Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 9 September 2014 - 6:00 pm

Conference Room, Barking Learning Centre, 2 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

Date of publication: 1 September 2014

Graham Farrant
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Laila Butt	(LBBD) Cabinet Member for Crime and Enforcement
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Education and Schools
Cllr Bill Turner	(LBBD) Cabinet Member for Children's Social Care
Anne Bristow	(LBBD) Corporate Director of Adult and Community
Helen Jenner	(LBBD) Corporate Director of Children's Services
Matthew Cole	(LBBD) 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 29 July 2014 (Pages 1 - 14)**

4. **Vision and Priorities for the Borough (Pages 15 - 27)**

CONSULTATIONS AND STUDIES

5. **Transforming Services, Changing Lives in East London (Pages 29 - 50)**

6. **Life Study - New UK Birth Cohort Study (Pages 51 - 56)**

7. **Making Intermediate Care Better (Pages 57 - 91)**

8. **Dementia Needs Assessment (Pages 93 - 106)**

LOCAL HEALTH ECONOMY UPDATES

9. **Better Care Fund Update (Pages 107 - 127)**

10. **Progress on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service from NHS England to LBBD (Pages 129 - 137)**

11. **Learning Disabilities Section 75 - Update (Pages 139 - 146)**

12. **Substance Misuse Strategy Board End Of Year Report 2013-14 (Pages 147 - 159)**

13. **Urgent Care Board Update (Pages 161 - 165)**

CONTRACTS AND PERFORMANCE

14. **Contract: Gateway and Recovery Drug Treatment Services - Request to Tender (Pages 167 - 175)**

15. Contract: Care Providers for Home Care and Crisis Intervention - Request to Tender (Pages 177 - 187)

16. End of Year Performance and Quarter 1 Performance (Pages 189 - 210)

STANDING ITEMS

17. Sub-Group Reports (Pages 211 - 222)

18. Chair's Report (Pages 223 - 227)

19. Forward Plan (Pages 229 - 243)

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, 29 July 2014
(6:00 - 8:35 pm)

Present: Cllr Maureen Worby (Chair), Dr Stephen Burgess, Anne Bristow, Cllr Laila Butt, Cllr Evelyn Carpenter, Frances Carroll, Matthew Cole, Chief Superintendent Andy Ewing, Cllr Bill Turner, Jacqui Van Rossum and John Atherton

Also Present: Dr Ravi Goriparthi, Sharon Morrow, Jackie Ross, Cllr Edna Fergus, Cllr Adegboyega Oluwole, Helen Oliver and Ann Graham Dr Eugenia Cronin

Apologies: Dr Waseem Mohi, Conor Burke, Helen Jenner and Dr John

17. Inquorate

The Chair advised that Councillors Butt, Carpenter and Turner had been delayed by another meeting but were on their way from the Town Hall and would be arriving shortly and in view of the heat and size of the agenda she would start the meeting and deal with the first couple of items. Councillor Carpenter arrived at the end of Agenda Item 3 and the meeting became quorate. Councillor Turner arrived during Agenda Item 5 and Councillor Butt arrived during Agenda Item 8.

18. Declaration of Interests

Jacqui van Rossum, Executive Director Integrated Care (London) and Transformation), NELFT, declared a pecuniary interest in regards to Agenda Item 8 and took no part in the discussion or decision.

19. Minutes - 17 June 2014

The minutes of the meeting held on 17 June were confirmed as correct, subject to the replacement of ‘Frances Carroll’ by ‘Marie Kearns’; in Minutes 4.

20. The Children and Families Act

Jackie Ross, SEN Consultant, LBBD, presented the report and reminded the Board that since October 2013 there had been two revised version of the Act before it became law in March 2014. In April 2014 there had been significant changes introduced in the new statutory guidance ‘Special educational needs and Disability code of practice 0-25 years’ and this new code would replace the existing SEN Code of Practice on 1 September 2014. The new Act and statutory guidance in the code would have significant service delivery implications for all partners and also increased post 16 to 25 support arrangements in regards to health, social care, adult services and education. Other changes meant that young people could ask for an Education, Health and Care assessment and would have the right to assessment whist in custody.

As part of the duty to engage with the local community and support the parents and young people work had been undertaken with stakeholders and external

forums, including the BAD Youth Forum. The Parent Partnership will be re-commissioned to input parent voice into the specifications and quality assurance for the bids. The community engagement, including that undertaken for the Local Offer, has become recommended by the DfE as an exemplar of good practice. Ms Ross confirmed that the Local Offer and Education Health and Care Planning is on course and ready for 1 September implementation. As part of this the Borough was publishing on its website its perspective on the Act requirements and there would also be interactive website section for stakeholders and service users.

The Education, Health and Care Plans had been developed in partnership with parents and were being trialled in readiness for the 1 September. A training programme to support staff with implementation was already underway. Work in relation to transition to adulthood and joint commissioning had still to be taken forward as there were a number of gaps in providing information to young people though the health stream.

Councillor Carpenter raised the issue of the additional work that needed to secure some aspects of health engagement, particularly in regard to the need for significant awareness raising with GPs and others, and pointed the Board to the concerns set out in section 4 of the report in regards to underdeveloped joint commissioning. Sharon Morrow, Chief Operating Officer, B&D CCG, advised that the governance used for adults would also suit the needs of children. Ms Morrow also advised that a recent workshop had been held and children and maternity had identified work for the coming 12 months. In addition, GP clinical leads would be raising awareness with GPs.

The Board received the report and, to enable compliance with the Children and Families Act, agreed:

(i) To support 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) The Board also noted:

   (a) Full implementation was required by 1 September 2014 and the implications this would have for strategic and commissioning decisions.

   (b) The statutory guidance required 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"

   (c) The refresh of the Joint Strategic Needs Assessment (JSNA) is currently underway and would be expected to take account of the requirement, in preparation for a future refresh of the Health and Wellbeing Strategy.

   (d) Structured programmes are in place for implementation of both the Children and Families Act and the Care Act, which would consider

the implications of the new guidance for the overlap between Care Act and Children and Families Act requirements and 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.

21. OFSTED Children's Social Care Inspection Feedback

Ann Graham, Divisional Director Complex Needs and Social Care, presented the report on the OFSTED inspection which occurred between 29 April and 22 May 2014 on the services for children in need of help and protection, looked after children and care leavers and a review of the local safeguarding Children Board. The report had been published on the 7 July. Ms Graham advised that whilst the Inspectors recognised the enormous pressures that all agencies have been under, they had determined there were some areas that required improvement, including areas of health and police linkage and communication.

In response to questions Ms Graham advised that, that every child tracing will enable Education, Health and Care assessment to be undertaken and followed through. Ms Graham also advised that although OFSTED had not raised any issues in regards to CAMS the CAMS Strategy would also be refreshed.

The Board noted:

(i) The publication of the full OFSTED report.

(ii) Agencies would need to respond proactively to action planning to address gaps in provision now that the report is published.

(iii) Note that a full report will be presented at the October Board 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.

22. Breastfeeding Pathway Review

Dr Eugenia Cronin explained the aims, methodology and outcomes of the Breastfeeding Pathway Review. As part of the review interviews had been held with health professionals, new mothers and support providers to ascertain why mothers were not breastfeeding. Dr Cronin stated that breastfeeding had undisputed health benefits, in both the short and long-term, for baby and mother and breastfeeding also produced lower risks than formula feeding for the vast majority of mothers. Although there had been some improvement towards the England average since 2008, the initiation and sustained breastfeeding rates in the Borough were the second lowest in outer north east London.

Dr Cronin indicated that ten peer support volunteers had been identified and these volunteers were dedicated and of good quality. However, the service support for these had recently transferred to Children’s Services and there were still some issues to be resolved in regards to management structure and reporting mechanisms to enable this peer support service to be more effective. The decision to bottle or breastfeed was often taken long before pregnancy had occurred. Dr Cronin stated this decision appeared to be associated with the lack of knowledge or perceived support for breastfeeding due to cultural pressure or

conflicting / outdated information from friends and family.

A more joined up approach between antenatal and health visitors was also required, which together with peer support networks could encourage and support more mothers to choose the breast over bottle. Dr Cronin also cited the local infant feeding scheme, such as that operating in Redbridge, as a potential option for the future.

Anne Bristow, Corporate Director of Adult and Community Services, asked what the current status was in regard to midwives to UNICEF accreditation standards. Dr Burgess, Interim Medical Director, BHRUT, advised that training within health and maternity services is progressing and staff were very keen to undertake the training and to press the breastfeeding benefits to clients. Dr Burgess confirmed that he had spoken to the Director of Nursing and the issue was lack of funding at the present time, not lack of will, and he and Matthew Cole would report back on what actions would be needed to resolve this.

Councillor Turner asked if the data was available on a ward level so that services could see if there were particular GPs or Clinics that could be targeted with extra support. Dr Cronin advised she would be happy to provide the local data she held.

Dr Goriparthi suggested that as there needed to be a generational shift in attitudes and suggested that the possibility of including the benefits of breastfeeding as part of school's education / PHSE may need to be explored Dr Goriparthi also felt that training to UNICEF standards would be welcomed GPs and Practice Nurses.

The Chair asked if there was a timetable or action plan to look at the issues around breastfeeding. Sharon Morrow advised that breastfeeding had been discussed at an away day in April and would become a prime issues for the Children and Maternity Sub-Group from September.

The Board received and noted the contents of the report and the recommendation contained within it and in order to progress this issue agreed:

(i) A refresh of the CCG commissioning plan must include greater emphasis on support for breastfeeding.

(ii) A breastfeeding strategy should be developed and this would be owned by the Children and Maternity Sub-Group.

(iii) The employment of an Infant Feeding Coordinator should be explored.

(iv) Improved training was desirable and supported the review and up-skilling of relevant staff, in particular training for midwives should be refreshed and in place by September, with a view to obtaining UNICEF accreditation for local maternity services.

(v) The Chair of the Children and Maternity Sub-Group should work with key stakeholders to improve data collection across the pathway.

(vi) Improved antenatal education was needed.

(vii) To expand and improve coordination and change the management

configuration of maternity and maternity support services, including the Peer Support Workers programme.

(vii) The Board also requested that the Children and Maternity Sub-Group should report to the 9 September Health and Wellbeing Board on the Action Plan and timetable that the Sub-Group would be working to.

(ix) 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.

The Chair advised that the BAD Youth Forum had indicated an interest in health projects and she would approach them to see if they may wish to include potential consultation work on this issue in their work plan.

23. Child Death Overview Panel Annual Report

Matthew Cole, Director of Public Health, presented the Annual Report on behalf of the Child Death Overview Panel (CDOP) and advised that the CDOP provided a comprehensive and multi-agency review of child death. The aim of the reviews is to understand how and why children die in the Borough and use the finding to improve the health and safety of children in the area and reduce the risks of future child deaths. There had been 27 deaths in the period and for a variety of reasons only 18 of those had been reviewed by the CDOP.

Councillor Turner stated that a version of this report had also been presented to the Local Safeguarding Children Board and he was concerned that the Borough had a high level of occurrence against the London average for neonatal deaths. Mr Cole advised that the average for a year usually ranges from one to four neonatal deaths per year and with such small numbers the percentages could easily askew the London average rating.

Councillor Carpenter asked for a further explanation in regard to paragraph 4.2 of the report. Mr Cole advised that because child deaths are rare and intervals can be wide apart it is difficult to detect true statistical differences in death rates. During 2014-15 data will be pooled from several north east London boroughs and analysed to see if this can increase the power to detect differences.

The Board were advised that Health Visitors and Midwives were also being reminded of the advice on back-to-sleep position and cessation of smoking, the two highest risks to neonatal deaths.

The Board noted the recommendations made during 2013/14 by Child Death Overview Panel to the Local Safeguarding Children Board and agencies and requested:

(ii) BHRUT to provide further details on the reports of communication issues between BHRUT and the Ambulance Service at the 9 September 2014 meeting.

(ii) A short update report to the 28 October 2014 Board, to include a further analysis of the figures.

24. Contract: Extending the Contract for Public Health Healthy Child Programme 5 - 19 Years Old

Matthew Cole, Director of Public Health, presented the report which requested the extension of the current Healthy Child Programme 5-19 Years Old to 31 March 2016 in readiness for the transfer of the responsibility to the Local Authority in October 2015. This would also allow the Council to review and develop its 0-19 provision (including early years and school based public health programmes), to meet the changing needs of the Borough, provide a more seamless service with fewer transition issues and look to deliver efficiencies. To allow for stability in service, the Department of Health had also requested that 5-19 contracts do not end at the same time as the Health Visitor transition.

The Board noted the details set out in the report and, in accordance with the Council's Contract Rules section 54.1.3, the Board:

(i) Agreed to the extension of the Public Health Healthy Child Programme 5-19 contract until 31 March 2016; and,

(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 current contract to 31 March 2016 under the same terms and conditions; with a break clause of three months.

25. The Care Act

Anne Bristow, Corporate Director of Adult and Community Services, presented the report on the adult social care reforms following the Care Bill being granted Royal Assent. The report provided reminders of the thrust of the Care Act and its major provisions and also alerted the Board to the draft statutory guidance and secondary legislation that was currently out for consultation. Mrs Bristow advised that this consultation was of some magnitude, as over 500 pages of draft regulations had been received and changes were still occurring. The Act, guidance and regulations would certainly have a significant impact on the Council or relevance to partner organisations.

There were also a number of operational challenges that would need to be worked through, such as:

- informal carers provisions
- assumptions about rational decisions being made by people for their own care
- an explicit duty to cooperate
- local authorities being bound to ensure provision of service choices for individuals to purchase under personal budgets,

The aim was to provide a seamless delivery of the Care Act and its funding reforms to residents who have eligible for unmet social care needs.

The changes would be in two phases, April 2015 and April 2016, with the funding reforms being in the 2016 phase.

Councillor Butt asked how much it would cost to implement, and was advised that as the Regulations were still being changed or clarified there were a number of different models for assessing the costs, however, the ball park figure was £6m to £8m, but with the phasing this could in the order of £4.5m on 2015. As a result negotiations on funding are being undertaken at national level with the Department of Health.

Councillor Carpenter drew the Boards attention to the support required for job and training opportunities and the provisions available within the Borough to assist with this aim.

The Chair then drew the Board's attention to the details that appear to be required for the personalised statements and the potential for this provision to be resource heavy.

Dr Goriparthi commented that the estimated cost of unpaid carers nationally was estimated to be in the region of £111b. If that was the case then the £4.5m may not be enough.

The Board received the report and following discussion:

(i) Noted:

 (a) The need to support carers to remain in employment and the potential for the Adult College to be able to assist in this area.

 (b) The challenges in regard to advocacy numbers and training of the advocates to levels envisaged by the draft Regulations within the voluntary sector.

 (c) The high level of administration that would be needed to produce personalised statements.

 (d) There were a number of variables that will affect the potential cost of implementation to the Council and currently the best estimates had averaged around £4.5m, but could be as high as £8m.

 (e) The Carers Strategy was currently being refreshed and it was anticipated this will be reported to the Board on 28 October 2014.

(ii) Approved the response of the Board, to the consultation on the Care Act draft guidance and regulations, as set out in Appendix 2 to the report.

(iii) Agreed the actions to be undertaken by partner organisations to contribute to the implementation programme.

(iv) To a schedule of further Care Act programme implementation reports to ensure the Board is well-sighted on issues and to further explore issues or parts of the implementation that impact on partner organisations.

26. Mental Health Tariff

Sharon Morrow, Chief Operating Officer Barking and Dagenham CCG presented the briefing on the national tariff payment system for 2014/15. NHS England and Monitor are responsible for setting the NHS payment system and they had published the national tariffs for 2014/15 There had been a period of consultation with commissioners and providers prior to publication. The tariff deflator of -1.8% had been applied to mental health service contracts.

Ms Morrow advised that whilst Monitor recognised the challenges being faced by providers and commissioners in transforming patterns of care and improving operational efficiency, they still believed that there were opportunities to improve care and safety by more efficient use of resources and had required providers to make 4% productivity improvements in 2014/15. It was expected that productivity improvements would be made through operational efficiencies.

John Atherton, Head of Assurance North Central and East London, NHS England, advised that the deflators had caused a range of discussions across both acute and non-acute services, but the NHS, like much of the public sector, had been charged by the Government to make saving year-on-year. The decisions were taken at a national level and it is that settlement that NHS London then had to implement.

Councillor Carpenter asked for a candid response to the impact and difference in services that the users would see as a result in the cuts in tariff. Sharon Morrow responded that as this was a 'block contract' the Trust was putting together plans to achieve cost savings through back-office efficiencies and added that she had not been made aware of any effects on patients.

Councillor Turner commented that he was a little sceptical that such a level of cut could be found for back office efficiencies as the public sector has been undergoing cuts for a number of years and there was unlikely to be areas that could be trimmed further without impacting on service delivery.

Dr Burgess advised that each scheme has to be considered by a panel, which included clinicians, to make sure that savings do not affect the quality of patient care.

Jacqui van Rossum, Executive Director Integrated Care (London) and Transformation), NELFT, commented that from 2016 there would no longer be 'block contracts', which could impact on savings options in the future and could affect service parity across London.

Anne Bristow added that it would be interesting trying to make savings whilst at the same time the 'Closing the Gap' programme had increased demands.

The Board wished to record its concerns in regards to the tariff provision, which equated to a funding reduction, and the felt this was not supportive of the policy of achieving parity of esteem' between mental health and physical health provision. The Board also noted that this could be further exacerbated by the disparity between acute and non-acute service availability. The Board also made note of the safeguarding implications and costs following on from the Francis report.

Accordingly, the Board asked the Mental Health Sub-Group monitor this closely and escalate issues to the Board if necessary.

27. Impact of the Recession Scrutiny (Action Plan)

Gillian Mills, Integrated Care Director, NELFT, presented the report on the Health and Adult Services Select Committee's (HASSC) scrutiny review on the 'Potential Impact of the Recession and Welfare Reforms on Mental Health'. The issue had been originally been part of the Board's agenda for the 25 March 2014 Board, which had subsequently been inquorate. The full scrutiny review could be obtained from the link within the report and attached as Appendix 1 to the Board report were the HASSC review executive summary and recommendations, which were:

- 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.

Ms Mills advised that the Mental Health Sub-Group had subsequently been tasked with producing a plan to meet those recommendations and the resulting Action Plan was attached as Appendix 2 to the report. The Plan provided details on what areas the Sub-Group Members would lead on implementing within their respective bodies. A user engagement event had also been arranged for October 2014 at which feedback on the Action Plan would be sought.

Councillor Carpenter commented that there were a number of base timelines mentioned in the Plan in regards to 2014 and asked if these had been agreed. Ms Mills confirmed that they had been agreed and work was already going on to ensure the timescales were achieved.

The Board received the report and:

(i) Noted the Mental Health Sub-Group had looked at seven recommendations from the Health and Adult Services Select Committee and had developed an Action Plan to take things forward, as set out in Appendix 2 to the report,

(ii) Noted there would be an engagement event in October 2014 to obtain user feedback on the Action Plan, and

(iii) Requested an update on the progress achieved is provided to the Board for six months thereafter.

28. 'Closing the Gap': Priorities for Essential Change in Mental Health

Gillian Mills, Integrated Care Director, NELFT, advised that two years ago, in its mental health strategy, 'No Health Without Mental Health', the Government had 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. There was also clear recognition that more needed to be done to prevent mental ill health and promote mental wellbeing.

Since that time a lot of positive changes had occurred but more still needed to be done and nationally, people who use mental health services, and those caring for them, continue to report gaps in provision and long waits for services. There was still an enormous gap in physical health outcomes for those with mental health problems. Ms Mills commented that there was clearly a disparity in treatment and evidenced that 70% of those with heart conditions and 90% of those with diabetes receive regular treatment but only 20% of those with anxiety are receiving any treatment. There was also far less provision of acute or emergency mental health support services out-of-hours, for example at weekends and bank holidays.

The February 2014 Department of Health 'Closing The Gap' report had challenged the health and social care sector to go further and faster to transform the support and care available to both children and adults with mental health problems. The 'Closing The Gap' report also challenged Public Health services to give greater attention to mental health and wellbeing promotion and prevention.

The Board were also informed that a benchmarking audit, against the 25 recommendations, was being undertaken and the issues would form part of an engagement event in October 2014.

Councillor Carpenter pointed out that in section 20 of the LGiU document, attached as Appendix 1to the report, there was mention of £43m to support a small number of housing projects designed with and for people with mental health problems and leaning disabilities and asked if the Borough was going to receive any of this funding. The Chair advised she would investigate and advise the Board Members of the results.

Dr Goripathi suggested that mental health needs to be a core part of other strategies, such as alcohol and drug abuse strategies as well as general health strategies, as mental health issues could result from long-term physical health problems and were often an underlying cause of substance abuse.

Councillor Turner commented that it might be useful to have a self-assessment on where we were as a Borough on this issue. Ms Mills confirmed that this was currently being undertaken and we would then be in a position to identify our strengths and any weaknesses.

Anne Bristow advised that the Health and Wellbeing Strategy is currently being refreshed and suggested that cross referencing of mental health issues should be fed into that.

The Board noted:

(i) The 25 recommendations highlighted within the Closing the Gap report.

(ii) The Mental Health Sub-Group members were undertaking a benchmarking audit within their respective organisations to establish the level of services commissioned and provided within Barking and Dagenham against those 25 priorities.

(iii) An implementation plan would be presented to the 28 October 2014 Board outlining the actions that need to be taken for local services to meet the report's recommendations.

(iii) There was a link between mental health and long-term physical conditions (e.g. diabetes, heart disease, COPD) and accordingly it would be efficient to link and coordinate the strategies and this would be part of the refresh of the Health and Wellbeing Strategy.

(iv) The Chair would ascertain if the Borough was to benefit from the £43m for housing projects designed with and form people with mental health problems and leaning disabilities and would advise the Board Members accordingly.

29. Urgent Care Board Update

The report provided an update on the work of the Urgent Care Board and the workshop that was held on 30 June 2014. Following discussion, the workshop members had 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).

The Chair indicated that she had concerns that the 'surge plan' of three extra appointments in each GP's practice would be sufficient. Dr Goriparthi gave a verbal update on the work that was being undertaken which included the linking-up of GP IT systems. There were also other projects being progressed, for example links with Havering to provide urgent care.

John Atherton advised that NHS England had also committed to distribute winter funds much earlier this year and would also be looking at resilience plans over the next few weeks.

The Board noted the report and in particular:

(i) The work that had been undertaken and was ongoing in regards to the

linking-up of GP's IT systems.

(ii) NHS England's commitment to provide winter pressure funds much earlier and also that they are reviewing resilience plans over the next few weeks in preparation for the winter season.

(iii) The still needed to be some evidence that the 'hub' and surge appointments were being used by 'ill people' rather than for additional routine appointments.

30. Care City: Update

Helen Oliver, Care City Programme Lead for NELF and LBBD, presented the report and an in addition to the details within the report provided and update on recent changes.

Councillor Carpenter was supportive of the project and indicated that the Borough's Adult Education College could be beneficial resourced for the project and Councillor Turner commented on the positive action to increase the level of respect for the carer professions.

The Board noted:

(i) The outline business plan had been presented to NELFT Board on 22 July 2014, and funding had been approved. This would allow for NELFT and LBBD to work together for a further two years and 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 of 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.

(v) It was anticipated that a decision will be made on 4 August by the Council's Cabinet, which would result in a permanent site for Care City.

(vi) That the Adult College could be also be a useful partner in this project.

31. Better Care Fund - Update

The Board received a verbal update from Glynis Rogers, Divisional Director Commissioning and Partnerships, which informed the Board that the position had changed since the report had been written. The Board noted that further guidance had now been released by the Department of Health and the deadline for response was 19 September 2014. This would enable a detailed report to be presented to the 9 September Board. In the meantime, and to enable preparations to continue, the Board noted:

(a) A workshop was planned for 13 August to finalise plans.

(b) NHS England's comments that there had been some very positive narratives and shifts in activity for LBBD.

(c) Good progress had been made already and there would be a further focus on financial and monitoring issues over the coming weeks.

(d) The Board still maintained its shared and clear ambition which was, locally reflected within both the Better Care Fund Plan and the strategic five year plan.

(e) In preparation for our approval at the 9 September meeting, 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.

32. Progress on the Diabetes Actions from the Health and Adult Services Select Committee Scrutiny Review

The report provided an update on the progress of implementation of the recommendations of the Health and Adult Services Select Committee in 2012/13. Collaborators and stakeholders had worked in a very positive manner to start to achieve change. There was still work to be done but there was now a strategic group (the Diabetes Sub-Group of the Planned Care Steering Group) that could take forward the ongoing work. This included identifying diabetics within high risk groups in primary care and elsewhere and the need for NHS England to address the problem of some underperforming GP practices.

Dr Goriparthi's advised that work was now being undertaken in a united way with BHRUT and staff based at Porters Avenue were now doing outreach work at GP's surgeries and this would provide additional training for GP's and Practice Nurses and ultimately improve patient outcomes.

The Board noted the report and agreed:

(i) The Diabetes Action Plan had been completed, as set out in table 1 of the report, and was now fit for return to the Health and Adult Services Select Committee.

33. Sub-Group Reports

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

The Board noted the updates provided in regards to

- Integrated Care Sub-Group
- Mental Health Sub-Group
- Learning Disability Partnership Board
- Children and Maternity Sub-Group

The Board also noted that the Public Health Programme Board, had not met since the last meeting of the Board, and was given assurances by the Director of Public Health that it would be meeting within the next couple of weeks.

34. Chair's Report

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

- Five Year Strategic Plan Final Submission
- Letter sent to NHS England Regarding Safeguarding Concerns
- New Community Services Up for a National Award
- Marking Intermediate Care Better – Consultation
- Lord Darzi Event on 7 July 2014
- Update on the Progress of Transfer of Children's Public Health Commissioning
- Transforming Services, Changing Lives – Case for Change
- News from NHS England.

Dr Burgess advised that a response to the letter sent to NHS England regarding safeguarding concerns was in preparation.

35. Forward Plan

Noted the draft Forward Plan and that there had been some changes and items added since the publication of the agenda. The Board also noted that the deadline for changes or additions for any items to be considered at the 9 September meeting or later was 7 August 2014.

HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	Vision and Priorities for Barking and Dagenham
Report of the Leader of the Council	
Open Report	**For information**
Wards Affected: All	**Key Decision: Yes**
Report Author: Karen Wheeler Head of Strategy & Communications	**Contact Details:** Tel: 020 8227 2317 E-mail: karen.wheeler@lbbd.gov.uk
Accountable Director: Graham Farrant, Chief Executive	
Sponsor: Cllr Maureen Worby, Chair of the Health and Wellbeing Board	

Summary:

This report sets out the proposed new vision and priorities for Barking and Dagenham.

They are intended to reflect the changing relationship between the Council, partners and the community, and our role in place shaping and enabling community leadership within the context of a significantly reducing budget. They also reflect the ambitions of the new Administration.

The proposed vision for the borough is:

One borough; one community; London's growth opportunity

The three corporate priorities that will support the vision are:

- Encouraging civic pride
- Enabling social responsibility
- Growing the borough

Cabinet have agreed the vision and priorities for consultation with partners and the community, and will recommend them to Assembly for approval on 17th September 2014.

Recommendation(s)

The Health and Wellbeing Board is asked to consider the vision and priorities and provide feedback for consideration by the Leader before the report is recommended to Assembly for agreement in September.

Reason(s)

Although there is no longer a statutory requirement for the Council to produce a Community Strategy or Corporate Plan, it is good governance to frame the vision for the borough and agree the Council's policy priorities to inform decision making and allocation of resources.

The new vision and priorities have been supported by Cabinet on 4th August and will be recommended to Assembly for approval in September following consultation with partners and the community.

1 **Introduction**

1.1 This report sets out the proposed new vision and priorities for Barking and Dagenham. They have been developed to reflect the changing relationship between the Council, partners and the community, and our role in place shaping and enabling community leadership within the context of a significantly reducing budget.

1.2 As a result of reductions in the money received from the Government and other pressures on services from the growing population and national policy changes, the Council will have to make approximately £55-60m of savings over the three years between 2015/16 and 2017/18. This reduction in funding is unprecedented, requiring a fundamental change in the way the Council approaches addressing the budget gap and in considering the future shape of the Council going forward. This means that the development and delivery of the vision and priorities and relationship with the Medium Term Financial Strategy (MTFS) and resources available to achieve them is key.

1.3 The proposed vision and priorities also reflect the ambitions of the new Administration. Barking and Dagenham has the most untapped potential for growth in London, and the Council needs to define its role and champion the delivery of that ambition and aspiration for its communities. In doing so it recognises that with an increasingly diverse population, community cohesion and the active engagement and participation of the community are key components to improving the quality of lives of our residents and maximising the opportunities created by growth. It also reflects that wherever possible we enable our residents to help themselves, support their neighbours and live more independently, whilst still offering a safety net for the most vulnerable.

1.4 Cabinet has agreed the vision and priorities, set out below and in Appendix 1, for consultation with partners and the community, and will recommended approval to Assembly in September 2014.

2. Vision and Priorities

2.1 The proposed vision and priorities for the borough are:

One borough; one community; London's growth opportunity

- Encouraging civic pride
- Enabling social responsibility
- Growing the borough

2.2 Each priority has a set of key objectives sitting beneath them that define the areas of focus for the Council, partners and community. These are set out below and in full at Appendix 1. A more detailed narrative for each priority and its objectives is included at Appendices 2 to 4. This will inform the overall strategic narrative about the

borough for use in our communication and engagement activity with residents, partners, including the voluntary sector and businesses, and in London to demonstrate our ambition and build our reputation and profile locally and nationally.

Encouraging civic pride
- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility
- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough
- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

2.3 Having been agreed at Cabinet, the vision and priorities will be recommended to Assembly on 17 September 2014 for adoption by the Council. Partners and the community will be asked for their views through existing boards and groups, and given the opportunity to adopt them as community priorities for the borough. The wording of the vision and priorities put forward to Assembly will be finalised in consultation with the Leader. The Council is also developing new values that will closely integrate with and run alongside the vision and priorities. The Health and Wellbeing Board are therefore asked for their feedback by way of this report.

2.4 In order to ensure that the Council’s contribution to achieving the priorities is proactive, co-ordinated, resourced in line with the MTFS and monitored so that Members and residents can see progress, an annual corporate delivery plan will be developed along with key performance indicators and targets. These will be reported to Cabinet in September 2014 for approval. Progress will be reported quarterly to Cabinet and six-monthly to Public Accounts and Audit Select Committee (PAASC).

3. Consultation

3.1 The new vision and priorities for the Council were developed with the Leader, Cabinet members and Leadership Group during Strategy Week in June 2014.

3.2 Partners and the community will be asked for their views on the vision and priorities through existing boards and groups, and given the opportunity to adopt them as community priorities for the borough. Feedback from the consultation will inform the

final vision and priorities which will be put to Assembly in September 2014.

4. Mandatory Implications

4.1 Joint Strategic Needs Assessment

A number of the key objectives of the vision and priorities have the potential to improve population health and wellbeing and address health inequalities in Barking and Dagenham. The refresh of the Joint Strategic Needs Assessment will need to be consulted to guarantee that actions taken to meet the vision and priorities outlined in this paper are based on robust information on population need, for example, in identifying the most vulnerable.

4.2 Health and Wellbeing Strategy

There are no specific implications as a result of this report, however, the need to improve the health and wellbeing of the borough's residents is reflected in the new priorities. The Health and Wellbeing Strategy will influence the delivery of the vision and priorities and inform the key projects for inclusion in the delivery plan. The refresh of the Health and Wellbeing Strategy will need to reflect the vision and priorities to ensure strategic fit.

4.3 Integration

The report sets out the proposed new vision and priorities for Barking and Dagenham. They have been developed to reflect the changing relationship between the Council, partners and the community and will inform the overall strategic narrative about the Borough. The vision and priorities reflects and promotes the integration agenda, particularly under the 'enabling social responsibility' priority, by stating that the Borough will 'protect the most vulnerable, keeping adults and children healthy and safe' and 'fully integrate services for vulnerable children, young people and families'. Partners are encouraged to give their feedback on the vision and priorities and adopt them as community priorities for the Borough.

4.4 Financial Implications

Prepared by Tamara Beckford, Interim Group Manager - Corporate Finance

The new vision and priorities reflect the Council's context and priorities. These have been written in line with the funding arrangements identified at a high level within the Medium Term Financial Strategy (MTFS).

Officers are responsible for ensuring that service plans are aligned to available budgets in order to set and maintain a balanced budget while delivering quality services. Essential actions are being delivered to ensure the sustainability of the Council's new vision and priorities. This will be monitored through the existing financial management process to identify and address potential issues on a timely basis.

4.5 Legal Implications

Prepared and verified by Eldred Taylor-Camara, Legal Group Manager

The Assembly is the central political focus of the Council and the co-ordinating body for all elements of the political structure. It sets the overall corporate direction, policy

framework and financial limits for the Council within which all operations and policies are carried out.

Under the Council's Constitution it is the responsibility of the Assembly to approve and adopt the Council's Community Strategy, the Community Priorities and the Council Plan.

It is the function of Cabinet to determine all major issues affecting the Council, particularly strategic, financial, policy related and corporate management matters, within the overall policy framework set by the Assembly.

Should Cabinet endorse the new Vision and Priorities (Community Strategy) document and agree to the development of a corporate delivery plan as proposed in this report, the documents will then be submitted to Assembly (as the Council's policy-making body) for final decision and adoption. Once Assembly approves and adopts the plan, the responsibility for implementation will rest with Cabinet.

4.6 Risk Management

There are no specific risks associated with this report. The corporate delivery plan and ongoing monitoring will set out any risks and mitigating action. The Council's business planning process sitting underneath the vision and priorities describes how risks are mitigated by linking with the Corporate Risk Register

4.7 Patient/Service User Impact
There are no specific impacts on patients or users as a result of this report.

5. Non-mandatory Implications

5.1 Crime and Disorder- The priority **Encouraging civic pride** encompasses activities to tackle crime and disorder issues and will be delivered through the Community Safety Partnership.

5.2 Safeguarding- The priority **Enabling social responsibility** encompasses activities to safeguard children in the borough and is delivered through the Local Safeguarding Children Board and Children's Trust.

5.3 Property/Assets
N/A

5.4 Customer Impact- The new vision and priorities give a clear and consistent message to residents and partners in Barking and Dagenham about the Council's role in place shaping and providing community leadership.

5.5 Contractual Issues- Any contractual issues relating to delivering activities to meet borough priorities will be identified and dealt with in individual project plans.

5.6 Staffing issues- There are no specific staffing implications.

Public Background Papers Used in the Preparation of the Report:
Cabinet report – Vision and priorities for Barking and Dagenham, August 2014

List of Appendices:

Appendix 1: Vision and priorities
Appendix 2: Priority 1: Encouraging civic pride
Appendix 3: Priority 2: Enabling social responsibility
Appendix 4: Priority 3: Growing the borough

One borough; one community; London's growth opportunity

Encouraging civic pride
- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility
- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough
- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

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Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

With an increasingly diverse population, community cohesion and the active engagement and participation of the community are key components to improving the quality of lives of our residents. According to the Census 2011 the current population of the Borough is 190,560 but is projected to rise to over 247,400 by 2030. This places ongoing and increasing demand on the borough and Council services. We saw almost a 50% rise in 0-4 year olds between 2001 and 2011, and subsequently a 7.5% rise in 5-9 years olds between 2012 and 2013.

We will work the voluntary, community and faith sector to build pride, respect and cohesion across the borough. Residents will be encouraged to share responsibility for their community, their environment and the area in which they live.

Community safety is important to all residents particularly the most vulnerable groups. We will continue to work with partners and our community to tackle the fear of crime by building resilient communities where people look out for each other, whilst also supporting and protecting those most at risk.

Promoting and protecting our green and public open spaces will be a priority, however this needs to be approached innovatively and within the context of significantly less government funding in this area. Encouraging our community to take pride in the borough and working with our partners to build civic responsibility will support this aim.

We want a stronger community where everyone feels they have a place, whatever their background, age and aspiration. This is why the Leader of the Council has chosen to personally lead on this portfolio area and bring our community together.

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Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

With reduced government funding for the Council we will have to work differently with our partners and the community. This means that wherever possible we need to ensure there are support mechanisms to enable our residents to live more independently, whilst still offering a safety net of support for our most vulnerable.

We will work with our partners to build resilience in local communities by supporting active citizens, local assets and neighbourhood networks. We want to enable and empower local communities to develop, manage and sustain local community hubs.

We will support the connection of public health with the local community and help create a place that supports well-being thereby encouraging residents to make informed choices for a healthy lifestyle and behaviours which improve their own health.

We will continue to work with our health partners to ensure our residents can get good quality healthcare when they need it from their local surgery, hospital, or at home - ensuring the voice of local residents informs decisions about health and social care that affect them and their families.

Our vision for the borough’s youngest residents is that every child is valued, supported and challenged so that they develop the ambition, skills and resilience to succeed. We need every child to know that they are a part of, and have a responsibility to contribute to building a strong, empowered and cohesive community.

Collectively, we will work with our partners and the communities to help Barking and Dagenham residents live long, fulfilling and healthy lives.

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Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

Barking and Dagenham has the most untapped potential for growth in the capital, has excellent accessibility and is London's next big growth story after Docklands and Stratford. Barking and Dagenham will deliver 17,000 new homes and 10,000 new jobs over the next twenty years. The Council is committed to growth, to playing its role in London and delivering for its community. We have ambition and aspiration to become a destination of choice, where people stay and feel welcome.

We have **five** growth hubs and an unrivalled opportunity to deliver a wide range of new jobs and housing across the borough. They are:

1. **Barking Riverside** – one of the largest residential developments in the UK, 11,000 homes with superb River Thames frontage, in a strong partnership with the GLA
2. **Beam Park/Ford Stamping Plant** – major brownfield site with great potential for housing and commercial activity **with** 2,500 new homes and over 1,000 new jobs
3. **Barking Town Centre** – 15 minutes from Central London, east London's cultural hub, a vibrant and culturally rich community, with space for creative industries, superb accessibility, and opportunity for at least 4,000 more homes
4. **London Sustainable Industries Park (LSIP)** – addressing the low carbon economy, the platform for B&D to become London's greenest Borough
5. **londoneast- uk** – working with the private sector to transform the former Sanofi site into a bio tech based economic hub that is unique in the capital

Barking and Dagenham has strength and potential for growth across six economic sectors:

1. **Green tech** - recognising the potential for green energy and the opportunities at LSIP
2. **Bio tech** - based on the superb laboratory facilities at Business east
3. **Health and social care** opportunities, including the development of Care City
4. **Creative industries** - centred on the Ice House Quarter and Broadway Theatre in Barking
5. **Logistics** and other London serving industries harnessing our excellent accessibility
6. **Advanced manufacturing** - building on the borough's manufacturing heritage

To deliver this growth and realise this ambition we are committed to working with the Mayor, GLA, other London partners, with neighbouring boroughs, businesses and communities. Together we need:

- The Gospel Oak to Barking line extended to Barking Riverside
- Barking Town Centre to be designated as a 'London Housing Zone'
- High quality 'gateways' into Barking Riverside
- An East London network of enterprise hubs for start-up and growing businesses
- Barking as East London's new creative industries hub at the Ice House quarter along the River Roding
- An eastern spur of Crossrail 2 to link Barking and beyond, to Stratford
- 'Care City' established in Barking Town Centre
- Business east as London's bio tech centre of excellence
- Beam Park and the site of the Ford Stamping Plant to become an aspirational new mixed use commercial and residential centre
- The London Sustainable Industries Park vision to be delivered so that we become London's greenest borough
- The A13 as a priority transport corridor for investment to relieve congestion and facilitate movement.

Barking and Dagenham is open for business, with space for growth, an ambitious and aspirational community and a local authority committed to deliver and succeed.

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BARKING AND DAGENHAM HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	Transforming Services, Changing Lives
Report of the Accountable Officer, Barking and Dagenham Clinical Commissioning Group	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Neil Kennett-Brown, Programme Director	**Contact Details:** Tel: 020 3688 1222 E-mail: neil.kennett-brown@nelcsu.nhs.uk
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group (CCG)	

Summary:

The Clinical Commissioning Groups (CCGs) of Barking and Dagenham, Redbridge, Tower Hamlets, Waltham Forest and Newham, plus NHS England, Bart's Health and other local providers have established a clinical transformation programme called Transforming Services, Changing Lives (TSCL), which will consider how services need to change to provide the best possible health and health care for local residents**. It does not, at this stage, outline any recommendations for change.**

A key element of the programme is to consider how best to ensure safe, effective and sustainable hospital services at Bart's Health hospitals, set in the context of local plans to further develop and improve primary, community and integrated care services.

The work of the programme, which was launched in February 2014, and is expected to run until October 2014, will develop a baseline assessment of the drivers for change in the local health economy and support further discussions about the scope, scale and pace of change needed.

Key milestones:

- **9 July:** Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn:** Publication of final Case for Change.
- **After publication of Case for Change:** Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Provide comment and feedback to the programme team based on their review of the Interim Case for Change. This will be used in the development of the final case for change, which is due to be published in October.

(ii) Consider and confirm requirements and timings for future updates and presentations about the final Case for Change and any future work programmes.

1. Background and Introduction

1.1 The five CCGs involved in Transforming Services, Changing Lives have a duty to promote a comprehensive health service for their populations of around 1.3 million people. Today, local NHS services face the very real challenge of providing care for a rapidly growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.

1.2 The health economy is never static. Change is happening all around the system. In the last year, since the establishment of CCGs, we have seen the introduction of NHS 111, the development of integrated care and soon the launch of personal health budgets. We need to respond to these changes to ensure that benefits are realised and unintended consequences are avoided.

1.3 However, we also know that some services simply need to improve to meet local needs. We need to address the areas where we are not so good. We know that the quality of care we provide is inconsistent. We need to work better with providers and with social care to address the challenges we face and decide how we can introduce new and different ways of providing care.

1.4 Collectively commissioners have agreed with providers to look at the challenges we face, to ensure we can continue to provide the care our patients need, at the best possible place for them. Organisation boundaries must not and cannot impede the commitment to deliver improvements at scale across the partnership. We also need to make sure that any changes in the future happen safely and effectively.

1.5 In developing their case for change, clinicians will be guided by the principles of the Francis Report to ensure delivering first class care for patients and local populations is the driver for change.

2. Proposal and Issues

2.1 Local clinicians have been asked to use their own knowledge of national and international best practice to review the quality and performance of East London health services, highlight areas of good practice that should be maintained and developed, and set out if, why, and in what specialties they think there may be a case for change to ensure the very best care for local residents. They are not, at this stage, setting out any recommendations for change.

2.2 Their work has been published as an 'Interim Case for Change', which is available to view at www.transformingservices.org.uk.

2.3 Key milestones:

- **9 July:** Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn:** Publication of final Case for Change.
- **After publication of Case for Change:** Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

3. Governance Arrangements

3.1 The governance arrangements for the programme have been established and include:

- A Programme Board – tasked with providing the strategic oversight for the Programme. To reflect the external decision making requirements, the Programme Board reports to the relevant statutory bodies of CCGs, providers and the NHS England. CCGs ensure a clear link through to HWBBs. Additionally Waltham Forest, Tower Hamlets and Newham councils (the boroughs in which Barts Health hospitals are located) have been invited to sit on the Programme Board. Barking and Dagenham Council is welcome to be represented on the Programme Board if they would like to be and / or can be briefed through CCG representatives / regular updates provided to HWBB meetings.

- A Clinical Reference Group and clinical working groups – these reflect the key clinical leadership role in exploring and shaping a 'Case for Change'. CCGs, Barts Health, Homerton Hospital, community and mental health service providers and the London Ambulance service have = nominated clinicians and other front-line staff to join clinical working groups. Links are also being established with academic partners. The clinical working groups focus on:
    - unplanned care (urgent and emergency care, acute medicine, non-elective surgery)
    - long-term conditions
    - elective surgery
    - maternity and newborn care
    - children and young people, and;
    - clinical support services

- A Public and Patient Reference Group – this group meets on a regular basis to provide ideas and feedback to clinicians leading the TSCL programme and support and advise on public engagement activities. Representatives have been invited from three broad groups:
    - local branches of Healthwatch. Healthwatch Barking and Dagenham has received regular email updates.
    - patient representatives from the CCGs involved in the programme. An invitation was extended to the Barking and Dagenham CCG Patient Engagement Forum.
    - patient representatives from the providers involved in the programme.

4. Consultation

4.1 Although TSCL does not, at this stage, set out any recommendations for change, the programme recognises the importance of engaging local stakeholders in our work at an early stage.

4.2 This includes, but is not limited to:

- The formation of clinical working groups, made up of clinicians including GPs, doctors, nurses and therapists, who have developed the interim case for change.
- The formation of a public and patient reference (refer to page 3) to support the development of the interim case for change.
- Two large events in April and July for key stakeholders. Invitations to Health and Wellbeing Board Chairs, as well as other local authority members, such as Directors of Public Health, Directors or Social Care, Chairs of Overview and Scrutiny Committees etc
- Barking & Dagenham Healthwatch team has been invited to sit on the Transforming Services, Changing Lives Public and Patient Reference Group in order to help shape the Case for Change. They have acknowledged the invitation and have received ongoing, regular email updates about the programme.
- A series of large engagement events for Barts Health staff
- A range of public events, including attendance at the Barking and Dagenham CCG Patient Engagement Forum and stands at hospital sites
- A series of patient focus groups

4.3 The engagement period runs until 21 September, with feedback collected via online survey, post and at meetings and events. All feedback and requests for amendments to the final Case for Change are logged and reviewed for inclusion in the final document.

5. Mandatory Implications

5.1. Health and Wellbeing Strategy

The TSCL Case for Change will consider how services need to change to provide the best possible health and health care for Barking and Dagenham and other east London residents. It will establish the foundations for a longer term joint transformation programme, should partner organisations conclude this is necessary in order to bring forward whole system, health economy-wide improvements in the clinical and financial viability of local services in east London. Given TSCL Case for Changes extensive public and patient engagement, the Health and Wellbeing Strategy refresh will take into consideration its findings to ensure the high level strategic support that inclusion in the Health and Wellbeing Strategy brings.

5.2. Joint Strategic Needs Assessment

The refresh of the Joint Strategic Needs Assessment (JSNA) includes information that needs to inform a number of the clinical working groups where appropriate, for example, long-term conditions, maternity and newborn care and children and young people. To ensure that TSCL Case for Change takes into account the needs of the population in Barking and Dagenham all elements of the workstream need to

incorporate the findings of the JSNA. Following the publication of the JSNA refresh, the Public Heath Intelligence team should ensure that the Programme Board and clinical working groups are fully and appropriately briefed.

5.3. Integration

TSCL is closely linked to all other change programmes that are under way in east London to ensure we are not 'reinventing the wheel'. This includes the Integrated Care Coalition.

The TSCL programme strongly supports the development of integrated care. One of the key principles of the programme is: *"We will work collaboratively across providers, commissioners and different sites to ensure that overall healthcare system addresses our populations' needs now and in the future."* (Interim Case for Change page 8).

As outlined in Governance Arrangements (page 3), clinicians, patients, providers, commissioners and other non-NHS organisations are working together to develop the Case for Change.

5.4. Financial Implications

There are no financial implications arising from this report. Any costs associated with LB Barking and Dagenham representation on the TSCL Programme Board are met through existing budgetary provision.

Implications completed by Neil Kennett-Brown**,** Programme Director.

5.5. Legal Implications

There are no legal implications arising from this report.

Implications completed by Neil Kennett-Brown**,** Programme Director.

6. List of Appendices:

Appendix 1: Transforming Services, Changing Lives, Interim Case for Change Summary

For the full Case for Change document, please visit:
http://www.transformingservices.org.uk/interim-case-for-change.htm

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NHS

Transforming Services
Changing Lives

We would like to hear your views on how we can improve people's health and healthcare in East London – Newham, Tower Hamlets and Waltham Forest

The interim case for change

July 2014

Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups

Introduction

Transforming Services, Changing Lives aims to:

- describe the current state of NHS services in East London
- identify if change is needed to improve services for patients
- begin to develop a shared vision of how we could improve services

All key health and social care organisations across east London have been working together to develop this interim Case for Change. We believe significant change is required. Now we would like your views.

If you would like to know more:

- You can see the full document at www.transformingservices.org.uk or for a paper copy you can email tscl@nelcsu.nhs.uk or phone us on 0203 688 1678.
- We will be making presentations at councils, clinical commissioning group meetings and community meetings throughout the summer. Take a look at www.transformingservices.org.uk. Please contact us if you would like to attend a meeting, or if you are part of a community group and wish to request a speaker at one of your events.

To let us have your views by 21 September 2014:

- Fill in the survey at the back of this booklet
- Or visit www.transformingservices.org.uk and fill in the same 5-10 minute survey
- Or email us or phone us (the same contact details as above)

Who we are

Patients and public

Integrated acute and community trusts

- Barts Health NHS Trust (including hospitals at The Royal London, Whipps Cross, Newham, Mile End and The London Chest)
- Homerton University Hospital NHS Foundation Trust

Waltham Forest and East London Clinical Commissioning Groups (CCGs)

- NHS Newham CCG
- NHS Tower Hamlets CCG
- NHS Waltham Forest CCG

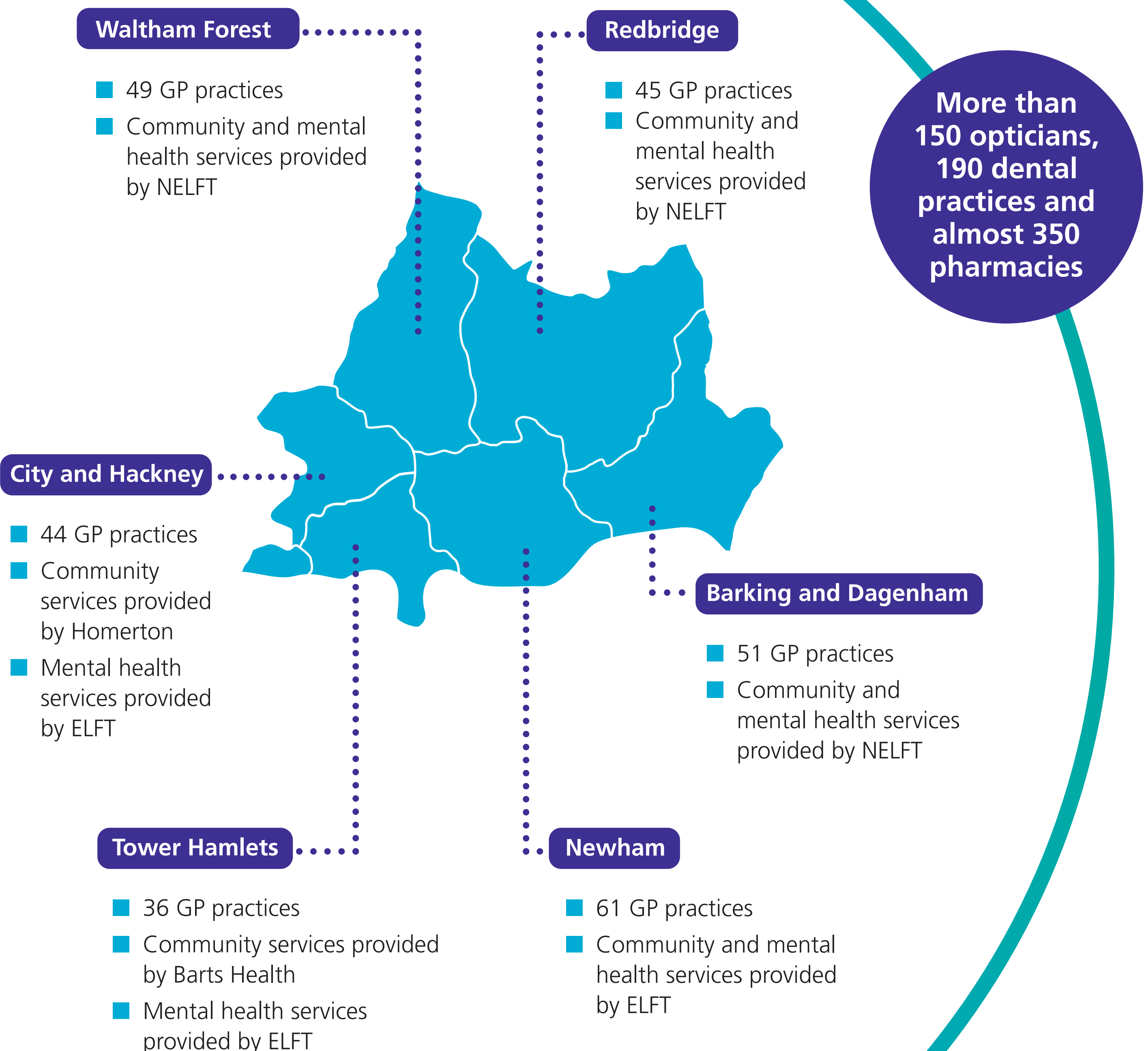
Community and mental health trusts

- East London NHS Foundation Trust (ELFT)
- North East London NHS Foundation Trust (NELFT)

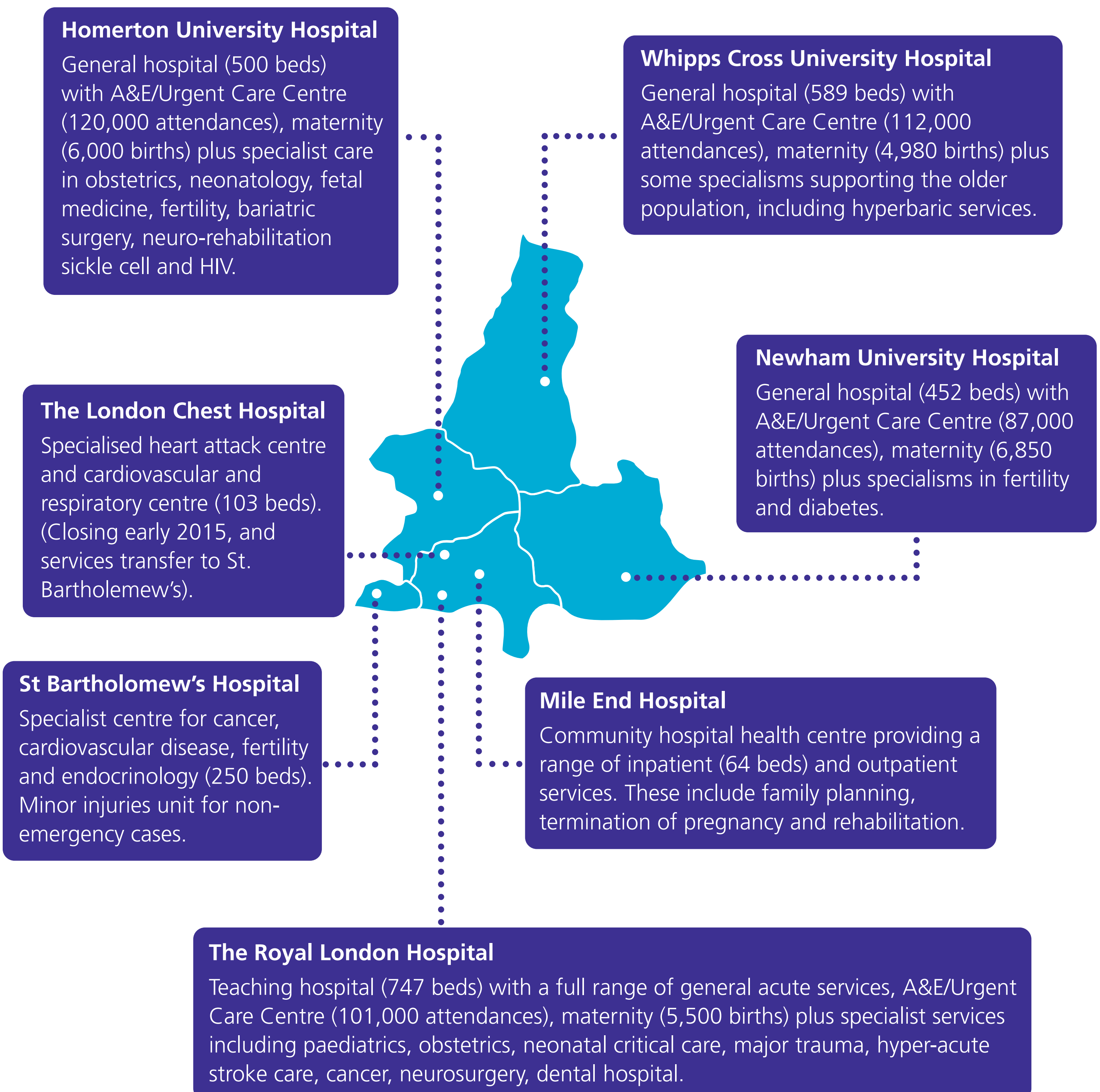
Other commissioners

- NHS England
- NHS Barking and Dagenham CCG
- NHS Havering CCG
- NHS Redbridge CCG
- Local authorities

Existing services in the community



Existing hospital services



Our vision for the NHS in East London

1

Work in partnership with other organisations and with patients to improve health and prevent the need for health services

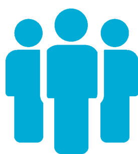
The NHS working with an active local authority and voluntary sector to improve health, reduce health inequalities and prevent the need for health services

People take personal responsibility for their own health, are supported to to manage their own health, to self-care and to use NHS services appropriately – back up by high quality and responsive primary care services

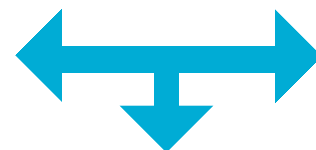
2

When need arises, ensures right care, right time, right place

Rare / dangerous / complex needs best treated by a specialist



Specialised services



Acute episodes of care treated efficiently according to severity / urgency

Local hospital services

Long term conditions which are actively managed with patients to reduce the need for unplanned care

Enhanced primary and community care services

We looked at what influences people's health and the quality of services

Health and wellbeing

We work with patients to help prevent illness, but more needs to be done if we are to keep people healthy and manage their conditions:

- **The health of our population is not good**. In Tower Hamlets and Newham in particular, life expectancy is lower than the national average and more people die early from heart disease, strokes, cancer and other big killers than in other parts of the country. Whilst we need to improve NHS services, there are other factors that contribute to this problem. Deprived communities (of which there are many in East London) tend to have poor health. The transient population means it is difficult for patients and the NHS to establish a good relationship; and the rich ethnic mix brings additional challenges to delivering a high quality service.

- These challenges will not go away as the **population is growing** at a higher rate than anywhere else in the country – particularly in regeneration areas. The highest proportionate change is amongst the over 65s.

- **Everyone has a responsibility for good health**, the NHS, local councils, businesses, schools, and patients and the public – who need to be empowered to take responsibility for their own health and to use NHS services responsibly.

World class services

We have some world-class services, for instance treatment of heart attacks, major trauma and stroke, but not every services is always excellent:

- Patient experience is often poor. **GP patient satisfaction** scores are low. Barts Health has lower than national average scores on inpatient, A&E and friends and family scores. Out of 22 London hospital **maternity services**, Barts Health is ranked 19th and the Homerton 21st (Care Quality Commission, 2013), although a recent CQC inspection of maternity services at the Homerton rated the services as good.

- Services are of differing quality depending on whether the patient is the focus of integrated, acute, social and mental health care and where they live; what service they need; and what time of the day or week they need care.

- At **the start of life**, there is not enough antenatal care in the community; too few women have their first antenatal assessment by 13 weeks; and we need more midwives and more consultant presence on the labour ward.

- **Children and young people** are too often treated in adult settings; those with complex needs are passed from pillar to post; and mental health conditions are identified and treated too slowly.

- We have a population with **very high levels of mental illness**; physical health outcomes of people with mental illness are poor; readmission rates for people who have been discharged are too high and we need to improve access to psychological therapies.

- People living with **long term conditions** often don't get the individual service they need, taking into account their personal situation; too few cancers are being diagnosed in the community; too many people have to be readmitted to hospital, perhaps because the services are not good or accessible enough in the community; and an average 91% of patients in East London responded "no" when asked whether they had a written care plan (GP Survey, 2014) – something that clinicians feel is essential if the NHS and patients are to work together managing a condition.

- We use **urgent services** (particularly A&E) more than most other parts of the country. Newham's Urgent Care Centre found 30-40% of people could have been cared for closer to home; ambulance handovers, particularly at Whipps Cross are often too long; and patients often stay too long in hospital waiting for care to be arranged in their home or to have a discharge assessment.

- Some **non-urgent surgery** is best done in large centres of excellence which leads to improved efficiencies and outcomes. In other cases it may be better and possible to deliver services more locally. At times and in some specialities we are too slow to treat people (often called the 18 week standard). Too many patients are having their operations cancelled.

- To deliver improvements we will need high quality **support services**. But as the population increases we need at least two million extra tests by 2020/21. We need to improve turnaround times for test results and ensure specialised diagnostics such as interventional radiology are available to everyone.

- We need to recognise the essential nature of **research** which drives many of the most important improvements in care.

Finally, we need to provide more services 24/7. NHS England estimates over 500 lives could be saved a year in London if patients admitted in an emergency at weekends had the same standard of care as patients admitted on weekdays.

Workforce

We have developed some innovative schemes to build a sustainable, flexible, professional workforce, such as Barts Health's apprenticeships for local people. But there are big challenges in recruiting for specific posts.

Some of these recruitment challenges (e.g. for A&E consultants, paediatric nurses, neonatal nurses and midwives) are national. But some challenges are more local, for instance the high cost of living; the shortage of GPs – particularly when many existing GPs are close to retirement; and often poor staff motivation – which tends to suggest a poorly performing service. We need to develop the clinical leadership and work closely with local authorities to recruit a local workforce that has the skills to deliver high quality services now and in the future.

Resources

The NHS and local government are facing significant real terms reductions in funding. We need to work together to make better use of our resources. The NHS has invested £50 million in Whipps Cross and Newham hospitals in the past few years, and we have already saved millions by making efficiencies, but we need to:

- make more than **£400m of savings** over the next five years and get better at preventing ill health.
- **improve communication and information sharing** so patients can better care for themselves and do not have unnecessary appointments and tests.
- make **more effective use of technology** – last year the first person in the UK was fitted with a wireless pacemaker at Barts.
- make **better use of estates.**
- **make choices** about the best way to spend resources.

Based on our findings, we believe the key areas for change in local NHS services are…

We think these changes would mean that, together, we could achieve great health and health outcomes for people in East London, such as:

1. People supported to manage their long term condition in the community
2. More people surviving life-threatening events such as stroke, heart attack or major trauma
3. Patients reporting improvements in their quality of life as a result of health care interventions
4. Patients reporting an excellent experience when accessing healthcare
5. People supported to die at home where it is their choice to do so

Now tell us what you think

To see the full reports and fill in this survey online please go to www.transformingservices.org.uk

Q1 How satisfied are you with the NHS?

- Very satisfied
- Quite satisfied
- Not satisfied or dissatisfied
- Quite dissatisfied
- Very dissatisfied
- Don't know

Q2 How much to you think the NHS needs to change?

- A lot
- A little
- Not at all
- Don't know

If you think the NHS needs to change, let us know why – our ideas are on page 11.

Q3 Do you agree with our vision of care on page 6 and 12?

- Yes, completely
- Mostly
- Partly
- Not at all
- Don't know

Let us know any thoughts you have on what a good NHS looks like.

Q4 Do you think we have described the challenges facing the NHS?

- Yes, completely
- Mostly
- Partly
- Not at all
- Don't know

Let us know if you can think of other challenges or if you don't think some of the challenges described are very important.

Q5 How do you think we could work better with our partners – for example local authorities?

Q6 How can we help patients and the public to take more responsibilty for their care and encourage them to self-care?

Q7 Do you think we have described well the key areas we need to change - our ideas are on page 11?

☐ Yes, completely ☐ Mostly ☐ Partly ☐ Not at all ☐ Don't know

Let us know if you think there are other key areas we need to focus on, or if you don't think we should focus on our proposed key areas for change.

Q8 We would like to illustrate points made in the final case for change with quotes from members of the public. Do you have any experiences of the NHS, good or bad, that you are willing to share with us? We will anonymise any quotes used.

Please tell us a little about yourself. This helps us understand whether there are different views from different groups or parts of the community.

You don't have to answer these questions. We will take your views into account whether you answer them or not.

Are you providing this response as a representative of a group:

☐ Yes ☐ No If yes, what is the name of the group

Are you…

☐ Male ☐ Female ☐ Prefer not to say

How old are you?

☐ Under 16 ☐ 16-25 ☐ 26-40 ☐ 41-65 ☐ Over 65 ☐ Prefer not to say

Are you responding as a…

☐ Service user ☐ NHS staff member ☐ Carer ☐ Local resident ☐ Other ☐ Prefer not to say

What is your ethnic background

White
- ☐ White British
- ☐ White Irish
- ☐ Any other white background

Mixed
- ☐ White and Black African
- ☐ White and Black Caribbean
- ☐ White and Asian
- ☐ Any other Mixed background

Asian
- ☐ Asian British
- ☐ Indian
- ☐ Bangladeshi
- ☐ Pakistani
- ☐ Chinese
- ☐ Any other Asian background

Black
- ☐ Black British
- ☐ Black African
- ☐ Black Caribbean
- ☐ Any other Black background

- ☐ Any other ethnic group
- ☐ Prefer not to say

Which belief or religion, if any, do you most identify with?

☐ Agnosticism ☐ Atheism ☐ Buddhism ☐ Christianity ☐ Hinduism
☐ Islam ☐ Judaism ☐ Sikhism ☐ Other ☐ Prefer not to say

Do you consider you have a disability?

☐ Yes ☐ No ☐ Prefer not to say

Which borough do you live in

☐ Newham ☐ Tower Hamlets ☐ Waltham Forest ☐ Barking and Dagenham
☐ City / Hackney ☐ Redbridge ☐ Other

Would you like to be kept up to date with information about this NHS programme

☐ Yes ☐ No

If yes, please give us your email or postal address

Please tear off this questionnaire with your answers and send to: Transforming Services Changing Lives, NEL CSU, Clifton House, 75-77 Worship Street, London EC2A 2DU

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Life Study**
Report of the Accountable Officer, Barking and Dagenham CCG	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Professor Carol Dezateux	**Contact Details:** Tel: 020 7905 2114 E-mail: c.dezateux@ucl.ac.uk
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group	

Summary:

The purpose of this paper is to provide a brief for the Health and Wellbeing Board on the strategic partnership, established under the University College London Partners (UCLP) umbrella, between the ***Life Study*** and Barking Havering & Redbridge University Hospital NHS Trust (BHRUT).

Within this partnership, the ***Life Study*** team is working with BHRUT and local stakeholders (NELFT and BHRCCGs) to deliver the first ***Life Study*** Centre in mid-2014. Wider involvement with other stakeholder groups may occur at a later date, with the possible inclusion of other members of the Integrated Care Coalition.

This paper provides a summary of the arrangements in place and the strategic benefits to the local population and all stakeholders.

Recommendation(s)

The Health and Wellbeing Board is asked to note the contents of the report, in particular:

(i) The development of the strategic relationship between ***Life Study*** and BHRUT
(ii) The benefits delivered via this integrated delivery model
(iii) The impact of the 'in kind benefits' to the Study

1. Background and Introduction

1.1 ***Life Study*** is a UK cohort study designed to recruit up to 83,000 children across England, Scotland, Wales and Northern Ireland and to follow them through childhood and into adult life. Around 60,000 of these children will be recruited during pregnancy by contacting mothers in selected maternity units.

1.2 The Study aims to understand how family, social and physical environment in early life influences child development, health and wellbeing. It offers an opportunity to develop and test our understanding of social and biological mechanisms operating through the life course, and to identify translational opportunities which might have early impact in relation to health and social policy. The study is innovative in design and its size means it will have enough statistical power to examine the interplay between biology, behaviour and environment (including by ethnic groups).

1.3 Women and their partners will be recruited during pregnancy and invited to attend specially designed ***Life Study*** centres in pregnancy and later with her baby when they are 6 months and 12 months old.

2. Proposal and Issues

2.1 Involvement by BHRUT in the Study means that mothers and their nominated partners will be invited to attend a specially commissioned ***Life Study*** Centre based at King George's Hospital on one occasion during pregnancy. The ***Life Study*** Centre is a facility similar to a large GP surgery or an NHS outpatient facility where Study participants can attend to undertake the various assessments and tests required as part of the Study.

2.2 Mothers will be invited to attend the same centre with their baby when their baby is aged 6 and 12 months. Attendance at a ***Life Study*** Centre will enable a richer assessment of the child's development than is possible in the home, as is a more traditional model for a cohort study. Further contacts with participants throughout childhood and into adult life are anticipated and further funding for these will be sought.

3. Consultation

3.1 A communications and engagement strategy have been developed specifically for ***Life Study***. To date this has involved an engagement phase involving many types of consultation activities such as presenting at large scale events, face to face discussions with members of the public and science fairs.

3.2 To maximise the benefit of the Study for the local population and ensure the longer term success, it is essential that the Study is well embedded in local services, in the primary care and community services as well as within the Trust.

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

Five major research themes will be explored through the cohort, which align with the health priorities identified in Joint Strategic Needs Assessment:

- Inequalities, diversity and social mobility
- Early life antecedents of school readiness and later educational performance

- Developmental origins of health and ill health in childhood

- Social, emotional and behavioural development: the interplay between infant and parent

- Neighbourhoods and environment: effects on child and family

4.2. Health and Wellbeing Strategy

The aims of the Study fully support the recommendations outlined in the Health and Wellbeing Strategy. ***Life Study*** seeks to understand how the family, social and physical environment in very early life influences child development, health and wellbeing.

This cohort will provide a rich and internationally unique longitudinal resource of data, environmental and biological samples that can be used to address future questions and hypotheses regarding early life origins of disease, health, wellbeing and development.

The design and scale of this study will also allow exploration, for the contemporary UK population, of cross cutting issues such as intergenerational influences on child outcomes and issues relating to diversity arising from, for example, different family structures, ethnic groups, early life experiences, and prematurity. The study offers an opportunity to develop and test our understanding of social and biological mechanisms operating through the life course, and to identify translational opportunities which might have early impact in relation to health and social policy. The study is innovative in design and its size means it will have enough statistical power to examine the interplay between biology, behaviour and environment (including by ethnic groups).

4.3. Integration

The Trust offers an opportunity to integrate the Study into a large modern maternity unit with a commitment to research and the wider environment and partner providers, which service a diverse population. The Study will provide benefits to the Trust in terms of benefits via the NIHR portfolio as well as direct and indirect benefits to staff development and recruitment. Finally in the longer term BHRUT is part of a wider stakeholder group and civic environment that will support the longer term follow up of recruited babies through childhood and into adolescence and ensure integration of the ***Life Study*** into the local community.

4.4. Financial Implications

BHRUT and its strategic partners have undertaken to host and support the first ***Life Study*** Centre, within the King George's hospital site and to

- A suitable outpatient style facility, up to 500m2 by time of peak operation, in a child and family friendly environment and ideally co-located with maternity services with

weekend and evening opening options and associated office space for the local and UCL ***Life Study*** staff ready for operation from June 2014

- Services and facilities to support the running of the facility including water, heating and lighting, IT connectivity, cleaning and clinical waste removal and security monitoring for the duration of the operation of the facility

- Appointment centre support and clinic facility on the hospital information system (HIS)

- Non-specialist equipment as per clinic outpatient facilities

Life Study has been adopted on the NIHR portfolio and once the model has been agreed with the local provider, a joint application will be submitted for NIHR to fund aspects of the staffing model.

Implications completed by: Anne Carey, Chief Operating Officer, Life Study

4.5. Legal Implications

Life Study has been approved by the City and East London Research Ethics Committee, the Confidentiality Advisory Group of the Health Research Authority and has been notified to Information Commissioners' Office. It has been approved by the BHRUT Caldicott Guardian and has been adopted onto the NIHR research portfolio. Collection and management of biological samples collected for research will comply with the Human Tissue Act. In addition, the Study has been accredited to ISO27001 and NHS IG toolkit standards.

Life Study complies with all ethical, legal and information governance requirements for research.

Implications completed by: Anne Carey, Chief Operating Officer, Life Study

4.6. Risk Management

There is a ***Life Study*** Risk Management Plan (RMP) in place to describe the methodology for identifying, tracking, mitigating, and ultimately retiring ***Life Study*** Project risks. It sets out the internal and external risks to the Study and how these will be managed. The primary purpose of the strategy is to identify potential problems before they occur so that risk-handling activities may be planned and invoked to mitigate adverse impacts on achieving objectives. This risk management plan contains an analysis of measures to identify risks with both high and low impact and will periodically reviewed by the project team at the commencement of each project phase to avoid having the analysis become stale and not reflective of actual potential project risks.

This risk management process incorporates the BHRUT-Life Study Strategic Partnership.

4.7. Patient/Service User Impact

Life Study offers several benefits to the local population and health research needs. Specific health issues flagged as strategic priorities in the local current public health and health and well-being reports are integral to the ***Life Study***. These include antenatal smoking, infant feeding, maternal and childhood obesity and physical activity, mental health and well-being, and environmental risks. These are important health improvement targets which cut across the acute, community and public health sectors.

In addition, engagement with ***Life Study*** also affords an opportunity to gain momentum in the aspirations to develop a research capacity centred on the local population and one in which local people and health professionals can engage.

Similar birth cohort studies such as Born in Bradford (BiB) or Avon Longitudinal Study of Parents and Children (ALSPAC) focused in a single location have demonstrated the benefits of an ‘on-site’ study team integrated with the clinical care team and perceived as being part of that community. BHRUT and their community partners will provide the environment and infrastructure to form these close links with both the clinical service and the local communities.

5. Non-mandatory Implications

5.1. Safeguarding

The Study complies with all local safeguarding policies and feeds into the systems in place within the host organisation: all ***Life Study*** staff have level 2 child protection training.

5.2. Property/Assets

The ***Life Study*** centre, located at King George’s Hospital might provide a venue for parenting and other pregnancy and baby related classes, which in time could support the vision of King George’s as a hub for women & children’s services for the local population.

5.3. Customer Impact

5.4. Contractual Issues

All staff within the ***Life Study*** Centre at BHRUT are employed on NHS contracts hosted at BHRUT with honorary contracts at UCL. Thus NHS terms & conditions apply and all staff employed to work on ***Life Study*** are subject to the scrutiny of NHS employment checks.

5.5. Staffing issues

All key midwifery posts within the ***Life Study*** centre are employed as joint roles with the clinical service and the post-holders spend fifty percent of their time working within the clinical service. In this was the Study is closely aligned with the clinical service as well as well as enhancing the appeal of midwifery roles within BHRUT to retain existing staff or attract new staff to the organisation.

HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Intermediate Care Consultation**
Report of the Accountable Officer, Barking and Dagenham Clinical Commissioning Group	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: No**
Report Author: Tara-Lee Baohm, Deputy Director, Strategic Delivery Rob Adcock, Deputy Director, Finance Rod McEwen, Legal and Governance Adviser Sharon Morrow, Chief Operating Officer	**Contact Details:** Tel: 020 822 3016 E-mail: tara-lee.baohm@onel.nhs.uk
Sponsor: Dr J John, Clinical Director Barking & Dagenham CCG	

Summary:

This report will detail the progress made to develop and trial two new home based intermediate care community services in Barking and Dagenham.

It will detail the case for change in the model of intermediate care, informed by evidence gathered through the trial.

It will provide an overview of the consultation process currently underway and detail the preferred option of the CCG.

It will request the HWBB support the intermediate care consultation process and note the preferred option of the CCG.

Recommendation(s):

The Health and Wellbeing Board is asked to note and comment on:

- the outcome of the trial of the new services and case for service change
- the preferred option of the CCG
- the current consultation process

1. Background and Introduction

1.1 Barking and Dagenham CCG and the London Borough of Barking and Dagenham have been working with Havering and Redbridge CCGs and local authorities and NELFT through 2013/14 to develop proposals to deliver improved intermediate care community services in line with the recommendations of the Integrated Health and Social Care Commissioning Strategy including:

- Improving quality and productivity in the community rehabilitation bed base.
- Trialling the provision of home base intermediate care services - intensive rehabilitation service (IRS) and community treatment team (CTT).

1.2 In November 2013, the trial of the expanded community treatment team (CTT) and the new intensive rehabilitation service (IRS) began in Barking & Dagenham.

Community treatment team (CTT) - a team of doctors, nurses, physiotherapists, social workers and others who together care for people having a health or social care crisis at home so that they either don't need to go into hospital or return home from hospital sooner. It runs from 8am – 10pm, seven days a week.

Intensive rehabilitation service (IRS) - a team of physiotherapists, occupational therapists, healthcare assistants and others offering intensive physiotherapy and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

1.3 In June 2014, following receipt of a pre consultation business case, the Barking and Dagenham CCG governing body agreed to publically consult on the future model of intermediate care in Barking and Dagenham. Havering and Redbridge CCG governing bodies are also consulting on a new model for intermediate care.

1.4 The public consultation 'Making intermediate care better in Barking and Dagenham, Havering and Redbridge' launched on 9 July 2014 and will run until 1st October.

2. Case for Service Change

2.1 The pre consultation business case presents the case for service change as a result of evidence gathered through the trial, key headlines of which are as follows:

Improved service access

2.2 There is confidence in using the new services - both CTT and IRS services have been well utilised during the trial with both services performing above activity trajectories. Over 2000 Barking & Dagenham patients have been seen by the new services to the end of June 2014.

2.3 People are able to access the services more quickly than before the trial. 2012/13 data reported an average of 5 days for patients to access community beds. Since the trial began, patients can now access IRS and community beds within 2 days on average from the point of referral. This performance is better than national averages (4.8 days for home based services and 3.4 days for bed based services). The majority of patients referred to CTT are responded to within 2 hours (faster than A&E).

Improved patient choice

2.4 Through provision of appropriate community based alternatives to bed based provision. The system and patients have demonstrated confidence in using the new services. 34% of referrals to CTT are from family/carers/self referral

Improved outcomes

2.5 CTT and IRS are demonstrating better outcomes with regard to reducing admissions to acute care when compared to bed based services - 90% of patients receiving care from CTT and IRS are supported at home and do not require admission to hospital (10% require admission). For bed based services, 84% of patients are cared for in a community setting (16% require admission). Prior to the trial 23% of patients receiving intermediate care were readmitted to the acute.

2.6 94% of patients referred to IRS demonstrated improved patient outcomes scores.

2.7 Improved recovery rates, with the average length of stay in community beds 19 days in line with best practice benchmarks (previously 29 days) and average length of treatment in IRS 9 days, providing some evidence that patients are recovering quicker at home.

2.8 83% reduction in hospital acquired clostridium difficile (C Diff) cases.

Improved patient experience

2.9 Patient and public engagement to date has indicated support for the new services and approach. Both CTT and IRS have consistently rated high with respect to patient experience, scoring 8.7 and 9.0 out of 10 respectively.

Improved system performance

2.10 During the trial we have seen a reduction in A&E attendances, non elective (emergency) admissions and delayed transfers of care.

2.11 In 2013/14 fewer community rehabilitation beds were needed to meet 'winter pressures' than in 2012/13 across the BHR CCGs. In 2012/13, 32 extra beds were commissioned October 2012 to March 2013. In 2013/14 an average of extra 14 beds were commissioned January 2014-March 2014 to meet this demand (only 9 of which were used).

Too many community rehabilitation beds

2.12 Productivity improvements and the trial of new services has led to 24% underutilisation of the existing community rehabilitation bed base. This means we have more beds across BHR than we need.

2.13 Activity modelling indicates the required community rehabilitation bed base will range month on month between 40-61 beds (average 50).This is significantly less than the current capacity of 104 beds across the 3 units of Heronwood & Galleon, Grays Court and Foxglove ward at King George Hospital. This modelling has been independently assured by NHS England.

3. Consultation

3.1 We are consulting on the future model of services provided by NELFT as follows: community treatment team (CTT); intensive rehabilitation service (IRS); required number of community rehabilitation beds and their future locations.

3.2 Five possible options were developed in partnership with key stakeholders. These options were then reviewed and assessed by the Intermediate Care Steering Group against a range of non-financial (clinical outcomes, safety and quality, patient experience) and financial criteria. Scoring criteria was weighted 60:40 (non financial: financial).

3.3 The preferred option identified by the BHR CCGs is Option 5, outlined in the consultation document:

- Member of community rehabilitation beds in line with demand (flex between 40-61 depending on the month) Continue with CTT and IRS
- Reduce our number
- Locate these beds on one site - King George Hospital

3.4 This option would mean:

- People would continue to benefit from the popular home based services (CTT and IRS) and there would still be access to rehabilitation beds for those that need them.
- The total number of community rehabilitation beds would be reduced - our evidence tells us we don't need the number of community beds we currently have as these aren't being used.
- Community rehabilitation beds commissioned by the Barking and Dagenham, Redbridge and Havering CCGs will be centralised on the King George Hospital site and community rehabilitation beds will no longer operate from Grays Court.

3.5 This is the best option clinically. Clinicians tell us the safest way to provide high quality care is by having bed services in one place. Running one unit would mean we could use staff much more efficiently and flexibly.

3.6 Greatest value for money and best use of resources. We will pay to keep the new services by reducing our spend on community beds and reduce the duplication of costs of running 3 sites

3.7 Consultation period and process:

- 12 week consultation – 9 July to 1 October
- Hard copy consultation documents widely distributed
- Consultation documents are on the CCG website
- Online questionnaire
- Public events will be held in each Borough. In Barking & Dagenham, we have an event scheduled Thursday 11 September at Barking Learning Centre, 4 - 7pm.
- Attending other meetings with community groups and stakeholders by request and actively engaging with key community groups

4. Mandatory Implications

4.1. Joint Strategic Needs Assessment

Barking and Dagenham expects the size of the older population to increase up to 2020 at a slower rate than England overall. Domain 3 of the NHS Outcomes Framework focuses on helping people to recover from episodes of ill health or following injury. The rate of emergency readmissions in Barking and Dagenham is higher than the London and England rate and commissioners are advised to consider developing care in the community to avoid unnecessary hospital admissions.

4.2. Health and Wellbeing Strategy

The Health and Wellbeing Strategy aims to deliver improved health and social care outcomes through integrated services. The new model of intermediate care
supports delivery of outcomes primarily across the theme of improvement – keeping people well and independent and ensuring that they receive the services that they need if they become unwell. We aim to prevent ill health and support people to recover from illness and stay well at home, reducing the need to access secondary care in a crisis.

4.3. Integration

The Barking and Dagenham, Havering and Redbridge Integrated Care Coalition has agreed a strategic plan that sets out a number of system objectives to be delivered across the health and social care economy over the next five years. The Coalition has agreed an out of hospital strategy that sets out the programme of work that will deliver improved health and social care outcomes. Developing a new model for intermediate care services is a key work stream of the out of hospital strategy.

In Barking and Dagenham, the new model of intermediate care forms one of the Better Care Fund schemes which contributes to the Better Care Fund ambitions to:

- Reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, closer to home.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and the community.

4.4. Financial Implications

Funding for intermediate care services is planned to be included in the Better Care Fund.

The investments reported in the consultation documentation will deliver better quality whilst also achieving a cost reduction of £929,985 for the preferred

option 5 against the previous model, across the BHR Health economy. As a result, the changes will bring about: cost reductions, improved quality and outcomes, and more patients will have access to services in the preferred model, which ultimately results in greater value for money.

Rob Adcock, Deputy Director of Finance, Barking and Dagenham CCG

4.5. Legal Implications

Pursuant to their statutory obligations to consult and guidance, Barking and Dagenham, Havering and Redbridge CCGs have commenced a 12 week public consultation on a new model of intermediate care. The preferred option to provide intermediate care, is set out as option 5 in the consultation paper, but no final decision on the option will be made until the conclusion of the consultation process and all views having been taken into account. The final decision will be made by each CCG governing body subject to the outcome of the consultation.

Rod McEwen, Legal and Governance Adviser, Barking and Dagenham, Havering and Redbridge CCGs

4.6 Patient/Service User Impact

Under the proposals more people would have access to quality care, more quickly and with better outcomes.

Patients have expressed very high satisfaction with regard to both CTT and IRS
scoring 8.7 and 9.0 out of 10 respectively.

For many people, retaining the new services will mean that people receive care within their own homes, negating the need to travel-this is an improvement.

Patients are generally transported to community rehab units by patient transport- there will be no change for patients to this.

Depending on where patients' family/friends reside there may be an impact on those family members and friends who do have to travel to visit patients at the KGH site. They won't do this for as long as they would have previously, as improved care means patients recover quicker and are discharged home sooner. There are good transport links to KGH. For visitors from:

- East of the borough very near to Romford with good travel links to KGH - several buses travel from Romford to KGH (387 bus from Dagenham Town Hall for example, takes around 40 minutes).

- South of the borough – 387 bus direct to KGH from the very south = 1 hour travel. This is an improvement in terms of travel, as travel from the very south to Grays Court, although closer, would take the same amount of time with more interchanges (walk, bus, train, bus, walk).

A stage 1 equalities impact assessment was completed as part of the evidence base underpinning the pre consultation business case which in turn informed the consultation plan.

A full equalities impact assessment will be completed during the consultation process, this will include specific engagement with cohorts of patients potentially affected by the proposals.

5. Non-mandatory Implications

5.1. Property/Assets

There is capacity for 26 community rehabilitation beds at the current sited at Grays Court Dagenham, which is owned by the London Borough of Barking and Dagenham. In addition to the above, Grays Court also accommodates 17 stroke rehabilitation beds - 10 for B&D and 7 for Havering. The Havering stroke beds were moved from St Georges Hospital in November 2012. Grays Court is leased to NELFT.

5.2. Contractual Issues

All services subject to the consultation are funded by the CCG and provided by North East London Foundation Trust. From 2015/16, funding for intermediate care services will be included in the Better Care Fund pooled budget. Any changes to the 2015/16 contract will be made following agreement by the commissioners with appropriate notice given to the provider.

6. Background Papers Used in Preparation of the Report:

Integrated Care in Barking and Dagenham, Havering and Redbridge: The Case for Change
Intermediate care briefing for stakeholders: November 2013
Intermediate care briefing for stakeholders: March 2014

7. List of Appendices:

Appendix 1: Making Intermediate Care Better in Barking and Dagenham, Havering and Redbridge Consultation Document

Pre consultation business case is available via:
www.barkingdagenhamccg.nhs.uk/intermediatecare

Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

NHS

Making intermediate care better

in Barking and Dagenham, Havering and Redbridge

Foreword from the clinical directors

As doctors, we want to help people live as healthily as possible, making sure they get the right care, when they need it. As local GPs, we've always known what our patients need and want. Now we're also in a position to lead changes that we believe will make a real difference to local people.

We've always known that people don't want to go into hospital unless they really have to and that if they do, they want to come home again as soon as they can. We also know that they are likely to recover better outside hospital, in a familiar place, close to their family and friends - as long as they also have the right care and support from nurses, therapists and care workers. That's what we want to make happen.

In the past we haven't done as well as we could to provide care for people at home. We've known for some time that in other areas they do things differently and people generally recover more quickly. We wanted to learn from them and provide a different, better sort of care, but we didn't want to make any permanent changes until we knew that they really were an improvement and until we'd heard what patients thought of them. We have looked at evidence from the UK and overseas which shows better results for patients and want to implement this locally. We're pleased to see that the trials of the new community treatment team and the intensive rehabilitation service have helped more people to get care and treatment outside hospital.

We are also pleased to hear from patients and carers that they've appreciated this support at home. This success means we're now in a position to talk about what we do in the longer term.

This document explains what we want to do. Please do read about our proposals, ask us if anything's not clear and let us know what you think about what we want to do.

It's your NHS and we want you to help shape it locally.

Dr Jagan John, clinical director, integrated care, Barking and Dagenham Clinical Commissioning Group

Dr Gurdev Saini, clinical director, frail elders, Havering Clinical Commissioning Group

Dr Mehul Mathukia, clinical director, integrated care, Redbridge Clinical Commissioning Group

"I couldn't have got a better service if I went private."

Introduction

This document talks about intermediate care in Barking and Dagenham, Havering and Redbridge. It explains what we have been doing during the past year to try out new ways of working and what we would like to do in the future to make those services better.

We have set out different options and what we think would be the best option and why. We want to know your views, whether you agree or disagree, and if there is anything else you want us to consider.

We want to establish permanently the new intermediate care services that we have been trialling, which would mean that more people could receive care in their own homes. We also want to merge the three existing community rehabilitation units into one unit, on the King George Hospital site in Goodmayes. We believe this would result in better, more individual care that would help people to recover more quickly.

These services are currently provided by North East London NHS Foundation Trust (NELFT), and we intend for these services to continue to be provided by NELFT.

We would especially like to hear from local residents, people aged 65 years and over (as most of the people who use intermediate care services are in this age group), carers, health professionals and our partners in the community and voluntary sectors about whether they think our proposals would improve intermediate care services for local people.

Intermediate care means services that provide people with specialised care from nurses, therapists and other professionals, without them needing to go to (or stay longer in) hospital. These services can be provided in different places - people's own homes, community rehab units or residential homes, for example.

Our new intermediate care services are the **community treatment team (CTT)** – a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home having a health or social care crisis at home – and the **intensive rehabilitation service (IRS)**, a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's home.

Rehabilitation means helping people to recover after an illness or injury. **Community rehabilitation (or rehab) units** are buildings with beds for people who don't need to be in hospital any more, but can't go home because they need intensive 24 hour support and care.

How to make your views known

There are a number of ways in which you can give your views:

Visit our websites and fill in the online questionnaire

Complete the questionnaire at the end of this document and send it back to us

Write a letter to
FREEPOST I Y 426
ILFORD
IG1 2BR

Email: haveyoursay@onel.nhs.uk

Call: 020 3688 1089

All comments must be received by 5pm, Wednesday 1 October 2014.

How to find out more

If you want to find out more about our work to improve intermediate care before you comment, you can visit the intermediate care page on our websites. Or call us and we can send information to you.

We will be out and about in Barking and Dagenham, Havering and Redbridge talking to people about our proposals – the dates and times for these events are below, and you can also find the latest information on our websites.

If you would like someone to come and talk to your community group about our proposals, please email **haveyoursay@onel.nhs.uk** or call **020 3688 1089**.

Barking and Dagenham – Thursday 11 September, 4-7pm
Barking Learning Centre
2 Town Square
Barking IG11 7NB

Havering – Thursday 21 August, 4-7pm
Romford Central Library
St Edwards Way
Romford RM1 3AR

Redbridge – Thursday 31 July, 4-7pm
Redbridge Central Library
(formerly Ilford Central Library), Clements Road
Ilford IG1 1EA

Our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

Background to the proposals

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) have been working together with the local councils and local health service providers to improve health and social care services for local people. We want to make services more joined up with each other and focused on what individual people need, not on what is convenient for the services.

We need to improve people's experience of care and make sure it's the best quality, so we know we are delivering the right care, in the right place, at the right time.

We need to make sure the health and social care system is 'future proof'. We know the population is growing and getting older. We need a system that will care better for people now and can also care for more people in years to come.

We must ensure that services are efficient and deliver value for money.

As part of this work, we have been focusing on improving local intermediate care services.

"This is an outstanding brilliant service, what you have done in 21 days is unbelievable. My mum was in hospital for 13 weeks and was nowhere near where she is today with her walking. My mum is now able to walk which I never thought would happen."

So what is intermediate care?

Intermediate care helps people get better quicker without needing to go to hospital, and also helps get people out of hospital and back home, sometimes after a stay in a community rehab unit.

These services are most often needed by older people, for example if they have a fall and hurt themselves which makes them less mobile and less able to care for themselves. They can also be needed by younger people, though, if they have an ongoing health problem that sometimes flares up making them unwell and needing help. We do not include specialist care for people who have had a stroke when we talk about intermediate care.

Historically, local people needing this kind of care have generally been cared for in beds at community rehab units when they could have been cared for at home, if the right services were in place to help them. This means that there are more intermediate care beds across our area compared with other areas.

This is an old-fashioned way of providing care and it does not take into account people's individual needs. The results for patients are generally not quite as good as if care was provided in other ways. For example, it often takes longer for people to recover fully. Being in a bed makes patients more likely to get an infection and to lose their independence.

People tell us they want to be cared for and supported in their own homes. We know people locally have been spending longer in community rehab units than people do elsewhere, and this can make it much harder for them to return home and live independently. By providing home-based services, patients recover more quickly and have a good experience of care.

To find out more about the evidence behind this, visit our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

By caring for people at home where possible we would prevent most people from having to go into a community rehab unit.

Of course, there are times when people *do* need to stay in a community rehab unit – for example they're not mobile enough to go home – and we would make sure that they can do this and the care they get there is excellent.

By improving the way we look after people in a community rehab unit and making sure they get personalised, focused care, with access to a range of therapies, patients would need to spend less time there.

To be clear, both the care at home and the care in a bed at a community rehab unit are intermediate care.

What are the new services we have been trialling?

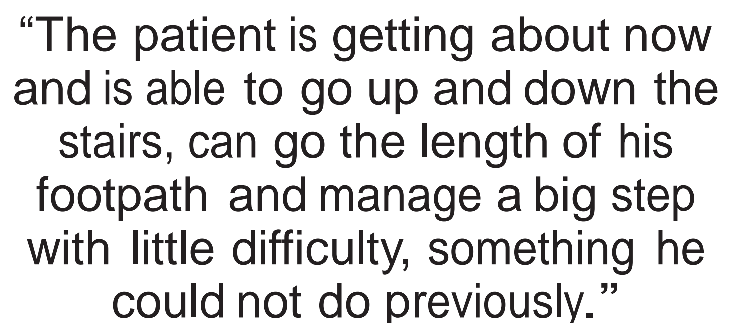
We have been trialling two new services to help people to stay at home.

Community treatment team (CTT)
This is a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home so that they either don't need to go into hospital or return home from hospital sooner.

The CTT started in Barking and Dagenham and Havering in January 2013, where it ran from 8am - 8pm, seven days a week. In November 2013, the service was expanded to include Redbridge, and the hours across the three boroughs were extended for an additional two hours a day, until 10pm.

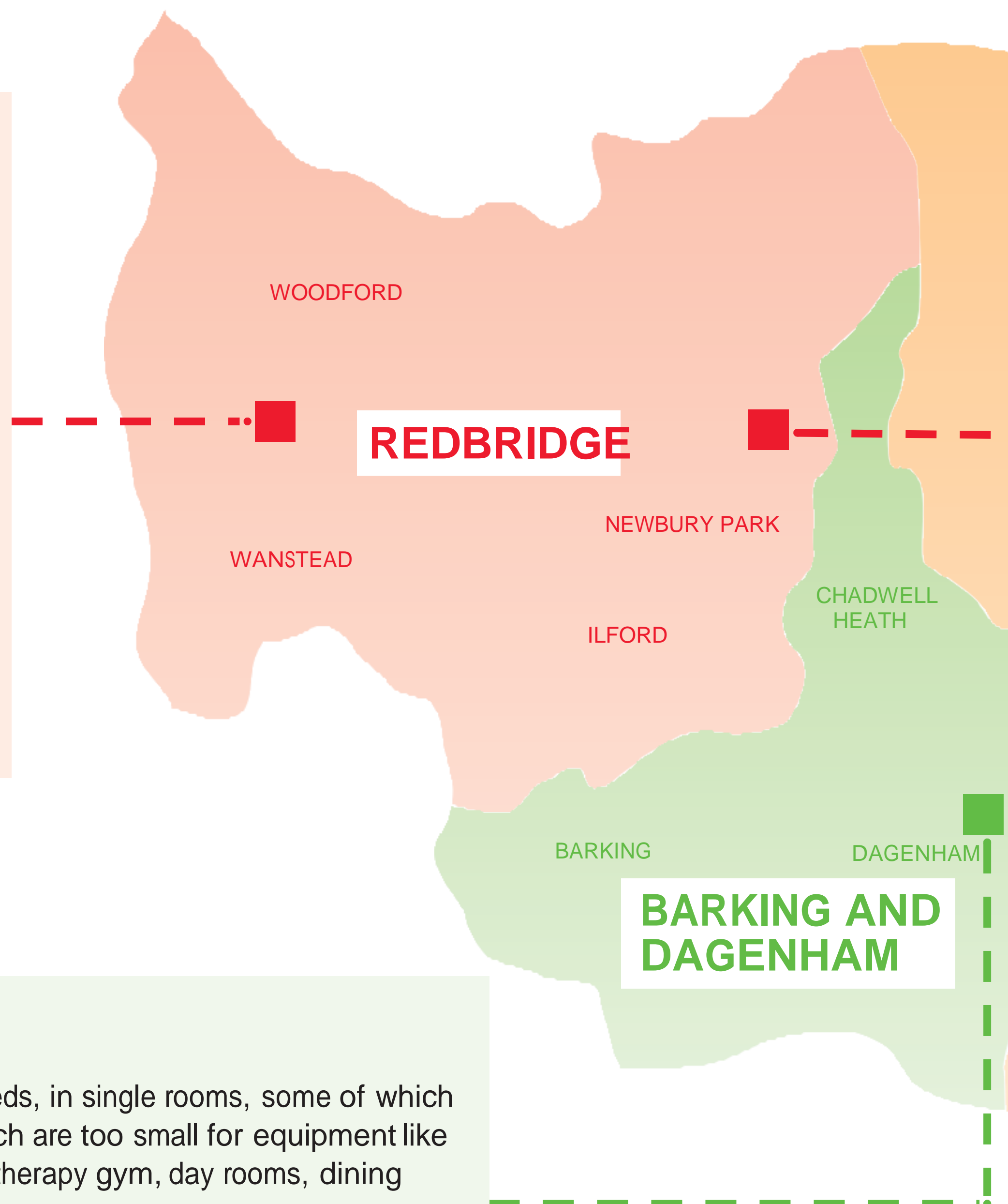
Intensive rehabilitation service (IRS)
This is a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

What do patients think of these services?
Patient satisfaction rates for both the new services have been consistently high across the three boroughs since the trials began. On a scale of 1-10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. You can see some of the comments patients have made about the services throughout this document.



Community rehab units

At the moment there are three community rehab units used by people from Barking and Dagenham, Havering and Redbridge.



Heronwood and Galleon Unit in Wanstead

Capacity and facilities: 48 beds, in two wards. Physiotherapy gym, dining room and day room.

Public transport: Average links. Two bus routes are within five minutes' walk. Nearest underground station is 10-15 minutes' walk.

Parking: Free limited parking on site for staff and visitors. Limited parking in residential streets.

Grays Court in Dagenham

Capacity and facilities: 26 beds, in single rooms, some of which have en-suite facilities but which are too small for equipment like hoists and wheelchairs. Physiotherapy gym, day rooms, dining area, consultation rooms.

Public transport: Poor links. Nearest bus route is 10 minutes' walk away. Nearest underground station is 20 minutes' walk.

Parking: Free limited parking on site, used by staff and visitors. Limited parking on residential streets.

Foxglove Ward (King George Hospital) in Goodmayes

Capacity and facilities: 30 beds, in one ward (with another ward identified for expansion). Day room, physiotherapy gym on ward and access to a larger hospital gym. Access to other hospital services and facilities.

Public transport: Good links. Four bus routes stop in King George grounds. Nearest station is 15 minutes' walk.

Parking: Large on-site carpark for staff and visitors. Charges apply.

Intermediate care services used to be provided at St George's Hospital in Hornchurch, but this site was closed for health and safety reasons in October 2012 and remains closed.

Anyone who needs care in a community rehab unit is offered the next available bed in any of the three units. This might not be the one closest to where they live. This is so they can get access to rehabilitation as quickly as possible, which should help to speed up their recovery. If they prefer to wait for a bed at another unit, they can do so, but generally people want to start their rehabilitation quickly.

Bed numbers: now and in the future

There is capacity for 104 community rehab beds across these three sites. However at the moment these beds are not all being used as there is no need for them. From looking at how the services have been operating recently and particularly since the trial of new services began, we have worked out that we would only need between 40-61 community rehab beds over a year if the home-based CTT and IRS were both running all the time. This is because most people would receive care in their own home and so would not need a community rehab bed.

When working this out, we have taken into account the fact that more beds are generally needed over the winter months.

This means if we did not reduce the numbers of available beds, at any one time during a year there would be between 43 and 64 unused community rehab beds. It costs hundreds of thousands of pounds to keep these available, whether they are occupied or not, in building upkeep, electricity and so on. We also need to duplicate staffing across the sites.

Case study: Sunita stays in a community rehabilitation unit

Sunita is a 77 year old woman who is unsteady on her feet and is in hospital following a fall. She also has a chest infection. She no longer needs to be in the hospital, but she's not mobile enough to go home, and she is afraid of falling over again. CTT and IRS won't be enough for her – she needs help to move around safely, but she also needs 24 hour care. Sunita is referred to a community rehab unit. A nurse from the unit comes out to visit her, assesses her to make sure that the unit is the right place for her to go. It is and she's offered the next available bed.

While in the unit, Sunita receives 24 hour nursing care, physio and occupational therapy. The team regularly assess her and set her small but achievable goals to build her confidence and make sure she is progressing. After two and a half weeks, Sunita is feeling confident enough to go home, and the unit team supports this. They plan how she will manage after leaving. IRS staff visit her on the ward and once she's back home and develop an intensive rehab plan for her. The district nurses and the social care team also review Sunita's needs and provide the support she needs to stay at home safely, with the support of her family.

Sunita is happy to go home, pleased that she will have the support she needs to continue to recover. She is feeling stronger and more confident.

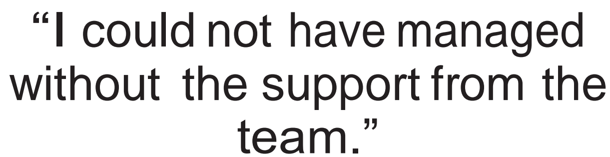
Why we want to change the way we offer intermediate care

We want people to get better care and to recover more quickly. We want them to be able to stay at home, if at all possible, because that's what patients and their families want. Keeping people at home helps them to stay independent for longer and it reduces the risk of them picking up a new infection and becoming more unwell.

We want to make sure that we are using NHS money in the best possible way. This means spending our budget on services that would help patients the most. It means making sure that we are running services as efficiently as possible, saving money where we can so we can reinvest it in different and better services.

Since introducing CTT and IRS on a trial basis, we have found that a lot of beds in community rehab units are not now being used, because the teams care for people in their own homes (in the first six months of the trial, 29 beds weren't used). During the trial we have found that people are able to access care and support sooner. We know that for the majority of people care at home is the right thing, they do not need to go to hospital or a community rehab unit, and they recover as well, and in some cases better and quicker at home. Patients who have used the new services have told us they have had a very good experience and received high-quality care.

"Everybody wants to go home from hospital – as soon as they are ready and able to."



Case study: Reg is helped at home by the Community Treatment Team

Reg is 55 years old. He lives on his own and he has Chronic Obstructive Pulmonary Disease (COPD) which sometimes makes it hard for him to breathe.

Reg visits his GP a lot about his COPD because he's not confident about managing it and he's ended up in A&E in the past. His GP tells him about the local community treatment team (CTT), who can help him to manage his condition.

Reg has struggled to breathe all day but tries to manage with his existing medication. By 4pm, Reg is finding it harder to breathe and this triggers a panic attack. (Panic attacks can be very frightening and intense, but they are not dangerous and won't cause you any physical harm).

Instead of calling 999, as he would have in the past, he calls the CTT. The administrator asks him some questions and tells him how long it will be before someone calls him back. He's called back within 10 minutes as his case is a priority because it is clear he is having difficulty breathing. (The CTT will contact all patients within two hours). A senior nurse asks him questions about how he's feeling. Because of what he says, she allocates his case to a community nurse who arrives at his house within two hours. Reg is thankful that he can receive help at home as, like lots of people, he finds hospitals stressful, which generally makes him feel worse.

The nurse does various tests and notes his temperature has gone up and his oxygen levels are outside the normal range. They talk through his medical history and what medication he is on. The nurse advises Reg that he should now start taking the medication he has for when he has an attack. They discuss how he can manage his shortness of breath, and she carries out a blood test to rule out any further medical concerns. The CTT continues to monitor Reg's progress over the next two to three days and they keep his GP informed.

The nurse also refers Reg to the specialist respiratory team who will work with him in the longer term to help him manage his condition, looking in detail at the medication he's on and working with a physio and occupational therapist.

Reg feels much more confident about managing his COPD in the future, and knows he can always call the CTT if he needs them.

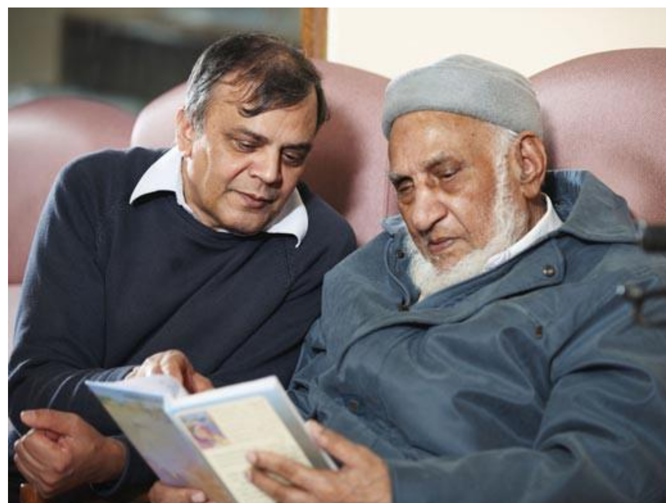
What are the options for intermediate care?

We looked at the possibilities for improving intermediate care services for local people then drew up a list of five options. We then looked at the advantages and disadvantages of each option.

- What would be best for patients and help them to recover as quickly as possible?
- What would be easiest for patients and carers to help them live their normal lives where possible?
- How well does each option fit in with all the other local health and social care services and any plans there might be to develop those in the future?
- Could we afford to pay for the services in each of the options and are some options more or less expensive than others?

We have to make sure that we spend our limited NHS money in a way that makes sure we get the most we can for local people. We do not have enough money to spend on everything that everyone wants and if we spend more on one service then we have less to spend on another. That's why it's really important that we get the balance right.

As well as thinking about how much it would cost to run the services in the future, we thought about how much it would cost to make any changes. This would include the cost of any changes that we might need to make to modernise buildings, for example.



When we evaluated the options, we took into account both non-financial and financial criteria and we weighted these 60:40, meaning the financial aspects were not as important as things like quality of care and patient experience. Detail of these processes and the evidence behind our thinking, including information on finances and the pre-consultation business case is on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

"Walks well now, able to walk with a stick."

The five options we considered in detail were:

Option 1: Stay as they are now

CTT and IRS – same number of beds – beds on three sites

This option means things would not change from how they are now. There would be the same number of beds on the same sites and there would be the new CTT and IRS services that we have been trialling.

Under this option, patients would benefit from the popular home-based care services which help patients to recover more quickly. They would also have more choice if they needed care in a community rehab unit as there would be three community rehab units offering care.

Under this option, there would be unused beds in the community rehab units because more people would be cared for in their own homes. This means money would be wasted.

This option would not be affordable because it is the most expensive option. We would not be able to pay for the new home-based services while still running the same number of beds across three community rehab units. We managed to find additional money to pay for the trial but we cannot carry on running both home-based and bed-based services at this level in the long term.

Option 2: Go back to before the trial

No IRS – No CTT in Redbridge and reduce CTT hours in BD and Havering – same number of beds – beds on three sites

This option means we would go back to how things were before we started trialling the new services. That means there would be no IRS in any of the boroughs and no CTT in Redbridge. The CTT in Barking and Dagenham and Havering would reduce their hours again, by two hours a day. There would be the same number of beds on the same sites.

Under this option patients in all areas would get a reduced service, particularly in Redbridge. The reduction in services would be in the home-based services that patients and carers really like and which help people to recover more quickly.

This option is not affordable in the longer term. No IRS (and no CTT in Redbridge) to support other services would mean longer waits for the services that do exist. That would make those services less productive and patients would take longer to leave hospital. That would be more expensive in the long term than what we are proposing.

“We’re extremely happy with the service and have recommended to our friends already.”

Option 3: New services and three sites

CTT and IRS – fewer beds – beds on three sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs and we would still have three community rehab units. There would be fewer beds overall though because we would take out the ones that aren't needed.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would still be able to choose from the three current units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

This option is not the most affordable option because we would have to pay all the costs of keeping three community rehab units open, even if we weren't using all the space in each building.

Option 4: New services and two sites

CTT and IRS – fewer beds – beds on two sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to two and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to choose from two units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

We considered all combinations of which two sites could stay open, but for the reasons explained above, did not feel this option would provide high quality care. For a detailed description of this process, see the pre-consultation business case on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

This option is more affordable than options 1-3, but it doesn't offer the best value for money because we would still have to run two separate units on two separate sites.

Option 5: New services and one site

CTT and IRS – fewer beds – beds on one site at King George Hospital

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to one at King George Hospital and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to.

This option would be the most affordable because we would pay for the new services with the money that we saved by reducing bed numbers and by reducing the number of sites from three to one. It would also be the best value for money as we would reduce duplication (for example paying to run three buildings).

This is also the best option clinically – it would allow us to deliver a better service, with better results for patients. Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly and patients would have better access to specialist therapy and nursing support.

This option is our preferred option and we explain why in the following section.

Summary of options

Option	Is there a community treatment team?	Is there an intensive rehab service?	How many beds overall?	How many community rehab units?
1	Yes	Yes	104	3
2	Yes, with reduced hours (Barking and Dagenham and Havering) No (Redbridge)	No	104	3
3	Yes	Yes	40-61	3
4	Yes	Yes	40-61	2
5	Yes	Yes	40-61	1

What do we think would be best in the future?

We want to be able to continue the new services that we have been trialling – the community treatment teams in all three boroughs for 14 hours a day, and the new intensive rehabilitation service, because the trial has been very successful. We have had really good feedback from patients and carers about the services – they think they are an improvement.

As much as possible, patients have been helped to stay at home, which has helped them to get better quicker and to stay independent.

We also want to make sure that we have the right number of beds for people who do need to stay in a community rehab unit. We want those beds to have the right supporting services around them.

After thinking about the advantages and disadvantages of all the options, we think option five is the best option. This is because we think it would result in the best and safest care.

Option five would mean:

- We would continue to run the community treatment team and the intensive rehabilitation service that we have been trialling.

  This means most people would get care at home and would not need to travel or stay in hospital. They would be able to lead as normal a life as possible and stay close to family and friends. We know that helping people to stay out of hospital means they are more able to stay independent for longer. Those people who do need to go into hospital would be helped to return home more quickly than in the past. This is because people who have been helped by these services think they are much better than going into hospital.

- We would reduce the total number of beds across the three boroughs to between 40 and 61.

  This means that we would always have 40 beds and we would always be able to increase the number of beds up to a maximum of 61, depending on how many people need a bed at a time. We do not think we would ever need more than 61 beds at any one time. This is because fewer people would need a bed because they are being cared for at home and those who do need a bed for a while would not have to stay in the unit for as long.

- We would move all the beds onto one site

  Having a service in one place rather than in a number of smaller units, means patients get better more quickly. It is much easier to make sure care is of consistent quality and clinicians say this is the safest way to provide care (rather than on two or three sites).

  We could use staff much more efficiently and flexibly and we would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

  We realise that moving from three sites to one would make it harder for some people to visit a relative or friend, but we think the benefits to patients should make it worthwhile. For example, patients will go home sooner than they do now. Some people are already travelling – people in Havering travel to Redbridge to visit Foxglove ward. We think this can be offset by the majority of people being seen in their own home, and not needing to travel.

- We would locate the service on the King George Hospital site.

  This location is fairly central to the three boroughs, there are good, well-established transport links and car parking is available on the site.

Locating the service on this site means it could link in with other health services where necessary. There is enough room here to be able to have up to the maximum number of beds that we think we might need at any one time. There is not enough room on either of the other two sites for 61 beds.

It would mean that we would no longer need two community rehab units – Heronwood and Galleon unit in Wanstead and Grays Court in Dagenham.

We do not own either of these sites, so we cannot make decisions about what would happen to them, but we would work with the owners and other local stakeholders to help them decide how best to use the sites.

For information on the advantages and disadvantages of the different sites, look at the 'Community rehab units' section.

"The service has made a massive difference to my mobility. I would not have been able to recover to the level I have."

Case study: Doreen goes home from hospital with the help of the Intensive Rehabilitation Service

Doreen is an 86 year old widow living by herself. She has high blood pressure, rheumatoid arthritis and walks with a stick but is otherwise in good health.

One day, Doreen falls down her stairs and can't get up, so her neighbour calls 999. An ambulance takes her to Queen's Hospital where an x-ray shows she's broken her leg. She has her leg set under anaesthetic, and spends three weeks recovering on an orthopaedic ward.

While she is in hospital, Doreen has physiotherapy to work on her strength and mobility and an occupational therapist helps her to practise tasks like washing and dressing and moving about safely.

When Doreen no longer needs to be in hospital, instead of going to a community rehab unit, she is referred to the Intensive Rehabilitation Service (IRS). Staff from the service talk to the hospital therapists, nurses and doctors and to Doreen about her situation - how she is recovering, and what kind of care she needs to complete her recovery at home.

Once Doreen is back home, the IRS team visit her and talk to her about her goals. She wants to be able to climb her stairs safely, and walk to her neighbour's house, so between them they work out a plan to help her achieve this.

This involves up to 21 days of intensive rehabilitation at home. She is visited twice a day every day and receives care from a physio, occupational therapist, rehabilitation assistants and a nurse. As Doreen becomes more confident moving around, the team does more with her – helping her to manage the steps in her back garden.

The team reviews Doreen's progress throughout her rehabilitation and looks at what other help she needs. Both they and Doreen think she has recovered well, thanks to the intensive support. They let Doreen's GP know about her progress so she can follow up and refer Doreen to other services such as district nursing. They also talk to the council's social care team to make sure she has someone to help her do her shopping

Doreen feels safe to continue to live in her own home, with the support of NHS and council services.

Questions and answers

How did you decide on the preferred option?

The executive committees of the three CCGs set up a steering group with senior doctors and managers (including the nurse director and finance director) from all three boroughs. This group developed and appraised the options against a set of criteria, coming up with a recommended preferred option. The governing bodies of the three CCGs then considered what they had done, and agreed we should consult the public and other stakeholders on that preferred option.

When would you make these changes?

If agreed, we would need to talk to Barking, Havering and Redbridge University Hospitals NHS Trust, which owns King George Hospital, to agree when we would be able to start to use more space. We'd need to take the time to make any changes properly, at minimum disruption to patients, so any move would probably take place in the 2015/16 financial year.

Have you factored population changes into the planning?

Yes. We always use the most up-to-date population information and projections to make sure that we plan appropriately for current and future needs.

Isn't this just all about saving money?

No. The reason we want to make changes is because we think we can make things better for patients so they recover more quickly and most of the time recover in their own homes. We have also had great feedback on the services – patients like them. This is about spending money where it will have the greatest impact and result in the best care and results for patients.

But anything we do has to be affordable. We have a limited NHS budget and if we spend more on one service then we have to cut what we spend on something else.

What if I want to recover in a bed at a community rehabilitation unit, not at home?

If you wanted to recover in a bed at a community rehab unit, we would talk to you about why you wanted to do this. If we thought you would recover more quickly at home we would explain why. We would discuss any social care needs you might have and we would talk to you about how we could help you remain independent. Of course, anyone who is in clinical need of a bed would get a bed.

Why can't we keep three community rehab units?

Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly. We would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger community rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

What would happen to the buildings if the decision is made to centralise services?

We do not own the sites, so we cannot make decisions about what would happen to them. We would work with the owners and other local stakeholders to help them decide how best to use the sites.

Work would also need to be done to the available space at King George Hospital. This would mean looking at the way the space is laid out so government requirements to put men and women in different areas are met. Other work, such as painting and decorating and getting IT systems set up would also be needed.

What about the St George's Hospital site in Hornchurch?

Havering CCG is still working with the site's owners and NHS England to develop a new health centre on the site. That is still in the planning stage and so any new centre would be some way off.

Wasn't it the plan to put the rehabilitation beds that moved off the St George's Hospital site in 2012 back into the new health centre?

The public consultation on the redevelopment of St George's supported the preferred option not to include any beds, but to ensure flexibility the CCG has made sure there is enough space in the plans for some short-term care beds (not intermediate care beds). As this is still at the planning stage, it would be some time before any new centre was up and running and we want to make these improvements more quickly.

What about involving social care and social workers?

The CTT includes social care staff as well as NHS staff, so the team thinks about the patient's needs as a whole, rather than separating them out into health or social care. The IRS also has very good links with social care.

Do local authorities and care providers support these proposals?

These proposals have been agreed by the Integrated Care Coalition (ICC), a group of health and social care partners including local councils and care providers, which was established to review and propose how health and social care services can be made better for local people.

Following an in-depth review of local services, the ICC published a 'case for change' which identified a need to improve and modernise the way intermediate care services are delivered. A strategy was developed which took into account examples of alternative models and approaches here and overseas, and involved extensive local clinical, professional and public engagement.

"I would like to be able to score higher than 10."

We want your views

We want you to tell us what you think of these proposals. Please complete the questionnaire at the end of this booklet and send it back to us, or write to:

FREEPOST I Y 426
ILFORD
IG1 2BR

If you'd prefer to send an email, send it to **haveyoursay@onel.nhs.uk**

You can also call: **020 3688 1089**

All comments must be received by 5pm, Wednesday 1 October 2014.

How your views will be considered

Once the consultation closes, we will review and analyse all the responses we receive.

We will use this information to write a report for each of the three CCGs' governing bodies to consider, alongside any other evidence and/or information available (for instance the equalities impact assessments) and make a decision on the most appropriate way forward. They will also be able to see all the consultation responses in full.

If you are responding on behalf of an organisation or you represent the public (like an MP or a councillor) your response may be made available for the public to look at. If you are responding in a personal capacity, we will not publish your response but we may use unnamed quotes to show particular points of view.

We will put the dates of the governing bodies' decision-making meetings on our website. These are meetings held in public, so you are welcome to attend and all the reports they will look at will be published on our websites.

If you let us know your contact details (by filling this in on the questionnaire), we can keep you up to date with our work.

"Brilliant service, helpful, good treatment, and good communication."

23

Questionnaire

Please tell us to what extent you agree or disagree with the following statements:

1 The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.

Strongly agree Strongly disagree Agree Don't know Disagree

Comments

2 The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.

Strongly agree Strongly disagree Agree Don't know Disagree

Comments

3 The NHS should reduce the number of community rehabilitation units because this is the best way to provide high quality, safe care.

Strongly agree Strongly disagree Agree Don't know Disagree

Comments

Questionnaire continued

4 We believe that option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds - is the best way to organise intermediate care services in the future.

Strongly agree   Strongly disagree   Agree   Don't know   Disagree

Comments

5 If you disagree with our preferred option (option 5) please tell us what you think we should do instead.

Option 1   Option 2   Option 3   Option 4   None of them

Comments

Use this space if you want to tell us anything else

Monitoring questions

We would find it useful if you could tell us a bit about yourself so we can see what sorts of people are responding and whether they think differently from other groups. That helps us to understand if what we want to do might have more of an impact on some groups of people than others.

You don't have to give us your name if you don't want to and we will still take your views into account.

Name

Are you providing this response as a representative of a group:

Yes No

If yes, what is the name of the group

Would you like to be kept up to date with information about the NHS (including this consultation)

Yes No

If yes, please give us your email or postal address

Which borough do you live in

Barking and Dagenham Havering
Redbridge Other

Are you?

Male Female Prefer not to say

Are you responding as a…

Service user NHS staff member
Carer Local resident
Other Prefer not to say

Are you employed by the NHS?

Yes No Prefer not to say

What is your ethnic background

White

White British White Irish
Any other white background

Mixed

White and Black African
White and Black Caribbean
White and Asian
Any other Mixed background

Asian

Asian British Indian
Bangladeshi Pakistani
Chinese
Any other Asian background

Black

Black British Black African
Black Caribbean
Any other Black background

Any other ethnic group
Prefer not to say

Which belief or religion, if any, do you most identify with?

Agnosticism Atheism
Buddhism Christianity
Hinduism Islam
Judaism Sikhism
Other Prefer not to say

Do you consider you have a disability?

Yes No Prefer not to say

How old are you?

Under 16 16-25
26-40 41-65
Over 65 Prefer not to say

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

English

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

Bengali

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Lithuanian

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Portuguese

Este documento é acerca dos nossos planos para melhorar alguns dos serviços de saúde em Barking e Dagenham, Havering e Redbridge. Se não puder ler o documento e desejar saber mais, contacte-nos e informe-nos que tipo de ajuda necessita. Informe-nos se necessita em tamanho maior ou num formato diferente. Se não fala Inglês, informe-nos qual o seu idioma preferido.

Punjabi

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Romanian

%$#"! do$um#n! #"!# d#"pr# planuril# noa"!r# d# a îmbunătăţi o par!# din "#rvi$iil# d# "ana!a!# din Barking şi Dag#nham, Hav#ring şi R#dbridg#. În $azul în $ar# nu pu!#ţi $i!i a$#"! do$um#n! şi aţi dori "a aflaţi mai mul!#, vă rugăm "ă n# $on!a$!aţi şi "ă n# "pun#ţi d# $# aju!or av#ţi n#voi#. Spun#ţi-ne dă$ă do$um#n!ul !r#bui# "ă fi# în!r-un format mare sau într-un format diferit. Dă$ă nu vorbiţi limba #ngl#ză, vă rugăm "ă n# informaţi $# limbă vorbiţi.

Tamil

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Urdu

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This document was developed with the help of patient representatives from across our area.

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Dementia Needs Assessment**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:**
Report Author: Zoë Garbett Head of Public Health Commissioning	**Contact Details:** Tel: 020 227 2311 E-mail: zoe.garbett@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

In March 2012 a national challenge was set, by the Prime Minister, to improve dementia diagnosis and care. In 2013, an estimated 1537 people in Barking and Dagenham had dementia, of these, 669 were diagnosed and recorded on GP registers. Locally, the number of people with dementia is predicted to increase by 10% over the next decade.

London Borough of Barking and Dagenham's Public Health service commissioned the Office of Public Management (OPM) to deliver a Dementia Needs Assessment to gain a local picture of need, services and areas for improvement in order to plan for current and future need. OPM presented a final report in April 2014.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Endorse the recommendations and action plan.

(ii) Task the Integrated Care Subgroup, with support from the Mental Health Subgroup, to lead and review progress against the action plan and provide updates in line with the Better Care Fund.

Reason(s)

The Dementia Challenge was launched in March 2012 by the Prime Minister to improve diagnosis and care in hospitals for people with dementia. The Dementia Needs Assessment was completed to understand the local picture including prevalence, services and stakeholder opinion.

1. Background and Introduction

1.1. Central to the Prime Minister's challenge is to improve diagnosis (currently only 42% of people with dementia have a formal diagnosis) and improve care in hospitals where a quarter of all beds are occupied by someone with dementia.

1.2. The Dementia Needs Assessment was considered necessary to better understand the local picture and aimed to–

- Understand the prevalence of dementia in Barking and Dagenham and patterns of future need.
- Consult with key stakeholders including carers to obtain a wide range of views on current services and unmet needs.
- Produce an agreed set of recommendations and supporting actions that can be used to improve the state of dementia care in the borough.

1.3. Dementia support is a key scheme within our Better Care Fund plan within which the following priorities were established:

- Building on systems and processes already in place, particularly ensuring that integrated cluster teams and adult social care's market development and personalisation efforts continue to lead demonstrable benefits for people with dementia and their carers
- Responding to the appetite for more joint working and better integration across the dementia pathway and between health and social care systems; using the momentum around integration and personalisation to improve care.
- Planning for new patterns of demand, particularly the expected high levels of vascular dementia and the increasing diversity of the dementia population.
- Changing the relationships and ways of working between mainstream and specialist services. This involves specialist services- who hold the core knowledge and experience in the system- working to up-skill mainstream services so that they can do more themselves and make fewer, and more appropriate, referrals.
- Ensuring that training and capacity- building activities use the right approaches and mechanisms to ensure that staff have the appropriate, referrals.

1.4 In April 2013, London Borough of Barking and Dagenham's Public Health service invited agencies to tender to deliver a Dementia Needs Assessment. The Office of Public Management (OPM) was commissioned and completed a final report in April 2014.

2. Methodology and consultation

2.1. OPM worked closely with the Public Health service and used the Joint Strategic Needs Assessment (JSNA) as well as other service representatives to access relevant demographic, epidemiological and service data.

2.2. Telephone interviews were conducted with 18 stakeholders, representing managers, providers and commissioners of dementia services in the borough.

2.3. The OPM project team visited two specialist dementia care homes in Barking and Dagenham to speak with service users, relatives and staff and held a focus group with recent and former carers in the borough.

2.4. On 10 October 2013, a stakeholder workshop was held, attended by 20 stakeholders. The workshop involved small group discussion on the quality of care and services along the care pathway, and a whole group exercise which generated specific recommendations for improving services.

3. Local prevalence and report highlights

3.1. Key findings in terms of the situation and needs of the current and predicted future dementia population in Barking and Dagenham:

- In 2013, an estimated 1537 people in Barking and Dagenham had dementia. Of these, 669 were diagnosed with dementia and recorded on GP registers (figures from August 2013).
- Overall, it is expected that the number of people with dementia in Barking and Dagenham will rise by approximately 10% over the coming decade; however, this increase is much steeper in the 90+ age group, with the number of people with dementia in this age group increasing by nearly 50% in this time.
- Barking and Dagenham's poor general health and high levels of risk factors for vascular dementia, such as heart disease, diabetes and smoking rates, may result in a more rapid increase in dementia prevalence than is predicted in the figures above.
- Diagnosis rates of dementia have improved in the borough (currently standing at an estimated 43%-46%) but further work is needed to reach the 60% target. Combined with the expected prevalence increase, if diagnosis rates are successfully increased to this level by 2023, over 1,000 people in the borough will be diagnosed with dementia (compared to a current 669), increasing service demand.
- It is important to take into account the specific needs of people with dementia who live on their own, as more than a third of people aged 65+ in Barking and Dagenham currently live alone.
- The ethnic diversity of the dementia population in Barking and Dagenham is expected to increase substantially over the coming years, services and awareness raising programmes will need to adapt to the different needs of these groups.

3.2. Key feedback about services in Barking and Dagenham:

- The integrated cluster team approach is working well and the borough has made good progress in taking forward the personalisation agenda.
- The Memory Service plays a core role in supporting people through assessment, diagnosis and treatment of dementia. Memory Service capacity needs to be monitored. The Memory Service contributes to service improvement such as feedback on inappropriate referrals and visiting care homes to improve the way they manage challenging behaviour and use medications.
- The recruitment of a Dementia Advisor from the Alzheimer's Society was welcomed by stakeholders because it has helped to introduce good practice and ways of working into the borough. Carers of Barking and Dagenham play a central role in delivering a range of services and support for people with dementia and their carers.
- Barking, Havering and Redbridge University Hospitals NHS Trust have placed a greater emphasis on training. Commissioning for Quality and Innovation (CQUIN)

framework has led to dementia screening for all over 65s admitted. A buddy system at meal times is proposed.
- There is growing awareness of dementia in the borough and this means that more people are being assessed and diagnosed in the early stages. This is giving service users greater scope to exercise choice and control over their lives and future care.

3.3 Following the recommendations and findings an action plan (attached Appendix 1) has been developed by Local Authority and CCG with key partners including Care City and the Alzheimer's Society.

4. Recommendations

4.1. Recommendations put forward by OPM in the Dementia Needs Assessment have been considered by the Integrated Care Subgroup and the Mental Health Subgroup. The Health and Wellbeing Board is recommended to:

4.2. Endorse the recommendations and action plan are appropriate (attached Appendix 1).

4.3. Task the Integrated Care Subgroup, with support from the Mental Health Subgroup, to lead and review progress and provide updates on the implementation of recommendations in line with the Better Care Fund.

5. Mandatory Implications

5.1 Joint Strategic Needs Assessment (JSNA)

The needs assessment uses the analysis from the JSNA and offers new information that will be embedded in the refresh.

The needs assessment also reviews the recommendations made in 2012 includes and builds on these where these were identified as outstanding –

- Commissioners should monitor and support increase in diagnosis by GPs.
- Commissioners should consider exploring means of achieving reductions in hospital stay to assess their cost effectiveness, e.g. liaison nurses.
- Commissioners should lead and monitor progress in reducing anti-psychotic medicines.
- Findings of the audit into Memory services should be implemented.

5.2 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
- Service providers have and use person centred skills across their services that makes every contact with a health professional count to improve health.
- More older people feel healthy, active and included.

- Early diagnosis and increased awareness of signs and symptoms of disease will enable residents to live their lives confidently, in better health for longer.

5.3 **Integration**

The implications for integration are highlighted in the report and will be taken forward by the Integrated Care Subgroup.

5.4 **Financial Implications**

There are no financial implications directly arising from the recommendations in this report as they are to generally be met from within existing resources. 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, the recommendation to consider increasing the capacity of hospital dementia liaison teams, Admiral Nurses and the Memory service.

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

5.5 **Legal Implications**

There are no implications from this report which intends to implement recommendations from the OPM report finalised in April 2014, which I have not seen. It is noted that elements of the Care Act 2014 have been incorporated into the Action Plan.

Implications completed by: Dawn Pelle, Adult Care Lawyer

6. List of Appendices:

Appendix 1: Dementia Action Plan

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Appendix 1

Dementia Action Plan

- Once approved by the HWBB the lead officer for each action will develop a more thorough plan for delivery.
- Funds for activities, outside of current work programmes and contracts, are being considered for funding as part of the BCF.

Recommendation	Proposed actions	Partner lead/officer lead	Timeline	People who need to be involved
Personalisation and market development				
Enabling people with dementia to stay in their own home rather than automatically placing them into a care home where the cost is the same. Review support offer for people who do not meet the critical or substantial need threshold to ensure that a wide range of signposting and options are being provided Conduct further work to see how personal budgets can be promoted and taken up amongst people with dementia and their carers.	As part of the boroughs personalisation and market development work – to review the inclusion of dementia	Mark Tyson (Integration and Commissioning, LBBD)	November 2014 for position (ongoing work)	Tudur Williams (Social Care, LBBD) Helen Oliver (Care City - Economic Regeneration Development Centre)

Support for carers				
Offer a range of more appropriate respite and support options for people with dementia (including early onset) and their carers exploring non traditional models and approaches, better use of Extra Care, reducing barriers, voluntary input and new funding streams.	To be included in the development of the new Joint Carer's Strategy recommendations – building on key messages to date re carers and dementia from consultation phase on carers work and informing key service and support requirements for the coming financial year.	David Millen (LBBD)	October 2015	Carer's Strategy Steering Group (which includes Carer's of Barking and Dagenham) Alzheimer's Society (Carer Information and Support Programme)
Diagnosis and assessment				
Implementing the Dementia Friendly Communities programme (Alzheimer's Society Guidance) which includes 10 key areas such as challenging stigma, access to services, asset and community based solutions. This may also include the setup of an Alzheimer's Café. This would involve liaising with the existing voluntary and	Dementia Friendly month promotional activity Dementia Friendly task and finish group to meet to review the Alzheimer's Society Guidance to ensure that this links and underpins what we do locally.	Zoë Garbett (Public Health, London Borough of Barking and Dagenham, LBBD)	PHE campaign completed May 2014 Task and Finish Group to meet by December 2015 with recommendations in January 2015 with a six month action plan.	(As a project group) Alzheimer's Society North East London NHS Foundation Trust (NELFT) Memory Service Monica Needs (Integration and Commissioning, LBBD) Lorraine Goldberg (Carer's of Barking and Dagenham)

community sector and memory service to see what is already in place and what additional needs to be put in place.				North East London Local Pharmaceutical Committee representative Council for Voluntary Services representative Patient Engagement Forum Ellen Doran (Public Health Communications Officer, LBBD)
Using the information presented in the report, outline a dementia pathway in a format that can be utilised by professionals, carers and residents. High quality information materials could be produced including generic and specific/targeted advice as well as a rolling programme of campaigns. Promotion work needs to build on	Develop map of current services including community and voluntary services Test current map with clinicians and service users to agree map and identify issues. Use map to promote awareness with clinicians and wider community. Review primary care role in dementia pathway in light of parity of esteem and link with physical health.	Gemma Hughes/ Sarah D'Souza (Clinical Commissioning Group, CCG)	Initial service map development October 2014 Complete changes to map by March 2015	Monga Mafu (Clinical Commissioning) Dr Kumar (CCG clinical lead) Barking Havering Redbridge University Hospitals NHS Trust representative North East London Foundation Trust representative -

the good work of the Memory Service's (Memory Matters Roadshows) and the Alzheimer's Society.				Memory Service as part of the Memory Services National Accreditation Programme (MSNAP) review
	Map availability of service user information – building on work by Alzheimer Society locally to date. This will inform development of pathway and development of further information/promotional materials.	Alzheimer's Society	October 2014	Alzheimer's Society
Review GP contact with older people • Pursue contact where this is absent or refused • Target and engage at risk, isolated older people • Considering risk factors and other 'triggers' for making contact such as building triggers into GP record systems	Develop locality based dementia improvement plan building on Integrated Case Management process and current risk profiling, linking to mental health social workers and link workers resource and using the unplanned admissions enhanced service to support implementation.	Gemma Hughes/ Sarah D'Souza (CCG)	Develop plan October 2014 Implement changes from January 2015	Mental health outside hospital BCF project group: Dr Kumar (CCG clinical lead) Monga Mafu (CCG) North East London NHS Foundation Trust (NELFT) Tudur Williams (LBBD Social Care)
Address under recording of dementia in primary care – • Awareness raising across all	Undertake programme of Dementia awareness raising for GPs to include review of current dementia diagnosis rates, GP engagement and awareness raising at Protected Time sessions (PTI).	Gemma Hughes/ Sarah D'Souza (CCG)	Data validation – September 2014 Training and development plan	Dr Kanika Rai (Clinical Champion) Dr Kumar (Clinical Lead MH)

GP practices to standardise care • Addressing how dementia is recorded	Resolve data validation between Primary and Community services around dementia diagnosis to increase number of people identified in primary care with dementia.		October 2014 Implementation of plan complete March 2015	Ross Kenny (Public Health, LBBD) Monga Mafu (CCG)
Early stages of dementia				
Ensure that decisions and advanced planning related to end of life care are raised with dementia patients by the appropriate range of professionals and agencies	Build dementia specific elements into the advanced care planning in end of life care programmes/work stream Incorporate dementia specific discussion into end of life care (EOLC) engagement meetings (Dying Matters) with professionals. That this informs the EoLC action plan to be considered by the HWBB in October 2014 Link the outcome of above work to service mapping and promotional material development above.	Gemma Hughes/ Sarah D'Souza (CCG)	EOLC Engagement events – August 2014 Subject to agreement by the HWBB to implement the actions within the EoLC action plan with timescales applied	David Millen (LBBD) Ruth Crossley - End of Life care facilitator (NELFT) Alzheimer's Society
Middle and later stages of dementia				
In residential homes consider: • Family carer assisted handover scheme to support the transition into care homes. • Increasing one-to-one support in care homes to avoid unnecessary hospital admissions.	Commissioners to incorporate into contractual mechanisms for residential homes. Review best practice and share across all residential care homes. Undertake review looking at costs and benefits implications for patients of 1:1 support in care homes particularly in light of other arrangements in place to address unplanned admissions from care homes.	Mark Tyson (Integration and Commissioning, LBBD)	Plan – October 2015 Implementation complete – March 2016	Monga Mafu (CCG) Alzheimer's Society

• Increasing rehabilitation so that people leaving hospitals avoid being placed in residential or nursing homes earlier than necessary. • Provision of residential facilities for younger people with dementia which can be specialist, age appropriate and centres of excellence. • Increase levels of stimulations and activities for residents	Link with EoLC action plan and proposals to incentivise improved support to at risk groups This has financial implications and will need to be subject to business case process. Review and improve the raft of services in place to support effective discharge to ensure these cater effectively for people with dementia – including intermediate care services, targeted support packages and Joint Assessment Discharge (JAD) review training and development and required service performance outcomes Review current offer and market for younger people with dementia such as personal budgets and other service arrangements			
Living well with dementia				
Making life history and reminiscence techniques core skills, continue the roll out of 'This Is Me'.	Review training offer for all professionals working with people with a diagnosis of dementia with a particular focus on residential care homes. Consider any contractual mechanisms needed to ensure effective implementation in provider services. Review market offer for life history and reminiscence groups.	Mark Tyson (Integration and Commissioning)	Training offer developed from – January 2015 Implementation – June 2015	Helen Oliver (Care City)

Consider how activities and daytrips, particularly those linked to music and arts, can be boosted in the borough by working with a range of partners.	Review market offer and accessibility for people with dementia. Use Older People's Week as an engagement opportunity.	Mark Tyson (Integration and Commissioning)	June 2015	Zoë Garbett (Public Health, LBBD) Monica Needs (Integration and Commissioning, LBBD) Voluntary sector providers (Carer's of Barking and Dagenham, Alzheimer's Society)
Skills and capacity				
Review training and skills programmes in different settings especially - • Up-skilling frontline staff to reduce reliance on specialist services to ensure that mainstream services have the skills and capacity to identify and care for people with dementia • Settings with high staff turnover, monitor how quickly new staff are trained	Commissioner - Ensuring best practice is reflected in contracts and monitored (KPIs) Work with all providers to understand and ensure reduction in antipsychotic medication – currently a KPI for NELFT but further work needed to understand prescribing in homes and other care settings Providers Providers to review staff induction and training, improvement plan in NELFT and BHRUT focussing on induction, training and refreshers. Providers to undertake training needs	Gemma Hughes/ Sarah D'Souza (CCG)	September 2014 –March 2015 and September 2015 – March 2016 (commissioning and contract negotiations) Providers – January 2015 (end of quarter 3)	Mark Tyson (Integration and Commissioning) NELFT BHRUT Residential Care Homes Helen Oliver (Care City - Education and Skills Escalator and Frailty Academy) Alzhiemer's Society (Awareness raising

and how frequently refresher courses are completed	assessment			sessions and training offer)
Consider increasing the capacity of – • Hospital specialist dementia liaison teams to ensure they can consistently attend to cases which may be deemed low risk. • Admiral Nurses. • Memory service; to allow an increase in its training and public awareness raising work.	Business cases to be developed by providers including cost and benefit analysis. Planning for new patterns of demand.	Gemma Hughes/ Sarah D'Souza (CCG)	Business cases by November 2014 Commissioning position January 2015	Barking Havering Redbridge University Hospitals NHS Trust North East London NHS Foundation Trust (NELFT) Memory Service as part of the Memory Services National Accreditation Programme (MSNAP) review
Integration and joined-up working				
Factor voluntary and community sector organisations into the integration agenda as a number of organisations play a key role in service provision in this area.	Included in other actions	N/A	N/A	N/A
Consider crisis/rapid response service.	Community Treatment Team already in place – review management of dementia within this service and further steps required	Gemma Hughes/ Sarah D'Souza (CCG)	September 2014 for position	Integrated Care Operational Group

HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Better Care Fund Re-submission**
Report of the Integrated Care Sub-Group	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: YES**
Report Authors: Glynis Rogers, Divisional Director Community Safety & Public Protection Sharon Morrow, Chief Operating Officer Barking and Dagenham Clinical Commissioning Group.	**Contact Details:** Tel: 020 8227 2749 Email: glynis.rogers@lbbd.gov.uk
Sponsors: Anne Bristow, Corporate Director of Adult & Community Services Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups	

Summary:

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 the progress towards integration.

An earlier plan for the Better Care Fund was signed off by the Health and Wellbeing Board and submitted to NHS England and the LGA on 4 April 2014. NHS England and the LGA provided the Borough with positive feedback on the initial submission. However, since this submission, updated guidance has been issued which supersedes previous guidance and a requirement has been made that plans are re-submitted by all areas on the 19 September 2014. The main policy change, as described in the letter to Health and Wellbeing Board Chairs on 25 July from Andrew Ridley, Better Care Fund Programme Director, is to revise the payment for performance framework so that payment is linked to reductions in total emergency admissions with an expected reduction of 3.5% against baseline. The implications of this change are outlined in this paper for discussion by the Health and Wellbeing Board. Other changes are; to provide general and bespoke support for local areas and; the introduction of an assurance process which will be carried out by NHSE local area teams and Local Government Regional leads after plans are submitted before sign-off by Simon Stevens, Sir Bob Kerslake and Ministers.

Whilst our focus has been on delivering each of our 11 individual schemes in line with the previously agreed Better Care Fund plan we have needed to undertake further work to revise our Better Care Fund Plan in order to meet further requirements from NHS

England and the LGA and consider the implications of the new national assurance process. Our revised plan is currently well on the way to being finalised and an update on progress for each of our 11 schemes is attached for discussion and agreement by the Health and Wellbeing Board ahead of the new submission deadline of the 19 September. The plan will also need to be agreed by the CCG. This report also provides an update on our work to develop governance and management arrangements.

Recommendation(s)

It is recommended that Members of the Health and Wellbeing Board:

- Discuss and agree the approach to setting the target reduction in emergency admissions for the Barking and Dagenham BCF to enable the plan to be finalised for submission on 19 September.
- State their view on the possibility of setting a target lower than the 3.5% reduction in emergency admissions.
- Note the risks associated with setting a target lower than 3.5% for emergency admission reduction and the other associated risks for the BCF including those identified in the national assurance framework.
- Note the progress on developing governance and management arrangements and endorse the direction of travel for these.
- Consider the progress made in the delivery of the individual scheme plans provided within **Appendix 1.**
- 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 and to further test our approach against national assurance with the Accountable Officer on behalf of Barking and Dagenham CCG, with the Chair of the HWBB, prior to formal submission to NHS England.

Reason(s)

It is a requirement of submission of the plan that it is signed off by the Health and Wellbeing Board ahead of submission to NHS England. If the plan includes a target for a reduction of less than 3.5% of emergency admissions this must be explicitly agreed by the Council.

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

1 Introduction

1.1 The Better Care Fund (BCF) provides an opportunity to transform local commissioning and services so that people are provided with improved integrated care and support to achieve their health and social care outcomes. The Fund is intended to support the scale and pace of integration between health and social care and reduced reliance upon bed based services.

1.2 As Board Members will remember from the previous reports and presentations to the Health and Wellbeing Board in February and March the Fund is made up of a number of existing funding streams to the Clinical Commissioning Group (CCG) and the local authority as well as recurrent capital allocations.

1.3 In addition to the overarching integration agenda, a number of conditions and indicators are attached to the Fund, designed to move resources across the system towards prevention and short term care interventions and away from high cost packages in acute or care home settings. The main policy change from the April submission has been the revision to the requirements for reduction in the total emergency admission rate for the local area (not just a reduction of avoidable admissions) with guidance stating that area plans should seek a minimum of 3.5% reduction in total admissions for 2015/16 . Failure to meet the agreed target will result in funds being withheld proportional to performance. Since discussions at the last meeting and since receiving feedback from NHSE on the earlier submission, Officers from across the Council and the CCG have been working to ensure that the Borough's Better Care Fund Plan resubmission due in September, as well as the eleven priority schemes that make up the Plan, are robust and focused on delivering high quality and effective outcomes for residents. We have however, had to shift our focus from delivering the schemes to revising our plan and meeting the new additional requirements.

1.4 Key changes are as follows:

- Requirement to now set targets for 15/16 in addition to 14/15
- A significant re-focusing on reductions in total emergency admissions (not just avoidable admissions as per the previous submission); a specified target for reduction (3.5%) and re-introduction (from earlier guidance) of a performance element (£1b nationally) linked to the achievement of this target with the balance to be spent on NHS Commissioned out of hospital services..
- A clear requirement to show that at least £135m nationally (and therefore Barking & Dagenham's estimated proportion of this) has been addressed in the BCF to support the additional cost burdens for the Council of the Care Act.
- A requirement for principal service providers – notably the hospital trust - to contribute to the plan. Local acute providers are required to explicitly state that they recognise the emergency admissions reductions and agree with them.
- An assurance process which will follow submission.

Whilst in some areas the guidance has been prescriptive there have been and remain, a number of challenges, not least those of late guidance and a determination that local areas find and agree solutions without the benefit of clear direction from central government. However, both the CCG and the Council are confident that the September BCF Plan and a summary of our progress against each of the individual Scheme Plans (**Appendix 1)** reflect a jointly held ambition to deliver 'better care' in Barking and Dagenham. We have also made good progress in developing governance and management arrangements for the fund.

1.6 The remainder of this report summarises the vision for the BCF in Barking and Dagenham and the feedback received to date from NHS England; the vision and proposed schemes remain as previously agreed by the HWB. The report then discusses the approach we might take to setting our local target and the associated risks and implications particularly of the assurance process, provides an overview of progress on developing governance arrangements and remaining issues to be

discussed by the Board and the final process for the submission of the BCF Plan in September.

1.7 The timetable for the submission and assurance process is outlined in brief below:

- Health and Wellbeing Board 9 September – agree approach.
- CCG Joint Executive Team 11 September – agree approach.
- BCF templates finalised w/c 15 September.
- Sign off BCF submission by Corporate Director of Adult and Community Services and CCG Accountable Officer w/c 15 September.
- Submission 19 September.
- Assurance and moderation process concludes 10 October.

1.8 Members of the Health and Wellbeing Board are asked to consider and agree the approach to take to respond to the revised guidance to enable the delegated officers to agree the final plan for submission to NHS England on 19 September 2014. Members of the Board are also asked to consider and note the progress on a) delivery of the BCF schemes outlined in the report and b) development of governance arrangements.

2 Vision

2.1 Barking and Dagenham Council and the Clinical Commissioning Group have been working together with shared intent and as trusted partners to ensure that the BCF Plan puts residents at the heart of the health and social care system. Against a backdrop of increased demand and reductions in resources, the BCF in Barking and Dagenham aims to:

- Improve how people experience care and ensure the best possible quality to deliver the right care, in the right place, at the right time;
- Ensure the health and social care system is ‘future proof’ and able to effectively manage increasing demand and need, not only today, but in years to come;
- Reduce reliance upon bed based services and ensure improved support closer to home.
- Ensure that services are efficient, sustainable and deliver value for money.

2.2 The Borough has a strong track record in developing integrated systems which are designed around people’s needs. The development of the locality model, in which clusters of General Practices are brought together with community health and social care professionals to assess, plan and coordinate the care of patients at high risk of admission to hospital (as identified through risk stratification), exemplifies this approach. Additionally, the new Joint Assessment and Discharge service brings together discharge functions undertaken by acute trust staff and those undertaken by social care in order to improve hospital discharge and ensure that decisions are made closer to individuals and their families.

2.3 The Council and the CCG therefore seek to build on these approaches within the BCF, working with key partners such as Barking and Dagenham, Havering and Redbridge NHS University Hospital Trust (BHRUT) and the North East London Foundation Trust (NELFT) to deliver better health and care outcomes for residents.

2.4 The national ambition has been further strengthened, with guidance asserting that "… health and care services need to change from a 'sickness service' which treats people as a one –off and then sends them away to another part of the system to a joined up health and social care service...the ambition must be that people need to go into hospital as little as possible and when they do, they are admitted quickly, treated well and discharged as quickly as possible to enable them to get on with their lives. " (NHS E and LGA July 14).

2.5 Guidance states that "Of 5.3 million emergency admissions each year across the country – more than half of these are amenable to avoidance. The example provided within the latest guidance suggests that 380,000 admissions each year relate to falls for older people".

2.6 The locally agreed ambition for reducing emergency admissions is to be now measured from a baseline of the 12 month period Q4 13/14 to Q3 14/15 and is therefore based on our plans to reduce admissions previously submitted as part of the BCF in April.

3 Feedback from NHS England on earlier submissions

3.1 NHS England, in partnership with the London Social Care Partnership and London Councils, provided feedback to the local authority and the CCG on 28 February on the Borough's Draft Better Care Fund Plan.

3.2 At this point the Borough received positive feedback on its draft submission and NHS England expressed confidence in the plan, stating that they felt that remaining issues would be resolved ahead of final plan submission. This was very favourable when compared to feedback given to other areas.

3.3 NHS England also previously raised a concern for all Boroughs in the North East London sub-region regarding the reflection of patient and service user experience in the BCF Draft Plan. There are two main ways in which this has been addressed; firstly through the development of a BCF stakeholder engagement strategy which has already delivered engagement events on end of life care and on the emerging carers' strategy; secondly through the inclusion of the metric which measures the proportion of people who feel supported with a long term condition (LTC). This metric is drawn from the national GP survey which is an established method for gathering patient views. There has been and remains a lack of central guidance about how patient and service users experience can be measured in the BCF. In the absence of this guidance this metric is regarded as the best way to ensure that some measure of patient and service user experience is included in the BCF metric, drawing as it does on an ongoing national survey which allows for trends over time to be seen as well as using an established and robust methodology.

3.4 NHS England will be providing further assurance on the September submission of the BCF. This is expected in the two weeks following the submission date of 19 September.

3.5 Support is available to local areas on developing BCF plans and related governance processes and regular "temperature checks" are being requested to provide feedback to NHSE on progress on developing the final submission. Barking and Dagenham has indicated moderate to high confidence on progress and has indicated that additional support could be helpful to ensure the BCF resubmission is as robust as possible in terms of benefits management and evidence-based planning.

4 Update on remaining actions to be worked through

4.1 The development of the Better Care Fund has been a positive process for both the CCG and the Council and a great deal of discussion and work has been undertaken by colleagues to resolve issues that have arisen as part of the production of the BCF.

4.2 Agreeing a target for further reductions of emergency admissions

4.2.1 The resubmission requires a different kind of target to the previous submission; the April submission included a target which was calculated as a monthly average reduction in avoidable admissions. The target agreed for Barking and Dagenham was around 7 admissions avoided each month on average. This target took account of predicted changes in the population (growth). The September submission requires a target to be set which is a reduction on all emergency admissions, with an expectation that this will be a reduction of 3.5%. This target does not take account of changes in the population. Therefore a different metric needs to be calculated.

4.2.2 Our current estimates are that the target of 3.5% reduction in emergency admissions for Barking and Dagenham would require a reduction of more than 700 admissions in 2015/16. This would equate to a performance payment of c. £1million.

4.2.3 Data released by NHSE on 20 August along with further guidance on the 3.5% reduction target for emergency admissions provides some information on the trend for Barking and Dagenham's emergency admissions and comparative information. This data shows that from 2009/10 to 2013/14 there has been an 11.3% reduction in emergency admissions. The reduction rate has averaged 3% during the period 2010/11-2013/14. Barking and Dagenham's reduction in emergency admissions over this period compares well with other CCGs, in the top quartile nationally and with greater reduction than both Havering and Redbridge. It is not clear from this data what impact population change has had on admissions, and there are ongoing queries about the data source that need to be addressed to get a full understanding of what this shows us. The spreadsheet can be downloaded at http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

4.2.4 In setting a revised target the following factors need to be considered:

What is an optimum level for emergency admissions? Given that, according to the data referenced in 4.2.3 above, Barking and Dagenham has already seen a reduction in emergency admissions over the last 4 years, and a reduction that is greater than other comparators, it is important to have an understanding of what the end state is expected to be, a realistic trajectory can then be set. This question has been asked of the colleagues providing BCF support and we await a response.

The size of the target. Achieving the 3.5% target will require a reduction of c. 700 admissions. This is a much higher figure than has been previously calculated by the CCG for avoidable emergency admissions for 2014/15 (reflected in but not directly aligned with the previous BCF submission). Work done by the CCG to calculate

avoidable admissions built up a target of around 300 admissions based on a detailed understanding of the capacity and capability of the community services that are part of the BCF schemes to manage specific conditions in the community. To achieve a further c. 700 admissions in 2015/16 over and above this is a very significant task.

Ability to influence the target. The BCF schemes target specific cohorts of people who can benefit from preventative measures (e.g. falls prevention) that can stop them needing an admission; integrated measures (integrated health and social care) that provide better co-ordination of care to avoid crises and the need for admission and; care in the home that will otherwise be required in hospital or other institutional/bed-based settings (end of life care, Community Treatment Teams and Intensive Rehabilitation Service). These schemes are planned to have an impact on avoidable admissions. A target to reduce the total admission rate will potentially require a different approach, and be aimed at different groups of people. There are many factors that drive the total emergency admission rate and there are not always clear commissioning levers to affect these factors.

Maximising performance payment. We want to maximise the likelihood that the BCF receives the full sum available from the performance component of the Fund linked to the reduction in admissions. . For example, if a reduction target of 3.5% was chosen, and this was achieved in full, the BCF would receive approximately £1million. If half of the target was achieved, the BCF would receive half of the £1 million and so on. So, if the target is not achieved in full, the CCG will retain the money proportional to performance, and this is to be spent by the CCG in consultation with the Health and Wellbeing Board.

Setting a realistic and reasonable target. We need to ensure that the target reduction is deliverable; will have the maximum benefit for local people; and will meet the needs of our population.

4.2.5 The latest guidance is quoted below and confirms that local area target setting should take into account:

- The position from which the area is starting; e.g. an area which has already achieved top quartile performance in reducing emergency admissions may not be able to achieve further improvements as extensive as areas in the lowest quartile; as experienced in Barking and Dagenham
- The local trend in performance – Barking and Dagenham is showing an improving trend
- How current performance compares to peer areas; Barking and Dagenham compares well nationally and with local peers (Havering and Redbridge)
- Whether the local population is projected to increase more than the national average: this is the case for Barking and Dagenham
- A plan which sets an ambition lower than 3.5% in 2015/16 must explain how the planned level of improvement will contribute to a longer term trajectory: we are seeking further support on how we might set a longer term trajectory
- Any revised ambition lower than the assumed 3.5% must have the explicit support of the Council and must have the explicit written commentary of acute providers.

- Each area should ensure the contingency plans and risk sharing agreement make prudent provision for the costs of unplanned activity if emergency admissions are not reduced in line with the plan. The lower the planned reductions, the less money will be available through payment for performance element of the fund and more will need to be invested in NHS commissioned out of hospital services.
- The national assurance process introduces new risks in relation to how area plans will be graded and will take into account the extent to which the above requirements and conditions have been met.

4.2.6 The Health and Wellbeing Board is invited to discuss the factors above and in particular to state their views on the possibility of submitting a target for reducing emergency admissions lower than 3.5%.

4.3 The national assurance process has been subject to significant revision and it will be required that area plans are considered against national criteria and the extent to which BCF planning criteria have been met, the quality of the plans, the assurance checkpoint assessment of the risk to delivery due to the local context facing each health economy. The assurance process now has several layers and plans will be placed into four categories:

1. Approved
2. Approved with support
3. Approved with conditions
4. Not approved.

5. Governance

5.1 A workshop was held with the CCG and the Council on 13 August to develop governance arrangements. The two organisations agreed to establish a BCF s75 Board which would report to both the Health and Wellbeing Board and the CCG Governing Body. This Board will meet in shadow form for the first time in October 2014 ready to develop the s75 agreement that will need to be in place by April 2015.

5.2 The preferred model of a single “umbrella” s75 with schedules specifying lead commissioner responsibility for different schemes and contracts is currently being discussed with legal advisors.

5.3 The arrangements for sharing financial risk and hosting the budget will be subject to further discussion as the s 75 develops.

6. Delivery

6.1 The Integrated Care Sub-Group of the Health and Wellbeing Board (which also includes provider representation) will continue to oversee delivery of each of the 11 schemes and will also provide reports from time to time to the Health and Wellbeing Board.

6.2 As outlined under Scheme 5 (Integrated Commissioning), a joint commissioner post has been created who will initially be focused on managing the BCF programme and driving forward delivery of the schemes. We have now recruited to this role and also have interim programme support in place.

7. Risk

7.1 There are two orders of risks in relation to the BCF, firstly around submission of the revised BCF in September and the implications of the revision and secondly risks inherent in the BCF including risks to delivery. The latter are included in a high level risk register for the BCF which is provided at Appendix 2 and once finalised will form part of the submission.

7.2 The risks relating to the BCF submission in September are in summary, that the submission is not accepted (if for example the 3.5% reduction target is not set) or that the assurance process does not approve the plan. An assurance template has been provided which summarises the requirements of the plan. These are that the plan demonstrates that it meets the national conditions of:

- Protection of social care spending
- Seven day services to support discharge
- Data sharing
- Joint assessment
- Accountable lead professional for high-risk populations
- Agreed impact on the acute sector

7.3 The previous submission addressed each of these areas. The main areas of concern in relation to the national conditions for the new submission are; protection of social care spending and; agreed impact on the acute sector. Both of these areas carry financial risks. These are described in more detail in the finance section below The problem in relation to protecting social care spending is that the total of the funds that the HWB need to identify to cover the new costs of the Care Act (£513k), the allocation for carers and the existing services that are already commissioned with the funds that have been included in the BCF is greater than the current BCF budget. This risk will be further compounded by any reduction in performance payments which could be the consequence of either not setting a target of 3.5% for admissions reduction or of failing to achieve such a target. This would mean that payments intended to be included in the BCF and committed to e.g. community services would potentially be diverted to pay for over-performance of emergency admissions. The consequences of this could be to further undermine efforts to avoid admissions if resources are diverted from the services that are working to keep people well at home. Further work is required to agree the best way of managing these risks and will be reflected in the s75 agreement that will be developed by the end of the financial year.

8. Finance

8.1 There remains no clear guidance on some elements of how the Care Act burden is to be funded from the BCF, although there is now a clear requirement within our plan to state that the costs relating to the national £135million in the BCF will be spent from the BCF on elements of the Care Act costs. For Barking and Dagenham the proportionate share of the identified £135m is £513k-this is an estimate based on figures supplied by NHSE. It is recognised by both the Council and the CCG that this presents a financial risk to the local health and social care economy. Also, the risk of

not achieving the full reduction in emergency admissions target would be to reduce the potential funding for the BCF.

9. Next steps

9.1 Following discussions at the Board meeting, and with the Board's agreement, the Better Care Fund Plan will be finalised by the Corporate Director of Adult and Community Services on behalf of the Council and the Accountable Officer on behalf of the CCG. This will include finalising the target for the emergency admissions reduction. This will allow any further steps to be readily taken should further direction and guidance be forthcoming from the Department of Health or NHS England. The Plan will then be submitted to NHS England by the deadline of 19 September 2014.

9.2 The Shadow BCF s75 Board will be established in October and will report back to the Health and Wellbeing Board.

10. Mandatory Implications

10.1 Joint Strategic Needs Assessment

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

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

Social care and health Integration is a recommendation of all seven key chapters of the JSNA but in particular the sections that relate to:

- Supported living for older people and people with physical disabilities
- Dementia
- Adult Social Care
- Learning Disabilities
- Mental health- Accommodation for People with Mental Illness
- End of Life Care

The relevant sections of the JSNA can be found by visiting the following link:
http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx

10.2 Health & Wellbeing Strategy

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

10.3 Integration

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

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

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

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

11. Financial Implications

11.1 The draft Better Care Fund was discussed at the meeting of the Health and Wellbeing Board at its meeting on 11 February 2014, and the covering report set out broad financial implications for the Council and the CCG.

11.2 The Better Care Fund (BCF) is expected to lead to the transformation of health and social care services for people in the community; this is to be achieved through the integration of services between health and social care using pooled budget arrangements. These pooled budget arrangements are required to be in place from April 2015. NHSE is currently developing further guidance on pooled budgets. Further to this guidance being received the proposed shadow BCF board will develop S.75 pooled budget arrangements for the Health and Wellbeing Board to approve for implementation.

11.3 The delivery of integrated health and social care services at greater scale is expected to deliver improvements against national and local outcomes.

11.4 The Department of Health has indicated that the CCG revenue allocation includes funding for some of the costs arising from the Care Act 2014 (putting carers on a par with users for assessment, implementing statutory Safeguarding Adults Boards, and setting national eligibility). The national CCG allocation is £135m, an indicative allocation for Barking and Dagenham would be £513k based on figures from NHSE. In the next few months consideration will need to be given to how this additional £535k will be funded from the BCF; for example, de-commissioning of existing services; considering if there are any services which are currently being commissioned separately by the CCG or the Council which would be more efficiently commissioned jointly.

11.5 The proposed Better Care Fund is £13.182m in 2014/15 and £21.610m in 2015/16; in both years the Council proposes to include in the pool more than the minimum contribution it needs to make.

11.6 The substantive change in policy for the new BCF submission, is that of the £1.9billion additional NHS contribution to the BCF, £1billion will now be either commissioned by NHS on out of hospital services or be linked to a reduction in total emergency admissions. The intention of this policy change is to ensure that the risk of failure for the NHS in reducing emergency admissions is mitigated, and CCGs are effectively compensated for unplanned admissions.

The payment for performance element related to reducing emergency admissions, is to be determined by the Health and Wellbeing Board i.e. it is determined by the level of the reduction target. The balance is required to be spent on NHS commissioned out of hospital services.

There is a risk therefore that if the full activity reductions are not achieved there will be a reduction in payments for the BCF. The payments not made to the BCF will stay with the CCG, to be spent by the CCG in consultation with the Health and Wellbeing Board

11.7 Discussion are being held with local acute providers to agree the emergency admissions activity reduction targets.

12. Legal Implications

Implications completed by: Chris Pickering, Principal Solicitor

12.1 There are no specific legal implications that arise from this report at this stage. It is however, evident that legal implications will need to be fully considered in the development of the S.75 and pooled budget which is due to return to the Board for consideration.

13. Non-Mandatory Implications

13.1 Workforce Implications

The Better Care Fund and accompanying schemes will have various workforce implications and all relevant HR procedures will be followed to ensure that staff are consulted as these new services are developed. The BCF has included money for training and workforce development initiatives within the scheme plans. Each of the

organisations will have their own change management processes and the Council and the CCG will need to ensure that the appropriate processes are followed. Members of the Board should note that the development and implementation of the Joint Assessment and Discharge service has shown the complexity of working across a number of organisations and this complexity should not be underestimated.

13.2 Customer Impact

Integrating health and social care services is expected to not only generate cash efficiencies but to improve the patient/service user experience in a myriad of ways. The benefits for patient/service user experience can be read in each of the schemes of work.

14. List of appendices:

Appendix 1: **Progress in each of the 11 schemes** which are:

1. Integrated Health and Social Care Teams
2. Admissions avoidance and improved hospital discharge
3. Intermediate Care
4. Mental health support outside hospital
5. Integrated commissioning
6. Support for family carers
7. Care Bill Implementation
8. Prevention
9. End of Life Care
10. Equipment and adaptations
11. Dementia support

Appendix 2: **High-level risk register (revised for September submission)**

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Appendix 1

Summary of progress of the BCF

Overall good progress has been made on establishing the BCF and component schemes. A joint post has been created of Integrated Care Programme Manager who will be leading on the overall delivery of the BCF. This post has been recruited to, a start date for the autumn is to be agreed. Interim programme management support will start on 1 September with a focus on establishing the BCF programme management arrangements and driving forward delivery of each of the schemes. An overall of progress against each scheme follows.

Scheme 1: Integrated Health and Social Care teams
Building on the integrated case management structure that is in place for people most at risk of hospital admission, the Integrated Health and Social Care teams will incorporate a wider range of services at Tier 1 and 2 including community nursing, therapies, integration of mental health social worker support and long term conditions services. Progress has included a workshop of all practices, with representatives from community health services and social care in July. Integration of mental health workers is underway and a single point of access at cluster level is now in place.

Scheme 2: Admissions avoidance and improved hospital discharge
This scheme was designed to further the development of the Joint Assessment and Discharge service and seven day working. The Joint Assessment and Discharge Service is now in place and operational.

Scheme 3: New model of intermediate care
A new model of intermediate care has been trialled in BHR including the implementation of two new services - a Community Treatment Team and an Intensive Rehabilitation Service. This work has been shortlisted for an HSJ Value in Healthcare award (Award ceremony 23 September 2014) and has resulted in reduced need for intermediate care beds and positive patient feedback. The new model is now out to consultation. Consultation is due to close at the end of September 2014.

Scheme 4: Mental health support outside hospital
This will bring together health and social care commissioned services that work to support people with mental health problems through talking therapies, primary care, social care, accommodation and employment and recovery services. A review of employment support services is planned for 2015. Work is now underway to deliver the project plan.

Scheme 5: Integrated commissioning
An integrated commissioning approach will be developed to deliver the commissioning changes required in the BCF with an agreed resource to manage the programme across health and social care. The joint Integrated Programme Manager post has been created and recruited to.

Scheme 6: Support for family carers
This will see the development of a joint Carers Strategy with a focus on aligning BCF funding to support carers locally and to take into account the requirements of the Care Bill and determine our service requirements for the coming financial year. Working with our partner Carers UK, stage 1 has now been delivered according to schedule and has included:

- Completion of stakeholder engagement- including service providers, commissioners

- Engagement with local carers and carers

- Mapping of the borough – carer prevalence, ill health, age and income deprivation

- Identification of priorities for carers and what is currently felt to be working well alongside areas for improvement

- The next stage is underway with our local position compared against outcomes and best practice achieved nationally.

Scheme 7: Care Act implementation
This scheme will support the implementation of the Care Act, and an agreed process to take this forward has been determined by the local authority and the CCG. Based upon formula allocations Barking and Dagenham's share of the £135m allocated nationally would be £513k to support the Council with the additional cost burdens for the Care Act. Financial pressures are also increased through formula adjustments to funding for the Council direct from Central Government which have reduced the financial support available to this Council. Support for social care will be managed through the proposed S.75 Steering Group and the management of the BCF pooled fund.

Scheme 8: Prevention
This scheme will look at evaluating current prevention work that is already being conducted by the local authority, particularly regarding physical activity and falls prevention, and how this prevention work aligns with and can support the other schemes outlined here. An integrated working group is now in place which has completed service and activity mapping across health and social care with the identification of target groups, access and eligibility criteria and universal services. The group has a clear role in co-ordinating disparate activity which contributes towards improved prevention and well being and in identifying further steps which will positively impact upon our current approach. A scoping report is due to be considered by the HWBB subgroup 'taking integrated care forward in Barking and Dagenham in October.

Scheme 9: End of life care
This scheme will support the work that is being developed on end of life care following the discussions that were held at the last Health and Wellbeing Board, particularly focusing on supporting training and service improvements across agencies and services, and integrating this into cluster teams. A draft action plan has now been completed by the Council and the CCG which supported stakeholder engagement (front line staff and people with experience of end of

life care) which took place on the 12th and 14th August. Stakeholder engagement was undertaken with our partner National Council for Palliative Care – ‘Dying Matters’ who are compiling a report for inclusion in our paper to the HWBB scheduled for October 14. This will usefully draw together local findings and proposals against national best practice.

Scheme 10: Equipment and adaptations
This will bring together the commissioning and provision of equipment and adaptations that are required to support people in their homes. The scope also includes commissioning and provision of Assistive Technology and Tele-health. A project plan has now been completed with a scoping paper scheduled for our HWBB sub group – taking integrated care forward in Barking and Dagenham

Scheme 11: Dementia support
This focuses upon improving early diagnosis and support to people with dementia. A dementia needs assessment has now been completed with and a report is due to be considered by the HWBB at its September meeting with a proposed action plan for further improving our local position. The CCG has also

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Appendix 2

Key risks and contingencies - Better Care Fund

Key risks to the success of the BCF programme are outlined below with proposed contingencies to mitigate potential impact and review and reporting arrangements.

Ref	Risks:	Review and reporting points:	Review date and required actions:
R1:	**Current resources/ investment not maintained by partners**		
To be addressed through risk share as part of s 75 agreement. Plan delivers increased investment over period.		Established within risk share agreement and review by HWBB sub group.	
R2:	**Given the additional burdens of the Care Act investment cannot be secured and capacity of LA to maintain current services is compromised impacting upon plan delivery**.		
	There remains insufficient clarity as to how the Care Act burden is to be funded. It is recognised by the CCG and the Council that this presents a financial risk to the local health and social care economy and cost modelling is currently underway. More detailed work has been undertaken to further scope the nature of the pressures- alongside a reduction in the formula based burdens grant direct to the Council from Central Government which has informed the initial development of our risk management strategy. This will be developed as a schedule of the S.75 which will set out the responsibility of partners in managing financial and operational risks and arrangements for shared risk management.	Established within risk management strategy between the CCG and the Council and reflected in the s75 agreement. Managed through the proposed BCF s75 Board.	Shadow BCF s75 Board to be established October 2014.

Ref	Risks:	Review and reporting points:	Review date and required actions:
R3:	**Performance against required outcomes is not achieved**		
	Guidance now provides for a single focus for payment by performance which is wholly related to reductions in admission to acute care. Indications are that performance will be monitored quarterly with monies released upon successful performance against target. We are therefore need to give careful consideration to the setting of the Barking and Dagenham target in order to avoid significant risks of less money being available for deployment within our Better Care Fund schemes. In broader terms we have also carefully considered the targets within our BCF plan to ensure that these are measurable and achievable providing both a level of ambition and sustainability over the life of the plan. There is also sufficient linkage with CCGs 5 year strategic plan. These are however not subject to performance related funding.	Monthly reporting to Executive Steering Group and HWBB Sub-group: taking Integrated Care Forward in Barking and Dagenham. Recommendations for deployment of monies to be considered with the HWBB. Engagement with NHS England and Local Government Association in our review of progress to seek necessary on-going support as may be required and to agree acceptable progress.	
R4:	**BHRUT's quality and performance issues. As a part of our local system the local hospital trust faces substantial challenges to deliver quality care and financial sustainability.**		

Ref	Risks:	Review and reporting points:	Review date and required actions:
	BHRUT is currently in special measures and are subject to a range of assurances processes via CCGs, NHS England and the TDA. Oversight is also supported through the governance of the Urgent Care Board and our system plan. The BCF aligns with the Trust's improvement plan, ensuring that BCF steps such as those of 7 day working positively impact upon the management of acute resources. Strengthening services in the community through the BCF schemes is intended to reduce reliance on the acute provider, thus helping the Trust manage its activity. The admissions reduction targets will be agreed with the provider to ensure that they align with the Trust's long term financial model.	Monthly review through Urgent Care Board and system plan reporting arrangements.	
R5:	**Barking and Dagenham's plan is not approved.**	**Satisfactory grading**	**Through assurance process**
	A poor outcome from assurance would result in a significant amount of further work and loss of confidence in our local system. We therefore propose to test key elements of the plan against current assurance process prior to submission deadline of 19th September. We have pro-actively engaged with area teams to draw down support for strengthening our evidence base and modelling approaches so we can further test against 'best'.	Complete further actions based upon further guidance, best evidence and support available to NHS E and LGA. Provide assessment to Corporate Director for the Council and Chief Operating Officer for the CCG prior to submission.	

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Update on the preparation for transfer of the 0-5 year Healthy Child Programme (Health Visiting) Service from NHS England to London Borough of Barking and Dagenham**

Report of the Director of Public Health

Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Authors: Matthew Cole Director of Public Health Meena Kishinani, Divisional Director Strategic Commissioning, Safeguarding and Early Help Jacqueline Hutchinson, Strategic Lead for Health, Early Intervention	**Contact Details:** Tel: 0208 227 3657 Email: matthew.cole@lbbd.gov.uk Tel: 020 8227 3507 Email: meena.kishinani@lbbd.gov.uk Tel: 020 8724 1830 Email: Jacqueline.hutchinson@lbbd.gov.uk

Sponsors:

Helen Jenner, Corporate Director of Children's Services

Matthew Cole, Director of Public Health

Summary:

The purpose of this report is to give an update on the work underway to plan for the transfer in October 2015 of Early Years Programme (Health Visiting) services to Barking and Dagenham Council. These services are currently commissioned by NHS England and provided by North East London NHS Foundation Trust (NELFT). A programme of regular updates to the Board was agreed in November 2013.

Recommendation(s)

The Health and Wellbeing Board is recommended:

(i) To review the progress being made to deliver the national programme, which is intended to increase Barking and Dagenham's health visiting workforce in line with Call to Action numbers before the transfer in October 2015.

(ii) To review the identified risks and address the necessary mitigation required to be ready for the full transition in October 2015.

(iii) To note the London and local position.

1. Background

1.1 On 28 January the Parliamentary under Secretary of State for Health, Dr Dan Poulter MP, confirmed the transfer of 0-5 public health commissioning. The transfer of commissioning responsibilities will now take place on 1 October 2015.

1.2 The scope of the transfer includes the 0 to 5 Healthy Child Programme (Universal/Universal Plus), specifically:

- Health Visiting services (universal and targeted services)
- Family Nurse Partnership services

1.3 The following commissioning responsibility will remain with NHS England:

- Child Health Information System (CHIS)
- The 6 – 8 week GP check (Child Health Surveillance (CHS))

1.4 Responsibility for commissioning the CHIS will remain with NHS England in order to improve system functionality nationally, although a commitment has been made by the Department of Health (DH) to review the responsibility for commissioning in 2020.

1.5 Responsibility for commissioning the 6-8 week GP check will remain with NHS England (NHSE) due to the nature and complexity of commissioning arrangements which suggest there is both risk and little or no return to be gained from transferring this responsibility.

1.6 The Government announced on 22nd August 2014 that certain universal elements of the Healthy Child Programme will be mandated in regulations in the same way it has for sexual health and some other public health services. The universal elements which will be mandated are:

- antenatal health promotion review
- new baby review, which is the first check after the birth
- 6-8 week assessment
- 1 year assessment
- 2 to 2 and a half year review

The Department of Health have published a factsheet on mandation to explain what this means for local authorities and to set out next steps.

2. Planning and Milestones

2.1 The following are the key national transfer milestones:

- **27 June 2014** - Area Teams submitted their first analysis of financial data to NHSE for discussion at dialogue meeting on 15 August (see below).
- **July and August 2014** - Area Teams requested to undertake a second return, refining the financial data against the scope of the transfer and attempting to address issues raised by outliers.
- **September/October 2014**– DH consultation on baseline budgets.
- **1 December 2014**- local authority financial allocations announced

- **December 2014/January 2015** – DH to lay regulations on the mandatory aspects of the service (informal consultation on this expected between September and December)
- **1 October 2015** - mid-year transfer of commissioning responsibility.

2.2 The period between now and 1 December 2014 will involve a period of intense activity, both nationally and regionally. Pan-London activity and dialogue is planned to meet these milestones.

3. London Dialogue

3.1 In London, under the joint health and local government Health Visiting and Early Years Transformation Board a Finance and Workforce Task and Finish Group has been established to guide the task of mapping and refining finance and workforce allocations by borough. The Task and Finish Group met on 9 June and agreed the information which each borough would require in order to engage in dialogue. This information includes:

- Inherited PCT budget for years prior to 2013/14 (where possible)
- Costs for health visiting and Family Nurse Partnership for the year 2013/14
- Projected costs for 2014/15 (by borough)
- Budget projections for 2015/16 and 2016/17
- Health Visitor Call to Action trajectory by provider
- Health Visitor latest budgeted establishment and actual WTE by provider
- Workforce (health visitor and skill mix) split by borough for 2014/15
- The National Health Visiting Service Specification 2014/15 and Family Nurse Partnership specification
- Provider contract

3.2 Given the national milestones, the priority of the London transfer programme during the summer will be to facilitate the process of transfer planning dialogue. In London, this process is significantly more complicated by the fact that many providers of health visiting and Family Nurse Partnership services serve multiple boroughs.

3.3 Each borough (though the Director of Public Health and Director of Children's Services) has been invited to make two nominations to engage in the dialogue. All boroughs have now made their nominations. For London Borough of Barking and Dagenham the Director of Public Health and the Corporate Director for Children's Services are the designated officers.

3.4 The dialogue meeting for the London Borough of Barking and Dagenham took place on 15th August 2014. Matthew Cole and Helen Jenner attended. Also present were, Kenny Gibson, NHSE London; Clive Grimshaw, NHSE London/London Councils; Alex Morton, NHSE London

3.5 The process of dialogue between local government and the London Area Team aims to:

- Give greater clarity to issues around resources being transferred and issues for reconciliation.
- Provide a strong foundation for determining commissioning intentions between sender (NHS England) and receiver (local government).
- Establish an environment for multilateral dialogue later in the transfer process which can incorporate wider stakeholders.
  The first meeting was very positive with strong strategic leadership in the Borough recognised as ensuring transition in Barking and Dagenham is likely to be smooth and well planned.

3.6 The process of dialogue between NHS England (London) and the boroughs is an iterative one. There are a range of issues which local government will wish to understand, consider and respond to in advance of the local government financial allocations being announced in December. It is unlikely that all of these issues will be resolved through one meeting. Therefore, the expectation is that dialogue will be ongoing and will be tailored to borough needs where possible. Clive Grimshaw provided a brief over view of expected next steps

- Through Area Teams NHSE are conducting a second analysis of provider finance and workforce data expected completion early September.

- Second analysis data would, based on current planning, need to be signed off by local government before submission.

- Department of Health (DH) planned a national consultation exercise on baseline budgets in October.

- Final financial allocations would be announced on 1 December.

- DH would lay mandation regulations in January/February 2015.

3.7 While at this stage, dialogue between Area Team commissioners and local government is the priority, as the process closes in on the transfer deadline the focus will shift from dialogue between Area Teams and local government to dialogue between local government and providers. In Barking and Dagenham, as with the rest of London, this process is particularly complex since there is not a simple “lift and shift” of contracts, finance and workforce.

3.8 The Local Government Association, Public Health England, NHS England and the Department of Health are working in partnership to deliver a series of regional events to support local authorities and Area Teams prepare for the transfer. The London regional event is on 9 October at Local Government House, Smith Square, SW1P 3HZ

4 Emerging dialogue issues for comment/consideration

4.1 There appears at the early stage of dialogue meetings some high level issues for comment/consideration, although this list is not exclusive:

- July/August NHSE data return – this data will inform the DH consultation on baseline budgets. A view will need to be taken over the summer about the aspects where confidence is lowest in data accuracy and movement to a position where councils will be in a position to sign-off.

- Contract transfer – this is likely to be most challenging to resolve in those areas where the provider serves multiple boroughs. However, in all cases discussion over the summer will need to begin to consider:

  - Whether contract novation is suitable?
  - If contract novation is not suitable (particularly in a multi-borough provider patch), would a lead commissioner arrangement be workable?
  - What are borough commissioning intentions for 2015/16, 2016/17 and beyond?
  - Where commissioning intentions do not assume entering into new contracting arrangements for 2016/17, what contract arrangements would be needed to avoid needing to consider a waiver of Standing Orders in 2015/16?
  - Is there value added in regional coordination of provider level local dialogue?

4.2 Those issues relating to commissioning intentions and potential need for contract waiver will potentially be determined, in part, by the service aspects which are to be mandated by the DH.

5. Update in Barking and Dagenham

5.1 Barking and Dagenham has established a Transition Steering Group between the Council and NELFT that meets monthly. A transition manager has been appointed.

5.2 NHS England currently commission NELFT to provide the 0 to 5 Healthy Child Programme under a single contract and specification to the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest.

5.3 London Borough of Barking and Dagenham, NHS England and NHS Barking and Dagenham Clinical Commissioning Group jointly commission NELFT to provide the Family Nurse Partnership programme. The Council's Childrens Services is the lead commissioner under a memorandum of understanding. There is currently concern about the number of recruitees to the programme.

5.4 The Council's current thinking is to develop a borough specific integrated early years model after October 2015.

5.5 Through 'Call to Action' growth allocations, the 2012/13 established health visitor posts within Barking and Dagenham increased by 13WTE from 40 to 53.84WTE. The growth allocation for 2013/14 is 17.5 WTE and for 2014/15 is 11WTE. The figures are subject to confirmation with NHS England (London)

5.6 The current number of health visitors in post is 43.52 WTE due to some leavers and some reducing hours. This is worrying and is being addressed by NELFT through a detailed recruitment implementation plan. Their response includes ongoing recruitment campaigns outside of the applications for training Health Visitors to encourage more experienced staff to take up the existing vacancies. Council Officers have been invited to sit on recruitment panels and Senior Mangers from NELFT and the Council have agreed to meet with students to encourage them to take up the Barking and Dagenham positions.

5.7 Although the transfer dialogue meeting discussed the funding for the full complement of health visitors and the role and funding of the MASH and Family Nurse Partnership Health visitors, this has not been included in the note of visit. Helen Jenner has responded asking for the position to be put in writing.

5.8 Due to the national shortage of qualified health visitors, the NELFT recruitment implementation plan predominantly focuses on the organisation growing its health visiting workforce by supporting the training of student health visitors. Currently there are two cohorts totalling 76 students in training, who are due to qualify in September 2014 and January 2015 across all NELFT boroughs. A further 22 students are due to commence their training in March 2014, qualifying in March 2015. While this approach is a good one, there is a risk that newly qualified health visitors will choose to work in other boroughs where NELFT operates rather than Barking and Dagenham. Much effort is being made to reinforce London Borough of Barking and Dagenham as a good employer. Whilst a number of students have stated they will come after qualification, some wish to work in inner London boroughs due to London weighting.

5.9 Health visiting teams are currently being reconfigured across the six geographical localities within Barking and Dagenham to help with delivering an integrated early years service linked with Children's Centres and GP surgeries.

5.10 There are now named health visitors for each Children's Centre. They work closely with the Children's Centres on development of services, and are members of the Children's Centre Advisory Board. This should ensure that services are joined up and that when children and families are identified as requiring additional support, they receive the right evidence based interventions which are delivered as part of an integrated package of public services. This approach reflects the National Health Visiting Service Specification to provide:

> *'On-going support from the health visiting team, plus a range of local services working together and with families, to deal with more complex issues over a period of time. These include services provided by Sure Start Children's Centres, other community providers including charities and, where appropriate, the Family Nurse Partnership (FNP).' 2014 p8*

5.11 NELFT have agreed to share information about live births with Children's Centres. This issue was raised by Ofsted in a recent Children's Centre Inspection and was felt by the Inspectors to be critical to engaging families early. The transition steering group agreed for this to be in place from the start of July 2014.

6 Transformation Funding for 2014/15

6.1 In June, NHS England invited expressions of interest from Area Teams for funding support a programme of transformation activity in 2014/15. The letter inviting expressions of interest was sent to Directors of Public Health. We have agreed with the London Boroughs of Havering, Redbridge and Waltham Forest to put in a joint submission.

6.2 The London Area Team has worked with the Office for London clinical commissioning groups and London borough representatives to develop a London

proposal, which was circulated to Directors of Public Health and Childrens Services the week commencing 30 June. The London proposal is broad and will require significant development if approved by NHS England as an initial expression of interest.

7 Conclusion

7.1 The coming 5-6 months are important to transfer planning and supporting local government, NHSE and providers to be in a secure position ahead of the October 2015 transfer. There are likely to be a number of points at which we are invited to engage in formal regional and national transfer process activities. At this stage there is scope to add to and alter the London transfer planning arrangements, and in particular to shape thinking and preparation.

7.2 As the process nears the DH consultation in September/October, it will be increasingly difficult to achieve substantial shift in transfer planning and data analysis. Furthermore, as the process closes in on the autumn, the debate and discussion locally with the London Boroughs of Havering, Redbridge and Waltham Forest is likely to intensify.

8. Recommendations

8.1 The Health and Wellbeing Board is recommended:

- To review the progress being made to deliver the national programme, which is intended to increase Barking and Dagenham's health visiting workforce in line with Call to Action numbers before the transfer in October 2015.

- To review the identified risks and address the necessary mitigation required to be ready for the full transition in October 2015.

- To note the London and local position.

9. Mandatory Implications

9.1 Joint Strategic Needs Assessment (JSNA)

The outlines the recent increases and changes in the 0 – 5 population which highlights the need for provision for this group. 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 services plays a vital role in supporting our increasing and changing 0 – 5 population to become and remain healthy and preparing for a healthy adulthood.

9.2 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.

9.3 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.

9.4 Financial Implications

Completed by Patricia Harvey, Interim Group Manager, Children's Finance

The London Borough of Barking and Dagenham has been allocated from the Department of Health a Public Health Grant of £14.213m for 2014/15 and included within this allocation is £1.593m that is currently attributable directly to Children' s Services directorate and an additional £3.680m that is attributable to services to children.

The Transition Steering group have met and the latest reporting on the current number of health visitors is now 48.16 WTE, so the growth allocations are not on target and unconfirmed clarification of whether the Multi-Agency Safeguarding Hub post and Family Nurse Partnership Health Visitor posts are counted in the final growth target. The transition steering group is also awaiting clarification on the infrastructure costs from NELFT prior to October 2015.

9.5 Legal Implications

Completed by Lindsey Marks, Principal Solicitor Children's Safeguarding.

None at present. However legal and HR implications will be significant and must be included in programme planning.

9.6 Risk Management

From 1 October 2015 the responsibility for commissioning public health services for 0-5 year olds will transfer from NHS England to local authorities. The transfer marks the final part of the overall public health transfer. The Department of Health intend to lay regulations on the mandatory aspects of the service (informal consultation on this expected between September and December). The Council will wish to undertake detailed risk assessment once the statutory responsibilities are confirmed.

10. Supporting Documentation

- Joint Strategic Needs assessment http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.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

9 September 2014

Title:	**Learning Disability Section 75 Update**
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Mark Tyson, Group Manager Integration and Commissioning	**Contact Details:** Tel: 020 8227 2875 E-mail: Mark.Tyson@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult and Community Services	

Summary:

One of the key recommendations from the Winterbourne View concordat was that local authorities and Clinical Commissioning Groups put in place joint and collaborative commissioning arrangements, with pooled budgets where possible.

Following an initial report in March 2014 which set out the intentions for the Borough's Section 75 agreements around learning disabilities, this report provides a progress update on the arrangements that have been negotiated between the Clinical Commissioning Group and the Council for the creation of a Section 75 partnership agreement to cover both parties' commissioning budgets for learning disability services. It also sets out the progress made in the Section 75 arrangement for the provision of an integrated Community Learning Disability Team, comprising officers from NELFT and the Council.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Note the progress made in the negotiations of the learning disability Section 75 agreements.

Reason(s)

The Council has committed to 'encourage growth and unlock the potential of Barking & Dagenham and its residents'. This requires good quality support to be in place for those with a learning disability, to assist them to live independent lives and unlock their own potential. The Section 75 agreements will provide a better framework for considering the needs of service users and carers, and for meeting those needs. This will deliver, in particular, the Council's priority to improve health and wellbeing through the whole of life, and to increase household incomes through supporting those with a learning disability into employment.

There are national requirements to strengthen the arrangements for jointly commissioning and providing learning disability services in order to improve the quality of services provided to service users by health and social care. Furthermore, integration is a core policy driver in health and social care, as evidenced by the introduction of the Better Care Fund, with the aim of improving both efficiency and service user experience. This

arrangement provides the framework for taking that work forward locally.

1. Introduction and Background

1.1 In December 2012 the Department of Health published its final report on the abuse that took place at the Winterbourne View Hospital. The report identified 63 actions to be completed by health and social care in relation to the findings of the investigation. One of the key recommendations was that local authorities and Clinical Commissioning Groups put in place joint and collaborative commissioning arrangements, with pooled budgets where possible.

1.2 Back in March 2014, the Health and Wellbeing Board received a report on the overview of the arrangements that are being negotiated between the Clinical Commissioning Group and the Council for the creation of a Section 75 partnership agreement to cover both parties' commissioning budgets for learning disability services. The Board agreed to delegate authority to the Corporate Director for Adult & Community Services to conclude the negotiations and enter into the agreement on behalf of the Council. Additionally, the March report also set out the intention to revise the Section 75 arrangements for the provision of an integrated Community Learning Disability Team (CLDT), comprising officers from NELFT and the Council.

1.3 This report gives the Board an update on the progress of both the Commissioning and CLDT Section 75 agreements.

2. The Section 75 Agreement (Commissioning)

2.1 Powers to enable health and local authority partners to work together more effectively came into force on 1 April 2000. These were outlined in Section 31 of the 1999 Health Act, which has since been repealed and replaced, for England, by Section 75 of the National Health Service Act 2006.

2.2 A Section 75 is a partnership agreement of equal control whereby one partner can act as a "host" to manage the delegated functions, including statutory functions of both partners who remain equally responsible and accountable for those functions being carried out in a suitable manner.

2.3 Over the last few months the Council and the CCG have been working together to agree the terms of a Section 75 arrangement to bring together the commissioning of learning disability for both services. This is just one of the agreements that are being developed to govern more formally the approach to integration of services, sitting alongside a related agreement (with NELFT) proposed for the direct provision of an integrated learning disability team, and a similar agreement for the provision of mental health services.

Scope of Services

2.4 The Section 75 partnership agreement between the CCG and the Council will cover the commissioning of services. The lead commissioner for the Section 75 agreement will be the Council, who will take on the responsibility of commissioning services in behalf of the Clinical Commissioning Group, when the function is delegated.

2.5 The most significant service within the portfolio is the Community Learning Disability Service, an integrated team between the Council and North East London NHS Foundation Trust. A separate Section 75 agreement between those parties is being drafted to govern the operation of this function, but it will also be represented in the commissioning agreement.

2.6 In addition to the CLDT, the contracts currently held by both parties that are currently intended to be managed through the joint commissioning arrangement include:

- From London Borough of Barking & Dagenham:
    - Supported living services under block contract (as at 30/9/14; due for retender for 1/2/15), provided at 144 & 148 Longbridge Road; 2 Gardners Close; 98a Ford Road; 28 Vicarage Road; 110 Bromhall Road; 1/3 Vicarage Road; 99 Burdett's Road; 48 Raydons Road
    - Day provision under block contract (to 31/3/14; thereafter purchased under personal budget or managed personal budget arrangements):
    - Individual spot-purchased placements based on assessed need, for residential care; supported living; day care and activities; home care.
    - Personal budgets provided to service users;
- From B& D Clinical Commissioning Group:
    - Continuing healthcare placements arranged to meet individual need;
    - Optometry services ('Bridge to Vision').

2.7 A piece of work is currently being undertaken to map out the commissioned services above which will form the specification for the Commissioning Section 75 agreement.

Joint Commissioner

2.8 As part of the agreement, a Joint Commissioner post has been created. The post will be funded jointly by the Council and the Clinical Commissioning Group: 80% from the local authority and 20% from the CCG. The post will commission services on behalf of both parties and management responsibility will rest with the

Group Manager, Integration & Commissioning, in the Council's Adult & Community Services directorate.

2.9 A recruitment exercise was carried out in May and June 2014, and interviews were conducted by a panel made up of representatives from both organisations. A Joint Commissioner was successfully appointed and the Council is currently confirming a start date for the post for October 2014. The work programme for the Joint Commissioner will be agreed through the Learning Disability Executive Group, which will oversee performance against expected outputs for the Section 75 agreement, and a joint induction will be arranged over the coming month.

Governance

2.10 Whilst accountability for the day-to-day commissioning of services will rest with the Joint Commissioner, the two organisations have agreed to establish a joint committee, the Learning Disability Executive Group (LDEG), to provide strategic oversight of the performance of the partnership and the commissioning of services. The LDEG will be formed of representatives from both the Council and the CCG.

2.11 The emphasis of this group will be on ensuring that the outcomes set out in the agreement are delivered for both parties and effective management of the pooled budget. A separate and similar arrangement is proposed between the Council and NELFT for the management of the integrated service. Links will also be maintained with the Learning Disability Partnership Board, which will remain as a subgroup of the Health & Wellbeing Board and an important forum through which the joint commissioner will work on the future development of services.

Finance

2.12 In Year 1 (2014-15), following sign off of the section 75, it was intended that budgets would be aligned and not pooled. Pooled budgets are intended for the second year of the agreement from 1 April 2015 and thereafter.

2.13 Through the contracts and functions detailed above, the local authority is committing £7,714,600 of existing expenditure and the CCG £3,349,083, giving a total aligned budget of £11,063,683. It should be noted that this expenditure is from the 2014/15 budget and that the 2015/16 budget has not yet been confirmed and may be subject to savings.

2.14 At the point at which the CCG is able to delegate continuing healthcare functions to the local authority it will transfer the agreed monies to the local authority under the section 75 agreement. Work has started to transfer existing contract information to the Council. Existing continuing health care contracts will continue to be managed by the CCG on behalf of the partnership until new contracts are in place with the local authority. This process will be done collaboratively with the joint commissioner and in line with national guidelines on continuing health care.

2.15 During the first year of aligned budgets, the two partners will negotiate arrangements for pooled budgets to be in place.

Duration and Commencement

2.16 The partnership agreement will be for a minimum of three years with the option to extend by mutual agreement and the agreement requires six months' notice of termination.

2.17 Officers have been working towards an implementation date of **1 April 2015** for this work.

2.18 The previous report to the Health & Wellbeing Board noted that the CCG were to give the required notice (6 months) on the NELFT contract relating to the health provision in the Community Learning Disability team with the intention that the service would be commissioned by the local authority after this period. The contract would continue to be managed by the CCG on the partnership's behalf for the six months until a new contracting arrangement with the local authority was in place under the proposed second Section 75 agreement, at which point the commissioning of the service and management of the contract would shift to the local authority.

2.19 Notice was given, and work commenced to draw up the agreement for signature, alongside a programme of work on the new section 75 agreement to govern the direct provision. However, there remain some outstanding matters which mean that formal responsibility for commissioning cannot transfer from the CCG to the Council. These are set out below. In the interim, a further six-month extension has been agreed with NELFT, with the intention that the new arrangements are run in shadow form from 1 January 2015, to come into full effect on 1 April 2015.

Outstanding matters

2.20 The main body of the section 75 agreement and the majority of schedules have been completed and agreed by the CCG and Local Authority as planned. ue to the Joint Commissioner not yet starting in the Borough, there have been delays in the completion of some key actions required to finalise the agreement. These include the specifications and contracts for the CLDT, and for the wider services being commissioned. In addition, detailed processes for the management of continuing healthcare need to be developed so that the arrangements commence with confidence on the CCG's part about the management of this important statutory function.

2.21 It is for this reason that the new timelines have been proposed, with the 'shadow running' intended to ensure that any concerns are addressed and problems resolved before formal commencement in April 2015.

3. Second Section 75 Agreement for Integrated Service Provision

3.1 Meanwhile, work has begun to develop the Section 75 agreement to govern the provision of an integrated Community Learning Disability Team (CLDT), between the Council and North East London NHS Foundation Trust.

3.2 A group comprising of representatives from NELFT, the CCG and the Council are regularly meeting in order to develop the Section 75 agreement.

3.3 The group are currently reviewing the existing operational procedures and specification for the CLDT, particularly as these documents will form the basis for the Section 75. Due to the fact that these documents have ramifications for staff, it has been agreed that staff within NELFT and the Council will be consulted using their constituent organisation's processes for consultation. It is intended that the consultation and the preparation of the Section 75 agreement will be concluded by March 2015, ready for signing before the formal commencement date of 1 April 2015.

3.4 Although the Learning Disability Executive Group (LDEG) will be established to provide strategic oversight of the performance of the partnership arrangements and the commissioning of services, it is proposed that a separate steering group is set up to oversee the Section 75 arrangement for the integrated service. This group will maintain oversight of the running of the service and will discuss operational issues which require escalation.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

The refresh of the Joint Strategic Needs Assessment (JSNA) will include sections on adults, and children and young people with Learning Disabilities. These sections will identify the needs of this vulnerable population. Once published, the needs as outlined in these sections should be fed into the commissioning process to ensure that service configurations meet the needs, and optimise the health and wellbeing of, people with Learning Disabilities.

4.2 Health and Wellbeing Strategy

People with Learning Disabilities experience high levels of health inequalities. The refresh of the Health and Wellbeing Strategy should prioritise this population as a vulnerable group with specific needs as outlined in the JSNA.

4.3 Integration

Responsibility for ensuring the delivery of the things set out the concordat rests with both the NHS and the Local Authority and there is commitment on both sides to enable this to happen. Both the strategic plan and the Section 75 will actively increase integration.

4.4 Financial Implications

Barking and Dagenham Council:

There are no new financial implications to this update other than that the LBBD contribution to the pooled budget will be subject to 15/16 onwards savings options that are currently in the process of being finalised.

Implications completed by: Faysal Maruf, Group Accountant, Finance

Barking and Dagenham Clinical Commissioning Group:

Financial processes will have to be agreed within the section 75 agreement, this will need to include; authorisation of new packages, management of financial risk, reporting of financial positions and treatment of under and overspends. The CCG and LA are committed to not increasing the financial risk for each partner through the establishment of the section 75.

Implications completed by: Rob Adcock, Deputy Director of Finance, Barking and Dagenham CCG

4.5 Legal Implications

Barking and Dagenham Council:

This report is seeking to update the Health and Wellbeing Board on the progress made in entering into a section 75 partnering arrangement between the Council and the Clinical Commissioning Group (CCG) for the commissioning of learning disability services.

This report sets out a detailed update of the current progress. There are no specific legal implications to add to this updating report.

Legal Services continue to work with Adult and Community Services in the drafting and negotiation of the section 75 arrangement with the CCG. Legal Services will also be assisting in the drafting of the section 75 arrangement between the Council and the North East London Foundation Trust for the integrated service provision as outlined in the report.

Implications completed by: Daniel Toohey, Principal Corporate Solicitor, Legal and Democratic Services

Barking and Dagenham Clinical Commissioning Group:

It is understood that it is proposed that the Learning Disability Executive Group is to be a joint committee under regulation 10 (2) of the 2000 Regulations. The CCG intends to make an amendment to the CCG's constitution but for the time being as the CCG's commissioning functions are reserved to the Governing Body of the CCG (as is the case with the vast majority of CCGs) and not the Group, whilst the

Group could enter into a joint committee, the Group would not be able to exercise any commission functions in such a joint committee.

As such therefore for the time being it is proposed that a working group be established which would constitute individuals from the CCG and the local authority to whom authority had been delegated.

It is also noted that notwithstanding that section 75 of the NHS Act 2006 permits delegation of final decision making functions to a local authority that the CCG remains legally responsible for all eligibility decisions made.

Implications completed by: Rod McEwen, Legal and Governance Adviser, Solicitor and in house Counsel for Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

5. Public Background Papers Used in the Preparation of the Report:

‘Learning Disability Section 75 and (as part of the former) Joint Strategic Plan on Behaviour that Challenges’ – Report to the March 2014 Health and Wellbeing Board

AGENDA ITEM 12

HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Substance Misuse Strategy Board End of First Year Report**
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: Dan Hales, Group Manager Community Safety and Integrated Offender Management	**Contact Details:** Tel: 020 8227 3723 E-mail: Dan.Hales@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult and Community Services	

Summary:

The Substance Misuse Strategy Board is a sub-group of the Community Safety Partnership which is responsible for addressing issues relating to drugs and alcohol in the Borough. It is attended by organisations from across the Community Safety Partnership, including: Public Health, the Police, NHS England, Job Centre Plus and substance misuse agencies. The Board discusses performance relating to substance misuse, the performance of substance misuse services and emerging substance misuse issues in the Borough.

The Board has now completed its first full year. This report is presented for information only and highlights end of year 2013-14 performance report (Section 1), work completed regarding the identified emerging issue of New Psychoactive Substances (Section 2) and the work of the Community Alcohol Detox as an example of good practice (Section 3).

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) note the content of these reports.

1. **Performance of Substance Misuse Services**

1.1 This report summarises the main performance points for substance misuse services in Barking and Dagenham for the 2013/14 period. This report uses official National Drug Treatment Monitoring System (NDTMS) data provided by Public Health England, where possible. These indicators are selected by Public Health England and distributed nationally.

Adult Performance - Drugs

1.2 **Public Health Outcome Framework –** This indicator looks at the number of individuals who have successfully completed drug treatment, as a proportion of the total case load and not re-presented to treatment within 6 months. The evidence of success for drug treatment systems is now on recovery, individuals successfully completing treatment and not re-presenting within 6 months. This indicator features within the Public Health Outcomes Framework.

1.3 The reports show that:

i) that the percentage of opiate users in treatment who have successfully completed and not re-presented to treatment within 6 months has increased from 9.6% in 2010[1] to 16.1% in 2013[2]. This rate is above the national average of 7.8% for opiate users, which is good.

ii) the percentage of non-opiate users in treatment who have successfully completed and not re-presented to treatment within 6 months has increased from 33.6% in 20102 to 47.8% in 20133. This is above the national average of 40.6% for non-opiate users.

1.4 **Numbers in Effective treatment –** In order for an individual to be in effective treatment they must have been in treatment for 12 weeks or more or have completed treatment in a successful way e.g. treatment complete, drug free. In the past, under the National Treatment Agency, this measure was used as the main performance indicator and was directly linked to funding. This remains an important measure, however the emphasis is now on recovery i.e. successfully completing treatment and not re-presenting.

1.5 The reports show that

i) the number of non-opiate users in effective treatment within Barking and Dagenham continues to grow with a 40.1% increase in numbers in effective treatment between January and December 2013 compared with the previous calendar year. This is high compared to the London growth of 5%.

ii) There has been a 5.8% growth in the number of opiate users in effective treatment between January and December 2013. This is above the national trend which has seen a 1.9% reduction.

1.6 **Prevalence and Opiate and Crack Users (OCU) penetration –** The University of Glasgow produce estimates of Opiate and Crack users (OCU) residing in the country and down to a local authority level. The Glasgow estimate gives an

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[1] Successful completions between January and December 2010 with re-presentations up to 30th June 2011.

[2] Successful completions between 1st October 2012 to 30th September 2013 with re-presentations up to 31st March 2014.

indication of the number of users residing in each area, as well as the rate per thousand population, based on the mid-year ONS population estimates. The latest Glasgow estimate is for 2011/12 and shows that Barking and Dagenham have a estimate of 1,079 OCUs, up 85 on the previous year's estimate but still lower than 2009/10 (1,102).

1.7 Between January and December 2013 Barking and Dagenham had 487 OCUs in effective treatment. It is estimated that in Barking and Dagenham we have a treatment penetration level of 45%, thus we have reached around half of the estimated OCUs within the local borough. This puts Barking and Dagenham slightly below the national average of 52% and slightly above the London average of 43%.

1.8 **Successful completions –** Barking and Dagenham are performing in the top quartile for both opiate and non-opiate successful completions as a proportion of those in treatment.

1.9 **Re-presentations –** A re-presentation is an individual who has completed treatment successfully, i.e. drug free, and has presented to treatment services again within 6 months using substances. This indicator shows the effectiveness of treatment and the sustainability of recovery. Re-presentations for opiate users has remained fairly static over the course of 2013/14 with 22% of individuals re-presenting to services in quarter 4. The re-presentation rate for non-opiate users has decreased in quarter 4 from 8.6% in quarter 3 to 5.9% in quarter 4.

1.10 The introduction of aftercare provision at all services enables individuals to access further support following their treatment and aid them with the transition from treatment life back into the community. The result of the aftercare provision will not however reflect in the official performance reports until the end of quarter 1 2014/15. This is because these reports look at individuals exiting treatment within a 6 month rolling period allowing 6 months for them to re-present to services.

1.11 **Harm Reduction –** As well as addressing substance misuse issues, services are tasked with addressing the physical health of individuals especially those where substance misuse is a risk factor. Blood Borne Virus (BBV) testing and vaccinating is therefore offered to all service users who enter treatment in the borough.

1.12 **Hepatitis B –** Barking and Dagenham have a better than national average commencement and completion rate for Hepatitis B vaccinations, 40% locally compared with 18.7% nationally. Barking and Dagenham do however have a lower than national average rate of individuals accepting the offer of a Hepatitis B vaccination, 31.2% compared with 43.1% nationally.

1.13 Services are currently offering service users Hepatitis B vaccinations at the start of their treatment when they are at their most chaotic. Services have been tasked to start offering Hepatitis B vaccinations at care plan reviews, where they are more stable and settled into treatment and at other points in their treatment journey where it is appropriate to offer.

1.14 **Hepatitis C –** Injecting drug users are at risk of contracting Hepatitis C especially if they are sharing injecting paraphernalia. Barking and Dagenham continues to demonstrate an excellent rate of Hepatitis C testing, with 90% of eligible clients (previous or current injectors) receiving a test in 2013/14.

1.15 **Drug Intervention Programme (DIP) –** DIP data recording has recently been moved from the Home Office to Public Health England and the NDTMS team. Barking and Dagenham are currently performing above the Metropolitan Police

Service level for percentage of DIP referrals to enter structured treatment. The quarter 4 Police Force Area DIP report shows that 64% of DIP clients who were referred by the DIP service engaged in structured treatment. This is above the 41% within the Metropolitan Police Service area. This is an increase from quarter 3 (61%).

Adult Performance – Alcohol

1.16 **Numbers in treatment –** The number of individuals aged 18 years and over accessing alcohol treatment in Barking and Dagenham over a 12 month period. Public Health England report that the number of people receiving alcohol treatment has shown a 15% rise compared to 12/13.

1.17 **Successful completions –** This indicator measures individuals successfully completing alcohol treatment as a proportion of the total number of individuals in treatment during the previous 12 month period. This demonstrates that individuals are being moved through the treatment system and not being held onto or becoming stuck in treatment.

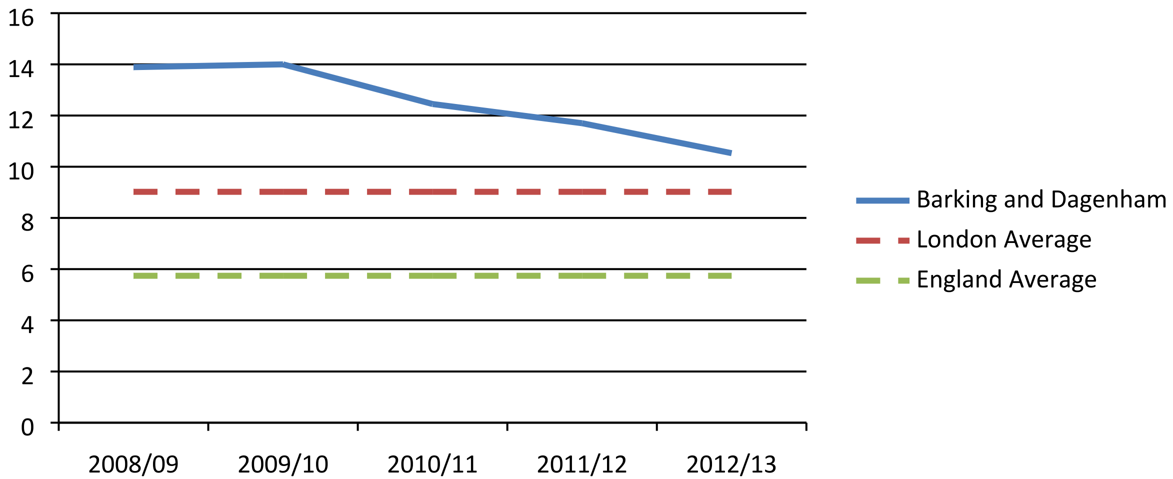
1.18 The successful completion rate for quarter 4 (2013/14 period) was 33.7% which has reduced from 36.9% in quarter 3. The successful completion rate for the Community Alcohol Service in 2013/14 was 58% under the previous provider. Following a review of discharge procedures the new alcohol service now works with individuals for slightly longer to ensure that they are ready to exit treatment in a planned way. The successful completion rate has reduced from the previous year due to this longer work, however the quality of successful completions has improved. This extra work should lead to a reduction in the number of individuals re-presenting to treatment services.

1.19 **Re-presentations –** A re-presentation is an individual who has completed treatment successfully, i.e. alcohol free, and has presented to treatment services again within 6 months using substances. This indicator shows the effectiveness of treatment and the sustainability of recovery. A high representation rate means poor performance for this indicator.

1.20 The re-presentation rate for Barking and Dagenham has reduced slightly from 12.3% in quarter 3 to 11.8% in quarter 4. This is in line with the national average (11.2%). This is a new measure that Public Health England is now reporting and is likely to support local performance against the Public Health Outcome indicator of alcohol related admissions to hospital.

1.21 **Alcohol Attributable Recorded Crime –**This indicator is calculated using the former UK Prime Minister's Strategy Unit's alcohol-attributable fractions and applying them to the total number of recorded crimes, based on urine tests of arrestees.

1.22 Barking and Dagenham has the sixth highest rate of alcohol related crime and violent crime in the country and the fifth highest in London per 1,000 population. Substance misuse reoffending is a CSP priority in the borough. This indicator has seen a consistent and significant decrease since 2008/09.

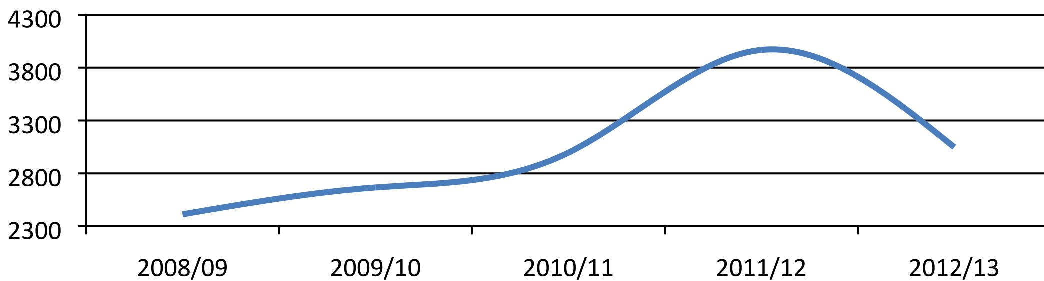


Source: Local Area Profiles for England

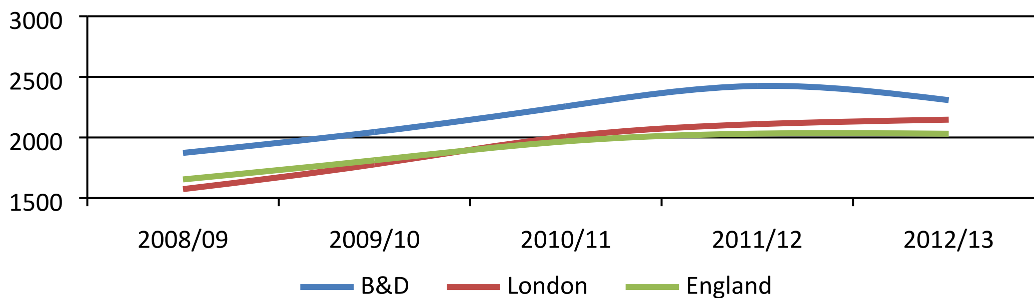
1.23 **Alcohol related Hospital Admissions –** This indicator measures the number of people who have attended hospital in relation to alcohol related harm and have stayed overnight and occupied a bed space. On average Barking and Dagenham has seen a 10% increase in alcohol-related admissions over the past 9 years (since 2002/3). In comparison the average for London and England was 12% and 10% respectively.

1.24 However, the official 2012/13 data shows the number of hospital admissions for the borough has starting to decrease 3048 (-5%) whilst the London average shows a 2.9% increase and the England average shows a 0.93% increase.

LBBD No. of admissions



Rate per 100,000 population

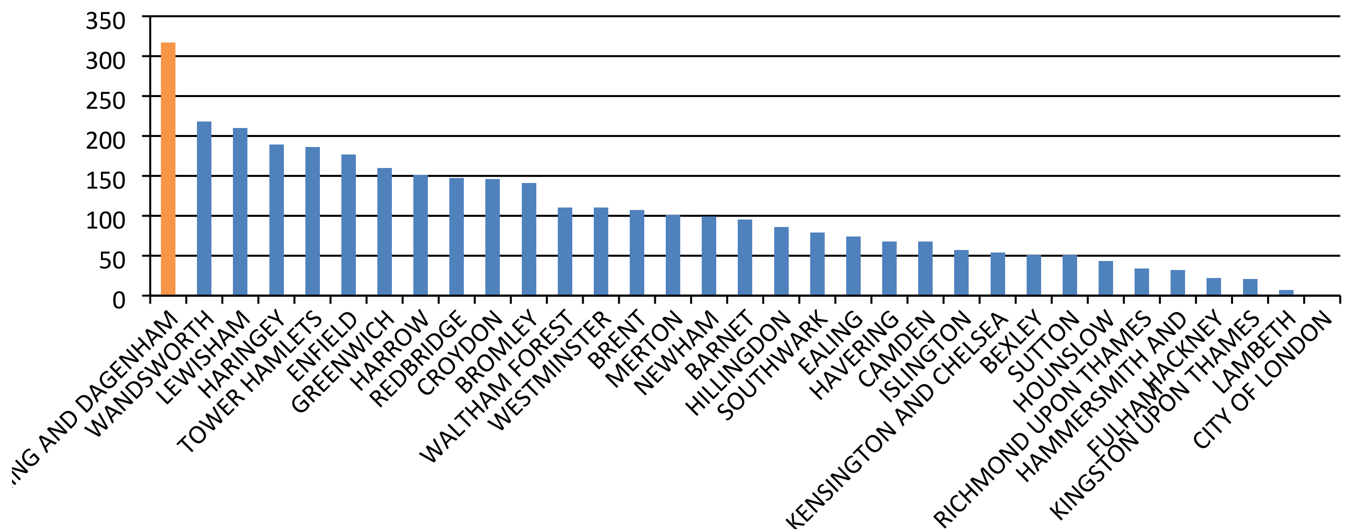


Source: Local Area Profiles for England

Young People Performance

1.25 **Numbers in treatment –** The number of young people accessing treatment during the 2013/14 period for both drugs and alcohol. This is a combination of individuals accessing treatment at SubWize and treatment with the substance misuse workers at the Youth Offending Service (YOT).

Barking and Dagenham have had 317 young people in treatment during 2013/14. On examination of the data behind the report it is possible to say that Barking and Dagenham had the highest number of young people accessing treatment in London from April 2013 to March 2014 and the 5th highest in England. This is due to the accessibility of services and clear signposting to services.



Source: NDTMS YP executive summary Quarter 4 2013/14

1.26 **New treatment starts –** As well as looking at numbers in treatment it is important to look at the number of new individuals entering treatment at the service. This shows that people are moving through treatment and that new individuals are starting. The Young People (YP) services in LBBD have had 219 new young people accessing services between April 2013 and March of 2014.

1.27 The target for new starters into YP treatment for 2013/14 was 260. This target has not been met for the year; however the number of young people entering treatment in Barking and Dagenham reflects a reduction in the number of young people entering treatment nationwide. Despite not achieving the locally set target, Barking and Dagenham are currently out performing all other London boroughs with regards to the number of young people entering treatment.

1.28 **Hidden Harm referrals –** Although not officially reported to NDTMS, SubWize work closely with adult treatment services as well as social services and the police to work with children of individuals who are using substances. This hidden harm work is about supporting these young people to cope in the situation that they are in and to understand the substance misuse of their parents, carer or relative.

1.29 During quarter 4 of 2013/14 SubWize received 37 referrals for young people from adult services and 34 referrals from social services.

1.30 **School referrals –** Barking and Dagenham's SubWize team worked over the last couple of years to deliver a presence in the local schools. SubWize currently offer satellite sessions and groups in every school in Barking and Dagenham.

1.31 Barking and Dagenham have the 3rd highest number of referrals from schools in London with 61 individuals referred to treatment in 2013/14.

1.32 **Successful completions –** measures individuals successfully completing treatment as a proportion of the total number of individuals in treatment during the previous 12 month period. Barking and Dagenham had a successful completion rate for young people of 80% between April 2013 and March 2014. This is in line with the national average rate of 79%, however due to having greater numbers of young people in treatment Barking and Dagenham have a much higher number of individuals exiting treatment successfully.

Recommendations

1.33 These recommendations were made by NHS England from these performance figures. They were presented to the Substance Misuse Strategy Board and have been approved by the Board.

1.34 **Re-presentations –** All services to provide aftercare support, this started in October 2013. The aftercare provision supports service users after treatment and reduce the number of individuals relapsing and re-presenting to structured treatment.

1.35 **Numbers of young people in treatment –** YP services to continue to work with partners to engage appropriate young people into treatment.

2. New Psychoactive Substances

2.1 New Psychoactive Substances (NPS), also known as 'Novel Psychoactive Substances' and 'Legal Highs' are intoxicating substances that are not prohibited by UK law or have only recently been illegalised. Although the issue of NPS is not new, in recent years due to developments in 'chemical technologies, market availability, internet supply, trends in substance misuse, price and others' (Advisory Council on the Misuse of Drugs 2011) it has become much more prominent.

2.2 An initial report was presented to the Substance Misuse Strategy Board on the 25 February 2014, which proposed a set of recommendations for the Team to take forward to address the issue of NPS locally. These recommendations were agreed by the Board.

History

2.3 NPS have existed for a long time, mostly created as legal compounds to replace substances that become prohibited. In recent years, with developing technologies, NPS have become more prominent and available. Where there has been a decline in the use of illegal drugs nationally, the use of 'legal highs' has increased rapidly. It is estimated that 150 NPS were created in the last three years, this equates to a new compound being created every week.

2.4 The issue of NPS is particularly significant in the UK. According to the United Nations Office on Drugs and Crime, the UK has the largest market for legal highs in the European Union.

2.5 NPS can be broken down into four categories; stimulants, depressants, hallucinogens and synthetic cannabinoids. Common examples of NPS include 'spice' a synthetic cannabinoid and Alpha Methyl-tryptamine (AMT) a compound mimicking ecstasy.

2.6 Currently, NPS are readily available online and in 'Head Shops', which can be found on most UK high streets. Legislating against these sellers is a challenge, as enforcers must prove that the vendor is selling the product for human consumption. Further to this, many of the online sites used to sell NPS fall outside of UK jurisdiction making it almost impossible to legislate against them.

2.7 At present, UK law allows a 12 month temporary banning order to be placed on any new psychoactive compound that may have a detrimental impact on humans, while further investigations are made into its properties and potential illegalisation. Further to this, the government have launched a review into NPS, due for completion in mid to late 2014. It is anticipated that this will significantly alter UK drug legislation.

Risks Associated with NPS

2.8 Like all psychoactive substances, NPS can have a significant detrimental impact on the user's mental and physical health.

2.9 As the majority of NPS are initially legal they are readily accessible and often cheaper than illegal substances, making them an attractive alternative for drug users.

2.10 The term 'legal highs' is often used to describe NPS. This is problematic, as it reinforces the legality of drugs (many of which are in fact illegal). In addition, individuals may associate less harm with substances that are legal and be more inclined to use them,

2.11 Due to changes in legislation, it is now illegal to suggest that substances may be used for human consumption at point of sale. Where previously substances have included safety information and dosage guidance, packaging now simply states 'not for human consumption'. This has led to individuals being uninformed about what they are consuming and, in some circumstances, over-dosing.

2.12 Further to this, as NPS mimic other illegal drugs, individuals may be inclined to consume them in the same way, however NPS can often be more potent than the drugs they mimic and have increased side effects. For example, there are over 300 synthetic cannabinoids, which have been seen to induce psychosis.

2.13 It is estimated that one new psychoactive compound is created every week, this heightens risks, as newer substances have had less testing and thus both their short and long-term effects on humans are unknown.

What Can Be Done?

2.14 Scoping can be conducted to understand the availability and use of NPS locally. Having a better insight into the prevalence of NPS in Barking and Dagenham will enable appropriate strategy and resources to be developed to address the issue.

2.15 To further build the local NPS picture, work can be done to scope potential NPS vendors and to use legislation where possible to reduce the selling of NPS to residents.

2.16 Education can be used to build factual awareness for young people about the risks associated with using NPS, as well as harm reduction advice for those using NPS. CRI, for example, offer training and awareness building workshops in other Boroughs, which have been reported as an effective way of spreading the important information concerning NPS.

2.17 Training can be delivered to substance misuse and school staff to ensure that they are up-to-date on information around NPS and can disseminate this to young people and service users. Ensuring that schools are informed is essential to ensure that they can identify signs that a young person may be consuming legal highs and make appropriate referrals. It would be beneficial to have an NPS lead in every secondary school in the Borough.

2.18 Work can also be done with hospitals to identify admissions who present toxic symptoms and drug induced psychosis and to ensure that they are referring these individuals to the appropriate services.

Recommendations

2.19 This paper was taken to the Substance Misuse Strategy Board on 25 February 2014, and the Board agreed the following six recommendations:

Recommendation 1 - work with licensing to identify vendors of NPS in the Borough and to conduct spot purchasing

Recommendation 2 - work with hospital admissions in the Borough to identify toxic symptoms and drug induced psychosis and ensure appropriate referrals are made to services

Recommendation 3 - extend research into NPS with young people to gain more accurate and comprehensive results

Recommendation 4 - commission NPS training for substance misuse and PSHE leads in schools. It would be beneficial to have at least one individual fully trained in NPS in each service and school

Recommendation 5 - create a leaflet on the dangers of nitrous oxide and disseminate in the Borough, in particular to parents and schools

Recommendation 6 - deliver an education programme in all secondary schools in the Borough teaching young people about the risks of NPS and harm minimisation

Update Against Recommendations

Recommendation 1

2.20 At the Substance Misuse Strategy Board on 25 of February 2014, it was agreed to initiate Test Purchasing locally for NPS, in line with local principles. The results of the Test Purchase will be fed back to the Substance Misuse Strategy Board for discussion and agreement of further action.

Recommendation 2

2.21 The Young People's Hospital Worker has been briefed on NPS and is to deliver training with Accident & Emergency staff, informing them of signs and symptoms

that may identify young people and adults as having consumed NPS. Further to this, the substance misuse team are establishing a recording mechanism for the Young Person's Hospital Worker to ensure that incidents of NPS use are reported and appropriately referred. This will enable us to have a better understanding of NPS use in the borough.

Recommendation 3

2.22 A survey on NPS for young people continues to be conducted through Substance Misuse Services. To-date there have been 38 responses, which is a small sample, but gives a suggestion of local young people's awareness of NPS. The survey will continue to be deployed in order to broaden the Board's knowledge of young people's understanding and use of NPS in the Borough

Recommendation 4

2.23 PSHE leads have now been briefed on the issue of NPS. Further training, which will enable them to deliver NPS workshops with their students, has been planned for September 2014.

Recommendation 5

2.24 The copy for a Nitrous Oxide leaflet aimed at parents has been drafted based on research. Once approved, the leaflet will be designed and produced by the Council's Communications team to be disseminated in schools, GPs surgeries and Substance Misuse services.

Recommendation 6

2.25 The Borough's education lead for substance misuse is in the process of commissioning a project to deliver sexual and relationship education in schools. Part of this will involve drug education, including a section on NPS. Subwize continue to incorporate NPS as part of their substance misuse work in schools. The Substance Misuse Strategy Team are currently scoping the potential for an interactive workshop that is specifically about NPS. Subwize have also released an NPS newsletter to young people, which specifically warns of the risks around NPS and includes a young person's account of their experience of NPS.

3. Community Detox

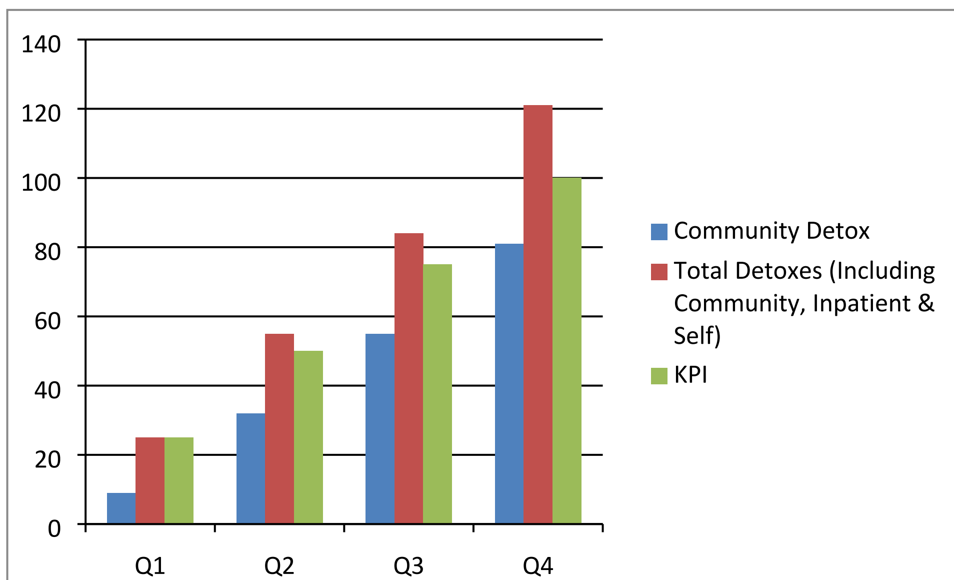
3.1 This section was prepared by CRI, the Borough's commissioned service providing community detox. The report demonstrates the effectiveness of the current community detoxification pathways at CRI Community Alcohol Service, as well as offering insight into the methods the Community Alcohol Service uses in order to secure positive outcomes for service users. At present the majority of community detoxes are provided through an ambulatory detox (where service users attend the service daily for monitoring with the clinical lead) with exceptional cases being offered a home detoxification (see below for more information). Policies and procedures were drawn up in 2013/14 to ensure that the detoxifications are clinically sound. With these procedures assured CRI are delivering detoxifications that sit comfortably within NICE guidelines which gives the greatest likelihood of delivering positive outcomes for service users.

Performance

3.2 Throughout the year the number of community detoxes have remained at a strong level, with a total of 85 detoxes completed. During the 3 full quarters of 2013/14 CRI have been running the service they have reached their targets, with the shortfall coming in quarter one when there was no premises and were only operational for 1 month.

	Community Detox	Inpatient Detox	Self Detox	Total
Q1	9	16	0	25
Q2	23	7	0	30
Q3	23	4	2	27
Q4	26	7	4	37

3.3 The graph below shows the number of community detoxes, and the amount of detoxes CAS supported in total (including self detox and inpatient detox).



3.4 Completions of detoxifications in 2013/14 was 100%, with every single service user seeing their detox through to the end, without relapse, demonstrating that CAS in only putting service users through for detoxification who are motivated and ready to do so.

3.5 There are actions in place to ensure that CRI are maximizing the amount of detoxifications that take place, whilst ensuring that they only carry out detoxifications when the client is ready, and it is deemed clinically safe to do so.

Pre-detox Work

3.6 Currently the service user is identified at assessment stage, or later in their treatment journey by their CRI keyworker as being potentially suitable for a detox. At this point they are referred to the clinical lead, who completes a full medical assessment to assess suitability for detoxification. This is based on the length of their drinking career, quantity of alcohol consumed on a weekly basis, indicators of dependency, social support etc. At this point a clear picture of previous withdrawals is also documented to exclude service users with a substantial history of withdrawal seizures, delirium tremens and so on. If suitable the clinical lead draws up a

chlordiazepoxide detoxification regime that would suit them based upon their level of alcohol use. They would also discuss the use of Carbemazepine as an anticonvulsant if appropriate and the use of Oxazepam for those with advanced liver disease or on the transplant waiting list or who have already had this. If the service user is deemed to be unsuitable for community detoxification at this point other options would be discussed, for example residential detoxification, or a reduction plan. At all stages of detox planning consults are held with the CRI Consultant Doctor who can advise on further medications recommended or other considerations to be made.

3.7 After medical assessment the service user starts to attend the pre-detox group. This was set up to last for a period between three weeks, (however this can be extended dependent on the service user's motivation, or if there is a delay in the GP providing relevant information). The pre-detox group covers the following topics:

- reasons for wanting a detox. Discussion of the negative effects of alcohol on health, mental health and social and family life and what this means to the individuals. Including body map. Importance of taking thiamine and vitamin B now;
- detox process itself. How to prepare and deal with cravings. Give leaflets for chlordiazepoxide and acamprosate. Give leaflets about nutrition and diet. Discuss sleep hygiene and ways to aid sleep and what to avoid; and
- discussion of the components of robust aftercare and the menu on offer at CRI and the benefits and research showing that attending aftercare has better outcomes.

During Detox

3.8 Whilst undertaking an ambulatory detoxification service users meet with the nurse daily to discuss any positive and negative effects that they are experiencing. Their blood pressure is taken and they are breathalysed to ensure that they are detoxing safely and have not resumed any drinking behavior.

3.9 During quarter 4 a new protocol was also been developed whereby during the ambulatory detox itself service users attend one group per day to offer further peer support. The group itself is designed to provide a forum for Service Users to openly discuss their detox experience and provide each other with feedback and support to further enhance the intervention. At this stage they are also introduced to Foundations of Life group, so that they can start to experience the groups that will be available to them post-detox. The full detoxification timetable can be found below.

3.10 The ambulatory detox length will vary according to the level of prior alcohol use however on average, detoxification lasts between 7-10 days.

Post-Detox

3.11 Following the completion of a detox the service user is passed back to the keyworker, who will ensure that the pre-agreed post detoxification aftercare package is in place, and the service user is being provided with adequate support to remain abstinent, as well as being informed and encouraged to attend mutual aid groups within the Borough.

Home Detoxification

3.12 In some instances, it may not be suitable or possible for a service user to commit to the full timetable expected of the ambulatory detoxification. Examples of this include:

- physical health problems such as chronic obstructive pulmonary disease, heart disease, advanced peripheral neuropathy and orthopaedic problems such as on the waiting list for hip replacement;
- psychiatric illness such as social phobia and agoraphobia, paranoia as part of major psychiatric diagnosis i.e. paranoid schizophrenia;
- reasons that prevent them from entering certain parts of the borough due to injunction and court orders; and
- the frail and elderly.

3.13 In the above cases the clinical lead would make the assessment that a home detoxification may be more suitable. In these instances another CRI nurse who is contracted to work flexible hours will visit the service user in the morning and the evening to monitor the service users health and wellbeing, and complete the same clinical checks that would take place in the ambulatory detox as mentioned above. During the home detox the nurse remains in contact with the service users keyworker to provide updates and ensure that the aftercare package is set up on completion of detoxification.

Case Study

3.14 CRI were able to offer a home detox to a service user who has a diagnosis of agoraphobia. This home detox, coupled with regular home visits from the outreach worker, has allowed this service user to access a full service, despite her mental health diagnosis.

Barriers and Recommendations

3.15 Although the community detoxification pathway is working well at present there are still actions that can be taken to ensure it runs even smoother. Currently, there can be a delay in gaining the relevant information from GP's (for example blood results, medical history) and there can also a delay in the GP writing the required prescription in a timely manner. Although CRI works closely in partnership with a number of GP's more work can be done to improve these partnerships. CRI plan to deliver further training to GP's and deliver relevant literature, as well as attending relevant meeting (PTI and CCG meetings) to ensure that GP's are aware of the benefits of their community detoxification service to their patients, as well as their surgery outcomes and figures.

3.16 CRI will continue to review the community detoxification process and performance and will adapt and develop the process as and when the need arises. CRI will also be gaining some service user feedback of the new ambulatory detoxification process.

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 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 an update on the UCB meeting held on the 1 August 2014 which can be found attached at Appendix 1.

It also discusses the operational resilience proposals that are being submitted for funding to help the local health economy meet projected pressures and capacity in BHRUT over the winter period.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- 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.

1 Systems Resilience Bids

1.1 Systems Resilience Groups (in Barking and Dagenham's case, the BHR Urgent Care Board) have been asked to submit systems resilience proposals for funding for the local health economy. Indicative allocations are similar to 2013/14. The Urgent Care Board is reviewing how, taken together, the proposals will meet projected pressures and capacity in BHRUT over the winter period.

1.2 Within BHR, systems resilience proposals can be grouped under the following:

- **Frailty** – this includes a number of proposals that will strengthen services for older people attending A&E at King George Hospital, improved support in hospital for people with dementia, and community based schemes.

- **Joint Assessment and Discharge Service** – this includes additional staffing to increase flexibility, hours and responsiveness at times of peak pressures and the interface with the BHRUT schemes.

1.3 In addition LBBD has led on pulling together proposals that seek to mitigate anticipated community pressures in the winter, and on care budgets.

1.4 Proposals have the full support of the BHR health and social care economy and have been submitted to NHS England. Decisions on funding are anticipated by the end of September which will allow time for mobilisation.

2 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: 1 August 2014

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BHR Systems Urgent Care Board (UCB) Briefing

Meeting dated – 1 August 2014	Venue – Barking Learning Centre, Barking

Summary of paper	This paper provides a summary of the key issues discussed at the July 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
Operational resilience and capacity planning (non-elective)	The operational resilience and capacity planning templates 2014/15 was presented to the UCB. Leads provided an outline of their proposals: Joint Assessment Discharge – aims to make safe and timely discharges. Frailty – aims to provide better, more appropriate and accessible care for patients. Primary Care – aims to improve access to primary care. Members noted and endorsed the proposals and agreed to a panel meeting to further review and strengthen the proposals.
Improvement Plan update	Members noted the progress of the Improvement Plan initiatives.
Reporting / escalation	Members received the latest update of the dashboard. The key highlight noted was that the Trust achieved the 95% target on one of the days last week. Members noted that a draft updated dashboard will be presented at the next meeting.
Letter from Rob Larkman to CCG system resilience groups	Members noted the report from LAS on next steps in response to the letter received regarding LAS performance.
Urgent Care Board forward planner	Members reviewed the forward planner setting out the workplan for the next six months.
AOB	Members noted the Intermediate Care is out to consultation.
Next meeting	Monday 1st September 2014 (1pm – 3pm) Committee room 3a, Havering Town Hall

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title: Contract: Re-procurement of Drug Treatment and Prescription Services	
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Decision**
Wards Affected: All Wards	**Key Decision:** Yes
Report Author: Mark Reed, Category Manager	**Contact Details:** Tel: 020 8227 5481 E-mail: mark.reed@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director Adult and Community Services	

Summary:

Barking and Dagenham Council currently has provision in place for drug treatment services which are on a three year contractual basis, two of which expire in March 2015.

The Gateway Service is an open access service which is the main entry for drug treatment. The service is free to residents of Barking and Dagenham who have issues with drug use. The service can provide advice and information as well as referral to more intensive drug treatment. The Gateway service also provides treatment for Class A drug use for those individuals involved in the Criminal Justice System. This part of the service is also known as the Drug Intervention Programme (DIP).

The Recovery Service is a prescribing service for Barking and Dagenham residents who require substitute medication for heroin. The total cost for these two services is approximately £1.262m per annum.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Agree that the Council proceeds with the re-procurement of the Gateway Service as set out in the report;

(ii) Agree that the Council proceeds with the re-procurement of the Recovery Service as set out in the report;

(iii) Delegate authority to the Corporate Director of Adult and Community Services to conduct the procurement in accordance with the procurement strategy set out in this report, and award the contract, in consultation with the Chief Finance Officer and the Head of Legal and Democratic Services, to the successful bidders.

Reason(s)

The reprocurement of the two services will support the Barking and Dagenham Community Strategy in the following areas :

a) Maximise growth opportunities and increase the household income of Borough residents through use of local businesses to provide the service;
b) Create thriving communities by minimising impacts of drug addiction, use and misuse, and subsequent crime and antisocial behaviour.

1. Introduction and Background

1.1 Barking and Dagenham has a range of services in place for the needs of service users with drug and substance misuse problems. The Gateway and the Recovery service are two of the drug treatment services in the Borough and their contracts come to an end in March 2015. In 2013/14, 500 people accessed the Gateway Service, and 400 people accessed the Recovery Service, with some overlap between the two and a total of 831 individuals accessed the services.

1.2 The Gateway and the Recovery service are currently managed by the Crime Reduction Service. Both services are run from the Red Lion premises in George Street, Barking. The services are free for Barking and Dagenham residents to access. Residents who live out of Borough who try to access the service are signposted and re-directed to appropriate services in other Boroughs. The Gateway is the initial entry point in to the treatment system for most drug and alcohol users. It serves as a support in to treatment, referral pathway management and for exit strategy. The Recovery Service delivers a specific element of the National Framework for drug treatment, namely prescribing of substitute medication.

The Gateway Service

1.3 The Gateway Service is available to residents who require advice and information or treatment for drug misuse. Access to this service can be via self referral, GP, hospital or referral from the Criminal Justice System. Service users can get support with housing issues such as rent arrears and help with claiming benefits as well as support for their drug use. For those individuals requiring more intensive treatment such as counselling and group-work there are services that they can be referred to that have that provision.

1.4 The Criminal Justice aspect to the service is also known as the Drug Intervention Programme (DIP). The service works with those individuals who commit crimes in order to supplement their Class A (cocaine and heroin) drug use. There are drug workers in police custody who assess and refer offenders who have drug issues to the Gateway (DIP) service. Since January 2013, Police have been drug testing individuals for Class A (cocaine or heroin) if they suspect that they are drug users or that their offence is linked to drug use. If an offender tests positive for Class A drugs they are required to undergo an assessment and attend one appointment at the Gateway service. If they fail to comply they can be charged and sentenced. The DIP service also work with Drug Rehabilitation Requirement (DRR) clients. These individuals have been given a community sentence from the court that require them

to attend drug treatment. If the individual fails to comply or attend any appointment they can be referred back to court for re-sentencing.

1.5 In addition to providing drug treatment, service users also address their offending behaviour and the links to drug misuse through the Gateway Service. Service users look at the reasons why they offend and the barriers that prevent them from reducing or stopping offending. Addressing offending behaviour in keywork sessions is imperative to success, as many individuals in this cohort have spent many years committing crime.

1.6 Under the Crime and Disorder Act 1998, local authorities have a statutory obligation to have a strategy for reducing crime and disorder, combating the use and misuse of drugs, alcohol and other substances. As such, the Gateway Service is central to the response of the local authority to the Crime and Disorder Act.

1.7 The current contract for the Gateway Service began on 1 April 2012 and expires on 31 March 2015. The contract is funded from the Public Health Grant, as well as other local authority monies and funding from the Mayor's Office for Policing and Crime (MOPAC). The value of the contract in the last financial year was £593,241 and the estimated spend over the contractual period has been approximately £1.8million. The MOPAC element of the funding is £98k per annum and is available until end of 16/17.

The Recovery Service

1.8 The Recovery Service is available to residents of Barking and Dagenham who require substitute prescribing for heroin (such as Methadone or Buprenorphine – also known as Subutex). Referrals to this service are predominately from the Gateway Service, although referrals can come from prison establishments for those individuals on substitute medication who have been incarcerated and who are due for release back into the community.

1.9 People within this service receive this treatment as part of a combined service including key working, counselling, and other interventions with the outcome of cessation of use of controlled substances and substitutes.

1.10 Delivery of this service aligns to Council objectives and its strategies to reduce crime and improve the well being of the Borough, and fulfils the statutory obligations specified in The Controlled Drugs (Supervision of Management and Use) Regulations 2013.

1.11 This service is also offered in an equitable, near-identical manner in all neighbouring boroughs and failure to provide the service exposes the Council to potential risk around recidivism, relapse, and potential health risks around safe administration of controlled substances. In addition, the Council is at risk of litigation around not fulfilling duties of care.

1.12 The current contract for the Recovery Service was established on 4 May 2011 and expires on 3 May 2015. The value of the contract in the last financial year was £638,944 and the estimated spend over the contractual period has been approximately £1.97million. The contract is funded from Public Health Grant.

2. Proposed Procurement Strategy

2.1 The proposal is for the Health & Wellbeing Board to delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer and Head of Legal & Democratic Services, to reprocure the services described above and award contracts for provision in line with regulations, legislation, Council Rules, and best practice.

2.2 It is proposed that the services can be bid for separately or together, resulting in a two year contract with two 12 month extension options up to a maximum of four years. The service model and specification will be reviewed prior to tender issue. Providers will be requested in their tender response to propose how to best deliver the services with room for innovation.

2.3 In order to ensure the most attractive commercial outcome for the Council, it is proposed to ask capable suppliers to submit proposals for delivery of the requirement based on quality and cost. As part of the response, suppliers will be tasked to propose how to best meet the minimum requirements of the statutory obligations whilst minimising the incidences of relapses, recidivism, and anti social behaviour.

2.4 The total contract value for the reprocurement of the Gateway and Recovery Service is estimated to be circa £5m based on previous spend.

i) With an annual spend of circa £593,241 for Gateway Services, the estimated spend for a four year contract period would be £2,372,964.

ii) With an annual spend of circa £638,944 for Recovery Services, the estimated spend for a four year contract period would be £2,555,776.

iii) The total annual spend would be circa £1.232m

iv) The total four year spend would be circa £4.92m

With a consolidation and streamlining of the service, it is anticipated that some cost reductions can be achieved of circa 10%.

2.5 It should be noted that given the uncertainty over the future of the Public Health Grant, if the decision is taken to procure services over a four year period, the contracts will need to contain appropriate break clauses if Public Health funding ceases.

2.6 It is envisaged that this will be a single stage procurement process in compliance with the Council's Contract Rules for requirements. Suppliers will be asked to provide proposals which will detail both:

i) the costs of providing the service and the cost model (i.e. payment by results, or payment by patient, dependent upon a

market analysis of what is most likely to deliver best value for money) in an innovative value-for-money way and;

ii) the service proposal that will detail how the service will be delivered in terms of, but not limited to, provision of the service, controls and risk assessments, customer experience, checks and balances, outcomes, treatment options and measurement of success (i.e reduce number of relapse episodes, duration of dependency), control of substances and substitutes, outcomes, reporting, controls, responsiveness, added value and other factors. Bidders will be requested to submit proposals on how to streamline the service whilst fulfilling the statutory obligations, and how to ensure the service is equable to similar peer local authorities and bodies. This could include looking at operating the service only within 'office' hours, or an out-of-hours service at selected locations that would have been open anyway, or other innovative service proposals that may be successful in other boroughs.

2.7 The expected outcomes for the reprocurement process is as follows:

- Compliant and best practice Contractual Arrangements that remove risk of challenge and reputational damage through using standard Terms & Conditions and regulating performance to minimize risk
- Clear set of controls and restrictions for usage to prevent abuse
- Potentially generate efficiencies and / or reduce costs through recompetition of service
- Potential additional reporting opportunities
- Delivery of the service will reduce on-costs to Council by £2.50 per £1 invested

2.8 The proposed split for the criteria against which the contracts will be awarded will be quality (50%) and price (50%). However, both areas will have a minimum acceptable threshold, meaning an acceptable price and minimum quality standard to ensure a good balance is achieved between quality and price. The minimum quality standard threshold will be ensured to determine that providers can demonstrably meet our requirements.

Proposed Timetable

2.9 Currently it is thought that the following timetable will be adhered to during the Procurement exercise:

- Health & Well Being Board Approval – 09 September 2014
- Tender Issue – 07th November 2014 (latest date)
- Tender Return – 07th December 2014
- Tender Evaluation – 07 December 2014 - 31st January 2015

- HWB Approval to award – 10 Feb 2015 (if applicable)
- Award and Mobilise – 01 March 2015
- Start – 01 April 2015

2.10 Tender evaluation (qualitative and financial) would require a paper-based compliance, marking and financial assessment, as well as a set of interviews with potential suppliers and possible site visits. Evaluation would take a period of approximately four weeks, and require allocation of resource from internal clients to ensure the most appropriate informed individuals contribute to the decision making process.

2.11 Please note that these timescales rely on availability of internal resources and ability to balance to the existing workload with this Procurement.

3. Options Appraisal

3.1 Continue Existing Arrangement: *This is not recommended*. The existing arrangements have been in place for three years old and there is now an opportunity to improve the service and reduce costs There is an option to extend the Gateway Service by a further two years to 2017, and the 12 month option to extend the Referral Service expires 31st March 2015 with no further extension options. The extension options could be taken up as service is currently being delivered to a satisfactory level, however as the Recovery Service cannot be extended, and the Recovery and Gateway Services serve common purposes and objectives within the borough with an overlap of suppliers, there is an opportunity to reprocure both elements at the same time which could yield efficiencies, service improvements, and reduce costs.

3.2 Utilise Existing Framework: None are available for the Borough due to the limited geographical nature of delivery.

3.4 New Procurement Exercise: *Recommended*. This will require a full tender process that is compliant with the requirements of the Council Contract Rules and EU Regulations at the time of commencement. This is the most practical route to take, as both services will require reprocurement and to do so together will reduce the overall workload and harness economies of scale as well as yield benefits sooner rather than later. There are a number of potential options and the recommended route is the Open Process : the ITT will be designed so suppliers will be required to meet minimum qualitative thresholds that meet the legal obligations, statutory requirements, and aims of LBBD. Using the Open Process will reduce the minimum timescales to complete the requirement. As there is an opportunity to do so - and suppliers and services are similar and compliment each other across both services - it is expedient to compete both requirements as separate lots simultaneously.

3.5 Cessation of Service: *This is not recommended.* Cessation of this service would be contrary to the Council Objectives and its strategies to reduce crime and improve the well being of the Borough, and in breach of statutory obligations as specified in The Controlled Drugs (Supervision of Management and Use) Regulations 2013. The consequential effects of failure to provide this service would result in failure to reduce, and likely increase in, use of drugs, and criminal / antisocial activities related to their use, such as burglary, theft and violence.

3 Consultation

3.1 Consultation with key internal clients was conducted in May-July 2014 with a number of key internal stakeholders including the Drug Strategy Manager, Group Manager, Community Safety and Offender Management , Divisional Director Commissioning and Partnerships, Corporate Director of Adult and Community Services and the Procurement Board. Consultation with service users takes place as part of the overarching drug and alcohol needs assessment for the borough. Service users will be involved with the commissioning and procurement of these services, as in previous commissions.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

Drug and alcohol use is highlighted in the Joint Strategic Needs Assessment (JSNA) and Crime and Disorder Strategic Assessment. Compared to the rest of London, Barking and Dagenham does not have an especially high drug use. However, to address health inequalities in the borough and to protect residents from the harm associated with drug and alcohol use, services should be configured to ensure that they meet the needs of this vulnerable population, as outlined in these documents.

4.2 Health and Wellbeing Strategy

Securing a service for this population fits in with theme 1(Prevention) in the Health and Wellbeing Strategy and priority 3 to "increase the number of people with problematic drug or alcohol use accessing support services through improving referral pathways, raising awareness of services and improving quality and retention of service users". The refresh of the strategy will also need to include actions for drug users in order to address the health inequalities they face.

4.3 Integration

There are no direct implications, although following the reprocurement process Providers will need to ensure that they work effectively with Partners to ensure a seamless transition, particularly through the treatment system.

4.4 Financial Implications

Implications completed by: Roger Hampson Group Manager Finance, Adult and Community Services

This report proposes the reprocurement of Drug Treatment and Prescription Services within the current contractual budget.

The contract period would be from April 2015 to March 2017, with a possible extension to March 2019 and a contract value over the potential four years of approximately £5m.

These services are currently funded by ring fenced Public Health Grant. It has been confirmed that the grant will continue for 2015/16, but the amount available has yet to be announced. Given the uncertainty over the future of the grant, and if the decision is taken to procure services over a four year period, the contracts will need to contain appropriate break clauses if funding ceases.

4.5 Legal Implications

Implications completed by: Daniel Toohey - Principal Corporate Solicitor, Legal and Democratic Services

This report is seeking approval from Health and Wellbeing Board to tender the Contracts noted in the report. Under the Public Contracts Regulations 2006 (the 'Regulations') health care services are classified as Part B Services and therefore are not subject to the full tendering requirements of the Regulations. However in conducting the procurement, the Council still has a legal obligation to comply with the relevant provisions of the Council's Contract Rules and with the EU Treaty principles of equal treatment of bidders, non-discrimination and transparency in conducting the procurement exercise.

Contract Rule 28.8 of the Council's Contract Rules requires that all procurements of contracts that are health and social care related and are above £500,000 in value must be submitted to Health and Wellbeing Board for approval.

In line with Contract Rule 47.15, Health and Wellbeing Board can indicate whether it is content for the Chief Officer to award the contract following the procurement process with the approval of the Chief Financial Officer.

The report author and responsible directorate are advised to keep Legal Services fully informed at every stage of the proposed tender exercise. Legal Services are on hand and available to assist and answer any questions that may arise.

4.6 Risk Management

The following risks have been identified during this process:

Challenges and Risks	**Opportunities and Mitigating Factors**
Lack of controls	Additional information from potential suppliers on controls, checks and balances available to LBBD, to reduce risk of failure to escape drug addiction, and misuse/sale of controlled substances and substitutes
Failure of Service	Competent quality control and evaluation at procurement stage
Failure to reduce costs	Appointment of a strong commercial offering
Internal Resource Issues	Recruit and plan workload accordingly

LBBD can reduce the possibility of unsuitable bids by the use of financial evaluations, and to also weight the award criteria appropriately to emphasise quality and delivery, as seen in the relevant section regarding Quality and Price in 2.8

Qualitative thresholds will be employed in the Procurement process and will be set at the pretender stage.

5. Non-mandatory Implications

5.1 Crime and Disorder

This proposal will if successful, reduce crime and / or disorder and / or Anti Social behaviour, by reducing demand for, and incidences of drug dealing and consequential criminal behaviour to fund addiction. A smaller number of residents that are dependent upon drugs will reduce instances of crime such as prostitution, mugging, burglary, shoplifting, theft etc., and reduce instances of antisocial behaviour such as drug dealing, violence, etc.

5.2 Safeguarding

This proposal will impact upon safeguarding of children through consequence of desired outcomes reducing risk to children as residents / dependents of addicted individuals. Cessation of service will increase risk to children in these circumstances.

This service will support safeguarding adults work across the borough, by merit of working with vulnerable client group and linking in with other commissioned services across adult social care.

5.3 Property/Assets

The proposal will have a neutral impact upon the property or assets.

5.4 Equalities and Customer Impact

As part of the procurement process, potential suppliers will be assessed for adherence to the necessary legislation and regulations, as well as the Council's policies in relation to race, gender, disability, sexuality, faith, age, community impact and cohesion, the Councils legal obligations, objectives, and any other factors, as well as mitigating steps taken where appropriate.

5.6 Staffing issues

TUPE is possible however there are only a limited number of suppliers operating in the borough : any TUPE is considered to affect employees of external suppliers and thus no directly employed Council Staff are considered to be affected at this point.

Background Papers Used in the Preparation of the Report:

1. Public Health England Report : "National Treatment Ageny : Why Invest?" report, September 2013, : http://www.nta.nhs.uk/uploads/whyinvest2final.pdf

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HEALTH & WELLBEING BOARD REPORT

9 SEPTEMBER 2014

Title: Appointment of Approved List of Care Providers for Home Care and Crisis Intervention for Older People and Physical Disabilities	
Report of Corporate Director Adult and Community Services	
Open	**For Decision**
Wards Affected: All Wards	**Key Decision:** No
Report Author: Mark Reed, Category Manager	**Contact Details:** Tel: 020 8227 5481 E-mail: mark.reed@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director Adult and Community Services	

Summary:

The Council provides or arranges care and support in the home through two main routes. Principally, and increasingly, this is through the provision of a personal budget with associated support for the service user to arrange themselves a personal assistant to provide them with flexible, responsive support. In some cases, the Council operates a 'managed personal budget' whereby the Council arranges and pays for the care, delivered through more traditional 'homecare' agencies.

In addition, when people are discharged from hospital, a short-term non-chargeable package of social care support is provided whilst they are settled back into their home and their longer-term needs are assessed. This is crisis intervention (often called in other boroughs 'reablement') and is delivered by homecare agencies contracted by the Council.

The Council wishes to invite homecare agencies to tender for delivery of these services. There will be two specifications to tender against, for homecare and for crisis intervention, and it is expected that an 'approved list' of between 10 and 15 providers will be established, from which individual care packages will be arranged. This report seeks permission to issue that invitation to tender, and delegated authority to conclude the award of contracts.

In the interim, the current provision of services is outside of the Council's contract rules, where the volume of activity with some providers takes them over the thresholds requiring formal tendering. This report also therefore seeks Health & Wellbeing Board permission to waive contract rules in order to continue to provide these essential services whilst the tendering process is run. In all cases, since it is personal care that is being arranged there is justification for the waiving of contract rules in these circumstances.

Recommendation(s)

The Health & Well Being Board is recommended to:

(i) Approve the procurement of Home Care and Crisis Intervention Services, on the terms detailed in the report;

(ii) Delegate authority to the Corporate Director of Adult and Community Services, in consultation with the Chief Finance Officer and Head of Legal & Democratic Services, to award contracts to the successful bidders upon conclusion of the procurement process; and

(iii) Waive the application of the Contract Rules until 31 May 2015, as detailed in the report, on the grounds that these are essential services and of a specialist nature, and to cease them would give rise to an emergency situation.

Reason(s)

The services form part of the Council's statutory obligation to provide social care support under various pieces of legislation, including the National Assistance Act 1948, the Chronically Sick & Disabled Persons Act 1970 and the NHS & Community Care Act 1990. The statutory duties owed by LBBD to provide social care support under the statutes referred to above will remain extant until the Care Act 2014 comes into force in April 2015. The Care Act will extend the duties of a local authority considerably in relation to social care in that it will not only be responsible for those who cannot fund their care but also for those who can. Therefore it is expected that the population to whom duties are owed will increase especially as there is a duty to prevent, reduce and delay the need for services.

Whilst personalisation is a strong element of the services the Council arranges to meet these duties, it will never be the entirety of its service provision, and some provision of crisis intervention and homecare will always be required. The tendering will not commit the Council to purchasing specific volumes from the successful bidders, so will remain flexible to respond to changing demand, either from increased preventive activity, changes in demography, or implications of the Care Act 2014.

The requested waiver is required to ensure that provision can continue whilst a compliant procurement exercise is undertaken to properly scope out the requirement, and establish a suitable long term provision.

1. Introduction and Background

1.1. There are two types of service provided, being:

- **Homecare (or 'domiciliary care')** is a service provided to people in their homes to help them live their daily lives where they have need for care and support. Activities can include getting the service user up or helping them to bed, washing, dressing, meal preparation or prompting medication.
- **Crisis intervention** is the short-term service, for which the Council cannot charge, that follows a service user's discharge from hospital. It is intended to stabilise their situation so that a social care assessment can form a reasonable view of their future care needs. Crisis intervention is intended to last for no more than 6 weeks, but can take any period up to then dependent on the service user's recovery. It is typically provided by homecare agencies, and the result of the assessment process would generally be to

see the service user move into a longer-term care arrangement with a personal budget and support from a personal assistant or other services.

1.2. Personalisation means that there is a decreasing quantity of homecare purchased as part of longer-term care planning by the Council, as people are encouraged to take up a direct payment through which they can arrange and contract their own care directly. However, there are always likely to be some service users for whom the Council must arrange care, albeit that numbers will be more volatile and their needs more specific and diverse.

Current Position

1.3. The Council has recently published its Market Position Statement which sets out the vision for homecare services. The intention is to move towards the use of personal assistants thereby giving more choice and control to clients. The Council does recognise the value of home care agencies at the point of crisis and will still be using the homecare service for this. Home care services will also be used in the transition period to enable client to make an informed choice regarding their personal budgets and the use of personal assistants.

1.4. There are currently 11 suppliers for provision of these services within the borough that are commissioned to provide care in response to individual needs as demand arises. These spot purchasing arrangements are a response to the need to tailor care to service users' particular requirements and caused by unpredictable demand and in crisis intervention circumstances. As a result there is a general consistency of cost, terms and conditions of delivery, and other contractual arrangements; however this is not uniform across all providers.

1.5. 40 purchase orders have been raised totalling £1.33m in value for the provision of these services between 1 April 2014 and 30 August 2014. These purchase orders are for 'blanket' provision of services to multiple service users, often covering multiple cases of individual care for personal requirements to a single supplier. In effect, a large number of contracts for individual care are covered by these orders. Spend is approximately £3.19m per annum.

2. Proposal and Issues

2.1. This report proposes two decisions to be taken, one to establish contracts for the provision of these services from 1 April 2015, the other to waive contract standing orders for the intervening period to ensure that essential services can continue.

Establishing contracts for homecare services for older people

2.2. The proposal is for the Health & Wellbeing Board to delegate authority to the Corporate Director of Adult And Community Services, in consultation with the Chief Finance Officer and Head of Legal & Democratic Services, to reprocure the services described and award contracts for provision in line with regulations, legislation, Council Rules, and best practice.

2.3. The services to be procured are of two types:

a) Crisis Intervention services; and
b) General care and support in the home as and when required.

2.4. The proposal is to prepare and execute a procurement process to a separate specification for each of the two categories of service identified above, which can be bid for separately or together, resulting in a three year contract (with two 12 month extension options) with a total value of up to circa £15.95m over the full contract period.

2.5. The approximate values are as follows:

- **General Care:** £2.5m per annum; however demand is expected to continue to reduce due to increasing numbers of personal budgets;
- **Crisis Intervention:** £1.1m per annum for approx 240,000 hrs care pa.

2.6. The envisaged outcome is for a number of suppliers (approx 10-15), who will hold a contract with no minimum volume or commitment which will allow for change in demand over time. The continued movement of care to personal budgets is expected to reduce demand for the services described is required, as will prevention activity around hospital admissions which should see fewer crisis intervention placements required over time.

2.7. This report proposes an OJEU compliant procurement designed to adhere to the principles of best value, and satisfactory service, additionally with a set of standard terms & conditions that protect the interests of the borough in its relationship with a suitable number of suppliers. The exact number is not known, however it is anticipated that the number of awards will be led by service need in the Borough. In order to ensure the most attractive commercial outcome for LBBD, it is proposed to ask capable suppliers to submit proposals for delivery of the requirement based on quality and cost, with the following steps :

- Pre-Tender preparation and review of the specification and service.
- Advertisement of the requirement on LBBD website for interest, in conjunction with additional activity to ensure that all potential suppliers are aware of the reprocurement (such as trade adverts and direct communication with existing contractors). There is not likely to be much cross border interest, given the nature of the services and the concentrated geographical area of provision required so an OJEU notice may not be placed.
- Issue of Tenders to all interested parties including all existing suppliers.
- Receipt and evaluation of tenders, which would be evaluated on the basis of price, quality, suitability to supply, and other factors.

2.8. The Invitation to Tender will be designed so suppliers will be required to meet minimum quality thresholds that meet the legal and performance requirements of the Council.

2.9. The proposal is to establish a set of legally compliant contracts with performance controls and outcome measurement with a set of suppliers that are able to deliver the requirement efficiently and to a standard of safety and competency. The process will also ensure adherence to a standard set of the Council’s approved terms and conditions.

2.10. The outcome is therefore expected to be :

- The establishment of approx 10-15 contracts with suitable providers within the Borough that meet clear requirements;
- Fixed costs set for contract periods as much as reasonably possible;

- Delivery managed through use of supplier performance monitoring;
- Standardisation of contracts and outputs;
- Clear set of suppliers that meet LBBD standards that can be appointed promptly;
- Benchmark and create transparent, market-competitive pricing that is fixed for contract duration;
- Removal of risk of RPI/CPI-linked uplift in costs which is currently minimum 2.7% per annum: decisions on uplift have to date been made on a case-by-case basis, and this would reduce these risk in any future arrangements.

2.11. In terms of the relationship with the Council's requirement for cost reductions, it is difficult to quantify savings. The benefits of good, established relationships with suppliers are already felt as a small number do benefit from a substantial proportion of the work. More clearly specifying the requirements of crisis intervention, as distinct from general homecare, will help to ensure that quality (and therefore duration, and hence cost) are better monitored and controlled by Commissioning. Savings and cost reduction / controls will be achieved in the following areas :

- Maintaining price of service delivery for contract period (avoiding potential price uplifts)

- Potential cost per hour reduction by establishing long term agreement with providers and potential larger volume of work for some providers

- Standardisation of service outputs and stronger contractual position

2.12. The contract will be awarded on the basis of Most Economically Advantageous Tender. Award Criteria are proposed to be as follows :

- Quality – 60%
- Price – 40%

Both areas will have a minimum acceptable threshold, meaning an acceptable price and minimum quality standard will ensure a balance is achieved. This price weighting indicates the importance of cost to the Council and the contract will be modelled to keenly minimise the cost of delivery whilst maintaining service and flexibility. However, in terms of crisis intervention poor quality provision has the potential to increase costs as the length of the package increases. In the case of both types of provision, poor quality has the potential to lead to costs elsewhere in the social care system, for reassessment or for the provision of additional support services to stabilise failing care arrangements.

2.13. The Qualitative Element will include Method Statements, Interviews, and, if appropriate, Site Visits. Evaluation will be weighted towards successful, timely, local delivery of the programme, quality of performance, flexibility of provision, acceptable working practices, and proximity to the area of delivery. All qualitative responses would be required to meet a minimum quality threshold specified by the client and thus, not be able to underprice and risk quality of delivery.

2.14. The proposed timescale for the procurement is as follows:

- Health & Well Being Board — 9 September 2014
- Tender Preparation to — 30 September 2014

• Place Advert	1 October 2014
• Tender Returns	1 November 2014
• Evaluation (Method Statements, Interviews, etc.) to	Nov- Feb 2015
• Award and Mobilise	February 2015
• Go Live	1 March 2015

3. Waiver of Contract Rules for the remainder of the year

3.1. This report requests Health & Wellbeing Board's approval to waive contract rules and continue provision with the below listed providers for homecare services and crisis intervention care services for an interim period of no more than 9 months (to end of May 2015) to allow this procurement process to conclude. The providers are:

- Genesis Recruitment Agency
- Starcare
- Westminster Homecare
- DABD(uk)
- Ark Home Healthcare
- Outlook Care
- Plan Care
- Rosemont Care
- Sincere Care
- StaffLine Employment Agency

Further providers may be required where demand exceeds the capacity of this group of agencies to meet the need or specialist requirements arise.

3.2. The value of the waiver would be approximately £2.6m, split between two financial years.

3.3. Given the implementation of the new contract rules, this document requests a waiver for a limited period to enable the authority to establish suitable contracts that will establish standard terms for the service provision, control cost, and rationalise the supply base as set out above.

3.4. The work is specialist as it is a complex and demanding provision with rigorous quality standards. Poor quality care is both high risk and very visible, which has recently had a high profile in the media. To perform a satisfactory procurement would take time and require stringent quality checks as the work is not uniform but often tailored for individuals and their needs which are not set and vary over time, and there are risks with a 'one size fits all' approach. It is not possible, and would be a breach of the Council's statutory duties to provide care to meet individuals' needs, were we to cease provision pending the procurement.

4. Options Appraisal

4.1. Continue Existing Arrangement: *This is Not Recommended*. The existing arrangements are not compliant with current Contract Rules in the council, and to extend or continue them would not represent best value or practice. However they should be allowed to continue for enough time to permit a reprocurement of the services.

4.2. Utilise Existing Framework: *This is Not Recommended*. Given the size of spend, there are a number of options, however, none of the existing Frameworks offer any contracts that are able to provide the degree of flexibility that LBBD desires in order to meet the particular needs of individual service users, or do so through local suppliers.

4.3. Create Framework : *Not Recommended.* A framework would require the submission of bids from the contractors on the framework for each package of care, which would not be appropriate given the complexity, and high degree of customisation, required by each recipient of the services, which would have to be tailored on a personal basis for each individual. These requirements also change over time (for example, moving from short notice, intensive Crisis Intervention to longer term treatment and assistance of lower-intensity chronic conditions), and a framework would be too rigid for flexibility required.

4.4. Dynamic Purchasing Systems *Not Recommended.* Given the nature of Dynamic Purchasing Systems, and the varying nature of care and requirements for each individual served by the current arrangements, there is no parity or consistency between any two cases. A Dynamic Purchasing System would struggle to provide the flexibility at short notice required.

4.5. New Procurement Exercise *Recommended.* This will require a full tender process that is compliant with the requirements of the OJEU process at the time of commencement. This is the most practical route to take. There are a number of potential options and the recommended route is to run a Council compliant process that broadly follows the principles of the Open Process without necessarily placing an OJEU advertisement: the ITT will be designed so suppliers will be required to meet minimum qualitative thresholds that meet the legal obligations, statutory requirements, and the Council's aims. Using the principles of the Open process will reduce the minimum timescales to complete the requirement and allow the Borough to deliver on time the requirement.

4.6. These services are Part B Services. As a result they are subject to the applicable procurement processes and regime which will be planned in accordingly. The regulations will change in January 2015, however it is not possible to defer commencement of the Procurement until January 2015, as the new contracts are required to be in place by April 2015. Additionally, the procurement will be executed in compliance with the applicable legislation at the time of commencement. As a result of these being Part B Services, there is not currently a requirement for a full OJEU process, as long as the principles of the process are followed.

5. Financial Implications

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

5.1. The Health and Wellbeing Board at its September meeting is to be asked to approve the procurement strategy set out in this report for the appointment of care providers for home care and crisis intervention. Contracts are proposed to be for three years from 1 March 2015 (with two 12 month extensions), with the likelihood that many individual service users will request access to selected providers through the use of personalised budgets. There will be no minimum volume or commitment to any provider, however the total potential value of these contracts including

personalised budgets is likely to exceed £15m over the five years, based on current activity levels.

5.2. The financial context the Council is facing means that substantial further savings will need to be considered across all service areas including adult social care.

5.3. Home care is a service currently provided following an assessment of need using locally agreed eligibility criteria. However, the introduction of the 2014 Care Act introduces a national minimum threshold for eligibility from April 2015. The Government is currently consulting on the detailed provisions as set out in draft regulations and associated guidance and inviting comments by 15 August 2014.

5.4. Chapter 4 of the Draft Guidance provides guidance on section 5 of the Care Act in relation to market shaping and commissioning of adult care and support. The tender preparation will need to take account of this draft guidance, and to make any further changes when the regulation and guidance are published in their final form later in the year. The guidance stresses that local authorities should commission services having regard to the cost-effectiveness and value for money that the services offer for public funds. Local authorities must also consider how to help foster and enhance the skills of people working in the care sector to underpin effective, high quality services, and have regard to funding available through grants to support the training of care workers in the independent sector.

5.5. When commissioning services, the draft guidance states that local authorities should also assure themselves and have evidence that service providers deliver services through staff remunerated so as to retain an effective workforce. Remuneration should be at least sufficient to comply with the minimum wage legislation, and will include appropriate remuneration for any time spent travelling between appointments.

6. Legal Implications

Implications completed by: Daniel Toohey, Principal Solicitor, Corporate and Commercial Law

6.1. This report is initially seeks approval to waive the requirement to conduct a tender exercise on the grounds that the services to be procured are of a specialist nature. This report proposes that the granting of a waiver would allow for the provision of the Home Care and Crisis Intervention Services by specified providers while a robust procurement exercise is being undertaken.

6.2. Clause 6.3 of the Contract Rules states that approval to waive a Contract Rule must be obtained from Health & Wellbeing Board where the contract value is above £500,000.

6.3. This report is seeking a waiver on the ground that the services to be procured are of a specialist nature. Contract Rule 6.6.2 allows for a waiver to be granted should there be evidence that the service to be procured is of a specialist nature.

6.4. Approval is also sought in this report, for the procurement of the Home Care and Crisis Intervention Services. The Public Contracts Regulations allows local authorities to enter into a contract with a service provider, following a competitive tendering process.

6.5. The services to be procured are Part B services which do not fall within the strict rules of the EU public procurement regulations. Given the high value of the contracts however, consideration must be given to the possibility of there being a cross border interest in the contracts. This possibility has been address in this report.

6.6. The Council, in conducting the procurement, still has a legal obligation to comply with the relevant provisions of the Council's Contract Rules and with the EU Treaty principles of equal treatment of bidders, non-discrimination and transparency in procuring the contracts.

6.7. The report sets out in the proposed tender timetable for the procurement of the services in paragraph 2.13. The report also states in paragraph 2.7(a) that trade adverts will be placed as well as advertisement of the tender on the Council's website. In keeping with the EU Treaty principles noted above it is appropriate that the Council publicises the contract in a manner that would allow any providers likely to be interested in bidding for the contracts identify the opportunity and bid for the contracts should they wish to do so.

6.8. The report also states that tenders will be evaluated on a 60:40 quality:price ratio, and the contracts will be awarded to the most economically advantageous tenders.

6.9. In deciding whether or not to approve the proposed procurement of the contract, Health & Wellbeing Board must satisfy itself that the procurement will represent value for money for the Council.

6.10. The Health & Wellbeing Board is able to delegate authority to the commissioning Corporate Director, in consultation with the Chief Finance Officer, to approve the award of contracts upon conclusion of a duly conducted procurement exercise.

7. Other Implications

7.1. Joint Strategic Needs Assessment

Information contained in the refresh of the Joint Strategic Needs Assessment (JSNA) will assist in understanding the current and future needs and demands of older people and people with physical disabilities. As they are two key vulnerable groups, ensuring adequate and appropriate provision will help address health inequalities in the borough.

7.2. Health and Wellbeing Strategy

The refresh of the Health and Wellbeing Strategy will need to acknowledge the flexible nature of provision demanded by residents.

7.3. Integration

Although there are no direct implications for integration in this report, by having clearer specifications and testing service quality through the tendering process, the Council will be better able to support the Joint Assessment & Discharge arrangements that have been implemented, providing smoother transition for the service user from hospital to homecare.

7.4. **Risk Management**

If the extension of the current contract is not approved it will be necessary to undertake the full Tender process in a much more condensed manner which may reduce the rigour of the process and affect the service provision. However, it is likely there will be a short period which may result in the Council being unable to provide services under contract. The risks of cessation the service would place the Council in breach of obligations and remit – therefore the risks of not approving the waiver outweigh the risks of approval. Risks of approval are that the council would be acting non-compliantly in conjunction with recently introduced internal Contract rules, however there is a strategy to bring current provision into a compliant, best practice environment in a managed process within a set timescale.

7.5. **Contractual Issues**

There are no cohesive or standardised contractual models and the number of suppliers and spend are uncontrolled, such that there are differing levels of service, specifications, standards of delivery, pricing models, and terms and conditions (if any exist). Continued exposure to such risks is not best practice. A reprocurement which would standardise specification, service, outcomes, and place this inside a contract with the optimum number of suppliers would reduce these risks considerably

7.6. **Staffing Issues**

Recipients of these services are often vulnerable and have received individual and tailored care from known persons for extended periods of time. A continuity of staffing would be preferred. It is not anticipated that there are any staffing implications for Council Employees.

7.7. **Customer Impact**

The provision of this service has a direct impact upon the health and wellbeing of residents of the borough through providing assistance and care to residents in need.

7.8. **Safeguarding Children & Vulnerable Adults**

Better quality management of home care services through a more formalised contracting process will ensure that quality concerns are more likely to be acted upon before they escalate to safeguarding concerns.

7.9. **Health Issues**

The provision of the service will improve the economic, social and environmental well being of the Council's area and the lives of the residents, by maintaining and improving the quality of the living environment for Council residents receiving the services, controlling costs and standardizing service which may be received to differing standards and quality.

7.10. **Crime and Disorder Issues**

No foreseen impacts

7.11. **Property / Asset Issues**

Delivery of these services will allow recipients to occupy their own homes for a longer period of time until such time as they may require care in a different environment such as a nursing home.

7.12. **Waiver**

A waiver of the Contract Rules is required for a limited period to enable the authority to establish compliant best practice contracts. In the current circumstances, the nature of the services required are of a specialist and proprietary nature with a limited supply market fulfilling the requirements of rule 6.6.2, and in some circumstances, there is only one supplier capable of fulfilling the requirement known to the Authority, fulfilling requirement 6.6.3.

7.13. Failure to provide this service would also place the Authority in an Emergency Situation as there would be a breach of statutory obligations of the Authority and a failure of the duty of care to safeguard the residents of the borough.

7.14. **Consultation**

The consultation process has included the following:

Consultee	**Name/Title**	**Date consulted**
Portfolio Holder	Mark Tyson (Group Manager, Integration & Commissioning)	May-July 2014
Ward Councillor(s)		
Other Council Bodies		
Corporate Directors		
Other required Officer(s)	Tudur Williams (Group Manager, Assessment and Care Planning) Susanne Knoerr (Project Manager, Personalisation)	May-July 2014 May-July 2014
Statutory/Proper Officer		
Others (Specify)	Martin Storrs (Head Of Procurement) Mark Reed (Category Manager, Procurement)	May-July 2014

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

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title: Health and Wellbeing Outcomes Framework Performance Report – Quarter 1 (2014/15)	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Mark Tyrie, Public Health Scientist	**Contact Details:** Tel: 020 8227 3914 Email: mark.tyrie@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

Performance reporting to the board is developed from the Health and Wellbeing Outcomes Framework, which sets out the indicators by which Health and Wellbeing is assessed in the borough. Originally a summary of these indicators representing the overall aims of the Outcomes Framework was reported quarterly to the board. In July 2014, a new process and format for performance reporting, including a wider selection of indicators from within the more comprehensive Outcomes Framework agreed in 2012, was agreed. The choice of indicators is designed to provide an overview and more detailed monitoring of areas of concern. This report follows the format of the Quarter 4 2013/14 report, which was the first report using the new format.

As with the 2013/14 Quarter 4 performance report, unplanned admissions for ambulatory care sensitive is highlighted as an area of poor performance, although new data is not due for release until September. Chlamydia screening, which was highlighted as an area of concern previously has seen an improvement, meeting its monthly target for June. Teenage Conceptions in the borough continue to fall, with the gap between the relatively high Barking and Dagenham rate and the national average narrowing to the closest it has been over the last five years.

Childhood immunisations and cancer screening both continue to perform better than regional averages, but provisional childhood obesity figures indicate an increase in those that are overweight or obese. There has also been an increase in the rate of tuberculosis cases in the borough.

Updates are provided on the performance of the numbers of four week smoking quitters, delayed transfers of care, injuries due to falls, and breastfeeding.

An update is also given to the board on published reports from the Care Quality

Commission (CQC) inspections in the quarter and also how CQC Social Care Inspection reports will be reported in future when the new system is implemented in October 2014.
Recommendation(s) Members of the Board are recommended to: • Review the overarching dashboard, and raise any questions to lead officers, lead agencies or the chairs of subgroups as Board members see fit. • Note the further detail provided on specific indicators, and to raise any further questions on remedial actions or actions being taken to sustain good performance.
Reason(s) The dashboard was chosen to represent the wide remit of the Board, but to remain manageable. It is important, therefore, that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking further monitoring across the wider range of indicators in the Health and Wellbeing Outcomes Framework and, when areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

1. Background

1.1. The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity.

1.2. In July 2014, a new process and format for performance reporting, including a selection of indicators from within the more comprehensive Outcomes Framework agreed in 2012, was agreed. The choice of indicators is designed to provide an overview and more detailed monitoring of areas of concern. This report follows the format introduced in the Quarter 4 2013/14 report.

1.3. The indicators contained within the report have been rated according to their performance, measured against targets and national and regional averages, with red indicating poor performance, green indicating good performance and amber showing that performance is similar to expected levels.

1.4. The performance report for 2013/14 Q4, which is not presented to the board here, has been reviewed by Councillor Worby, and areas of poor performance have been noted. The full report is available upon request.

2. Overview of performance in Quarter 1

2.1. **Appendix A** contains a dashboard summary of performance in Q1 2014/15 against the indicators selected for the Board in July 2014.

3. Data availability and timeliness of indicators chosen

3.1. As mentioned in previous reports, there continues to be substantial gaps in monitoring information due to indicators being on annual cycles or having significant delays in the data becoming available. Difficulties remain in data flows to Public Health from parts of the NHS; however, issues are close to being resolved, particularly in relation to access to Hospital Episodes Statistics data.

4. Areas of concern

4.1. **Appendix B** contains detailed sheets for areas of concerning performance highlighted this quarter, as below.

4.2. **Indicator 21: Emergency admissions for ambulatory care sensitive conditions**

Although performance has shown signs of improvement over the last two quarters, decreasing from a high of 1,202.1 per 100,000 population in 2013/14 Q1 to 1,108.1 per 100,000 population in Q3, the rate remains far in excess and statistically significantly higher than both national and regional averages, which are both more than 400 admissions per 100,000 population below than Barking and Dagenham's figure.

5. Areas of Improved Performance

5.1. **Appendix B** also contains detailed sheets for areas of improved performance highlighted this quarter, as below.

5.2. **Indicator 7: Under 18 conception rate**

The most recent figures for under 18 conceptions, from 2012/13 quarter 4, show that Barking and Dagenham is continuing the decrease seen in the borough since 2010/11. The gap between Barking and Dagenham's relatively high rate and the national and regional averages has also greatly narrowed over the last year and is now the closest it has been over the course of the last five years.

5.3. **Indicator 8: Number of positive Chlamydia screening tests**

Quarter 1 has seen an upturn in the number of positive screenings, with the quarterly figure only five below target. June's count of 54 is the highest single month figure since June 2012 and is the first time a monthly target has been met since May 2012, representing real progress.

Performance had been below target for this indicator over the course of the last financial year but work has been done with the provider (Terrence Higgins Trust) to address the shortfall in performance and also to ensure that Chlamydia testing will be part of the new Integrated Sexual Health procurement. Targets have also been adjusted to a more realistic and attainable figure.

6. Further highlighted areas

6.1. Indicators 1 & 2: Childhood Immunisations

Barking and Dagenham continues to have childhood immunisation coverage that is higher than the London average for both two doses of MMR (81.7%), and DTaP (82.4%) at five years of age. Barking and Dagenham also performs better than neighbouring boroughs, although coverage levels remain below that required to achieve herd immunity.

6.2. Indicators 3 & 4: Childhood Obesity

Provisional figures from the NCMP for 2013/14 show a slight increase in Barking and Dagenham's proportion of both 5 and 11 year olds that are overweight or obese. Local figures cannot be contextualised against London or England figures until these are released in the finalised data set in December 2014.

6.3. Indicator 9: Four week smoking quitters

There were 1,174 four week smoking quitters in Barking and Dagenham in 2013/14, which was below the target set for the provider. The provider of the smoking contract has changed and the data system through which the number of quitters is reported is still in development. As such, numbers for quarter 1 will only include those that have quit through GPs and pharmacies, but will be updated to include those who have quit through the commissioned provider once data systems are fully operational. At present, 169 people are recorded as having quit in quarter one.

The rate of smoking related deaths has reduced from 404.3 per 100,000 population aged 35 and over in 2009/11 to 386.0 per 100,000 in 2010-12, but remains significantly worse than the England average (291.9 per 100,000)[1].

6.4. Indicators 10 & 12: Cancer Screening

The borough has a slightly higher proportion of the eligible population that are adequately screened for both cervical and breast cancer than regional averages, with 74.9% and 68.7% screened, respectively. These figures are, however, below national averages.

6.5. Indicator 15: Injuries due to falls

Although new data is not available for injuries due to falls for 2013/14, a recently released briefing by PHE (Public Health England) London on the Public Health Outcomes Framework[2] highlighted that injuries due to falls is one of five priority

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[1] http://www.tobaccoprofiles.info/profile/tobacco-control/data#gid/1000110/pat/6/ati/102/page/0/par/E12000007/are/E09000002

areas in the region due to the rate being significantly worse than the national average and showing a worsening trend between 2010/11 and 2012/13. This indicator was selected as one of Barking and Dagenham's Better Care Fund indicators and will be a key indicator moving forward.

6.6. Indicators 17 & 18: Delayed transfers of care

In 2014/15 Q1, a total of 500 days were lost due to our residents having delayed transfers of care (DTOC), of which 285 were reported to be the responsibility of the NHS, 55 were reported to be the responsibility of Social Care and the remaining 160 were jointly the responsibility of both.

Rates for both total delayed transfers of care and social care responsible transfers of care are below national and regional averages.

6.7. Breastfeeding

Due to data validation issues since the breastfeeding reporting system was changed in 2013, it is difficult to compare performance to previous years, and caution should be exercised when doing so. In 2013/14, 2,022 infants out of 4,350 (46.5%) recorded maternities were either partially or wholly breastfed at their 6-8 week check. This compares to 1,948 infants out of 3,711 (52.5%) recorded maternities in 2012/13 that were wholly or partially breastfed. Although this appears to indicate a fall in the percentage of mothers that are breastfeeding, the lack of data validation makes it difficult to draw sure conclusions.

6.8. Tuberculosis

The recently published 2014 PHE Health Profiles showed that the rate per 100,000 of people with new cases of TB has worsened from 35.0 in 2012 to 37.3 in 2013. This is significantly worse than the England value of 15.1 per 100,000 population and represents 76 new cases in the borough that were reported to PHE in 2013.

7. Summary of the Local Health Economy

7.1. During Quarter 1 2014/15 the local CCGs have continued to function effectively and have settled into the role of Health System Leadership. They are continuing to pursue a transformation agenda for the local health economy but are also successfully holding the local providers to account for their performance.
The GP federations are now progressing at pace and will be delivering additional access for local residents from late in the second quarter of 2014/15. This is a significant step forward in the development of primary care.

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[2] Public Health Outcomes Framework update August 2014 London Briefing, London Knowledge and Intelligence Team

7.2. In secondary care Barking, Havering and Redbridge University Hospitals NHS Trust have appointed Matthew Hopkins as their new permanent CEO and Steve Russell as his Deputy. Other leadership positions have been recruited to and individuals will start in post during Quarter 2 and Quarter 3. Whilst performance has yet to improve, the new team have identified and articulated a clearer diagnosis of the problems and have started to address the root causes. They have developed and approved, with local support, an 'Improvement Plan'. Implementation has already commenced and progress is being made. We are following developments closely and will continue to do so.

7.3. North East London NHS Foundation Trust, as the mental health and community services provider, continues to perform well and is financially secure. There is a joint programme in place with the local CCGs to review the detailed performance of these local services.

7.4. There are developments occurring nationally which are relevant to the local area. Commissioning of primary care and specialised services is being reviewed with the potential for additional local commissioning by CCGs to be the result. We will update on developments once the likely outcomes become clearer.

8 CQC Inspections in Quarter 1 2014/15

8.1 **Appendix C** contains an overview of overview of investigation reports published during the period on providers in the London Borough of Barking and Dagenham, or who provide services to residents in the borough.

8.2 During this period 7 reports were published on local organisations. Of these, 4 met all required standards set by CQC. The following list outlines the remaining three organisations with the standards they failed to meet

8.3 Sahara Parkside Limited, Standards 1, 2, 3, 4, 5 not met:

Treating people with respect and involving them in their care. (Consent to care and treatment)

Providing care, treatment and support that meets people's needs (Care and welfare of people who use services)

Caring for people safely and protecting them from harm (Safeguarding people who use services from abuse & Management of medicines)

Staffing (Requirements relating to workers)

Quality and suitability of management (Assessing and monitoring the quality of service provision, Notification of other incidents & Records)

8.4 Havilah Prospects Limited, Standard 5 not met:

Quality and suitability of management (People's personal records, including medical records, should be accurate and kept safe and confidential)

8.5 Laburnum Health Centre, Standards 1, 2 and 5 not met:

Treating people with respect and involving them in their care. (Respecting and involving people who use services)

Providing care, treatment and support that meets people's needs (Care and welfare of people who use services)

Quality and suitability of management (Complaints)

Since the inspection reports were published, Sahara Parkside has been re-inspected and are now meeting the standards expected.

9. Changes to CQC Social Care Inspections

9.1 The CQC are changing the way in which they carry out inspections. They will be carrying out a mixture of both announced and unannounced inspections, aiming to get to the heart of patients' experiences. The new inspection regime comes into force in October 2014 for Adult Social Care, however changes are already in effect for Hospitals and GPs.

9.2 Their aim is to look at the quality and safety of the care provided based on the things that matter to people. They will look at whether the service is;

- Safe.
- Effective.
- Caring.
- Responsive to people's needs.
- Well-led.

9.3 With this approach CQC plan to have a richer and broader understanding of the quality of services provided, they will also comment on new areas around leadership and governance. The teams undertaking the inspections will be led by an experienced CQC manager and be chaired by a senior NHS clinician or executive.

9.4 They will always include professional and clinical staff, experts by experience, patients and carers.

9.5 Whist undertaking inspections the CQC will gather evidence whether or not the service is meeting the five areas above by;

- Speaking with people who use services, as well as their carers and

advocates.

- Holding focus groups with staff and people who use services.
- Observing care.
- Interviewing key members of the senior management team and staff of all levels.
- Visiting certain services out of hours and unannounced.

9.6 Once the inspections have been undertaken and decisions have been made the CQC will publish reports which clearly set out their judgments and the evidence used to make these. Where there are concerns and it is deemed necessary the CQC will take enforcement action against the service

9.7 Quality summits will be held with the service and local partners and the local Healthwatch which submitted information; these summits will give all parties the opportunity to hear about the findings of the inspection and to focus on the next steps needed for the service to improve. The CQC will publish their data packs and inspection reports on the CQC website the day after the quality summit.

10. Mandatory implications

10.1 Joint Strategic Needs Assessment

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

10.2 Health and Wellbeing Strategy

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

10.3 Integration

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

10.4 Legal implications

There are no direct legal implications at this stage, but a robust and efficient system must be embedded.

10.5 Financial implications

There are no financial implications directly arising from this report.

11. List of Appendices:

Appendix A: Performance Dashboard

Appendix B: Detailed overviews for indicators highlighted in the report as being in need of improvement and detailed overviews for indicators highlighted in the report as performing particularly well.

Appendix C: Overview of CQC Inspections published in Quarter 1 2014/15 on providers in the London Borough of Barking and Dagenham.

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Key

Appendix A: Indicators for HWBB - 2014/15 Q1

Key	Meaning
(grey)	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
(yellow)	Data missing and requires updating
(pink)	Provisional end of year figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

Title	2012/13	2013/14				2013/14	2014/15	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1			England Average	London Average		
1 - Children													
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	85.5%	83.8%	85.4%	82.4%	82.4%	..	..	→	A	89.0%	78.8%	1	PHOF
Year end figures not yet published. Data is published each quarter but when the full year figures are published they adjust for errors in the quarterly data and comprise all the children immunised by the relevant birthday in the whole year. 2014/15 Q1 data due to be published September 2014.													
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	85.0%	83.8%	85.5%	80.9%	81.7%	..	..	→	A	88.5%	80.2%	2	PHOF
Year end figures not yet published. 2014/15 Q1 data due to be published September 2014.													
Prevalence of children in reception year that are obese or overweight	25.9%					**26.9%**	..	↘	A	22.2%	23.0%	3	PHOF
2013/14 data due to be finalised December 2014.													
Prevalence of children in year 6 that are obese or overweight	40.1%					**42.1%**	..	↘	A	33.3%	37.4%	4	PHOF
2013/14 data due to be finalised December 2014.													
Number of children and young people accessing Tier 3/4 CAMHS services	879	592	627	589	596	1,053	528	↘	NC			5	HWBB OF
Year end figure is the number of unique people accessing CAMHS over the course of the year.													
Annual health check Looked After Children	71.2%	62.9%	69.2%	86.0%	93.4%	93.4%	..	↗	G	84.3%	88.1%	6	HWBB OF
2 - Adolescence													
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	33.1	..	..	..	..	..	..	↘	A	26.0	23.8	7	PHOF
	-37.9%	..	..	..	..	..	..			-44.2%	-53.4%		
Number of positive Chlamydia screening results	585	126	147	127	111	511	141	↗	A			8	HWBB OF
Please note that a higher number is considered to be good performance as the goal is to find an increased number of people with an under-reported condition.													
3 - Adults													
Number of four week smoking quitters	1480	431	325	233	185	1,174	169	→	A			9	HWBB OF
Please not that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.													

* Data from 2011/12

Key

Appendix A: Indicators for HWBB - 2014/15 Q1

Key	Description
(grey)	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
(yellow)	Data missing and requires updating
(pink)	Provisional end of year figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

										BENCHMARKING			
Title	2012/13	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2013/14	2014/15 Q1	DoT	RAG Rating	England Average	London Average	HWBB No.	Reported to
Cervical Screening - Coverage of women aged 25 -64 years	69.4%					..	..	↘	A	73.9%	68.6%	10	PHOF
Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31st March													
Percentage of eligible population that received a health check in last five years	10.0%	1.9%	3.5%	3.4%	2.6%	11.4%	1.7%	↘	A	1.9%	2.1%	11	PHOF
Please note that annual figures are a cumulative figure accounting for all four previous quarters.													
4 - Older Adults													
Breast Screening - Coverage of women aged 53-70 years	68.7%					..	..	→	A	76.3%	68.6%	12	PHOF
Percentage of women whose last test was less than three years ago - 2013/14 end of year figures due to be released 27 February 2015.													
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	879.1					696.8	240.1	↘	NC	668.4	463.9	13	BCF/ASCOF
Year end figure will represent the sum of the four quarter figures. Rate per 100,000 population													
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	91.5%					88.3%		↘	A	81.9%	87.8%	14	BCF/ASCOF
Injuries due to falls for people aged 65 and over	2336.0					..	..	↘	A	2011.0	2242.0	15	BCF/PHOF
Directly age-sex standarised rate per 100,000 poulation over 65 years. Unable to calculate more recent figures due to lack of access to HES data.													
5 - Across the Lifecourse													
The percentage of people receiving care and support in the home via a direct payment	42.1%	59.2%	66.6%	71.1%	73.4%	73.4%	74.7%	↗	G	62.1%	67.4%	16	ASCOF
Delayed transfers of care from hospital	3.0					5.5	4.2	↘	G	9.7	6.9	17	ASCOF
Rate per 100,000 population (average per month)													
Delayed transfers due to social care	2.4	0.8	1.1	1.2	1.1	1.1	2.22	↗	G	3.1	2.3	18	ASCOF
Rate per 100,000 population (average per month)													

* Data from 2011/12

Key

Appendix A: Indicators for HWBB - 2014/15 Q1

Key	Description
(grey)	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
(yellow)	Data missing and requires updating
(pink)	Provisional end of year figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

Title	2012/13	2013/14				2013/14	2014/15	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1			England Average	London Average		
Emergency readmissions within 30 days of discharge from hospital	13.3%*	..	..	..	..	..	..	→	A	11.8%	11.8%	19	PHOF
Percentage of emergency admissions occurring within 30 days of the last, previous discharge after admission, Indirectly standardised rate - 2011/12 is most recent data and was published in March 2014.													
A&E attendances < 4 hours from arrival to admission, transfer or discharge	84.1%	88.9%	90.5%	88.4%	86.6%	88.8%	85.6%	→	A	95.2%		20	HWBB OF
BHRUT Figure													
Emergency admissions for ambulatory care sensitive conditions	1193.9	1202.1	1163.2	1108.1	..	..	..	↘	R	780.0	745.4	21	HWBB OF
DSR per 100,000 population, rolling 12 month average. i.e. 2013/14 Q3 is January 2013 - December 2013. 2013/14 Q4 due to be published September 2014.													

* Data from 2011/12

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Appendix B – Detailed overview of selected indicators

Health and Wellbeing Board Performance Indicators **Admissions due to Ambulatory Care Sensitive Conditions**		**Source: Health and Social Care Information Centre**	August 2014 **Date: 08/14**
Definition	Directly age and sex standardised rate of unplanned hospitalisation admissions for chronic ambulatory care sensitive conditions, directly standardised rate (DSR) for all ages per 100,000 registered patients.	**How this indicator works**	The numerator is Continuous Inpatient Spells (CIPS). The CIP spells are constructed by the HSCIC HES Development team. The denominator is Unconstrained GP registered population counts by single year of age and sex from the NHAIS (Exeter) Systems; extracted annually on 1 April for the forthcoming financial year
What good looks like	For the number per 100,000 population to be as low as possible, indicating that long term conditions are being effectively managed without the need for hospital admission.	**Why this indicator is important**	The indicator is intended to measure effective management and reduced serious deterioration in people with ACS conditions. Active management of ACS conditions such as COPD, diabetes, congestive heart failure and hypertension can prevent acute exacerbations and reduce the need for emergency hospital admission.
History with this indicator	2010/11: 1,042.9 per 100,000 population 2011/12: 1,122.9 per 100,000 population		

	2010/11	2011/12	2012/13
B&D	**1,042.9**	**1,122.9**	**1,193.9**
London	**737.0**	**764.1**	**811.3**
England	**775.9**	**765.8**	**802.8**

Unplanned admissions due to ambulatory care sensitive conditions

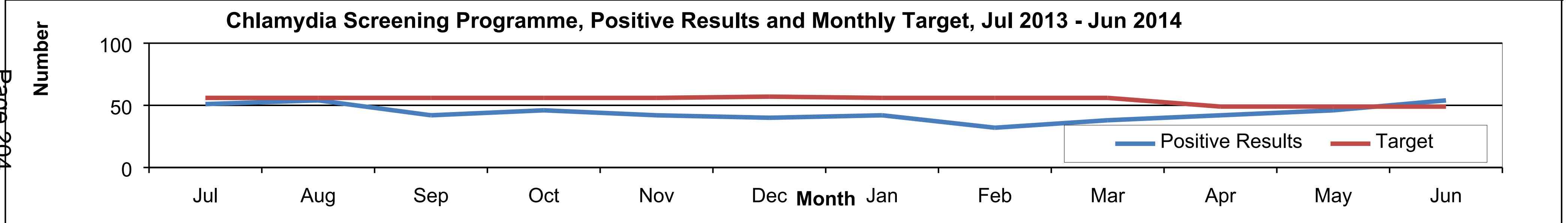
Performance Overview	Barking and Dagenham's rate has been increasing over the last three years, remaining significantly higher than both the national and regional averages throughout this time.	**Actions to sustain or improve performance**	Recommended actions to improve on this indicator include: disease management and support for self-management, , behavioural change programmes to encourage patient lifestyle change, increased continuity of care with GP, ensuring local, out-of-hours primary care arrangements are effective for those with acute exacerbations and ensuring there is easy access to urgent care without hospital admission unless clinically appropriate.
RAG Rating			
Benchmarking	London 2012/13: 811.3 England 2012/13: 802.8		

Health and Wellbeing Board Performance Indicators — August 2014

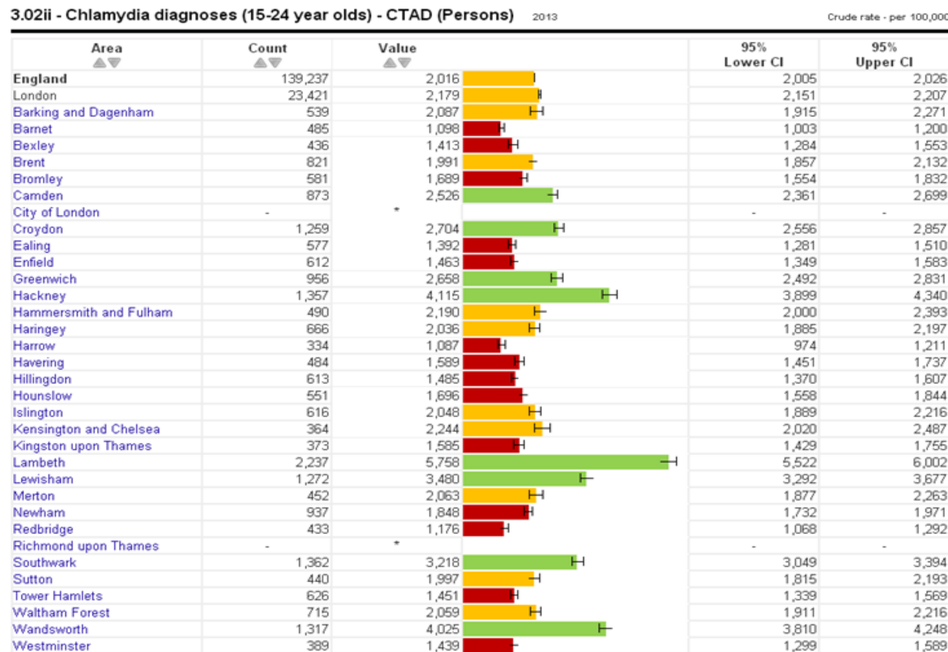
Chlamydia Screening Programme — **Source: Terrence Higgins Trust** — **Date: 08/14**

Definition	Number of positive tests for Chlamydia among those aged 15-24.	**How this indicator works**	This indicator is reported monthly by the Terrence Higgins Trust, who provide numbers screened and testing positive for Chlamydia.
What good looks like	The number of positive results to be greater than target levels on a monthly basis.	**Why this indicator is important**	Chlamydia is the most commonly diagnosed sexually transmitted bacterial infection among young people under the age of 25. The infection is often symptomless but if left untreated can lead to serious health problems including infertility in women.
History with this indicator	2011/12: 587 positive results. 2012/13: 585 positive results against target of 726.		

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Positive Results	46	48	37	45	42	40	42	32	38	42	46	54
Target	56	56	56	56	56	56	56	56	56	49	49	49
Quarterly		Quarter 2	131/168		Quarter 3	127/168		Quarter 4	112/168		Quarter 1	142/147



Performance Overview / **RAG Rating**	Quarter one has seen an upturn in the number of positive screenings, with the quarterly figure only five below target. June's count of 54 is the highest single month figure since June 2012 and is the first time a monthly target has been met since May 2012, representing real progress.	**Actions to sustain or improve performance**	The new Health Services Liaison Officer for Barking and Dagenham has been contacting all GPs and pharmacies in order to promote and publicise the Chlamydia testing and results service. The aim is to increase Chlamydia screening activity and we will be following up all the practices and pharmacies visited monthly to monitor and assess the impact and effectiveness of the training. Additionally, large group joined up training sessions on Chlamydia testing and c-card will be run for pharmacies covering pharmacists and counter staff across the rest of the year, starting in Q2
Benchmarking	The annual positivity rate was 2,395 per 100,000 population aged 15-24 years in 2011/12 whilst the 2012/13 rate for positivity was 2,390 per 100,000 population aged 15-24 years. In 2013/14 the rate was 2,084 per 100,000 15-24 year olds.		



Benchmarked against goal: <1,900 | 1,900 to 2,300 | ≥2,300

3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD (Persons) 2013 — Crude rate - per 100,000

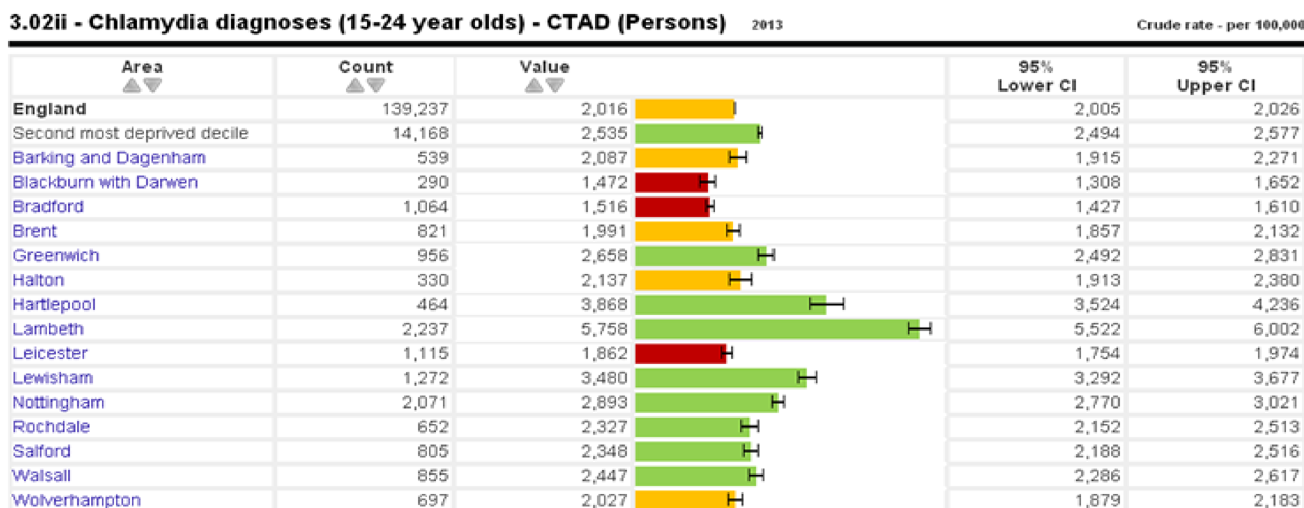
Area	Count	Value	95% Lower CI	95% Upper CI
England	139,237	2,016	2,005	2,026
London	23,421	2,179	2,151	2,207
Barking and Dagenham	539	2,087	1,915	2,271
Barnet	485	1,098	1,003	1,200
Bexley	436	1,413	1,284	1,553
Brent	821	1,991	1,857	2,132
Bromley	581	1,689	1,554	1,832
Camden	873	2,526	2,361	2,699
City of London	-	*	-	-
Croydon	1,259	2,704	2,556	2,857
Ealing	577	1,392	1,281	1,510
Enfield	612	1,463	1,349	1,583
Greenwich	956	2,658	2,492	2,831
Hackney	1,357	4,115	3,899	4,340
Hammersmith and Fulham	490	2,190	2,000	2,393
Haringey	666	2,036	1,885	2,197
Harrow	334	1,087	974	1,211
Havering	484	1,589	1,451	1,737
Hillingdon	613	1,485	1,370	1,607
Hounslow	551	1,696	1,558	1,844
Islington	616	2,048	1,889	2,216
Kensington and Chelsea	364	2,244	2,020	2,487
Kingston upon Thames	373	1,585	1,429	1,755
Lambeth	2,237	5,758	5,522	6,002
Lewisham	1,272	3,480	3,292	3,677
Merton	452	2,063	1,877	2,263
Newham	937	1,848	1,732	1,971
Redbridge	433	1,176	1,068	1,292
Richmond upon Thames	-	*	-	-
Southwark	1,362	3,218	3,049	3,394
Sutton	440	1,997	1,815	2,193
Tower Hamlets	626	1,451	1,339	1,569
Waltham Forest	715	2,059	1,911	2,216
Wandsworth	1,317	4,025	3,810	4,248
Westminster	389	1,439	1,299	1,589

Source: Public Health England

As can be seen on the left, Barking and Dagenham has a Chlamydia diagnosis rate for 15-24 year olds that is statistically similar to the London average.

When compared to other London boroughs, Barking and Dagenham is performing better than most, ranking 11th out of 33 London Boroughs.

Out of the four London Boroughs that are classified as ‘statistical neighbours’ (Brent, Greenwich, Lambeth and Lewisham), three are far outperforming Barking and Dagenham, with only Brent failing to meet the nationally set target of 2,300 diagnoses per 100,000 population.



3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD (Persons) 2013 — Crude rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	139,237	2,016	2,005	2,026
Second most deprived decile	14,168	2,535	2,494	2,577
Barking and Dagenham	539	2,087	1,915	2,271
Blackburn with Darwen	290	1,472	1,308	1,652
Bradford	1,064	1,516	1,427	1,610
Brent	821	1,991	1,857	2,132
Greenwich	956	2,658	2,492	2,831
Halton	330	2,137	1,913	2,380
Hartlepool	464	3,868	3,524	4,236
Lambeth	2,237	5,758	5,522	6,002
Leicester	1,115	1,862	1,754	1,974
Lewisham	1,272	3,480	3,292	3,677
Nottingham	2,071	2,893	2,770	3,021
Rochdale	652	2,327	2,152	2,513
Salford	805	2,348	2,188	2,516
Walsall	855	2,447	2,286	2,617
Wolverhampton	697	2,027	1,879	2,183

Source: Public Health England

The chart on the left compares Barking and Dagenham to its statistical neighbours, which are defined as being the local authorities that are in the second most deprived decile nationally.

When compared to these similar areas, Barking and Dagenham has a significantly lower rate of Chlamydia diagnoses, with only five other boroughs having a lower diagnosis rate.

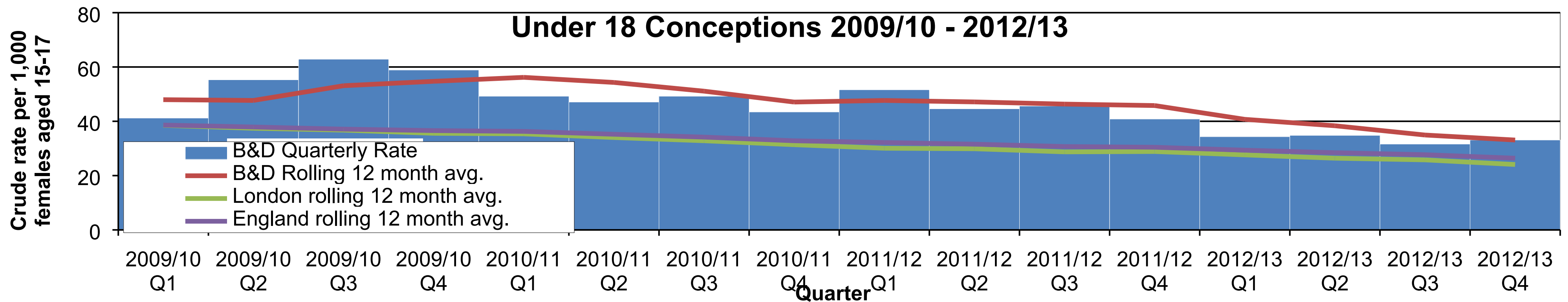
This shows that boroughs with similar levels of deprivation are successfully screening more of the right people in the target group than Barking and Dagenham, and that while the majority of similar boroughs are meeting the nationally set target of 2,300 diagnoses per 100,000 population, Barking and Dagenham is behind its statistical neighbours.

Health and Wellbeing Board Performance Indicators August 2014

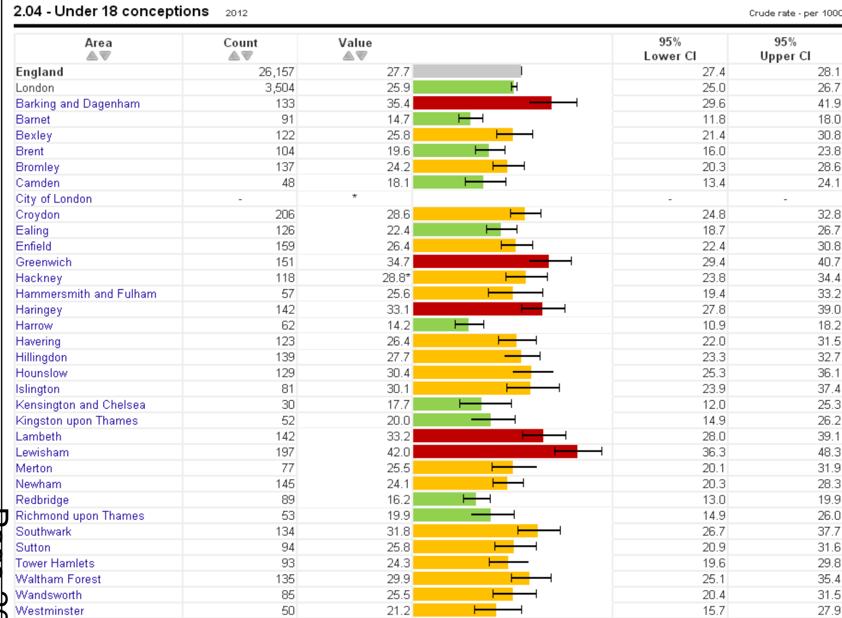
Teenage Conceptions **Source: Office for National Statistics** **Date: 03/14**

Definition	Conceptions in women aged under 18 per 1,000 females aged 15-17.	**How this indicator works**	This indicator is reported annually by the Office for National Statistics and refers to pregnancy rate among women aged below 18.
What good looks like	For the number of under 18 conceptions to be as low as possible, with the gap to regional and national averages narrowing.	**Why this indicator is important**	Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.
History with this indicator	2009: 54.7 per 1,000 women aged 15-17 years 2010: 54.9 per 1,000 women aged 15-17 years		

	2010/11 Q2	2010/11 Q3	2010/11 Q4	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4
B&D Quarterly Rate	47.08	49.22	43.40	51.60	44.50	45.40	40.80	34.30	34.80	31.6	33.1
B&D Rolling 12 month avg.	54.31	51.10	47.08	47.67	47.13	46.33	45.80	40.72	38.35	34.94	33.10
London rolling 12 month avg.	34.02	32.83	31.37	30.07	29.88	28.74	28.87	27.62	26.41	25.79	24.08
England rolling 12 month avg.	35.22	34.17	32.82	32.18	31.58	30.70	30.43	29.36	28.43	27.69	26.41



Performance Overview	The rate of under 18 conceptions is showing a generally decreasing trend, with the quarterly-rolling annual average falling from 56.2 at the start of 2011-12 to 33.2 in 2012/13 Q4. The gap between B&D and the regional and national averages is also narrowing.	**Further Actions & comments**	Barking and Dagenham remains above the national and London averages (26.4 and 24.1 per 1,000 respectively), who both saw a continued decline in their conception rate.
RAG Rating			
Benchmarking	In 1998 (baseline year), there were 156 conceptions reported among 15-17 year old women in Barking and Dagenham. This was an equivalent of 55 per 1,000 births. See overleaf for further benchmarking information.		



Compared with benchmark: Better Similar Worse Lower Similar Higher Not compared

2.04 - Under 18 conceptions 2012 — Crude rate - per 1000

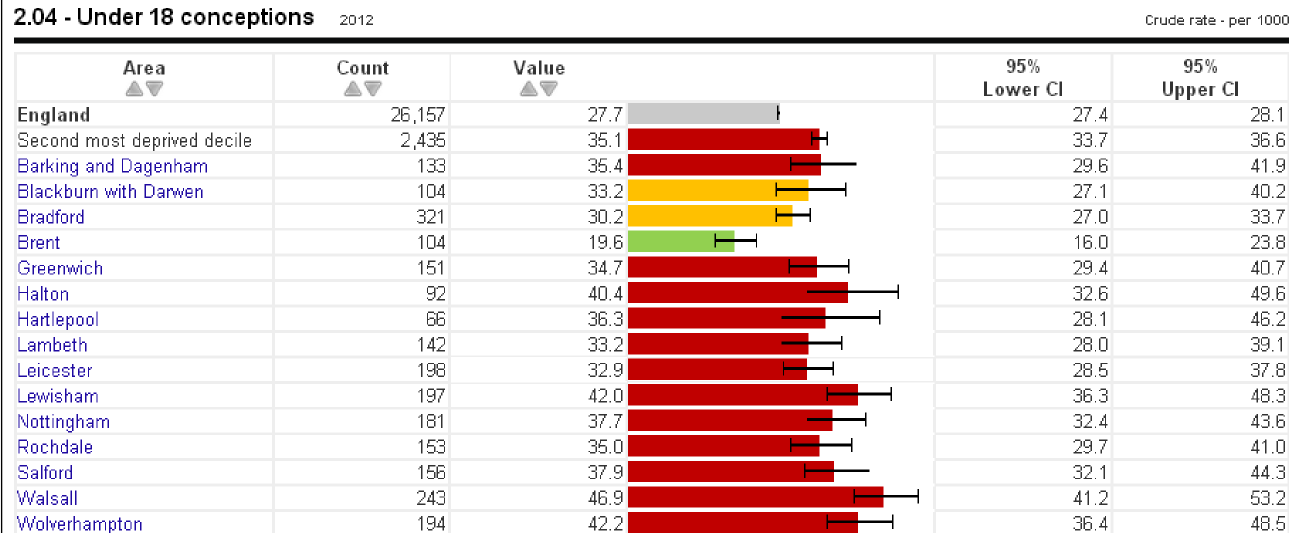
Area	Count	Value	95% Lower CI	95% Upper CI
England	26,157	27.7	27.4	28.1
London	3,504	25.9	25.0	26.7
Barking and Dagenham	133	35.4	29.6	41.9
Barnet	91	14.7	11.8	18.0
Bexley	122	25.8	21.4	30.8
Brent	104	19.6	16.0	23.8
Bromley	137	24.2	20.3	28.6
Camden	48	18.1	13.4	24.1
City of London	-	*	-	-
Croydon	206	28.6	24.8	32.8
Ealing	126	22.4	18.7	26.7
Enfield	159	26.4	22.4	30.8
Greenwich	151	34.7	29.4	40.7
Hackney	118	28.8*	23.8	34.4
Hammersmith and Fulham	57	25.6	19.4	33.2
Haringey	142	33.1	27.8	39.0
Harrow	62	14.2	10.9	18.2
Havering	123	26.4	22.0	31.5
Hillingdon	139	27.7	23.3	32.7
Hounslow	129	30.4	25.3	36.1
Islington	81	30.1	23.9	37.4
Kensington and Chelsea	30	17.7	12.0	25.3
Kingston upon Thames	52	20.0	14.9	26.2
Lambeth	142	33.2	28.0	39.1
Lewisham	197	42.0	36.3	48.3
Merton	77	25.5	20.1	31.9
Newham	145	24.1	20.3	28.3
Redbridge	89	16.2	13.0	19.9
Richmond upon Thames	53	19.9	14.9	26.0
Southwark	134	31.8	26.7	37.7
Sutton	94	25.8	20.9	31.6
Tower Hamlets	93	24.3	19.6	29.8
Waltham Forest	135	29.9	25.1	35.4
Wandsworth	85	25.5	20.4	31.5
Westminster	50	21.2	15.7	27.9

Source: Office for National Statistics (ONS)

Higher Not compared

As can be seen in the data on the left, which is from the Public Health Outcomes Framework using figures for the 2012 calendar year rather than the quarterly figures seen on the previous page, Barking and Dagenham has a higher rate of teenage conceptions than the majority of London Boroughs, with only Lewisham having a higher rate in the region.

Barking and Dagenham has a rate that is significantly higher than both the London and England averages, although the borough's rate is decreasing at a faster rate than London and England's.



2.04 - Under 18 conceptions 2012 — Crude rate - per 1000

Area	Count	Value	95% Lower CI	95% Upper CI
England	26,157	27.7	27.4	28.1
Second most deprived decile	2,435	35.1	33.7	36.6
Barking and Dagenham	133	35.4	29.6	41.9
Blackburn with Darwen	104	33.2	27.1	40.2
Bradford	321	30.2	27.0	33.7
Brent	104	19.6	16.0	23.8
Greenwich	151	34.7	29.4	40.7
Halton	92	40.4	32.6	49.6
Hartlepool	66	36.3	28.1	46.2
Lambeth	142	33.2	28.0	39.1
Leicester	198	32.9	28.5	37.8
Lewisham	197	42.0	36.3	48.3
Nottingham	181	37.7	32.4	43.6
Rochdale	153	35.0	29.7	41.0
Salford	156	37.9	32.1	44.3
Walsall	243	46.9	41.2	53.2
Wolverhampton	194	42.2	36.4	48.5

Source: Office for National Statistics (ONS)

The chart on the left compares Barking and Dagenham to its statistical neighbours, which are defined as being the local authorities that are in the second most deprived decile nationally.

When compared to these similar areas, Barking and Dagenham has a statistically similar rate of teenage conceptions, raking 8th out of the 15 local authorities.

Barking and Dagenham is, therefore, performing to the same level as those boroughs that are most similar statistically. Teenage conceptions have been shown to have a strong link to deprivation and, with Barking & Dagenham being in the second most deprived decile, it is performing at levels that you would expect to see.

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Appendix C - Overview of CQC Inspections published in 2014/15 Quarter 1

Weblinks	Location Organisation Type	Report Date	Inspection Date	Result	Comments / Summary
http://www.cqc.org.uk/directory/1-101668892	Social Care Org	Inspection Report published 10/04/2014	24-Feb-14	**All standards met**	
http://www.cqc.org.uk/directory/1-164893164	Social Care Org	Inspection Report published 23/04/2014	23-Dec-13 & 3-Jan-14	0/5 standards met	**Report Standards not met:** Standard 1, Outcome 2: Consent to care and treatment - Enforcement action taken Standard 2, Outcome 4: Care and welfare of people who use services - Enforcement action taken Standard 3, Outcome 7: Safeguarding people who use services from abuse - Enforcement action taken Standard 3, Outcome 9: Management of medicines - Action needed Standard 4, Outcome 12: Requirements relating to workers - Action needed Standard 5, Outcome 16: Assessing and monitoring the quality of service provision - Enforcement action taken Standard 5, Outcome 20: Notification of other incidents - Action needed Standard 5, Outcome 21: Records - Action needed CQC carried out this unannounced inspection in response to concerns that one or more of the essential standards of quality and safety were not being met. The provider assessed people's needs on admission. However, people's progress was not regularly reviewed and people's needs were not always being met. For example, some people had not received one-to-one support from a member of staff although they had been assessed as needing this. CQC also found that the home's procedures for recording and administering medicines were not being followed by staff. CQC could not be sure that people were taking their medicines as prescribed. Some people using the service experienced profound learning disabilities affecting their capacity to consent to care. The provider had not documented people's consent and could not demonstrate that people's mental capacity had been formally assessed when appropriate. CQC found that the staff were not always clear about safeguarding arrangements and when to raise an alert. Some of the home's procedures and checks, for example around managing people's money, did not adequately safeguard people from the risk of abuse. The managers had identified a number of key risks and were taking action to address these. However the provider's systems to recruit staff and monitor the quality of care in the home were not robust and placed people using the service and staff at risk. CQC have asked the provider to send them a report by 26 April 2014, setting out the action they will take to meet the standards. CQC will check to make sure that this action is taken. CQC have also referred their findings to Local Authority: Safeguarding and will check to make sure that action is taken to meet the essential standards. CQC have taken enforcement action against Sahara Parkside to protect the health, safety and welfare of people using this service. Current status (31.07.2014): CQC have reassessed Sahara Parkside Limited as meeting all 5 standards
http://www.cqc.org.uk/directory/1-189037049	Social Care Org	Inspection Report published 08/05/2014	10-Apr-14	**All standards met**	
http://www.cqc.org.uk/directory/1-146917848	Social Care Org	Inspection Report published 16/05/2014	10-Apr-14	**All standards met**	

Weblinks	Location Organisation Type	Report Date	Inspection Date	Result	Comments / Summary
http://www.cqc.org.uk/directory/1-731726527	Social Care Org	Inspection Report published 20/05/2014	25-Apr-14	4 out of 5 standards met	Standard not met: 5) Quality and suitability of management People's personal records, including medical records, should be accurate and kept safe and confidential (outcome 21) During the course of the inspection CQC asked to see various records. They found records in place relating to staff recruitment and training, policies and procedures and quality assurance processes. However, not all required records were in place. For example, there was no plan of care in place for one of the people who used the service and there was no record of any notifications to the Care Quality Commission (CQC). The manager said that on two occasions the service had reported incidents to the police and on another occasion they had reported a safeguarding allegation to the local authority. The provider is required to notify the CQC of these events and had not done so. Current status (13.08.2014): Awaiting update from CQC
http://www.cqc.org.uk/directory/1-559160107	Primary Medical Services	Inspection Report published 20/06/2014	25-Apr-14	2 out of 5 standards met	Standard not met: 1) Treating people with respect and involving them in their care - Respecting and involving people who use services People's privacy, dignity and independence were not always respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. Standard not met: 2) Providing care, treatment and support that meets people's needs - Care and welfare of people who use services People should get safe and appropriate care that meets their needs and supports their rights Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare with the exception of the management of patients on methotrexate. Standard not met: 5) Quality and suitability of management - Complaints People should have their complaints listened to and acted on properly There was an ineffective complaints system available. Current status (13.08.2014): Awaiting update from CQC
http://www.cqc.org.uk/directory/1-811281854	Social Care Org	Inspection Report published 28/06/2014	18-Feb-14	**All standards met**	

HEALTH AND WELLBEING BOARD

9 SEPTEMBER 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: • 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

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

Items to be escalated to the Health & Wellbeing Board

- The Health and Wellbeing Board is asked to note progress of the integrated care sub group

Meeting Attendance

28 July 2014: 50% (7 of 14)

Performance

Please note that no performance targets have been agreed as yet; going forward the group will review progress against Barking and Dagenham targets delivered through achievement of milestones in Better Care Fund (BCF) schemes. Further national Better Care Fund guidance has now been issued which will inform development of the BCF outcomes.

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

- Following review at the previous two meetings (May and June 2014) of detailed project plans to support Better Care Fund schemes, the July meeting focused on reviewing progress of the Better Care Fund schemes, reviewing final project plans and risks, and agreeing next steps.
- The group noted the significant progress to date around the majority of the majority of the Better Care Fund schemes, and agreed that the final 'enabling' schemes where less progress has been made (equipment and adaptations) will be progressed as a matter of urgency.
- A Better Care Fund Workshop took place on Wednesday 13th August which will seek to strengthen the governance arrangements around the schemes; outputs of this session will be fed back to the next Integrated Care Group meeting in August.
- The Group noted that further Better Care Fund guidance has been released by NHS England which will require result in further development of the outcomes for the Better Care Fund schemes.
- The Group noted that the Intermediate Care Consultation is now live and received copies of the consultation document.
- The Dementia Strategy Plan is currently being tested with Public Health and Local Authority partners and has been reviewed by the Mental Health, Health and Wellbeing Board Sub Group. The Integrated Care Sub group were asked to review and comment on the plan.

Action and Priorities for the coming period

- The group are finalising the Better Care Fund scheme project plans, monitoring delivery, and addressing any issues arising from Better Care Fund implementation; regular updates will be provided to the Health and Wellbeing Board.
- Following receipt of further guidance from NHS England, Better Care Fund metrics will be discussed in more detail and a reporting template developed. An update on Better Care Fund outcomes and data is being provided to the Health and Wellbeing Board in September.
- Reablement metric proposals have been developed; an update paper is being sent to the Health and Wellbeing Board in September.
- The Mental Health sub-group is leading on developing the implementation plan for dementia based on the dementia needs assessment, both of which will be discussed at the Health and Wellbeing Board in September.
- The group has reviewed the end of life care update paper for the Health and Wellbeing Board. Final amendments are being made and the paper will be presented to the Board in September.

Contact: Emily Plane, Project Manager, Strategic Delivery, BHR CCGs
Tel: 0208 822 3052; Email: Emily.Plane@onel.nhs.uk

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APPENDIX 2

Mental Health sub-group

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

Items to be escalated to the Health & Wellbeing Board

(a) None to note.

Performance

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

Meeting Attendance

25 July, 2014: 62.5% (10 of 16)

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

(a) Service user engagement event being planned for 10 October to coincide with world mental health day. The focus of the event will be to gather service user information and input into the mental health needs assessment.
(b) Impact of recession and welfare reforms (Scrutiny Committee report) action plan discussed ahead of presentation to the July Health and Wellbeing Board.
(c) Agreed self-assessment template to be populated by sub group members relating to the 25 ‘Closing the Gap’ recommendations. A report detailing the collated self-assessment information will be presented to a future Health and Wellbeing Board.

Action and Priorities for the coming period

(a) MH sub group oversight of the Mental Health Needs Assessment that has been commissioned by LBBD Public Health.

Contact:

Julie Allen, PA to Integrated Care Director (NELFT)

Tel: 0300 555 1201 ext 65067; **E-mail:** Julie.allen@nelft.nhs.uk

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APPENDIX 3

Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Commissioning and Partnerships

Items to be escalated to the Health & Wellbeing Board

(a) None

Performance

The Board is working well and a review of the service user /carer representatives was completed at sub group level. Both the carers/service user forums are in agreement that their representatives continue to represent their views and are feeding back to them about the actions of the LDPB. The Provider forum has been revamped moving from a top down approach where information is given to them about a range of subjects to the providers leading the agenda of issues they wish to discuss/receive reports and information about. This is working well with providers arranging a pre meet for the next meeting in October 2014.

Meeting Attendance

LDPB meeting 1st July the attendance was 45% (9/20 attendees)

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

(a) Learning Disability Partnership boards continue to be held regularly a comprehensive forward plan is in operation.

(b) The LDPB has been developing its understanding of the Care Act and specific areas of interest are the improvements to information, advice and guidance including the need for financial advice, transitions to adult services and meeting the needs of carers under the new act. The implementation of the Care Act is now a standing agenda item.

(c) The LDPB has been inputting into the development of implementation of the Children and Families Bill and has noted the continued work in this area.

(d) The LDPB is keen to be part of the consultation for the refresh of the Housing Strategy in particular with regard to needs of the learning disability community/supported housing.

(e) Finally the LDPB has been supportive of the Autism Strategy refresh and has noted reports on the diagnostic pathway from NELFT and is particularly interested in how the Adult Autism Strategy will interlink with the existing strategy in this key growth area.

(f) LDPB were pleased to note that service user engagement was a key feature of the recruitment of the LD Joint Commissioner and were pleased to note that their views were considered very carefully in the appointment of the successful candidate.

Action and Priorities for the coming period

(a) To continue to develop the members of the LDPB's understanding of the implementation of the Care Act and its impact on adult social care for people with a learning disability.

(b) To hear more about the market position statement with regard to learning disability and how the views of people with a learning disability can shape the market development of services and improve the range of services that people with a learning disability are able to buy.

(c) Review the contribution with reference to learning disability on the Joint Strategic Needs assessment.

(d) To engage with the plans for Care City and a particular interest is the development of skills of personal assistants to work with people with learning disability and autism.

(e) To continue to support the work on healthy eating, obesity and healthy lifestyles which is considered a priority by the LD community at large.

(f) To be part of the process this is seeking to tender the supported living contracts for the future.

Contact: Karen West-Whylie, Group Manager – Learning Disabilities

Tel: 020 8724 2791 **Email:** karen.west-whylie@lbbd.gov.uk

Children and Maternity Group

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

Items to be escalated to the Health & Wellbeing Board

- The Health and Wellbeing Board is asked to note progress of the Children and Maternity Group.

Meeting Attendance

The group has not formally met since the July 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.

Performance

A performance dashboard has been drafted which will be reviewed when the workplan is finalised.

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

A workshop was held on 2nd July to:

- 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

12 priority areas were identified which were ranked as follows:

1. Improving health outcomes for children with disabilities and special needs
2. Improving health outcomes for looked after children, are leavers and young offenders
3. Early years development
4. Childhood obesity
5. Childrens mental health and wellbeing
6. Breastfeeding
7. A&E attendance/ urgent care
8. Health visitor transition
9. Developing the annual plan for the children and maternity group
10. Good embedded universal services in universal provision
11. Immunisation
12. Teenage pregnancy and sexual health

Emerging actions were developed for the top 4 priority areas.

Action and Priorities for the coming period

- Organisations to confirm leads for priority areas
- Work plan to be finalized and agreed across LBBD and CCG.

Contact: Mabel Sanni, Executive Assistant, Barking and Dagenham CCG
Tel: 0203 644 2371 mabel.sanni@barkingdagenhamccg.nhs.uk

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Public Health Programmes Board

Chair: Matthew Cole Director of Public Health

Items to be escalated to the Health & Wellbeing Board

Update on Ebola. Information and preparedness actions have been taken across the partners. "Within the UK, Public Health England (PHE) has informed medical practitioners about the situation in West Africa and requested they remain vigilant for unexplained illness in those who have visited the affected area, and actions to take in the event of a possible case. PHE has also provided advice for humanitarian workers planning to work in areas affected, and continues to engage with the Sierra Leone diaspora in England."

The risk to the UK and to UK travellers to the area remains very low. No cases of imported Ebola have ever been reported in the UK.". Further information can be found on:

https://www.gov.uk/government/news/public-health-england-ebola-support-and-surveillance-continues-but-risk-remains-low-in-england

Performance

Following a review of the performance of the Group and attendance. It is proposed the remit of the group has a tighter focus that doesn't duplicate the work of other sub groups. The proposed membership of the group moving forward is made up of the following officers:

Matthew Cole	Director of Public Health (Chair)
Glynis Rogers	Divisional Director Community Safety and Public Protection
Meena Kishinani	Divisional Director Strategic Commissioning , Safeguarding and Early Help
Robin Payne	Divisional Director Environment
Sharon Morrow	Chief Operating Officer Barking and Dagenham CCG
Paul Hogan	Divisional Director Culture and Sport

The Obesity Task and Finish Group, Health Protection Committee and the Integrated Sexual Health and Reproductive Board are proposed to report into it as part of the Board's governance.

The groups remit moving forward will be to :

- have an overall view of the 'health' of the Public Health Programme's performance across the life course in delivering outcomes
- act as a reference group for advice on the development of the refreshed joint Health & Wellbeing Strategy and Joint Strategic Needs Assessment
- hold the above 3 groups to account

Agreed meetings for the rest of the calendar year

- 19th September
- 28th October
- 9th December

The Obesity Task and Finish Group are meeting on 22nd August

Health Protection Committee met on 1st August

Integrated Sexual Health and Reproductive Board met on 16th July

Meeting Attendance

Prior to the review attendance at the Board was poor. Attendance at the Health Protection Committee and Integrated Sexual Health & Reproductive Board was good.

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

(a) Board has been reviewed and a proposed new focused remit

(b) Attendance has been clarified

(c) Health Protection Committee has reviewed the immunisation coverage as requested by the Board at its July meeting. It was recorded that Barking & Dagenham have maintained their performance:

- Dip T 92.7% Uptake – better than London
- MMR 88.9% Uptake – better than London
- MMR2 81.7% Uptake

Discussion took place on herd immunity being 95%. Overall it was noted that there is a big improvement for Barking & Dagenham. We need to see if we can go further and push for the 95% due to the demographics of area it will probably be challenging to meet the 95% target.

(d) Procurement of the integrated sexual health contract – the PPQ stage has commenced.

Action and Priorities for the coming period

(a) September will be the first review of the Public Health programmes to access impact and financial performance.

(b) Integrated Sexual Health service invitation to tender to be dispatched 10th October.

(c) 3rd October – Exercise Panacea Pandemic Flu emergency planning exercise.

(d) Notification in September of the indicative allocation for commissioning the 0-5 Healthy Child Programme and Family Nurse Partnership.

(e) Seasonal flu vaccinations will start in October.

Contact: Pauline Corsan

Tel: 0208 227 3953 ; **Email:** pauline.corsan@lbbd.gov.uk

HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Chair's Report**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Louise Hider, Health and Social Care Integration Manager	**Contact Details:** Tel: 020 8227 2861 Email: louise.hider@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: Please see the Chair's Report attached at **Appendix 1.**	
Recommendation(s) The Health and Wellbeing Board is recommended to: a) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.	

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In this edition of my Chair's Report I discuss plans for Alcohol Awareness Week and the Care Act financial modelling currently being carried out by the Council. I also discuss our recently launched Market Position Statement and the response received from Dr Anne Rainsberry from NHS England regarding safeguarding assurance. 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

Chair's Report

9 September 2014

Alcohol Awareness Week

Alcohol Awareness Week is a national annual event organised by Alcohol Concern. This year's Alcohol Awareness Week will run 17 - 23 November and the national theme is "**taking back our health and high streets**". The Borough's Alcohol Alliance is coordinating Alcohol Awareness Week in Barking and Dagenham and has drafted a plan of proposed activities for this year's event, including:

- Setting up a mock bar in the Town Square to provide information and advice relating to alcohol consumption and alcohol service promotional material;
- Holding information and advice stalls in Queen's and King George Hospitals and Becontree Heath Leisure Centre;
- Posting alcohol-related health messages on our social media channels;
- Promoting healthy eating and drinking through the Recovery Café cooking workshops;
- Publicising Alcohol Awareness Week and alcohol treatment service details through the new GP Shared Care newsletter;
- Delivering awareness and training sessions to Council staff and GP surgeries;
- Providing health information in pubs throughout Alcohol Awareness Week;
- Commissioning a piece of theatre to be performed in community centres and residential homes for older people, looking at the effects of alcohol use on health.

Subwize, the Borough's specialist substance misuse service for young people will also be holding a number of activities including workshops in schools, colleges and tuition centres, stalls in the Borough's supported housing schemes for young people and developing a newsletter for professionals.

The Substance Misuse Board and the Community Safety Partnership will be signing off proposals for Alcohol Awareness Week over the coming weeks. If Board Members have any thoughts or comments about Alcohol Awareness Week plans, please email Sonia Drozd on sonia.drozd@lbbd.gov.uk or call 020 8227 5455. I hope to see you at some of the events!

Care Act Financial Modelling

Board members should be aware that the Council are currently undertaking a Care Act financial modelling exercise. Some other Councils, particularly Lincolnshire County Council, have developed robust financial models which include estimates of the number of carers and anticipated additional assessments that will be required through the implementation of the Act. Barking and Dagenham are using these models to inform our own modelling, which will in turn inform the Council's planning around the Care Act, as well as the Council's Medium Term Financial Strategy (MTFS). The Council will also feed the results of our modelling into the regional lobbying that is currently being undertaken by London Councils, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association around Care Act costs. Further information on the results of our financial modelling will be brought to the Board in due course.

London Borough of Barking & Dagenham

Launch of our Market Position Statement

The Board may wish to note that the Borough has now launched its 'Market Position Statement' for Adult Social Care. The statement is entitled 'The Business of Care in Barking and Dagenham' and sets out the current status of the social care market in the Borough and how we see the market developing in the future. We see the statement as a tool to help inform local businesses of the needs and interests of local residents.

The Market Position Statement was launched at a conference for social care providers in July 2014, attended by 54 different providers and local businesses as well as health and social care partners. The document has received good feedback so far, but we would welcome any comments from the Health and Wellbeing Board to inform future versions of the statement. The Market Position Statement can be found on http://www.lbbd.gov.uk/adultsocialcare/pages/marketdevelopment.aspx and comments can be sent to marketdevelopment@lbbd.gov.uk.

Market Management Peer Review

Between 7 – 9 October, the Council will be taking part in a peer review as part of a pan-London 'sector-led improvement' initiative in Adult Social Care. A number of London Boroughs have taken part in the Peer Review process so far, looking at topics and processes such as safeguarding and case management. Following the launch of the Market Position Statement (above) and the work that Barking and Dagenham has done to encourage micro-enterprises to enter the market and provide services for personal budget holders, it was felt that it would be timely for the Peer Review in Barking and Dagenham to focus on market management. The Peer Review will look at what the Borough currently does in terms of market development, what we do well, and will make suggestions on processes and improvements that can be implemented. Once the Peer Review report is published, the results will be shared with the Health and Wellbeing Board for further comment and discussion.

A new approach to cancer and cardiovascular care

A pioneering approach which will link local hospitals and GPs with specialist 'centres of excellence' for cancer and cardiovascular care has been given the go ahead in North and East London and west Essex following consultation. It is hoped that the new centres will save over 1,000 lives per year and deliver savings of over £94 million.

St Bartholomew's Hospital and University College London Hospitals respectively will act as 'hubs' within a comprehensive network of care including local hospitals, GPs and other community services. This integrated system will focus on the needs of patients, providing the safest care and a more highly skilled workforce available 24/7, whilst ensuring people are still able to receive the majority of their care locally.

Under the new system, St Bartholomew's Hospital will become the centre for specialist treatment of heart disease. University College London Hospitals, working within a system of hospitals including The Royal London, St Bartholomew's, The Royal Free and Queen's in Romford, will become a centre for the specialist treatment of five types of cancer – brain, prostate and bladder, head and neck, oesophago-gastric and blood cancers. The Royal Free Hospital will become a centre for the specialist treatment of kidney cancer.

Now approved, these new arrangements will be delivered progressively over the next four years. Services will begin moving into the cardiovascular centre at St Bartholomew's Hospital from early 2015, and patients can expect to see changes to cancer services from the middle of next year. Updates will be presented at the Health and Wellbeing Board in due course.

GP Patient Survey Results

The GP Patient Survey was published in July 2014. The survey covered a number of different aspects of patient engagement, including making an appointment, waiting times, satisfaction with opening hours and their overall experience of GP service. Patients were able to complete the survey on paper, online or by telephone.

A total of 4,523 people completed the survey in Barking & Dagenham and highlights from the survey results for the Borough include the following:

- 75% of those surveyed have seen a GP in their GP surgery in the past 6 months.
- 48% of those surveyed have seen a nurse in their GP surgery in the past 6 months.
- 71% of those surveyed find it "very easy" or "fairly easy" to get through to someone at the GP surgery on the telephone.
- 63% of those surveyed were able to get an appointment when requesting one.
- 35% of those surveyed were able to get an appointment on the same day or the next working day.
- 69% of those surveyed said their experience of booking an appointment was "very good" or "fairly good".
- 78% of those surveyed in Barking and Dagenham say their overall experience of their GP surgery was "very good" or "fairly good".

Response from NHS England

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). 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 wrote a letter to Dr Anne Rainsberry, Regional Director 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.

Dr Rainsberry responded to me on 31 July 2014, stating the following:

Neil Roberts (presenter of the June report) apologised for his comments made on the night, particularly for any concern that his comments raised about the implementation of the Francis Report recommendations in primary care. It was stated that his comments were made in the context of the vague nature of the primary care contracts in this regard and the CQC related standards being more specific in this area.

Assurance was given regarding safeguarding training: it was stated that every professional has a responsibility to have mandatory safeguarding training, for GPs this is 9 hours over a 3 year period (usually a half day of multidisciplinary training on an annual basis). All non-clinical practice staff are also obliged to undergo safeguarding training on an annual basis. GPs are required to show that they are up to date with their mandatory training and this is confirmed as part of their annual contract review with NHS England and their appraisal and revalidation. It was also stated that any significant events or serious incidents in safeguarding are required to be included as part of a GP appraisal.

In addition, the letter stated that a named GP is provided to offer advice and guidance to practices regarding child safeguarding queries and referrals.

I would welcome any comments from members of the Health and Wellbeing Board on the above response.

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HEALTH AND WELLBEING BOARD

9 SEPTEMBER 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 October 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 to be taken at least 28 days notice of the meeting. This enables local people and partners to 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) Note the draft forward plan and to advice Democratic Services of any issues of decisions that may be required so they can be listed publicly in the Board'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 29 September. Any changes or additions to the next issue should be provided before that date.

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HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT - October 2014 Edition

Publication Date: 29 September 2014

DRAFT

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://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).
In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk.

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2014 / 2015 Council year, in accordance with the statutory 28-day publication period:

Edition	Publication date
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://moderngov.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: 28.10.14	**Autism Strategy** : Community 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 • Wards Directly Affected: All Wards	Open	Glynis Rogers, Divisional Director, Community and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)
Health and Wellbeing Board: 28.10.14	Health and Young Offenders The Board will receive a report that outlines the health needs and challenges for young offenders as a cohort. The Board will discuss gaps in service provision and how health inequalities can be addressed for this group. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 28.10.14	**Joint Strategic Needs Assessment** : Community This Board will be asked to agree key strategic recommendations arising from the refresh of the Joint Strategic Needs Assessment (JSNA) for 2014. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

Health and Wellbeing Board: 28.10.14	**'Closing the Gap': Implications for Mental Health Services and Commissioners** : Community 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. • Wards Directly Affected: All Wards	Open	Gillian Mills, Integrated Care Director (Tel: 0300 555 1201) (gillian.mills@nelft.nhs.uk)
Health and Adult Services Select Committee: 28.10.14	**BHRUT Improvement Plan - Update** The Board will be presented with an update on the Barking Havering and Redbridge University NHS Hospitals Trust's improvement programme. • Wards Directly Affected: All Wards	Open	Steven Russell, Improvement Director for Barking Havering and Redbridge University NHS Hospitals Trust (steve.russell@bhrhospitals.nhs.uk)
Health and Wellbeing Board: 28.10.14	**Local Account 2013/14** : Community The Local Account is the Council's statement to the local community and service users about the quality of adult social care services in Barking and Dagenham. The Board will be asked to approve the Local Account 2013/14. • 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: 28.10.14	**Joint Carers Strategy and Contract for Carers Services** : Community,: Financial In order to improve support to family carers and meet the requirements of the Care Bill the Board will be asked to: 1. Agree a new Joint Carers Strategy between LBBD 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. • 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: 28.10.14	**Children's Social Care Inspection: Action Plan** : Community 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. 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. • 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: 28.10.14	Children's Social Care Annual Report The report will provide an overview of the work that has been undertaken in 2013/14 in Children's Social Care. • Wards Directly Affected: All Wards	Open	Ann Graham, Divisional Director of Complex Needs & Social Care (Tel: 020 8227 2233) (ann.graham@lbbd.gov.uk)

Health and Wellbeing Board: 28.10.14	**Local Safeguarding Joint Protocol - Safeguarding Partnership Arrangements between Local Safeguarding Children Board, Safeguarding Adults Board and Health and Wellbeing Board** The protocol sets out the expectations of the relationship and working arrangements, between Barking and Dagenham's Health and Wellbeing Board (HWBB), Barking and Dagenham Safeguarding Children Board (BDSCB) and the Safeguarding Adults Board (SAB). It covers their respective roles and functions, arrangements for challenge, oversight and scrutiny and performance management. • Wards Directly Affected: All Wards	Open	Anne Bristow, Corporate Director of Adult and Community Services, Helen Jenner, Corporate Director of Children's Services (Tel: 020 8227 2300), (Tel: 0208 227 5800) (anne.bristow@lbbd.gov.uk), (helen.jenner@lbbd.gov.uk)
Health and Wellbeing Board: 28.10.14	Adoption Annual Report The Adoption Annual Report will be presented to the Health and Wellbeing Board for information and discussion. • Wards Directly Affected: All Wards	Open	Ann Graham, Divisional Director of Complex Needs & Social Care (Tel: 020 8227 2233) (ann.graham@lbbd.gov.uk)
Health and Wellbeing Board: 28.10.14	Child Death Overview Panel - Update Report The report to the Board will set out how the recommendations made in the Child Death Overview Panel (CDOP) Annual Report have been taken forward. • 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	**Contract: Children's Emergency Duty Team Shared Service** : Financial In 2013 the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest agreed in principle to merge their Children's Emergency Duty Teams (EDT) and to have a single Children's EDT partnership for the four boroughs, which will be known as the Four Boroughs' Children's EDT Service. The Board will be asked to approve participation in the contract led by LB Redbridge. • 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: 9.12.14	**Child and Adolescent Mental Health Services (CAMHS) Strategy** : Community 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. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2378) (Sharon.Morrow@barkingdagenhamccg.nhs.uk)
Health and Wellbeing Board: 9.12.14	**Diabetes Scrutiny: Final Update** : Community 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. • 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: 9.12.14	Quarter 2 Performance The Quarter 2 performance dashboard will be presented to the Board for the Board to analyse and discuss. • 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: 9.12.14	Adult Social Care Peer Review This Board will be presented with the outline the findings of the Adult Social Care Peer review and recommendations. • 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: 10.2.15	Quarter 3 Performance The Quarter 3 performance dashboard will be presented to the Board for the Board to analyse and discuss. • 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: 10.2.15	Health and Wellbeing Board Strategy Refresh (Draft) One of the key roles of the Health and Wellbeing Board is to oversee the development, authorisation and publication of the Health and Wellbeing Strategy. The Health and Wellbeing Strategy is the mechanism by which the Board addresses the needs identified in the Joint Strategic Needs Assessment (JSNA), setting out agreed priorities for collective action by the commissioners. The current Health and Wellbeing Board Strategy is due to be refreshed in 2015. The Board will be presented with the draft refresh of the Health and Wellbeing Board Strategy for discussion in order that the final version can be presented at the March 2015 Board meeting. • 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: 10.2.15	Procurement Plan 2015/16 Under the Council's Contract Rules (Rule 25) there a requirement to report the Procurement Plan for all new contracts (including extensions, additions and renewals) with a Contract Value of £500,00 or above scheduled to start in the next financial year, which are funded in part or in whole from the Public Health Grant or from within social care budgets. The Board will be presented with Procurement Plan and be asked to agree the proposed Plan in its entirety or identify any individual procurements / contracts which the Board requires separate more detailed Procurement Strategy Reports to be submitted to it for closer consideration. • 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: 17.3.15	**Health and Wellbeing Board Strategy Refresh (Final)** : Community One of the key roles of the Health and Wellbeing Board is to oversee the development, authorisation and publication of the Health and Wellbeing Strategy. The Health and Wellbeing Strategy is the mechanism by which the Board addresses the needs identified in the Joint Strategic Needs Assessment (JSNA), setting out agreed priorities for collective action by the commissioners. The current Health and Wellbeing Board Strategy is due to be refreshed in 2015. The final refreshed version of the Health and Wellbeing Strategy will be presented for approval. • 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: 17.3.15	**Director of Public Health Annual Report** The Director of Public Health Annual Report identifies key issues, flags up problems, and reports progress. The Annual Report will also be a key resource to inform local inter-agency action. The Board will be asked to note the 2014/15 Annual Report. • 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: 5.15	Quarter 4 Performance The Quarter 4 performance dashboard will be presented to Board for the Board to analyse and discuss. • 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: Not before 1.6.15	Annual Health Protection Profile *[Annual Item]* Representatives from Public Health England are invited to the Board to present and discuss Barking and Dagenham's Health Protection Profile which is compiled annually. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

APPENDIX 1

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)
Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation (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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