joint Strategic Needs Assessment is currently underway and should be expected to take account of this requirement, in preparation for a future refresh of the Health & Wellbeing Strategy.

- (iv) Note that structured programmes are in place for implementation of both the Children and Families Act and the Care Act, which will consider the implications of the new guidance for the overlap between Care Act and Children & Families Act requirements. Irrespective of any discrepancies identified, there remains a statutory duty to put the arrangements described in the Children and Families Act in to place by 1 September.

Reason(s)

1. Local authorities and health partners have a statutory duty to implement the Children and families Act from 1 September 2014. The DfE has directed local authorities, health and other partners to use the ‘special educational needs and disability code of practice 0-25 years’ as statutory guidance for this Act. Although it is still in draft form there is a clear directive to follow this. The DfE has monitored progress of this work across all local authorities and will continue to do so to make sure that there is statutory compliance.
2. There are also good practice recommendations in this guidance to improve outcomes for children and young people.
3. The Children and Families Act sets out duties on Health and Wellbeing Boards in relation to children and young people with specialist educational needs and disability.

1. Background

- 1.1 As the Children and Families Act has been through Parliament, there have been two revised versions since October 2013. The April 2014 version brought in significant changes:
- A greater focus on children and young people with disability within the text. The Code is now the ‘special educational needs **and disability** code of practice 0-25 years’.
 - The legal duties in the code have now been clarified to reflect the distinction between statutory and non statutory duties, in particular, in relation to
 - schools’ duties,
 - joint commissioning
 - local authority duties to support young people over 18.
 - There is stronger accountability on schools to support pupils without Education, Health and Care Plans and on local authorities in relation to the Local Offer.

- There is greater focus on a) disabled children and b) transition to adulthood, in particular, post-16 arrangements.
- More explicit involvement of children, young people and their parents in the design of services.
- New chapters have been added to separate out information for early years, schools and post-16 practitioners and on preparation for adulthood. (source: NASEN).

1.2 The June version adds further clarification in relation to mediation arrangements.

1.3 There has been significant work within Children's Services and with partners to get ready. This has covered a number of areas which are statutory duties:

- The duty to publish the Local Offer.
- The duty to engage with the community.
- The duty to establish information, advice and support for parents and young people
- The duty to replace statements with Education, Health and Care Plans
- The duty to prepare children and young people for adulthood and set out arrangements for transition to adulthood
- The duty to work together with health and other partners.

2. Achievements to date

For the duties listed above, progress is described below.

2.1 The duty to publish the Local Offer

This is on course. The interactive website is due to go live before September 1st. The section on preparing for adulthood is still underway. The partnership work with our young people and our parent's forum (Just Say) in order to produce the Local Offer has forged closer community links.

2.2 The duty to engage with the community

Our engagement with the local community to develop the local offer is now a national example of good practice. Consequently, Barking and Dagenham have been invited to work with the DfE and champion pathfinders on disseminating good practice to other local authorities.

2.3 The duty to establish information, advice and support for parents and young people

This is also underway. Parent Partnership will be re-commissioned. We have been working with our Parent's Forum to input the parent voice into the specifications and quality assure the bids. Our young people's Progress Project have given feedback on how they would like this delivered—This work is ongoing.

2.4 The duty to replace statements with Education, Health and Care Plans

We have conducted pilots to trial our EHC template and process. We are now at a stage where this is being rolled out to schools so that they are ready to implement from September. There will also be training to social care.

The statutory assessment team within Children's Services is being realigned in readiness to meet the new approach to assessment and review.

2.5 The duty to prepare children and young people for adulthood and set out arrangements for transition to adulthood

This work is ongoing. There is a statutory duty to have arrangements in place for the September deadline. Although these can be reviewed at a later date in the light of development of the Care Act following consultation, we have to have arrangements ready for September 1st.

2.6 The duty to work together with health and other partners

The work to establish joint commissioning protocols with health partners is underway.

3. Consultation

3.1 There has been consultation with parents, children and young people. We have developed a close partnership with our Young People's Progress Forum and Just Say Parents' Forum. An Equality Impact Assessment has been undertaken. As referred to above, the community engagement in relation to producing our Local Offer has been published as an example of good practice, to support other local authorities.

4. Challenges and Gaps

4.1 A number of challenges and gaps are currently being worked on. We are establishing robust ways of working across Health and Local Authority Services that takes account of both the Children and Families Act and the Care Act that complies with statutory requirements to be ready for September 1st (Children and Families Act). There are plans to later realign to match the Care Act which may be amended as a result of the current consultation (April 1st 2015). The 'special educational needs and disability code of practice 0-25 years', provides statutory guidance to the Children and Families Act. It refers to duties that local authorities have under the Care Act, which are to work to promote the integration of adult care and support with health services. We must ensure:

- the provision of preventative services
- the diversity and quality of care and support services for adults
- provision of information and advice on care and support locally.

4.2 The Care Act (and associated regulations and guidance) sets out requirements on local authorities when young people approach or turn 18 and are likely to require an assessment for adult care and support:

- Local authorities must continue to provide children's services until adult provision has started or a decision is made that the young person's needs do not meet the eligibility criteria for adult social care. (Children's services must not be discontinued simply because a young person has reached their 18th birthday).
- Local authorities and their partners must cooperate in the provision of adult care and support.
- Consider the provision of resources that prevent, delay or reduce the need for care for those who require support but do not have eligible needs under the Care Act 2014.

4.3 Local authorities and their partners should therefore work together to ensure:

- effective and well supported transition arrangements are in place;
- assessment and review processes for both Care plans and Education, Health and Care (EHC) Plans are aligned;
- there is effective integration with health services
(See Appendix 3: The Children and Families Act references to the Care Act).

4.4 It is important therefore that children's and adult services, along with health partners, determine what these duties will look like in relation to service provision for 1 September 2014. Although there needs to be greater clarification between the Children and Families Act and the Care Act, it is clear that the Children and Families Act is to be implemented on 1 September.

4.5 Whilst the Joint Strategic Needs Assessment includes a profile of the needs of children and young people with SEN and disability, a particular emphasis may need to be placed on this through the refresh which is currently underway, to ensure that it will deliver the influence on local commissioning that is envisaged by the guidance. This would then inform and develop further joint work between partners, to ensure robust forecasting and understanding of risk, and to support services to be needs-led rather than demand led.

4.6 It is important that the community is aware that we are working with a limited cash envelope. The close engagement with community partners has to an extent mitigated this risk and provided refreshing input to ensure the focus is on value for money in relation to meeting the needs of children and young people to support positive outcomes. The Local Offer will help to empower parents by helping them know what is available at universal and targeted service level and establish clear expectations, and clarify eligibility for specialist services. This will also provide a robust audit tool for providers to ensure that earlier levels of intervention and support are robust.

4.7 This report is part of efforts to ensure that all partners fully understand the implications of the Act for future work. However, capacity issues have meant that the level of engagement in the developments has varied across agencies. In particular there is additional work needed to secure some aspects of health engagement, but it is to be noted that new appointments have been made to support this work. There is still significant awareness raising to be done with GPs and others and joint commissioning is underdeveloped currently.

5. Specific Recommendations to be considered linking the Care Act and the Children and Families Act

5.1 Outcomes and Wellbeing

- Develop a shared vision for preparing for adulthood with young people 14-25. (co-production, in both Children and Families Act and Care Act). This work has begun with the Young People's Progress project.
- Develop capacity and competency in outcome focused support planning across children's and adults' services.
- Develop common core of person-centred skills for Education, Health and Care Plans, and Child's Needs Assessments. (A shared training programme will support more seamless service delivery and may also lead to financial efficiencies).
- Develop a 'lifespan' approach to outcomes—so that professionals at each stage understand their role and responsibilities and how they relate to other stages of a young person's preparation for adulthood.

5.2 Assessment and Planning: Align EHC and CNA Planning

- Ensure that the care element of the EHC planning process is aligned to the Adults' Needs Assessment for Care and Support for young people post-18.
- Ensure close liaison between professionals involved with CNA (Child Needs Assessments) and EHC planning.
- Adult social care input into year 9 (transition) review of a young person so that young people and families receive information on how to request a CNA.
- Develop clear processes so that both EHC and CNA plans produce indicative personal budgets.

5.3 Joint Commissioning

- As part of the refresh of the JSNA and the development of commissioning strategies, ensure that children, young people and their families are engaged in partnership ('co-production') to inform plans, and that they are drawing on information on EHC plans and the Local Offer.
- Develop a process to allow the information from EHC Plans, CNAs and personal budget holders' choices, to inform the joint commissioning strategy.
- Ensure that work streams to develop joint commissioning across the 0-25 age group and the Better Care Fund are joined up, and that a common process is developed.
- Ensure that work on market development takes account of intended outcomes of the Children and Families Act and Care Act.
- Explore how personal budgets across education, health and social care (and personal health budgets) can be integrated to develop post-16 options and support that lead to better outcomes for young people.
- Ensure that young people and their families have access to good information, advice and support in relation to what is available and to purchase it.

- Provide young people and their families with better opportunities to pool budgets and commission mutually beneficial support.

5.4 Information, Advice and Support

- Consider establishing a joint information and advice offer across all age groups, or the 0-25 age group.
- Ensure that professionals responsible for developing the Information and Advice Service (Care Act) work closely with those developing the Partnership and young people's information service.

6. Mandatory Implications

6.1 Joint Strategic Needs Assessment

The Council and our health partners monitor the changing needs of children and young people with SEN and disability and assess whether or not the available provision is improving their outcomes. The SEND code emphasises the need for this process of assessing need, provision and identifying outcomes to be linked to the existing JSNA carried out by the Health and Wellbeing Board and make full use of the available local data. Children and young people who have a Special Education Need and/or Disability have a diverse range of health needs, which include children and young people with long term health conditions, children and young people with autism and children and young people with sensory impairments and children and young people with mental health issues. It will also include children and young people with multiple and complex needs who may be dependent on technology, children and young people with behaviour that challenges and children and young people with a life-threatening or life-limiting condition. Meeting these health needs will often require a range of different NHS services, provided by different professionals which often cut across organisational boundaries. Children with SEN and disability are therefore disproportionately disadvantaged by a system that does not integrate services, support them to make decisions about their own care or adequately support them during the transition to adult services. The Local Offer will need to build on the JSNA and the analysis of local SEN and disability needs. As well as providing information about the services that the Council expects to be available the Local Offer should also perform an important function as a tool to improve provision by setting out how services will meet local need and achieve the outcomes set out by the joint commissioning arrangements.

6.2 Health and Wellbeing Strategy

The Children and Families Act 2014 has major implications for how the NHS organises and delivers services to children and young people who have a Special Education Need and/or Disability between the ages of 0 and 25. It will reform the system of support across education, health and social care to ensure that services are organised with the needs and preferences of the child and their family firmly at the centre, from birth to the transition to adulthood. The refresh of our Joint Health and Wellbeing Strategy being undertaken this year provides an opportunity for local partners to think about how they can work together to achieve their existing outcomes. This may include how joint commissioning for SEN and disability can help partners meet goals in the Joint Health and Wellbeing Strategy, objectives in the NHS Mandate, or indicators in the NHS Outcomes Framework, the Public Health Outcomes Framework, or the CCG Commissioning Outcome Indicator Set.

6.3 Integration

Integration is at the heart of the Children and Families Act and the Act will require robust multi-agency working. For example, the legislation sets out the need to promote integration around educational provision and training provision with health care provision and social care provision. The Children and Families Act also places a duty on the local authority and partner commissioning bodies to make joint commissioning arrangements around education, health and care provision for children and young people for whom the local authority is responsible who have special educational needs and children and young people in the local authority's area who have a disability.

6.4 Financial Implications

There are resources in the form of a one-off Special Educational Needs (SEN) Reform Grant 2014-15 from the Department for Education (DfE) totalling £425,304. The grant is to provide support for expenditure lawfully incurred to recognise the programmes of change underway in the areas of SEN, however local authorities can spend this grant in order to best meet the local need.

The Children and Families Bill will transform the lives of children and young people with SEN. It will improve outcomes for children and young people with SEN; increase choice and control for parents; and promote a less adversarial system. We are currently undertaking a range of reforms to prepare for these changes including personalisation that includes personal budgets. The details of these will be included in the EHC plans that are currently being piloted and resources will be within the current funding envelope.

Implications completed by: Patricia Harvey, Interim Group Manager, Children's Services

6.5 Legal Implications

Local Authorities must publish a 'local offer' showing the support available to disabled children and young people and those with special educational needs and their carers, and introduce mediation for disputes with a right to appeal for those unhappy with their support.

Under the Care Act 2014, young people have the right to request transition assessments for adult care that will enable them to see whether they are likely to have eligible needs that will be met by adult services once they turn 18. The Care Act 2014 came into force on 15 May 2014.

The body of the report outlines the key achievements and challenges. The Board is specifically asked to agree to support the statutory duties arising from the Children Act 2014 baring in mind that provisions are also reflected in the Care Act 2014 and to consider how it shall jointly commission assessment and intervention services.

The legal implications of this are outlined in the Code of Practice:

Publication: Local authorities are required to consult with parents and young people with SEN when setting up their local offer. It is expected that parent carer forums will play a key role in doing this. Parent carer forums are groups of parents of children with SEN and disabilities who work with local service providers to ensure the needs of children with SEN and disabilities are met. Under the Code, the Local Authority must publish and keep under review its Local Offer of provision in consultation with children, their parents and young people. This will mean that Local authorities will publish all comments they receive via the Local Offer, together with their response including details of what they will do. The comments received will be used by the local authority and their health partners to understand local needs and to identify gaps in services, in order to make changes.

- Co-operation: Local authorities must keep their educational and training provision and social care provision for children and young people with SEN or disabilities under review (. In carrying out this duty, the local authority will gather information from early years providers, schools and post-16 institutions. In most cases, these institutions must, in turn, co-operate.
- Joint commissioning: The Children and Families Act creates a new duty on local authorities and health bodies to jointly commission services across education, health and care. The Care Act includes general duties on local authorities to promote integration and on local authorities and “relevant partners” (including the NHS) to cooperate generally and in relation to individuals. ‘Joint commissioning that encompasses the transition to adult services will need to involve a wider range of partners, such as housing and employment support. The Care Act also provides the legislative framework for the Better Care Fund, which includes existing NHS, and social care funding, that will now be jointly invested.’
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270417/Factsheet_19_Better_Care_Fund.pdf)
- Lawful decision making: Both the Children and Families Act and the Care Act promote better choice and control over care and support for young people and families. The Board has duties in relation to disabled children and young people under the Equality Act 2010 in its’ decision making not to discriminate, to make reasonable adjustments for disabled children and young people and to promote equality of opportunity.

Implications completed by: Alison Stuart, Principal Solicitor, LBBD

6.6 Risk Management

There has been work underway to ensure that the statutory assessment team is realigned to deliver Education, Health and Care Plans. There is risk in relation to team capacity and skills in readiness for 1 September.

There is an urgent need to identify where responsibility for carrying out Education, health and care assessments sits for 19-25 year olds, -- either in Children’s or Adult’s Services. The skills and capacity do not at this time sit within Children’s Services and this could be an opportunity to ensure a wider range of skills are used to develop personalised, holistic assessment.

6.7 Patient/Service User Impact

This work will improve outcomes for children and young people with special educational needs and disability, and support to their families, by ensuring a more holistic approach to meeting needs.

Background Papers Used in Preparation of the Report:

1. Children and Families Act (2014)
2. Special educational needs code of practice 0-25 years' (June draft)
3. NASEN response to the consultation on the special educational needs and disability code of practice 0-25 years.
4. Preparing for Adulthood Factsheet: The links between the Children and Families Act and the Care Act.

List of Appendices:

- Appendix 1. Children and Families Act – detailed information
- Appendix 2. Barking and Dagenham's Case Study snapshot - The Local Offer.

Useful Links:

1. Barking and Dagenham Case Study:
<http://www.sendpathfinder.co.uk/infopacks/lo/>
2. Young People's Progress Forum film:
<http://www.youtube.com/watch?v=CYshV85EBEY>

Appendix 1: Children and Families Act-detailed information.

The Children and Families Act (March 2014) replaces the SEN Code of Practice (2001) with a new 'special educational needs and disability code of practice 0-25 years'.

The new code introduces a number of changes in relation to making provision for children and young people with SEN:

- The code now covers the 0-25 age range (rather than as previously-2-18 age range) and includes guidance relating to disabled children and young people as well as those with SEN
- There is a clearer focus on the participation of children and young people and parents in decision-making at individual and strategic levels
- There is a stronger focus on high aspirations and on improving outcomes for children and young people
- It includes guidance on the joint planning and commissioning of services to ensure close co-operation between education, health and social care
- It includes guidance on publishing a Local Offer of support for children and young people with SEN or disabilities
- There is new guidance for education and training settings on taking a graduated approach to identifying and supporting pupils and students with SEN (to replace School Action and School Action Plus)
- For children and young people with more complex needs a co-ordinated assessment process and the new 0-25 Education, Health and Care plan (EHC plan) replace statements and Learning Difficulty Assessments (LDAs)
- There is a greater focus on support that enables those with SEN to succeed in their education and make a successful transition to adulthood.
- There is a clear focus on children and young people with disability.

Who must have regard to this guidance?

From 1 September 2014 all the organisations listed **must** have regard to this Code of Practice which will be in force from that date. These are as follows:

- local authorities (education, social care and relevant housing and employment and other services)
- Education providers:
- the governing bodies of schools, including non-maintained special schools further education
- colleges and sixth form colleges.
- the proprietors of academies (including free schools, University Technical Colleges and Studio Schools)
- the management committees of pupil referral units

- independent schools and independent specialist providers (approved)
- all early years providers in the maintained, private, voluntary and independent sectors that are funded by the local authority
- Health partners:
 - the National Health Service Commissioning Board
 - clinical commissioning groups (CCGs)
 - NHS Trusts
 - NHS Foundation Trusts
 - Local Health Boards
- Youth Offending Teams and relevant youth custodial establishments
- The First-tier Tribunal (Special Educational Needs and Disability)

The Principles:

Local authorities, in carrying out their functions under the Act in relation to disabled children and young people and those with special educational needs (SEN), **must** have regard to:

- the views, wishes and feelings of the child or young person, and the child's parents
- the importance of the child or young person, and the child's parents, participating as fully as possible in decisions, and being provided with the information and support necessary to enable participation in those decisions
- the need to support the child or young person, and the child's parents, in order to facilitate the development of the child or young person and to help them achieve the best possible educational and other outcomes, preparing them effectively for adulthood

These principles are designed to support:

- the participation of children, their parents and young people in decision-making
- the early identification of children and young people's needs and early intervention to support them
- greater choice and control for young people and parents over support
- collaboration between education, health and social care services to provide support
- high quality provision to meet the needs of children and young people with SEN
- a focus on inclusive practice and removing barriers to learning
- successful preparation for adulthood, including independent living and employment

Statutory guidance on working together:

The new Code provides guidance on the joint planning and commissioning of services to ensure close co-operation between education, health and social care.

The legal framework

The Children and Families Act places a duty on:

- local authorities to ensure integration between educational provision and training provision, health and social care provision, where this would promote wellbeing and improve the quality of provision for disabled young people and those with SEN.
- local authorities and clinical commissioning groups (CCGs) to make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities.

The Care Act 2014 requires local authorities to ensure:

- co-operation between children's and adults' services to promote the integration of care and support with health services, so that young adults are not left without care and support as they make the transition between child and adult social care.
- availability of preventative services for adults, a diverse range of high quality local care and support services and information and advice on how adults can access this universal support.

The NHS Mandate, which CCGs have a duty to follow, contains a specific objective on supporting children and young people with SEN or disabilities, including through the offer of Personal Budgets.

Joint commissioning arrangements should enable partners to make best use of all the resources available in an area to improve outcomes for children and young people in the most efficient, effective, equitable and sustainable way. Under the Public Sector Equality Duty (Equality Act 2010), public bodies (including CCGs, local authorities, maintained schools, maintained nursery schools, academies and free schools) have a duty to eliminate discrimination, promote equality of opportunity and foster good relations between disabled and non-disabled children and young people when carrying out their functions. They have a duty to publish information to demonstrate their compliance with this general duty and **to** prepare and publish objectives to achieve the core aims of the general duty. Objectives **must** be specific and measurable.

Specific duties:

A duty for services to collaborate:

When carrying out their statutory duties under the Children and Families Act 2014, local authorities have a duty to do so with a view to making sure that services work together where this promotes children and young people's wellbeing or improves the quality of special educational provision. –

Joint commissioning duty:

There is a statutory duty for local authorities and health bodies to have arrangements in place to plan and commission education, health and social care services jointly for children and young people with SEN or disabilities.

Local authorities and CCGs have duties to ensure there is clear local governance and decision making structures and therefore accountability for commissioning services for children and young people with SEN and disabilities aged 0-25.

Joint commissioning must also include arrangements for:

- securing EHC needs assessments
- securing the education, health and care provision specified in EHC plans, and
- agreeing Personal Budgets

Local joint commissioning arrangements **must** consider:

- what advice and information is to be provided about education, health and care provision for those who have SEN or are disabled and by whom it is to be provided
- how complaints about education, health and social care provision can be made and are dealt with, and
- procedures for ensuring that disagreements between local authorities and CCGs (and NHS England for specialist services) are resolved as quickly as possible

These arrangements must be presented publicly in the Local Offer.

The duty to work together focusing on outcomes:

Local authorities, education providers and their partners should work together to help children and young people to realise their ambitions in relation to:

- higher education and/or employment – including exploring different employment options, such as support for becoming self-employed and help from supported employment agencies
- independent living – enabling people to have choice and control over their lives and the support they receive, their accommodation and living arrangements, including supported living

- participating in society – including having friends and supportive relationships, and participating in, and contributing to, the local community
- into employment and independent living

Joint commissioning arrangements should enable partners to make best use of all the resources available in an area to improve outcomes for children and young people in the most efficient, effective, equitable and sustainable way. They should aim to provide **personalised, integrated support that delivers positive outcomes for children and young people**, bringing together support across education, health and social care from early childhood through to adult life, and improves planning for transition points such as between early years, school and colleges, between children’s and adult social care services, or between paediatric and adult health services.

“If children and young people with SEN or disabilities are to achieve their ambitions and the best possible educational and other outcomes, including getting a job and living as independently as possible, local education, health and social care services should work together to ensure they get the right support”.

The term ‘partners’ refers to the local authority and its partner commissioning bodies across education, health and social care provision for children and young people with SEN or disabilities, including clinicians’ commissioning arrangements and NHS England for specialist health provision.

Local partners should identify the outcomes that matter to children and young people with SEN or disabilities to inform the planning and delivery of services and the monitoring of how well services have secured those outcomes --- as a result of an intervention at three levels:

- **Individual outcomes** such as might be set out in an EHC plan: for example, Martha can communicate independently with her friends at playtime.
- **Service level outcomes:** for example, paternal mental health has improved in 10 families
- **Strategic outcomes:** for example, there has been a 10% increase in young people supported

Duty to for partners to carry out a health needs assessment:

There is the duty for local authorities, CCGs and other partners to work together in local Health and Wellbeing Boards to assess the health needs of local people, including those with SEN or who are disabled. This assessment, the Joint Strategic Needs Assessment, is to inform a local Health and Wellbeing Strategy which sets priorities for those who commission services, including prevention, identification, assessment and early intervention and a joined-up approach.

Duty to publish a Local Offer:

A local authority’s Local Offer should reflect the services that are available as a result of strategic assessments of local needs and reviews of local education and

care and of health provision (Joint Strategic Needs Assessments and Joint Commissioning). The expectation is that linking these assessments and reviews to the Local Offer will help to identify gaps in local provision.

Duty to provide information:

Local authorities **must** arrange for children with SEN or disabilities for whom they are responsible, and their parents, and young people with SEN or disabilities for whom they are responsible, to be provided with information and advice about matters relating to their SEN or disabilities, including matters relating to health and social care. This **must** include information, advice and support on the take-up and management of Personal Budgets. In addition, local authorities **must** have regard to the importance of providing children and their parents and young people with the information and support necessary to participate in decisions.

The joint arrangements that local authorities and Clinical Commissioning Groups (CCGs) must have for commissioning education, health and care provision for children and young people with SEN or disabilities must include arrangements for considering and agreeing what information and advice about education, health and care provision is to be provided, by whom and how it is to be provided to young people and parents of children with SEN and disability. These joint arrangements should consider the availability of other information services in their area (services such as youth services, Local Healthwatch, the Patient Advice and Liaison Service (PALS) and the Family Information Service) and how these services will work together. CCGs and local authorities should ensure that this information is clearly available to families, including through the Local Offer.

Duty to engage children, young people and their families in strategic planning:

At a strategic level, partners have a duty engage children and young people with SEN and disabilities and children's parents in commissioning decisions, to give useful insights into how to improve services and outcomes. Local authorities, CCGs and NHS England **must** develop effective ways of harnessing the views of their local communities so that commissioning decisions on services for those with SEN and disabilities are shaped by users' experiences, ambitions and expectations. There is already a duty for CCGs (NHS Act 2006) to ensure that planning involves the individuals to whom services are or may be provided for)

Duty for the CCG to consult with parents in relation to individual children and young people:

Clinical Commissioning Groups (CCGs), NHS Trusts or NHS Foundation Trusts who are of the opinion that a child under compulsory school age has or probably has SEN or a disability **must** give the child's parents the opportunity to discuss their opinion with them before informing the local authority.

Partners should ensure there is a Designated Medical Officer (DMO) to support the CCG in meeting its statutory responsibilities for children and young people with SEN

and disabilities, primarily by providing a point of contact for local partners, when notifying parents and local authorities about children and young people they believe have, or may have, SEN or a disability, and when seeking advice on SEN or disabilities. This does not alter the CCG's responsibility for commissioning health provision.

This is a non-statutory role which would usually be carried out by a paediatrician, but there is local flexibility for the role to be undertaken by a suitably competent qualified and experienced nurse or other health professional (in which case the role would be the Designated Clinical Officer). The person in this role should have appropriate expertise and links with other professionals to enable them to exercise it in relation to children and young adults with EHC plans from the age of 0 to 25 in a wide range of educational institutions.

Children's social care

Where a child or young person has been assessed as having social care needs in relation to their SEN or disabilities, social care teams:

- **must** secure social care provision under the Chronically Sick and Disabled Persons Act (CSDPA) 1970 which has been assessed as being necessary to support a child or young person's SEN and which is specified in their EHC plan
 - should provide early years providers, schools and colleges with a contact for social care advice on children and young people with SEN and disabilities
 - **must** undertake reviews of children and young people with EHC plans where there are social care needs
 - should make sure that for looked after children and care leavers the arrangements for assessing and meeting their needs across education, health and social care are co-ordinated effectively within the process of care and pathway planning, in order to avoid duplication and delay, to include in particular liaising with the Virtual School Head (VSH) for looked after children
- Where children or young people with SEN or disabilities also have a child in need or child protection plan, the social worker within the SEN team should ensure the statutory timescales for social care assessments are met and any assessments are aligned with EHC needs assessments wherever possible. *Working Together to Safeguard Children* (2013) gives full details.

Adult social care:

Young people with SEN or disabilities turning 18 may become eligible for adult social care services, regardless of whether they have an EHC plan or whether they have been receiving services from children's social care.

The Care Act 2014 and the associated regulations and guidance set out the requirements on local authorities when young people are approaching, or turn, 18 and are likely to require an assessment for adult care and support. These are

intended to support effective transition from children's to adult social care services. For those already receiving support from children's services, the Care Act makes it clear that local authorities **must** continue to provide children's services until adult provision has started or a decision is made that the young person's needs do not meet the eligibility criteria for adult care and support following an assessment. Children's services **must not** be discontinued simply because a young person has reached their 18th birthday.

Health services for children and young people with SEN and disabilities and their families

Health services for children and young people with SEN or disabilities provide early identification, assessment and diagnosis, intervention and review for children and young people with long-term conditions and disabilities. In addition, public health services for children ensure a whole population approach to health and wellbeing including preventative services such as immunisation for the whole population and targeted immunisation for the most vulnerable

Local authorities and CCGs should consider how best to integrate the commissioning of services for children and young people with SEN with the CCG's broad responsibility for commissioning health services for other groups, including preventative services, and the local authority's responsibility for health protection and health improvement for the local population

Health commissioning duty

As health service commissioners, CCGs have a duty under the NHS Act 2006 to arrange health care provision for the people for whom they are responsible to meet their reasonable health needs. This is the fundamental basis of commissioning in the NHS. Where there is provision which has been agreed in the health element of an EHC plan, health commissioners **must** put arrangements in place to secure that provision.

Duty to publish a Local Offer:

Local authorities **must** publish a Local Offer, setting out in one place information about provision they expect to be available across education, health and social care for children and young people in their area who have SEN or are disabled, including those who do not have Education, Health and Care (EHC) plans. This should cover:

- support available to all children and young people with SEN or disabilities from universal services such as schools and GPs
- targeted services for children and young people with SEN or disabilities who require additional short-term support over and above that provided routinely as part of universal services
- specialist services for children and young people with SEN or disabilities who require specialised, longer term support .

Each CCG will determine which services it will commission to meet the reasonable health needs of the children and young people with SEN or disabilities for whom it is responsible.

Duty to provide and review health care provision on EHC Plan:

The health care provision specified in section G of the EHC plan **must** be agreed by the CCG.

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Setting the vision

Barking and Dagenham has an effective multi-agency Children's Trust with a clear vision for children and their families. The Director of Children's Services recognised the need to take a holistic approach by embedding SEN and Disability across all service areas and cement the importance of cross-agency working. The Children's Trust and Safeguarding Board around all agencies is strong. In order to cover the vast agenda Children's Trust meetings are themed around agreed Children's Trust priorities. This means that partners can target themes for which they have the most responsibility and expertise, rather than spending their time on an over cluttered agenda with lack of space. This enables challenging and mature partnership decision-making.

Parents and young adults, as well as children have made strong contributions in what they want to see in the local offer, what they would like it to look like, how to access it, and what they experience as 'barriers' to support. Communication each way has been via film, drawings and discussion.

Developing a phased approach

Within this context Barking and Dagenham has looked to developing their response to the Children and Families Bill as a continuation of their journey and invested in a post to create capacity to really get on with this in a staged approach.

Stages:

A. **Established** SEND Transformation Board. The themes for this are—the local offer, Assessments and Plans (EHC Planning), Integrated Commissioning, Personal budgets, Transitions, Information Systems and also Operational Design.

B. **Local Offer theme identified the following stages:**

1. Audit (completed)

- Invested in a post from April last year to do a service audit and ensure all information correct on what the current local offer is. Involved engagement with providers.
- Got together key partners representing providers to form small steering group to oversee this.
- This audit was also used to input into more parent friendly version (using format of York's local offer which parents were engaged in). The 'audit' version can be viewed by [clicking here](#).

2. Engagement: (on- going)

- Post continued to the next stage: to engage with the community as widely as possible
- Questions to stakeholders:
 - What should be in the local offer
 - What should it look like—how should information be arranged?
 - How would they like to access it?
 - Developmental: Where are the gaps, what is not working?

The audit of services, drawing in all existing services, has been really an important first step to make sure that all providers know they are part of this work. In this first stage Barking and Dagenham took the risk of publishing on line something which is not perfect or polished, but which encouraged all to get on board.

Learning has shown that co-production should have been started earlier for all of this work and it has been agreed that the approach to engaging the local community to develop the local offer will widen to include all areas of the Children and Families Bill.

Ways for working to deliver effective engagement & co-production

To ensure we listened to stakeholder agendas first, we asked parents their views first and then asked them to comment on the parent friendly version to consider layout, accessibility etc. In addition, Barking and Dagenham has engaged with parent groups, schools (SENCOs, children and young people, head teachers), the voluntary sector, the Youth Parliament, the Young People's Progress Project (representing young people and young adults with SEN and disability, as well as with our special school youth council). This work is on-going to ensure Barking and Dagenham capture the input of children and young people and young adults in mainstream schools, our special school, children and young people with SEN (including LAC) and parent workshops advertised and supported via Parent Partnership.

Barking and Dagenham are using different ways of communicating and engaging, as appropriate, and decided by stakeholders. For example, young adults were presented with a personal picture of the speaker's likes and dislikes at work and leisure. Then young adults chose how they wanted to express their take on this at college/work and leisure in any form they like-some chose to make a film. This can be viewed by [clicking here](#).

One young adult has been co-opted for informal work experience (after college) to find out the views of his peers. There is currently a process in place to provide a traineeship/work experience for a young person with SEN or who is disabled to work alongside the project lead. This will also encourage young adults with SEN and disability who may currently be NEET to look at traineeship options, and be part of sustainable on-going training/education for independent adulthood, regardless of whether they are appointed.

Next steps

- Communication strategy for wider transformation programme to be developed via the SEND Transformation Board and stakeholder co-production group and then disseminated by the sector representatives more widely. The audit, stakeholders' views and parent friendly version (changed and adapted by parents) will be used by a co-production group with stakeholders to replace our audit version with an

interactive website, and text version for those unable to access computers. These will be put into accessible formats.

- Film already made by young adults (progress project) will be put online as well as further films (in process). Interactive website and mobile phone access planned as well as written accessible publication for those unable to access computers.
- Wide dissemination of information on the Children and Families Bill and the consultation using ordinary places—estates, shops, G.P. surgeries etc. Frequently asked parent questions, information bulletins, flyers etc.
- Develop a review and response process engaging stakeholders to ensure that this is more than a service directory.
- Ensuring this process reaches out as far and wide as possible to those families/parents and young people who might not usually engage.

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HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	OFSTED Children's Social Care Inspection Feedback		
Report of the Corporate Director of Children's Services			
Open Report	For Information		
Wards Affected:	Key Decision: No		
Report Author: Helen Jenner, Corporate Director of Children's Services	Contact Details: Tel: 020 8227 5800 E-mail: helen.jenner@lbbd.gov.uk		
Sponsor: Helen Jenner, Corporate Director of Children's Services			
Summary: OFSTED undertook an inspection of services for children in need of help and protection, children looked after and care leavers, and a review of the effectiveness of the Local Safeguarding Children Board (LSCB) between 29 April and 22 May. The full OFSTED report was published on 7 July and can be found here: http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/barking_and_dagenham/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf It should be noted that Members of the Board will receive a verbal update at the July Board meeting on the outcome of the inspection, feedback processes and the action plan that is currently being put together to address gaps in provision.			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ol style="list-style-type: none"> 1. Note the publication of the full OFSTED report. 2. Encourage agencies to respond proactively to action planning to address gaps in provision now that the report is published. 3. Note that a full item on the inspection will be presented at the September Health and Wellbeing Board meeting to enable the Board to ensure that the proposed action plan to address the areas of weakness identified by the inspection is fit for purpose. 			
Reasons Inspections are conducted under section 136 of the Education and Inspections Act 2006 and the review of the Local Safeguarding Children Board is carried out under section 15A			

of the Children Act 2004.

Following the inspection of services in Barking and Dagenham for children in need of help and protection, children looked after and care leavers, and the LSCB, all agencies will be required to input into the integrated action plan to address gaps in provision highlighted by the inspection report. This will also contribute to the Council priorities of ensuring every child is valued so that they can succeed and improving health and wellbeing through all stages of life.

1. Background and Introduction

- 1.1 OFSTED's single inspection framework was published in October 2013 and came into effect in November 2013 on a universal three year cycle. The inspection brings together into one inspection: child protection; services for looked after children and care leavers, and local authority fostering and adoption services. As well as the single inspection, the framework also includes a review of the work of the Local Safeguarding Children Board. The framework for the inspection was shared with the Health and Wellbeing Board on 11 February 2014.
- 1.2 London Borough of Barking and Dagenham was the fourth London Borough to receive an inspection under the new single inspection framework. The inspection took place between 29 April and 22 May.
- 1.3 The purpose of this report is to alert Health and Wellbeing Board members to the publication of the OFSTED report which can be found here:

http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/barking_and_dagenham/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf
- 1.4 Members of the Board should note that the overall judgement for the inspection is 'requires improvement' and that the effectiveness of the Local Safeguarding Children Board (LSCB) is also 'requires improvement'.
- 1.5 Members of the Board will receive a verbal update at the July meeting on the outcome of the inspection, feedback processes and the action planning that is currently being undertaken to address gaps in provision highlighted by the inspection report. Please also note that there will be a full item on the agenda for September to enable the Board to ensure that the proposed action plan is fit for purpose.

2. Consultation

- 2.1 Regular multi-agency meetings are held to plan for inspections and these (including the Local Safeguarding Children Board) will be used to put together an integrated action plan to address the areas of weakness identified by the inspection.
- 2.2 The voices of all young people shape our services; we need to ensure that the voices of Looked After Children are heard by all agencies. Work with Healthwatch and BAD Youth Forum needs to ensure that views of Barking and Dagenham Looked After Children placed out of the Borough are clearly heard and communicated.

3. Mandatory Implications

3.1. Joint Strategic Needs Assessment

The JSNA was referred to in the inspection and the exceptional growth in the number of children in the Borough was a key feature in the inspection. Identifying how the Borough will meet this accelerated demand must be a key feature of our refreshed JSNA.

3.2. Health and Wellbeing Strategy

Similarly, the huge increase in need and numbers must be reflected in the Health and Wellbeing Strategy, children now make up a third of our population. The revised Health and Wellbeing Strategy will reflect this.

3.3. Integration

As stated above, an integrated action plan is now being worked up to address the areas of weakness identified by the inspection. The result of the inspection will require all agencies to work together to improve services for vulnerable children.

3.4. Financial Implications

Financial implications will be considered in the full report being presented to the September Health and Wellbeing Board.

3.5. Legal Implications

Legal implications will be considered in the full report being presented to the September Health and Wellbeing Board.

3.6. Safeguarding

The Board should note that OFSTED stated the following regarding safeguarding: "There are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help and care for children, young people and families." The integrated action plan will address these identified weaknesses.

4. Background Papers Used in Preparation of the Report:

Report to Health and Wellbeing Board – 11 February 2014, 'Summary of the New Ofsted Single Inspection of Services for Children' - <http://moderngov.barking-dagenham.gov.uk/documents/s76831/HWBB%20Single%20Inspection%20Report%20v0.1.pdf>

Ofsted Inspection Report for London Borough of Barking and Dagenham – 7 July 2014 -

http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/barking_and_dagenham/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

5. List of Appendices:

OFSTED Inspection Key Issues Summary **(to be tabled)**

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Breastfeeding Pathway Review		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: All		Key Decision: Yes	
Report Author: Monica Imbert, Health Improvement Advanced Practitioner		Contact Details: Tel: 020 8227 2223 E-mail: Monica.Imbert@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary:			
<p>Breastfeeding has a major role to play in public health, promoting health in both the short and long term for baby and mother. Breastfeeding is also more cost-effective and has lower risks than formula feeding for the vast majority of women.</p>			
<p>The UK has one of the lowest rates of breastfeeding worldwide, especially among families from disadvantaged groups, in particular, among disadvantaged white young families. Data on initiation of breastfeeding reported by maternity services at Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) suggests that, although Barking and Dagenham initiation rates are the second lowest in outer north east London, the work undertaken since 2009 has closed the gap between the borough and the England average. However, concerns still remain over persistent low rates of sustained breastfeeding.</p>			
<p>The Joint Health and Wellbeing Strategy recognise the importance of breastfeeding to health and wellbeing. Following concerns around performance, the Director of Public Health commissioned DELTA Public Health Consulting Ltd to undertake a review of breastfeeding support services and make recommendations to future commissioning to the Council, NHS England and NHS Barking & Dagenham Clinical Commissioning Group (CCG).</p>			
<p>It should be noted that Dr Eugenia Cronin, Managing Director of DELTA Public Health Consulting Ltd will present the outcomes of the Breastfeeding Pathway Review to the Board at the July meeting.</p>			

The Health and Wellbeing Board is recommended to:

- (i) Note the contents of the report.
- (ii) Agree that the appropriate recommendations are being taken forward
 - Refresh of the CCG commissioning plan to include greater emphasis on support for breastfeeding
 - Develop a breastfeeding strategy owned by the Children and Maternity Sub-Group
 - Explore employing an Infant Feeding Coordinator
 - Improve Training – review and up skill for relevant staff
 - The Chair of the Children and Maternity Sub-Group to work with key stakeholders to improve data collection across the pathway
 - Improve antenatal education
 - Expand and improve coordination and change the management configuration of maternity and maternity support services including the Peer Support Workers programme
 - Improve management of LoveMums website updates including data analysis
- (iii) Agree that the Chair of the Children and Maternity Sub-Group will lead the implementation of the recommendations and to update the Board on progress over the next 12 months.

Reasons

The Health and Social Care Act 2012 introduced the requirement for Health and Wellbeing Boards to prepare joint Health and Wellbeing Strategies for their local areas. The Joint Health and Wellbeing Strategy should provide an over-arching framework to ensuring a strategic response to the health and social care needs of the local population. The outcome to increase the prevalence and initiation of breastfeeding is a key target within the Strategy's delivery plan to improve early years outcomes.

1. Background and Introduction

- 1.1 The importance of breastfeeding is undisputed. It has a major role to play in public health in improving child health outcomes. Breastfeeding reduces the risk of infants developing many illnesses and provides protection against later childhood diseases. It has a positive effect upon maternal health and wellbeing and promotes bonding between mother and baby.
- 1.2 Breastfeeding rates in England (73.9%) and within the London Borough of Barking and Dagenham (73.7%) remain low and are lowest in those groups with the poorest health; thus compounding health inequalities.
- 1.3 Breastfeeding is important in our efforts to improve resident's health and is a key component of several public health priorities including:
 - Reduction in infant mortality
 - Reduction in preventable infections and paediatric hospital admissions

- Improvement in child outcomes and wellbeing
- Reduction of health inequalities
- Reduction of obesity in under-11s

- 1.4 Current government policy is to promote exclusive breastfeeding (feeding only breast milk direct from the mother or a bottle where necessary) for the first six months. Thereafter, it recommends that breastfeeding should continue for as long as the mother and baby wish, while gradually introducing a more varied diet.
- 1.5 Although breastfeeding is the ideal we acknowledge that there may be situations where breastfeeding is not the safe or preferred option. In such cases support will be given to ensure that mothers are supported and provided with information on correct formula preparation, frequency of feeds and equipment sterilisation.

2 Methodology and consultation

- 2.1 Given the importance of breastfeeding, we need to consider the impact of the investments made to date, gain a local picture of need, evaluate the effectiveness of currently commissioned services and identify areas for improvement.
- 2.2 DELTA Public Health Consulting Ltd was commissioned by the Director of Public Health to undertake the review.
- 2.3 DELTA conducted face to face and telephone interviews with 13 stakeholders, representing managers, providers and commissioners of breastfeeding related services in the borough.
- 2.4 On 31 January 2014, a stakeholder workshop was held, attended by 23 stakeholders. This provided an opportunity to gather additional views.

3 Key findings

- 3.1 A strong commitment to breastfeeding was demonstrated in the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA), whilst the Children's and Young People's Plan seeks to increase breastfeeding through the Family Nurse Partnership (FNP) – a home visiting programme for first time young mums, aged 19 or under (and dads).
- 3.2 The borough has significant demographic challenge with a fast growing, relatively young population which is increasingly ethnically diverse, and has the highest fertility rate in London. Added to this challenge, a range of socio-demographic factors have been recognised as causal factors in the borough's relatively low rates of breastfeeding. These include relatively young age of mothers; likely younger age of girls leaving education; smoking status; and socioeconomic status/profession. The commissioning of the breastfeeding pathway needs to keep pace with these demographic challenges.
- 3.3 Although there has been some improvement in breastfeeding performance against national targets over recent years noted in the JSNA, Barking and Dagenham has relatively low breastfeeding initiation rates compared with London, but they are similar to the England average. 2013 data suggests that around three in every four mothers begin breastfeeding soon after birth but that only one in four are still doing

so, exclusively, at 6-8 weeks. It is acknowledged that some mothers are not able to breast feed for a variety of reasons.

- 3.4 There appear to be stark differences between wards with those in the west of the borough having higher rates of breastfeeding at 6-8 weeks, than those in the north and centre; but analyses should be treated with caution as there has also been fluctuation in the completeness of data for breast feeding status at the 6-8 week check, although responsibility for this is with general practice rather than with maternity services.
- 3.5 The recent reconfigured maternity pathway has resulted in a more diverse provider landscape and additional complexity in patient pathways. The review suggests that some women and partners lack access to antenatal parental education.
- 3.6 A summary of feedback about services from stakeholders and residents are set out below:
 - New mums reported positive experiences at Barking Birthing Centre
 - LBBB maternity providers are not UNICEF baby friendly accredited, although there is enthusiasm for this
 - Not all midwives are up to date with UNICEF accredited breastfeeding training
 - Midwives and Health Visitors who engaged in the review showed energy, passion and commitment. However there were areas in need of service development to support mothers and breastfeeding
 - With Lifeline no longer wishing to continue the Peer Support Worker programme, and the Children's Centres picking up this service as an interim solution pending the outcomes of this review. There were a range of issues identified around management, supervision, coherent delivery and numbers of peer support workers. These issues are being actively addressed by Children's Services
 - The model of early intervention delivered by North East London NHS Foundation Trust is not consistent across the three boroughs it serves. For example, the provision in Barking and Dagenham does not include a dedicated infant feeding team.

4 Recommendations

The Chair of the Children and Maternity Sub-Group to lead the implementation of the recommendations and to update the board on progress over the next 12 months

- 4.1 Refresh of the CCG commissioning plan to include greater emphasis on support for breastfeeding.
- 4.2 Develop a multi-borough breastfeeding strategy owned by the Children and Maternity Sub-Group.
- 4.3 Explore employing an Infant Feeding Coordinator.
- 4.4 Improve Training – review and up skill for relevant staff.

- 4.5 The Chair of the Children and Maternity Sub-Group to work with key stakeholders to improve data collection across the pathway.
- 4.6 Improve antenatal education.
- 4.7 Expand and improve coordination and change the management configuration of maternity and maternity support services including the peer support workers programme.
- 4.8 Improve management of LoveMums website updates including data analysis.

5 Progress since the review

- 5.1 The Director of Public Health has been working with the Corporate Director of Children's Services to ensure that when the commissioning of the 0-5 Healthy Child Programme becomes the responsibility of LBBD on 1 October 2015, that commissioners address the recommendations and findings of the review.
- 5.2 The Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Five Year Strategy includes the need for maternity services to achieve and maintain UNICEF baby friendly accreditation within the next 24 months.
- 5.3 An audit of members of staff in six children centres using the UNICEF BFI audit tool 2013 took place in May 2014. The audit found that at present, the children's centre staff who have been trained to deliver breastfeeding information and run breastfeeding cafes do not have sufficient information to fully support mothers to successfully breastfeed. Refresher training and support to further develop staff is being explored by the Health Lead for Early Intervention in Children's Services at LBBD.

6 Mandatory Implications

6.1 Joint Strategic Needs Assessment

The review is being used to update Section 2 (Children-the best start in life) of the JSNA.

6.2 Health and Wellbeing Strategy

If agreed and taken forward, the recommendations from the report will contribute to a number of the Health and Wellbeing Strategy outcomes:

- Residents are supported to make informed choices about their health and wellbeing to take up opportunities for self help in changing lifestyles such as giving up smoking and maintaining a healthy weight. This also involves fostering a sense of independence rather than dependence.
- Every resident experiences a seamless service.
- Children having the best possible start in life from conception, so breaking the link between early disadvantage and poor outcomes throughout life.
- Service providers have and use person centred skills across their services that makes every contact with a health professional count to improve health.
- Being able to take part in the design and delivery of services that are suitable for their needs.

6.3 Integration

The implications for integration are highlighted in the report and it is proposed that this will be taken forward by the Children and Maternity Group.

6.4 Financial Implications

A number of recommendations in this report are likely to have resource implications, for example potentially employing an Infant Feeding Coordinator, and up skill training for relevant staff. These recommendations need further evaluation to inform commissioning decisions later in the year when the Public Health grant for 2015/16 is confirmed.

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

6.5 Legal Implications

There are no legal implications of this report, however it should also be noted that breast feeding is covered by the Equality Act 2010.

Implications completed by: Dawn Pelle, Adult Care Lawyer, LBBD.

7 Background Papers Used in Preparation of the Report:

Ball and Wright 1999; Hoey and Ware 1997; Riordan 1997

Dyson et al, 2005, HDA Guidance; Promotion of breastfeeding initiation and duration
Department of Health, Giving all children a healthy start in life

<https://www.gov.uk/government/policies/giving-all-children-a-healthy-start-in-life>

LBBD Breastfeeding Needs Assessment (May 2014) – Copies available on request
Breastfeeding profiles

<http://atlas.chimat.org.uk/IAS/dataviews/report?reportId=351&viewId=355&geoReportId=3198&geold=4&geoSubsetId>

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title: Barking and Dagenham Child Death Overview Panel Annual Report 2013/14	
Report of the Director of Public Health	
Open Report	For Information
Wards Affected: All	Key Decision: No
Report Author: Matthew Cole Director of Public Health / Chair Child Death Overview Panel Roselyn Blackman CDOP Co-ordinator	Contact Details: Tel: 020 8227 3657 E-mail: matthew.cole@lbbd.gov.uk Tel: 0208 227 2826 Email: roselyn.blackman@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	
Summary: The aim of the Child Death Overview Panel Annual Report is to inform the Local Safeguarding Children Board (LSCB) and the Health and Wellbeing Board of child death patterns. Through a comprehensive and multi agency review of child deaths, the Child Death Overview Panel (CDOP) aims to understand how and why children die in Barking and Dagenham and use the findings to take action to reduce the risks of future child deaths and to improve the health and safety of the children in the area. The Report provides a breakdown of child deaths notified to CDOP, child deaths reviewed and recommendations made during 2013/14.	
Recommendation The Health and Wellbeing Board is asked to note the recommendations made by CDOP as well as those arising from other investigative processes.	
Reason(s) There is a requirement to present an annual CDOP report to the LSCB which recommends its findings to the Health and Wellbeing Board as part of the process of influencing health and social care commissioning priorities. Under Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, set out the function of the Local Safeguarding Children Board (LSCB) in relation to child deaths, made under section 14(2) of the Children Act 2004. The LSCB is responsible for: <ol style="list-style-type: none"> a) collecting and analysing information about each death with a view to identifying: <ul style="list-style-type: none"> • any case giving rise to the need for a review mentioned in regulation 5(1)(e); 	

- any matters of concern affecting the safety and welfare of children in the area of the authority;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) establishing procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Barking and Dagenham CDOP is asked to categorise the likely cause of death, record the event that caused the death and any modifiable factors.

1. Background and introduction

1.1 The Child Death Overview Panel (CDOP) is a Committee of the Barking & Dagenham Local Safeguarding Children Board (LSCB) with the responsibility of reviewing all child deaths between 0-18 years. This statutory duty is intended to ensure that factors contributing to the death that may have been modifiable are identified. The CDOP is required to look at trends and patterns and makes recommendations to reduce the risks of future child deaths, to the LSCB, Department for Education through an annual return and relevant agencies.

1.2 This paper is an executive summary of the annual report and readers are advised to read the whole report which can be accessed via the following link <http://www.bardag-lscb.co.uk/Pages/CDOP.aspx>.

2. Summary of CDOP activity

2.1 Deaths that have been notified to the Barking and Dagenham CDOP are not all reviewed and closed during the same year of notification. The Department of Education recognise it may take a number of months (or years in some cases) to gather sufficient information to be able to fully review a child's death. This can be due to criminal proceedings, autopsies, coroners' reports, serious incidents (SIs) and serious case reviews (SCRs). Barking and Dagenham CDOP will await the conclusion of these investigations before a review is undertaken. In 2013-14, 18 out of 27 child deaths have been reviewed by CDOP due to the points raised above. The activity undertaken by CDOP is summarised in the table below:

Summary of Child Death Review Process activities 2013-14	
Number of child deaths notified to CDOP	27
Of the deaths notified to CDOP, the number of rapid response meetings	10
Number of LSCB CDOP meetings	6
The number of child death reviews completed by BDCDOP	18
Of the deaths where the review was completed, the number the panel assess and identifying Modifiable Factors	5
Of the deaths where the review was completed, the number the panel assess and identifying No Modifiable Factors	13
Of the deaths where the review was completed, the number the panel assess and identifying Insufficient information	0
Of the deaths where the review was completed the number identified as unexpected	8
Of the deaths where the review was completed the number identified as expected	10

3. Child Death Reviews

3.1 In 2013-14, the CDOP spent considerable time reviewing its governance and practice against Chapter 5 Child Death Reviews in the Working Together to Safeguard Children 2013 <https://www.gov.uk/government/publications/working-together-to-safeguard-children>. This was required as preparation for the anticipated Ofsted inspection which took place 29 April to 22 May. The following key points should be noted:

- Concern has been expressed on how the outcomes and learning identified through the child death reviews is then incorporated into frontline practice. In order to close the quality loop, the CDOP will now share learnings with the Learning and Improvement Committee of the LSCB. The recommendations presented in the CDOP's monitoring reports to the LSCB will now be monitored through the Performance and Quality Assurance committee, providing both assurance to CDOP Chair and the independent Chair of the LSCB.
- CDOP training was delivered to Child Protection Education Leads to reduce the time delay of late notifications from schools.
- A briefing was developed and circulated to all GPs surgeries and frontline staff in response to a non receipt of child death notification.
- London Ambulance Service (LAS) are one of the first professionals on the scene and the professional confirming the fact of death; however they are not required by their procedures to notify CDOP of a child death. Work was commenced with the LAS to incorporate the CDOP notification process within their national procedures.
- Serious Incident alerts are now received by the Single Point of Contact in a timely manner
- A consent form was devised so that full Post Mortems can be included in the CDOP review. The form was shared with Havering and Redbridge CDOPs to promote consistency in local working.
- National CDOP responses are inconsistent to babies born prior to 24 weeks gestation. Barking and Dagenham CDOP agreed that all live births will be reviewed by CDOP regardless of weight or gestation. This criterion was shared with Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Havering and Redbridge CDOPs to promote consistency in local working.

4. Summary from the cases reviewed

- 4.1 The highest number of deaths notified to CDOP are within the neonatal age (0-27 days) and children under 1 year of age. Some CDOPs are responding to this national trend by having specialist neonatal meetings where neonatologists and obstetricians are in attendance. Scheduled in the 2014-15 priorities will be how BD CDOP will respond to this trend.
- 4.2 The rate of childhood mortality in Black African and Caribbean children has been higher than the rate in other ethnic groups over the past six year period from 2008/09. The Director of Public Health did not find a statistical significant difference in the rates. This means that currently there is no evidence of a true difference in rates. Because childhood deaths are a rare event the confidence intervals are wide and it can be difficult to detect true differences in death rates where they do exist. Pooling data from several boroughs would increase the power to detect differences. As a result, further analysis will be made through examining the deaths across the boroughs of north east London. This work will be conducted in 2014-15.
- 4.3 Barking and Dagenham contributed to 48% of all Sudden Unexpected Death in Infants (SUDI)s in London since 2005. In the east region, 61% of SUDI)s occur in Barking and

Dagenham, Hackney and Newham combined. As these deaths are very few, ranging from 1-4 deaths per year, the specific questions are a challenge as the answers can only be drawn out from individual child death reviews. Apart from those cases where there is an underlying clinical condition the only other modifiable associations are with parental smoking and sleep position. The Director of Public Health has this under review as a CDOP priority.

- 4.4 Since 2009- 2014, the child deaths where modifiable factors were identified have varied but collectively account for 32%. This shows the majority (68%) of child deaths, during the past five years, did not include modifiable factors.
- 4.5 Where death is confirmed by the London Ambulance Service (LAS), notifications are delayed. Working Together recommends that the professional confirming the death should inform the Designated Paediatrician for Unexpected Child Deaths at the same time as informing the coroner and police. This recommendation is not included in the Pan London LAS Procedures. Work is continuing to incorporate this to speed up the process of child death reviews.
- 4.6 The number of deaths that occur abroad is very small however the issues identified are important to note.
- CDOP is unable to determine a cause of death as this is not always recorded on the death certificate
 - There is no coroner involvement if the body is not returned to the UK
 - Metropolitan Police have no jurisdiction to investigate these deaths occurring abroad.
 - Information sharing between countries is inconsistent
 - The review is not thorough as CDOP is unable to obtain all the necessary information

5. Learning and recommendations:

Appendix 1 outlines the modifiable factors and recommendations made following the child death reviews in 2013-14. The following sub-sections below summarises the recommendations from the review of cases by organisation. As previously mentioned, these recommendations will be monitored through the Performance and Quality Assurance committee, providing both assurance to CDOP Chair and the independent Chair of the LSCB that they have been enacted.

5.1 London Ambulance Service (LAS)

LAS to ensure crews have checked their equipment and have different sized masks within its paediatric bag valve mask pack - a neonatal mask, an infant mask and a child mask.

5.2 Barking, Havering, Redbridge University Hospitals NHS Trust (BHRUT)

Calls and triage notes into the labour ward at Queens will be reviewed to ensure documentation of appropriate advice is relayed to LAS and families. Training was carried out by BHRUT Safeguarding of the Maternity Midwives with regards to late child death notifications.

5.3 North East London NHS Foundation Trust (NELFT)

Associated factors relating to co-sleeping, alcohol consumption and placing the baby

face down to sleep (against national recommendation) were identified in the SUDIs reviewed.

5.4 General Practitioners

Changes in NHS from 2013 have presented challenges in performance management of general practitioners' responses to CDOP learning and contributions, as well as how learning is incorporated into general practice. CDOP recommends that there is an NHS England representative on CDOP.

5.5 Barts Health NHS Trust (Newham)

Newham University Hospital to review local guidance for responding to LAS calls for assistance. Local flowchart to record all LAS calls and support clear communication and decision making.

5.6 Response times to actions and recommendations

CDOP agreed the maximum response time to an action is between 1-6 months and should be in response to the need of the individual action. CDOP Recommendations will be reviewed 6 months after the case is closed. This review will be included in the 6 monthly report to LSCB.

5.7 CDOP

All CDOP minutes are to be succinct with actions clearly assigned. When action is complete, this is to be recorded in the minutes and removed from the action log.

5.8 Tri-borough Learning

Barking and Dagenham, Havering and Redbridge are working together to share learning and improvement at Manager and Panel levels.

6. Priorities for 2014-15:

In addition to the recommendations outlined above, the following priorities were agreed by the Panel for the coming year:

- Raise the profile of CDOP by attending the LSCB Conference.
- Devise and carry out CDOP Training to professionals.
- Lead on the CDOP Tri Borough Development/Study Day. This event is intended to share learning and promote joint working with BHRUT, Havering and Redbridge CDOPs to develop the effectiveness of CDOP.
- As some deaths bypass the usual A&E route and are taken directly to the mortuary, CDOP will liaise with BHRUT Mortuary so they are included in the CDOP Notification process to reduce the risk of non receipt of notification.
- Continue to work with the 7 borough CDOP for statistical analysis of neonatal, infant and child mortality rates.
- Revise national forms in response to local need.

7. Mandatory implications

7.1 Joint Strategic Needs Assessment (JSNA)

The JSNA has a section dedicated to the analysis of child deaths. The annual CDOP report is used to update this section of the JSNA annually.

7.2 Health and Wellbeing Strategy

The review of child deaths is an integral part of the safeguarding elements in our Health and Wellbeing Strategy. At this point there is no need to change the focus of the Health and Wellbeing Strategy as a result of this annual report.

7.3 Integration

The review of child deaths and the work of the Barking and Dagenham Local Safeguarding Board for Children is multiagency and integrated in its approach.

7.4 Financial implications

There are no financial implications to this report and it is assumed that all CDOP training will be conducted by the CDOP Manger and not commissioned externally.

Implications completed by: Patricia Harvey Interim Group Manager Children's Finance

7.5 Legal implications

There are no specific legal implications arising out of the recommendations in this report. The statutory provisions relating to the child death review processes have been set out in the body of this report. Legal services will continue to support the service delivery to achieve the improvements identified. In addition appropriate advice will be given on any changes to governance arrangements to ensure responsibilities are clearly defined and information exchanged to support the continued delivery of these improvements.

Panel is invited to note that child deaths and the review process can lead to interest from the media and other parties, such as the local community. Panel should be aware of the management of requests for information, from whatever source. Legal services shall support the appropriate marketing and communications team in managing such requests.

Implications completed by: Chris Pickering, Principal Solicitor - Litigation & Employment, Legal and Democratic Services

7.6 Risk management

The work of the CDOP links very closely into the Francis Report recommendations in respect of safeguarding and quality of care. The comprehensive and multi agency review of child deaths aims to understand how and why children die in Barking and Dagenham and use the findings to take action to reduce the risks of future child deaths and to improve the health and safety of the children in the area.

8 Appendices

Appendix 1 – Modifiable Factors / Recommendations to child death reviews 2013-14

Appendix 1 – Modifiable Factors / Recommendations to child death reviews 2013-14

No.	Agency	Un/expected classification	Modifiable factors/ recommendations	Status
1.	London Ambulance Service (LAS)	UN	<p>Due to a lack of formalised processes to support clear communication and decision making to respond to LAS requests for urgent assistance, Newham University Hospital failed to provide a midwife to attend the birth.</p> <p>No root cause was attributed to the London Ambulance Service. The LAS actions below arise from lessons learned from this incident.</p> <p>Escalation Path The Consultant Midwife has drafted an escalation path for Emergency Operation Centre (EOC) when requesting a midwife, which includes statements for EOC to make regarding the Hospital Trusts' statutory obligation to provide a midwife, as per SHA/London Midwifery Supervisors recommendations. The investigation recommends that this is discussed with the Head of Operations for potential inclusion in OP035 Obstetric Care policy and OP061 Dispatch Procedures</p> <p>Operational Policy Review Pre-Arrival Instructions (PAIs) for breech presentation do not include a situation where a baby's foot is out. The Emergency Medical Dispatcher (EMD) had a choice between a) baby is born and b) baby's head is stuck (arms out) and decided that the latter was the most appropriate and continued with the next relevant card on delivery. EMDs are not clinically trained, but the PAIs are very detailed and did allow the EMD to provide instructions and reassurance to the patient's husband before the crew arrived. The investigation recommends that the PAIs for protocol 23 are reviewed by the Consultant Midwife to ensure that all clinical scenarios are covered. If any additional scenarios are felt essential and not adequately covered by the current PAIs this will be highlighted to the Academy for international review as to whether the PAIs should be amended. If the review identifies that this is training issue on the process flow of the PAIs, a clinical bulletin will be issued to Control Room staff.</p>	

No.	Agency	Un/expected classification	Modifiable factors/ recommendations	Status
			<p>The investigation also recommends that an immediate clinical update is provided to call handlers to clarify breech birth stages and terminology so that they are clear on which PAIs to follow</p> <p>Operational Policy Review The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Birth Imminent (normal delivery and delivery complications) provides a decision tree on maternity assessment and early identification of obstetric high risk complications, which is mirrored in the Trust's OP035 Obstetrics Care Policy. However, step 5 of the obstetric high risk complications states if "presentation of part other than head/buttocks/feet" is ambiguous and open to interpretation.</p> <p>The investigation recommends that statement 5 in OP035 should be amended to "presentation of a single limb, i.e. a hand or a foot" to remove the ambiguity. It is also recommended that this is discussed with JRCALC for potential inclusion in later versions of the guidance.</p> <p>The JRCALC/OP035 maternity assessment does not provide any clinical, environmental or logistical criteria to allow the crew to fully assess the risk to either the mother or the baby in immediately transporting to the nearest obstetric unit. The investigation recommends that the Trust provides clear guidance to staff on the risk factors involved in immediately transporting the mother, when birth is in progress.</p> <p>This guidance should be included in the obstetric training programme.</p> <p>Risk Register Review That the existing Risk Register entry Reference 031-2002 is reviewed in the light of recent Serious Incidents declared around the Trust's capacity to respond to obstetric emergencies.</p> <p>Target Date for implementation: 31 March 2013</p>	

No.	Agency	Un/expected classification	Modifiable factors/ recommendations	Status
	Newham General Hospital		<p>Newham University Hospital to review local guidance for responding to LAS calls for assistance. Local flowchart to record all LAS calls and support clear communication and decision making.</p> <p>Local Supervisory Authority; to investigate into midwifery practice.</p> <p>Obstetric staff to receive training regarding their role in relation to LAS calls.</p> <p>Review midwifery mandatory training.</p> <p>Recommendation that Line manager review the leadership skills of the Coordinator as a Band 7 midwife in line with Capability Policy.</p>	
	Queens Hospital		<p>Excerpt taken from LAS Serious Incident Report: <i>“Although Queens Hospital has not provided the LAS with a formal report, from the information provided in the call transcripts and in discussions with the Risk Manager, it would appear that the hospital also lacks formalised processes to support clear communication and decision making to respond to LAS requests for urgent assistance”.</i></p> <p>Calls and triage notes into the labour ward at Queens will be reviewed to ensure documentation of appropriate advice is relayed to LAS and families.</p>	
2.	London Ambulance Service (LAS)	UN	<p>The call handler should have employed the shift function and selected the ‘<i>Third Trimester Haemorrhage</i>’ which would have resulted in a ‘R2’ priority level – returning a higher priority response time</p> <p>A Quality Assurance manager has fed back to the call handler concerned and provided advice and guidance. We are confident this will enhance the future practice of the member of staff involved accordingly.</p>	Complete
3.	London Ambulance Service (LAS)	UN	<p>No suitable sized mask, to bag and mask ventilate this baby either at the scene or on the way to the hospital. CDOP to write to LAS</p>	Complete – March 2013

No.	Agency	Un/expected classification	Modifiable factors/ recommendations	Status
4.	Partnership of East London Co-operatives (PELC)	UN	An investigation and review to be carried out into whether the Urgent Care Centre at Queens has the equipment to carry out eye swabs in the event of an emergency	
5.		UN	Issues identified were co-sleeping 2 days prior to death and baby put face down to sleep – not in accordance with national recommendation Findings to be communicated to NELFT	
6.		UN	Alcohol use and co-sleeping Findings to be communicated to NELFT	
7.	General Practitioners	UN	Changes in NHS from 2013 have presented challenges in performance management of general practitioners' responses to CDOP learning and contributions, as well as how learning is incorporated into general practice. CDOP recommends that there is an NHS England representative on CDOP	

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Extending the Contract for Public Health Healthy Child Programme 5 – 19 Years Old		
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		Contact Details: Tel: 0208 227 2311 Email: zoe.garbett@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary:			
<p>The purpose of this report is to request an extension of the current Healthy Child Programme 5 – 19 Years Old to 31st March 2016. The current contract expires on 31st August 2014.</p> <p>From October 2015, Local Authorities will be responsible for the Early Years Programme 0-5 Years Old (Health Visiting) service currently commissioned by NHS England. Extending the current Healthy Child Programme 5 – 19 Years Old to 31st March 2016 will allow the Council to review its 0-19 provision (including early years and school based public health programmes) which will be developed to meet the changing needs of the borough, provide a more seamless service with fewer transition issues and look to deliver efficiencies. Also, the Department of Health have requested that 5-19 contracts do not end at the same time as the Health Visitor transition to allow for stability in service.</p> <p>The commissioning of these programmes will require an intensive procurement programme to ensure the process complies with both Contract Rules and where applicable, the Public Contracts Regulations 2006 (as amended). It will also be necessary for officers to comply with the Public Services (Social Value) Act 2012 requirements prior to commencing any procurement process.</p>			
Recommendation(s)			
The Health and Wellbeing Board is asked to:			
<ol style="list-style-type: none"> 1. Agree to the extension of the Public Health Healthy Child Programme 5-19 contract until 31st March 2016. 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 current contract to 31st March 2016 under the same terms and conditions; except the break clause will be reduced from six months to three months. 			

Reason(s)

To allow for a comprehensive early years and school based service offer to be developed. The Healthy Child Programme contract needs to be extended to allow for the programme to be joined with the Early Years Programme (Health Visiting) service which becomes the responsibility of the council in October 2015, transferring from NHS England. Officers are requesting an extension in accordance with Contract Rules 54.1.3.

1. Background

- 1.1 On the 1st April 2013 the Council assumed the responsibility for Leadership of the Public Health System locally, under reforms set out in the Health & Social Care Act 2012. The Statutory Transfer Scheme, enacted by the Secretary of State allowed public health contracts to legally “Novate” to the Council by a written Transfer Order from 1 April 2013. This included the transfer of all rights and liabilities existing under all clinical and non clinical arrangements. The Healthy Child Programme 5-19 transferred to the Local Authority from the Primary Care Trust (PCT).
- 1.2 From October 2015 the Local Authority will be responsible for the Early Years Programme (Health Visiting) service currently commissioned by NHS England. The Early Years Programme (Health Visiting) was discussed at a previous board, 5 November 2013. The Council have been asked by NHS England, through the London Health Visitor Transition Group to not reprocur the service before the transition in October 2015 and ideally wait for twelve months after. This is supported by the current partners of the programme (London Borough’s of Waltham Forest, Redbridge and Havering).
- 1.3 The date of transfer of the Health Visiting service to Local Authorities has moved from March 2015 to October 2015 and it is therefore advisable to extend the Healthy Child Programme to March 2016 in case of further changes to the transfer date to ensure that the borough is not left without any provision. Also, as many boroughs have expressed interest in developing a 0 – 19 programme, the Department of Health have requested that provision remain in place during the transition and that contracts do not end at the same time as the Health Visitor transition to allow for stability in service.

2. The Healthy Child Programme 5 – 19 Years Old

- 2.1 The current Healthy Child 5 -19 service contract commenced on the 1st April 2013 for a duration of 17 months and is due to expire on the 31st August 2014. The contract value is currently £1.2 million per annum and is delivered by North East London Foundation Trust (NELFT).
- 2.2 Table 1 outlines the core elements delivered by the Healthy Child Programme.

Table 1: Healthy Child Programme 5-19 has core elements:

Universal	Progressive/ Universal Plus and Partnership Plus	Enhanced elements
Three universal health reviews	Participation in Common Assessment Framework process where related to direct case load	Health absenteeism support
National child measurement programme, including parental feedback	Participation in TaMHS process where related to direct case load	Tier 2 child weight management
Support for schools to develop health related policies, e.g. pupil medicine management	Participation in safeguarding and child protection procedures where related to direct case load	Additional drop-in school based sessions beyond universal provision
Regular access for children, young people and educational professionals to professional health advice and support in school and community youth settings.	Tier 1 child weight management advice and signposting	Additional input to school curriculum/assembly health related sessions beyond universal provision
Access, for secondary school children, to sexual and reproductive health advice and guidance and, where school SRE policies allow, access to condoms where appropriate	Support to school in signposting and accessing SEN related health services	
Access, for secondary school children, to Level One smoking cessation advice and support where needed.	Support and signposting to services for specific groups of vulnerable young people: <ul style="list-style-type: none"> • Young carers • Children living with chronic diseases e.g. sickle cell disease, diabetes • Lesbian, gay, bisexual and 	

	trans identifying youth <ul style="list-style-type: none"> • Young mothers in education • Youth offenders in education 	
	Signposting of support for vulnerable parents	

3. **Proposals and Issues**

- 3.1 From October 2015, Local Authorities will become responsible for the Early Years Programme (Health Visiting) service currently commissioned by NHS England. Extending the Healthy Child Programme 5 – 19 Years Old for the same period allows the Council to review its early years and school based public health programmes which will be developed to meet the needs of the borough, provide a more seamless service and look to deliver efficiencies
- 3.2 Recently the responsibility of the commissioning provision for 0 - 19 year olds has been split between NHS England (0 - 5) and the Local Authority (5 - 19) this has meant a risk of commissioning in isolation and therefore possible fragmentation in provision. The transfer of responsibility to the LA for the 0 - 5 programme gives the LA an opportunity to bring the programmes together to avoid fragmentation, reduce duplication, have oversight of the full 0 - 19 programme and to enable a seamless service for people who use this provision. Therefore it is desirable to commission the full Healthy Child Programme (0 - 19) as one programme rather than two separate services.
- 3.3 Due to the later transition date of the Early Years Programme (Health Visiting), the Healthy Child Programme 5 – 19 Years Old requires further extension so that the programmes can be reviewed and procured together.
- 3.4 These arrangements have been informed by the Commissioning Priorities agreed at the Health and Wellbeing Board 5 November 2013 and 11 February 2014 (Improving Child Health and Early Years). A procurement plan will be developed with a timeframe for the procurement exercise to allow for officers to implement the agreed proposals. This plan necessitates further issuing of contracts to current providers to allow for the procurement process to be completed and new contracts awarded.
- 3.5 In order to allow sufficient time and facilitate the process for completing the necessary steps of obtaining approvals, undertaking consultation, running procurement processes in accordance with Contract Rules and the Public Contracts Regulations 2006 (as amended) it will require the existing contract to be extended to the incumbent provider until 31 March 2016. The extension will be issued to the current provider on the same terms and conditions that presently exist; except the break clause will be reduced from six month to three months.
- 3.6 The interim period of nineteen months will enable the council to focus on stabilising the services for people from 0 – 19 years old. The Council are keen to continue to support the development of these services and ensure best value without destabilising the delivery for people who need the service.

- 3.7 The values of the interim contract will be frozen at current levels (or where appropriate price reductions sought) until the proposed end date of the contract.
- 3.8 The 19 month extension of the Health Child Programme (0 – 5) has a value of 1.9 million which will be paid for out of the Public Health grant.
- 3.9 To not award an extension would result in fragmented commissioning of services and therefore disjointed provision. The procurement process will ensure that the services provide value for money for the Council. The Healthy Child Programme contract will be joined up and procured as a single contract (with the Early Years Programme) to get maximum integration and efficiencies.

4 Consultation

Consultation with partners and providers has taken place (via the Health and Wellbeing Board in November) and a regular dialogue is ongoing.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment (JSNA)

The outlines the recent increases and changes in the 5 – 19 population which highlights the need for provision for this group -

- The population of children and young people (5-19 years) in Barking and Dagenham has grown by over 15% between the 2001 and 2011 Census. The largest growth has been in the 5-7yrs (20%) and the 16-17yr (18%) age groups. This is due to increase births and inward migration of children and young people being greater than outward migration.
- There has also been a 43% growth in the number of lone parent households with dependant children in the borough.
- There has been a continued increase in the number of school age children in Barking and Dagenham.
- The school population is becoming more diverse. More than 60% of pupils in local schools are now classified as BME compared with 45% in 2007.

The complexity of provision of this age group is a reflection of several factors including ethnicity, poverty and parental life-style factors such as obesity, smoking and substance misuse. The current service plays a vital role in supporting our increasing and changing 5 – 19 population to become and remain healthy and preparing for a healthy adulthood.

5.2 Health and Wellbeing Strategy

If agreed and taken forward, the recommendations from the report will be integral to the delivery of a key Health and Wellbeing Strategy outcome –

- Children having the best possible start in life from conception, so breaking the link between early disadvantage and poor outcomes throughout life.

5.3 Integration

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

5.4 Financial Implications

This report seeks the Health and Wellbeing Board's agreement to an extension of the Public Health Healthy Child Programme 5-19 contract until 31 March 2016 for the reasons set out in the report.

The estimated value of the 19 month contract extension is £1.9m over two financial years. Budgetary provision has been agreed for 2014/15, and has been included in indicative budget allocations for 2015/16. Final decisions on 2015/16 will be made later in the year after the level of the Public Health grant is confirmed by the Department of Health. The contract for the extension will include a break clause of three months to provide flexibility should the grant be lower than anticipated.

Implications completed by Roger Hampson, Group Manager Finance (Adult & Community Services).

5.5 Legal Implications

The Health and Wellbeing Board (HWB) is being asked to authorise the extension of this existing contract from 31st August 2014 until 31st March 2016.

It is noted that the request to extend this existing contract is sought so that the service can be brought in line with the Early Years Programme (Health Visiting) as detailed in the report.

Rule 45.1.3 of the Council's Contract Rules state that extensions can be made where there is a provision stipulated in the original contract for an extension. Legal Services note that this contract at Clause A3 allows for the extension of the initial period provided that the duration of the contract will not exceed three years in total. The initial duration of 17 months and the extension up to 31st March 2016 will mean the total duration of the contract is 3 years, in accordance with Clause A3.

Legal Services note that the contract has a value of £1.2 million per annum and in accordance with Contract Rule 54.5 the HWB can indicate whether it is content for the existing contract to be extended for a further 19 months.

Legal Services will be on hand to assist in the preparation of a Deed of Variation in order to extend this Contract.

Implications completed by Daniel Toohey (Principal Corporate Solicitor, Legal and Democratic Services).

5.6 Risk Management

The Healthy Child contract is important to the continuing health of the residents of the London Borough of Barking and Dagenham. Risk will be managed through the procurement process.

6. Background Papers Used in Preparation of the Report:

- Joint Strategic Needs assessment
<http://www.barkinganddagenhamjsna.org.uk/Pages/jsnashome.aspx>
- Joint Health and Wellbeing Strategy
<http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf>
- Public Health Commissioning Priorities 2014/15 (Health and Wellbeing Board papers 5 November 2013 and 11 February 2014)
- The 0-5 year Healthy Child Programme (Health Visiting) Service (Health and Wellbeing Board paper 5 November 2013)

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HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	The Care Act 2014		
Report of the Corporate Director of Adult and Community Services			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: NO	
Report Author: Anne Bristow, Corporate Director, Adult and Community Services		Contact Details: Tel: 020 8227 2300 E-mail: anne.bristow@lbbd.gov.uk	
Sponsor: Anne Bristow, Corporate Director, Adult and Community Services			
Summary: This report updates the Board on the adult social care reforms following the Care Bill being granted Royal Assent by Parliament. In particular the report seeks to: <ul style="list-style-type: none"> • Remind the Board of the thrust of the Care Act and its major provisions. • Alert the Board that the draft statutory guidance and secondary legislation is out for consultation. • Highlight to the Board key issues contained within the detail of the Act, guidance and regulations and flag issues which have a significant impact on the Council or relevance to partner organisations. 			
Recommendation(s) The Health and Wellbeing Board is recommended to agree: <ol style="list-style-type: none"> (i) That the draft response attached at Appendix 2 will be the response on behalf of the Health and Wellbeing Board to the consultation on the Care Act draft guidance and regulations. (ii) Actions to be undertaken by partner organisations to contribute to the implementation programme. (iii) To schedule further Care Act programme implementation reports to ensure the H&WBB is well-sighted on issues and to further explore issues or parts of the implementation that impact on partner organisations. 			
Reason(s) Successful and seamless delivery of the Care Act by April 2015, and April 2016 for the funding reforms, is crucial for the Council to meet its statutory obligations to residents who have eligible or unmet social care needs. The Adult Social Care Reform Programme therefore contributes to the corporate priority of having a well run organisation. The Care Act itself will contribute to the corporate priority of improving the health and			

wellbeing for residents. New duties mean that the Council has responsibility to prevent and delay a person's need for care and Councils must have regard to a person's holistic wellbeing at all stages of that person's journey through the social care system.

1. Introduction

- 1.1. The Care Act 2014 received Royal Assent on 14 May 2014 and is being brought into force via a complex series of regulations and annexes, as well as statutory guidance. The provisions of the Act and its associated guidance will come into force in two phases: April 2015 and April 2016, as shown in Table 1 below.

Key requirements	Timing
Duties on prevention and wellbeing	From April 2015
Duties on information and advice (including on paying)	
Duty on market shaping	
National minimum threshold for eligibility	
Assessments (including carers' assessments)	
Personal budgets and care and support plans	
Safeguarding	
Universal deferred payment agreements	
Extended means test	From April 2016
Capped charging system	
Care accounts	

- 1.2. The main provisions of the Act are summarised in Appendix 1 for ease of reference, although commentary on the implications of some key aspects is provided in section 2 of this report.
- 1.3. The Government is currently consulting on the detailed provisions as set out in the draft regulations and associated guidance and inviting comments by 15 August 2014.
- 1.4. Whilst officers are contributing via regional events to the responses being prepared by the Local Government association (LGA) and the Association of Directors of Adult Social Services (ADASS) it is also proposed that the response attached as Appendix 2 is submitted on behalf of this Health and Wellbeing Board.
- 1.5. Members should however be aware that given the extensive nature of the draft regulations and guidance and the engagement work undertaken with the sector (principally LGA and ADASS) it is not anticipated that there will be further significant

or wholesale changes. The final regulations and associated guidance are due to be published in October/early November - less than six months prior to them coming into force in April 2015.

- 1.6. At the same time further draft guidance for the provisions due to come into force in April 2016 is due to be issued in the autumn. It is essential therefore that implementation planning for the April 2015 changes proceeds on the basis of the draft regulations. Even working on this basis the scale of change is significant and is likely to require additional short term staffing resources to enable the authority to meet this challenging implementation timetable. The anticipated costs can be met from within existing resources.

2. Some challenges posed by the legislation

2.1. Information and Advice

- 2.1.1. The regulations and guidance extend the duties placed on the local authority much further than anticipated. The extent of the 'offer' goes much further than the service we currently provide and includes much wider general advice on care and support options and likely costs, the process of assessments and who may or may not receive help, and signposting for specialist independent financial advice.
- 2.1.2. At several points it states that it will not be sufficient to seek to discharge our responsibility to provide information and advice by signposting people to information on websites. Given the different push by the Cabinet Office for local government to encourage digital take up and to achieve economies and efficiencies through channel shift this would seem to be a contradiction in policy terms which has real implications for us.
- 2.1.3. This is further compounded by further requirements to '*personalise*' any information or advice provided and to provide a copy of the information or advice in writing at various stages of the assessment, review or service provision. This will require system and procedural changes if we are to be able to achieve this without writing a bespoke letter on each and every occasion.

2.2. Assessment and eligibility

- 2.2.1. This changes the legal foundation of the assessment requiring that the assessment is initially conducted as if no informal support is available; in other words based on the needs if there was no informal carer input available, to arrive at the eligible needs. This will potentially bring many more people into the ambit of requiring an assessment and being eligible for support, whether they require it or not at the moment, and we anticipate a growth in people coming forward to request an assessment.
- 2.2.2. The Guidance makes clear the Department of Health view that much of this work is complex and requires the skills most commonly found in Registered Social Workers. Perhaps, fortuitously, we have been moving back towards a fully qualified workforce over a number of years and so this is unlikely to pose any particular problems in Barking and Dagenham but may do so elsewhere.
- 2.2.3. It also will require each individual to be given a 'ball park' figure of the likely sum of money that will be made available to meet their needs early in the process although it allows for revision as the care and support plan is finalised. The intention is this will allow service users to better understand the choices available to them for meeting

their care needs. It also requires that the process for determining the amount of cash to be made available is published in a clear and transparent format that is easy to understand.

- 2.2.4. Separately informal Carers will have strengthened rights to their own assessment and allocation of resources to meet their needs and enable them to continue to carry out their caring role. The issues to be taken into account in determining their needs are wider than at present including support for them to work and to pursue recreational interests.
- 2.2.5. It is not clear yet where the final eligibility test will lie and how it will compare with our current thresholds, whether this will lead to more or less people being eligible for support overall. It still seems probable that it will be broadly similar, but as late as early July the formulation being proposed was still being tested.
- 2.2.6. However, what is introduced by the regulations and guidance is a new obligation to promote wellbeing and a duty to provide or arrange for services that would prevent, delay or reduce a person's need for care and support or the needs for support of their carer. This will have the effect of introducing responsibilities towards a whole cohort of people who currently do not get access to services as they do not meet the authority's eligibility criteria.
- 2.2.7. Furthermore, we are expected to develop a Prevention Strategy that looks at present and future demand and sets out how we will meet this new duty. In this context we are reminded of the duty of key partners to co-operate (particularly the council and the NHS) and the focus expected on integration.
- 2.2.8. Throughout the documents it is made clear that it is expected that everyone will have a Personal Budget (including for carers in their own right) though it is accepted that as now it can be one of several types of Personal Budget:
- a managed Personal Budget where the local authority arranges and provides the services;
 - an individual service fund where a specific pot of money held by a service provider with the service user directing how it is spent
 - a Direct Payment
- 2.2.9. Not surprisingly the preference as now is for more Direct Payments. Again there is emphasis on joint Direct Payments with health services but given the very low numbers¹ currently available in our local health economy this will be an area requiring development.
- 2.2.10. The complexity that may arise in some caring situations is acknowledged and guidance provided on possible solutions. Whilst the concept of Direct Payments is promoted in the Children and Families Act it is used to mean a payment to the parent /carer (not a payment for the child or young person paid to the parent/carers) and we could anticipate some transition issues arising as the balance shifts to making payments to the young person even if a carer's direct payment was also proposed.

¹ Less than 10.

2.3. Advocacy

2.3.1. Throughout the documents it states that there will be a requirement to offer or provide suitable trained and qualified independent advocacy support at a wide range of stages of all the processes envisaged. It also provides clarity on the qualifications and training advocates are expected to have. This is an area that will require detailed further consideration as it differs substantially from our current approach which has been to mainly use advocates in specified situations. It is also unclear at this stage whether the labour market could supply sufficient qualified advocates to meet the growth in demand that can be anticipated.

2.4. Transition Planning

2.4.1. Detailed Guidance is provided on how the transition from childhood to adult life should be managed for those with care and support needs and those likely to have Continuing Health Care needs. The Care Act contains provisions to help preparation for three particular groups: children and young people who have their own needs, young people who are carers, and carers of young people. It is explicit that for those young people who have an Education, Health and Care plan then transition planning should start in Year 9.

2.4.2. It should though be remembered (see report elsewhere on the agenda) that the system being introduced by the Children and Families Act will also be new albeit coming into force from September 2014. The guidance maintains the position that the services offered at 18 may be different to those available prior to 18 but seeks to ameliorate the concerns about a 'cliff edge' by providing sufficient information early enough to allow the young person and their family to plan ahead with confidence.

2.4.3. It is also explicit about the expectation of co-operation between professionals. It is to be expected that many young people and their families will wish to establish that the young adult has eligible needs at age 18 as this will determine their right to free care for the remainder of their adult life. If the adult social care assessment therefore differs substantially from the children's service assessment (even if services to prevent reduce or delay needs but not eligible needs are funded) then a high level of appeals might be expected particularly until case law establishes some legal precedents.

2.4.4. The detailed annexes to the Guidance make no reference to the Children and Families Act, referring to preceding legislation. It is clear that this is one area where we will need to undertake detailed work to map pathways and ensure that as an authority we have the right capacity in the right areas to ensure young adults who need services get the help and assistance they require.

2.5. Charging for services, Deferred Payments and Care Accounts

2.5.1. Much of the national publicity around the Care Act has focussed on the financial reforms arising from the Dilnot Report. However much of this does not take effect until April 2016 and as such will be the focus of the further guidance and regulations due to be issued this autumn. This will therefore be subject to a further report to the Board.

2.5.2. What has been clarified however is that the ability to levy charges for community-based services will remain a matter for local determination and will not become a nationally prescribed scheme in the way that residential care and nursing home charges are prescribed.

2.5.3. Work will now need to be undertaken to review our existing *Fairer Charging Policy* to take account not only of the Care Act but also the welfare reforms. This is a substantial piece of work to balance the need for individuals to make a contribution to the cost of their care with the wider needs of tax payers generally whilst complying with the guidance now issued; again this will need to be a matter for further detailed consideration as the Council sets its 2015-16 budget.

2.6. **Safeguarding**

2.6.1. As expected the regulations and guidance put the Safeguarding Adults Board on a Statutory footing, specifying that the lead agency is the local authority and setting out key duties to:

- Make enquiries if it believes an adult is being abused or at risk of abuse
- Set up a Safeguarding Adults Board
- Arrange where appropriate for an independent advocate
- Co-operate with each of its partners in order to protect adults experiencing or at risk of abuse

2.6.2. The guidance is clear that the inter-agency arrangements must be set up in such a way as to put people in control of their own lives and do not revert to paternalistic or interventionist ways of working. It also stresses that safeguarding is everyone's business and that there is the need to ensure that workers from a range of disciplines (for example: welfare, police, banking, trading standards, leisure, faith organisations, and housing) are engaged in safeguarding.

2.6.3. Safeguarding Adults Boards are charged with agreeing inter-agency procedures, publishing a strategic plan and increasing public awareness and vigilance. A more detailed report on these issues was considered by the Safeguarding Adults Board on 18 July 2014.

2.7. **Integration ,cooperation and partnerships**

2.7.1. Given this section is key to the functions of the Health and Wellbeing Board this chapter of the statutory guidance is reproduced in full at Appendix 3.

2.7.2. Whilst much of it is as may have been expected, stressing the need to integrate health and social care services at all levels, it nevertheless is prescriptive about what it expects in terms of the JSNA and the Joint Health and Wellbeing Strategy. In our case we have recently agreed a sector wide five year strategy which will clearly inform our thinking. We are due to review both the Health and Wellbeing Strategy and the JSNA over the coming months and can take account of these matters.

2.7.3. Changing operational practice in the ways envisaged in the guidance may be more challenging. More unexpected are the repeated references throughout the documents to the role of housing services. It should be less problematic for Barking and Dagenham as we are a unitary authority encompassing housing responsibilities than for other kinds of local authority. However it does raise some issues that will require separate consideration such as whether or not Housing should be explicitly represented on the Health and Wellbeing Board or the CCG Governing Body.

2.8. Market Shaping

2.8.1. The regulations and guidance make explicit the local authority's duty to 'shape' the local care market in order to ensure that there is sufficient diversity in provision to enable service users to exercise real choice. Whilst the Council will for some time to come continue to commission a range of services, increasingly those with Direct Payments will commission their own personalised services. Earlier this month the first Market Position Statement 'The Business of Care in Barking and Dagenham' was published setting out for care providers the likely direction of travel for the different care groups.

3. Implications

3.1. The extent of the regulations and the breadth of the statutory guidance, and bearing in mind there is another tranche to come in the autumn, is much further reaching than could have been anticipated from the wording of the Act itself and the parliamentary debate during the legislative process.

3.2. There are significant implications for policy, professional practice and costs arising from the detail and a very short timescale to make the necessary changes for the April 2015 phase. For instance, it is not yet clear whether or when our electronic records provider will be able to deliver all the necessary system changes and upgrades. Certainly our existing processes will require review and amendments to take into account the very specific 'customer journey' mapped out in the legislation.

3.3. It is also envisaged that considerable staff training will be required but again there is a relatively short window of opportunity between the finalisation of the regulations and guidance and implementation. At present our best estimate is that within the Council:

- key assessment staff and their managers are likely to need at least 10 days training in different modules;
- a further group of commissioners, some housing staff, finance staff and provider staff needing 3-5 days training;
- a much larger cohort of staff will need one day general awareness training.

To release these numbers of staff will in some instances require us to secure additional temporary staffing cover.² A further issue is the fact there are no training courses available in the market to provide the training, and Skills for Care are releasing online training modules which provide a superficial view of what is required. We are intending to employ our own dedicated trainer to design and deliver a bespoke training programme for our own staff. Additionally significant numbers of NHS staff will require training as well as staff in social care providers and voluntary sector organisations

3.4. There are a number of policy documents that we either do not currently have or which will require significant revision. Work for some areas is in hand for example in the Better Care Fund Reports we identified the need for a new Carer's Strategy and this is being developed but others such as a Prevention Strategy will need to be initiated.

² Potentially another 6 members of staff for a period of 6 months. This would cost in the region of £150k.

- 3.5. Most procedural documents will require revision. In some instances such as Safeguarding Procedures these were developed previously on an inter-agency pan-London basis and we would expect that to be the case again.
- 3.6. The new requirements to put substantially more information in a personalised written format will mean that we need to review all the forms and letters we use. Wherever possible we will seek to automate the production of user friendly communications but the short lead-in time may mean that a two phased approach is required
- 3.7. Local authorities have been lobbying for the Department of Health to lead a major public information campaign to support the implementation of the Care Act. There now seems to be agreement that they will produce national TV and poster campaigns along the scale of Change4life or some of the HMRC campaigns as well as producing materials that can be adapted for local use.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

The new requirements will need to be reflected in the refresh of the JSNA (See paragraph 2.7.2)

4.2. Health and Wellbeing Strategy

The new requirements will need to be reflected in the refresh of the Health and wellbeing Strategy (See paragraph 2.7.2).

4.3. Integration

The Care Act drives forward the Government's policy intention that further service integration should follow. Helpfully it puts the duty to co-operate on a statutory basis in a number of areas.

4.4. Financial Implications

- 4.4.1. The Department of Health has already announced a number of funding streams to support the implementation of the Care Act in 2014/15 and 2015/16, but not yet for 2016/17.

2014/15

Every authority with adult social care responsibilities has been awarded £125k as a Care Act Implementation Grant. The purpose of the grant is to provide additional support to local authorities in England towards expenditure lawfully incurred or to be incurred by them. The table overleaf sets out how this funding is proposed to be spent within Barking and Dagenham. If additional resources are needed, a further report will be presented at a later date unless these can be agreed by the Corporate Director in consultation with the Chief Financial Officer.

Care Act implementation Grant: Proposed Spend	Amount
Project officer costs	£40,000
Additional legal capacity	£15,000
Consultation events with 3 rd sector, service users and carers	15,000
Organisational development – training, briefing, e-learning development	15,000
Systems development – information and advice, assessment, and financial assessment	40,000
Total	125,000

4.4.2. In addition, the Better Care Fund plan, agreed by the Health and Wellbeing Board earlier in the year, included £100k of on-going funding for the costs of meeting statutory costs of safeguarding adults requirements; this is funded from the increased Adult Social Care grant in 2014/15 and CCG revenue funding from 2015/16.

2015/16

4.4.3. A New Burdens Grant of £1,084k has been allocated by the Department of Health to Barking and Dagenham in respect of costs of the Care Act arising for the changes coming into effect from April 2015. The grant is to be used for early assessments and reviews, deferred payments, capacity building including recruitment and training of staff, and an information campaign. Proposals on how to allocate the total grant will be presented to the Health and Wellbeing Board later in the year when regulations and guidance are published in their final form.

4.4.4. Within the Better Care Fund plan, £200k of the local authority adult social care capital grant has been earmarked for any potential costs of computer system changes which need to be implemented as a result of the Care Act.

4.4.5. Funding of £135m at national level is included in the Better Care Fund but the local allocation of £500k has yet to be agreed locally; progress in reaching agreement is to be reported back to the September meeting of the Health and Wellbeing Board. Recent announcements on the operation of the Better Care Fund raise some concerns that funding from the CCG may not be available towards meeting certain costs listed below, which may therefore add to financial pressures for the local authority.

4.4.6. The activities deemed by the Department of Health to be funded at national level from the Better Care Fund as a result of the Care Act are:

Personalisation

- Create greater incentives for employment for disabled adults in residential care

Carers

- Put carers on a par with users for assessment.
- Introduce a new duty to provide support for carers

Information advice and support

- Link local authority information portals to national portal
- Advice and support to access and plan care, including rights to advocacy

Quality

- Provider quality profiles

Safeguarding

- Implement statutory Safeguarding Adults Boards

Assessment and eligibility

- Set a national minimum eligibility threshold at substantial
- Ensure councils provide continuity of care for people moving into their areas until reassessment
- Clarify responsibility for assessment and provision of social care in prisons

Veterans

- Disregard of armed forces Guaranteed Income Payments from financial assessment

Law reform

- Training social care staff in the new legal framework

2016/17

- 4.4.7. The major financial impact of the Care Act will begin in 2015/16 as a result of the extended means test, the capped charging system and the introduction of Care accounts. Draft guidance and regulations on these aspects of the Care Act are expected to be published in the autumn.
- 4.4.8. The Department of Health is re-evaluating the likely financial impact of the April 2016 changes at national level; announcements on the total funding to be made available are likely to be made as part of the provisional local government finance settlement for 2015/16, expected in December 2014. This may include allocations to be made to individual local authorities, and the payment mechanism, e.g. whether or not additional funding will be made available as a ring-fenced specific grant.
- 4.4.9. In addition, the local authority is working up its own financial modelling in order to inform the budget process. Further information is needed on the potential numbers of people looking to the authority for financial support who would be self-funding their care under current arrangements, and on the numbers of informal carers who will have strengthened rights to their own assessment and allocation of resources to meet their needs to enable them to carry out their caring role. Given the uncertainties the Chief Financial Officer will consider at a later stage whether it is appropriate for some funding to be retained within the general contingency.

Implications completed by: Roger Hampson, Group Manager, Finance

4.5. Legal Implications

- 4.5.1. The Care Act will bring in a sea change for Adult Services and the way in which services to the population is to be delivered. The principles underpinning the statute are the wellbeing principles and the prevent/reduce/delay principle, which places duties on staff other than social care staff. Because of these changes in some cases staff across the authority will need to be trained in concepts entirely unfamiliar to them. Staffing implications are alluded to throughout the report and specifically mentioned at paragraph 5.2.
- 4.5.2. Further to section 2.1, it is noteworthy that Information and Advice duties go beyond mere signposting. Staff will have to confirm outcomes and decisions in writing and it is suggested that there are template letters, which can be adapted to particular situations to fit with the personalised approach. Independent Advocacy is going to be arranged for those with capacity as well as those without capacity.
- 4.5.3. Safeguarding (see also paragraph 5.1) has now been placed on a statutory footing and a gap analysis has been undertaken to ascertain where the authority is at present and where it needs to be by April 2015.
- 4.5.4. There is no mention of the new appeals process pursuant to s.72 of the Act. This will divert challenges from the High Court – Judicial Review, which will lessen the financial burden of defending these challenges. The Act states that Regulations will set out the process and procedure for Appeals but no regulations have been issued in relation to the appeal process.

Implications completed by: Dawn Pelle, Adult Care Lawyer

4.6. Risk Management

The scale, complexity and pace of the Care Act implementation present considerable risk to the Council, and to a lesser extent partners. Risks and mitigation actions have oversight at all levels and are monitored systematically and with regularity. The Care Act implementation programme has its own risk log to capture and manage risks. The identified risks are also being monitored on the ACS departmental risk register and the delivery of the Care Act is flagged on the corporate risk register.

The risks related to the programme centre around the short time period in which to adapt to major reform and the challenges this brings for systems and workforce development.

5. Non-mandatory Implications

5.1. Safeguarding

The proposals will strengthen the role and functions of the Safeguarding Adults Board and clearly define the way in which practitioners should work with adults at risk, stressing the need to ascertain the individual's views and wishes, and to seek their consent. They also cover the responsibilities of the care sector employers.

5.2. Staffing issues

The changes the Care Act will bring into force will require service redesign in a number of areas which may well result in changes to job roles and organisational structures. Normal staff consultation processes would need to apply as soon as the

detail is available. At this stage it is not possible to quantify the number of posts affected.

However, what is clear is that the role changes will affect not only social care staff but also other local authority staff (such as housing officers) and staff from a range of other organisations (particularly the NHS) where multi-disciplinary team working is the norm. Substantial training will be required for significant numbers of staff in order to effectively implement the legislative change. Work is underway to identify those who will require training and establish modular programmes.

6. Background Papers Used in Preparation of the Report:

- Health and Wellbeing Board reports (05 November 2013 and 10 December 2013)
- Secondary Legislation: Draft regulations for consultation - Part One of the Care Act 2014 (Department of Health, June 2014)
- Care and Support Statutory Guidance (Department of Health, June 2014)
- Care Act, Part One: Factsheets 1-11 (Department of Health, June 2014)
- The Care Act 2014 and Safeguarding Provisions (Safeguarding Adults Board, 18 July 2014)
- 'The Business of Care': Adult Social Care Market Position Statement 2014-2016 (LBBB, July 2014)

7. List of appendices

- Appendix 1: Summary of the provisions of the Act
- Appendix 2: Draft consultation response on the statutory guidance and regulations
- Appendix 3: Statutory guidance on integration, co-operation and partnerships

Provisions of the Act

1.1. Wellbeing and prevention

- Councils will have a duty to consider the physical, mental and emotional wellbeing of the individual needing care.
- Furthermore, there is a duty on councils to provide preventative services to maintain people's health to delay a person's need for care.

1.2. Eligibility

- The Act introduces a nationally set minimum threshold for care making it clear when local authorities will have to provide support to people.

1.3. Information and advice

- Councils must establish and maintain a service for providing people in its area information and advice relating to care and support for adults and carers.
- Councils must deliver the information and advice duties in a strategic manner and have regard for the wellbeing principle and prevention in the provision of information
- Councils must help people to make good financial decisions and provide general financial advice. Where appropriate the Council must signpost people to independent financial advice.

1.4. Carers

- All carers will be entitled to an assessment of need. If a carer is eligible for support for particular needs, they will have a legal right to receive support for those needs, just like the people they care for.

1.5. Independent advocacy

- The Care Act places a duty on the Council to appoint an independent advocate, or identify a suitable 'appropriate person', to support a person throughout their journey through the social care system.

1.6. Personalisation and market shaping

- The Act outlines a person-centred planning process with a duty to involve both the person and their friends and family.
- Personal budgets and direct payments are now enshrined in law giving people choice and control about how their care and support is provided.
- Personalisation is strengthened by giving Councils a role to shape the care and support market in order to guarantee quality and diversity of local services.

1.7. Funding reforms

- A lifetime cap on care costs is introduced following the recommendations of the Dilnot Commission.
- Universal deferred payments will be offered, where certain criteria is met, to prevent people having to sell their homes before their death to pay for their care.
- The upper and lower financial thresholds have changed meaning that more people (i.e those with moderate wealth) will receive a contribution towards their care costs from the state.

1.8. Integration

- There is a general duty on the Council to promote integration with health services and health-related services.
- This is complemented by a more specific provision which links to the Better Care Fund. The Act facilitates the pooling of NHS budgets and allows NHS England to set CCGs integration objectives where it judges levels of integration to be inadequate.

1.9. Transitions

- A transition assessment must be carried out for young people, young carers, and carers of children.
- These new duties directly relate to the provisions in the Children and Families Act which adopts a birth to 25 years approach to planning. However the harmonisation between the two acts is patchy.

1.10. Safeguarding

- Under the Care Act Safeguarding Adults Boards are now statutory. The core membership of the SAB is prescribed in the legislation.
- Partner agencies or persons have a duty to co-operate with the Council on safeguarding matters and to supply information upon request.
- Serious Case Reviews have been given a statutory status in circumstances where there is serious neglect/abuse or death.

1.11. Market oversight and provider failure

- The Care Quality Commission will have the authority to intervene in the commercial affairs of large-scale providers and conduct business sustainability reviews where appropriate.
- Where there is a threat of business failure care and support providers must share commercial information with the Council and regulators so that plans can be made for continuing care.
- In the event of provider failure Councils will have a temporary duty to meet the needs of individuals receiving care from that provider, this duty applies regardless of the person's needs or status.

1.12. Other provisions in the Act relate to regulation and improving standards of care in response to the Francis Report. Further clauses establish Health Education England and the Health Research Authority. These new independent bodies will ensure the NHS has robust and future-proof workforce development plans, and ensure that research is regulated to make it safe and ethical.

1.13. For further information about the core duties within the act, the legislation, as enacted, can be found at this link:

<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

Response of Barking & Dagenham Health and Wellbeing Board to consultation on the Statutory Guidance and Regulations to support implementation of the Care Act 2014.

1. General observations

- 1.1 The Borough welcomes the reform of adult social care legislation as well as the reform of funding systems for individuals in receipt of social care. We continue to support the broad thrust of the new legislation.
- 1.2 Since receipt of the Statutory Guidance and Regulations, in common with other affected organisations, we have been working through the detail and have begun to explore the implications, stepping up our own implementation programme to meet the challenging timescale.
- 1.3 We continue to work collaboratively with other parts of the sector and, in particular, with the Association of Directors of Adult Social Services, the Local Government Association and London Councils. Whilst submitting our own separate brief response, we have also contributed to their collective submissions and would wish to confirm this Barking and Dagenham's support for them.

2. Observations on the timescales for implementation

- 2.1 With draft guidance currently out for consultation, and due for formal publication in October, this gives less than six months, and barely more than 9 months if we act on draft guidance, to implement one of the most substantial reforms of adult social care in a generation. We will no doubt get the basics of the systems and processes required in place by 1 April 2015. However, particularly in the case of new processes for assessment, financial assessment, deferred payment, information and advice provision and advocacy, it is almost inevitable that across the country the 'go live' date will see systems in place that are not in their full and final form, and continue to evolve as system issues are worked through and resolved.
- 2.2 Like many Councils, our processes are dependent on IT, with detailed workflow arrangements to ensure our social workers time is used as efficiently as possible, service users receive a consistent level of service, and we can keep track of spend and performance in real time. It is unrealistic to expect these "back-office" systems, on which we are heavily reliant, will be in place and tested by April 2015.
- 2.3 Whilst this may be acceptable in 'strategic' terms, for our service users they will be recipients of significantly different approaches to the co-ordination of their care, and there is therefore a risk that confidence in the new system is undermined by this rushed approach to planning its introduction. Councils, and their strategic partners,

have reduced business administration support in response to wider Government reductions in expenditure: our responsive capacity is therefore markedly reduced and a longer lead-in time would have recognised this change in capacity, and given greater confidence that our service users would have a positive experience of the transition.

3. Resourcing

- 3.1 In many areas, the requirements of the Statutory Guidance and Regulations are likely to increase the cost pressures on social care, including the implications of the revised eligibility criteria which are still being scoped in detail. We note that the Public Accounts Committee's 2 July report on Adult Social Care in England has highlighted many of these issues, as well as the implementation timescales, and we share their concern. A number of models have been developed to predict costs for implementing the Care Act, all forecasting some millions of pounds for Barking & Dagenham, where a savings programme for the next three years already runs into some tens of millions of pounds. Limited additional unring-fenced sums provided by Government to offset increased costs appear to be well short of the likely burden.
- 3.2 In addition, the Statutory Guidance comes out at the same time that we are assimilating the emerging guidance on the Better Care Fund, which appears to shift the emphasis away from protection of social care services towards the acute sector.

4. Other specific matters

- 4.1 **Digital take-up:** the Guidance is very strongly worded in its requirement that information should be provided in many forms, according to service user preference as well as need. Whilst, of course, we would always seek to ensure that reasonable adjustments are made, these sections of the Guidance seem incompatible with the Government's Digital Strategy. We would suggest that they be revisited in the light of this Strategy, bearing in mind Francis Maude's words when launching it:

"Until now government has been slow to realise the benefits of the digital age. In the future our services will be fit for the 21st Century – agile, flexible and digital by default." [GDS Press Release, 10/12/13]

- 4.2 **Wider workforce:** in some areas we would question whether the Statutory Guidance takes a wide-enough view of the workforce implications of the changes. Two particular areas are worthy of mention. Firstly, the advocacy changes appear to assume the existence of a more extensive workforce of trained advocates than are in fact in place, and these provisions may prove difficult to implement if there is not the training in place, and a suitable cohort of independent advocacy workers who can meet the new demand. Secondly, there are ramifications for the NHS in how social care will work differently which would appear to require a national programme of NHS skills development, on which we have yet to see any details.
- 4.3 **Public decision support tools:** whilst we understand that they are in development, we are yet to see details of the care cost calculator and similar tools for the public to use to understand the impact of the changes and their rights and

liabilities under the Act. Development of these, or release of some provisional algorithms, would appear to be a matter of urgency.

- 4.4 **Safeguarding:** we would suggest that the human rights emphasis of the safeguarding section of the Statutory Guidance needs to be revisited to ensure that local authorities' duties of care are also given due weight when considering whether to intervene with vulnerable people at risk, either through their own actions or the actions of others. Whilst we understand the rationale for the removal of Section 47 powers, it is our view that there needs to be appropriate enabling legislation to support professionals' intervention in these circumstances, and as currently phrased, the safeguarding provisions are not sufficiently specific on these points. In practice the local authority Adult Social Services is the lead in these situations, yet has no formal powers to intervene.

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15. Integration, cooperation and partnerships

This chapter provides guidance on:

- *Sections 3, 6, 7, 22, 23, 74 and Schedule 3 of the Care Act 2014;*
- *The Care and Support (Provision of Health Services) Regulations 2014;*
- *The Care and Support (Discharge of Hospital Patients) Regulations 2014.*

This chapter covers:

- integrating care and support with other local services;
 - Strategic planning;
 - Integrating service provision and combining and aligning processes;
- cooperation of partner organisations;
 - General duty to cooperate;
 - Who must cooperate;
 - Cooperation within local authorities;
 - Cooperating in specific cases;
- working with the NHS;
 - The boundary between the NHS and care and support;
 - Delayed transfers of care from hospitals;
- working with housing authorities and providers;
- working with welfare and employment support.

15.1. For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing. The vision is for integrated care and support that is person-centred, tailored to the needs

and preferences of those needing care and support, carers and families.

15.2. Sections 3, 6 and 7 of the Act require that:

- local authorities **must** carry out their care and support responsibilities with the aim of promoting greater **integration** with NHS and other health-related services;

- local authorities and their relevant partners **must cooperate generally** in performing their functions related to care and support; and, supplementary to this,
- local authorities and their partners **must cooperate** where this is needed in the case of **specific individuals** who have care and support needs.

Integrating care and support with other local services

15.3. Local authorities **must** carry out their care and support responsibilities with the aim of joining-up the services provided or other actions taken with those provided by the NHS and other health-related services (for example, housing or leisure services). This general requirement applies to all the local authority's care and support functions for adults with needs for care and support and carers, including in relation to preventing needs (see chapter 2), providing information and advice (see chapter 3) and shaping and facilitating the market of service providers (see chapter 4).

15.4. This duty applies where the local authority considers that the integration of services will:

- promote the wellbeing of adults with care and support needs or of carers in its area;
- contribute to the prevention or delay of the development of needs of people;
- improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

15.5. The local authority is not solely responsible for promoting integration with the NHS, and this responsibility reflects similar duties placed on NHS England and clinical commissioning groups (CCGs) to promote

integration with care and support.¹¹⁷ Under this provision, NHS England must encourage partnership arrangements between CCGs and local authorities where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities. Similarly, every CCG has a duty to exercise its functions with a view to securing that health services are provided in an integrated way, where this would improve the quality of health and/or reduce inequalities in access or outcomes. The Care Act adds further coherence by placing an equivalent duty on local authorities to integrate care and support provision with health services and health related services, for example housing (see paragraphs 15.7-15.8 below about the integration of health and health related services).

15.6. There are a number of ways in which local authorities can fulfil this duty, where they think this will integrate services: at the strategic level; at the level of individual service; and in combining and aligning processes. Some examples are discussed below.

Strategic planning

Integration with health and health-related services

15.7. A local authority **must** promote integration between care and support provision, health and health related services, with the aim of joining up services.

15.8. To ensure greater integration of services, a local authority should consider the different mechanisms through which it can promote integration, for example;

¹¹⁷ See sections 13N and 14Z1 of the National Health Service Act 2006

- (a) Planning – using adult care and support and public health data to understand the profile of the population and the needs of that population. For example, using information from the local Joint Strategic Needs Assessments to consider the wider need of that population in relation to housing. The needs of older and vulnerable residents should be reflected within local authorities' development plans with reference to local requirements for inclusive mainstream housing and specialist accommodation and/or housing services.

Case study: Promoting the integration of housing, health and social care across Leicestershire

District Councils in Leicestershire have taken a strategic approach to working with county wide providers on priority issues, including housing, health and wellbeing. A District Chief Executive leads across the 7 District Councils working with a network of senior managers in each individual council. This has built the influence and credibility of District Councils with health and social care leaders who now have an increasing understanding of the vital role housing and housing based services play in the delivery of better outcomes for vulnerable people.

The Housing Offer to Health in Leicestershire is built into the County's Better Care Fund priorities and work is underway across health, social care and housing in the following key areas:

- Housing's Hospital to Home discharge pathway – looking to place housing options expertise within the day-day discharge assessment and planning work of both acute and mental health providers so that the planning and decisions around an individual's hospital discharge includes early

consideration, and actioning of appropriate and supportive housing options.

- Establishing an integrated service to provide practical support to people in their own homes across all tenures so that aids, equipment, adaptations, handy person services and energy efficiency interventions are available and delivered quickly. Through this we hope to reduce the time taken to provide practical help to individual people with care and support needs, reduce process costs for services paid for through the public purse and support vulnerable people to access the low level practical support that helps them remain independently at home.
- Establishing a locality based approach to prevention and housing based support which includes Local Area Co-ordination, Timebanking and delivery of low level support services to vulnerable older people through a mixture of community volunteers and multi-skilled workers.

- (b) Commissioning – a local authority may wish to have housing represented at the Health and Wellbeing Board/Clinical Commissioning Groups (CCGs) making a visible and effective link between preventative spend (including housing related) and preventing acute/crisis interventions. Joint commissioning of an integrated information and advice service covering health, care and housing would be one way to achieve this.
- (c) Assessment and information and advice – this may include integrating an assessment with information and advice about housing, care and related finance to help develop a care plan (if

necessary), and understand housing choices reflecting the person's strengths and capabilities to help achieve their desired outcomes. There may be occasions where a housing staff member knows the person best, and with their agreement may be able to contribute to the assessment process or provide information.

- (d) Delivery or provision of care and support – that is integrated with an assessment of the home, including general upkeep or scope for aids and adaptations, community equipment or other modifications could reduce the risk to health, help maintain independence or support reablement or recovery. For example, some specialist housing associations and home improvement agencies may offer a support service which could form part of a jointly agreed support plan. A housing assessment should form part of any assessment process, in terms of suitability, access, safety, repair, heating and lighting (e.g. efficiency).

Joint Strategic Needs Assessments

15.9. Local authorities and clinical commissioning groups already have an equal and joint duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) through health and wellbeing boards. JSNAs are local assessments of current and future health and care needs that could be met by the local authority, CCGs or the NHS Commissioning Board, or other partners. JHWSs are shared strategies for meeting those needs, which set out the actions that each partner will take individually and collectively.

15.10. Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are therefore key means by which local authorities work with CCGs to identify and plan to meet the care and support needs of the local population. JHWSs can help health and care and support services to be joined up with each other and with health-related services.

15.11. Under the Act, local authorities, when contributing to JHWSs, must consider greater integration of services if doing so would achieve any or all of the objectives set in paragraph 15.4 above (promoting wellbeing; preventing or delaying needs; improving the quality of care). The JHWSs should set the local context and frame the discussion with partners on how different organisations can work together to align and integrate services. However, local authorities should bear in mind that carrying out the JSNA and JWHS on their own is unlikely to be sufficient to fulfil the requirement to promote integration; it will be the agreed actions which follow the strategies and plans that will have the greatest impact on integration and on the experience and outcomes of people.

Integrating service provision and combining and aligning processes

15.12. There are many ways in which local authorities can integrate care and support provision with that of health and related provision locally. Different areas are likely to find success in different models. Whilst some areas may pursue for integrated organisational structures, or shared funding arrangements, others may join up teams of frontline professionals to promote multi-disciplinary working. There is no required format or mechanism for integrating provision, and local authorities should consider and develop their strategy jointly with partners.

15.13. At the strategic level, there are many examples of how local authorities can integrate services including:

- the use of “pooled budgets”, which bring together funding from different organisations to invest jointly in delivering agreed, shared outcomes.¹¹⁸ For example, the Better Care Fund, which provides local authorities and CCGs with a shared fund to invest in agreed local priorities which support health and care and support, will be a key opportunity to promote integration in provision.¹¹⁹
- the development of joint commissioning arrangements.

15.14. In terms of working practices to encourage greater integration at an individual level, this could include recruiting and training individual care coordinators who are responsible for planning how to meet an adult’s needs through a number of service providers. Another example could be in relation to working with people who are being discharged from hospital, where staff from more than one body may be involved with providing or arranging care and support to allow the person to return home and live independently.¹²⁰ As with other examples of integration, this would not necessarily require structural integration – i.e. organisations merging – but a seamless service, from the point of view of the person, could be delivered by staff working together more effectively, for example, integrating an assessment with information and advice about housing options see paragraphs 15.54-15.75 on housing and integration.

¹¹⁸ <http://www.england.nhs.uk/wp-content/uploads/2012/10/lga-nhscb-concordat.pdf>

¹¹⁹ Link to BCF guidance: <http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

¹²⁰ Hospital 2 Home guide http://www.housinglin.org.uk/hospital2home_pack/

15.15. Local authorities, together with their partners, **should consider** combining or aligning key processes in the care and support journey, where there may be benefit to the individual concerned from linking more effectively. For example, combining assessments may allow for a clearer picture of the person’s needs holistically, and for a single point of contact with the person to promote consistency of experience, so that provision of different types of support can be aligned. A number of assessments could be carried out on the same person, for example a care and support needs assessment, health needs assessment and continuing health care assessments. Where it is not practicable for assessments to be conducted by the same professional, it may nonetheless be possible to align processes to support a better experience, for example, the 2nd or 3rd assessor could be obliged to read the 1st assessment (provided there is a lawful basis for sharing the information) and not ask any information that has already been collected, or the different bodies could work together to develop a single, compatible assessment tool. Local authorities have powers to carry out assessments jointly with other parties, or to delegate the function in its entirety.

Co-operation of partner organisations

15.16. All public organisations **should** work together and co-operate where needed, in order to ensure a focus on the needs of their local population. Whilst there are some local services where the local authority must actively promote integration, in other cases it must nonetheless co-operate with relevant local and national partners.

15.17. Co-operation between partners **should** be a general principle for all those concerned, and all should understand the

reasons why co-operation is important for those people involved. The Act sets out five aims of co-operation between partners which are relevant to care and support, although it should be noted that the purposes of co-operation are not limited to these matters:

- promoting the wellbeing of adults needing care and support and of carers;
- improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- smoothing the transition from children's to adults' services;
- protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
- identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

15.18. The processes and systems behind the areas noted above, as well as how working with partners is integral to achieving the best outcomes, are set out in more detail in other chapters of this guidance.

15.19. Local Authorities and relevant partners **must** co-operate when exercising any respective functions which are relevant to care and support. This requirement relates to organisations existing functions only, and the Act does not confer new functions.

15.20. “Co-operation”, like integration, can be achieved through a number of means, and is intended to require the adoption of a common principle, rather than to prescribe any specific tasks. There are a number of powers which local authorities may use to promote joint working. For example, local authorities may share information with other partners, or provide staff, services or other resources to partners to improve

co-operation. Some of the actions may be the same as those undertaken to promote integration, for example under section 75 of the NHS Act 2006, a local authority may contribute to a “pooled budget” with an NHS body – a shared fund out of which payments can be made to meet agreed priorities. Other actions may be specific to particular circumstances or the needs of a specific group, for example the local authority co-operating with prisons in its area to develop a joint strategy for meeting the care and support needs of prisoners.

Who must co-operate?

15.21. The local authority **must** co-operate with each of its relevant partners, and the partners **must** also co-operate with the local authority, in relation to relevant functions. The Act specifies the “relevant partners” who have a reciprocal responsibility to co-operate. These are:

- other local authorities within the area (i.e. in multi-tier authority areas, this will be a district council);
- any other local authority which would be appropriate to co-operate with in a particular set of circumstances (for example, another authority which is arranging care for a person in the home area);
- NHS bodies in the authority's area (including the CCG, any hospital trusts and NHS England, where it commissions health care locally) [see paragraphs 15.29-15.53 about care and support and the NHS];
- local offices of the Department for Work and Pensions (such as Job Centre Plus) [see paragraphs 14.75-14.81 about care and support, welfare and employment];
- police services in the local authority area;

- prisons and probation services in the local area [see chapter 17 on care and support in Prisons].

15.22. In addition, there may be other persons or bodies with whom a local authority **should** co-operate if it considers this appropriate when exercising care and support functions, in particular independent or private sector organisations. Examples include, but are not limited to, care and support providers, NHS primary health providers, independent hospitals and private registered providers of social housing. In these cases, the local authority should consider what degree of co-operation is required, and what mechanisms it may have in place to ensure mutual co-operation (for example, via contractual means).

Ensuring co-operation within local authorities

15.23. Local authorities fulfil a range of different functions that have an impact on the health and wellbeing of individuals, in addition to their care and support responsibilities (e.g. children's services, housing, public health). It is therefore important that, in addition to ensuring co-operation between the local authority and its external partners, there is internal co-operation between the different local authority officers and professionals who provide these services. Local authorities **must** make arrangements to ensure co-operation between its officers responsible for adult care and support, housing, public health and children's services, and should also consider how such arrangements may also be applied to other relevant local authority responsibilities, such as education, planning and transport.

15.24. For example, it is important that local authority officers responsible for housing

work in co-operation with adult care and support, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay deterioration. Similarly, the transition from children's social care to adult care and support will require local authority officers in the respective departments to co-operate to share information, prepare for transition, and ensure the young person's needs are met.

Co-operating with partners in specific cases

15.25. Co-operation should be a general principle for partners, which should inform how they undertake their day-to-day activities. However, there will be circumstances where a more specific approach will be required, and a local authority or partner will need to explicitly ask for co-operation which goes beyond the general approach, where this is needed in the case of an individual. The Care Act provides a new mechanism for the local authority, or partner, to use in such cases.

15.26. Where the local authority requires the co-operation of a partner in relation to a particular individual case, the Act allows for the local authority to request co-operation from that partner. The relevant partner **must** co-operate as requested, unless doing so would be incompatible with the partner's own functions or duties. The converse also applies: where a relevant partner asks for co-operation from a local authority in the case of an individual, then the local authority **must** co-operate, again providing this is compatible with its functions and duties.

15.27. This mechanism is intended to support partners with a means of identifying specific cases in which more targeted co-operation is required. In practice, it may be the case that general working protocols and

relationships between organisations mean that this further process is not required. However, there will be situations that arise which necessitate a more tailored response to fit around the person concerned. This might include, for example:

- when a person is planning to move from one area to another, and the authorities involved require co-operation to support that move;
- when an assessment of care and support needs identified other needs that should be assessed (for instance, health needs that may indicate eligibility for NHS Continuing Healthcare);
- when a local authority is carrying out a safeguarding enquiry or review, and requires the support of another organisation.

15.28. Where the local authority or relevant partner decide to use this mechanism, they should notify the other in writing, making clear the relevant Care Act provisions. If the local authority or the relevant partner decide not to co-operate with a request, then they **must** write to the other, setting out reasons for not doing so. Local authorities and their relevant partners **must** respond to requests to cooperate under their general public law duties to act reasonably, and failure to respond within a reasonable time frame could be subject to judicial review.

Working with the NHS

The boundary between care and support and the NHS

15.29. Local authorities **must** carry out an assessment where someone appears to have needs for care and support. It has a duty to meet those needs for care and support that

meet the eligibility criteria. Similarly, in the case of carers, the local authority must carry out an assessment if a carer appears to have, or is likely to have, needs for support and it has a duty to meet those needs for support that meet the eligibility criteria. However, local authorities cannot lawfully meet needs in either case by providing or arranging services that are clearly the responsibility of the NHS.

15.30. In order to support joint working, it is important that all partners involved are clear about their own responsibilities, and how they fit together. Section 22 of the Care Act sets out the limits on what a local authority may provide by way of healthcare and so, in effect, sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care.

15.31. Where the NHS has a clear legal responsibility to provide a particular service, then the local authority may not do so. This general rule is intended to provide clarity and avoid overlaps, and to maintain the existing legal boundary. However, there is an exception to this general rule, in that the local authority may provide some limited healthcare services as part of a package of care and support, but only where the services provided are “incidental or ancillary” (that is, relatively minor, and part of a broader package), and where the services are the type of support that an authority could be expected to provide.

15.32. The two most obvious relevant examples of healthcare that are clearly the responsibility of the NHS (and thus not something a local authority may provide) are nursing care provided by registered nurses, and services that the NHS has to provide because the individual is eligible for NHS Continuing Healthcare.

15.33. NHS Continuing Healthcare is a package of ongoing care that is arranged

and funded solely by the health service for individuals outside a hospital setting who have complex ongoing healthcare needs, and who have been found to have a ‘primary health need’. Such care is provided to people aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. NHS Continuing Healthcare is not dependent on a person’s condition or diagnosis, but is based on their specific care needs.

15.34. Where the person has a ‘primary health need’ as set out in regulations¹²¹ and as determined following an assessment of need under national guidance (the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*¹²² (‘the National Framework’), it is the responsibility of the health service to meet all assessed health and associated care and support needs, including suitable accommodation, if that is part of the overall need.

15.35. The National Framework sets out a process for the NHS, working together with its local authority partners wherever practicable, to assess health needs, decide on eligibility for NHS Continuing Healthcare, and provide that assessed care. ‘NHS-funded Nursing Care’, is the funding provided by the NHS to care homes providing nursing, to support the provision of nursing care by

a registered nurse. If an individual does not qualify for NHS Continuing Healthcare, the need for care from a registered nurse must be determined. If the person has such a need and it is determined that their overall needs would be most appropriately met in a care home providing nursing care, then this would lead to eligibility for NHS-funded Nursing Care. Once the need for such care is agreed, a CCGs (or in some case NHS England) must pay a flat-rate contribution to the care home towards registered nursing care costs.

15.36. The regulations and guidance referred to above, set out how the ‘primary health need’ test takes account of the limits of local authority responsibility. Although the regulations and guidance pre-date the coming into force of the Care Act 2014, the limits of local authority responsibility have not been changed by the Care Act 2014.

Supporting discharge of hospital patients with care and support needs

15.37. The provisions on the discharge of hospital patients with care and support needs are contained in Schedule 3 to the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 (‘the Regulations’). These provisions aim to ensure that the NHS and local authorities work together effectively and efficiently to plan the safe and timely discharge of NHS hospital patients from NHS acute medical care facilities to local authority care and support. The purpose of these provisions is to update existing provisions to reflect the current NHS and care and support landscape; in particular, the drive to improve integration between health and social care provision for those people whose needs span both areas.

¹²¹ See regulations under the National Health Service Act 2006 and the Health and Social Care Act 2012 (see Part 6 of *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*, as amended by *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013*) (‘the Standing Rules’),

¹²² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

15.38. Schedule 3 to the Care Act covers:

- the scope of the hospital discharge regime and the definition of the patients to whom it applies;
- the notifications which an NHS body must give a local authority where the NHS considers that it is not likely to be safe to discharge the patient unless arrangements for meeting the patient's needs for care and support are in place;
- the period for which an NHS body can consider seeking reimbursement from a local authority, where that local authority has not fulfilled its requirements to assess or put in place care and support to meet needs, or (where applicable) to meet carer's needs for support, within the time periods set such that the patient's discharge from hospital is delayed.

15.39. The Regulations and guidance both set out further details of the form and content of what the various types of NHS notification notices must and should contain to ensure the local authority has relevant information to comply with its requirements to undertake assessments, and to put in place any arrangements necessary for meeting any of the patient's care and support needs, or where applicable, carer's needs for support. They set out the circumstances when assessment notices and discharge notices must be withdrawn, and determine the period and amount of any reimbursement liability which a local authority may be required to pay the NHS for any delay in the transfer of care.

Definitions of delayed transfers of care

15.40. Delayed Transfers of Care (DTC) mean that individuals are in a setting that is

recognised as not being appropriate for the care they need. This potentially contributes to worse outcomes for the individual, particularly in the context of their quality of life, as well as placing additional and sometimes costly burdens on the NHS and local government.

15.41. The definition of a DTC is when a patient is ready for transfer after being in receipt of acute care, when:

- A clinical decision has been made that a patient is ready for transfer; **AND**
- A multi-disciplinary team decision (involving the NHS body and the local authority) has been made that a patient is ready for transfer; **AND**
- The patient is safe to discharge/transfer; **YET**
- The patient is still occupying a bed.

15.42. NHS and local authorities **should** work together in order to reduce the number of delayed days where a patient is ready to be transferred from NHS acute medical care to other settings but where arrangements for care and support needs are not in place in order to ensure a safe discharge from hospital. The NHS **may** seek reimbursement from local authorities for a delayed transfer of care in certain circumstances. The potential for reimbursement liability is intended to act as an incentive to improve joint working between the NHS and local government. However, the use of these reimbursements is discretionary.

15.43. The potential for NHS seeking reimbursement from local authorities is not to be seen to operate in isolation, but to be considered as part of the bigger picture in terms of promoting joint working between the NHS and local government. For example, the Better Care Fund, which aims through the establishment of £3.8 billion of joint funding between the NHS and local authorities to

promote joint working, includes performance on delayed discharge as one of the national indicators against which progress will be assessed and resources released. This, with the significant resources available will therefore be a powerful driver to improving performance on delayed discharge.

15.44. Also, even if a particular case falls outside the scope of the provisions so that no reimbursement could be sought, this **should not** prevent the NHS and local authority still working together to plan the safe and timely discharge of all its patients. Both the NHS and local authorities are under a common law duty of care to people with care and support needs, and the good practice guidance on safe discharge planning and duties to co-operate and promote integration will apply.

15.45. As around 70% of delayed discharge days are attributable to the NHS and because the issues behind them are within their gift to address, it is important that NHS organisations in particular review this guidance alongside other guidance such as the updated April 2013 SitRep Guidance,¹²³ which provides clear advice on the steps the NHS needs to take in relation to undertaking NHS Continuing Health Care and the way that data should be collected and reported, irrespective of whether delays are reimbursable days or not.

To whom do the delayed transfers of care provisions apply

15.46. The delayed transfers of care regime only applies to NHS hospital patients in England who are receiving acute care, and who the NHS considers are likely to have

care and support needs after discharge from hospital.

15.47. No notification notices can be issued, and accordingly no reimbursement liability could arise, in respect of any patient who falls outside scope of the regime. However, notwithstanding that a patient's case falls outside the reimbursement regime, this does not mean that the NHS and local authorities should not be working together to deliver the safe and timely discharges of all hospital patients with care and support needs for the reasons set out at paragraph 15.42 above.

15.48. NHS Hospital Patient in England: A hospital patient is a person who is ordinarily resident in England who is accommodated in an NHS hospital in England, or in an independent hospital in the United Kingdom under arrangements made by an English NHS body.

15.49. Adult Care and Support Needs: In terms of age, the discharge of hospital patient provisions do not apply in respect of patients who will be under the age of 18 at the proposed date of discharge, as they will have their relevant care and support needs met by children's social services provided under other provisions (e.g. the Children's Act 1989).

15.50. Acute Care: The provisions only apply to patients who are receiving, have received or can reasonably be expected to receive, acute care. Acute care means intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period after which the person receiving the treatment no longer benefits from it.

¹²³ *Monthly Delayed Transfers of Care Sitreps Definitions and Guidance Version 1.07*, www.england.nhs.uk/.../Monthly-Sitreps-Definitions-DTOC-v1.07.doc,

NHS hospital patients to whom the provisions do not apply

15.51. The following cases are excluded from the discharge provisions in the Care Act:

- (a) **Mental health care** – Mental health care means psychiatric services, or other services provided for the purpose of preventing, diagnosing or treating illness, the arrangements for which are the primary responsibility of a consultant psychiatrist. However, if the patient is receiving treatment in an acute setting for a physical condition and is under the care of an acute medical consultant but has post-care needs that relate, for example, to their dementia, the case could fall within the scope of the discharge of hospital patient provisions. If a person is admitted with a physical condition but during their stay is subsequently transferred to the care of a consultant psychiatrist, then delays to that person's discharge would not count towards any potential reimbursement. However delayed discharges for patients under the care of a consultant psychiatrist should be recorded as is expected under the DTOC Sitrep reporting requirements and the duties to co-operate in improving discharge arrangements clearly apply.
- (b) **Palliative care** – Patients with palliative care needs are excluded.
- (c) **Private patients** – As the regime only applies to NHS patients, the Discharge of Hospital provisions do not apply to patients who have given an undertaking to pay for their care in an NHS hospital or who are accommodated at an independent hospital under private arrangements. However, patients who are admitted to NHS hospitals as private patients but who subsequently elect to change their status and become NHS

patients while still receiving acute medical treatment fall within the scope of the Act from the point at which they start to be treated as NHS patients.

- (d) **Other** – In addition, maternity care, intermediate care (this is where patients, their families and carers are provided with support to help them manage illness and avoid becoming dependent on long-term care), and care provided for recuperation or rehabilitation are excluded from the definition of acute care.

Patients in independent hospitals receiving NHS-commissioned acute care

15.52. NHS patients can receive acute treatment which is arranged and funded by an NHS body, but which takes place in an independent sector hospital. As they are NHS patients, they are covered by the Discharge of Hospital Patient provisions and as such the requirements to plan and provide services in order to facilitate a safe discharge **must** be implemented.

15.53. As such, the duty to issue notices will apply in respect of these cases, as may the potential for the NHS to seek reimbursement from the local authority for any delayed transfers of care. The Act allows an NHS body which has commissioned acute treatment at an independent hospital within the UK to make arrangements for the independent provider to issue assessment or discharge notifications on its behalf. This means that independent providers can take decisions such as whether the patient is likely to need care and support services, when the patient is to be discharged, what follow-up health needs they may have, etc. However, the NHS body will retain ultimate responsibility for the functions, including

any claim for reimbursement that might be appropriate.

Working with housing authorities and providers

15.54. Housing or suitable living accommodation is a place which is safe, healthy and suitable for the needs of a person, so as to contribute to promoting physical and emotional health and wellbeing and social connections. For example, a healthy home would be dry, warm and insulated and a safe home would meet particular needs, e.g. of an older person. Housing refers to the home and the neighbourhood where people live, and to the wider housing sector including staff and services around these homes.

15.55. Suitable living accommodation includes all places where people live; for example a house, flat, other general dwelling or an adult placement or other specialist housing.

15.56. Housing and the provision of suitable accommodation is an integral element of care and support. The setting in which a person lives, and its suitability to their specific needs, has a major impact on the extent to which their needs can be met, or prevented, over time. Housing is therefore a crucial component of care and support, as well as a key health-related service.

15.57. Local authorities have broad powers to provide different types of accommodation in order to meet people's needs for care and support. The Care Act is clear that suitable accommodation can be one way of meeting needs. However, the Act is also clear on the limits of responsibilities and relationship between care and support and housing legislation, to ensure that there is no overlap or confusion. Section 23 of the Care Act

clarifies the existing boundary in law between care and support and general housing. Where housing legislation requires housing services to be provided, then a local authority must provide those services under that housing legislation. Where housing forms part of a person's need for care and support and is not required to be provided under housing legislation, then a local authority may provide those types of support as part of the care and support package under this Act.

15.58. This provision is to clarify the boundary in law between a local authority's care and support function and its housing function. It does not prevent joint working, and it does not prevent local authorities in the care and support role from providing more specific services such as housing adaptations, or from working jointly with housing authorities.

15.59. Housing plays a critical role in enabling people to live independently and in helping carers to support others more effectively. Poor or inappropriate housing can put the health and wellbeing of people at risk, where as a suitable home can reduce the needs for care and support and contribute to preventing or delaying the development of such needs. Housing services should be used to help promote an individual's wellbeing, by providing a safe and secure place in which people in need of care and support and carers can build a full and active life. That is why suitability of living accommodation is one of the matters local authorities must take into account as part of their duty to promote an individual's wellbeing.

15.60. Housing is an integral part of the health and care system and a local authority's responsibility for care and support. This could be in relation to a local authority's duty on prevention (see chapter 2) or through the duty to assess an adult or carer's needs for care

and support (see chapter 6), or in providing advice and information (see chapter 3).

15.61. Enabling individuals to recognise their own skills, ambitions and priorities and developing personal and community connections in relation to housing needs can help promote an individual's wellbeing. By way of example, providing good quality information and advice can help people make early choices about housing options and avoid leaving these until they are in crisis or decisions have to be taken by relatives or carers. Adaptations, modifications or extra support can help people stay independent for longer.

15.62. Health, care and support and housing services **should** centre on the individual and where appropriate their family and should support them in meeting the outcomes they want to achieve. By putting individuals and families at the centre and helping them to articulate the outcomes they want to achieve a local authority may be able to provide some support in or through the home.

Considering accommodation within the wellbeing principle

15.63. Local authorities have a general duty to promote an individual's wellbeing when carrying out their care and support functions. The Act is clear that one specific component of wellbeing is the suitability of living accommodation. Wherever relevant, a local authority **should** consider suitable living accommodation in looking at a person's needs and desired outcomes.

15.64. Housing has a vital role to play in other areas relating to a person's wellbeing. For example access to a safe settled home underpins personal dignity. A safe suitable home can contribute to physical and mental

wellbeing and can provide protection. A home or suitable living accommodation can enable participation in work or education, social interactions and family relationships.

15.65. In relation to housing, a local authority can make an important contribution to an individual's wellbeing, for example by providing and signposting information that allows people to address care and support needs through specific housing related support services, or through joint planning and commissioning that enables local authorities to provide (or arrange for the provision of) housing and care services or housing adaptations to meet the needs of the local population.

Housing to support prevention of needs

15.66. In many cases, the best way to promote someone's wellbeing will be through preventative measures that allow people to live as independently as possible for as long as possible.

15.67. A local authority **must** provide or arrange for the provision of services that contribute towards preventing, reducing or delaying the needs for care and support (see chapter 2). The provision of suitable living accommodation can be a way to prevent needs for care and support, or to delay deterioration over time. Getting housing right and helping people to choose the right housing options for them can help to prevent falls, prevent hospital admissions and readmissions, reduce the need for care and support, improve wellbeing, and help maintain independence at home.

15.68. Housing and housing services can play a significant part in prevention, for example, from a design/physical perspective, accessibility, having adequate heating and

lighting, identifying and removing hazards or by identifying a person who needs to be on the housing register. In addition, community equipment, along with telecare, aids and adaptations can support reablement, promote independence contributing to preventing the needs for care and support.

15.69. A local authority may wish to draw on the assistance of the housing authority and local housing services. Housing-related support staff and scheme managers can contribute to prevention, for example by being alert to early signs of ill health, e.g. dementia, and signposting or supporting individuals to access community resources which may prevent, reduce or delay the need for care and support or a move into residential care.

15.70. The links between living in cold and damp homes and poor health and wellbeing are well-evidenced.¹²⁴ Local authorities may wish to consider the opportunities to prevent the escalation of health and care and support needs through the delivery or facilitation of affordable warmth measures to help achieve health and wellbeing outcomes.^{125,126}

Integrating information and advice on housing

15.71. A local authority **must** establish and maintain a service for providing information

and advice relating to care and support, and this **must** include advice on relevant housing and housing services which meet care and support needs. The authority is not required to provide all elements of this service, rather, they are expected under this duty to understand, co-ordinate and make effective use of other statutory, voluntary and or private sector information and advice resources within their area in order to deliver more integrated information and advice.

15.72. A person-centred approach to information and advice will consider the person's strengths and capabilities and the information or advice that will help them to achieve their ambitions. Information and advice **should** include services in the home that bring health, care and housing services together. This means that information and advice on housing, on adaptations to the current home, or alternative housing options services should be included. This will enable a person to choose how best they can meet or prevent their needs for care and support. (See chapter 3 on information and advice).

15.73. A person using care and support or carer **should** be supported to make fully informed decisions about how to prevent or meet their needs for care and support. A local authority **should** make use of information and advice that is already available at local and national levels. Examples of some national resources are;

www.firststopcareadvice.org.uk
www.moneyadvice.service.org.uk
www.nhs.uk/CarersDirect/Pages/CarersDirectHome.aspx
wwwFOUNDATIONS.uk.com

15.74. People's care and support needs, their housing circumstances and financial resources are closely interconnected. It is only with full knowledge of the care and

¹²⁴ (<http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty>, www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhrs-guidance).

¹²⁵ The Energy Companies Obligation: <https://www.gov.uk/government/policies/helping-households-to-cut-their-energy-bills/supporting-pages/energy-companies-obligation-eco>

¹²⁶ Energy Saving Advice Service: <http://www.energysavingtrust.org.uk/Organisations/Government-and-local-programmes/Programmes-we-deliver/Energy-Saving-Advice-Service>

Case Study: Putting health back into housing

The Gloucestershire Affordable Housing Landlords' Forum (GAHLF), comprising of the seven leading local housing providers in the county, have set out an 'offer' to the Health and Wellbeing Board that demonstrates how each is working to improve the quality of life of their residents, the neighbourhoods and wider communities, by investing in new homes, supporting independent living, developing the community and supporting older and vulnerable people.

£12 million is being invested, by Stroud District Council, over five years, to improve the quality of housing stock and reduce fuel poverty for tenants. Stroud has been upgrading the heating supply in properties not currently served by mains gas. Many properties have electric storage heating which does not give the same level of control and is more expensive than gas or renewable energy. Dryleaze Court is a Supported Housing unit where 53 properties have had mains gas installed this year. At the same time, the team has also installed uPVC privacy panels, replaced porches with insulated cavity brick walls and fitted new double-glazed windows. The works have improved tenants' quality of life, helping them to live more comfortably and reduce their fuel bills.

All in all, over the three years ending March 2013, GAHLF has improved over 14,900 homes, with an estimated savings to the NHS of around £1.4 million per annum.

http://www.housinglin.org.uk/_library/Resources/Housing/Regions/South_West/GAHLF_Health_and_Wellbeing_V.II1.pdf

support options open to them, including possible housing options and the related financial implications that people will be able to exercise informed choice. For example, some people with their families have made early decisions about moving into residential care possibly sooner than is necessary. Information and advice about the full range of accommodation/housing options and how these might be funded can contribute to more informed decision making for individuals and can extend independent living.

Link to further Case Study - Commissioning Advice Services in Portsmouth

<http://www.adviceuk.org.uk/wp-content/uploads/2013/06/Breaking-the-Mould-Portsmouth.pdf>

Working with employment and welfare services

15.75. Local authorities and local offices of the Department for Work and Pensions (i.e. the JobCentre Plus) **must** co-operate when exercising functions which are relevant to care and support. "Co-operation" and integration can be achieved in a number of ways and will depend on local circumstances as outlined above. When considering opportunities for fuller integration of commissioning, planning and delivery of local services local authorities **should** consider the links between care and support, employment and welfare (see chapter 4 on market shaping and commissioning).

15.76. In particular, when working to promote a diverse market under section 5, local authorities **must** consider the importance of enabling people to undertake work, education and training. Local authorities **should** also recognise the importance of identifying the needs of those

carers in their local population when drawing up Joint Strategic Needs Assessments, including their need to participate in paid employment alongside caring responsibilities.

15.77. The Disability and Health Employment Strategy¹²⁷ identified that many disabled people and people with health conditions, particularly those with more **complex needs**, receive a range of different services at local level, for example, care and support, primary and secondary health services, as well as support offered by Jobcentre Plus and contracted providers. It highlighted feedback from stakeholders that the support on offer at a local level to disabled people and people with health conditions can be confusing and inconsistent and often results in them having to give the same information to different services.

15.78. Local authorities **must** establish and maintain an information and advice service, but they are not required to provide all elements of this service. Rather, local authorities are expected to understand, co-ordinate and make effective use of other statutory, voluntary and/or private sector information and advice resources available to people within their areas. The information and advice available to the local population should include information and advice on eligibility and applying for disability benefits and other types of benefits and, on the availability of employment support for disabled adults.

15.79. Different people will need different levels of support from the local authority and other providers of financial information and advice depending on their capability, their care needs and their financial circumstances. People may just need some basic information and support to help them rebalance their finances in light of their

changing circumstances. Topics may include welfare benefits, advice on good money management, help with basic budgeting and possibly on debt management. The local authority may be able to provide some of this information itself, for example of welfare benefits, but where it cannot, it should work with partner organisations to help people access it.

15.80. Local authorities, working with their partners, **must** also use the wider opportunities to provide targeted information and advice at key points in people's contact with the care and support, health and other local services. This **should** include application for disability benefits such as Attendance Allowance and Personal Independence Payments, and for Carers Allowance and access to work interviews.

Considering individual employment, training and education needs

15.81. In addition to considering how to join up care and support at a local level local authorities **must** consider education, training and employment when working with individuals. In particular:

- local authorities **must** promote wellbeing when carrying out care and support functions, or making a decision in relation to a person. This applies equally to people with care and support needs and their carers. In some specific circumstances, it also applies to children, their carers and to young carers (when they are subject to the transition assessments discussed in chapter 16). The definition of wellbeing includes participation in work education and training. As such local authorities **must** consider whether participation in work, education or training is a relevant

¹²⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

consideration when they are promoting wellbeing.

- local authorities, when carrying out a needs assessment, carer's assessment or child's carer's assessment **must** have regard to whether the carer works or wishes to do so, and whether the carer is participating in or wishes to participate in education, training or recreation and this should be reflected, as appropriate in the way their needs are met. Local authorities and the Department for Work and Pensions should cooperate to ensure people are given appropriate employment support and opportunities – in particular where this is a person's preferred outcome. This should include consideration of how direct payments may be used for employment support.¹²⁸
- sections 37 and 38 of the Act support people to move, including to pursue employment opportunities or move closer to family members. Local authorities **must** ensure continuity of care and support when people move between areas so that they can move without the fear that they will be left without the care and support they need (see chapter 20).

Sources of information

15.82. The integration clauses mirrors similar duties placed on Clinical Commissioning Groups and NHS England. There are a number of relevant documents that local authorities may find of interest:

- The Functions of Clinical Commissioning Groups, NHS England March 2013

<http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf>

- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, Department of Health, April 2012. See part 4: Promoting integration between services. http://www.wakefield.gov.uk/NR/rdonlyres/37D0E9D1-C438-4388-B270-A527139D9F37/0/StatutoryGuidanceonJSNAsandJHWSs_DH2013.pdf
- National Voices, a national coalition of health and social care charities, have produced a narrative for person-centred co-ordinated care and support, showing what this would look like from the perspective of people with care and support needs: <http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf>

The following links provide further sources of information in relation to housing service and practical examples which support integration with care and support on a local level:

- <http://www.housinglin.org.uk/Topics/browse/Housing/hwb/?parent=3691&child=8169>
- http://www.cih.org/publication-free/display/vpathDCR/templatedata/cih/publication-free/data/Developing_your_local_housing_offer_for_health_and_care
- <https://www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhsrc-guidance>
- http://www.housinglin.org.uk/hospital2home_pack/

¹²⁸ An example of personal budgets being used as a way to support and enterprise and employment can be found at: <http://www.serendipity-chic.co.uk/>

HEALTH AND WELLBEING BOARD

29 JULY 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 extent 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 Health 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

29 JULY 2014

Title:	Impact of Recession Scrutiny (Action Plan)		
Report of the Mental Health Sub-Group			
Open Report	For Decision		
Wards Affected: All	Key Decision: No		
Report Author: Gillian Mills, Integrated Care Director, NELFT	Contact Details: Tel: 0300 555 1201 ext 65053 E-mail: Gillian.mills@nelft.nhs.uk		
Sponsor: Jacqui Van Rossum, Executive Director			
Summary: The Health and Wellbeing Board received the findings of the Health and Adult Services Select Committee's scrutiny review on the 'Potential Impact of the Recession and Welfare Reforms on Mental Health' at its meeting on 25 March 2014. The Executive Summary and recommendations are included at Appendix 1 to inform the discussion at the meeting. Board Members who wish to read the full report of the Select Committee can access it from this link: http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Documents/HASSC%20Final%20Review%20Report%20050214.pdf In response to the review evidence findings the Board tasked the Mental Health Sub Group to produce a plan aimed to meet the seven recommendations for further exploration and action. The summarised recommendations are:			
<ul style="list-style-type: none"> • Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety • Recovery and resilience can be supported/built up through training and volunteering opportunities • Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge • The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants • The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need 			

- Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored
- The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate

The attached action plan sets out what the Mental Health Sub Group members will undertake to lead on implementing within their respective agencies and groups.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- (i) Note and discuss the implementation action plan (Appendix 2) from the Mental Health Sub Group
- (ii) Agree that an update on progress achieved is scheduled for six months thereafter

1. Background and Introduction

- 1.1. The Health and Adult Services Select Committee (HASSC) chose to conduct a scrutiny review on the impact of the recession and welfare reforms on mental health and wellbeing as their scrutiny topic for 2013/14. The review began in June 2013 and the final information gathering session was held in November 2013.
- 1.2. The review sought to answer three key questions:
 - How are economic austerity and the Welfare Reforms impacting on our citizens?
 - Will the austerity measures, reduction in income levels and increases in poverty lead to more mental ill health?
 - What can we do, or what are we currently doing, to mitigate the likely impact?
- 1.3. Over the course of the review, the Select Committee met for formal meetings on four occasions, attended two site visits and hosted a World Mental Health Day event with local residents. Through the evidence gathering the HASSC received information from a wide range of sources.
- 1.4. Following the evidence gathering, HASSC arrived at four broad conclusions:
 - Welfare reforms are a source of anxiety (especially to those with pre-existing mental health issues).
 - Financial hardship is putting strain on residents and is the cause of emotional distress.
 - There is increased demand for voluntary sector services.
 - There is increased demand for health service interventions.

- 1.5. In response to the evidence and findings the HASSC made 7 recommendations which are summarised as follows:
- Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety.
 - Recovery and resilience can be supported/built up through training and volunteering opportunities.
 - Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge.
 - The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants.
 - The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need.
 - Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored.
 - The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate

1.6. The review final report has been shared with stakeholders who participated in the review, the Mayor of London's Office, London Councils, the Centre for Public Scrutiny and LBBD's Strategic Welfare Reform Group.

1.7. Implementation Action Plan and Governance

1.8. The development of the Implementation Action Plan (Appendix 2) has been overseen by the Mental Health Sub Group members.

1.9. The implementation of the plan is intended to positively impact on the wider health and care systems and services to assist performance and quality improvements aimed at minimising the negative impact that current welfare reforms and austerity measures are having on the people experiencing mental health issues.

1.10. Under the Council's agreed scrutiny processes the Health and Wellbeing Board has responsibility for the implementation of the recommendations and action plan.

1.11. The action plan will be monitored at six-monthly intervals by the Board (for quality assurance purposes) and the HASSC (for measuring progress)

2. Mandatory Implications

2.1. Joint Strategic Needs Assessment

The JSNA has a strong mental health section that describes the need to addressing the social determinants of mental health and addressing inequalities – for example, having access to, having and keeping a good job, a decent home, a

good education, good health, a decent income and close relationships. The Annual Report of the Director of Public Health 2013 focuses on mental health and wellbeing recommending building on current work to:

- Improve access to and improve the quality of care and treatment
- Build community awareness and public understanding
- Intervene early and take action to prevent mental health problems
- Promote good mental health and resilience

2.2. Health and Wellbeing Strategy

Championing the public health agenda within the mental health arena is one of the cornerstones of our strategy. We view the causes of our major health challenges with a mental health lens – from obesity to drug and alcohol misuse to smoking. Without a focus on how people think, feel, behave and relate (their mental wellbeing), we will not make the progress we need to.

2.3. Integration

The implications for integration are highlighted in this report and the accompanying Action Plan. The Action Plan is a multi-agency plan and the actions will be taken forward by the constituent organisations of the Health and Wellbeing Board as stated in Appendix 2. The Mental Health Sub Group will be leading on ensuring that the Action Plan is delivered on behalf of the Board.

2.4. Financial Implications

There are no financial implications directly arising from this report. However, there are a number of actions in the Action Plan where a further report may be needed to set out the potential costs and how these are to be funded, unless these are from within existing budgets from which savings will be sought. For example, action 5A is to consider enhancing the floating support services that help residents maintain tenancies and avoid homelessness, and to develop fully costed proposals if required.

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

2.5. Legal Implications

As this report is for noting, there are no direct legal implications relating to the report itself or in the action plan.

Implications completed by: Chris Pickering – Principal Solicitor (LBBD)

3. Background Papers Used in Preparation of the Report:

- Final HASSC Review Report

4. List of Appendices:

- Appendix 1 – Executive Summary and Recommendations of the Scrutiny Review on the Potential Impact of the Recession and Welfare Reforms on Mental Health

— Appendix 2 – Scrutiny Review Action Plan

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Review on the Potential Impact of the Recession and Welfare Reforms on Mental Health

Health and Adult Services Select Committee

Final Report of the HASSC as agreed
on 5th February 2013

Executive Summary

The scrutiny process for the review took place between June 2013 and November 2013, with Members drawing information from a wide range of sources to gain an in-depth understanding of how mental health, voluntary and statutory services work to support local residents who are impacted by the recession and welfare reforms.

The Council has historically found that the tipping point that has led families, vulnerable adults and older people to need input from Council-funded social care services is often the result of a number of factors and life events that combine to reduce people's overall resilience. It was therefore hypothesised that the impact of the recession and welfare reforms may lead to a similar reduction in resilience, resulting in negative emotional and mental wellbeing being exhibited.

It was decided that the review would seek to answer the following three key questions:

1. How is economic austerity and the Welfare Reforms impacting on our citizens?
2. Will the austerity measures, reduction in income levels and/or poverty lead to more mental ill health?
3. What can we do/are we doing to mitigate the likely impact?

The following key findings were found as a result of the review. The findings should be read in conjunction with the recommendations on the following page which have been put forward for further exploration and action by the Select Committee as a result of their investigations.

How is economic austerity and the Welfare Reforms impacting on our citizens?

As the reforms are yet to be fully implemented the likely impact remains difficult to assess at this point in time and would benefit from further analysis in the future to fully determine the scale of impact. However from undertaking this review there is sufficient evidence to support that increased numbers are experiencing homelessness and presenting to the Council for support with Housing need. In addition large numbers are experiencing debt through rent and council tax arrears. Overall numbers of residents experiencing financial hardship continue to increase with a high number of applications for funds to cover basic needs such as food, electricity and gas.

There is also evidence to support that levels of mental health needs in the Borough are increasing. The review has found that increased numbers of people have been presenting with mental health needs since 2008 in GP practices. However it must be noted that causal factors are difficult to evidence.

The evidence collated within this review would reflect that early indications show that residents are experiencing financial hardship and many are also experiencing increased levels of anxiety and or depression with increased numbers presenting to GPs and other health colleagues.

Will the austerity measures, reduction in income levels and/or poverty lead to more mental ill health?

From the findings presented within the report it would suggest that potentially residents who have been directly impacted by the reforms are experiencing financial hardship due to the cuts and are therefore more likely to experience some level of anxiety and depression.

Early indications show that increased numbers of residents are presenting to mental health services and GP surgeries with depression. However it must be noted that it is much more difficult to quantify if this will translate into a diagnosed mental health condition, as this would be dependent on other variables such as the individual's resilience factors and how services were able to intervene at an early stage to prevent crisis.

What can we do/are we doing to mitigate the likely impact?

Locally there is a vast amount of work being undertaken from a proactive perspective. There has been a significant amount of assertive outreach work by the Council and its Partners to engage those who the Council has identified will be impacted by the welfare reforms and cuts in benefits and to work with them to establish solutions, e.g. gaining employment, moving home and downsizing.

There are already a number of services in place that offer information, advice and advocacy to help inform residents of their options and provide guidance around financial hardship and benefits advice, including practical support in the shape of the Barking and Dagenham Credit Union and Local Emergency Support Service.

North East London Foundation Trust (NELFT) also has clear pathways in place for those experiencing mental health problems and clinical support is available to support professionals in NELFT, as well as GPs, with the implementation of the Primary Care Depression Pathway. However, there are concerns that this pathway is overly-reliant on the prescribing of antidepressants and that more focus needs to be given to holistic treatment options.

There remain areas that can be further developed to prevent crisis or trigger additional mental health needs. The areas in which most impact can be

Executive Summary

achieved is a comprehensive approach in the sharing and dissemination of information, training for front line staff and ongoing analyses of information to inform ongoing plans to mitigate the further expected impact of the reforms. This scrutiny review has been timely and has been conducted at the same time as a great deal of media coverage, debate and discussion at a national and London-level. In particular, the Greater London Authority have conducted research into mental health in London and published a report in January 2014. Although the report was published at the end of the Barking and Dagenham scrutiny process, it gives a helpful context to the HASSC's own review, discussing prevalence levels, mental health inequalities and the socio-economic impact of mental health issues in London. The report can be found by visiting this link:

<https://www.london.gov.uk/sites/default/files/FINAL%20-%20LMH%20-Full%20Report.pdf>

Recommendations

Following the scrutiny review, the Health and Adult Services Select Committee have put forward the following recommendations for further exploration and action:

1. Access to Information and Support

It is identified clearly within the report that receiving advice early is a key determinant in enabling residents to minimise the impact of welfare reforms and prevent financial hardship which could lead to detrimental effects on general health and mental wellbeing. It is evident that generally people suffer greater anxiety during times of financial difficulty, therefore early intervention and prevention is essential to residents in preventing crisis.

Information about services offering welfare benefits advice and advocacy should be readily and widely available to three key groups to ensure that residents can access services, support pathways and practical advice when they need it most. Information and advice should also be available to help reduce the stigma of mental health. The three key groups identified are:

- Residents
- Practitioners
- Those already known to mental health services

The importance of up-to-date, easy to understand and timely information and advice was raised on a number of occasions during the review. It is therefore recommended that a mapping and consultation exercise on access to information, advice and support is carried out by the Health and

Wellbeing Board. This exercise would be beneficial in order to ascertain whether there are any gaps in information provision and to establish whether the information formats that are currently available are the right ones.

2. Training and Volunteering

During the review process it was reiterated on many occasions that volunteering played a valuable role in mental health and wellbeing and also provides opportunities to prevent isolation, gain necessary skills and experience, and increases local social capital. It is therefore recommended that the Health and Wellbeing Board:

Recognises the importance of volunteering in maintaining recovery and mental health and wellbeing, using all the opportunities provided by the Council's volunteering programmes and the Third Sector.

See Recommendation 7 below on Mental Health First Aid training.

3. Peer Support Opportunities

It is recommended that the Council and the Health and Wellbeing Board continues to monitor user-led organisations to ensure that robust peer support opportunities continue to be provided to prevent isolation, provide emotional support and aid access to information and advice services as required.

4. Joint Working and Partnerships

The Select Committee considered the appointment of an Elected Member Champion around mental health and recommends that the Cabinet Member for Health considers the appointment of a Mental Health Champion on a fixed term basis on a specific issue, for example reducing

the stigma of mental health. It is accepted that this would not be taken forward until after the elections in May 2014.

The Select Committee felt strongly that a holistic approach needed to be considered in the treatment options available to patients, particularly as the Select Committee felt that there was an over-reliance on antidepressants as a treatment option in the Primary Care Depression pathway. The Health and Wellbeing Board should give this consideration, as a result of which the Clinical Commissioning Group (CCG) could be tasked to provide evidence of effectiveness on the implementation of the Primary Care Depression pathway and explore inclusion of alternative therapies, particularly talking therapies, within the pathway. As part of this work, the Select Committee would like to see the CCG undertake a review to determine whether the prescribing of antidepressants is in line with the practice in other areas.

The Select Committee was very positive about the availability of emotional health support for employees in Barking and Dagenham Council. It is recommended that the Council draw on this good practice to support local small employers to provide similar support to their employees.

5. Continued Measure of Need

The Select Committee is aware that within the Council, a Welfare Reform Officer Group is coordinating the response to the austerity and the welfare reforms for Barking and Dagenham residents. The Select Committee supports their ongoing work to bring together data sources that describe the scale of the problem and wish to see this brought to Members at regular intervals. This is particularly important as this review

has been taken at the early stages of welfare reform implementation and so significant further impacts are to be expected.

6. Continued monitoring of Local Services

Commissioning Officers within the Council to continue to ensure that services that are commissioned by the Council continue to remain fit for purpose and meet the needs of residents in the Borough. These services include:

1. Enhanced Welfare Rights
2. Specialist Advocacy
3. Local Emergency Support services
4. Credit Union

7. Mental Health First Aid Training

It is recommended that the Council and the Health and Wellbeing Board offer Mental Health First Aid to professionals across the partnership, as well as other local employers. It is suggested that the Health and Wellbeing Board may wish to look at whether the training that is offered to professionals across partnership organisations is sufficient and offer additional mental health awareness training if appropriate.

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SCRUTINY REVIEW ON THE POTENTIAL IMPACTS OF THE RECESSION AND WELFARE REFORMS ON MENTAL HEALTH ACTION PLAN

This Action Plan should be read and considered in conjunction with the Scrutiny Review report on the potential impacts of the recession and welfare reforms on mental health action

(<http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Documents/HASSC%20Final%20Review%20Report%20050214.pdf>).

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
Recommendation One: Improved access and quality of Information and advice about services offering benefits advice and advocacy, and support for coping with stress/anxiety/depression should be readily and widely available to: <ul style="list-style-type: none"> • Residents • Practitioners • Those already known to MHS 	1A) Agencies and organisations to complete mapping exercise to identify gaps in current information and advice provision. The Mental Health Sub Group to review the mapping exercise findings, determine next steps for any identified gaps and feed into consultation below.	Mapping exercise completed, gaps in information and advice provision analysed and next steps identified.	NELFT LBBDD Primary care (GPs, pharmacists etc.) CCG BHRUT Job Centre Plus	December 2014	
	1B) Through public and service user consultation, establish preferred mechanisms and formats for ensuring timely information and advice is readily available.	MH Sub Group to host a service user engagement event and to have commissioned user and carer feedback to inform information and advice formats.	MH Sub Group	December 2014	

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
<p>Recommendation Two: To build recovery and resilience, prevent isolation and increase social capital through training and volunteering opportunities.</p>	<p>2A) To promote volunteering opportunities available within the Sub Group member organisations.</p>	<p>Evidence of member organisations having promoted volunteering, demonstrated by a % increase (baseline to be determined) in numbers of volunteers with mental health problems within each organisation's workforce.</p>	<p>Local third sector groups NELFT LBBD CCG BHRUT Job Centre Plus</p>	<p>December 2014 Baseline to be established by 30 August 2014</p>	
	<p>2B) Volunteer Plus to promote the role of volunteers to local statutory and small/medium business enterprises</p>	<p>% increase (baseline to be determined) in the number of volunteers with mental health problems within Barking and Dagenham.</p>	<p>Volunteer Plus</p>	<p>Quarterly reports to MH Sub Group from September 2014 Baseline to be established by 30 August 2014</p>	
	<p>2C) Review and alter LBBD, NELFT, BHRUT, CCG websites to promote role of volunteers within these organisations</p>	<p>Evidence of volunteer opportunities on member organisations' website pages.</p>	<p>NELFT LBBD CCG BHRUT</p>	<p>December 2014</p>	

Barking and Dagenham Health and Wellbeing Board, Mental Health Sub Group

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
	2D) Develop fully costed proposals for a training programme for volunteers in B&D.	Training Programme commissioned for volunteers to access. Volunteer Plus to conduct training evaluation and report % levels (baseline to be determined) of volunteer satisfaction, confidence and competence and numbers of people reporting that they feel 'job ready'.	Volunteer Plus NELFT LBBD CCG BHRUT	Quarterly reports to MH Sub Group from September 2014 Baseline to be established by 30 August 2014	
	2E) Promote utilisation of the North East London (NEL) Recovery College to Barking and Dagenham Mental Health service users	% increase (baseline to be determined) in the number of service users accessing the Recovery College.	NELFT	Quarterly reports to MH Sub Group from September 2014 Baseline to be established by 30 August 2014	
	2F) Ensure continued take up and evaluation of Mental Health First Aid – see Recommendation 7 actions below	See Recommendation 7 actions below	See Recommendation 7 actions below	See Recommendation 7 actions below	

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
	<p>2G) Commissioners to continue to ensure that the mental health specialist vocation support service is robust and providing good outcomes in consultation with service users.</p> <p>Commissioners to consider re-investment when the contract is up for re-tender.</p>	<p>Continued consultation with service users and contract monitoring and evaluation. Consideration given to re-tendering in 2015.</p>	<p>LBBB Commissioning</p>	<p>Quarterly reports to MH Sub Group from September 2014</p>	
<p>Recommendation Three: To ensure robust peer support opportunities are developed to prevent isolation, provide emotional support, and share knowledge</p>	<p>3A) Review services commissioned and provided within B&D e.g. Big White Wall that are aimed at younger people.</p>	<p>Review and evaluate current services and identify next steps.</p>	<p>LBBB CCG Public Health</p>	<p>October 2014</p>	
	<p>3B) Enhance use of peer trainer contribution in the co-production and delivery of the NEL Recovery College.</p>	<p>Evidence of increased contribution (baseline to be determined) of peer trainers in development and delivery of recovery-focused training, workshops and courses.</p>	<p>NELFT</p>	<p>Quarterly reports to MH Sub Group from September 2014</p> <p>Baseline to be established by 30 August 2014</p>	

Barking and Dagenham Health and Wellbeing Board, Mental Health Sub Group

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
	3C) Support local third sector organisations e.g. Alzheimer’s Society to develop role of peer educators in services they offer in B&D.	% increase (baseline to be determined) in number of peer educators available to offer information, advice and services as required.	LBBD Healthwatch	Quarterly reports to MH Sub Group from September 2014 Baseline to be established by 30 August 2014	
Recommendation Four: Joint Working and Partnerships	4A) The Cabinet Member for Adult Social Care and Health to consider the appointment of an Elected Member into a role as Mental Health Champion on a fixed term basis.	Evidence of the appointment of the Mental Health Champion	Cabinet Member for Adult Social Care and Health	September 2014	
	4B) Review the primary care depression pathway to ensure this is holistic and not overly reliant on the prescription of anti-depressants.	Complete evaluation of the Primary Care Pathway. Evidence of an enhanced holistic approach to managing depression, including alternative therapies e.g. CBT, within the pathway.	CCG Mental Health Clinical Lead NELFT	March 2015	

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
	<p>4C) Determine whether the prescribing of anti-depressants is in line with practices in other boroughs.</p>	<p>Complete benchmarking exercise with comparator Boroughs.</p> <p>Medicines Management team to complete a review report of anti-depressant prescribing and determine next steps.</p>	<p>CCG Medicines Management Team</p>	<p>December 2014</p>	
<p>Recommendation Five: The effects of austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need</p>	<p>5A) To consider enhancing the floating support services that help residents maintain tenancies and avoid homelessness and develop fully costed proposals if required. The MH Sub Group to be kept informed of the financial implications associated with any proposals associated with offering enhanced floating support.</p>	<p>Quarterly reports received from the LBBB Housing service to the MH Sub Group outlining impact of welfare reforms and austerity on B&D residents with known MH problems.</p> <p>Review current floating support services and model proposals for an enhanced floating support service if required.</p>	<p>LBBB Welfare Reform Officer Group</p> <p>LBBB Commissioning LBBB Housing</p>	<p>Quarterly reports from September 2014</p> <p>October 2014</p>	

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
	<p>5B) A report is prepared and presented to the MH Sub Group responding to the identified impact of the austerity and the welfare reforms for Barking and Dagenham residents.</p>	<p>MH Sub Group receives analysis of the data so far and projected needs of impact of reforms on MH in the future to determine next steps.</p>	<p>LBBB Welfare Reform Officer Group</p>	<p>September 2014</p>	
<p>Recommendation Six: Continued monitoring of Local Services</p>	<p>6A) Commissioning Officers within LBBB to continue to ensure that services commissioned by the Council continue to remain fit for purpose and meet the needs of residents in the Borough.</p> <p>These services include:</p> <ul style="list-style-type: none"> • Enhanced Welfare Rights • Specialist Advocacy • Local Emergency Support services • Credit Union 	<p>Continued consultation with service users and contract monitoring and evaluation.</p>	<p>LBBB Commissioning</p>	<p>Quarterly reports to MH Sub Group from September 2014</p>	
<p>Recommendation Seven: Continued take up and evaluation of Mental Health First Aid</p>	<p>7A) Mental Health First Aid to be provided to non-mental health professionals across the partnership, as well as other local employers.</p>	<p>Track number of staff who have completed training. Mental Health First Aid delivered to 1000 non-mental health professionals.</p>	<p>Public Health Commissioning</p>	<p>Quarterly reports to MH Sub-Group from September</p>	

Recommendation	Actions required to achieve recommendation	Measure of success	Lead responsibility	Date actions due for completion	Date actions completed
	<p>7B) MH Sub Group to receive training evaluation report that demonstrates the benefits and impact for staff and MH patients/carers.</p>	<p>Two cohorts to be evaluated six months after they receive training by Public Health (August 2014 and January 2015) to review impact. Analysis to be reviewed by MH Sub Group and determine if additional MH awareness training is required.</p>	<p>Public Health Commissioning</p>	<p>September 2014 and February 2015</p>	

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Closing the Gap: Priorities for essential change in mental health		
Report of the Mental Health Sub-Group			
Open Report	For Information		
Wards Affected: All	Key Decision: No		
Report Author: Gillian Mills, Integrated Care Director, NELFT	Contact Details: Tel: 0300 555 1201 ext 65053 E-mail: Gillian.mills@nelft.nhs.uk		
Sponsor: Jacqui Van Rossum, Executive Director, NELFT			
Summary: <p>In its mental health strategy, <i>No Health Without Mental Health</i>, the Government stated that mental health must have equal priority with physical health, that discrimination associated with mental health problems must end and that everyone who needs mental health care should get the right support, at the right time. It was recognised that more needed to be done to prevent mental ill health and promote mental wellbeing.</p> <p>Two years on, whilst there have been many positive changes, it is apparent still more needs to be done. Nationally, people who use mental health services, and those caring for them, continue to report gaps in provision and long waits for services. There is still an enormous gap in physical health outcomes for those with mental health problems.</p> <p>The Closing The Gap report (Department of Health, February 2014) challenges the health and social care economies to go further and faster to transform the support and care available to people with mental health problems, both children and adults, further, it challenges Public Health to give greater attention to mental health and wellbeing promotion and prevention.</p> <p>A presentation summarising the Closing the Gap report will be given at the July Health and Wellbeing Board meeting.</p>			
Recommendation(s) <p>The Health and Wellbeing Board is recommended to note:</p> <ul style="list-style-type: none"> (i) The 25 recommendations highlighted within the Closing the Gap report. (ii) That the Mental Health Sub-Group members are undertaking a benchmarking audit within their respective organisations to establish the level of services commissioned and provided within Barking and Dagenham against the 25 priorities. (iii) That an implementation plan will be presented to the October Health and Wellbeing Board outlining the actions to be taken for local services to meet the report recommendations. 			

Reason(s)

Mental health and wellbeing is a central focus for the Health and Wellbeing Board and its member organisations. The Closing the Gap report challenges the Health and Wellbeing Board to ensure that mental health provision and commissioning in Barking and Dagenham is robust, is given parity of esteem with physical health, and that people with mental health problems are given the right care and support at the right time.

1. Background and Introduction

- 1.1 In January 2014, the Department of Health published its priorities for bridging the gap between its long term ambitions for mental health and shorter term actions. The Government's strategy was originally set out in 2011 in the document 'No health without mental health' followed by its 2012 implementation framework and suicide prevention strategy.
- 1.2 These earlier papers had a long term population focus, whereas the Closing the Gap report seeks to show how changes in local service planning and delivery will make a difference in the next two to three years, to the lives of people with mental health problems.

2. Proposal and Issues

- 2.1 Closing the Gap covers 25 areas where the most immediate change and improvement is expected.
- 2.2 The 25 priorities are set out under four key themes and are a clear restatement by the Government of its commitment to the provision of high quality mental health services, placed on a par with acute hospital services. The measures, strategies and ambitions contained within the document have the potential to deliver improved patient care outcomes not only in mental health but across the entire health and social care system.
- 2.3 The four key themes are:
 - Increasing access to mental health services
 - Integrating physical and mental health care
 - Starting early to promote mental wellbeing and prevent mental health problems
 - Improving the quality of life of people with mental health problems
- 2.4 The Board will receive a presentation at their July meeting which will summarise the Closing the Gap report. A summary of the report, produced by the Local Government Information Unit, can be found at Appendix 1.
- 2.5 The full 'Closing the Gap' report can be accessed by visiting:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf
- 2.6 It should be noted that recent studies have shown that funding for mental health services in England has been reduced by 2% in real terms over the past two years. Additionally, there appears to be no provision for enhanced mental health services and standards arising from the priorities set out in the NHS Mandate.

3. Consultation

- 3.1 Members of the Mental Health Sub-Group have been asked to undertake an audit within their constituent agencies to benchmark service commissioning and provision against the 25 priorities. This will be aided by the Mental Health Needs Assessment which has been recently undertaken by Public Health. The outcome of the agency audit will be reviewed by the sub-group and will be utilised to inform an action plan aimed at achieving these priorities.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

Strategies to address mental wellbeing need to follow the life course approach set out in our Joint Strategic Needs Assessment and be directed at promoting mental wellbeing as well as effective management of mental illness. Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.

4.2. Health and Wellbeing Strategy

The public's mental health and well-being is a complex area of policy. It demands our attention because focusing more on mental well-being and improving people's mental health is the right way to go. This report shows that improving mental well-being is a significant and growing priority for local authorities and the NHS in spite of, and because of, the poor economic situation we find ourselves in. It is clear that building community resilience and improving mental well-being will improve social, health and economic outcomes. The Board will need to be assured in the pending refresh of the Joint Health and Wellbeing Board that the 25 priorities set out under the four key themes have the appropriate prominence to deliver improved patient care outcomes not only in mental health but across the entire health and social care system.

4.3. Integration

The implications for integration are highlighted in the report. Constituent organisations of the Health and Wellbeing Board have been asked to undertake an audit of service provision to identify gaps against the 25 priorities. The Mental Health Sub Group will be leading on the audit on behalf of the Health and Wellbeing Board and will ensure that a multi-agency action plan is put in place following the audit to ensure that the priorities are met.

4.4. Financial Implications

There are no financial implications directly arising from the recommendations in this report. However, a further report will be presented to the October Health and Wellbeing Board on actions proposed to be taken by local services to meet the recommendations in the "Closing the Gap" report.

The October report will need to set out which of the recommendations in “Closing the Gap” need additional investment locally, and whether this is to be from health or the local authority. Within limited and reducing resources, it may be necessary to consider reshaping current services for support and care available to people with mental health problems in order to deliver the recommendations.

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

4.5 Legal Implications

As this report is for noting only, there are no legal implications at this stage. The report notes appropriate consultation before an implementation plan is to be considered in October when decisions will be made.

Implications completed by: Chris Pickering, Principal Solicitor, LBBD

5. Background Papers Used in Preparation of the Report:

- ‘Closing the Gap: Priorities for essential change in mental health’, Department of Health, January 2014

6. List of Appendices:

- Appendix 1: Local Government Information Unit Policy Briefing, February 2014

Closing the gap: priorities for essential change in mental health

17 February 2014

Christine Heron LGiU associate

Summary

The Department of Health has published [its priorities for transforming support](#) for people with mental health problems over the next two to three years. The priorities are to be carried out at national and local level and include:

- a crisis care concordat setting out expectations for patients in crisis
- an 'information revolution' to improve data, including work by PHE to gather information on promoting wellbeing and preventing mental ill-health
- choice of consultant/mental health professional at first outpatient appointment.

Briefing in full

Background

Closing the Gap supports the measures in the national mental health strategy No Health Without Mental Health, the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through 25 priorities for action – issues that current programmes are starting to address and where 'strategy is coming to life'. The government will report on progress on these priorities next year.

Increasing access

1 High quality mental health services with an emphasis on recovery and meeting local need

Commissioners need better information on what works in mental health. Action to provide this includes.

- NICE has produced a range of quality standards and is producing more.

- NHS England has launched a mental health leadership programme for clinical commissioning groups (CCGs), is producing best practice specifications for specialist mental health services such as schizophrenia, and is developing a range of commissioning tools including those to support integration of physical and mental healthcare.
- The Joint Commissioning Panel for Mental health has produced value-based commissioning guidance.
- A national summit on best practice in psychosis in March 2014.
- PHE to build evidence on promoting wellbeing and preventing mental illness
- PHE, NHS England and the LGA are working together on joined up resources e.g. drug and alcohol and mental health.

2 An information revolution around mental health

There is a need for better understanding about mental health to be used as a basis for improvement.

- A mental health intelligence network (MHIN) – similar to the national cancer intelligence network – will be established to identify trends such as age, and geography, and information about what local services are provided and how effective these are. This information will be made publicly available but will primarily be for health and wellbeing boards, CCGs and other partners to implement change.
- PHE will run a new programme to gather information about mental health, wellbeing and prevention and will produce a framework for action early in 2014. The DH has produced the mental health dashboard to track key measures from the outcome frameworks; work will take place to assess whether these are the best outcome measures – currently there is work to investigate an outcome around recovery.
- Better local information sharing is important for ensuring personalised, joined up support.

3 Waiting time limits for mental health services

The Government's Mandate to the NHS sets out a commitment to developing access or waiting time standards to establish parity with physical health. NHS England is collecting data on this, and new standards will be introduced in 2015 for adults and children and young people's mental health.

4 Tackling inequalities in access

Work is taking place to address inequalities in service use and outcomes, e.g. low take up of psychological therapies by black and minority ethnic communities, older people and ex offenders and veterans; the DH is working with groups such as Age Concern and the Race Equality Foundation to increase take-up.

5 & 6 Increasing access to psychological therapies for adults and children

600,000 adults receive psychological therapies every year, and in the last three years 45,000 have been helped to come off benefits and return to work. The government intends to increase uptake to 900,000 a year. It is incentivising CCGs to increase access through the Quality Premium additional funding scheme. NHS England is planning a country-wide extension of the transformation programme for talking therapies for young people by 2018.

7 The most effective services will get the most funding

A new payment system for mental health was introduced in 2012 – assessing people in clusters of conditions (e.g. cognitive impairment or dementia) with a scale of seriousness (e.g. low-level need) that are linked to payments for care packages rather than block contracts. The government is working with NHS England and Monitor to develop the new payment and pricing system for mental health (payment by results although this term is becoming less common) to base it more on quality and outcomes rather than volumes of activity. From April 2014, the Health and Social Care Information Centre will provide monthly reports to commissioners on provider performance. The report indicates 'In the future this could mean that the best services i.e. those that deliver the most successful outcomes, such as highest recovery rates, get more funding'.

8 More choice

The government is establishing new legal rights for choice in mental healthcare similar to what is available in physical healthcare – choice of provider/consultant/mental health professional when people attend their first outpatient appointment (with some exemptions around emergencies or compulsory detentions). NHS England is working with local areas on applying personal health budgets in mental health.

9 Reduce all restrictive practices and end the use of high risk restraint

The government has asked the Royal College of Nursing to work with others to develop new guidance which will then be consulted on.

10 Friends and family test

The use of the test to allow patients with mental health problems to comment on their experience of services has been piloted and will be used routinely from December 2014. The report encourages providers to start in advance of this date.

11 Poor quality services identified sooner and action taken

The report points to measures being taken to make Care Quality Commission (CQC) inspection and regulation more robust. Specific measure relating to mental health include a thematic review of emergency mental health, and mental health inspections to be more focused on the views of people who use services and their carers, including those detained under the Mental Health Act.

12 Better support and involvement for carers

The Standing Commission on Carers is focusing its fact-finding visits on how carers of people with mental health problems are being supported. The Carers Trust has produced best practice guidance and an assessment tool for involving carers in the planning and delivery of mental health services.

Integrating physical and mental healthcare

13 Better integration of mental and physical health

As much as 80 percent of all mental health care takes place in GP surgeries and hospitals. Work to ensure staff in these settings understand mental health include.

- Health Education England (HEE) to develop training programmes to equip all healthcare workers to understand the links between physical and mental health
- A new NHS England programme to ensure equal priority with physical health across the entire health system
- Public Health England (PHE) has started work to improve understanding of mental health in the public health workforce
- The Royal College of GPs is working to improve GPs' understanding of severe mental illness including physical health needs and crisis care; it will appoint a mental health clinical lead and will enhance GP training to better cover mental healthcare.
- The government has allocated the Better Care Fund, and most of the 14 integrated care pioneers include a focus on joined-up mental health.

14 Front-line services respond more effectively to self-harm

The report indicates that emergency departments often ignore NICE guidelines to offer a comprehensive physical, psychological and social assessment of people who self-harm. GPs should also refer people to talking therapies where appropriate. A new measure in the NHS Outcomes Framework will identify the percentages of those who attend emergency departments that receive a psychosocial assessment. The government will also identify how other frontline services can improve their response to self-harm.

15 No one in mental health crisis should be refused a service

The report indicates that people in crisis are turned away from service at weekends or if they are full and that this must not continue. Crisis support should focus on avoiding hospital admission.

- A national Crisis Care Concordat developed with a range of stakeholders will be published shortly; this will set out what people in crisis should receive, focusing on better coordination between emergency and mental health services including a single point of access.

- The government is also piloting 'street triage' in which people with mental health problems work with police officers to provide rapid assessment and referral for people who have not committed crimes.

Promoting mental wellbeing and preventing mental health problems

16 Better support for postnatal depression

Around ten percent of women suffer mental health issues around pregnancy or birth. Health Education England is involved in mental health training for health visitors and midwives, with a specialist in every birthing unit by 2017.

17 Schools supported to identify mental health problems sooner

New developments include.

- The new special educational needs code of practice due to be introduced in September 2014 will provide statutory guidance on identifying children and young people with mental health problems who have a special educational needs.
- An interactive e-Portal providing access to the latest evidence, guidance and tools will be operational early in 2014.

The government also encourages all schools that have not implemented measures in the Mental Health Strategy Implementation Framework to do so as soon as possible.

18 End the cliff-edge of lost support at age-18

The report indicates that too many young people with ongoing mental health problems no longer receive the right levels of support when they turn 18, with the most affected often the most vulnerable and disadvantaged.

- NHS England is developing a service specification for transition from child and adolescent mental health services (CAMHS) which can be used by CCGs and councils to apply best practice and monitor performance.
- A high level scoping study is being carried out to examine the evidence for both physical and mental health services for people aged 15 to 24 years and the implications for care pathways.

Improving the quality of life of people with mental health problems

19 People with mental health problems will live healthier and longer lives

The report describes the health inequalities and lifestyle and social issues faced by people with mental health problems. It is encouraging GPs, mental health workers and people with mental health problems to take more action to improve their physical health.

20 More people will live in homes that support recovery

Although settled, safe accommodation is vital for people with mental health problems there are no clearly defined models for what this should look like. The government 'wishes' to allocate up to £43 million to support a small number of housing projects designed with and for people with mental health problems and learning disabilities and to learn from this to showcase good practice. A national forum on housing will be hosted in 2014.

21 A national liaison and diversion service

The government is introducing a Liaison and Diversion service at police interview and custody suites and courts to provide early assessment, support. Information about individuals' assessments will be shared with the court and will be taken into account in decisions about charging and sentencing. The service will be trialed in twenty areas over the next two years, evaluated, and rolled out swiftly thereafter. The government is also looking to change how people are treated post-sentencing, e.g. improving access to mental health treatment requirements.

22 Enhanced support to victims of crime

People with mental health problems are far more likely to be victims of crimes than perpetrators. The new Victim's Code which came into effect in December 2013 gives enhanced support to people with mental health problems in the criminal justice system, such as the right to ask to give testimony by video link. From October 2014 the majority of support for victims will be commissioned by local police and crime commissioners who can work with health and care commissioners to ensure a shared approach.

23 Support employers to help more people with mental health problems stay in or enter employment

NHS England is working with the Department for Work and Pensions to identify best practice for employers in recruitment, retention and support. PHE is carrying out a major programme of support for employers. From late 2014, the government is introducing a new health and work service to provide advice to employers, and assessment and support for employees who have been on sickness absence for four weeks to help them back to work.

24 New approaches to help people with mental health problems move into work and support them when unable to work

Psychological Wellbeing and Work: Improving Service Provision and Outcomes – research commissioned by DH and DWP – made a number of proposals which the Government is considering developing into pilots focusing on better integration between employment and health services. Initiatives may include developing the link between psychological therapies and employment support, resilience building in people out of work, and access to work and wellbeing assessments online, by phone and face to face. These will complement existing programmes such as Access to Work and Work Choice.

25 Stamping out discrimination

The report expresses the intention to 'continually challenge' and 'ultimately remove' stigma and discrimination. It points to the Time to Change campaign led by Mind and Rethink Mental Illness which aims to change public attitudes, and has already reached 29 million people. It describes research into the impact of the Equality Act 2010 which shows people with mental health problems are already experiencing less discrimination from friends, family and in society. The government wants all departments and NHS organisations to sign the Time to Change pledge.

Comment

This report is a useful update on significant developments such as the Crisis Care Concordat. It emphasises the government's intention for parity between mental and physical healthcare as set out in the NHS Mandate. It was signed off by the Deputy Prime Minister and the Secretary of State for Care and Support, perhaps emphasising the particular support for this policy from the Liberal Democrat part of the coalition.

As the document was published, a row was taking place about the decision by NHS England and Monitor to reduce the tariff for mental health and community trust services by 20 percent more than that for acute providers in 2014-15, in effect requiring a fifth higher savings; this was on the basis that implementing the Francis report did not apply to these providers. Health Service Journal (HSJ) reports that a coalition of organisations – the Mental Health Network, NHS Confederation and Foundation Trust Network – appealed to Jeremy Hunt, but no change has been made. HSJ understands that some may be considering whether to apply for a judicial review on the grounds that this breaches the Government's parity of esteem policy.

Care and Support Minister Norman Lamb has said he is 'appalled' by NHS England and Monitor's decision, and that trusts' draft budgets will be scrutinised by Government, with action taken if there was evidence that mental health finances were suffering unduly. NHS England has pointed to the need for better financial, activity and performance data in mental health which is being addressed by the 'information revolution' – one of the 25 priority areas. The clinical director for mental health warned providers against disinvestment in intensive clinical teams and pointed to major investment by NHS England in training CCG mental health leads to roll out parity of esteem.

The dispute rumbled on through February with NHS Board member Lord Adebowale expressing the view that the decision was 'astonishing' and 'unacceptable'. NHS England and Monitor issued a joint statement saying that commissioners and providers are able to negotiate and agree local prices under [the national payment system guidance](#) published in December. The Mental Health Network has countered by claiming that 'the starting point for local negotiations will be a differential'.

A further dispute took place in the House of Lords about the government's decision to stop the annual survey of mental health spending. Opposition representatives said the survey showed the proportion of NHS spending on mental health had fallen for two years, and that it was being scrapped because it revealed cuts. The government said that the survey had been stopped in 2012 to 'reduce bureaucracy' and that NHS England will publish data on mental health spending in 2012-13.

Establishing national *mandatory* tariff-based pricing has been a long and difficult process in mental health. This was due to be introduced in April 2014, but has been paused by Monitor due to problems with data quality and different stages of readiness in applying the cluster model across the country. The current system of national tariff and local negotiation will continue as data quality and work to link the tariff to outcomes improves; only then will a decision be made on whether setting national prices in mental health will be appropriate in the longer term.

Closing the Gap refers to basing future payment systems on outcomes and quality rather than activity, which are laudable aims. It would seem though that plans to target funding at providers delivering the most successful outcomes are unlikely to be achieved in the near future.

Related policy briefing

[Preventing suicide in England: one year on](#)

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Urgent Care Board Update		
Report of the Urgent Care Board			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: NO	
Report Author: Louise Hider, Health and Social Care Integration Manager, LBBD		Contact Details: Tel: 020 8227 2861 E-mail: louise.hider@lbbd.gov.uk	
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group			
Summary: This purpose of this report is to update the Health and Wellbeing Board on the work of the Urgent Care Board (UCB). This report provides updates on the UCB meetings held on the 28 March 2014 (Appendix 1), 28 April 2014 (Appendix 2) and 21 May 2014 (Appendix 3). Additionally, Members of the Board may wish to note that an Urgent Care Board workshop was held on Monday 30 June 2014 (Appendix 4). The workshop looked at demand and capacity and surge proposals for 2014/15 and the new planning guidance for operational resilience and capacity planning for 2014/15 which has recently been released by NHS England. The guidance states that following on from the successful work Urgent Care Working Groups (UCWGs) have undertaken since their creation (Barking and Dagenham's Urgent Care Board was created in June 2013), their next evolution is to expand their role to cover elective, as well as non-elective care. This shift is reflected in the change in name of UCWGs to System Resilience Groups (SRGs). The guidance states that SRGs should be the forum where all of the partners across the health and social care system come together to undertake the regular planning of service delivery. The group should plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers. Following the discussion, workshop members agreed that there would be no changes to the current structure of the Urgent Care Board (or its name) as it was felt that the UCB satisfies the new guidance from NHS England for System Resilience Groups (SRGs).			
Recommendation(s) The Health and Wellbeing Board is recommended to:			
<ul style="list-style-type: none"> • Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the 			

Urgent Care Board.

Reason(s):

There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.

1 Mandatory Implications

1.1 Joint Strategic Needs Assessment

The priorities of the Board is consistent with the Joint Strategic Needs Assessment.

1.2 Health and Wellbeing Strategy

The priorities of the Board is consistent with the Health and Wellbeing Strategy.

1.3 Integration

The priorities of the Board is consistent with the integration agenda.

1.4 Financial Implications

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

1.5 Legal Implications

There are no legal implications arising directly from the UCB.

1.6 Risk Management

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

2 Non-mandatory Implications

2.1 Customer Impact

There are no equalities implications arising from this report.

2.2 Contractual Issues

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

2.3 Staffing issues

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

3 List of Appendices

BHR Systems Urgent Care Board (UCB) Briefings:

- Appendix 1: 28 March 2014
- Appendix 2: 28 April 2014
- Appendix 3: 21 May 2014
- Appendix 4: Urgent Care Board workshop - 30 June 2014

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BHR Systems Urgent Care Board (UCB) Briefing	Meeting dated - 28 March 2014
	Venue – Havering Town Hall, Romford
Summary of paper	This paper provides a summary of the key issues discussed at the March Urgent Care Board meeting. The meeting was chaired by Conor Burke (Chief Accountable Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Key issues raised
BHRUT Improvement Plan	The Trust presented an overview of the draft Improvement Plan. Members asked the Trust to bring a final version back to a future meeting.
A&E threshold funds	The system is currently evaluating the 13/14 winter schemes. A decision on the 14/15 winter schemes will be agreed at a future meeting.
Urgent Care dashboard – an update on the performance of metrics that contribute to A&E performance.	<p>Members received an updated dashboard which now contains some of the London benchmarking data such as A&E 4 hour target, LAS blue light activity as a % of all conveyances and NHS 111 calls answered within 60 seconds. Highlights from the latest dashboard were:</p> <ul style="list-style-type: none"> • The KGH site has been consistently performing above trajectory against the 4 hour target but overall Trust performance is below plan as at 31/03. • Non elective admissions continue to be below plan. • Utilisation for the B&D and Redbridge surge scheme is good and further actions are being progressed to improve the utilisation at Havering. • Members agreed for an audit to be done to further understand the high A&E attendances rate on Mondays. • 7 day working and discharges across the week – improvement noted on discharges taking place on Mondays, Saturdays and Sundays.
Priority workstreams – an update from each area	<p>The following updates were provided:</p> <ul style="list-style-type: none"> • 7 day working – the current winter schemes are being reviewed for impact. • Urgent Care Centre (UCC) utilisation – utilisation rates have improved. The 2014/15 contract is being finalised and includes a new service specification that meets the London Quality Standards. • Primary Care Development – the project lead reported early positive results for the primary care surge / care homes schemes. The surge schemes in B&D and Havering have been extended for a further three months. • Joint Assessment and Discharge Service (JAD) – the project remains on track to start in June. • Frailty – the key actions from the frailty programme is to be aligned with the actions from the Trust Improvement Plan. Further discussions will take place at the ICC meeting on the 31/03.
AOB / Next meeting	Monday 28 April 2014 (12pm – 2pm), Board room A, Becketts House Ilford

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BHR Systems Urgent Care Board (UCB) Briefing	Meeting dated - 28 April 2014
	Venue – Beckett's House, Ilford
Summary of paper	This paper provides a summary of the key issues discussed at the April Urgent Care Board meeting. The meeting was chaired by Conor Burke (Chief Accountable Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Key issues raised
BHRUT Improvement Plan	The Trust presented an updated draft of the Improvement Plan which was welcomed and strongly supported by all members. A final version of the plan will be presented at the next meeting.
A&E threshold funds	The proposals for the use of the A&E threshold funds were presented at the meeting. A number of projects from 13/14 have now been mainstreamed into contracts.
Review of winter template submission	A paper was presented on the review of 13/14 winter funds before submission to NHS England.
Urgent Care dashboard – an update on the performance of metrics that contribute to A&E performance.	Members received the latest update of the dashboard. The highlights noted were: <ul style="list-style-type: none"> • A&E performance at the Trust this Easter has improved compared to the previous year. • NHS 111 call responses have improved. • London Ambulance Service (LAS) conveyances have remained low and now in line with London performance. The LAS call-outs from nursing homes have shown a reduction. • Non elective admissions continue to be below plan. • Utilisation for the B&D primary care surge scheme and Havering weekend opening has improved. • An analysis of A&E attendance rate on Mondays was presented to further understand the issues causing the high attendance.
Priority workstreams – an update from each area	The following updates were provided for each workstream: <ul style="list-style-type: none"> • Recruitment – phasing for new candidates joining the Trust outlined. • 7 day working – the current winter schemes are being reviewed for impact. • Urgent Care Centre (UCC) utilisation – utilisation rates have improved. The 2014/15 contract will include a new service specification that meets the London Quality Standards. • Primary Care Development – the schemes are working well to reduce A&E attendance. Members were provided with an update on the successful Prime Minister's Challenge fund bid. • Joint Assessment and Discharge Service (JAD) – the project remains on track to start in June. • Frailty – members agreed for an update to be provided at the May meeting on the next steps of the frailty programme.
Urgent Care Procurement	An update was provided to members on the urgent care pathway procurement.
Publication of the London Quality Standards self assessment 2013	Members noted that the outcomes of the A&E audit held in 2013 was now published and the need to note areas for improvement.
AOB / Next meeting	Wednesday 21 st May 2014 (12pm – 2pm), Committee Room 2, Havering Town Hall

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BHR Systems Urgent Care Board (UCB) Briefing	Meeting dated – 21 May 2014
	Venue – Havering Town Hall, Romford
Summary of paper	This paper provides a summary of the key issues discussed at the May Urgent Care Board meeting. The meeting was chaired by Conor Burke (Chief Accountable Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Key issues raised
Improvement Plan – update / sign off and implementation plans	The Trust tabled a briefing on progress of the Improvement Plan and next steps leading to final sign off.
System response to the 'asks'	Members agreed to hold a mini summit on 16 th June to review, and look to sign off the Improvement Plan.
Programme update – 14/15 forward planner	Members reviewed the forward planner setting out the workplan for the next six months and agreed to use the June meeting as a workshop to plan for key interventions to manage surge over winter.
Urgent Care dashboard – an update on the performance of metrics that contribute to A&E performance.	Members received the latest update of the dashboard. The highlights noted were: <ul style="list-style-type: none"> • A&E performance at the Trust has decreased slightly and discussions are taking place with the Trust to improve performance. • A&E and UCC attendances – the latest year to date position shows activity is over plan for all 3 CCGs. • Positive performance of the metrics in the discharge section of the dashboard.
Priority workstreams – an update from each area	The following updates were provided for each workstream: <ul style="list-style-type: none"> • Joint Assessment and Discharge Service (JAD) – the project remains on track to start in June. • Frailty – members received an update on the next steps of the frailty programme.
Urgent Care Procurement	An update was provided to members on the urgent care pathway procurement. The project preparation phase remains on track.
Winter resilience planning: Feedback from Tripartite Panel meeting	Members noted the positive feedback on last year's winter plan and system partnership working from the Tripartite Panel at a recent meeting held on the 16 May 2014.
AOB / Next meeting	Monday 30 th June 2014 (1pm – 4pm) Board room A, Becketts House, Ilford

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BHR Systems Urgent Care Board (UCB) Briefing	Meeting dated – 30 June 2014
	Venue – Board room A, Becketts House
Summary of paper	This paper provides a summary of the key issues discussed at the June Urgent Care Board meeting which was used as a workshop to prepare for winter 2014/15. The workshop was chaired by Conor Burke (Chief Accountable Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Key issues raised
<p>The workshop covered the following areas:</p> <ul style="list-style-type: none"> • Lessons learned from 2013/14. • Demand / capacity analysis for 2014/15, covering acute and non-acute. • Communications proposals for winter 2014/15. • Implications from the NHS England planning guidance 'operational resilience and capacity planning for 14/15'. • Proposals to manage surge for 2014/15. • Reporting and escalation arrangements. <p>Next steps - Leads to work up proposals with support from the CCGs and sign off prior to the submission on the 30th July.</p> <p>Next meeting</p> <p>Friday 1st August 2014, 1pm – 3pm Conference room, Barking Learning Centre, 2 Town Square, Barking IG11 7NB</p>

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HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Care City
Report of the North East London Foundation Trust and London Borough of Barking and Dagenham	
Open Report	For Decision
Wards Affected: ALL	Key Decision: No
Report Author: Helen Oliver Care City Programme Lead (Joint role) North East London Foundation Trust and London Borough of Barking and Dagenham	Contact Details: Tel: 0300 555 1201 Ext: 66228 E-mail: Helen.Oliver@nelft.nhs.uk Helen.Oliver@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director Adult and Community Services, LBBB Dr Steve Feast, Executive Medical Director, NELFT	
Summary: <p>This is the second Care City report presented to the Health and Wellbeing Board. It aims to provide the Board with an update on the joint development of Care City across LBBB and NELFT.</p>	
Recommendation(s) <p>The Health and Wellbeing Board is recommended to note:</p> <ul style="list-style-type: none"> (i) The presentation of the outline business plan on 22 July 2014 to the NELFT Board, if approved this will signify a commitment, in principle, for NELFT and LBBB to work together to provide the necessary capital and future revenue funding for Care City. (ii) The continuing development of a joint Memorandum of Understanding (MOU) between LBBB and NELFT which sets out the terms and conditions of this joint venture. (iii) Subject to agreement across both partners the proposed governance and legal structure. (iv) Subject to agreement across both partners that there will be an Interim Steering Board reporting to both LBBB and NELFT. 	

The Health and Wellbeing Board is recommended to agree:

- (v) The relocation of the Care City 'show home / demonstrator site' to an alternative Barking venue (Wigham House).
- (vi) To receive a further report on the full business plan, subject to NELFT agreement, detailing proposed legal structure, ownership and projected 5 year financial forecast.

Reason(s)

Barking and Dagenham's Community Strategy 2013-2016 vision to 'Encourage Growth and unlock the potential of Barking and Dagenham and its residents. To achieve the vision for Barking and Dagenham there are five priorities which underpin its delivery: Ensure every child is valued so that they succeed; Reduce crime and fear of crime; Improve health and wellbeing through all stages of life; create thriving communities by maintaining and investing in new and high quality homes and to maximise growth opportunities and increase household income of boroughs residents. Securing Barking and Dagenham as the main site for Care City will support the partnership to address all of these priorities. It will also contribute to tackling many of the health inequalities which impact upon our community as identified in our Health and Wellbeing Strategy.

1. Background

1.1 Mission statement

Care City aims to transform the quality of life for people living in Outer North East London through the innovative integration of health and social care. The model will inspire whole-system, locally driven change by fostering economic regeneration, developing new opportunities for education and employment, and by pioneering research in dementia care and other long term conditions. Care City will be delivered by the community for the community

1.2 What is Care City?

Care City is a centre for excellence and a new concept in urban health and community care. Based in one of the most deprived areas in England, Care City will enable the wider health and social care sector to improve health outcomes for Outer North East London and beyond, and will stimulate economic growth, investment and regeneration through partnerships with industry, social enterprises and the academic and charitable sectors.

The need to improve the management of long-term conditions including dementia is one of the most important challenges currently facing the health and social care sector. In England, more than 15 million people have a long term condition, and this figure is likely to increase over the next 10 years, particularly those people with three or more conditions at once. Examples of long term conditions include high blood pressure, depression, dementia and arthritis. Long term conditions can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities. Care of people with long term conditions accounts for 70% of the money we spend on health and social care in England. People with

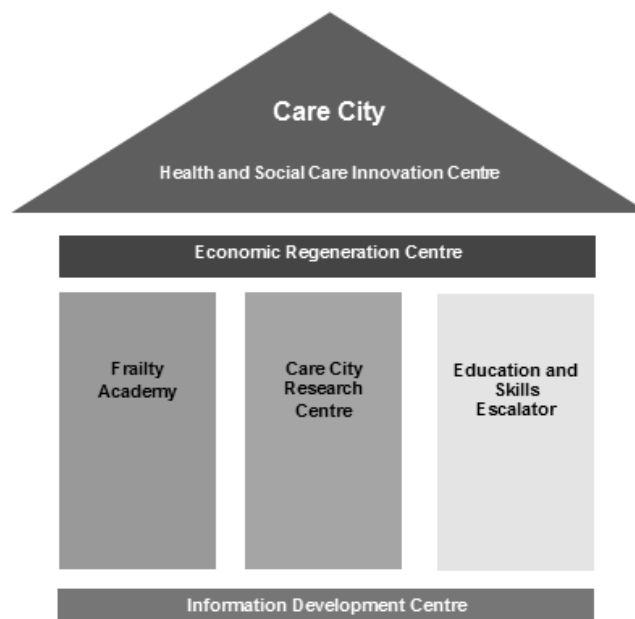
long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities.

Care City’s local, national and international collaborations will aim to modernise the provision, management and funding of health and social care. It will support a move from a model that is reactive and disease-focused, towards one that is proactive where people with long-term conditions have a leading role in their own care that will help to reduce stigma and improve community resilience.

Serving the people of Outer North East London and founded by North East London NHS Foundation Trust (NELFT) and the London Borough of Barking and Dagenham (LBBD). It will produce the knowledge and evidence required to help to prevent illness and, where that is not possible, it will support people to self-manage their symptoms better, avoiding admission to hospital and enabling them to remain independent in their own homes.

1.3 Care City Model

The five components of Care City will work together as a health and social care innovation centre to build a sustainable model to improve opportunities for the local community. The Information Development Centre will act as an enabler, providing support to new ideas and technologies that can support the aims of the Care City Research Centre, the Frailty Academy and the Education and Skills Escalator. The synergies of these components will realise the aim of the fifth component, i.e., economic regeneration, which will focus on creating a virtuous cycle of external investment, through innovation and entrepreneurship, amplifying the success of the other four components. On a larger scale, it will drive education and research into practice. We will develop, evaluate and implement the best research, co-develop innovative technologies, and pioneer training and education opportunities for staff to deliver integrated care. Care City will comprise:



Information Development Centre – aims to connect the voluntary, health and social care sector to industry and entrepreneurs. Care City will enable the

development and application of information products which make the best use of evolving technologies, to deliver person-centred services.

Frailty Academy– aims to redesign the way people interact with and experience health and social care by encouraging their collaboration with experts from academia and the private sector. This will help people better co-produce and experience improved health and independence at home.

Care City Research Centre – brings together academics, health and social care staff, patients and carers with the aim to develop world leading research relevant to health and social care and to build research capacity. The centre includes the new Institute of Dementia Care pioneering research and improving practice, and also a research and development department to support to research projects and to develop new applied research groups in long term conditions. The research centre will collaborate with world-class academic institutions to advance research and innovation, and to get best evidence into practice.

Education and Skills Escalator – aims to support local people to develop the capabilities they need to access employment opportunities, and to support those already in work to gain the leadership skills required to advance their careers in health, social care, research and information science.

Economic Regeneration Centre – aims to drive economic regeneration through attracting investment into community care, unleashing the energies of large and small businesses develop new services and products. The goal is to support individuals to self-manage, and thereby improve overall community resilience. It aims to create new jobs in research, start-up companies and SMEs. In addition local residents will be able to gain the skills needed to fill the needs of the health, social and voluntary care systems, and to improve their earning potential which will have a positive impact upon local communities.

1.4 Vision

The individual partners involved in Care City cannot by themselves transform the lives of the people they serve. The value of Care City is therefore in the ability to derive outcomes that are more powerful than the sum of its parts. These include:

- A well-functioning and sustainable health and social care system which is responsive to the needs of communities in Outer North East London.
- Person-centred services which support citizens to be proactive in maximising their own health independence and wellbeing.
- A workforce culture which is integrated, responsive and citizen focussed
- More effective self-management, better co-ordinated care and improved health outcomes for people living with long-term conditions.
- Measureable improvements in local health outcomes through equitable, accessible and high quality services.
- Increase in employment opportunities for local people- including progression into leadership roles
- Growth of local small and medium enterprises and create inward investment for the wider community interest.

2. Care City Update

2.1 Care City Business Plan

NELFT will formally receive the outline business plan on 22nd July 2014. This will seek to secure NELFT Board commitment to use strategic capital reserves to support the establishment of Care City. This will include funding the cost of the core team which will work across NELFT and LBBD to further develop the proposal. A verbal update on the outcome of these deliberations will be provided at the meeting.

2.2 Care City Interim Show-Home

In January 2014, the Bathhouse was identified as the preferred site for the interim show-home. In March 2014 the Barking and Dagenham Health and Wellbeing Board agreed £300,000 contribution towards the fit out costs and in April 2014 the NELFT Board agreed £1.8 million to purchase the long lease-hold.

However, by June 2014 a third party had made an offer on the site and this meant that the site could not be secured on our preferred terms. Therefore, LBBD and NELFT carried out a further scoping exercise where a second option (Wigham House) was identified as viable. As an existing NELFT leased property it was felt that this would also support the partnership to save time in securing the site.

The Care City team are in discussions with designers and it is envisaged that renovation work will begin by October 2014 and be completed by February 2015.

The interim site will comprise: Information Development Zone; Economic Regeneration Zone; Research and Development Zone; Frailty Zone; Education and Skills Zone; Agile working space; Tea and coffee service; Additional meeting rooms; Exhibition space; Care City Project Team; Reception and Storage.

2.3 Care City Legal structure and ownership

2.3.1 Legal structure

NELFT and LBBD are deemed to be the founding partners for Care City. A draft governance paper is currently under development and is due to be considered initially by the NELFT board on 22nd July 2014. The governance proposal will then be formally considered by the council. The proposed legal structure is based on the following assumptions:

- That the investors as public service organisations intend that any profit or dividend will be returned to the public purse in order to fund better local services
- That Care City will manage its day to day operations to a large degree as an 'arm's length body' from NELFT and LBBD, reporting via its interim governance to the Boards of NELFT and the Health and Wellbeing Board.

- That to allow for establishment, Care City will operate initially from an interim site for a minimum of three years before being considered and established as a fully 'stand-alone' body
- That once fully established, in approximately three years, Care City will operate with separate accounts, liabilities and governance from the investing public service partners, and in doing so will minimise the future risks to public services if significant losses were incurred
- That NELFT and LBBDD may in future consider using Care City as an additional trading arm of the business that through more flexible partnerships (i.e. with the Third Sector) will help keep or attract revenue streams in providing local services.

2.3.2 Interim Governance

In the start-up phase Care City will require an interim governance structure that is capable of representing the founding partner's interests. It will need to maintain sound financial oversight as well as provide non-executive oversight and guidance through from inception to potential establishment as a more independent body. The interim Care City Executive group will set the cultural tone for partnership working, and connect with organisations which could contribute the company mission. It is proposed that the interim Executive Group will report to the relevant accountable structures of the founding partners. Members of the Executive Group will be proposed to and approved by the founding partners and will include leads from those partners – NELFT and LBBDD. In addition a wider external Steering Group will meet quarterly. This group will provide external advice and help engage Care City within the wider pan London health and care programmes. Membership of the steering group will also require approval of the founding partners.

2.3.3 Financial Governance

The Boards of the Founding Partners will determine the level of investment to Care City from their organisations. These investments may take the form of capital investment and investment in kind, for example through deployment of staff. The Care City Executive Director will be accountable for deployment of these funds and the Care City Interim Executive Group will provide oversight. The Founding Partner Boards will receive an annual report of how these funds have been deployed.

Additional funds will be raised to support the activities of Care City through application of grants or via secured private sector investment. When funds are raised by Founding Partners or Partners using the Care City brand, the named lead for the grant or investment will be accountable to the Interim Care City Board for oversight of how the funds are deployed (they may also be required to report to the employing organisation).

2.4 Care City Permanent Site

A site has been identified by the London Borough of Barking and Dagenham (LBBDD) for the permanent Care City facility. This is subject to Cabinet approval and will be discussed by Cabinet at their meeting on 4 August 2014.

3. Care City key milestones

- Interim site refurbishment October 2014 -February 2015
- Interim site opening February 2015
- Permanent site building open summer 2017

4. Recommendations

The Health and Wellbeing Board is recommended to note:

- (i) The presentation of the outline business plan on 22nd July 2014 to the NELFT Board, and if approved this will signify a commitment in principle for NELFT and LBBD to work together to provide the necessary capital and future revenue funding for Care City.
- (ii) The continuing development of a joint Memorandum of Understanding (MOU) between LBBD and NELFT which sets out the terms and conditions of this joint venture.
- (iii) Subject to agreement across both partners the proposed governance and legal structure.
- (iv) Subject to agreement across both partners that there will be an Interim Steering Board reporting to both LBBD and NELFT.

The Health and Wellbeing Board is recommended to agree:

- (v) The relocation of the Care City 'show home/demonstrator site' to an alternative Barking venue (Wigham House).
- (vi) To receive a further report on the full business plan, subject to NELFT agreement, detailing proposed legal structure, ownership and projected 5 year financial forecast.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment

Care City support Section 2, 3, 4, 5, 6, 7 and 8 of the Joint Strategic Needs Assessment. It will support young people to enjoy healthier outcomes through creating wealth, employment opportunities as well as more efficient and integrated services. It will address wider health inequalities and deprivation facing the community through regeneration and community resilience. It will also support the safeguarding agenda through improving both the quality and effectiveness of health and social care services through improved training and skills development.

5.2 Health and Wellbeing Strategy

Care City will support improved health and wellbeing outcomes for the community through addressing health inequalities by improving access to employment, skills and improved health services.

5.3 Integration

Care City aims to provide a platform for health and social care integration.

5.4 Financial Implications

At its meeting on 25 March 2014, the Health and Wellbeing board agreed to:

“delegate authority to the Corporate Director of Adults and Community Services, in consultation with the Head of Legal & 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, and 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.”

At that time the Bathhouse was the preferred site. As explained in this report, the site is no longer available and it is now proposed to base the site at Wigham House. As this is already leased by NELFT, support for the first year of rent is no longer needed. However, £300k of funding from the Public Health grant towards fit out costs is still proposed. Funding is available to support this in 2014/15.

The NELFT Board is due to consider the case for making a significant investment from the NELFT’s capital reserves, to establish the permanent Care City site at its meeting on the 22nd July 2015. To inform its decision, the Board requested a full business plan for Care City, providing clear explanations of its rationale, core components, organisational approach and governance model, detailed financial projections for the next five years, and robust assessment of the key risks involved. At the time of writing this paper the full business plan (including financial projections) is not available to share. The Health and Wellbeing Board is recommended to agree to receive a further report on the full business plan, when available.

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

5.5 Legal Implications

There are no implications arising from this report, Care City puts into practice the integrated working envisaged in the Care Act 2014.

Implications completed by: Dawn Pelle, Adult Care Lawyer, LBBB

5.6 Patient/Service User Impact

Care City will support a greater platform for service user consultation and engagement in research and development. It also aims to improve services for patients and service users through improving the integrated response of health and social care services and widening product available to support individuals to self-care.

6. Non-mandatory Implications

6.1 Crime and Disorder

Through addressing health inequalities and poverty we would hope to reduce crime and disorder. We also hope that through inward investment we will support the regeneration of the town centre in a way which enables us to design out certain crime.

6.2 Safeguarding

Care City will enhance the skills and training of staff operating in the health and social care sector which in turn will improve reporting of safeguarding concerns.

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HEALTH AND WELLBEING BOARD

29 JULY 2014

Title:	Better Care Fund - Update		
Report of the Corporate Director of Adult and Community Services			
Open Report	For Decision		
Wards Affected: ALL	Key Decision: No		
Report Authors: Glynis Rogers, Divisional Director, Commissioning and Partnerships	Contact Details: Tel: 020 8227 2749 Email: glynis.rogers@lbbd.gov.uk		
Sponsors: Anne Bristow, Corporate Director of Adult & Community Services.			
Summary: The Health and Wellbeing Board considered and agreed papers on 11 February and 25 March 2014 which enabled the submission of the Borough's final Better Care Fund to NHS England. This paper provides an overview of the current position and response to recent announcements about further submissions being required to address national deficiencies in the programme. The delivery of Barking & Dagenham's Better Care Fund plan continues in the meantime with work underway to progress the individual schemes.			
Recommendation(s) It is recommended that Members of the Health and Wellbeing Board:			
<ul style="list-style-type: none"> • Note the latest position and that further guidance is still not forthcoming (including the attached DH press notice within the Background Papers). • Note that we maintain our shared and clear ambition, locally reflected within our Better Care Fund Plan and within the CCG's strategic 5 year plan. • Delegate to the Corporate Director of Adult and Community Services on behalf of the Council to finalise any outstanding matters from the Board's discussions with the Accountable Officer on behalf of Barking and Dagenham CCG. Also, to take further action as necessary in the event of further steps being required to make any adjustments to the BCF plan to comply with emerging requirements from the government, Department of Health or NHS England. 			

- That the Health and Wellbeing Board receive a detailed update on progress at its September meeting.

Reason(s)

The Better Care Fund is now a major driver of local activity to jointly improve health and social care services and, in particular, to manage pathways that run across the local hospital trusts and social care services. The Health and Wellbeing Board, having approved these plans as consistent with the Health & Wellbeing Strategy and delivering our shared ambition, should receive regular assurance that actions to meet emerging guidance are being taken, subject to the Board needing to consider any re-submission of Better Care Fund plans in response to Department of Health requirements.

The Better Care Fund underpins the Council's priority in improving local health and wellbeing through all stages of life.

1. Introduction

- 1.1. The Better Care Fund was announced in June 2013 as part of the 2013 Spending Round. The Fund provides an opportunity for the Council and the Clinical Commissioning Group to work together to transform local services so that people are provided with better care and support to enable the achievement of health and social care outcomes and accelerate our progress towards integration.
- 1.2. A draft plan for the Better Care Fund was signed off by the Health and Wellbeing Board on 11 February and submitted to NHS England on 14 February 2014. NHS England provided the Borough with positive feedback on the draft submission and expressed confidence in the Plan, stating that they felt that remaining issues would be resolved before the final submission on 4 April 2014.
- 1.3. The 25 March report to the Board provided an overview of the vision of the Better Care Fund and the priority work areas – the 'schemes' – that make up the Fund. It also outlined the remaining actions that would be worked through by the Council and the Clinical Commissioning Group over the subsequent weeks and what would return to the Board in its September meeting.

2. New guidance and possible resubmission of the Plan

- 2.1. Whilst it is clear nationally that Better Care Fund Plans are on course, Board members will be aware of the media speculation and communications from Government which have raised questions about the extent of the impact of Better Care Fund Plans on health services and demand – notably upon acute admissions.
- 2.2. Communications do clearly reflect the Government's shift in focus for Emergency Admissions from being one of the priorities to being the core driver of the Better Care Fund. Expected guidance will set the level of savings to be expected with a single cost per Emergency Admission. A key change here is that our submission was based upon an estimate of all Emergency Admissions (as they vary in cost). It

is also clear that target reductions have become more explicit in the setting of a minimum reduction of 3.5%. Our proposed target reduction of 170.1 to 163.3 (metric value) already exceeds the minimum requirement and will achieve savings of £700,000.

- 2.3. However, we propose to review our ability to increase this further in order to provide stretch and provide sufficient ambition. This will also be important as the Performance element (nationally £1bn) will be much more closely tied to reduced emergency admissions, and of the £1bn, a percentage will be paid to areas for delivering those reductions and the percentage will depend upon how ambitious the target is, further incentivising improved performance.
- 2.4. Current communications have raised some concerns, notably within the Local Government Association, that directions provide for any savings achieved from reduced emergency admissions should be spent on NHS commissioned services and would therefore appear to reduce local ability to determine further investment in and 'protection' of social care services.
- 2.5. It is important that we are reflective and able to act upon further guidance which may be issued. We are however confident that both the Council and the CCG are working together in the same direction, and have a clear vision for what we seek to achieve through our local Better Care Fund plans. Work is underway within each of the 11 schemes forming part of our Better Care Fund submission previously considered by the Board.

3. Resubmission

- 3.1. The Department of Health expect local areas to submit revised plans later in the summer, ahead of a further process of national assurance and ministerial sign off. Locally, we are making the case clearly that any revised plan will need to be seen by the Health and Wellbeing Board before resubmission, and that therefore no submission can be made ahead of 9 September when the Health and Wellbeing Board next meets.
- 3.2. It is thought that the resubmitted template will need to include testimony from significant hospital providers in the locality on how they have been engaged in the production of the plan, and its 'fit' with their own strategic activity.

4. Implications

- 4.1. The Council and the CCG will be working through anticipated guidance and making adjustments to the Better Care Fund Plan as required over the summer. As stated above, any revisions to the Better Care Fund plan will be presented to the Health and Wellbeing Board on 9 September. The Board will also receive a more detailed update on the progress of the Better Care Fund so far at that meeting. Detailed implications will therefore be included in the September Health and Wellbeing Board report.

5. Background Papers

Plans to improve out of hospital care for the elderly and vulnerable will reduce emergency admissions. Department of Health Press Release, 5 July 2014

<https://www.gov.uk/government/news/better-care-plans-to-provide-dignity-independence-and-reduce-ae-admissions>

HEALTH AND WELLBEING BOARD

29 JULY 2014

Title: Progress on the Diabetes Actions from the Health and Adult Services Select Committee Scrutiny Review	
Report of the Director of Public Health	
Open Report	For Decision
Wards Affected: All	Key Decision: No
Report Author: Ross Kenny Principal Public Health Specialist - Healthcare	Contact Details: Tel: 020 8227 2799 E-mail: ross.kenny@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	
Summary: This report updates the Health and Wellbeing Board on the progress of implementation of the recommendations of the Health and Adult Services Select Committee in 2012/13. Collaborators and stakeholders have worked in a very positive manner to start to achieve change. There is still work to be done but there is now a strategic group (the Diabetes Sub-Group of the Planned Care Steering Group) that can take forward the ongoing work that needs to focus on identifying diabetics within high risk groups in primary care and elsewhere together with the need for NHS England to address the problem of some underperforming GP practices.	
Recommendation The Health and Wellbeing Board is recommended to agree that the Diabetes Action Plan has been completed (table 1) and is fit for return to the Health and Adult Services Select Committee.	
Reason(s) The Health and Wellbeing Board is overseeing the Diabetes Action Plan from the Health and Adult Services Select Committee. Whilst some changes were easily actioned others require more integrated working, defined governance structures and a shared vision. The Health and Wellbeing Board can both define the issues and work through how to improve collaboration in order to improve the delivery of population health outcomes.	

1. Background and introduction

- 1.1. Barking and Dagenham has one of the highest rates of Diabetes in London and high rates of complications including kidney failure and amputations. Disease control measures including sugar levels are variable with patients at some practices having excellent results and others having significant room for improvement.
- 1.2. The actions suggested by the Health and Adult Services Select Committee concerning diabetes have been worked upon for a year and most areas show significant improvement.
- 1.3. In addition, the review of local diabetes services especially in the Integrated Diabetes service has identified some subtle but important discrepancies from best practice which could be worked upon by NHS Barking and Dagenham Clinical Commissioning Group's commissioners.

2. Additional progress to date and recommendation

- 2.1 The Diabetes Action Plan been completed (table 1) and been embedded in the Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Five Year Strategy. Apart from the progress outlined in table 1, the action plan has resulted in general improvements in communication, collaboration and pathways:
 - NHS Barking and Dagenham Clinical Commissioning Group (CCG) has prioritised diabetes clinical teaching and training for Practice Nurses and GPs from the allocated Public Health Grant.
 - The CCG has appointed a Director of Primary Care Improvement (Sarah See) which should improve aspects of performance and organisation.
 - The CCG has formed a Primary Care Improvement Group. Diabetes has been made a priority in the group's 2014/15 Forward Plan based on recommendations from the Director of Public Health Annual Report 2013
 - The Barking Havering and Redbridge group of CCGs has initiated a pathway redesign project to improve the diabetes pathway and rationalise costs.
- 2.2 The Health and Wellbeing Board is recommended to agree that the Diabetes Action Plan has been completed and is fit for return to the Health and Adult Services Select Committee.

Table 1- Progress on Diabetes Action Plan for The Health & Adult Services Select Committee

Number	HASSC recommendation	Responsible Officer:	Time Frame	R	Progress:
				A	
				G	
1	The Select Committee recommend that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.	Matthew Cole	Completed Jan 2014	G	The JSNA 2012/13 has been updated for accuracy and is currently being refreshed for 2014/2015.
2	The Select Committee recommend that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GPs to take a more pro-active role in diagnosis.	Matthew Cole	Completed 2013	G	A significant number of undiagnosed diabetics are identified routinely through the NHS Health Check programme. Proactive screening occurring in General Practice around high risk groups Gestational Diabetes and morbid obesity
3	The Select Committee recommend that action is taken to improve patients' understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.	Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group.	Completed September 2013	G	Diabetes patient booklet has been produced and distributed to practices and community services to share with all diabetic patients/carers.

4	<p>The Select Committee recommend that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual [Diabetes] Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.</p>	<p>Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group and Training Planning Group.</p> <p>Matthew Cole liaising with NHS England over GP performance.</p>	<p>Completed February 2014</p>	G	<p>Continued primary care training programme to ensure GPs and nurses include patient education as part of diagnosis and annual review.</p> <p>Training bid secured from HENCEL to develop primary care management of Long Term Conditions which will include following NICE recommendations. CCG developing clinical balanced scorecard to prioritise clinical improvement.</p> <p>The Primary Care Improvement Group has rolled out feedback and peer influencing sessions via the cluster structure. The locality management paper sets out the role of the CCG in influencing primary care improvements through the cluster model.</p> <p>The Primary Care Group has also selected Diabetes as a priority in their 2014/15 Forward Plan based on recommendations set out in the Director of Public Health Annual Report 2012, particularly around reducing variation in performance and care amongst GP Practices.</p> <p>The balanced scorecard and clinical champion programme will provide an infrastructure for improvement.</p> <p>Remuneration has been changed to requiring annual checks (rather than 15 months). Starts in 2013/14 so expect improvement to be 'visible' from late 2014/early 2015.</p> <p>The Quality and Outcomes framework has been altered for 2013/14 to raise the threshold for maximum payment on many indicators. Hence, remuneration structure should improve performance.</p> <p>Letter also written to NHS England about GP performance governance. CCG has appointed a Director Primary Care Improvement (Sarah See)</p> <p>Integrated Diabetes Service to develop and lead on structured education programme for practices, and to work with the CCG to develop and implement practice improvement plans. This needs to be prioritised in importance by all groups and develop closer working practices to improve attendance.</p> <p>The CCG, NHS England, The North East London Foundation Trust, The Local Medical Committee and GPs need to work together to focus on consistency in General Practice performance with plans to work with poorer performers.</p>
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5	For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.	Matthew Cole	March 2014	G	The Diabetes Community Health Profile and National Diabetes Audit are now produced annually and 2012/13 became available in December 2103. Will be incorporated into next JSNA.
6	The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.	Healthwatch	March 2014	G	Diabetes booklets have been revised and distributed to practices. Still need to promote their use in practices, pharmacies and community services.
7	That the Health and Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the borough, inviting the participation of the health group of the Barking and Dagenham Youth Forum.	Healthwatch	March 2014	G	Healthwatch Report completed, findings (Appendix A) being taken forward by the Diabetes Sub-Group of the Planned Care Steering Group.
8	That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health and Wellbeing Board.	Health Watch – Marie Kearns.	March 2014	G	Report available from ross.kenny@lbbd.gov.uk
9	That the Health and Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.	Dr Steve Feast (MD at NELFT) and Matthew Cole	March 2014	G	Report by Dr Sue Levi completed, findings (Appendix B) being taken forward by the Diabetes Sub-Group of the Planned Care Steering Group. Report available from ross.kenny@lbbd.gov.uk .
10	That the Health and Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.	Sharon Morrow/Sarah D'Souza/ Matthew Cole	March 2014	G	The Diabetes Sub-Group of the Planned Care Steering Group is in place covering BHRUT and CCGs and the first workshop took place in October 2013. The purpose of the diabetes project group is to support pathway redesign. Also, overlap with 9

3. Mandatory implications

3.1 Joint Strategic Needs Assessment (JSNA)

The JSNA shows there are some problems with diabetes care and outcomes in the borough. Diabetes is a critical disease for improving overall mortality measures and decreasing hospital admissions for ambulatory care sensitive conditions.

3.2 Health and Wellbeing Strategy

The Health and Wellbeing Strategy says that the Board will focus on improving the quality of care and support for people living with diabetes in the second year of the partnership (2014/15)

3.3 Integration

Improving diabetes outcomes will be complex and difficult to achieve. It will need to involve improvements in commissioning, contract monitoring and liaison between NHS England, the CCG, the Local Medical Committee (LMC) and The North East London Foundation Trust. It will also need improvements by GPs as providers and changes in the Community Service. The Health and Wellbeing Board might be a suitable location for high level discussions and identifying how to work better together.

3.4 Financial implications

There are no specific proposals with financial implications arising from the review at this stage.

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

3.5 Legal implications

There are no direct legal implications from this report. However, the author does highlight some deficits in the service and there is a limited risk of litigation if this results in poor outcomes for patients, particularly if the recommendations from this report are not put in place.

Implications completed by: Chris Pickering, Principal Solicitor - Litigation & Employment, Legal and Democratic Services

3.6 Risk management

The risk from this paper is that changes are slow or non-existent and the quality of care remains unchanged.

4. Background papers used in preparation of the report:

The Health and Wellbeing Strategy 2012-2015

The Health and Adult Services Select Committee: Review of Type 2 Diabetes Services across the London Borough of Barking and Dagenham. The report can be accessed here:

<http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Documents/Diabetes%20Scrutiny%20170413.pdf>

The Health and Adult Services Select Committee: Diabetes Action Plan October 2013.

5. Appendices

Appendix A: Recommendations derived from the engagement of Young People and Younger Adults conducted by Healthwatch regarding HASSC recommendation numbers 7 and 8

Appendix B: Recommendations derived from the Service Review conducted by Dr Sue Levi regarding HASSC recommendation number 9:

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Recommendations derived from the engagement of Young People and Younger Adults conducted by Healthwatch regarding HASSC recommendation numbers 7 and 8:

1. Commissioners of diabetic services need to have another look at the exercise programme for diabetic patients and ensure that the service is flexible enough so individuals can access without compromising their employment. It has been highlighted that people would like to access these services but the service only seems to be valid during working hours. Commissioners need to ensure that support is being provided to fit in with the needs and lifestyle of diabetic patients.
2. Many of the respondents have not been on any course/programme to increase their knowledge of their condition. Promotion of available courses needs to reach all diabetic patients and they need to be given the opportunity to attend. All GP practices need to write to their patients to see if they would like to attend a course and who to contact if they would like to go on one.
3. The findings from the questionnaires clearly show that individuals would like an online forum where individuals can; share their issues, exchange information, provide advice, receive advice and meet others who also suffer from type 2 diabetes. Therefore, commissioners and public health need to consider running an online forum as a pilot to see the impact of this on self management for diabetic patients.

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Recommendations derived from the Service Review conducted by Dr Sue Levi regarding HASSC recommendation number 9:

1. **Integration** – all the professionals, carers and patients join together in partnership to **own the health outcomes** of patients with diabetes in their local area – i.e. the diabetic population's average glucose control (HbA1C) belongs to the IDS, hospital staff and GPs.
2. **Leadership, partnership and clinical engagement.** The best achieving models of diabetes care have strong leaders, high levels of engagement and care seen as important by all contributors. Decisions need to be made locally as to the leadership role of the GP with a Special Interest, GP Clinical Director with responsibility for Diabetes and the Diabetes Consultant.
3. **Integrated IMT/data sharing** - poor outcomes e.g. sugar control, blood pressure and cholesterol must be owned by everyone and be visible to all in the service. This has been achieved elsewhere and auto-extraction would be possible via Health Analytics software access. This aspect could be researched elsewhere to see solutions elsewhere.
4. **Shared governance** – so that all are responsible for outcomes and all learn from poor experiences etc. Have to be accountable to someone even if not formal.
5. **Alignment of finances** – if providers are aligned towards outcomes e.g. blood sugar control or amputations etc then there will be a natural focus and increased cooperation. This could use the same metrics e.g. HbA1C but be used differently in the different organisations e.g. the Quality and Outcomes Framework in primary care but CQUINS (Commissioning for Quality and Innovation) for the community provider.
6. **Reconsider patient education provision** to approximately double availability. Needs new approaches to advertising the service, inviting patients, following up non-attendance etc. Also, increase the knowledge of the professional workforce on the vital role of patient engagement and ownership of their condition
7. The CCG, NHS England, The North East London Foundation Trust, The Local Medical Committee and GPs need to **work together** to:
 - Enhance and encourage prioritisation of diabetes care in each General Practice including monitoring if a practice has a named Lead Diabetes Clinician.
 - Monitor if the practice 'permits' in-reach training and peer education – and what to do if the practice doesn't allow entry.
 - How to manage poor Diabetes outcomes e.g. poor sugar control, high level of exception reporting etc.

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HEALTH AND WELLBEING BOARD

29 JULY 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, LBBD	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.		
Recommendations: The Health and Wellbeing Board is asked to: <ul style="list-style-type: none"> • Note the contents of sub-group reports set out in the Appendices 1 - 5 and comment on the items that have been escalated to the Board by the sub-groups. 		

List of Appendices

- Appendix 1: Integrated Care Sub-group
- Appendix 2: Mental Health Sub-group
- Appendix 3: Learning Disability Partnership Board
- Appendix 4: Children and Maternity Sub-group
- Appendix 5: Public Health Programmes Board

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Integrated Care Group

Chairs:

Dr Jagan John, Clinical Lead, NHS Barking and Dagenham Clinical Commissioning Group
Sharon Morrow, Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group

<p>Items to be escalated to the Health & Wellbeing Board</p> <ul style="list-style-type: none"> The Health and Wellbeing Board is asked to note progress of the integrated care sub group.
<p>Meeting Attendance</p> <p>27 May 2014: 53% (8 of 15) 23 June 2014: 56% (10 of 18)</p>
<p>Performance</p> <p>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. Further national guidance expected shortly re BCF which will impact on outcomes.</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <ul style="list-style-type: none"> The previous two meetings of the Integrated Care Group (May & June 2014) have been dedicated to the review of detailed project plans to support Better Care Fund (BCF) schemes. An engagement workshop has been organised on 16th July 2014 to improve how primary care, community services and social care can work together to deliver better care and outcomes for frail older people and patients with complex needs. The Group discussed the Intermediate Care Consultation process; Sharon Morrow is making arrangements for this to be presented at the H&WBB. The MH sub-group of HWB has identified dementia support priorities from the Dementia Needs Assessment recommendations. These will form basis of dementia action plan to be considered by HWB in September. The revised quality governance structure was presented and agreed at the Integrated Care Coalition meeting as part of a discussion around how the system reviews quality issues. Liaisons work with COOs taking place to implement First draft of an engagement plan for BCF schemes reviewed.
<p>Action and Priorities for the coming period</p> <ul style="list-style-type: none"> The group are finalising 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. Following receipt of further guidance from NHS England, BCF metrics will be discussed in more detail and a reporting template developed. An update on BCF outcomes and data will be provided to the Health and Wellbeing Board in September. The group is in the process of developing reablement metrics; the Health and Wellbeing Board will be updated on progress. The MH sub-group is leading on developing the implementation plan for dementia based on the dementia needs assessment. Both are due to go to Sept HWBB The group will review at the meeting on 28/07/2014 an updated end of life care paper to frame discussion at the HWBB meeting on 09/09/2014

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Mental Health sub-group

Chair: Gillian Mills, Integrated Care Director (Barking and Dagenham), NELFT

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>(a) None to note.</p>
<p>Performance</p> <p>Please note that no performance targets have been agreed as yet.</p>
<p>Meeting Attendance</p> <p>11 June, 2014: 40% (6 of 15)</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <p>(a) The Terms of Reference and membership of the group were agreed by those present at the meeting. Due to low attendance the decision was taken to review TOR in 6 months (December 2104)</p> <p>(b) User and carer engagement options paper considered. Agreement to organise a user and carer engagement event later in 2014, possibly October to coincide with Mental Health Day.</p> <p>(c) Discussion regarding the findings within the Dementia Needs Assessment report. The top 5 priorities were identified which will be shared with the Integrated Care Group to progress.</p> <p>(d) Impact of recession and welfare reforms (Scrutiny Committee report) draft action plan discussed.</p>
<p>Action and Priorities for the coming period</p> <p>(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.</p>

Contact:

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Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Commissioning and Partnerships, London Borough of Barking and Dagenham

<p>Items to be escalated to the Health & Wellbeing Board</p> <p>None.</p>
<p>Meeting Attendance</p> <p>1 July 2014: 45% (9 out of 20)</p> <p>29 April 2014: 65% (13 out of 20)</p> <p>18 March 2014: 60% (12 out of 20)</p> <p>3 February 2014: 58% (10 of 17 attendees)</p> <p>17 December 2013: 47% (8 of 17 attendees)</p> <p>4 November 2013: 71% (12 of 17 attendees)</p> <p>23 September 2013: 71% (12 of 17 attendees)</p> <p>12 August 2013: 88% (15 of 18 attendees)</p>
<p>Action(s) since last report to the Board</p> <ul style="list-style-type: none"> (a) One Learning Disability Partnership Board (LDPB) meetings have taken place since the last report in January 2014. (b) Topics that have been discussed recently include the Children and Families Bill, the market Position Statement, the ELF project, the Autism Plan, the Public Health Annual Report and Learning Disability Week. (c) Learning Disability Week took place from 14 to 20 June and included a range of fun events for people with learning disabilities and their families and carers. There was a sponsored walk in barking Park, a health information event, a five-a-side football tournament, healthy eating demonstrations, various fitness sessions including zumba, an Elvis and Abba night, a sports event held at Jim Peters Stadium and music and drama sessions.
<p>Action and Priorities for the coming period</p> <ul style="list-style-type: none"> (a) At future meetings the LDPB will discuss transport, the Care Bill, Fulfilling Lives, the Joint Assessment and Discharge Service, the Healthwatch consultation on personal budgets, Care City, the supported living contract and community safety issues.

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Children and Maternity Group

Chair:

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

<p>Items to be escalated to the Health & Wellbeing Board</p> <ul style="list-style-type: none"> ▪ The Health and Wellbeing Board is asked to note progress of the Children and Maternity Group.
<p>Meeting Attendance</p> <p>The group has not formally met since the last Health and Wellbeing Board. A Children and Maternity Group workshop was held on 2 July to agree joint priorities that will inform the workplan for the group, which was attended by 21 participants across health and social care.</p>
<p>Performance</p> <p>A performance dashboard has been drafted which will be reviewed when the workplan is finalised.</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <ul style="list-style-type: none"> ▪ A workshop was held on 2nd July to: <ul style="list-style-type: none"> – take stock of the progress that has been made one year on – agree joint priorities for the borough, understand where we are with progressing their delivery and the resources available to deliver – develop an implementation plan to progress those priority areas that are challenging to deliver including identifying risks and realigning resources if needed ▪ Leads were identified for the priority areas ▪ Emerging actions were developed for the top 4 priority areas
<p>Action and Priorities for the coming period</p> <ul style="list-style-type: none"> ▪ Organisations to confirm leads for priority areas ▪ Work plan to be finalized and agreed across LBBD and CCG

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Public Health Programmes Board

Chair: Matthew Cole, Director of Public Health

<p>Items to be escalated to the Health and Wellbeing Board</p> <ul style="list-style-type: none"> ▪ None
<p>Meeting Attendance</p> <p>The sub group has not met since the last Health and Wellbeing Board meeting.</p>
<p>Performance</p> <p>N/a</p>
<p>Action(s) since last report to the Health and Wellbeing Board</p> <p>N/a</p>
<p>Action and Priorities for the coming period</p> <p>N/a</p>

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HEALTH AND WELLBEING BOARD

29 JULY 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 . Please also note that the Barking and Dagenham, Havering and Redbridge Strategic Plan final submission is attached at Appendix 2 .		
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.		

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In this edition of my Chair's Report I discuss two documents that have been published for consultation, Making Intermediate Care Better and the Transforming Services, Changing Lives Case for Change. I also provide updates on the BHR Five Year Strategic Plan as well as the progress of the transfer of children's Public Health commissioning. 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*

Five Year Strategic Plan Final Submission

Members of the Health and Wellbeing Board should note that the Barking and Dagenham, Havering and Redbridge Five Year Strategic Plan was submitted to NHS England on 20 June 2014.

Back in December 2013, NHS England asked health commissioners to produce robust and ambitious Five Year Strategic Plans in collaboration with local authorities and providers, setting out the vision for how the local area will secure sustainable, high quality care for all over the next five years.

The BHR Strategic Plan has been developed by the BHR Integrated Care Joint Health and Social Care Steering Group (ICSG), a sub-group of the Integrated Care Coalition. The Health and Wellbeing Board commented on the draft Strategic Plan back in March 2014 before it was submitted to NHS England.

The Strategic Plan builds on the CCGs Operating Plan and the Borough's Better Care Fund Plan and sets out how colleagues across BHR will work together to deliver improved outcomes and patient experience, ensure a financially sustainable system, and meet the expectations of patients and the public.

It comprises a high level system narrative 'plan on a page' and a more comprehensive 'key lines of enquiry' section which includes the system vision, enquiries around the current position, improving quality outcomes, sustainability and improvement interventions.

The Five Year Strategic Plan can be found at **Appendix 1** of this Chair's Report. Although the Strategic Plan has been submitted to NHS England, I would invite Members of the Board to provide comments to Conor Burke, Accountable Officer or to Sharon Morrow, Chief Operating Officer at Barking and Dagenham CCG.

Letter sent to NHS England regarding safeguarding concerns

As Board Members will remember, a representative from NHS England gave a presentation at the June meeting on the processes for managing GP performance. In the discussion, points were raised about GP engagement in safeguarding procedures (both for children and vulnerable adults), as well as the contractual basis for GP performance management which the Board felt did not provide a very strong basis from which to intervene to improve quality of care.

In particular, a question was asked about whether the plan and process to address GP performance addressed the issues and recommendations laid out in the Francis Report on the care scandals at Mid-Staffordshire NHS Foundation Trust. The response was quite a clear 'no', which prompted concern from Board members.

I wanted to assure the Board that I have sent a letter to Anne Rainsberry at NHS England asking for her comments on NHS England's plans to implement the Francis recommendations in respect of general practice and, in particular, strengthening their role in safeguarding and practice for both children and vulnerable adults. I will ensure that I provide the Board with an update when I receive a response.

New community services up for national award

Please join me in congratulating the Barking and Dagenham Community Treatment Teams (CTT) and the Intensive Rehabilitation Service (IRS) who have both been shortlisted for a Health Service Journal (HSJ) Value Award. The judging panel includes senior figures from across the NHS in England.

The services also received a big thumbs up from patients in surveys commissioned by local GPs. On a scale of one to 10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. In May they also reached high scores of 9.5 out of 10 (CTT) and 9.6 out of 10 (IRS).

The CTT provides short term intensive care and support for people experiencing a health or social care crisis so they can be cared for in their own home, rather than in hospital. The team also helps people get home as soon as possible if they do need a short stay in hospital or community unit.

The IRS means that rather than needing a stay in a community bed for rehabilitation, people get support, such as physio, in their own homes where appropriate. The at-home support includes between one and four home visits each day, depending on the patient's needs.

Currently, the services, provided by the North East London Foundation Trust (NELFT), receive around 200 referrals a week across Barking and Dagenham, Havering and Redbridge. They are mainly aimed at older people, with 90 per cent of patients currently seen aged 65 or over.

Figures for the last seven months show nearly all patients supported by CTT – 90 per cent – do not go on to be admitted to hospital. IRS is similarly successful with 90 per cent of patients able to recover at home without needing to go to hospital.

Making Intermediate Care Better – Consultation

Following on from the above, Barking and Dagenham, Havering and Redbridge CCGs have begun a consultation exercise on improving intermediate care in the local health economy, entitled 'Making Intermediate Care Better'. The CCGs are consulting on making changes to intermediate care services, including permanently establishing the Community Treatment Teams (CTT) and Intensive Rehabilitation Service (IRS) as well as merging the three existing community rehabilitation units into one unit, on the King George Hospital site.

The Health and Adult Services Select Committee will be responding to the consultation document on behalf of the Council but other colleagues will no doubt also wish to comment. The consultation document can be found by visiting:

<http://www.barkingdagenhamccg.nhs.uk/intermediatecare>. Consultation responses can also be made via a questionnaire on this link. The closing date for the consultation is 5pm on Wednesday 1 October.

Lord Darzi Event

In September 2013, the Mayor of London set up the independent London Health Commission, chaired by Professor the Lord Darzi of Denham, to come up with innovative ways to meet London's health and healthcare needs. On Thursday 3 July, an event was held jointly between the London Health Commission and the BHR local health economy to reflect on the progress and achievements in integrated care so far. 120 people attended the event in Barking and heard from Lord Darzi, Cheryl Coppell, Chair of the Integrated Care Coalition and Chief Executive, LB Havering; Caroline Alexander, Chief Nurse (London) for NHS England; and representatives from our own Health and Wellbeing Board, Dr Jagan John and Dr Helen Jenner. I was pleased to be asked to close the event and I thought that it was refreshing to see health and local authorities on the same agenda, saying the same thing and working in partnership together. For more information on the event, or the London Health Commission, please visit <http://www.londonhealthcommission.org.uk/lhc-visits-outer-north-east-london/>

Update on the progress of the transfer of children's Public Health commissioning

As Board Members will remember from previous discussions, Public Health commissioning responsibilities for 0-5 year olds transfer to local authorities on 1 October 2015. The commissioning responsibilities for the 0-5 Healthy Child Programme (Universal/universal plus) include: health visiting services (universal and targeted services) and Family Nurse Partnership services (targeted service for teenage mothers).

It should be noted that it is the responsibility for commissioning, and not service provision, which will transfer. It is not therefore a transfer of the health visiting workforce, as this will still sit in provider organisations.

Child Health Information Systems (CHIS) and the 6-8 week GP check will remain as NHS England commissioning responsibilities.

On 1 December the Council will receive confirmation of the financial allocation which will accompany the transfer of commissioning responsibility for 0-5 year olds. The Department of Health expects to formally consult on allocations in September, so NHS England (London Region) and Directors have agreed that discussions should be convened now to jointly review a range of finance and workforce issues. The Director of Public Health and the Corporate Director of Children's Services will engage in a dialogue with NHSE commissioners and analysts. The purpose of these discussions will be to: understand the current and future spend data; receive an update on health visitor workforce numbers and growth; identify points for clarification; refine the data for later stages leading to the announcement of financial allocations; situate the finance and workforce data in the context of the health visiting specification and contracts.

A more detailed report on the transition of these responsibilities will be presented at the Board's September meeting. The transfer marks the final part of the overall Public Health transfer and the time between now and the transfer presents a vital period for partners to work together to ensure these services are in the best possible shape to help facilitate a seamless transition.

Transforming Services, Changing Lives Case for Change

Following the discussion at the last meeting, it should be noted that the Transforming Services, Changing Lives (TSCL) programme has published its interim [Case for Change](#). The Case for Change is out for consultation until the end of September and will be circulated to Health and Wellbeing Board Members in due course for discussion.

News from NHS England...

Making the NHS clearer for everyone

NHS England has produced a new guide to [Understanding the new NHS](#) which outlines the organisations and systems that define, sustain and regulate the NHS. This guide replaces a previous guide commissioned by Sir Bruce Keogh for junior doctors and incorporates changes to the structure and function of the NHS. The guide provides an understandable and informative guide for everyone working and training within the NHS.

NHS England works in partnership to improve care of the dying

NHS England, as part of the Leadership Alliance for the Care of Dying People has developed a new approach to caring for people in the last few days and hours of life. [One Chance to Get it Right](#), focuses on the needs and wishes of those dying and the people closest to them, and is based on five new Priorities for Care, and follows the recommendations of the independent Neuberger Report that included the phasing out of the Liverpool Care Pathway by 14 July 2014.

NHS England welcomes three new Non-Executive Directors

Professor Sir John Burn, Noel Gordon and David Roberts have been appointed by the Secretary of State as non-executive directors of NHS England, with effect from 1 July 2014, for a period of four years. They join the existing group of six non-executive directors.

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Barking and Dagenham, Havering and Redbridge Integrated Care Coalition

Strategic Plan final submission

June 2014

BHR strategic headline plan on a page

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

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

Consolidation of the three BHR boards objectives

System Objective 1

To reduce the number of years of life lost by 18%

System Objective 2

To improve health related quality of life for those with 1+ LTCs by 4%

System Objective 3

To reduce avoidable time in hospital through integrated care by 13%

System Objective 4

To increase the percentage of older people living independently following discharge by 3%

System Objective 5

To reduce the percentage of people reporting a poor experience of inpatient care by 12%

System Objective 6

To reduce the percentage of people reporting a poor experience of primary care by 15%

System Objective 7

To reduce hospital avoidable deaths; reducing the expected mortality rate by 9%

Achieved through the following interventions

Delivered through prevention and health promotion

Programmes of work informed by local Joint Strategic Health Needs Assessments/Health and Well Being Board Strategies and London wide preventative agenda.
Target areas: obesity/dementia/reduce inequalities/diabetes/cardiovascular disease/cancer/smoking cessation/breastfeeding/alcohol and substance misuse

Delivered through the primary care transformation programme

The Programme incorporates three major projects which are intrinsically linked to the ambition to improve patient experience of primary care services, the involvement of patients in the design of these services, and develop a sustainable primary care landscape which delivers accessible, responsive, and co-ordinated care.

Delivered through the integrated care strategy

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

Delivered through the acute re-configuration programme

Reconfiguring local A&E and maternity services to improve the quality of care for local people; developing KGH as a centre of excellence for children's and women's services with better co-ordination of services and pathways through collocation of services leading to enhanced experience for children and families and new and effective 24/7 Urgent Care Centres at Queens Hospital and King George Hospital (facilitated through the procurement of a high quality end to end urgent care pathway running through 2014/15).

Delivered through planned care programme

Implementing the Health for North East London programme for planned care which will see an improvement in clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. Other developments include productivity improvements for Musculoskeletal and ophthalmology pathways, service redesign for the diabetic pathway and re-procurement of the Independent Sector Treatment Centre.

Delivered through specialised commissioned services

Commissioning to consistently deliver best outcomes and experience for patients, working with local stakeholders to develop integrated services and align priorities

Delivered through the mental health service improvement plan

Strategic Commissioning Framework for Mental Health being developed and will include completion of full roll out of the access to psychological therapies programme by 2014/15 with the aim that at least 15% of adults with relevant disorders will have timely access to services

Delivered through the childrens services improvement plan

Develop childrens services improvement plan including assessment process for children needing an Education, Health and Care (EHC) Plan, Local Offer agreement to be confirmed and put children on EHC plans with cessation of 'statement system'

Managed via the following arrangements

Overseen through the following governance arrangements

Health and Wellbeing Boards (HWBB) oversee the process for strategic planning in each borough
Integrated Care Coalition (ICC): an advisory group to HWBBs - bringing senior leaders together to build a sustainable health and social care system
The coalition has two subgroups:

- Integrated care steering group: development and programme management of strategic plan
- Urgent care board: improvement plan for urgent care

All work streams have identified leads



Measured using the following success criteria

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

High level risks to be mitigated

Barking and Dagenham, Havering and Redbridge University Hospitals Trust quality and performance issues
Achieving financial targets
Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership)
Balancing increased patient expectation with improved outcomes at a time of less resource

Section Two | Key lines of enquiry (KLOE)

Segment	Key Line of Enquiry	Organisational Response	Supported by
<p>Submission details</p> <p>System vision</p>	<p>Which organisation(s) are completing this submission?</p>	<p>The organisations completing this submission comprise of:</p> <ul style="list-style-type: none"> • Barking and Dagenham Clinical Commissioning Group • Havering Clinical Commissioning Group • Redbridge Clinical Commissioning Group • London Borough of Barking and Dagenham • London Borough of Havering • London Borough of Redbridge • North East London Foundation Trust • Barking Havering and Redbridge University Hospital Trust <p>The senior leaders from the above organisations have committed to work together as the Integrated Care Coalition to build a sustainable health and social care system.</p> <p>The Integrated Care Coalition (ICC) is responsible for the development of the 5 year strategic plan. It is supported by the Integrated Care Steering Group (ICSG), a working sub group of the Coalition that coordinates input from across the system.</p>	<p>ToR Integrated Care Coalition. Yellow font denotes specific reference to strategic planning</p> <p> ICC_ToR.pdf</p> <p>ToR Integrated Care Steering Group:</p> <p> ICSG_ToR.pdf</p>
	<p>In case of enquiry, please provide a contact name and contact details</p>	<p>Ramesh Rajah BHR CCGs, Programme Management Office Tel: 0208 926 5327 Email: Ramesh.Rajah@onel.nhs.uk</p> <p>Jane Gateley BHR CCGs, Director of Strategic Delivery Tel: 0208 926 5136 Email: Jane.Gateley@onel.nhs.uk</p>	

		<p>Emily Plane BHR CCGs, Project Manager – Strategic Delivery Tel: 0208 822 3052 Email: Emily.Plane@onel.nhs.uk</p>	
	<p>What is the vision for the system in five years' time?</p>	<p>The vision for the BHR health economy is improving health outcomes for local people through best value care in partnership with the community.</p> <p>In five years time all people will have a greater chance of living independently longer; they will spend less time in hospital but when they do they will have a better experience than now. Services will be better integrated both within and across organisational boundaries, with more streamlined access and more of them being offered 24/7, delivering high quality health and social care to patients closer to home.</p> <p>Specifically, patients can expect the following outcomes in the next 5 years:</p> <ul style="list-style-type: none"> • Reduction of the number of years of life lost by 18% • Improved health related quality of life for those with 1+ LTCs by 4% • Reduced avoidable time in hospital through integrated care by 13% • Increase the percentage of older people living independently following discharge by 3% • Reduced percentage of people reporting a poor experience of inpatient care by 12% • Reduced percentage of people reporting a poor experience of primary care by 15% • Reduced number of hospital avoidable deaths by reducing the expected mortality rate at BHRUT by 9% 	

	<p>How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically:</p> <ol style="list-style-type: none"> 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the 	<p>The BHR vision clearly demonstrates the six characteristics:</p> <p>1. Citizen empowerment:</p> <p>The BHR vision and supporting interventions put the person at the centre of delivery.</p> <p>The responses from people to the local Call to Action events are addressed in the plan (held in response to the NHSE challenge to ensure that future development of services is framed around the 'I' statements to ensure that what the patient wants is at the heart of service development going forward). Local citizens specifically stated that they wanted:</p> <ul style="list-style-type: none"> • Better access to primary care • Partnership working with social care/integrated care • Improved hospital performance • Involvement of voluntary sector • More support for carers • Improved patient engagement/communication • Service co-design with patients and voluntary sector <p>Local people have been actively involved in:</p> <ul style="list-style-type: none"> • Developing and agreeing the case for change for acute reconfiguration and integrated care to ensure new services deliver improved performance, better outcomes and patient experience • Developing resulting new services e.g. A&E, Community Services, Childrens Services • On-going patient experience evaluation for Integrated Care and Community service developments <p>2. Wider Primary Care at scale:</p> <p>In response to NHSE's 'A Call to Action', BHR CCGs have established a Primary Care Transformation Programme (see intervention two below for more detail); working with the appropriate commissioning partners and other stakeholders, including patient representative groups. This programme will be the mechanism for delivering change</p>	
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	<p>productivity of elective care</p> <p>6. Specialised services concentrated in centres of excellence (as relevant to the locality)</p>	<p>within primary care through the commissioning of new and innovative primary care services at scale.</p> <p>The Programme incorporates three major projects which are intrinsically linked to the CCGs' ambition to improve patient experience of primary care services, the involvement of patients in the design of these services, and develop a sustainable primary care landscape which delivers accessible, responsive, and co-ordinated care. Two of the projects, Primary Care Improvement and GP Provider Development were specifically designed to deliver upon this ambition.</p> <p>A successful bid has been submitted for Prime Minister Challenge Fund monies to support the provision of new ways to access primary care and finding new ways to provide innovative services designed around the needs of the patient to reduce acute admission and A&E attendance and increase positive patient experience.</p> <p>All three projects have interdependencies and are aligned to many of BHR CCGs' other major programmes such as the urgent care procurement, integrated care programme and frailty programme.</p> <p>3. Modern model of Integrated Care:</p> <p>Implementation of the BHR Integrated Care Strategy agreed in 2012 and designed to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), and in particular to locality settings. The strategy seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to the quality of experience and outcomes. In 5 years, Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000) to enable more proactive management of the local population. The focus will be on those with long term conditions, high intensity service users, and those vulnerable to decline (see intervention three for more detail).</p> <p>4. Urgent and Emergency Care:</p> <p>The BHR economy faces significant challenges to improve the quality of urgent and emergency care.</p> <p>An Urgent Care Board has been established locally to drive forward improvement in services. Barking, Havering and Redbridge University Hospitals Trust (BHRUT) are in special measures and are currently in the process of implementing the Trust Improvement Plan to deliver tangible improvements through 2014. The Improvement Plan is aligned to the BHR strategic vision and principles.</p>	
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		<p>The acute reconfiguration programme targets improvements in urgent and emergency care and sets out the strategic plan for change (see intervention four below for more detail).</p> <p>5. Elective Care:</p> <p>Delivered by building on the Health for North East London programme for planned care which will see an improvement in clinical outcomes, patient satisfaction and a reduction in cancellations of scheduled elective care. The key developments over the next five years are the re-procurement of the Independent Sector Treatment Centre and a range of service re-design initiatives to manage demand within primary and community settings, improve the patient experience and deliver savings (see intervention five below for more detail).</p> <p>6. Specialised Commissioning:</p> <p>The national strategic plan for specialised commissioning has been paused during the national turnaround process. The intention remains to issue a draft strategy for 12-week public consultation in July 2014. Final publication of the 5-year strategy is expected in November 2014.</p>	
	<p>How does the five year vision address the following aims:</p> <ul style="list-style-type: none"> a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health 	<p>a) Sustainable NHS</p> <p>In 2013/14 Barking and Dagenham CCG achieved a 2% surplus, Havering CCG a 1% surplus and Redbridge CCG a breakeven position. The Strategic plan outlines a financial position that allows all CCG's to meet the 1% operating surplus requirement across the 5 year period and B&D CCG to continue to achieve the higher surplus amount. The CCG's will face a number of financial pressures to enable this position.</p>	

inequalities?

B&D

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	453	85	148	226	152	151
Surplus/(Deficit) Cumulative	4,768	4,854	5,001	5,228	5,380	5,531
Surplus/(Deficit) %	1.95%	1.92%	1.90%	1.93%	1.93%	1.93%

Havering

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(0)	28	99	78	59	77
Surplus/(Deficit) Cumulative	3,098	3,126	3,225	3,303	3,362	3,439
Surplus/(Deficit) %	1.02%	1.01%	1.01%	1.01%	1.00%	1.00%

Redbridge

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(2,919)	3,019	204	111	112	113
Surplus/(Deficit) Cumulative	0	3,019	3,223	3,334	3,447	3,559
Surplus/(Deficit) %	0.00%	1.00%	1.00%	1.00%	1.00%	1.00%

Financial Pressures

The three CCGs face a range of significant and ongoing financial pressures. It is estimated that at the end of 2014/15 the total CCG's budget will be underfunded against target in excess of £25m. At the end of 2014/15 Redbridge CCG will be underfunded by 6%, and Havering CCG underfunded by 3.8%. It is projected that Havering CCG will continue to move away from target during the operating plan period.

As a result of the financial pressures the CCG's are required to deliver large QIPP savings programmes.

BCF Schemes have been mapped to 7 outcome measures

**B&D**

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	8,020	10,916	7,763	5,588	5,596	5,649
Non-Recurrent		-	-	-	-	-
Total	8,020	10,916	7,763	5,588	5,596	5,649

Havering

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	10,778	14,729	11,095	7,740	7,130	7,290
Non-Recurrent		-	-	-	-	-
Total	10,778	14,729	11,095	7,740	7,130	7,290

Redbridge

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	15,600	12,268	11,128	5,735	5,911	5,931
Non-Recurrent		3,063	-	-	-	-
Total	15,600	15,331	11,128	5,735	5,911	5,931

Each of the CCG's faces the bulk of the QIPP requirement over the first two years. Redbridge CCG's requirement for QIPP will reduce most over the five year period as it will sustain a higher level of growth in allocation as it moves closer towards the funding target. Havering CCG's requirement remains relatively higher as a direct result of its lower funding increases.

b) Health outcomes

Each Borough within the BHR economy has reviewed their baseline position for the seven ambition targets and has planned five year reductions to align performance to equitable levels across the patch, as well as (where possible), closer to, or performing better against the national average. This is reducing health inequalities within the BHR system, which will make a significant change to the lives of patients living in Barking and Dagenham, Havering and Redbridge.

c) Reducing health inequalities

The supporting evidence to the right illustrates this shift towards equitable performance across the BHR economy.

The BHR economy is committed to ensuring a parity of service delivery across both physical and mental health conditions.

Who has signed up to the strategic

All Integrated Care Coalition organisations have signed up to the strategic vision. Health and Well Being Boards as well as individual organisations have been actively involved in

vision? How have the health and wellbeing boards been involved in developing and signing off the plan?

the development of plans and both draft and final version of the BCF, Operating Plans and the Strategic Plan go to Boards for sign off.

The draft Operating and BCF plans submitted on the 14 February were reviewed and signed off by the Health and Wellbeing Boards in each Borough on the following dates:

- Barking and Dagenham HWBB reviewed and approved the strategic plan on the 11 February 2014.
- Havering submission was agreed by the Havering Wellbeing Board at its formal meeting on Wednesday 12 February 2014.
- 17 February 2014: Redbridge HWBB reviewed and endorsed the draft Strategic Plan

Health and wellbeing boards have reviewed a draft version of the Strategic Plan prior to submission on 4 April 2014:

- 25 March 2014: Barking and Dagenham HWBB reviewed and endorsed the draft Strategic Plan
- 19 March 2014: Havering HWBB reviewed and endorsed the draft Strategic Plan
- March 2014: Draft Strategic Plan reviewed and endorsed by the Redbridge Chief Operating Officer and the Redbridge Director of Adult Social Care in lieu of the next Redbridge HWBB which is scheduled for July 2014





Development of the final plan in preparation for submission on 20 June has incorporated:




- NHS England feedback
- Outputs from the 'Call to Action' themes
- Review by the Integrated Care Steering Group including co-production of the 'prevention' element of the plan with BHR Public Health Directors
- Review by BHR Patient Engagement Forums

The sign off process for the final plan is as follows:

- 16 June: endorsement of the plan by the Integrated Care Coalition
- June 2014: Governing Bodies to receive the final Strategic Plan

	<ul style="list-style-type: none"> July 2014: Provider Boards to receive the final Strategic Plan July 2014: Health and Wellbeing Boards to receive the final Strategic Plan 	
How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	<p>There is complete alignment between plans.</p> <p>Integrated Care Strategy initiatives are embedded in the Better Care Fund plans, with the focus in years one and two being on the following initiatives:</p> <ul style="list-style-type: none"> Integrated Teams New model of intermediate care including Community Treatment Team / Intensive rehabilitation service Joint Assessment and Discharge Team A move to seven day working 	
What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	<p>To respond to the challenge of the NHSE Call to Action, each borough undertook a series of engagement events between October to December 2013. These involved and covered a wide range of stakeholder groups.</p> <p>The following themes were identified:</p> <ul style="list-style-type: none"> Better access to primary care Working in partnership with social care/integrated care Improved hospital performance Involvement of voluntary sector More support for carers Improved patient engagement/communication <p>The feedback from the CTA engagement programmes has informed development of CCGs' local and strategic five year plans for their respective populations.</p>	
Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and	<p>Yes, we will report back to public and patients through local forums including our regular CCG Patient Engagement Forums (PEFs) with cascade down to the practice level and Practice Participation Groups (PPGs).</p> <p>The draft Strategic Plan on a page was shared with the following patient groups:</p> <ul style="list-style-type: none"> 20 March 2014: B&D Patient Engagement Forum 	

	feedback has been included	<ul style="list-style-type: none"> • 26 March 2014: Havering Patient Engagement Forum • 7 May 2014: Redbridge Patient Engagement Forum <p>Feedback was positive, and suggestions received (for example, the inclusion of a glossary) have been incorporated into the final Strategic Plan.</p>	
Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	<p>Yes, there has been an ongoing assessment of the current state. The key system wide strategic assessments have been the Health for NEL programme (2009 – 2011) and the Integrated Care programme (2012) as evidenced in the following documents:</p> <ul style="list-style-type: none"> • Developing a Viable Acute Services Provider Landscape in North East London - INEL and ONEL Sector PCTs and acute trusts Case for Change (03 December 2008) • Health for NEL decision Making Business Case – December 2010 • August 2012: Integrated Care in Barking and Dagenham, Havering and Redbridge Case for Change • November 2012: Developing a Commissioning Strategy for Integrated Health & Social Care Services in Barking & Dagenham, Havering and Redbridge Strategic Outline Case <p>These form the foundation of the system plan. In addition, each borough has refreshed its JSNA and Health and Well Being Board Strategy, and CCGs have had external reviews (2013 and 2014) to support the identification of QIPP opportunities. CCGs have more recently worked with NHS England and both have confirmed back to the ICSG that opportunities identified in the value packs do correlate and have been included in Operating Plans.</p> <p>As part of the North East London challenged economy, the BHR SPG have been working with McKinsey (funded by the Tri-partite panel) who have stress tested the financial analysis across the five year period.</p>	 NEL Case for change_v20b 081201  DMBC 021210 FINAL V1.0. pdf  C4C. pdf  BHR ICS Strategic Outline Case 2012-11
	Do the objectives and interventions identified below take into consideration the current state?	Yes, they respond directly to the current state and agreed case for change.	

	Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	Yes, the plans are based on delivery of years one and two of the Strategic Plan.			
Improving quality and outcomes	At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?	Ambition area	Metric	Proposed attainment in 18/19	<p>Data analysis packs for each of the three BHR Boroughs detailing historic performance against each measure, trend analysis, position against national average and position against fellow BHR Boroughs.</p> <p> Redbridge baselines & trajectories.pdf</p> <p> B&D Ambitions & BCF baselines & trajectory</p> <p> Havering baselines trajectories narrative</p>
		To reduce the number of years of life lost	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people)	To reduce the number of years of life lost by 18%	
		To improve health related quality of life for those with 1+ LTCs	Health related quality of life for people with long term conditions (sum of the weighted EQ-5D values)	To improve health related quality of life for those with 1+ LTCs by 4%	
		To reduce avoidable time in hospital through integrated care	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	To reduce the number of avoidable hospital admissions by 13%	
		To increase the % of older people living independently following discharge	Number of people age 65+ discharged from hospital into reablement/rehabilitation services still at home after 91 days <i>CCG plans on this ambition map directly to Better Care Fund plans set for 2 years at Health & Wellbeing Board level. BHR Boroughs, particularly B&D are already performing well against this indicator and are achieving national average, therefore in part the targets for some boroughs involve a level of 'maintaining' current high performance levels</i>	To increase the percentage of older people living independently following discharge by 3%	
		To reduce the % of people reporting a poor experience of inpatient care	Patient experience of hospital care	To reduce the % of people reporting a poor experience of inpatient care by 12%	
		To reduce the % of people reporting a poor experience of primary care	Patient experience of GP services and GP Out of Hours service	To reduce the % of people reporting a poor experience of primary care by 15%	
		Reduced number of hospital avoidable deaths by reducing the expected mortality rate at BHRUT by 9%	Standardised Hospital-level Mortality Indicator (the ratio of the observed number of deaths to the expected number of deaths for a trust (provider).	To reduce the BHRUT SHMI ratio by 9% and maintain this reduction	

<p>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</p>	<p>Strategic plans for change in BHR (the Health for NEL and Integrated Care programmes) have been clinically led and have included extensive clinical engagement across the professions.</p> <p>Supporting corporate processes (e.g. Health and Well Being Boards; Integrated Care Coalition; Integrated Care Steering Group; Organisation level Boards; Executives; Clinical Director Meetings) have strong clinical input.</p> <p>Public Health in each borough have supported teams to produce coherent plans that describe priority areas for improving outcomes and associated interventions.</p>	
<p>What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?</p>	<p>As described above, a range of intelligence has been used including:</p> <ul style="list-style-type: none"> • Borough level JSNAs and Health and Well Being Board Strategies • Public/patient feedback • Health for NEL case for change/business case • Integrated Care case for change and strategy • Urgent and emergency care reviews at BHRUT (and supporting diagnosis evidence) • External CCG assessments (those carried out for authorisation process and QIPP reviews) • Local level service reviews • Primary care outcome data • Performance dashboards (e.g. urgent care dashboard, community services dashboard) • Data value packs • Five year assessment of the system wide financial position (McKinsey) 	
<p>How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?</p>	<p>The local JSNA / Health and Wellbeing Strategies have driven the identification of the quantifiable ambitions. The outcomes identified have been mapped to the JSNA and the 7 ambitions to ensure alignment and fit.</p>	

	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	As described above, Health and Well Being Boards in each borough have played an active role in both the development of plans and the formal endorsement process. This process includes the BCF, Operating Plan and Strategic plan so that boards can also assure themselves that there is alignment.																																																							
Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	<p>Key Planning Assumptions: Each CCG will attain different rates of growth across the next five years as their allocations move further towards incorporating the revised allocation formula. Redbridge CCGs allocation will continue to increase the most as they are furthest away from their target population driven allocation.</p> <p>B&D</p> <table border="1" data-bbox="667 563 1888 595"> <tr> <td>Notified Allocation Change (%)</td> <td>3.50%</td> <td>2.61%</td> <td>3.09%</td> <td>2.92%</td> <td>2.86%</td> </tr> </table> <p>Havering</p> <table border="1" data-bbox="667 647 1888 679"> <tr> <td>Notified Allocation Change (%)</td> <td>2.41%</td> <td>1.67%</td> <td>2.30%</td> <td>2.31%</td> <td>2.31%</td> </tr> </table> <p>Redbridge</p> <table border="1" data-bbox="667 735 1888 767"> <tr> <td>Notified Allocation Change (%)</td> <td>4.65%</td> <td>4.05%</td> <td>3.47%</td> <td>3.35%</td> <td>3.29%</td> </tr> </table> <p>A number of planning assumptions that relate to cost and activity changes have been made and are outlined below.</p> <table border="1" data-bbox="667 922 1917 1134"> <tr> <td>Tariff Change - Acute (%)</td> <td>-1.50%</td> <td>-1.60%</td> <td>0.40%</td> <td>-0.60%</td> <td>-0.70%</td> </tr> <tr> <td>Tariff Change - Non Acute (%)</td> <td>-1.80%</td> <td>-1.60%</td> <td>0.40%</td> <td>-0.60%</td> <td>-0.70%</td> </tr> <tr> <td>Demographic Growth / Non demographic growth (%)</td> <td>4.50%</td> <td>4.50%</td> <td>4.50%</td> <td>4.50%</td> <td>4.50%</td> </tr> <tr> <td>Non Demographic Growth - CHC (%)</td> <td>1.00%</td> <td>1.00%</td> <td>1.00%</td> <td>1.00%</td> <td>1.00%</td> </tr> <tr> <td>Non Demographic Growth - Prescribing (%)</td> <td>5.00%</td> <td>5.00%</td> <td>5.00%</td> <td>5.00%</td> <td>5.00%</td> </tr> <tr> <td>Non Demographic Growth - Other Non Acute (%)</td> <td>1.40%</td> <td>1.40%</td> <td>1.40%</td> <td>1.40%</td> <td>1.40%</td> </tr> </table> <p>Income & Expenditure: The table below highlights the projected spend profile over the 5 year period.</p> <p>Income and expenditure for BHR CCG's includes investments in community services and other programme areas as activity is transferred from secondary care into community settings.</p>	Notified Allocation Change (%)	3.50%	2.61%	3.09%	2.92%	2.86%	Notified Allocation Change (%)	2.41%	1.67%	2.30%	2.31%	2.31%	Notified Allocation Change (%)	4.65%	4.05%	3.47%	3.35%	3.29%	Tariff Change - Acute (%)	-1.50%	-1.60%	0.40%	-0.60%	-0.70%	Tariff Change - Non Acute (%)	-1.80%	-1.60%	0.40%	-0.60%	-0.70%	Demographic Growth / Non demographic growth (%)	4.50%	4.50%	4.50%	4.50%	4.50%	Non Demographic Growth - CHC (%)	1.00%	1.00%	1.00%	1.00%	1.00%	Non Demographic Growth - Prescribing (%)	5.00%	5.00%	5.00%	5.00%	5.00%	Non Demographic Growth - Other Non Acute (%)	1.40%	1.40%	1.40%	1.40%	1.40%	
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		BHR							
		£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	
		Acute	478,822	478,092	486,988	497,488	507,797	516,935	
		Mental Health	87,168	87,917	89,646	93,659	96,543	99,320	
		Community	81,137	80,035	83,220	88,397	91,013	94,000	
		Continuing Care	45,066	45,282	46,749	50,957	54,965	58,705	
		Primary Care	104,794	105,320	107,048	112,215	117,106	121,946	
		Other Programme	19,446	33,938	58,783	55,548	56,751	59,432	
		Total Programme Costs	816,432	830,584	872,435	898,264	924,175	950,338	
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	<p>Yes, the key themes raised from local engagement were:</p> <ul style="list-style-type: none"> • Better access to primary care – See Intervention 2 below • Partnership working with social care/integrated care – reflected in overall system approach • Improved hospital performance – See Intervention 4 below • Involvement of voluntary sector – reflected in overall system approach but recognised as an area that needs to be developed • More support for carers – recognised in borough BCF plans • Improved patient information / communication – relevant to all interventions of the BHR Strategic Plan • Service co-design with patients and voluntary sector – relevant to all interventions of the BHR Strategic Plan 							
	Can the plan on a page element be identified through examining the activity and financial projections covered in operational and financial templates?	<p>The plan on a page outcome targets for the BHR economy can be identified through examination of the activity projections covered in the operational templates. A mapping exercise has been completed using the baseline and five year reduction targets for each of the BHR Boroughs to produce a consolidated summary position of the BHR target projections for the BHR strategic plan outcome measures (see supporting evidence).</p> <p>CCGs are reviewing local data to make explicit links to the related ambition as part the Better Care Fund.</p>							
Improvement	Please list the material	<u>Intervention One: Prevention and Health Promotion</u>							

<p>interventions</p>	<p>transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the :</p> <ul style="list-style-type: none"> • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to 	<p><u>Public Health</u></p> <p>Public Health is about improving the health of the population, rather than treating the diseases of individual patients Public health professionals work with other professional groups to monitor the health status of the community, identify health needs, develop programmes to reduce risk and screen for early disease, control communicable disease, foster policies which promote health, plan and evaluate the provision of health care, and manage and implement change.</p> <p>Public Health Outcomes Framework</p> <p>The new public health outcomes framework concentrates on two high-level outcomes to be achieved across the public health system. These are:</p> <ul style="list-style-type: none"> • increased healthy life expectancy • reduced differences in life expectancy and healthy life expectancy between communities <p>The outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Using a measure of both life expectancy and healthy life expectancy will enable the use of the most reliable information available to understand the nature of health inequalities both within areas and between areas.</p> <p>A set of supporting public health indicators will help focus understanding of progress year by year nationally and locally on those things that matter most to public health. The indicators, which cover the full spectrum of public health and what can be currently realistically measured, are grouped into four 'domains':</p> <ul style="list-style-type: none"> • improving the wider determinants of health – tracking progress in wider factors that affect health and wellbeing such as housing, employment and the environment • health improvement – tracking progress in helping people to live healthy lifestyles and make health choices such as helping people to stop smoking, increase levels of physical activity and improving nutrition • health protection – tracking progress in protecting the population's health from major incidents and other threats • healthcare public health and preventing premature mortality – tracking progress in reducing numbers of people living with preventable ill health and people dying 	
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	<p>success</p> <ul style="list-style-type: none"> • Confidence levels of implementation <p>The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.</p>	<p>prematurely such as heart disease, stroke respiratory and liver disease</p> <p>All three boroughs have developed a Health and Wellbeing strategy with key priorities for delivery which is based on the needs of its population. Activities carried out to improve the wellbeing of residents in the boroughs will be monitored using a number of outcome measures identified from the following sources: the Public Health Outcomes Framework, Adult Social Care Outcomes Framework and the NHS Outcomes Framework.</p> <p>The public health priorities identified in this plan are key aspirations for the BHR economy. This builds on existing collaborative work between the three Local Authorities, BHR CCGs and other partners.</p> <p>The local Health and Wellbeing Strategies¹ set out the priorities for health improvement for the three boroughs, the objectives outlined below derive from these and can be actioned by individual organisations, or collectively as appropriate. There are a number of documents that offer evidence-based effective ways of achieving our objectives, these need to be reviewed and included in subsequent action plans i.e.</p> <ul style="list-style-type: none"> • The Institute of Health Equity’s “Working for Health Equity: The Role of Health Professionals”² - a report and range of Statements for Action (written by Royal Colleges and other representative organisations) regarding the actions health and social care professionals can take to tackle health inequalities through their practitioner role. • The World Health Organisation’s health promoting hospitals workstream³ - providing a useful framework for pulling these areas together in secondary care. <p>National Government organisations have also set out their roles, and examples of actions that can be taken at a local level, around reducing premature avoidable mortality⁴. Our joint aspirations to improve services in the BHR systems will be delivered through the following priorities:</p>	
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¹ <http://www.lbbd.gov.uk/AboutBarkingandDagenham/PlansandStrategies/Documents/HealthandWellbeingStrategy.pdf>,

<http://www2.redbridge.gov.uk/cms/idoc.ashx?docid=DD42296D-14C5-47AC-A1E6-2BF81626B4EC&version=-1> and <http://www.havering.gov.uk/Documents/Health-and-wellbeing/HAWBS%20Final%202012.pdf>

² IHE. 2013. Working for Health Equity: The Role of Health Professionals. University College London

Available at: <https://www.instituteoftheequity.org/projects/working-for-health-equity-the-role-of-health-professionals>

³ WHO. 2007. The International Network of Health Promoting Hospitals and Health Services: Integrating health promotion into hospitals and health services, Concept, framework and organization. WHO Europe.

Available at: http://www.euro.who.int/_data/assets/pdf_file/0009/99801/E90777.pdf?ua=1

⁴ DH. 2014. Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf

Priorities from the Cancer Commissioning Strategy for London 2014/15 – 2019/20

Alongside the rest of London, BHR aims to achieve significant, measurable improvements in outcomes for patients, including the saving of additional lives currently lost to cancer, improved patient experience and effective use of financial resources. This will be achieved through a collaborative, clinically-led, patient-centred approach, maximising the effectiveness of pan-London strategic leadership.

Cancer is one of 4 top priorities for outcome improvement across London and represents one of the top three causes for premature mortality across BHR CCG's. Survival rates, which although are good in places across BHR relative to England, vary with poorer 1 year survival from colorectal cancer in Barking and Dagenham and Havering and for Breast and lung cancer in Barking and Dagenham. It is the aspiration of BHR to achieve European and international best survival rates equating to approximately 135 lives saved per year through:

Priorities for the cancer programme in London include localising and supporting the implementation of the Cancer Commissioning Strategy for London 2014/15 – 2019/2020,⁵ which was produced in partnership between NHS England (London), London's CCGs, Public Health England, the Integrated Cancer systems and charity partners, which sets out a plan to boost cancer services, enhance patient experience and raise survival rates. The key areas in the Cancer Commissioning Strategy that the BHR system will aspire to include:

- Prevention - aspire to commission well-evidenced prevention programmes to tackle factors such as smoking, unhealthy diets and alcohol.
- Cancer screening - improve the take-up of national screening programmes.
- Earlier detection of cancer in the community – focus on early detection and population awareness strategy.
- Reducing variation – using contracts to improve hospital performance and in primary care.
- Reducing inequalities - consider all aspects of an individual when planning treatment decisions.
- Improving access to service - use contracts to improve access to some cancer services; alongside the rest of London for breast, colorectal and cancer of the

⁵ <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/01/lon-canc-comm-strat.pdf>

		<p>unknown primary and acute oncology.</p> <ul style="list-style-type: none"> • Living with and beyond cancer - improve support and care coordination for the BHR population living with and beyond cancer. • Improving the cancer patient experience for all patients living with cancer. <p>The planning of these initiatives in the above areas will be taken forward through the contracting route.</p> <p><u>NHS England priorities</u></p> <p>Cancer Screening</p> <ul style="list-style-type: none"> • Coverage and up take to be increased to at least minimum target (dependant on service) <p>Immunisations</p> <ul style="list-style-type: none"> • Patient experience and values are integrations into the design and delivery of services • Measured through the Friends and Family Test and other patient experience metrics <p>Military health and Health in the Justice system</p> <ul style="list-style-type: none"> • to improve the engagement and support for those in contact with the Health in Justice system • to reduce re-offending for individual offenders • to improve the efficiency and effectiveness through better collaboration of commissioning partners <p><u>Barking and Dagenham, Havering and Redbridge priorities:</u></p> <p>Alcohol</p> <ul style="list-style-type: none"> • All service users/patients where alcohol misuse is known or suspected to be screened and managed using an evidence-based pathway⁶ (currently in development) <p>Smoking cessation</p>	
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⁶ NICE. 2014. Nice Pathways: Alcohol-use disorders overview. Available at: <https://pathways.nice.org.uk/pathways/alcohol-use-disorders#content=view-node%3Anodes-prevention>

- To work towards smoking status being recorded for all patients and social care service users
- All smokers should be offered smoking cessation and this should be recorded
- Commissioned smoking cessation services should take into account the needs of vulnerable groups e.g. those with mental health issues, as well as carry out targeted work reaching hard to reach groups
- All GP practices to ensure chronic disease programmes have an effective smoking cessation component that is integral to the delivery of care
- Smoking cessation to be part of all inpatient care including pre and post-operative care and maternity services (to be delivered by midwives)

Sexual health

- A reduction in sexually transmitted infections following the commissioning of a tri-borough integrated sexual health service (in progress)

Obesity (see also **chronic disease and falls** section below)

- Each borough to have in place an obesity care pathway that incorporates prevention, tiers 1, 2 and 3 with services informed by The National Child Measurement Programme

Chronic disease and falls

- Primary care to embed active case-finding, screening and early identification and appropriate management of chronic disease e.g. CVD, diabetes, COPD and those at risk of falling
- All GP practices to ensure chronic disease programmes have an effective lifestyle component or linkage with an obesity care or healthy adult/child pathway that is integral to the delivery of care
- To identify low uptake of NHS Health Checks and take action in those communities affected

Health promotion messages

- All BHR organisations to ensure borough residents receive appropriate, effective, consistent messages through health promotion literature and campaigns that incorporate and complement relevant national campaigns including, obesity, cancer, diabetes and NHS Health Checks

Social determinants of health

- Social Prescribing⁷ to be embedded in GP surgeries and hospital discharge planning. That is, for a holistic approach to medicine to be taken by identifying any underlying social factors that are impacting on a patient's health (i.e. social determinants of health) and actively referring them to services for appropriate support e.g. existing housing services and poverty mitigation, also to opportunities that enhance social networks and community cohesion e.g. volunteering and timebanking⁸. Thus ensuring a reduction in inappropriate use of healthcare services

Children and Young People (see also **obesity** section below)

- To aim towards Baby Friendly accreditation⁹ across the BHR health economy
- To ensure women have a healthy pregnancy through targeted work to reduce smoking in pregnancy and encouraging women to access antenatal care early.
- To aspire to reaching herd immunity levels of childhood immunisations by including immunisation in treatment and care pathways for children in secondary and social care and by call and recall methods in primary care
- In conjunction with the transition of the health visiting service in 2015, an integrated early years programme linked to the 5-19 programme should be developed and commissioned
- All boroughs in conjunction with schools to aspire to be Non-smoking Boroughs by preventing children and young people initiating smoking

Mental ill health

- Aim towards all staff to attend Mental Health First Aid training to ensure they recognise the signs and symptoms of anxiety, depression, suicide and psychoses in people in their working and social/family life
- Increase access to IAPT services
- All boroughs to aim towards becoming Dementia Friendly¹⁰ communities

⁷ Brandling J and House W. Social Prescribing in General Practice: Adding meaning to medicine. Br J Gen Pract. Jun 1, 2009; 59(563): 454–456

⁸ Timebank UK: <http://www.timebanking.org/about/what-is-a-timebank/>

⁹ UNICEF. 2014. Moving from the current to the new Baby Friendly Initiative Standards: A guide for those working towards or maintaining Baby Friendly accreditation

Available at: http://www.unicef.org.uk/Documents/Baby_Friendly/Guidance/transition_guidance.pdf

¹⁰ <https://www.dementiafriends.org.uk>

Workforce

- All BHR organisations to develop a workforce health and wellbeing strategy (e.g. Barts and the London NHS Trust¹¹). These strategies should ensure the workplace is a health promoting environment
- To improve the income of the poorest members of the population

Aspirational milestones:**Year 1**

- Working groups to be set up to take forward the objectives above using the Statements for Action detailed in the Institute of Health Equity's report "Working for Health Equity: The Role of Health Professionals" the WHO's health promoting hospitals workstream and The Department of Health's "Living well for longer" report
- A digital referral process in place in all GP practices to allow primary care staff to easily refer patients into obesity care pathways and other lifestyle interventions and services that will improve their social determinants of health i.e. Social Prescribing
- Hospital discharge planning to be reviewed to ensure that social determinants of health support services are included
- A reduction in smoking during pregnancy and late access to antenatal care.
- Smoking prevention plans to be developed in conjunction with schools
- Working towards all staff across the BHR health economy to complete Mental Health First Aid training
- Working towards all smoking status of all health and social care users to be recorded
- All smokers to be offered smoking cessation and for this to be recorded
- Chronic disease pathways to be developed in primary care

Year 2

- All partners to be working towards gaining Baby Friendly status

¹¹ IHE. 2011. Barts and the London NHS Trust: Health promoting hospitals strategy. Available at: <https://www.instituteofhealthequity.org/projects/barts-and-the-london-nhs-trust---health-promoting-hospitals-strategy>

- Integrated early years programme to be commissioned
- A tri-borough integrated sexual health service to be commissioned
- All organisations to have a workforce health and wellbeing strategy and resulting action plan in place
- Smoking cessation to be part of primary care chronic disease programmes and inpatient care
- Obesity care pathways to be in place across 3 boroughs
- All appropriate service user/patients to be assessed against the alcohol care pathway
- Primary care to embed active case-finding, screening and early identification of chronic disease and people at risk of falls
- Low uptake of NHS Health Checks and screening programmes to be assessed and action taken in those communities affected
- A cross-borough communications strategy to be developed that incorporates and complements relevant national campaigns including, obesity, cancer, diabetes and NHS Health Checks

Year 3

- Population / herd immunity levels reached
- All boroughs to work towards becoming Dementia Friendly communities

These aspirational milestones are subject to further review once the implications of the Care Act, the Child and Family Bill (which includes allocations for the 0-5 year old programmes) and NHS England public health spending allocations from 15/16 onwards are understood.

Intervention Two: Primary Care Transformational Programme

BHR CCGs are committed to playing its part in ensuring that primary care services in the borough meet the needs of local people.

The CCGs want to empower and support patients and carers to maintain independence, and work in partnership in an integrated, co-ordinated health and social care system to achieve this. Fundamental to achieving this vision will be the role of general practice and

<p>the wider primary care 'family' (i.e. community pharmacy, dentistry and high street opticians), however, primary care needs to transform in three main ways to deliver:</p> <ol style="list-style-type: none"> 1) Improvement in the quality and performance of primary care 2) General practice working more effectively with others to deliver co-ordinated and integrated care 3) Where appropriate, smaller general practice units working together as a single unit to realise better outcome and benefits for patients and the local health economy <p>The Primary Care Transformation Programme aims to allow local GPs to lead a system that empowers patients to feel more supported to manage LTCs and increase positive patient experience and reduce unplanned attendances and admissions to hospital.</p> <p>The programme has three key areas of focus:</p> <ul style="list-style-type: none"> • The development of the primary care provider market to ensure that it is fit for purpose and ready to respond to commissioning intentions • Quality improvement: identifying local needs and working with partners to set standards • The co-commissioning of primary care services by NHSE, Public Health and the CCGs to provide a whole-system approach to meet our population needs <p>The programme will be shaped working with stakeholders and other commissioning organisations; ensuring alignment with other transformational programmes relating to urgent and integrated care. The programme will not be limited to general practice but seek to include other independent contractors, in particular community pharmacy, general ophthalmic providers and dentists as appropriate.</p> <p><u>Interventions required:</u></p> <p>A successful bid has been submitted for Prime Ministers Challenge Fund monies to support the provision of new ways to access primary care and finding new ways to provide innovative services around the needs of the patient. These will include:</p> <ul style="list-style-type: none"> • Extending standard primary care provision during the week, from 6.30-10pm • Alternatives to traditional out of hours provision, such as weekend access to routine and urgent GP and nurse appointments • GP-led triage services

- Specialist expertise provided in a community setting
- Implementation of a unified point of access
- Providing easier access to clinical support prior to A&E

The programme team will work with NHS England, NHS Property Services, the LETB, Local Authorities, Public Health and local professional committees, patient representative groups and other statutory organisations to address gaps in ambitions, smart solutions for IT, health informatics, workforce development and estates issues.

Expected outcome:

- Improved patient experience and satisfaction
- More accessible primary care services, with additional capacity to manage urgent primary care needs
- Reduced numbers of patients attending A&E
- Reduced number of non elective emergency admissions
- Patients supported by the complex care service, and achieving better health outcomes for a range of LTCs
- The project group will develop a full list of scheme specific outcome measures and targets

Investment costs:

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
Prime Ministers Challenge Fund	2,000	4,000	4,000	4,000	4,000
Over 75's Primary Care investment	3,618	3,698	3,808	3,939	4,139
	5,618	7,698	7,808	7,939	8,139

Implementation timeline:

The Primary Care Transformation Programme is a 5-year strategic programme comprising of 3 projects. The Primary Care Improvement project will run for the life of the programme.

The GP Provider Development project will run through 2014/15 only.

The Prime Ministers Challenge Fund project will run from 01.04.14 – 31.03.16, and the two main schemes within this project will be implemented as follows:

- Scheme 1: Improved Access; 14.04.14 – 28.02.15

- Scheme 2: Complex Care; 30.06.14 – 28.02.15

Barriers to success:

- Finance – achieving the shift from secondary care to primary care to enable continuation of schemes beyond the pump-priming of the Challenge Fund
- Information Governance – linking IT system across different organisations
- Engagement with key stakeholders
- 6 month timeframe to establish unified point of access
- Workforce – being able to attract suitably qualified, experienced medics, clinicians and non-clinicians to work in our boroughs

BHR will work with NHS England to develop practice succession strategies that will enable and support the creation of larger primary care centres with general practice services being provided through a refreshed delivery model so that these services are sustainable. The GP clinical workforce is at the heart of delivery of good family health care. BHR will work with NHS England and the LETB to identify career aspirations for young doctors and nurses so that this can inform the development of the models of service delivery. We believe that new models of service delivery and fit for purpose premises will make BHR a place where young doctors and other primary care clinicians will want to come to work. This element of primary care workforce development will be aligned with joint commissioning and continued delivery of the Integrated Care programme.

BHR commissioning of LISs, such as extended weekday and weekend opening, will support the delivery of GP provider federations.

Of necessity, this will also include work to improve and modernise the primary care estate also working closely with the Local Authorities, NHSE and NHS Property Services. By the end of the life of this 5 year programme, all GP premises will be DDA compliant and fit for purpose. Like for like premises renewals are not likely to be approved – opportunities for premises developments will be used as a lever for driving federations of practices/practice mergers etc. BHR acknowledges that this is likely to require joint investment with NHS England but will also look to partners in the Local Authorities to maximise opportunities through the Community Infrastructure Levies (CIL) on new developments/regeneration.

There is a need to improve general practice. Using the GP High Level Indicators as a proxy for good quality primary care, BHR will work with NHS England and local Public Health teams to identify where improvements need to be made and jointly agree development plans to secure those improvements. Over the life of this programme, BHR

expects to have no GP practices with 5 or more outliers (as currently measured) in any of the 3 CCGs. It is our expectation that the nascent federations within each of the boroughs will support the quality improvement agenda too, and aim to achieve all the draft GP Development Standards over-time.

Any work on improving access to services will include the thorough investigation of opportunities of service delivery via a wider role for community pharmacy, dentistry and ophthalmic services in the area, recognising their positioning and service availability.

BHR will ensure that its IT investment plans for primary care support the concepts of federations and larger groupings of practices. Continuity of care will be enhanced through the appropriate sharing of patient records and care plans between providers, and subject to patient consent, to support clinical decision-making.

Intervention Three: BHR Integrated Care Programme

Following extensive public engagement the BHR economy published a case for change in August 2012. The resulting vision and strategy for integrated care has been developed with the needs of people at its heart, aiming to help them live well, and independently, for as long as possible and empowering and supporting them to self care.

Person centred co-ordinated care is being delivered across the system, designing care around patients, making sure that they receive the right care in the right place, at the right time and ensuring that different services “talk” to each other, reducing inefficiencies in care.

The strategy aims to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), in particular locality settings. It seeks to transform the relationship with individuals by placing them at the centre of delivery, driving improvements to quality, experience and outcomes. The following patient example and diagram seek to illustrate what this will mean for patients in practice.

5 year vision:

Community services will have been remodelled (physical, mental and social) to support clusters of GPs (covering a population of up to 70,000) to enable more proactive management of the population. The focus will be on those with LTCs, high service users, and those vulnerable to decline.

This will result in less demand for community beds, with resources transferred into multi disciplinary teams based around GP practices supported by borough level community

response teams.

Patients will feel supported to manage their own conditions at home, escalating to community services for support (for example, the community treatment team) when experiencing a crisis. This will enable patients to live independently at home for longer, and will help to shift the focus of delivery of care closer to home.

Services will be jointly commissioned based on outcome measures and designed based on the principles set out in National Voices.

Characteristics of new service model:

- Risk stratification of patients
- Care planning across the comprehensive needs of individuals
- Care co-ordination, with clarity on who is responsible for patients at each level of acuity, linking to established disease pathways as appropriate, and end of life protocols as required (including Advanced Care Plans that are fully utilised and reflect peoples preferences and choices)
- A single point of access for patients/service users and their carers through co-ordinators
- Strong partnership and pathways with the voluntary sector
- Efficient provision of equipment and adaptations to help people self manage independently

A Joint Assessment and Discharge Service (JAD) will operate across the system to facilitate the safe return home of patients

Interventions required:

- The Better Care Fund
- Technology enabling information and data sharing
- Aligned funding arrangements and incentives across the system including personal budgets and building on local Year of Care work
- System wide focus on Frailty – a frailty academy has been established with UCL Partners to commence work on the priority areas that were identified from a patient audit in A&E. These are: (i) falls; (ii) care homes (iii) community alternatives to admission. A recent triangulation of data – year of care information; BHRUT improvement plan data; LAS deep dive – suggests the focus for teams should be

on people aged 65+ with 2 or more LTCs. Discussions are beginning with system partners in the context of BHRUTs Improvement Plan to implement a new streamlined pathway for this cohort of people. This will be supported by the development of a Complex Care Hub dedicated to the treatment of a specific cohort of circa 1,000 patients who require more intensive support. A Frailty Director has been appointed and the next stages of the programme are being developed with support from McKinsey; a proposal will go to the Integrated Care Coalition in June.

Led by NELFT and LBB, system partners are seeking to increase local system resilience through the establishment of Care City. In conjunction with the LETB and the NHS Confederation EU office, Care City will seek to significantly leverage additional investments in to NEL. Care City will build and spread world class 'frailty' knowledge and practice through the establishment of a local centre of research, innovation and care excellence.

Expected outcome

- Reduced A&E attendances and emergency admissions
- Reduced admissions to residential and nursing care
- Reduced delayed transfers of care
- Improved effectiveness of re-ablement
- Improved patient/user experience
- Reduced % of hospital deaths
- Shared care record

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
QJPP Investment	650	600	750	800	800
Integrated Care and CTT	1,463	1,463	1,463	1,463	1,463
Community Initiatives	0	100	350	750	1,300
	1,463	1,563	1,813	2,213	2,763

Locality based funding to be used to support delivery of workforce education and training.

Implementation timeline:

- Newly developed community intermediate care services in place 2013/14, the new intermediate care model will continue to be trialled 2014/15.

		<ul style="list-style-type: none"> • Integrated, locality based, community health teams will be in place from April 14 with plans to extend integration with partners e.g. social care/secondary care to form a community health and social care service in each locality by Sept 14. • JAD to be operational from June 2014 • Phase 3: Under review <p><u>Barriers to success:</u></p> <ul style="list-style-type: none"> • Building sustainable services and capacity in the right place with scarce resources (financial and workforce including clinical leadership) • Service delivery across organisational boundaries <p><u>Confidence levels of implementation:</u></p> <ul style="list-style-type: none"> ▪ The confidence levels are good and build on the previous success of delivering the community treatment teams and intensive rehabilitation services 	
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What does this mean in practice for patients?

Beryl, is an 88 year old widowed female living at home, supported by a social care package whose son who visits her often. One day, Beryl's morning carer (who helps her to get out of bed and washed and dressed) did not arrive and no replacement was sent by the care agency. When Beryl's son arrived at around lunchtime to see his mother, she was still in bed and in a state of distress, so he called 999. The ambulance crew arrived and subsequently conveyed Beryl to Queens hospital A&E. A&E was very busy. When Beryl was assessed, she had a bit of trouble walking (as she normally does) and she was eventually admitted to a ward. When questioned, Beryl and her son identified that they were aware of some of the community services available, but they hadn't attempted to contact them prior to calling 999.

What the Strategic Plan will mean for Beryl and her family in practice:

The BHR Strategic plan sets out a clear vision of improved community services that are more responsive to the needs of patients, aiming to deliver non emergency care closer to home, supporting patients to stay healthy and independent for as long as possible.

In the next 5 years, Beryl and her family can expect the following:

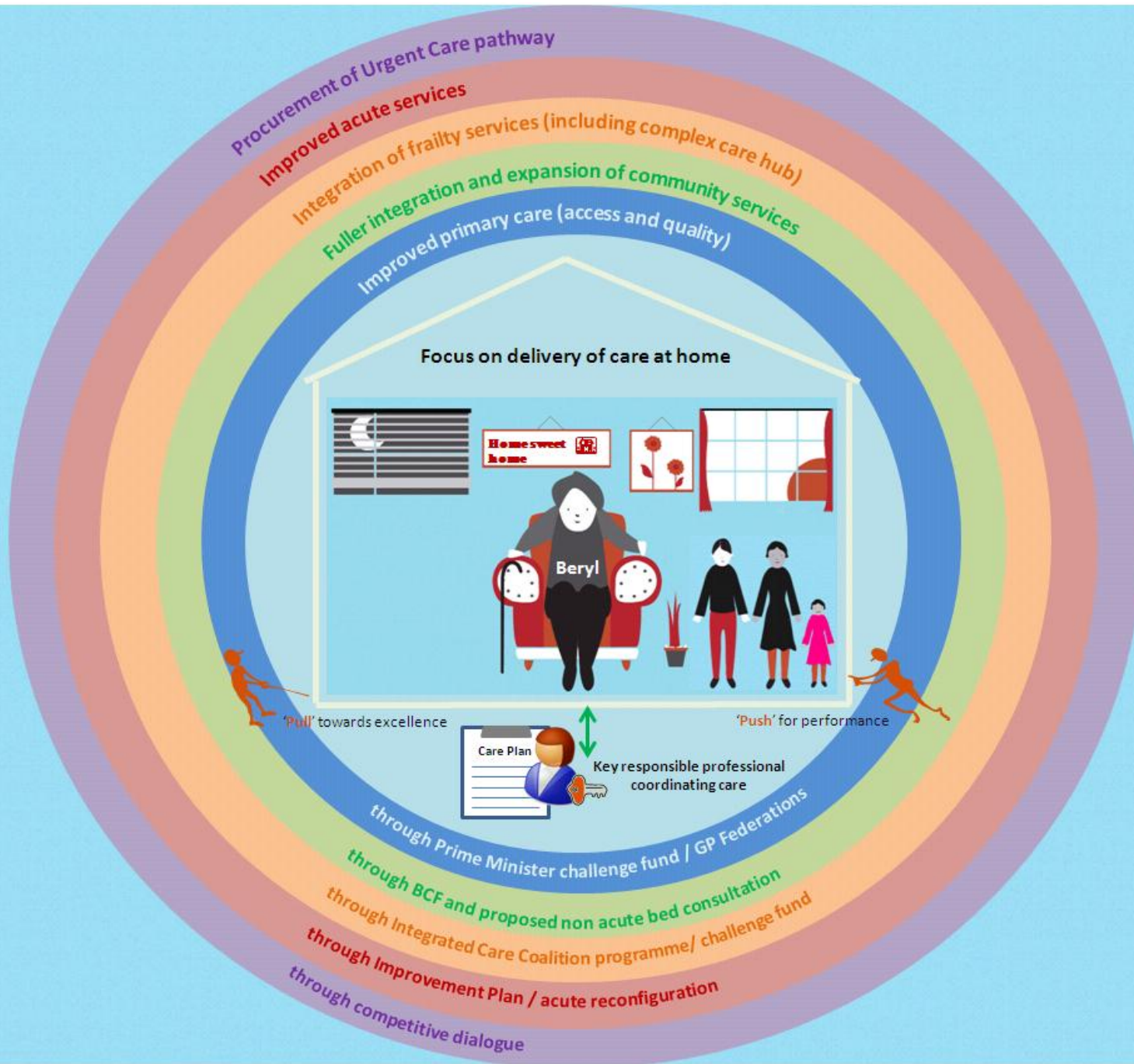
- A single professional responsible for coordinating Beryl's care
- Carers who are aware of alternative services available to them other than calling 999 (in non emergencies) in the community, achieved through better integrated health and social care services.
- A responsive primary care service that will provide improved access to GPs and better quality of care to enable Beryl (and her family) to manage their conditions at home. Beryl could be treated by the Complex Care service to better manage her long term conditions and prevent the need for hospital admission
- An acute hospital service that performs at or above the London Quality Standards of care that is supported by a Joint Assessment and Discharge service that ensures Beryl is discharged in a timely manner should a hospital admission be necessary
- An urgent care pathway that is streamlined, simple to access and responsive
- An enhanced children's service for Beryl's granddaughter with services that are centralised on a single site

The strategic plan includes improvements to the whole BHR system that will ensure that the care that Beryl's family receive is responsive, joined up and of a high quality.

Beryl and her family will receive the right care, in the right place, at the right time.

The illustration on the following page demonstrates the key interventions and improvements within the BHR Economy that will enable Beryl and her family to live at home independently, for longer

Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan – priority interventions



Intervention Four: Acute re-configuration programme

The Health for NE London programme, led by clinicians, was established as a major change programme in response to the case for change.

The key recommendations were:

- To reduce from six hospitals with A&E, acute medical, acute surgical, critical care, maternity and paediatric services, to five; to ensure all A&Es are fully supported by appropriate speciality cover and that there is early senior clinical review for all patients and a full range of available expertise for ongoing care.
- King George hospital, to provide 24/7 urgent care service, and A&E together with unscheduled inpatient medical and surgical services including critical care and paediatrics to be provided at other sites (Queens, Whipps Cross and Newham)

The maternity changes have been successfully implemented through 2013.

The focus is now on:

- Delivering the changes and improvements in emergency and urgent care
- Developing and agreeing the vision for King George Hospital
- Implementing the planned care changes (see intervention five below)

In 5 years time, service users will

- Experience a transformed emergency department at Queens Hospital with improved A&E quality of services
- Benefit from high quality end to end urgent care service delivered by one prime provider that meets or exceeds the London Quality Standards.
- Benefit from centralised and expanded critical care services
- Be treated by a centralised workforce with increased senior cover that will improve quality of care for patients to those that meet the London Quality standards.

Interventions required:

a) BHRUT Emergency Care business case approved

Approval of the full business case and agreement to implement (this will be dependent on the successful delivery of the BHRUT improvement plan, improving performance at Queens ahead of any change/transfer)

b) Urgent Care Procurement

Through 2014/15 BHR CCGs will go to the market to procure a prime provider for the urgent care pathway. This procurement will include a 24/7 urgent care centre at King George Hospital (this service will need to be in place ahead of the move of A&E services from the KGH site).

Plans will take account of Sir Bruce Keogh's recommendations for urgent and emergency care across England:

- Providing better support for people to self-care.
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- Connecting urgent and emergency care services so the overall system becomes more than just the sum of its parts

c) King George Hospital Vision Programme

Redbridge Clinical Commissioning Group are leading this programme to develop KGH as a centre of excellence for woman and childrens services. It will also consider the implications of the Integrated Care Strategy for the site.

The Transforming Services – Changing Lives (TSCL) Programme is considering the longer-term changes that may need to be made to the WEL health economy to meet the national, London-wide and local challenges and drivers for change. The programme is currently in its initial phase identifying the case for change on which any subsequent programme will be based. The BHR system will be represented and where appropriate plans will be updated.

The outcomes of the London quality standards self-assessment in 2013 was published recently. The report also identifies the pan-London benchmark of each standard within the 2013 self-assessment of progress towards meeting the overall London quality standards. To inform planning and commissioning of the London quality standards from April 2014 a self-assessment against the full suite of standards was undertaken by BHRUT to provide a baseline for commissioners. The actions to improve against the baseline position will be taken forward

through existing forums used to improve urgent care performance.

Expected outcome

- to improve the A&E 4 hour performance
- to reduce avoidable emergency admissions
- to reduce the number of years of life lost
- to reduce the percentage of people reporting a poor experience of inpatient care
- to reduce acute inpatient length of stay

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
QIPP Investment	300	200	300	400	400
Other Initiatives	0	100	350	700	1,100
	300	300	650	1,100	1,500

Locality based funding to be used to support delivery of workforce education and training.

Implementation timeline:

- The Trust are working on an implementation timeline

Barriers to success:

- The BHR Economy is in a challenged position with the difficulties faced in meeting the 4 hour A&E target. This is compounded by a difficulty in attracting healthcare professionals to work in the acute trust resulting in a strained workforce. In response to this and the recommendations raised in the recent CQC inspection report, BHRUT is in the process of implementing their Improvement Plan to address these issues. The improvement plan will be aligned to the Acute Reconfiguration programme which builds on Health for North East London work to reconfigure local A&E and maternity services in order to improve care for local people
- Risk that performance improvements on A&E target, length of stay and bed reductions not delivered
- Possible slippages in the programme timelines
- Risk that UCC service model does not deliver the agreed utilisation rates.
- Understanding the WEL system response to managing the flow when A&E service

transfers from the KGH site

Confidence levels of implementation:

- The Trust are working on an implementation timeline

Intervention five: Planned Care Programme

The Planned Care Programme aims to improve health services for local people by separating the planned surgery pathway from emergency pathways where appropriate and improving productivity.

Interventions required:

- Moving planned surgery from Queen's Hospital to King George Hospital except where there are benefits in co-locating services or clinical need (awaiting final BHRUT Clinical Strategy)
- Re-procurement of the Independent Sector Treatment Centre (priorities identified through benchmarking work)

Due to existing variations in local providers, services and contracting arrangements as well as patient demographics, the CCGs have different arrangements but are moving towards a more unified longer term strategy.

New Services

- Development of a digestive diseases service (Havering)
- Community services for diabetes, cardiology, care of the elderly and children's services (Havering)

MSK

- Review MSK pathways to develop a new service model that will manage elements of T&O, pain management and rheumatology activity (B&D and Havering)
- Procurement of MSK triage service to improve the patient pathway for T&O, Rheumatology, Pain, Physio and MSK associated diagnostics, whilst at the same time reducing activity (Redbridge)

Diagnostics

- Implementing the new diagnostic pathways (all modalities) after the recent procurement (Redbridge, B&D, Havering)

- Roll out new diagnostic pathways for calprotectin (B&D and Redbridge)
- Roll out new diagnostic pathways for ECG (B&D)
- Development of Diagnostic work stream, to include Pathology, MSK (MSK and Head) and Ultrasound (MSK and abdomen/pelvis) (Redbridge)
- New MRI pathways for hip and knees (Havering)

Ophthalmology

- Ophthalmology – optimise community eye service contract for glaucoma follow up (B&D)
- Procurement of new Ophthalmology service, including triage services for ophthalmology conditions (Redbridge and B&D jointly)

New models and pathways

- To develop new models for the management of outpatient specialties where the outpatient first appointment is above average (B&D)
- Using benchmarking data, to review pathways for general surgery, urology, gastroenterology, gynaecology and ENT, along with associated investigations, to identify best practice across providers and practices, and reduce referrals (Redbridge)
- Cardiology primary care pathways for heart failure, palpitations, angina and chest pain (B&D)
- Development of a continence pathway (Havering)
- Pilot a new model for dermatology with BHRUT (B&D)
- Implement newly procured community diabetes service (Redbridge)
- Roll out of the new heart failure pathway by introduction of BNP testing (Redbridge)

Expected Outcome

- To reduce inappropriate GP referrals and improve the patient pathway
- to improve patient experience by providing quality care close to home
- To improve equality of access to care for patients across the Boroughs and CCGs

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
QJPP Investment	300	200	450	550	550
Community Initiatives	0	100	300	650	1,050
	300	300	750	1,200	1,600

Implementation timeline:

- The timeline to the progression of planned surgery at Queen’s is subject to confirmation from the Trust. CCGs scheme to be taken forward in 2014 – 2016

Barriers to success:

- Risk that performance improvements will not be delivered
- Issues relating to the RTT backlog are resolved

Confidence levels of implementation:

- The planned care movements will be subject to the Clinical Strategy being finalised. CCG schemes will build on success of current community schemes in reducing A&E attendance and emergency admission

Intervention six: Specialised Commissioning Services

The national strategic plan for specialised commissioning has been paused during the national turnaround process. The intention remains to issue a draft strategy for 12-week public consultation in July 2014. Final publication of the 5-year strategy is expected in November 2014.

Intervention seven: Mental Health Services

We will engage with people and communities to help all across society to optimise their mental health and wellbeing. When services are needed they will be accessible, recovery focussed and will strive to help people to stay independent and outside of hospital. When inpatient care is required we will ensure safe, secure high quality mental health services for those who have the greatest need.

A Strategic Commissioning Framework for Mental Health will be developed in response to “Closing the Gap: Priorities for essential change in mental health” which was published on January 2014. The framework will be developed during Summer 2014 and will be jointly updated through the mental health subgroups of the respective Health and Wellbeing Boards.

CCGs and the Local Authorities will build joint commissioning relationships over the next two years and a borough approach is likely for the development of mental health and wellbeing commissioning strategies.

The key areas included in the scope of the strategic framework are likely to include:

- Adults and children
- Parity of esteem
- People diagnosed with mental illness
- Emotional health and wellbeing

The following areas have been proposed as part of the development of a mental health strategic framework/ improvement plan:

- Develop the road map to mental health improvement for the next 5 years
- Parity of esteem for mental and physical health (short term priority) - the BHR economy is committed to ensuring a parity of service delivery across both physical and mental health conditions; developing an Integrated Health and Social Care Service in each of the three Boroughs which will be delivered at locality level. This will include an expanded Integrated Case Management team to include Mental Health Social Workers and will ensure that patients are treated holistically as a whole person allowing mental health issues to be treated alongside physical conditions.
- Transforming the provider - community Service developments include the shift of focus to delivery of care closer to patients' homes including intensive rehab delivered at home, as well as a Community Treatment team. This forms a more inclusive model of care which is especially beneficial to vulnerable patient groups.

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
IAPT	450	450	450	450	450
Community Initiatives	0	100	300	550	850
	450	550	750	1,000	1,300

Locality based funding to be used to support delivery of workforce education and training.

Intervention eight: Children's Services

One of the key developments for children's services in the next 5 years is the development of a

Children's' Commissioning Strategy. The aim of the strategy will be to develop children's services with the point of view of children in mind and increase health gain in the system to save additional years of life, in the context of a cash flat environment. The core principles of the strategy can be described as:

- Built on and driven by real public and patient engagement
- Clinically led – aligned with national clinical strategies
- Outcome focussed – priorities set to optimise outcomes and quality within financial constraints
- Affordable – built on robust and consistent financial basis

Interventions required:

The BHR SPG will be working with the Children's Strategic Clinical Network (SCN) to define the challenges faced by children's services across the BHR SPG. The key areas likely to be included in the scope of the strategic framework are:

- Children with complex needs
- Children with asthma with high prevalence of hospital admissions
- Children with mental health problems
- Primary care prevention
- Children with specific needs
- Assessment process for all children (including disabled) needing an Education, Health and Care Plan (EHC) plan
- Joint Commissioning and Personal Budgets
- Taking forward the initiatives considered under the Children Services in the Life Study programme that is taking place in Redbridge
- The CCGs and the Local Authorities will also be working together to deliver the Safeguarding and looked after children outcomes required in the Children and Families Bill
- Local Safeguarding Boards, and implementation of work needed from CQC and OFSTED inspections

Expected Outcome

Using innovative, new, accelerated joint approach to deliver:-

- Improved outcomes
- Improved experiences
- Efficiencies
- Local plans for reducing child poverty
- Investment in early years
- Early identification, early effective interventions
- Improvements in transition
- Excellent communication and collaboration between professionals (health, education, criminal justice system and police)

Investment costs

BHR Investment	2014/15	2015/16	2016/17	2017/18	2018/19
Community Initiatives	0	100	200	350	500

Implementation timeline:

Production of the strategy is likely to be a key priority in the first year. Local ownership of the plans is imperative. The CCGs and the Local Authorities will be working in collaborative partnership arrangements to deliver the key priorities that are agreed.

Barriers to success:

Alignment with national Children's service commissioning strategy due to national strategy developments working to different timelines

Confidence levels of implementation



The development of the children's services will be closely linked to the development of the KGH site.

Governance overview

What governance processes are in place to ensure future

The supporting evidence attached details the Governance Structures in place within the BHR economy to ensure future plans are developed in collaboration with key stakeholders.
The members of the Coalition also work closely with Waltham Forest and East London (WEL) organisations to promote a shared case for change. This includes regular meetings with

BHR Governance Structure:

	<p>plans are developed in collaboration with key stakeholders including the local community?</p>	<p>organisational leads on cross cutting transformation issues including the Acute Reconfiguration programme and Urgent Care procurement.</p> <p>BHR CCGs have also been working closely with the London Ambulance Service (LAS) to ensure alignment of the respective strategic plans through schedule meetings throughout the year.</p> <p>This is underpinned by ongoing engagement with patients (via Patient Engagement Forums, as well as other methods of engagement for example periodical telephone interviews with patients accessing the Community Treatment Team and Intensive Rehab Service, the outcomes of which directly feed into ongoing service development).</p>	 BHR_Governance Arrangementsv4.pdf
Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	<p>The final values and principles of the Coalition will embed into the BHR system 5 years Strategic Plan to promote joint partnership working across the system.</p> <p>The values and principles provide the foundation for a system wide leadership development programme involving all organisations and a number of coalition members; UCL Partners and NHS Improving Quality have expressed a strong interest to take this forward.</p> <p>The values and principles provide an opportunity for the coalition to demonstrate to the public and stakeholders our commitment to work together to deliver improved outcomes.</p>	BHR values and principles:  BHR System Values and Principles.pdf

Glossary

A&E target	The four-hour target in emergency departments states that at least 95% of patients attending an A&E department must be seen, treated, admitted or discharged in under four hours.
IAPT	The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available.
ACP	Advanced Care Plan
Acute Reconfiguration	In November 2009, the Health for north east London programme published its pre-consultation business case setting out the case for change across north east London. The key proposals for north east London sites were around unscheduled care, scheduled care and maternity and newborn care. The key recommendations were: <ul style="list-style-type: none"> • To reduce from six hospitals with A&E, acute medical, acute surgical, critical care, maternity and paediatric services to five, to ensure all A&Es are fully supported by appropriate specialty cover; and there is senior clinical review for all patients and a full range of available expertise for ongoing care. • King George Hospital Ilford to provide 24/7 urgent care services but A&E, together with unscheduled inpatient medical and surgical services, including critical care and paediatrics to be provided at other sites (Queen's, Whipps Cross and Newham)
AML	Acute myeloid leukaemia
BCF	The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.
BH	Barts Health NHS Trust which includes the following hospitals: <ul style="list-style-type: none"> • Mile End Hospital • Newham University Hospital • The London Chest Hospital • The Royal London Hospital • St. Bartholomew's Hospital • Whipps Cross University Hospital
BHR Economy	Refers to the populations and services encompassed within the Boroughs of Barking and Dagenham, Havering and Redbridge, largely served by King George and Queens Hospitals.
BHRUT	Barking and Dagenham, Havering and Redbridge University Hospitals Trust which includes the following hospitals: <ul style="list-style-type: none"> • Queens Hospital, Romford • King Georges Hospital, Chadwell Heath
Borough Operating Plans	2 year operational plans detailing how each Borough within the BHR economy (Barking and Dagenham, Havering and Redbridge) will contribute to the achievement of the goals set out in the 5 year Strategic Plan.
CAHMs	Children and Adults Mental Health service

Cardiac cath lab	A catheterisation laboratory is an examination room in a hospital or clinic with diagnostic imaging equipment used to visualize the arteries of the heart and the chambers of the heart and treat any abnormality found.
CCGs	Clinical Commissioning Groups
Community Treatment Team	This team consists of doctors, nurses, occupational therapists, physiotherapists, social workers, and support workers. It: <ul style="list-style-type: none"> • provides short term intensive care and support to people experiencing health and/or social care crisis to help them be cared for in their own home, rather than be referred to hospital. • Supports people to return home as soon as possible following an acute/community inpatient stay where this is required/appropriate provides a single point of access to intensive rehabilitation at home or a bed in a community inpatient unit if necessary.
CQUIN	Commissioning for Quality and Innovation; The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
Education, Health and Care Plan (EHC)	An EHC Plan looks at all the needs that a child or young person has within education, health and care. Professionals and the family together consider what outcomes they would like to see for the child or young person. This plan identifies what is needed to achieve those outcomes.
Health and Well Being Board Strategies	A Strategy which sets out the ambitions and priorities for the Health and Wellbeing Board with the overall vision to improve the health and wellbeing of people in the local area
ICC	The Integrated Care Coalition acts to bring together senior leaders in the BHR health and social care economy to support the three Clinical Commissioning Groups (CCGs) and the three Local Authorities in commissioning integrated care and ensuring a sustainable health and social care system.
ICSG	The Integrated Care Steering Group has been established as part of the agreed governance architecture of the Integrated Care Coalition to: <ul style="list-style-type: none"> • Draw together clinical, provider, commissioner, managerial and programme management expertise • Generate recommendations for high impact changes that will deliver integrated care in the BHR economy • Produce a strategy and work plan for delivering the agreed changes
Independent Sector Treatment Centre	Private-sector owned treatment centres contracted within the English National Health Service to treat NHS patients free at the point of use. Typically they undertake 'bulk' surgery such as hip replacements, cataract operations or MRI scans rather than more complex operations.
Information Governance	Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information.
Integrated Case Management	Integrated Case Management Teams aim to deliver appropriate care to patients in the community to reduce avoidable hospital admissions and deliver a high quality service for high risk patients. Each Integrated Case Management team comprises of:

	<ul style="list-style-type: none"> • GP • Community Matron • District Nurse • Social Care Lead • Care Liaison Officer • Any other relevant staff for specific needs e.g. mental health team.
Intensive Rehab Service	This team consists of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants with access to a geriatrician as required via CTT. It aims to provide an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people within their own homes where it is appropriate to do so. The in-home support provided is intensive and will involve between one and four home visits each day, depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.
JAD	Joint Assessment and Discharge Team; an integrated team including social care and therapy staff working together to improve and streamline the discharge process out of Queens Hospital.
JSNAs	Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population.
LAS	London Ambulance Service
LETB	Local Education and Training Board
Local Authorities	In the context of this Strategic Plan the term 'local authorities' refers to the London Borough of Barking and Dagenham, London Borough of Havering, and London Borough of Redbridge.
Locality	Each borough in the BHR economy is broken down into smaller 'units' called 'localities', within which services and integrated teams work together to serve the health needs of that population.
LoS	Length of Stay (can refer to time spent in a hospital or community bed e.g. for rehab)
LTC	Long Term Condition, for example, Diabetes
MSK	Musculoskeletal; Relating to or involving the muscles and the skeleton
NHSE	NHS England; The main aim of NHS England is to improve the health outcomes for people in England
Ophthalmology	The branch of medicine that deals with the anatomy, functions, pathology, and treatment of the eye
Planned Care	Refers to services where you have a pre-arranged appointment, for example, a GP appointment or outpatient appointment at your local hospital
Prime Minister's challenge	In October 2013, the Prime Minister announced the Challenge Fund to improve access to general practice and test innovative ways of delivering GP services. NHS England was asked to lead on selecting and managing the pilot schemes.

QIPP	Quality Improvement Productivity and Prevention
SHMI	Standardised Hospital-level Mortality Indicator: the ratio between the actual number of patients who die following treatment at a trust, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI gives an indication of whether the mortality ratio of a trust is as expected, higher than expected or lower than expected when compared to the national baseline (England).
SPG	Strategic Planning Group; in the context of this plan, the BHR SPG consists of Barking and Dagenham, Havering and Redbridge.
UCC	Urgent Care Centre
UCH	University College Hospital
UCL Partners	UCL Partners is an academic health science centre located in London; It is the largest academic health science centre in the world.
Year of Care	The Year of Care programme sets out to learn how routine care can be redesigned and commissioned to provide a personalised approach, including support for self management, for people with long term conditions.

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HEALTH AND WELLBEING BOARD

29 JULY 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 Draft August/September 2014 issues of 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. d) To note that the next issue of the Forward Plan will be published on 11 August 2014. Any changes or additions to the next issue should be provided before that date.			

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APPENDIX 1



HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT August 2014 Issue

Publication Date: 3 August 2014

THE FORWARD PLAN

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://modern.gov.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

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://modern.gov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0> or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@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.

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: 29.7.14	<p>The Care Act : Framework</p> <p>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.</p> <ul style="list-style-type: none"> • 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: 29.7.14	<p>Diabetes Scrutiny: Update on Delivering the Recommendations</p> <p>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.</p> <ul style="list-style-type: none"> • 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: 29.7.14	<p>Impact of the Recession Scrutiny (Action Plan)</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Gill Mills, Director of Children's Services (gillian.mills@nelft.nhs.uk)

Health and Wellbeing Board: 29.7.14	<p>The Children and Families Act : Framework</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Helen Jenner, Corporate Director of Children's Services (Tel: 0208 227 5800) (helen.jenner@lbbd.gov.uk)</p>
Health and Wellbeing Board: 29.7.14	<p>Urgent Care Board Update</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Jane Gateley, Director of Planning and Delivery (Jane.gateley@onel.nhs.uk)</p>
Health and Wellbeing Board: 29.7.14	<p>Child Death Overview Panel Annual Report</p> <p>The Board will receive and discuss the Child Death Overview Panel Annual Report of 2013/14.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 29.7.14	<p>Improvements to the Breastfeeding Pathway : Community</p> <p>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.</p> <p>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</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>

Health and Wellbeing Board: 29.7.14	<p>Care City: Update : Community</p> <p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Helen Oliver, Adult Safeguarding (Tel: 0208 724 8857) (helen.oliver@lbbd.gov.uk)</p>
Health and Wellbeing Board: 29.7.14	<p>Contract: Extending the Contract for Public Health Healthy Child Programme 5 - 19 Years Old : Financial</p> <p>To allow for the commissioning of an Early Years programme in October 2015, when Health Visiting becomes the responsibility of the Council, the Board will be asked to authorise under Contract Rules and the extension of the current contract from August 2014 to 31 March 2016. The extension of the contract is allowed for within the current contract terms.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 29.7.14	<p>Children's Social Care Inspection - Headlines : Community</p> <p>In February 2014 a report was brought to the Health and Wellbeing Board which summarised the new Ofsted single inspection framework for children's social care and Local Safeguarding Children Boards (LSCBs), covering children in need of help and protection, looked after children and care leavers. Barking and Dagenham were inspected by Ofsted using the new framework in May 2014.</p> <p>This Board will be presented with a report which gives the headline results of the inspection prior to a detailed report coming to the Board in Autumn 2014.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Meena Kishinani, Divisional Director of Commissioning and Safeguarding (Tel: 020 8227 2786) (meena.kishinani@lbbd.gov.uk)</p>

Health and Wellbeing Board: 29.7.14	<p>Mental Health Tariff : Community</p> <p>Following the ministerial announcement that the mental health tariff will be cut by 20%, the Board will be considering what the implications of this are for the borough, whether any plans or strategies are affected by the cut, and to what extent parity of esteem between mental and physical health is damaged by this proposal.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Sharon Morrow, Chief Operating Officer</p> <p>(Sharon.Morrow@barkingdagenhamccg.nhs.uk)</p>
Health and Wellbeing Board: 29.7.14	<p>'Closing the Gap': Overview report</p> <p>This report and accompanying presentation will give an overview of the 'Closing the Gap' report which sets out 25 priorities for change in how children and adults with mental health problems are supported and cared for. The Mental Health Sub-Group will provide a summary of the report at the July meeting, with a full report on the implications for Mental Health services and commissioners at the Board's October meeting.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Gill Mills, Director of Children's Services</p>
Health and Wellbeing Board: 29.7.14	<p>Better Care Fund - Interim Update</p> <p>The Board will receive a report on the progress in implementing the Better Care Fund Plan and advise on emerging issues nationally ahead of a full update report scheduled for the Board's September meeting.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>David Millen, Integrated Care Delivery Manager, Anne Bristow, Corporate Director of Adult and Community Services</p> <p>(Tel: 020 8227 2300) (david.millen@lbbd.gov.uk), (anne.bristow@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.9.14	<p>Autism Strategy : Community</p> <p>The Board is asked to review the refreshed edition of the Autism Strategy which picks up improvements identified in the Autism Self Assessment Framework and independent mapping exercises</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Glynis Rogers, Divisional Director, Community and Partnerships</p> <p>(Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)</p>

Health and Wellbeing Board: 9.9.14	<p>End of Life Care: Progress on Actions</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>David Millen, Integrated Care Delivery Manager</p> <p>(david.millen@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.9.14	<p>Dementia Needs Assessment</p> <p>The Office of Public Management (OPM) 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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.9.14	<p>Joint Strategic Needs Assessment : Community</p> <p>This Board will be asked to agree key strategic recommendations arising from the refresh of the Joint Strategic Needs Assessment (JSNA) for 2014.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.9.14	<p>Life Study - new UK birth cohort study</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Conor Burke, Accountable Officer (Designate)</p> <p>(conor.burke@onel.nhs.uk)</p>

<p>Health and Wellbeing Board: 9.9.14</p>	<p>Contract: Gateway and Recovery Drug Treatment Services - Request to Tender : Financial</p> <p>The Board will be asked to approve the re-tender of the following services:</p> <p>Gateway service This is an open access service for all adults experiencing issues with drugs. The service provides advice, information, brief interventions and support for all those affected. The service also works with those in the Criminal Justice System providing the support necessary in order to stabilise them ready for structured treatment if appropriate.</p> <p>Recovery service This is the adult prescribing service. Those individuals who are using heroin and require a substitute such as Methadone can see a clinician who can provide the appropriate support. There is also a needle exchange on site.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	<p>Open</p>	<p>Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)</p>
<p>Health and Wellbeing Board: 9.9.14</p>	<p>Better Care Fund : Community</p> <p>Following the approval of the Better Care Fund plan at the March Health and Wellbeing Board meeting, the Board will receive a full update on the progress of the Better Care Fund.</p> <p>The update will provide detail of progress in the delivery of the 11 individual schemes comprising the plan, changes required by national policy changes and guidance and re-approval by the board of key changes that may be required for onward submission to NHS England</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	<p>Open</p>	<p>David Millen, Integrated Care Delivery Manager (david.millen@lbbd.gov.uk)</p>

Health and Wellbeing Board: 9.9.14	<p>Local Account 2013/14 : Community</p> <p>The Local Account is the Council's statement to the local community and service users about the quality of social care services in Barking and Dagenham.</p> <p>The Board will be asked to approve the Local Account 2013/14.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
Health and Wellbeing Board: 9.9.14	<p>Transforming Services, Changing Lives in East London : Community</p> <p>Local CCGs, NHS England, Barts Health and other local providers have established a clinical transformation programme called Transforming Health, Changing Lives in east London, which will bring together the existing Clinical Commissioning Group Integrated Care Programmes with a new 'sister "Improving Hospital Care" work-stream. This work will establish the appropriate foundations for a longer term joint transformation programme to bring forward whole system, health economy-wide improvements in the clinical and financial viability of local services in East London.</p> <p>The Board will be briefed on this programme and have the chance to comment on the case for change and the local implications of any proposed re-configuration of services before the programme moves to its next stage.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Conor Burke, Accountable Officer (Designate) (conor.burke@onel.nhs.uk)</p>

Health and Wellbeing Board: 9.9.14	<p>Substance Misuse Strategy Board End Of Year Report 2013-14 : Community <i>[Annual Item]</i></p> <p>The Board will be presented with a report on the work of the Substance Misuse Strategy Board in 2013-14. The report will provide information on positive performance and share good practice in commissioning and monitoring contracts, particularly in regard to Alcohol Abuse and Community Detox work.</p> <p>The Board will also be asked to approve the proposals for Alcohol Awareness Week.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Dan Hales (Tel: 020 8227 3723) (dan.hales@lbbd.gov.uk)
Health and Wellbeing Board: 9.9.14	<p>Progress on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service from NHS England to LBBDD</p> <p>To review the progress being made to deliver the national programme, review the identified risks and address the necessary mitigation required to be ready for the full transition in October 2015.</p> <ul style="list-style-type: none"> • 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: 9.9.14	<p>Children's Social Care Inspection: Action Plan : Community</p> <p>In February 2014 a report was brought to the Health and Wellbeing Board which summarised the new OFSTED single inspection framework for children's social care and Local Safeguarding Children Boards (LSCBs), covering children in need of help and protection, looked after children and care leavers. Barking and Dagenham were inspected by OFSTED using the new framework in May 2014.</p> <p>In September 2014, the Board will be presented with the full inspection headlines. The Board will also be asked to ensure that the proposed Action Plan, to address the areas of weakness identified by the inspection, is fit for purpose.</p> <ul style="list-style-type: none"> • 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: 9.9.14	<p>Contract: Care Providers for Home Care and Crisis Intervention - Request to Tender : Financial</p> <p>The Board will be asked to to approve the request to tender for the re-procurement of Care Providers for Home Care and Crisis Intervention and delegate authority to the Corporate Director of Adult and Community Services to complete the tender process.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 9.9.14	<p>Learning Disabilities Section 75 - Update</p> <p>This report provides an update on the arrangements that have been negotiated between the Clinical Commissioning Group (CCG) and the Council for the creation of a Section 75 partnership agreement to cover both parties' commissioning budgets for learning disability services.</p> <p>The report will also give an update on the Section 75 arrangements for the provision of an integrated Community Learning Disability Team, comprising officers from NELFT and the Council.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)
Health and Wellbeing Board: 9.9.14	<p>Quarter 1 Performance</p> <p>The Quarter 1 performance dashboard will be presented to the Health and Wellbeing Board for the Board to analyse and discuss.</p> <ul style="list-style-type: none"> • 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: 28.10.14	<p>Health and Young Offenders</p> <p>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.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
Health and Wellbeing Board: 28.10.14	<p>'Closing the Gap': Implications for Mental Health Services and Commissioners : Community</p> <p>The Mental Health Sub-Group has conducted a mental health service audit following the publication of the 'Closing the Gap' report which set out 25 priorities for change in how children and adults with mental health problems are supported and cared for. Following the overview report in July, this report will outline the implications of the report for mental health services and commissioners in Barking and Dagenham.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Gill Mills, Director of Children's Services</p>
Health and Adult Services Select Committee: 28.10.14	<p>BHRUT Improvement Plan Update</p> <p>The Board will be presented with an update on the Barking Havering and Redbridge University NHS Hospitals Trust's improvement programme.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Steven Russell, Improvement Director for Barking Havering and Redbridge University NHS Hospitals Trust</p> <p>(steve.russell@bhrhospitals.nhs.uk)</p>

<p>Health and Wellbeing Board: 28.10.14</p>	<p>Joint Carers Strategy and Contract for Carers Services : Community,,: Financial</p> <p>In order to improve support to family carers and meet the requirements of the Care Bill the Board will be asked to:</p> <ol style="list-style-type: none"> 1. Agree a new Joint Carers Strategy between LBB and Clinical Commissioning Group and proposed revisions to existing commissioning requirements 2. Authorise the Corporate Director of Adult and Community Services, with the Chief Operating Officer, Barking and Dagenham Clinical Commissioning Group, and in consultation with the Head of Legal and Democratic Services to seek tenders for Carers Services. <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)</p>
<p>Health and Wellbeing Board: 9.12.14</p>	<p>Child and Adolescent Mental Health Services (CAMHS) Strategy : Community</p> <p>The Children and Maternity Sub-Group will present the framework for a Child and Adolescent Mental Health Services Strategy for Barking and Dagenham for approval by the Board.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Sharon Morrow, Chief Operating Officer (Sharon.Morrow@barkingdagenhamccg.nhs.uk)</p>
<p>Health and Wellbeing Board: 9.12.14</p>	<p>Diabetes Scrutiny: Final Update : Community</p> <p>After giving an initial response to the recommendations on 4 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 final report that tracks implementation of the recommendations.</p> <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>

Health and Wellbeing Board: 9.12.14	Quarter 2 Performance <ul style="list-style-type: none"> • 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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Membership of Health and Wellbeing Board:

Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health (Chair)
Councillor Laila Butt, Cabinet Member for Crime and Enforcement
Councillor Evelyn Carpenter, Cabinet Member for Education and Schools
Councillor Bill Turner, Cabinet Member for Children's Social Care
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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