

Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 8 March 2016 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 29 February 2016

Chris Naylor
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 Services and Social Care
Anne Bristow	(LBBD) Strategic Director for Service Development and Integration and Deputy Chief Executive
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 Nadeem Moghal	(Barking Havering & Redbridge University NHS Hospitals Trust)
CS Sultan Taylor	(Metropolitan Police, Borough Commander)
John Atherton (Non-voting member)	(NHS England)

AGENDA

1. Apologies for Absence

2. Declaration of Members' 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 on 26 January 2016 (Pages 3 - 14)

BUSINESS ITEMS

4. Better Care Fund - End Of Performance Year 2015 Assessment and Plans For 2016/17 (Pages 15 - 39)

5. Transforming Care for People with Learning Disabilities (Pages 41 - 46)

6. London Ambulance Service Quality Improvement Plan (Pages 47 - 89)

7. Health and Wellbeing Board Performance Report - Quarter 3 (2015/16) (Pages 91 - 114)

8. Devolution Through an Accountable Care Organisation in Barking and Dagenham, Havering, and Redbridge (Pages 115 - 118)

9. Contract- Procurement of Healthy Child Programme 5-19 (School Nursing and National Child Measurement Programme) (Pages 119 - 129)

STANDING ITEMS

10. Systems Resilience Group - Update (Pages 131 - 133)

11. Chair's Report (Pages 135 - 140)

12. Forward Plan (Pages 141 - 148)

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

14. 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.***

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

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Our Vision for Barking and Dagenham

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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MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 26 January 2016
(6:00 - 9:02 pm)

Present: Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), Anne Bristow, Dr Muhammed Ali, Conor Burke, Cllr Laila Butt, Cllr Evelyn Carpenter, Frances Carroll, Matthew Cole, Helen Jenner, Cllr Bill Turner, Melody Williams and Sean Wilson

Also Present: Sarah Baker and Cllr Eileen Keller

Apologies: John Atherton, Dr Nadeem Moghal, Chief Superintendant Sultan Taylor, Dr John, Jacqui Van Rossum and Terry Williamson

58. Declaration of Members' Interests

NELFT representatives declared a Pecuniary Interest in agenda item 14 (Contract - Waiver for Healthy Child 5-19 Programme (School Nursing and National Child Measurement Programme)) and took no part in the discussions or decision.

59. Minutes - 8 December 2015

The minutes of the meeting held on 8 December 2015 were confirmed as correct.

60. Delivering the 2020 Ambition for World Class Cancer Outcomes

Matthew Cole, Director of Public Health, LBBB, introduced the presentation on the delivery of world class cancer outcomes ambition and explained how it would be essential to change how things were done to improve outcomes for patients.

The CCG advised that six strategic priorities had to be delivered over the next five years, which would put a focus on prevention, earlier diagnosis, patient experience and support for people with and after cancer through investment and commissioning, the details of which were set out in section 3 of the report.

London Cancer and the NHS England New Models of Care Cancer Vanguard, had been set up in 2011 to serve 3.2million people across the north east and central London and Essex and its aim was to improve outcomes by tackling late diagnosis, variation in practice, fragmented care pathways and experience of people with cancer. The Board's attention was drawn to the changes and successes that had emanated from those initiatives.

The Board discussed:

- The need to reduce variation in outcomes across the geographical area and cancer conditions and noted that four task and finish groups had been set up to develop and deliver a work plan.
- The need to improve people's knowledge around signs and symptoms.
- The cancers that were occurring in higher rates locally.
- The significant negative effect that smoking was having on cancer rates locally and action that might be taken to reduce smoking, including

- Partners using their own building / organisations estates and practices to make smoking less acceptable.
- Looking at providing smoking cessation services in a radical new way.
- Targeting young smokers in a different way and by empowering them to make healthy lifestyle choices.
- The potential to coordinate health messages /campaigns, which issues should be targeted jointly and if there needed to be prioritisation to stop information overload.
- The work that had been undertaken in Southcentral Foundation Nuka system of Care (Alaska USA) and by Camden CCG and how the lessons learned there could be of use locally.
- Accepted that areas with similar demographics may need to be targeted differently'
- Partners might want to jointly consider community needs and look at the potential to operate direct outreach services to difficult to target groups.
- Improved survivorship rates could result in long-term health / physical conditions, which would require an 'attitude and operational shift' to reflect this, especially at GP level.
- How this could be undertaken by supporting radical change through funding and commissioning initiatives.

The Board:

- (i) Noted the problem of LBBD residents presenting themselves at a late stage of symptoms for medical assessment, either at their GP's or through other medical routes, and how this late presentation affected the treatment available and the subsequent survival rates;
- (ii) Noted that GP's needed training in the tools available that would improve their identification of signs of cancer;
- (ii) Noted the need to improve residents' knowledge of signs and symptoms that should be checked by a medical professional and the need to increase residents' participation in medical screening / testing;
- (iii) Noted that rectal / colon and smoking related cancers were still of significant concern locally; and
- (iv) Agreed that a workshop session should be arranged to enable a more in-depth discussion between partners and stakeholders on how to provide future service delivery, improve residents' knowledge and testing take-up rates.

61. Improving Post - Acute Stroke Care (Stroke Rehabilitation) Consultation

Clare Burns, Deputy Chief Operating Officer (DCOO) of Havering Clinical Commissioning Group and the Lead for this consultation, delivered a presentation outlining the proposals for the delivery of stroke rehabilitation services across the London boroughs of Barking and Dagenham, Havering and Redbridge. Clare reminded the Board that the Case for Service Change was developed to remove the disparity of service provision and complicated pathways for post-acute stroke care for both medical professionals and patients and thereby provide an effective

community stroke rehabilitation service that would be able to achieve the best possible outcomes for patients. The ageing population was also a driver of demand for post-acute stroke care.

A stakeholder workshop had been held in October 2015, following which the CCG Governing Body agreed a pre consultation business case. This formed the basis of the proposed service changes under consultation, the details of which were set out in the report. The three local Healthwatch organisations had helped to produce the consultation document and the proposals were now in a 12 week consultation phase.

The Board discussed a number of issues including the proposals to have the service delivered by one team, based at King George Hospital, to increase early supported discharge (ESD) that would provide a full range of therapies to improve rehabilitation support in patients own homes, the benefits of individualised care and rehabilitation that would be tailored to each patients needs, for example patients learning to use their own kitchen and kettles again rather than a generic kitchen.

Councillor Keller advised that the proposals had been considered by the LBBB Health and Adult Services Select Committee at its meeting held on 13 January 2016.

The Board commended the clarity of the consultation document and the proposals within it.

The Board:

- (i) Noted the proposals set out in the report for changes to the Acute Stroke Care provision, which included the creation of a stroke expertise and treatment centre at King George Hospital;
- (ii) Noted the proposals to improve Early Supported Discharge (ESD) to enable patients to undertake rehabilitation in their own homes, which would include a full range of therapies such as physiotherapy, speech and language therapies and physiological support;
- (iii) Noted that the consultation programme on the proposed changes was underway;
- (iii) Agreed that the Chair would write to the CCG on behalf of the Board to advise that the Board supported the proposals set out in the report; and
- (iv) Noted that a further report would be presented following the completion of the consultation process.

62. Learning Disability Partnership Board Strategic Delivery Plan Update

Mark Tyson, Group Manager, Integration and Commissioning, LBBB, introduced the report and explained that the aim was to give assurance to the Board that the work plan, which included the Learning Disability Self Assessment Framework, Autism Strategy, Winterbourne View Concordat, Transforming Care agenda, Challenging Behaviour plan and the Carers Strategy, was being delivered by the

Learning Disability Partnership Board (LDPB).

The Board's attention was drawn to the details within the report and in particular the R.A.G. ratings within the plan. Mark advised that 27 actions were on track (green), 11 needed further action (amber) and only one needed further significant work (red), which was the need to review the accuracy of data recording and validation between cohorts for Health Checks for people with learning disabilities.

It was noted that the Winterbourne View Concordat had also been reviewed and the cohort turn-over had indicated that this was now performing better than the London average and, more importantly, there had been no re-admissions.

Discussion was also held on:

- The Autism Strategy and the transition service that was in place for children moving to adult services, and how this was working well.
- The report into a death in Walthamstow, where the lack of a Health Check had been cited as a contributory factor.
- The links across the Community Learning Disability Team (CLDT) and Primary Care provision locally and how this needed to be looked at further.
- The CCG were taking the Health Check issue back to their Board to discuss resources and potential changes in regards to GPs validating Health Checks.
- The Delivery Plan style and method of reporting adopted by the Learning Disability Partnership Board.

The Board:

- (i) Noted the progress that had been made in implementing the Learning Disability Partnership Board Delivery Plan and the actions that would be taken forward to maintain or improve services for people with learning disabilities and Autism;
- (ii) Agreed the actions set out in the Plan to improve current performance around health checks and health action plans for people with learning disabilities and Autism;
- (iii) Noted a further update on the LDPB Delivery Plan would be presented to the Board in the summer; and
- (iv) Agreed that the Delivery Plan style and method of reporting adopted by the Learning Disability Partnership Board provided assurance to the Health and Wellbeing Board that its requirements were being met and that the same style and method of reporting should be replicated by other Board sub-groups.

63. Market Position Statement Update 2015

Monica Needs, Market Development Manager, LBBD, presented the report and explained that the Market Position Statement (MPS) had last been published in July 2014. The context of social care had changed dramatically over the past 12 to 18 months and the MPS had now been refreshed to reflect those changes,

which included the implications of the Care Act, increased pressures on Council budgets, growth demands and other significant local developments, for example the personal assistant market.

The Board discussed a number of issues including:

- The changing focus for the market towards prevention and wellbeing.
- The support for an estimated 16,000 carers.
- Information pathways and advice for both providers and residents.
- The aim to provide more joined-up services in conjunction with partners
- The work being undertaken, in association with providers, to develop the local market for social care.

The Board:

(i) Noted the Market Position Statement (MPS) update and how the MPS was affected by the changing care market, including Care Act responsibilities, shifting demographics, budget pressures and growth opportunities, details of which were set out in the report

(ii) Noted that a further report would be presented in the autumn.

64. Health and Wellbeing Performance Report 2015/16 - Quarter 2

Matthew Cole, presented the report and drew the Board's attention to the performance details set out in the report.

The Board discussed a number of issues including:

- Urgent Care and the improved A&E performance locally, which had achieved 90% of people seen within four hours. Work was ongoing to achieve the 95% target.
- CQC Inspections for BHRUT, London Ambulance Service and Maternity Services at Homerton Hospital.
- The review of GP practices, four of which were rated as good. Two had been rated as needing improvement, although this was primarily around the need to improve processes, and work was being undertaken by the CCG and the practices involved to address the issues.
- Immunisations.
- TB rates.
- Mental health services including, CAMHS access and waiting times, Care Programme Approach and the IAPT standards and targets.
- Health Check Performance.
- Teenage Pregnancy rates, which locally were now the same as the London Average.
- Looked after children's health checks were now on an annual plan and this was on track to achieve target.
- The need for clarity of responsibility / 'ownership' for the delivery of a required improvement.

The Board:

(i) Noted the overarching dashboard;

- (ii) Noted the detail provided on specific indicators, and remedial actions being taken to sustain good performance;
- (iii) Noted the areas where new data was available and the implications of this data; specifically, the immunisation uptake, under 18 conception rate, Chlamydia screening, smoking quitters, NHS Health Check, permanent admissions of older people to residential and nursing care homes, delayed transfers of care, A&E attendance and Care Quality Commission Inspections;
- (iv) Requested that a named individual be listed against each performance indicator, in order to improve the clarity on 'ownership' for the delivery of a required improvement; and
- (v) Welcomed the offer from the London Ambulance Service (LAS) to present to the Board the LAS Quality Improvement Plan, which was in response to the CQC assessment of the LAS as inadequate.

65. Draft Homelessness Strategy

James Goddard, Group Manager, Housing Strategy, LBBD, presented the report and explained that the Council had to review the homelessness services every five years, which included assessing emerging trends and examining interventions employed to prevent homelessness. On the basis of the review, the Council was expected to prepare a prevention strategy to mitigate homelessness over the next five years and this was set out in the Draft Homelessness Strategy 2016/21. The public consultation on the Draft Strategy was due to end on 15 February and the final version was expected to be presented to the LBBD Cabinet in Spring 2016.

James drew the Board's attention to the categories of homelessness and a number of issues in the report, including the increase in demand and lack of affordable housing both locally and across the London area, the impact on the welfare funding reforms and private landlords' response to that resulting in transient population, which in turn had adverse social implications. In such a challenging housing market, a different approach would be needed.

The Board noted that 80% of the market in London could no longer be considered affordable. In response to a question from Cllr Butt, James advised that the Rent Deposit Scheme was not working as there was difficulty in obtaining properties because of the high demand in the London and local area.

The Board discussed a number of issues including:

- Looked after children leaving care needing stability
- Mental health and vulnerable adults and supporting individuals health / physical needs with appropriate housing and adaptations
- Young mothers
- Difficulties in obtaining health care for the homeless
- Gypsy and traveller needs.
- Further work that would be undertaken, in association with the Safeguarding Board and Council officers.

The Board:

- (i) Noted the high demand for affordable housing in the local area, which currently could not be met, and the effect of the increased cost of rents in the private sector, which had resulted in a growing affordability gap for local people;
- (ii) Noted that whilst the strategy was being further developed there was an opportunity to look at more radical options. In the meantime, effort would be concentrated on the top two or three objectives, set out in the report. This would initial be the accommodation needs for Looked after Children leaving care and teenage mothers;
- (iii) Noted that the Safeguarding Adults Board and Safeguarding Children's Board would also be part of the consultation process; and
- (iv) Raised concern with the CCG about the ability of homeless people being able to register at GP's and for other medical / health support. It was noted that it would be possible to reactive the existing GP Concordat.

66. Prevention Approach Update

Monica Needs presented the report and explained that with reducing resources and increasing demand the focus was on prevention, and in encouraging individuals to take the attitude of 'what can I do' to reduce their need for care and support.

The Prevention Steering Group had now been set up and the progress made in embedding the Prevention approach locally was set out in detail within the report.

The Board discussed a number of issues in regards to Ambition 2020, the next steps in the process, potential partnership initiatives and suggested that both the London Fire Brigade services and involvement of schools should be reflected more prominently.

The Board:

- (i) Noted the progress of embedding the Prevention Approach locally, as set out in the report; and
- (ii) Agreed that the next steps in the programme should be to:
 - (a) Develop a Prevention and Information and Advice Workshop for front line professionals across Barking and Dagenham.
 - (b) Review the Prevention Scheme within the Better Care Fund for 2016/17 to align future work to identified programme outcomes.
 - (c) Enhance understanding and support for the approach within the voluntary sector, via further engagement and mapping sessions.
 - (d) Implement the agreed 'Commissioning for Prevention' approach into existing and future contracts.

- (e) Continue to develop the Prevention Approach to align with and support Ambition 2020 projects going forward,
- (f) Requested that the involvement of schools and London Fire Brigade services should be reflected more prominently.

67. Overview of Complaint Handling

Francis Carroll, Chair of Healthwatch Barking and Dagenham, introduced the report and explained that Healthwatch had been asked by the Public Health Team to undertake some primary research into how complaints were managed when local people had felt cause to complain about the delivery of health and social care services. Healthwatch explained their investigative methodology and that they had looked at the annual complaint reports of six local organisations.

Francis indicated that the complainant's experience and feedback would allow the Board to consider ways in which the expectations of complainants could be more central to the complaints process. Healthwatch had found that complainants often viewed the stages of complaint in a different way to the organisation(s) investigating the complaint. Whilst complaints were recorded by service, department or timescale for operational needs, there was not any easy way for a complainant to know if a complaint had any effect on service ethos or delivery. From the complainant's view, organisations needed to be clearer about what changes were implemented as a result of service users raising concerns. Francis drew the Board's attention to the details in the report and recommendations set out in Appendix A.

The Board:

- (i) Noted the recommendations set out in Appendix A of the report, namely:
 - (a) That service providers make it a priority to engage with complainants at least once a year,
 - (b) That the views and experiences of complainants contribute to any re-design of complaints procedures.
 - (c) That organisations wishing to make their complaints procedures more user friendly follow the advice given in the report of the Complaints Programme Board '*My expectations for raising concerns and complaints*'.
 - (d) Organisations should consider including in their annual complaints reports more testimonials from complainants as to how the process worked for them.
 - (e) Organisational annual complaints reports should be clearer about what their analysis is saying and what changes will be brought about as a result. This should be fed back to complainants who have contributed through highlighting the situation.
 - (f) Complainants should be advised of agencies or advocates who can

help them with their complaint.

- (ii) Agreed that partners would take the recommendations back to their organisations and would actively consider implementing them within their organisation's processes.

68. Devolution Through an Accountable Care Organisation in Barking and Dagenham, Havering and Redbridge

Mark Tyson present the update on the potential devolution through and Accountable Care Organisation for Barking and Dagenham, Havering and Redbridge and stressed that this report was not about a decision to proceed with the ACO but an update on the work being undertaken to see if this was a feasible option through the development of a business case. The report also set out the governance arrangements for overseeing the development of the business case, including the membership of the Clinical and Democratic Oversight Group, ACP Executive Group, ACO Steering Group, the details of which were set out in section 2 of the report. However, each organisation would need to fully consider its own governance requirements in due course.

Mark drew the Board's attention to the project timeline and advised that the process was now approaching the consultation stage and that IPSOS / MORI surveys would be commissioned shortly.

The Board discussed the business case governance and the radical opportunity an ACO could provide for future health and social care provision and improved health outcomes locally.

The Board:

- (i) Noted the announcement by the Chancellor of the Exchequer, on 15 December 2015, of a devolution pilot for Barking and Dagenham, Havering and Redbridge for health and social care;
- (ii) Noted the current position with respect to the development of the business case to determine whether or not an Accountable Care Organisation (ACO) was a viable form for future integrated health and social care delivery across Barking and Dagenham, Havering and Redbridge;
- (iii) Noted the proposed approach to programme governance for the development of the ACO set out in the report and shown in Appendix A; and
- (iv) Agreed that at this time the process was about putting together a business case, which would be a radical new approach to improved health outcomes locally, and that progress should not be delayed by partners' governance or committee responsibility concerns, which would be resolved as the case was developed and proposals became clearer.

69. Agreement Between the London Borough of Barking and Dagenham and the North East London NHS Foundation Trust Under Section 75 of the National Health Service Act 2006 for the Provision of Integrated Mental Health Services

Louise Hider, Principal Commissioning Manager, LBBB, presented the report and advised that under Section 75 of the NHS Act 2006 the Council and health bodies could arrange to pool resources and delegate certain health related functions to the other partner to improve the way those functions would be provided.

Integrated mental health services were being provided by North East London NHS Foundation Trust (NELFT) through a Section 75 Partnership Agreement, which was initially established in October 2011 and subsequently extended in April 2014. However, the 2014 agreement only had the provision for a one year extension so had become necessary to agree a new Section 75 Agreement between LBBB and NELFT.

To enable the re-thinking of the future integrated service and development of the Mental Health Strategy it was considered advisable that this new agreement should be for one year and it was expect it would take a similar form to the 2014 version. Due to the timescale it would be necessary to delegate authority for the negotiation and execution of the new Section 75 Agreement, as set out in the report.

The Board:

- (i) Approved the renewal of the partnership arrangement between the Council and North East London Foundation Trust (NELFT) in accordance with Section 75 of the NHS Act 2006, for a period of one year from April 2016, as detailed in the report;
- (ii) Delegated authority to the Strategic Director of Service Development and Integration in consultation with the Director of Law and Governance and the Strategic Director of Finance and Investment, on the Council's behalf, to conclude the negotiation and execute the Section 75 agreement, in consultation with the Cabinet Member for Adult Social Care and Health as necessary; and
- (iii) Noted that NELFT were making equivalent arrangements to ensure authorisation of the agreement through their own governance mechanisms.

70. Contract: Waiver for Healthy Child 5-19 Programme (School Nursing and National Child Weight Measurement Service)

NELFT declared a Pecuniary Interest in this item and took no part in the discussion or decision.

Matthew Cole presented the report and explained that the Healthy Child 5 to 19 Programme was a mandated public health programme, the responsibility for which was transferred to the Council on 1 April 2013. The Programme offered school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion. The services also provided tailored support for children and families. The contract for the Healthy Child 5 to 19 Programme services was due to expires on 31 March 2016 and there was no provision for further extension.

The responsibility for the Healthy Child 0 to 5 Programme had also transferred to the Council in October 2015. This had provided the Council with the opportunity to

join up the commissioning of 0 to 5 and 5 to 19 Programmes into one fully integrated service. To enable the co-commissioning and creation of the new service it would be necessary to enter into a direct contract with NELFT for the 5 to 19 Programme for a six month period, 1 April to 30 September 2016, in accordance with the procurement strategy and details set out in the report.

The Board:

- (i) Waived the requirement to tender for the commissioning of the Healthy Child 5-19 Programme, in accordance with the Council's Contract Rules; and
- (ii) Delegated authority to the Strategic Director Service Development and Improvement and Deputy Chief Executive, in consultation with the Director of Public Health, Corporate Director of Children's Services, Strategic Director, Finance and Investment, and the Director of Law and Governance, to enter into a direct contract for six months for Healthy Child 5-19 Programme to NELFT from 1 April 2016 until 30 September 2016, in accordance with the strategy set out in the report.

71. Systems Resilience Group - Update

The Board received the report on the work of the System Resilience Group (SRG), which included the issues discussed at the SRG meetings held on 8 December 2015.

The Board noted that the BHRUT Action Plans, which had been put into place following the CQC assessment, were clearly starting to achieve improvements in performance in a number of areas and that A&E 4 hour waiting time performance had shown significant improvement against last year and was now achieving 90% against the 95% national target.

72. Sub-Group Reports

The Board noted the reports on the work of the:

- Public Health Programmes Board (PHPB)
Noted that a new Assurance Board had been set up and the Director of Public Health would be taking performance concerns raised in the PHPB report there.
- Children and Maternity Group

73. Chair's Report

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

- Accountable Care Organisation.
- CCG commissioning café drop-in event, Relish Café, Barking Town Square, 16 February 2016.

- News from NHS England
 - NHS Five Year Forward View – one year on.
 - Patients using online services to access local GPs.
 - Independent report on Southern Health.
- Update from Care City, opening of Healthy Ageing Innovation Centre, Barking, 18 January 2016.
- Leisure centres had been awarded the prestigious Chartered Institute for the Management of Sport and Physical Activity (CIMSPA) European Pool Safety Award.

74. Forward Plan

The Board noted the draft Forward Plan.

HEALTH AND WELLBEING BOARD

8 March 2016

Title:	Better Care Fund end of year 2015 assessment & 2016/17 Plans		
Report of the Strategic Director for Service Development & Integration			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: No	
Report Author: Glynis Rogers, Lead Divisional Director, Adult and Community Services, London Borough of Barking and Dagenham Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG		Contact Details: Tel: 020 8227 2749 E-mail: glynis.rogers@lbbd.gov.uk	
Sponsor: Anne Bristow, Strategic Director for Service Development & Integration Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups			
Summary: The Better Care Fund (BCF) plans for 2015/16 come to an end on the 31st of March 2016. This includes the Section 75 agreement signed between London Borough of Barking and Dagenham and Barking and Dagenham CCG. The Joint Executive Management Committee has managed the BCF, including regular monitoring of programme performance and the pooled budget, under delegated authority from the Health and Wellbeing Board (HWBB). The eleven schemes of the BCF have delivered most of the milestones that were set out in the BCF plans submitted to NHS England. Whilst there has been a high level of delivery against the key milestones in the schemes there has been under achievement against the BCF metrics. As highlighted in the report to the Board in December 2015, it was expected that delivering the scheme milestones would not impact on the metrics in 2015/16. The Policy Framework for the 2016/17 BCF was released in January 2016, with further detailed technical guidance and the template for the first round of submissions released in late February 2016. Work is currently underway to develop BCF plans to submit within the timeframes set out by NHS England. Our local BCF 2016/17 plans will take into account the national conditions and metrics for 2016/17 set out in the BCF Policy framework. However, trajectories for performance are going to be set in a manner which better reflects the current performance. The number of schemes will be reduced to increase the focus on schemes that will directly impact on the agreed metrics for 2016/17.			

The pooled budget arrangements formally end in March 2016. Spend in 2016/17 is expected to be at a similar level to 2015/16, however this is still to be confirmed. Further details about the finances of the BCF can be found in **Appendix A**.

The governance arrangements for the BCF as detailed in the section 75 agreement between the Local Authority and CCG will be expected to be similar to those agreed to in 2015/16. The pooled budget will be hosted by the Local Authority and is responsible for monitoring spending, accounting and audit arrangements, and the allocation of resources to lead commissioners for schemes. Monthly reporting on finance and performance is made to the Joint Executive Management Committee.

Recommendation(s)

It is recommended that the Health and Wellbeing Board (HWBB):

- (i) Notes the progress made in 2015 and the process for drawing up the 2016-17 Better Care Fund plans, the associated national timetable and the HWBB's role in approving the plan.
- (ii) Notes that the current draft Better Care Fund plan is provisional and may be subject to change.
- (iii) Endorses the current draft Better Care Fund plan, extension of the current section 75 agreement into 2016/17 and budget for 2016/17, which is as set out in the Finance report to JEMC in **Appendix B**, and will be used for the initial submission albeit that some amendment is likely as the plan is finalised.
- (iv) Agrees and delegates authority to the Strategic Director for Service Development and Integration, in consultation with HWBB Chair, to approve the BCF plan outside its normal meeting timetable.

Reason(s)

The Better Care Fund is a major plank of the Board's strategy for promoting integration of services, which forms part of the statutory remit of the Board. This contributes to the priorities of both the Clinical Commissioning Group and the Council, as well as other partner agencies. This report provides an opportunity to review progress made in delivery of the BCF for 2015/16 and to provide direction in shaping the Better Care Fund for 2016/17.

1 Introduction and Background

- 1.1 In December 2015 the HWBB received a detailed BCF progress report covering the programme report, financial report and metric report.
- 1.2 The 2015/16 Barking and Dagenham Better Care Fund (BCF) plan is currently coming to the end of its implementation period, and planning is underway for the 2016/17 period.
- 1.3 Regular reporting of the BCF is overseen by the Joint Executive Management Committee, with the Board's Integrated Care Sub-Group helping to shape the delivery of the 11 BCF schemes.

1.4 The purpose of this report is to:

- Provide an end of year assessment of the Better Care Fund and set out the process for drawing up the 2016/17 Better Care Fund plan and to confirm its approval timetable and approach.
- Present the draft Better Care Fund plan, section 75 agreement and budget for 2016/17 for HWBB feedback and initial endorsement prior to the first plan submission.
- Agree and delegate to HWBB Chair the final approval process for the plan, this may require the HWBB to approve the plan outside its normal meeting timetable.

2 End of year 2015 assessment of the BCF 11 schemes

2.1 A full account of the performance of each of the 11 BCF schemes was given in the December 2015 report to the HWBB. There are no further updates for the schemes, with the exception of Scheme 2, Prevention. The Prevention scheme focuses on preventative services to promote health and wellbeing with an emphasis on physical activity and falls prevention.

2.2 A falls prevention service aimed at helping people over 65 years in the borough with repairs around their homes to prevent trip hazards commenced in November 2015. This service is called Handyperson and is being delivered by Harmony House. Feedback on the service so far has been positive.

3 End of year 2015 assessment of BCF metrics

3.1 To evaluate Barking & Dagenham's performance NHS England will draw from national data returns. This section updates on the local view of that performance data since detailed report in December 2015. Please see Appendix B for details.

Non-elective admissions

3.2 The key target for the BCF is to reduce non-elective admissions by 2.5% in the calendar year 2015, compared to 2014. Performance on this target is linked to a payment for performance, amounting to £710k across both partners.

3.3 A non-elective admission is an admission to hospital for overnight stay where the patient's admission is not planned; it includes emergency admissions, and admissions for maternity, births, and non-emergency patient transfers.

3.4 Full year data has now been received from January 2015 to December 2015. It is evident from the data that the target has not been met and that the payment for meeting the target will not be received. Given that this is already built into the relevant budgets, this has a financial cost to local partners. LBBDD and the CCG agreed at the outset to split the penalty 50:50, but with the underspend of 2014/15 being utilised to pay down the penalty.

3.5 The new BCF 2016/17 technical guidance indicates that local areas will still be expected to monitor and work towards reducing non-elective admissions, however there is no clear target set and there will need to be a link to the CCG operational plans for reducing non-elective admissions.

Delayed Transfers of Care from Hospital

- 3.6 Ensuring people are supported in an integrated way to enable them to be safely discharged from hospital was a key BCF priority in 2015/16 and it is expected to remain a critical metric again in 2016/17.
- 3.7 There is still 3 months left for the current year. However, performance is not expected to return within the target trajectory within this time. A detailed plan to tackle DTOC performance is expected to be part of the 2016/17 metric plans.

Permanent admissions into residential/nursing placements

- 3.8 A further key aim of the Better Care Fund is the promotion of care closer to home, for social care this means avoidance of admission to residential care as far as possible.
- 3.9 There has been an increase in people being admitted in care homes this year. The target for 2015/16 was 125 and it is expected that this number will be exceeded, with current projections of around 180 admissions. After reviewing performance against this metric for the 4 years it was found that the average number of admissions is 171 (2011/12 – 200, 2012/13 – 170, 2013/14 – 135, 2014/15 – 179).

Re-ablement effectiveness

- 3.10 The Better Care Fund also seeks to ensure that hospital discharge is effectively setting people up for continued independent living, and that the care plans put in place are sustainable.
- 3.11 There is no change in this metric from what was reported in December 2015 report. The target for 2016/17 will take into account the current performance as well ensuring our reporting processes are similar to our neighbouring boroughs.

GP user survey – people feeling supported by services to manage their long term conditions

- 3.12 Performance has declined slightly against the baseline for this local metric, and is slightly below the London average of 58.4%.
- 3.13 There is no change in this metric from what was reported in December 2015. However, we are progressing with a plan to address the underperformance and expect to report on this in 2016/17 progress update.

Injuries due to falls in people aged 65

- 3.14 This indicator measures the number of emergency admissions due to falls related injuries. This indicator has been performing better than its baseline set in 2014. However, performance has declined in the past three months.
- 3.15 There is a reduction in falls admissions in 65-74 and 75-84 age group in Q3 when compared to same period last year.

4 End of year 2015 assessment of BCF Financial position

- 4.1 The pooled budget arrangements formally came into place April 2015. This has been delivered in line with the BCF plan. Please refer to Appendix A for a detailed report.
- 4.2 Based on the best available information as at Quarter 3 for 2015/16, actual progress is within the financial plan as per the BCF plan and section 75 agreement. The projected outturn is a break even position at year end for the total Pooled fund.

5 Better Care Fund Draft Plans 2016/17

- 5.1 The Policy Framework for the BCF 2016/17 was released in early January 2016, which set out the high level requirements for the BCF. The planning guidance was then released on 23 February and the planning template on 24 February. The deadline for submission of the completed initial template has been set as 2 March. Given the severe constraints in the time available to carry out work on the BCF and the lack of planning guidance or a template, it has not been possible to draw up detailed plans about what the BCF for 2016/17 will look like, although work has been underway on the broad thrust of the partnership's approach. The following section will set out the what has been completed and agreed as well as what will be done next to prepare and submit the finalised BCF plans.

National Conditions

- 5.2 As part of the BCF for 2015/16 there were 6 national conditions that every HWBB had to be working to deliver, covering issues such as the use of the NHS Number for social care records, 7-day working and information sharing. In all assurance reports to NHS England in 2015/16 detailed assurances were given of the progress made to meeting those conditions. For 2016/17 there has not been any change in our position on these conditions and we will continue to provide detailed narratives to NHS England on each of the 6 national conditions.
- 5.3 In 2016/17 there have been a 2 further conditions added to the national conditions (agreement to invest in NHS commissioned out-of-hospital services and agreement on a local target for Delayed Transfers of Care and a joint local action plan to address this). Plans for meeting these conditions are in development at this stage and there has not been wider stakeholder engagement, therefore we are reporting that we are not yet compliant.

National Metrics

- 5.4 The national metrics for the BCF will continue as they were set out for 2015-16, in line with the national guidance. While it was initially indicated in the Policy Framework that non-elective admissions would not be included, the Planning Requirements released on 23 February did include non elective admissions. Further information on each of the metrics included in the BCF for 2016/17 is set out below.

Non-elective admissions

- 5.5 As set out previously, performance against this target has been problematic, with limited impact by the schemes on reducing admissions. No clear target for this

metric is set out in the technical guidance and any target will need to link to the CCG operational plans for reducing non-elective admissions.

- 5.6 A risk sharing agreement tied to performance against this metric was a requirement for the BCF in 2015/16. However for the BCF 2016/17 there is no explicit requirement for there to be a risk sharing agreement tied to this metric or any other metric in the BCF. Any risk share agreement proposed as part of the BCF 2016/17 will be subject to discussed by JEMC.

Permanent admissions into residential/nursing placements

- 5.7 The target for 2015/16 was 125, with expected performance for 2015/16 to be 180 admissions.
- 5.8 After reviewing performance over the last 4 year, it was found that on average there are 171 admissions per year (2011/12 – 200, 2012/13 – 170, 2013/14 – 135, 2014/15 – 179).
- 5.9 The previous BCF guidance set out that targets should be based on 2013/14 performance, which as shown above was an unusually low figure for this metric. Therefore it is proposed that the target for 2016/17 is 170.

Re-ablement effectiveness

- 5.10 The performance drop from 88.3% in 2013/14 to 67.2% in 2014/15 is being investigated as a potential data issue, based around the definition of the indicator and whether we have included or excluded those who die between discharge and the 91-day point. It is suggested that the target is kept at 90% again this coming year.

Delayed Transfers of Care

- 5.11 Data suggests that the DTOC target is being met at our local hospital BHRUT which might suggest the Joint Assessment Discharge (JAD) is having an impact on DTOC.
- 5.12 Further analysis of the data has identified that the areas which are negatively impacting the metric are NELFT Mental Health patients awaiting discharge. Previously there have also been delays due to Barts Health NHS Trust (at Whipps Cross University Hospital and Newham University Hospital), however these delays have been addressed.
- 5.13 A detailed DTOC plan is being developed which will set out how the BCF for 2016/17 will improve DTOC performance. This is one of the national conditions for the BCF. As the area of concern has been identified and we are confident we are able to impact on this area, the suggestion is to maintain the same target level as in 2015/16. Any local work on DTOC will need to link into the work being carried out by the Barking and Dagenham, Havering and Redbridge Systems Resilience Group on DTOC.

Patient Experience (GP user survey – people feeling supported by services to manage their long term conditions)

- 5.14 Our performance which is 54% has been less than the target 61% as well being below the London average of 58%.
- 5.15 Due to the target being difficult to impact on we are suggesting that the London average of 58% as a more realistic target. We are developing a plan to impact this metric and will update the HWBB in year progress report.

Injuries due to falls in people aged 65 (locally agreed metric)

- 5.16 We have performed very well on this metric with a reduction in over 65 year group in Q3. The target for this metric will need to match with the target set out in the CCG operational plans.

Scheme proposals

- 5.17 After discussion at JEMC regarding performance of the BCF in 2015/16 it was felt that there were too many schemes. The proposal for 2016/17 is to have fewer schemes and to focus and align projects around the metrics they aim to impact on.
- 5.18 The three schemes proposed will focus on hospital discharge, hospital admission and integrated support in the community. Each of these schemes will have themes around dementia, mental health, prevention (including falls), carers and commissioning woven into them.
- 5.19 Further details of the schemes and what they will include will be available at the meeting on 8 March.

Process and timetable

- 5.20 The high level timetable for agreeing the 2016-17 plan is as follows:

		National milestones	Local milestones
Submission Round one	Jan 2016	Issue national guidance for BCF 2016-17	
	23 Feb 2016	Planning guidance issued	
	24 Feb 2016	Planning template issued	
	25 – 26 Feb 2016		Drafting planning template and discussions around schemes
	29 Feb 2016		CCG leads to sign off first submission
	1 Mar 2016		HWBB Chair to sign off draft outline BCF plans for 2016-17 on behalf of HWBB.
	2 Mar 2016	Planning template submitted to NHSE for assurance/moderation.	
	3 Mar 2016		BHR CCGs Joint Management Team (JMT)

Submission Round two	9 Mar 2016	2 nd planning template release – including narrative plan & updated planning return	
	2 – 16 Mar 2016	First assurance & initial feedback to local areas on plans	
	9 -16 Mar 2016		Draft 2 nd plans following initial feedback
	9 Mar 2016		BCF JEMC sign off 2 nd plans & BHR CCGs JMT
	15 Mar 2016		HWBB Chair Sign-off
	21 Mar 2016	Submission of planning template	
	22 Mar 2016		CCG Governing body
Submission of signed off plans	22 Mar - 13 Apr 2016	Second assurance of full plans	
			Update plans following second set of feedback
	13 Apr 2016		JEMC sign off Plans & BHR CCGs JMT sign off
	18 Apr 2016		Publication of HWBB agenda, which will include a draft version of the final submission which will be sent to NHSE
	25 Apr 2016	Final submission deadline	
	26 Apr 2016		HWBB meeting where final BCF submission will be jointly agreed by HWBB
	27 Apr		Submission of jointly agreed BCF Plan
	24 May 2016		CCG Governing body

6 Section 75 agreement in 2016/17

6.1 The current section 75 agreement will be extended and renewed for 2016/17 with same features as in 2015/16. This builds on the positive assessment of the governance arrangements which was provided by an audit review earlier in the year. It will continue to include:

- The pooled budget will be hosted by the Council
- The CCG will transfer its contribution to the BCF fund on a monthly basis.
- Monthly reporting on finance and performance will be made to the Joint Executive Management Committee.
- Each partner is responsible for managing overspend related to their own commissioning budget, unless otherwise agreed by the Joint Executive Management Committee.

7 Further integration between health and social care

7.1 There is a clear expectation from Central Government that local areas will from 2017/18 start to roll out plans for further integration between health and social care by 2020, with the Better Care Fund as a key part of this. In developing the Better

Care Fund for 2016/17, partners are aware of the need for longer term strategic integration between health and social care.

- 7.2 As part of the London Health and Care Collaboration Agreement announced in December 2015, Barking and Dagenham, Havering and Redbridge were awarded a pilot to test the concept of an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.
- 7.3 This pilot work will identify whether delivery of an Accountable Care Organisation will accelerate the delivery against the ambitions being set out by the partnership, and build a business case for it. If it is viable, then the eight statutory organisations that form BHR's Integrated Care Coalition will take the decision on whether to proceed with an ACO from 2016/17. In 2016/17 Better Care Fund will continue in its role integrating services and contributing to the work around developing an Accountable Care Organisation and a system-wide vision.

8 Mandatory Implications

Joint Strategic Needs Assessment

- 8.1 The Better Care Fund is specifically mentioned in Recommendation 11 of the 2015 JSNA as a key programme to ensure services promote residents' independence. The Better Care Fund also contributes to Recommendation 12, reducing hospital admissions and re-admissions as well as Recommendation 14, allowing terminally ill adults to die with dignity in a supported and planned way with real choice about where they die.

Health and Wellbeing Strategy

- 8.2 The Better Care Fund reinforces the aims of the Health and Wellbeing Strategy and aligns to three of the four priorities set out in the Health and Wellbeing Strategy: Care and Support, Improvement and Integration of Services; and Prevention. In particular, it is a significant vehicle for the delivery of integration of services, principally for frail older people.

Integration

- 8.3 Integrated commissioning and provision is at the heart of the Better Care Fund and the report sets out a number of ways in which the management of the Fund has furthered integrated service delivery.

Financial Implications

- 8.4 All financial implications are included in Appendix A, Finance report - Better Care Fund 2015/16 Period 6 (Sept 2015), which was provided to the JEMC.

Legal Implications

- 8.5 Since this paper is an update on progress, there are no formal legal implications to consider arising from the content of this report.

Risk Management

- 8.6 Risks are identified in the Better Care Fund Programme Highlight report. The Joint Executive Management Committee considers these risks on an on-going basis.

Patient / Service User Impact

- 8.7 The purpose of the Better Care Fund is as a vehicle to improve services to patients and service users through greater integration. Across a number of areas, including hospital discharge, falls prevention and end of life care, improvements are being made through BCF schemes. It also provides an opportunity to engage with frontline staff and patients/service users themselves about potential improvements that could be made to their services.

9 Non-mandatory Implications

Contractual Issues

- 9.1 Across the Better Care Fund there are investments which are delivered through contracts held by either the Clinical Commissioning Group or the Council. Where procurement activity is taking place (such as proposals that have been before the Health & Wellbeing Board already around carers' services) they are planned jointly, even where one partner is taking the procurement lead. This report proposes no specific changes in itself, and no decisions are required on contractual matters as a result of this update.

List of Appendices:

Appendix A - BCF Financial report

Appendix B - BCF Metric report

REPORT

To: Joint Executive Management Committee (JEMC)

Date: 11 February 2016

Subject: Finance report - Better Care Fund 2015/16 Period 9 (Dec 2015)

Contact: Richard Tyler richard.tyler@lbbd.gov.uk
020 8227 5834

1. Scope of report

1.1 This report reflects the forecast position for the Better Care Fund (BCF) as at 31st of December 2015. It also provides an update on the payment schedule.

2. Better Care fund (BCF) – Period 9

2.1 The BCF budget for 2015/16 excluding the 2014/15 carried forward underspend, amounts to £21.299m of which the CCG also receives £7.7m to carry out its various activities. Appendix 1 reflects the detailed breakdown of the schemes. The table below summarises the forecast:

	Better Care Fund (BCF)	2015-16 Net Budget	Forecast Outturn	Projected Overspend / (Underspend)	
		£000	£000	£000	%
1	Community Health and Social Care	9,158	9,158	0	
2	Improved hospital discharge	2,019	1,984	(35)	
3	New model of intermediate care	3,143	3,143	0	
4	Mental Health Support outside hospital	1,096	1,151	55	
5	Integrated Commissioning	220	170	(50)	
6	Support for Family Carers	925	925	0	
7	Care Act Implementation	1,586	1,586	0	
8	Prevention	1,529	1,512	(17)	
9	End of Life Care	105	0	(105)	
10	Equipment & Adaptations	1,171	1,358	187	
11	Dementia Support	347	347	0	
	Total BCF:	21,299	21,334	35	0.2%

2.2 The summary table above reflects a net pressure of £35k at year end. This is a reduction from last period's reported figure of a £117k overspend excluding the performance penalty. The movement has mainly arisen from the reflection of underspends from uncommitted schemes.

2.3 The total pressures amounting to £242k within the fund are as a result of the following:

- i) Equipment & Adaptations - £187k: This overspend is based on current activity data following assessments carried out by the team. This would continue to be monitored closely and the forecast adjusted accordingly
- ii) Mental Health - £55k: This pressure reported within the BCF represents a proportion of the overall forecast overspend of £267k currently reported against the Mental Health budgets held by the Council due to pressures against its placement budgets.

2.4 The pressures are currently being offset by underspends in the plan mainly arising from schemes which have not been committed. The table below reflects the relevant schemes.

Workstream	SC Grant LBBD £000	Reablement CCG £000	Total projected underspend £000
Improved hospital discharge – Workforce Development	25	10	35
Integrated Commissioning – Strengthening User and Carer Voice	50	0	50
End of Life Care – Services and training	90	15	105
Total uncommitted schemes:	165	25	190

Committing any of these schemes at this stage of the financial year could still potentially lead to an underspend position at year end.

2.5 The Prevention workstream is expected to underspend by £17k against the falls prevention scheme funded through Reablement monies as works where commissioned halfway through the financial year.

2.6 In summary the BCF plan reflects an overall net overspend of £35k and the assumption is that any pressures arising would be managed by the responsible commissioning parties. The table below summarises the impact of the net position on both parties i.e.

Net pressure Analysis	LBBD £000	CCG £000	Total £000
Total Pressures	242	0	242
Total Underspends	0	(17)	(17)
Total Uncommitted Schemes	(165)	(25)	(190)
Net Pressure:	77	(42)	35

- 2.7 It should also be noted that there would be a roll forward request at year end for part of the Social Care Capital grant currently a total of £508k. This roll forward would go towards the replacement of the Social Care IT System. At this stage it is likely most of the costs would be incurred in the new financial year 2016-17.

3. BCF Performance Penalty

- 3.1 LBBB and the CCG are responsible for the risk of services it commissions but the risk share for the performance penalties are to be split 50:50.
- 3.2 The performance penalty is currently estimated as £0.710m, if this is not managed within the BCF this would be split between LBBB and the CCG as follows:

Split of BCF penalty - £710k	LBBB	CCG
	£000	£000
Performance Penalty	355.10	355.10
Use of 2014/15 BCF Underspend	(173.50)	(173.50)
Total	181.60	181.60

4. Payment Schedule

- 4.1 Of the £21.299m the host borough (LBBB) is required to draw down the total of £13.055m from the CCG at £1.088m per month. The balance of the funding i.e. £8.244m relates to other funding streams within LBBB. In turn the CCG draws down funds from the host borough a sum of £7.7m to enable it pay its providers at a sum of £642k per month.
- 4.2 To date, 2015/16 funding drawn down from the CCG and payments made to the CCG are as follows:

Monthly BCF drawdown from CCG	Amount	Invoice Raised by LBBB	Paid
April	£1.088m	Yes	Yes
May	£1.088m	Yes	Yes
June	£1.088m	Yes	Yes
July (less penalty)	£0.914m	Yes	Yes
August	£1.088m	Yes	Yes
September	£1.088m	Yes	Yes
October	£0.910m	Yes	Yes
November	£1.088m	Yes	Yes
December	£1.088m	Yes	No
January	£0.910m	Yes	No
February	£1.088m	Yes	No

Payments to the CCG	Amount	Invoice Received from CCG	Paid
April	£0.642m	Yes	Yes
May	£0.642m	Yes	Yes
June	£0.642m	Yes	Yes
July	£0.642m	Yes	Yes
August	£0.642m	Yes	Yes
September	£0.642m	Yes	Yes
October	£0.642m	Yes	Yes
November	£0.642m	Yes	Yes
December	£0.642m	Yes	No
January	£0.642m	Yes	No
February	£0.642m	Yes	No

5. BCF 2016-17 funding allocation

- 5.1 The funding allocation for the grant has recently been released and a summary of the tentative funding available across various streams are as follows:

Funding stream	2016-17 £000	2015-16 £000	Variance increase/ (reduction) £000	% Change
CCG Funding including Reablement	8,922	8,870	52	
Local Authority base funds **	5,100	5,100	0	
Contribution to each LA based on RNF for Social Care	4,257	4,185	72	
Disabled Facilities Grant (DFG)	1,264	672	592	
Social Care Capital grant	0	508	(508)	
New burdens grant**	1,044	773	271	
Public Health grant**	1,191	1,191	0	
Total Estimated BCF allocation	21,778	21,299	479	2.2%

** Final figures to be included in the pool to be confirmed.

- 5.2 Based on the table above the following assumptions have been made which would need to be confirmed:
- Local Authority base funds have been held at 2015-16 levels but contributions made to schemes needs to be reviewed which could potentially lead to increases or reductions in the contributions to the fund.
 - The allocation for the Contribution to each LA based on the Relative needs formula (RNF) funding for Social Care is assumed to be the former Social Care grant.

- iii) The DFG has increased significantly and the assumption is that the Social Care Capital grant has now been subsumed into this funding but further confirmation would be sought.
- iv) The former New Burdens – Care Act grant has increased and has now been included in the Council's base funds from 2016-17. A decision would need to be made by the Local Authority to confirm whether this should remain part of the BCF or whether it would be taken out.
- v) The Public Health grant is assumed to remain at the same level as 2015-16. The overall grant did receive a reduction and further confirmation would be sought to confirm that the allocation to the BCF would not change.

6. Conclusion

- 6.1 The BCF budget is currently projected to overspend by £35k assuming all underspends offsets the current pressures. A decision would need to be made regarding the underspends highlighted in section 2.4 as this would determine the overall outturn position.
- 6.2 There is also a performance penalty charge of £710k at year end reduced by the BCF 2014/15 underspend of £347k to be mitigated because current activity reflects that the target for the non elective admissions has not been achieved.
- 6.3 The tentative allocation for 2016-17 reflects a 2.2% increase to the pool, but discussions need to take place within the Local Authority to finalise the contribution to the pool and JEMC would need to finalise the 2016-17 Plan to be submitted for approval by the Health and Wellbeing Board.

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1. Non-elective Admissions to Hospital (General & Acute) April 2015

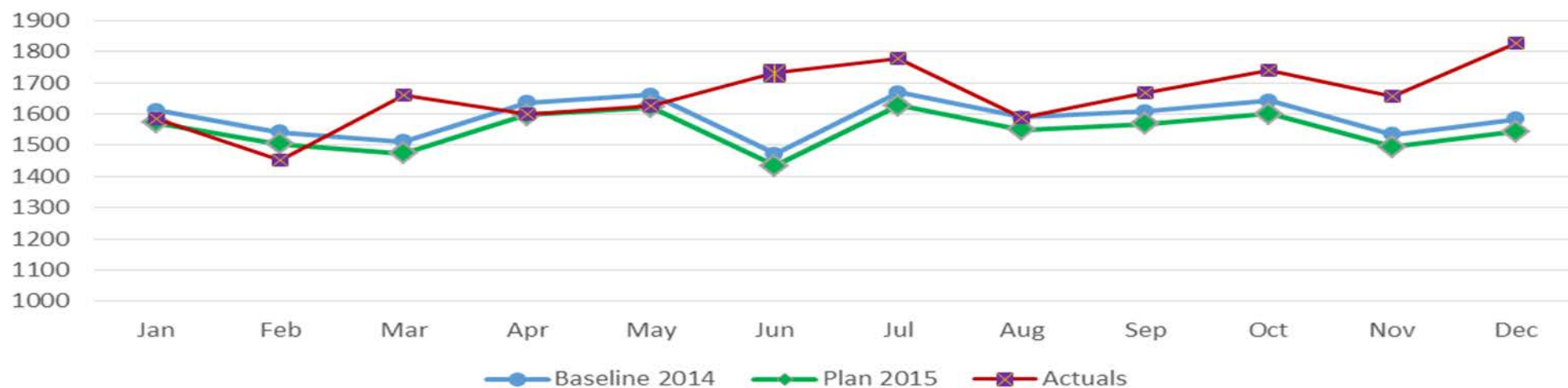
Source: SUS DATA

Definition	The national definition is non-elective admissions general and acute into hospital of all ages in the borough. The aim being to reduce non-elective admissions which can be done by collaboration of health and social system.	How this indicator works	This indicator measures the total number of all non-elective admission (general & acute) of all ages in B&D.
What good looks like	Good performance is meeting the planned reduction actual monthly target with total annual reduction of 477	Why this indicator is important	This indicator is a 'Payment for Performance' metric. This is monitored against a target reduction of 2.5% which has a financial implication if not achieved.
History with this indicator	Monthly Baseline figure in 2014 below indicate 1472 as lowest in June and highest in July - 1668	Any issues to consider	The Metric is monitored by Calendar year rather than Financial year. This indicator was reported on MAR data up until last month. NHSE has revised this and the metric will be reported based on SUS data. The data however includes children, Maternity and Hospital transfers where there were no schemes planned to reduce activity. BHRUT has identified the ambulatory care records and has flagged them.

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Baseline 2014	1613	1543	1512	1638	1662	1472	1668	1589	1609	1643	1534	1583	19066
Planned reduction	40	39	38	41	42	37	42	40	40	41	38	40	477
Plan 2015	1573	1504	1474	1597	1621	1435	1627	1549	1569	1601	1496	1543	18589
Actuals	1586	1452	1660	1600	1627	1731	1778	1589	1667	1740	1655	1826	19911
% Planned reduction(from baseline)	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Variance from baseline	-27	-91	148	-38	-35	259	110	0	58	97	121	243	845
Variance from baseline %	-1.7%	-5.9%	9.8%	-2.3%	-2.1%	17.6%	6.6%	0.0%	3.6%	5.9%	7.9%	15.4%	4.4%
Variance from plan	13	-52	186	3	6	296	151	40	98	139	159	283	1321
Variance from plan %	0.8%	-3.5%	12.6%	0.2%	0.4%	20.6%	9.3%	2.6%	6.3%	8.7%	10.7%	18.3%	7.1%

Barking and Dagenham - Non elective admissions



Performance Overview	<ul style="list-style-type: none"> Oct to Nov 2015 is the last quarter of the BCF 2015. Although October was slight higher than baseline and plan in November the performance was not far off from the baseline and plan. November was also one of the lowest overall number of admissions throughout the year. There has been an increase in non-elective admissions in December when compared to previous months. 	Actions to sustain or improve performance	This metric will not be monitored in 2016/17 by the BCF but will form part of the overall CCG performance monitoring which will bring in line with other strategies that are in place to impact on admissions.
RAG			
Benchmarking	<ul style="list-style-type: none"> Benchmarking information is the 2014 performance. 		

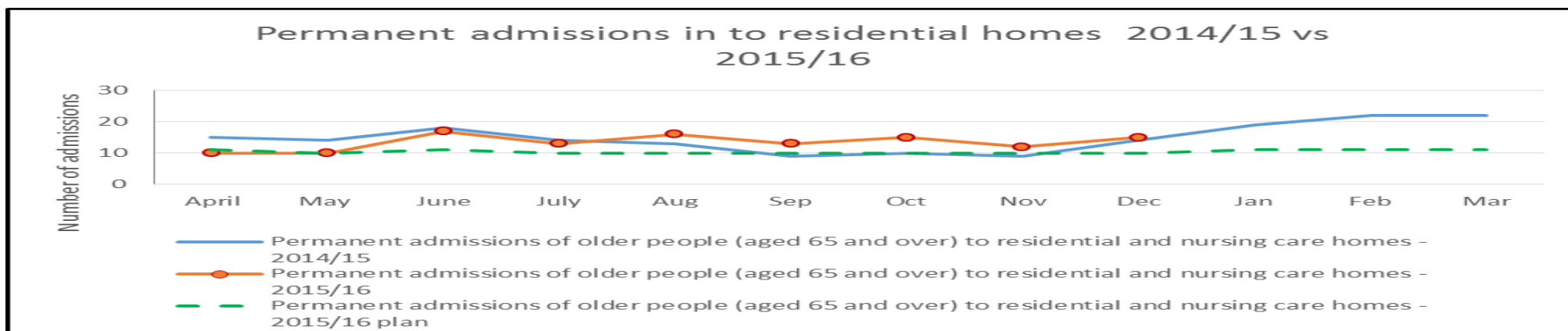
2. Permanent admissions into residential /nursing placements for older people (65) April 2015

Source: Social Care

Definition	The national definition is admissions into care(residential/nursing) for older people 65+ in the borough. The aim being to reduce inappropriate admissions of older people (65+) into care.	How this indicator works	This indicator measures the total number of permanent admission into residential and care for older people 65+ in B&D. (ONS estimated population figure for 2015/16 is 19,669
What good looks like	BCF target is 125 admissions in total in 2015/16. The target for rate per 100,000 population is 635.5 for the year. Good performance would be under the annual target of 125 admissions or 635.5 rate per 100,000 population	Why this indicator is important	The number of permanent admissions to residential and nursing care homes is a good measure of the effectiveness of care and support in delaying dependency on care and support services, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions where appropriate. This includes placements made through the Older People Mental Health team.
History with this indicator	In 2014/15, there were 179 admissions against the plan of 130 admissions. 40 more admissions when compared against plan	Any issues to consider	Please note that admissions encompass both those agreed by the Councils Divisional Director (and delegates) and admissions outside of these such as those within Mental Health. Figures below are actual numbers of admissions and not rate per 100,000.

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Whole year
Admissions (65 and over)-2014/15	15	14	18	14	13	9	10	9	14	19	22	22	179
Admissions (65 and over) -2015/16	10	10	17	13	16	13	15	12	15				121
Admissions (65 and over) -2015/16 plan	11	10	11	10	10	10	10	10	10	11	11	11	125

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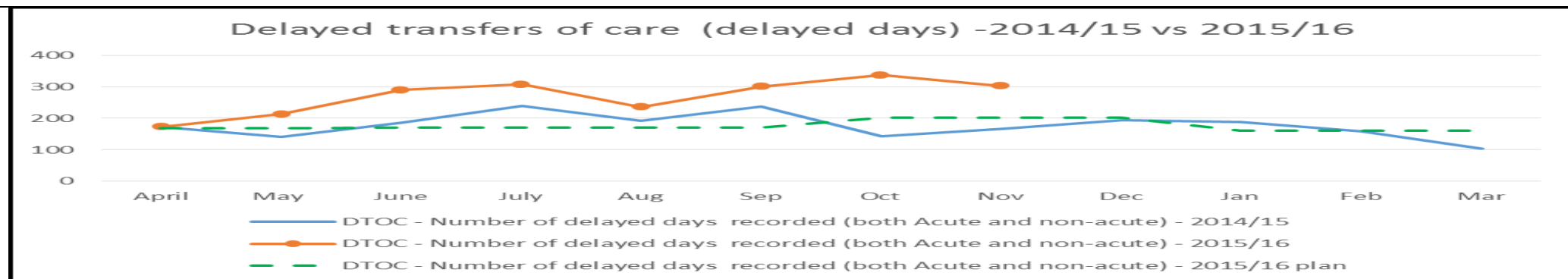
Performance Overview	<ul style="list-style-type: none"> Q3 Oct – Dec 2015 actual of 42 has overall been above plan and baseline. Plan was for 30 admissions in a quarter which was 3 down from the baseline of 33 admissions in 2014/15. It has been note there has been increasing in people being admitted in care homes this year that in the past. Our target was 125 for 2015/16 we currently expect performance to be much higher than this in the region of ?180 admissions. Reviewing the last performance over the last 4 year (11/12 – 200, 12/13 – 170, 13/14 – 135, 14/15 – 179) has been on average has been 171 admissions. 	Actions to sustain or improve performance	<p>A number of actions have been taken by Adult social care team to manage and monitor the number of admissions.</p> <p>A review of the target for 2016/17 needs to be based on the average 171 admissions per year than anything lower than 125.</p>
RAG			
Benchmarking	<ul style="list-style-type: none"> Number of permanent admissions in 2014/15 was 179. 		

3. DTOC – Total Delayed Days in the Month April 2015

Source: NHS England published

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Definition	The national definition of a delayed transfer of care is when a patient is ready for transfer from acute care, but is still occupying an acute bed.	How this indicator works	This indicator measures the total number of delayed days recorded in the month regardless of the responsible organisation (social care/ NHS). The figures shown are number of delayed days (18+ population of 142,593 for first 3 Quarters and 145,357 for Q4). (This is as per BCF submitted plan)									
What good looks like	Good performance would be under 509 delayed days for Q1, under 513 delayed days for Q2, under 618 delayed days for Q3 and 491 delayed days for Q4.	Why this indicator is important	This indicator is important to measure as the average number of delayed days per month (per 100,000 pop) is included in the Better Care Fund performance monitoring.									
History with this indicator	In 2014/15, Q1, Q3 and Q4 targets were met. In Q2, there were 669 delayed days reported against a plan of 504 days.	Any issues to consider	Please note that these figures are taken from the Department of Health website and have not been verified by Barking and Dagenham Social care, these figures will also include patients from Mental Health.									
	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DTOC - 2014/15	172	141	187	239	192	238	143	167	194	188	158	103
DTOC - 2015/16	173	213	290	308	236	301	337	303				
DTOC - 2015/16 plan	169	169	171	171	171	171	202	202	202	161	161	161



Performance Overview	<ul style="list-style-type: none"> Of the 303 delayed days in November, 138 delays are due to NHS, 157 delays are due to Social care and 8 are due to both Health and Social care. The main reasons for delayed days are due to public funding, assessment not being completed and awaiting nursing home placement or availability. Most of the DTOC are inpatient mental health due to embargo. 	Actions to sustain or improve performance	The causes are known and are being discussed at senior level. Once these are resolved performance will return to trajectory.
RAG			
Benchmarking	The number of delayed days in November 2014/15 was 167.		

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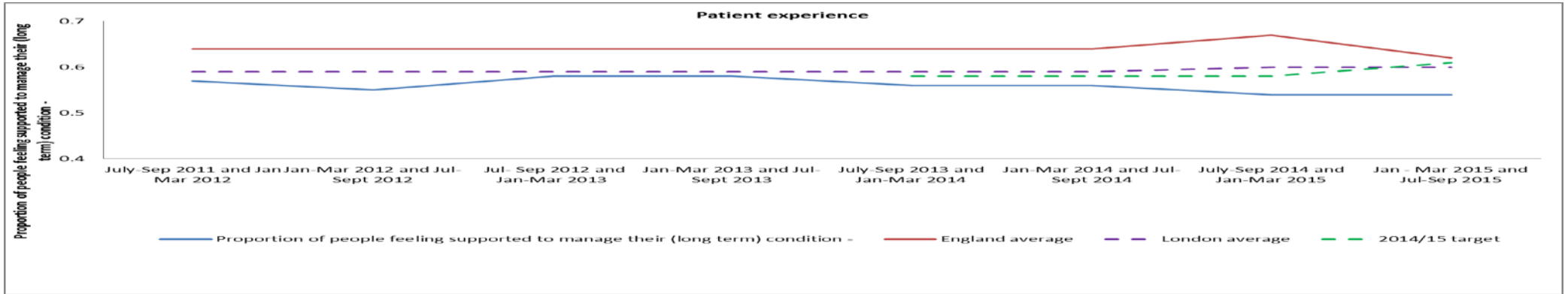
4. Proportion of older people 65+ still at home 91 days after discharge 2015												
											Source: Social Service	
Definition	Older people still at home 91 days after discharge from hospital into reablement/rehabilitation services. The aim is to increase in effectiveness of reablement/rehabilitation services whilst ensuring those offered service does not decrease					How this indicator works	This indicator measures the total number of older people 65+ in B&D offered reablement services remaining at home 91 days after discharge. The figures shown below are. (ONS 12-13 estimate population of 198,409)					
What good looks like	Increase in the number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital remaining in their homes 91 days after discharge. The target in 2014/15 – 89.3% . Target in 2015/16 – 90%					Why this indicator is important	This one of the metric for the BCF that LBBD & CCG have agreed to add to national metrics.					
History with this indicator	In 2013/14 88.3 % of older people are reported to be still at home 91 days after discharge from hospital in to reablement/ rehabilitation services					Any issues to consider	This is an annual indicator there is no data to report on a monthly basis.					
	Apr-15	May-15	June-15	July-15	Aug-15	Sept-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Reablement Metric	In 2014/15 , the proportion of people (65 and above) who were still at home, 91 days after discharge is 89.3%											

Performance Overview	<ul style="list-style-type: none"> The target for 2015/16 is 90%, the actual is 67.2% This is lower when compared to 88.3% in 2014/15 Part of the review has shown there were significantly more deaths in 15/16 which explains why the figure dropped from 88.3% in 2013/14 to 67.2% 	Actions to sustain or improve performance	We are reviewing our data collection methods to ensure its in line with other others and we are comparing unfavourable to similar boroughs.
RAG			
Benchmarking			

5. Proportion of people feeling supported to manage their (long term) condition December 2014

Source: GP Survey

Definition	A proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition.	How this indicator works	The indicator is based on responses to questions in the GP Patient Survey which is as follows: In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)? Responses will be weighted according to the following 0-100 scale: "No" = 0 , "Yes, to some extent" = 50 , "Yes, definitely" = 100	
What good looks like	A greater proportion of people with long-term condition feeling supported to manage their condition. 2014/15 target is .58. The target for 2015/16 is .61	Why this indicator is important	This one of the metric for the BCF that LBBD & CCG have agreed to add to national metrics.	
History with this indicator	0.56 – based on the aggregated data collected from July-Sep 2013 and Jan- Mar 2014. In other words 56% of people(aged 18 and over)suffering from long-term condition felt supported to manage their condition	Any issues to consider	This publication uses aggregated data collected across two separate waves of fieldwork, from July –Sep 2014 and again from Jan-Mar 2015.	
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Proportion of people feeling supported to manage their LTC	.54		.54	
Plan	.58		.61	



Performance Overview	<ul style="list-style-type: none"> As per the latest released data this metric has remained at .54% The last data collection Jul-Sept 2015 which was published in December 2015 and has remained the same as in the previous collection of Jan-Mar 2015 	Actions to sustain or improve performance	There is further work planned with local Patient Participation Groups and Health watch to understand patient experience.
RAG			
Benchmarking	<ul style="list-style-type: none"> England average is .63 and London average is .59 		

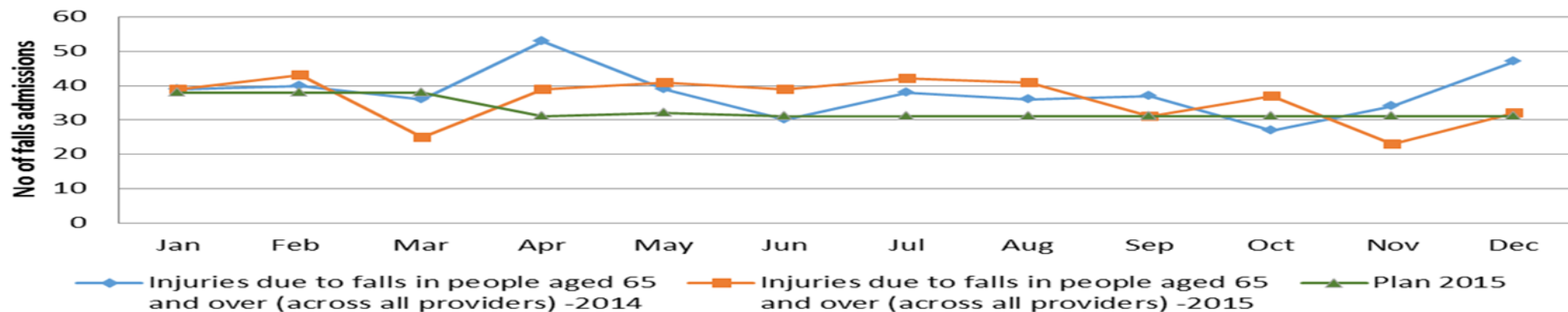
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6. Injuries due to falls in people aged 65 April 2015

Source: SUS residence based data

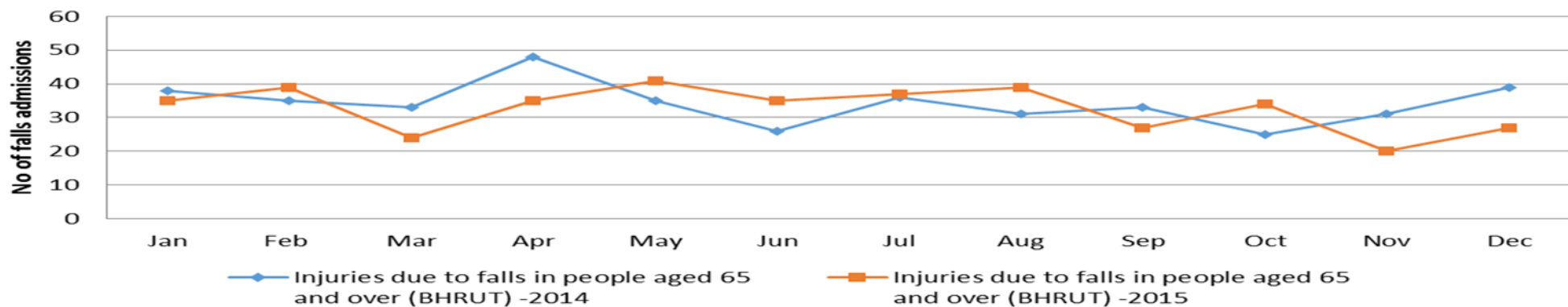
Definition	Emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population						How this indicator works	This indicator measures the number of emergency admissions due to falls related injuries. (65+ population of 19,669). (This is as per BCF submitted plan). Reduction of 394 admissions in 2015 Calendar year					
What good looks like	A reduction in rate when compared to previous year will reflect the success of services in preventing falls which will give an indication of how the NHS, public health and social care are working together to tackle issues locally.						Why this indicator is important	This indicator is one of the metrics for BCF (local metric)					
History with this indicator	The average admission rate for injuries due to falls across all providers for B&D resident population (per 100,000) in 2013/14 is 211.4 The average admission rate for injuries due to falls in BHRUT for B&D resident population (per 100,000) in 2013/14 is 198.1						Any issues to consider	According to latest NHSE submission, this metric will be monitored on a calendar year (similar to Non-elective admissions) rather than the Financial year. The table below shows the actual number of admissions rather than the rate					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Falls admissions 65 and over (across all providers)- 2014	39	40	36	53	39	30	38	36	37	27	34	47	
Falls admissions 65 and over (across all providers)-2015	39	43	25	39	41	39	42	41	31	37	23	32	
2015 Plan	38	38	38	31	32	31	31	31	31	31	31	31	

Falls related admissions (across all providers)- 2014 vs 2015



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Falls admissions 65 and over in BHRUT-2014	38	35	33	48	35	26	36	31	33	25	31	39
Falls admissions 65 and over in BHRUT -2015	35	39	24	35	41	35	37	39	27	34	20	27

Falls related admissions (BHRUT)- 2014 vs 2015



Performance Overview	<ul style="list-style-type: none"> • There is a reduction in Falls admissions in November 15/16 when compared to same period last year. • Q2 (July – Sep) 15/16 Plan (across all providers) is 93 where the actual is 114. This is 21 admissions more than what was planned for Q2. 	Actions to sustain or improve performance	<ul style="list-style-type: none"> • Handyperson's service commenced in Nov, the referral criteria is being reviewed and would take into account the over 85 age group which have had significant number of admissions related to falls.
RAG (Q3 Position)	<ul style="list-style-type: none"> • Q3 (Oct-Dec) 15/16 Plan (across all Providers) is 93 whereas the actual is 92. • There has been an increase in the number of falls related admissions for over 85 age group in Q2 and Q3 . • 65-74 and 75-84 age group shows reduction in falls 		
Benchmarking			

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HEALTH AND WELLBEING BOARD

8 March 2016

Title: Transforming Care Partnership	
Report of the Strategic Director for Service Development and Integration	
Open Report	For Information
Wards Affected: ALL	Key Decision: NO
Report Author: Karel Stevens-Lee Joint Commissioning Manager, Learning Disabilities	Contact Details: Tel: 020 8227 2476 Email: Karel.stevens-lee@lbbd.gov.uk
Sponsor: Anne Bristow, Strategic Director for Service Development and Integration	
Summary: <p>This is a report updating the board on the developments of the newly formed Barking and Dagenham, Havering and Redbridge Transforming Care Partnership (BHR TCP) for young people and adults with learning disabilities and/or autism including those with a mental health condition.</p> <p>The BHR TCP is a partnership with membership from the three Local Authorities, Clinical Commissioning Groups (CCG), Specialist Commissioning (NHS England) and North East London NHS Foundation Trust (NELFT).</p> <p>In October 2015, NHS England (NHSE), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called <i>'Building the Right Support'</i>. The programme is an extension of the Winterbourne View programme and aims to ensure that more people are supported in the community rather than in placements in institutional settings, namely Assessment and Treatment Units (ATUs), within the next 4 years.</p> <p>In order to achieve this outcome, a number of actions have been set out for each TCP to deliver within a timeframe. This includes:</p> <ul style="list-style-type: none"> • Mobilisation: BHR TCP will need to have a solid foundation upon which to base its transformation with strong leadership and sound governance. • Developing a vision: BHR TCP will need to develop a shared vision of how the service will change across the new TCP geographical area. • Implementation: BHR TCP will need to clearly set out how it will deliver the outcomes of the vision and identify the resources it will need to ensure success. 	

BHR TCP is required to submit its vision and work plan by 11 April 2016. The submission is required to include consultation with stakeholders and approval of the vision and plan by all of the relevant Health & Wellbeing Boards (HWBB) across Barking and Dagenham, Havering and Redbridge. The BHR TCP has begun to shape the vision in preparation for 11 April submission. This report provides an outline of the initial vision for the TCP programme and the steps that will be taken to consult with stakeholders and groups over the next 6 weeks.

As the final submission date is before the next Health and Wellbeing Board, the report asks to delegate authority to the Accountable Officer for BHR Clinical Commissioning Groups and the Strategic Director for Service Development and Integration for the local authority to finalise the plan before submission. The final TCP plan will be presented to the HWBB in April 2016.

The report will be accompanied by a presentation at the March Health and Wellbeing Board meeting outlining the initial vision and priorities for the BHR TCP transformation plan in more detail.

Recommendation(s)

Members of the Board are recommended to:

- (i) Note the progress that has been made in developing the BHR Transforming Care Partnership vision to date.
- (ii) Discuss and agree the proposed actions and consultation activity that will be undertaken to finalise the vision and plan before 11 April 2016.
- (iii) Delegate authority to the Strategic Director for Service Development and Integration (LBBD) and the Accountable Officer (BHR CCGs) to sign off the final submission before the 11 April 2016 deadline.

Reason(s)

The Transforming Care Partnership is an extension of the good work that has already been undertaken in the Borough to improve the care and support available for service users with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

The scope and potential implications of delivering the BHR TCP will require commitment from all partners.

1. Introduction & Background

- 1.1 In October 2015, NHS England, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called '*Building the Right Support*'. The plan, agreed by all national partners, aims to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. The programme is expected to achieve a closure of 40-65 % of inpatient facilities nationally within the next 4 years. *Building the Right Support* is the next step in the vision set down in the Winterbourne View

Concordat which seeks to ensure that people with learning disabilities are given the support that they need close to home.

- 1.2 Transforming Care Partnerships have been set up to achieve the aims set out in the national plan. Locally, our Transforming Care Partnership includes Barking and Dagenham, Havering and Redbridge and includes the three local authorities, CCGs and North East London NHS Foundation Trust. Each TCP is expected to produce a transformation plan by 11 April 2016 setting out how it will work together to reduce the usage of institutional settings, namely Assessment and Treatment Units (ATUs), and provide more services in the community.
- 1.3 Transforming Care Partnerships will work alongside people who have experience of using services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement these joint transformation plans.
- 1.4 It is intended that TCPs will bring commissioners together at a scale larger than most CCGs and many local authorities. It is envisaged that these wider partnerships will enable TCPs to:
 - Build where possible on existing collaborative commissioning arrangements in place in the area (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities).
 - Develop local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services it makes sense for those CCGs to implement change collaboratively.
 - Commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive.

2. Our local vision

- 2.1 Over the last month, representatives from Barking and Dagenham, Havering and Redbridge have been working together to produce an initial vision for the TCP. At this stage, no resources have been committed by any of the representative organisations although partners will be expected to align existing resources to achieve the vision for this cohort of individuals.
- 2.2 Locally across BHR our vision is consistent with the national service model and is currently (subject to further stakeholder engagement to confirm exact wording):

“People with a learning disability and/or autism, including people with complex and challenging behaviour, can lead fulfilling and rewarding lives while being part of a community that is able to support them with dignity and respect and ensure that people’s individual wellbeing is at the heart of decisions.”
- 2.3 The Partnership have stated that they are committed to achieve the vision by designing and implementing care and support services that:
 - Provide support and interventions in the least restrictive manner and for the shortest time possible;

- Provide respite for families and carers that enables at home placements to be maintained with positive family relationships;
- Ensure that people who need inpatient care do not have to travel long distances to access it;
- Strengthen multi-disciplinary and multi-agency working to reduce health inequalities;
- Make better use of community provision across the three boroughs;
- Ensure that people have choice and control over their own health and care services;
- Ensure that early identification and early support is commissioned and provided;
- Enable people with learning disabilities and or autism and their family and carers to have access to the right level of information, advice and advocacy.

2.4 Our initial thoughts on our vision were presented to NHS England on 25 February 2016 by a panel of BHR TCP members and officers from the representative organisations. We are currently awaiting our formal feedback which will be used to inform the final transformation plan. An update will be given at the Health and Wellbeing Board meeting on 8 March 2016. The deadline for the final plan is 11 April 2016.

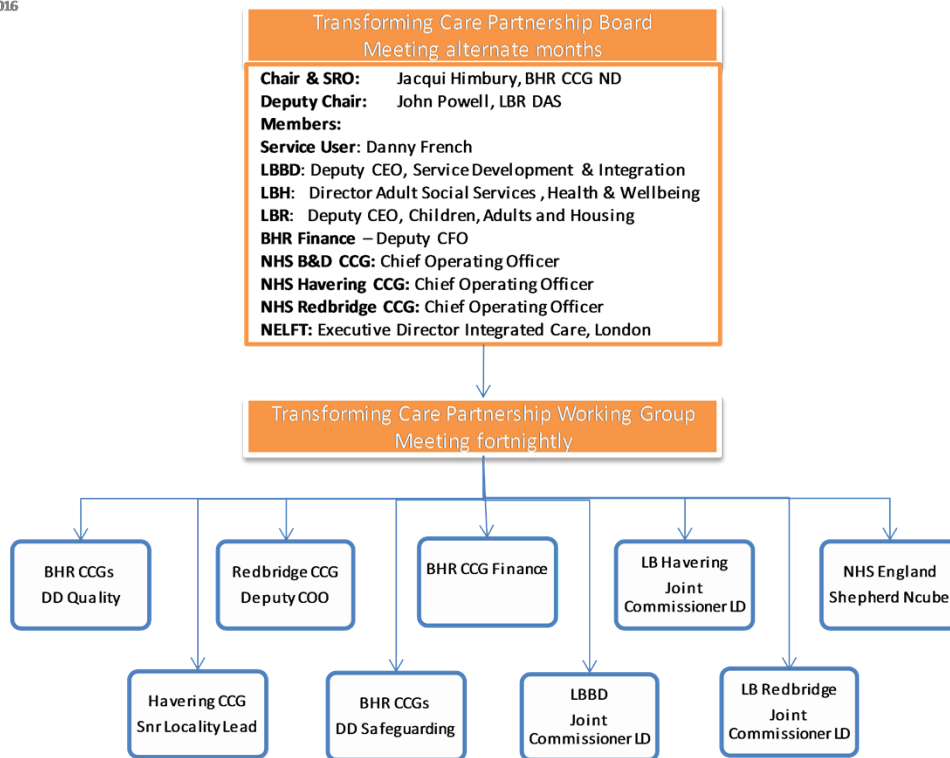
2.5 More detail on the proposed vision and priorities for the TCP transformation plan will be provided in the presentation accompanying this report at the Health and Wellbeing Board meeting.

Governance and membership

2.6 The Barking and Dagenham Havering and Redbridge Transforming Care Partnership will provide leadership on the delivery of the TCP plan and is accountable for the delivery of the programme. The Transforming Care Programme has a working group which consists of representatives from all Boroughs, CCGs and NHS England, which is described in the diagram below:

Detail of Transforming Care Partnership Board

Updated February 2016



3

- 2.7 Service users, carers and providers will also be invited to participate in the Board, as well as representatives from the community and voluntary sector.
- 2.8 A Project Manager is supporting the development of the transformation plan and is working closely with the TCP Board and officers within Barking and Dagenham, particularly the Integrated Commissioning Manager for learning disabilities and the Joint Commissioning Manager in children's.
- 2.9 It should be noted that the Learning Disability Partnership Board have already taken the lead in shaping the TCP vision and objectives on behalf of the Barking and Dagenham Health and Wellbeing Board and an initial discussion took place at the LDPB meeting on 2 February 2016 to inform the transformation plan. This included representatives from the carer, provider and service user forum.

Consultation

- 2.10 Over the next six weeks, the Chair of the TCP, Jacqui Himbury, the Project Manager and Integrated Commissioning Manager for Learning Disabilities will consult with stakeholders in Barking and Dagenham to develop the final vision and priorities of the BHR TCP transformation plan.

2.11 The following groups will be consulted. The Board are asked to discuss this proposed consultation activity and comment upon whether any other groups should be consulted within the time available:

- Learning Disability Partnership Board (including service user, carer and provider forums);
- Mental Health Sub-Group;
- Safeguarding Adults Board;
- Local Safeguarding Children's Board;
- SEND Programme Board.

3. Mandatory Implications

3.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment has a strong learning disability analysis and the detail contained in this report aligns well with the strategic recommendations of the Joint Strategic Needs Assessment. The importance and issues of suitable housing has previously been presented to the Health and Wellbeing Board. Housing solutions will be incorporated in the overall vision of the TCP.

3.2 Health and Wellbeing Strategy

The report describes priorities outlined in the strategy on service improvement that need to be provided now and in the future to enhance the lives of people with a learning disability.

3.3 Integration

The BHR TCP has representation from the local authority, the CCG and NELFT. The voluntary and community sector will also be invited to participate in the Board. The TCP will have representation from service users, carers and providers of learning disability services.

HEALTH AND WELLBEING BOARD

8 March 2016

Title:	London Ambulance Service NHS Trust Improvement Plan		
Report of the London Ambulance Service NHS Trust			
Open Report	For Information		
Wards Affected: ALL	Key Decision: No		
Report Author: Terry Williamson Stakeholder Engagement Manager, London Ambulance Service NHS Trust	Contact Details: Tel: 0207 783 2873 E-mail: Terry.Williamson@lond-amb.nhs.uk		
Sponsor: Terry Williamson, Stakeholder Engagement Manager, London Ambulance Service NHS Trust			
Summary: The London Ambulance Service NHS Trust was inspected by the Care Quality Commission (CQC) Chief Inspector of Hospitals in June 2015. The result of the inspection was that the Service was rated as “inadequate”. The report contains the Service’s Quality Improvement Plan which outlines its intention to provide a better service to patients and to become a better place to work.			
Recommendation(s) The Health and Wellbeing Board is recommended to note the contents of the report.			
Reason(s) The Board has previously expressed an interest in the performance of the London Ambulance Service and the way that it provides services to the residents of Barking and Dagenham. Following the announcement of the CQC inspection, London Ambulance Service offered to update the Board on the Service’s Quality Improvement Plan and the impact locally.			

1 Introduction and Background

- 1.1 The London Ambulance Service NHS Trust (LAS) responds to over 1.9m calls and attends over 1 million incidents each year. It provides emergency medical services to the whole of Greater London, which has a population of around 8.9 million people and is the busiest emergency ambulance service in the UK. The Service employs over 4,600 whole time equivalent (WTE) staff, who work across a wide range of roles based in over 70 ambulance stations and support centres.
- 1.2 LAS is commissioned by 32 Clinical Commissioning Groups for London and by NHS England.
- 1.3 The Care Quality Commission (CQC) Chief Inspector of Hospitals inspection of The London Ambulance Service NHS Trust took place between 1st and 5th June 2015, and 17th and 18th June 2015, with further unannounced inspections on 12th, 17th and 19th June 2015. This inspection was carried out as part of the CQC's comprehensive inspection programme. Four core services were inspected:
 - Emergency Operations Centres
 - Urgent and Emergency Care
 - Patient Transport Services
 - Resilience planning including the Hazardous Area Response Team
- 1.4 The CQC inspection report was published on 27th November 2015. Overall, the trust was rated by the CQC as "Inadequate".
- 1.5 In response, the LAS developed a Quality Improvement Plan to address the findings of the CQC report and improve the Inadequate rating of the Trust. The Quality Improvement Plan has identified five work streams –
 - Making the London Ambulance Service a great place to work
 - Achieving good governance
 - Improving patient experience
 - Improving environment and resources
 - Taking pride and responsibility
- 1.6 In each of these work streams key improvement projects have been identified that will underpin our work to deliver the improvement plan. The Trust has been working intensively to deliver these projects. For these detailed projects to deliver there are five critical enablers:
 - Staff engagement
 - Strong programme governance
 - Visible leadership
 - Our partnership with Defence Medical Services
 - Outcome of the 2016/17 contracting round
- 1.7 The LAS Quality Improvement Plan is attached in full at **Appendix A**.

2 Impact for Barking and Dagenham

- 2.1 LAS responds to calls in Barking and Dagenham using resources that are dynamically deployed throughout the Borough, primarily from ambulance stations in Dagenham, Ilford, Hornchurch and Romford which constitutes the North East London sector, but also using resources from neighbouring areas such as Newham, Hackney and Waltham Forest. All 999 calls are received and prioritised in our Emergency Operations Centres at Waterloo and Bow. There are approximately 200 operational staff working to cover the vehicles deployed in North East London including, Paramedics, Emergency Medical Technicians; International Paramedics and Emergency Ambulance Crews. This is managed by a North East London team of operational front line Clinical Managers and other specialist managers to support front line operations.
- 2.2 Year to date (01/04/2016 to 19/02/2016) LAS performance is at 63.8% on Category A (life threatening) calls responded to in Barking and Dagenham. This compares to 64.6% for London and 64.5% for North East London. Abbey ward has seen the highest number of Category A calls at 970 and Parsloes ward the least with 542. Activity in Barking and Dagenham overall is up 4.7%, year to date on all calls. The North East sector is currently the highest performing area in LAS.
- 2.3 LAS continues to recruit Paramedics from around the world and Barking and Dagenham will be served by some of these starting in March 2016. An innovative alternative resource scheme, operated in partnership with NELFT and targeted to respond to calls from elderly fallers, continues to provide an appropriate care pathway for these patients and prevents attendance at hospital. The Quality Improvement Plan will involve our staff in all its work streams to ensure local operations maintained and improved upon.

3 Mandatory Implications

Joint Strategic Needs Assessment

- 3.1 There are none

Health and Wellbeing Strategy

- 3.2 A well-rated and high-performing London Ambulance Service underpins the delivery of Barking and Dagenham's Health and Wellbeing Strategy. The actions set out in the Quality Improvement Plan support the Improvement and Integration of Services priority through improving treatment and care by benchmarking against best practice and where we identify that care has failed.

Integration

- 3.3 There are a number of actions identified in the Quality Improvement Plan that promote better integration between the LAS and partner organisations, including improved access to urgent care centres and working with challenged providers to drive actions to support timely hospital handovers.

Financial Implications

- 3.4 There are none

Legal Implications

3.5 There are none

Risk Management

3.6 Not applicable

Patient / Service User Impact

3.7 Currently London residents are served by and Ambulance Service which has been rated as Inadequate by CQC. Actions set out in the Quality Improvement Plan will improve the quality of the service that residents in London receive.

List of Appendices:

Appendix A London Ambulance Service NHS Trust Improvement Plan January 2016



London Ambulance Service
NHS Trust



Our quality improvement plan



Moving Forward Together

January 2016



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Our Quality Improvement Plan – The Five Work Streams	.. page 15
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How we will deliver our Quality Improvement Plan	.. page 33
<ul style="list-style-type: none">• Staff engagement• Strong programme governance• Visible leadership• Our partnership with Defence Medical Services• Outcome of the 2016/17 contracting round	
Working in Partnership to Ensure Delivery	.. page 38

The context

The London Ambulance Service NHS Trust is one of 10 Ambulance Trusts (and Ambulance Foundation Trusts) in England, responding to over 1.9m calls and attending over 1 million incidents each year. We provide emergency medical services to the whole of Greater London, which has a population of around 8.9 million people. We are the busiest emergency ambulance service in the UK. The Service employs over 4,600 whole time equivalent (WTE) staff, who work across a wide range of roles based in over 70 ambulance stations and support centres.

‘The London Ambulance Service NHS Trust is here to care for people in London: saving lives; providing care; and making sure they get the help they need.’

Our purpose is supported by the following values:

In everything we do we will provide:

Clinical excellence: giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

Care: helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

Commitment: setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

The main role of the Service is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the Emergency Operations Centres (EOC), which provides call handling, triage, disposition, emergency ambulance dispatch, hear and treat, and clinical advice. Other services provided include: Non-



Emergency Transport (NETS) for patients not requiring further assessment or intervention; Patient Transport Services (PTS) for transporting non-emergency patients between healthcare locations or their home address; NHS 111 in SE London (the non-emergency number for clinical advice); and other specialist services including the Hazardous Area Response Teams (HART) who are trained to work in challenging or difficult environments.

At its heart our Quality Improvement Plan is about delivering better care for patients and making The London Ambulance Service a better place to work. In order to achieve this, we need to fundamentally transform the Service. This document describes how we will do this.

What the Care Quality Commission said about The London Ambulance Service

The Care Quality Commission (CQC) Chief Inspector of Hospitals inspection of The London Ambulance Service NHS Trust took place between 1st and 5th June 2015, and 17th and 18th June 2015, with further unannounced inspections on 12th, 17th and 19th June 2015. This inspection was carried out as part of the CQC's comprehensive inspection programme.

Four core services were inspected:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience planning including the Hazardous Area Response Team

The CQC inspection report was published on 27th November 2015. Overall, the trust was rated by the CQC as 'Inadequate'.

Of the five CQC domains: Safe was rated as 'Inadequate', Effective was rated as 'Requires Improvement', Caring was rated as 'Good', Responsive was rated as 'Requires Improvement', and Well-led was rated as 'Inadequate'.

The report identifies a number of "must do" and "should do" actions for the Service and these are embedded within the section entitled: "Our Quality Improvement Plan – The Five Work Streams"

We are pleased the CQC recognised:

- That patients in London receive good clinical care
- Our staff are caring and compassionate
- Paramedics and nurses in our control room give good advice to frontline staff while our intelligence conveyance system prevents overload of ambulances at any one hospital



- In the event of a major incident we have clear systems and plans in place and an alert system for staff who have proved they are always keen to respond – even when not on duty
- We have effective systems to manage large scale events such as Notting Hill Carnival and the central London New Year’s Eve event
- We are highly skilled at responding to major incidents in London and practice our response regularly with our 999 partners
- Staff were positive about local leadership and said the management style of the new Chief Executive would improve the service and staff retention.

Improvements we have already made since the CQC inspection

The CQC inspected The London Ambulance Service in June 2015. We were already acutely aware of many of the issues that the CQC inspection and report raised, and many actions were already in progress to improve the organisation for our staff and patients.

In broad terms since the inspection:

- We have 284 additional frontline staff responding to incidents in London and over 177 in training and supervision while our recruitment campaign continues. More staff will help take some of the pressure from our staff who work incredibly hard in often difficult circumstances
- Our Chief Executive and members of our Executive Leadership Team have met over 900 people during October 2015, during our staff road shows, and the discussion and feedback from these sessions have helped shaped the projects within our plan
- We have introduced the London Ambulance Service Academy to offer existing non-clinical staff the opportunity to train as paramedics and are working with universities to create more graduate paramedic places
- We have new leadership teams in place that are resolutely determined to create a positive working environment for everyone
- We have trained all of our most senior managers on how to tackle inappropriate behaviour in the work place.

In detail - progress since the inspection

Between the CQC inspection in June 2015 and December 2015 we have taken action and made significant progress in five particular areas across the Service:

- Resilience
- Medicines Management
- Risk and Governance
- Culture
- Workforce and staff morale

There is still work to do in each area and this is described later in this document in an overview of the Quality Improvement Plan, but it is important to emphasise the progress that has already been made to deliver better care for patients and provide a supportive working environment for our staff.

This progress was discussed at The London Ambulance Service CQC Quality Summit and our stakeholders, in particular our Clinical Commissioning Group lead commissioners, NHS England (London) and the Trust Development Authority, have asked that their appreciation of the progress made already by the Service was acknowledged in this document.

Resilience

CQC said we must :

Recruit to the required level of Hazardous Area Response Team (HART) paramedics to meet its requirements under the National Ambulance Resilience (NARU) specification.

Progress as of January 2016



- Recruited to all of of the 84 HART posts; 83 of these posts will have completed national HART training and be fully operational by 31 March 2016
- We have issued a guidance document setting out the rare occasions when HART resources can be used on the frontline. This has been communicated to all relevant staff
- The Major Incident Protocol has been revised and approved by Trust Board
- New rosters have been designed and implemented to spread skill-mix and increase capacity and flexibility
- We have reviewed staffing on rosters, and for January 2016 we were compliant 94% of the time. This figure continues to improve
- We have negotiated a formal agreement with South East Coast Ambulance Service to provide additional cover at Heathrow Airport should we need it
- Core Skills Refresher (CSR) training has now been redesigned and now includes Major Incident training for all frontline staff
- We have implemented a physical competency assessment for all HART staff
- We have set up a Resilience Action Group to ensure compliance against the HART National Ambulance Resilience Unit specification
- We have deep cleaned the HART premises and we are conducted an announced mock-inspection for medicines management
- The Executive Leadership Team have considered a proposal about HART vehicles and are now awaiting the reviewed national specification for these vehicles before making a final decision.

Medicines Management

CQC said we must improve its medicines management including:

Formally appoint and name a board director responsible for overseeing medical errors and formally appoint a medication safety officer; Review the system of code access arrangements for medicine packs to improve security; Set up a system of checks and audit to ensure medicines removed from paramedic drug packs have

been administered to patients; Set up control systems for the issue and safekeeping of medical gas cylinders.

Progress as of January 2016

- Appointed a medicines safety officer in August 2015, and the Medical Director is the executive lead for medicines safety on the Board
- Undertaken a review and process- mapped the journey of a drug from when it arrives in the Service to when it is administered to a patient. As a result we have implemented audits at key points during this journey
- Medicines management communication campaign started called “Shut it, Lock it, Prove it” co-designed with Clinical Team Leaders and supported by communication with clinical staff
- We are working with the Trust Development Agency (TDA) and CQC to review and update the guidance for administering drugs by paramedics in the UK.

Risk and Governance

CQC said we must:

Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly; Address under reporting of incidents including the perceived pressure in some departments not to report incidents

Progress as of January 2016

- Baseline audit of the status of all local risk registers completed for all departments and all group stations



- Designed a risk-management training programme for all managers, which launched in November 2015 and we will have trained all managers by 31 March 2016
- The Governance Team are attending local meetings to raise the profile of risk management and provide advice and support
- All local risk registers will be updated by the end of March 2016
- HART and EOC risk registers have been reviewed and updated
- As a result of the new operational management structure being fully implemented in September 2015, clear accountability for risk management and governance is now specified and understood
- Duty of Candour training has been underway since the end of 2015 for staff leading Serious Incident investigations. We are beginning to see evidence of the application of Duty of Candour for serious incidents and potential serious incidents
- To simplify and improve incident reporting we are in the final stages of preparation for the launch of *Datix Web*, a new electronic risk management system for all staff to use, in April 2016 and full implementation will be complete by June 2016.

Culture

CQC said we must:

Develop a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.

Progress as of January 2016

- Awareness training in bullying and harassment has been completed for the Executive Leadership Team and the Senior Leadership Team
- An independent Telephone Advisory Service has been in place since July 2015



- In November 2015 we appointed a specialist Bullying and Harassment Lead
- We commissioned independent investigators to lead on any bullying allegations within the Service
- We have designed and launched simple and easy-to-follow guidance for staff to understand and report bullying and harassment
- We appointed an Organisational Development Specialist in November 2015 to support our work on changing the culture within the Service
- We have designed a training course for all staff on bullying and harassment which is currently being tested with key staff groups
- We have appointed a Non-Executive Director to lead on bullying and harassment.

Workforce and Staff Morale

CQC said we must:

Recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements; Improve staff morale

Progress as of January 2016

- By the end of December 2015, since the CQC inspection in June 2015 we have an additional 284 frontline staff responding to patients
- Further 177 in training and supervision
- 297 more staff to join by end of March 2016
- Frontline staff turnover has decreased from 15.1% in April 2015 to 12.6% in December 2015
- Frontline sickness is 6.5% compared to 6.9% at the same point last year
- Over 5,000 more patient facing vehicle hours per week than last year
- The 2016/17 recruitment plan has been designed to ensure that the Trust maintains its staffing levels



- The new operational management structure has now been implemented (September 2015) and we now have dedicated local management teams in place to lead and support staff
- Since the 1 July 2015, our Clinical Team Leaders have had 50% of their time protected to support frontline clinicians
- We have submitted a bid to Health Education England to support the training and development of our clinical staff
- We have agreed with commissioners and Local Education and Training Boards (LETB) bursary funding for graduates training in London if they then agree to take up a role at The London Ambulance Service in qualifying
- In January 2016 we opened The London Ambulance Service Academy to train non-registered clinical staff to become our paramedics of the future
- We have met 900 people at the staff road shows in October 2015 their feedback has shaped our work plan for the coming months
- The second round of VIP nominations with category winners has been announced and a celebration event has taken place.
- To improve our non-pay benefits offer to staff we have launched new bicycle and lease car schemes

An overview of the London Ambulance Service Quality Improvement plan

The Board of The London Ambulance Service welcomed the CQC report and its findings and will make sure swift and comprehensive action is taken to improve for Service for patients and make it a better place to work for staff.

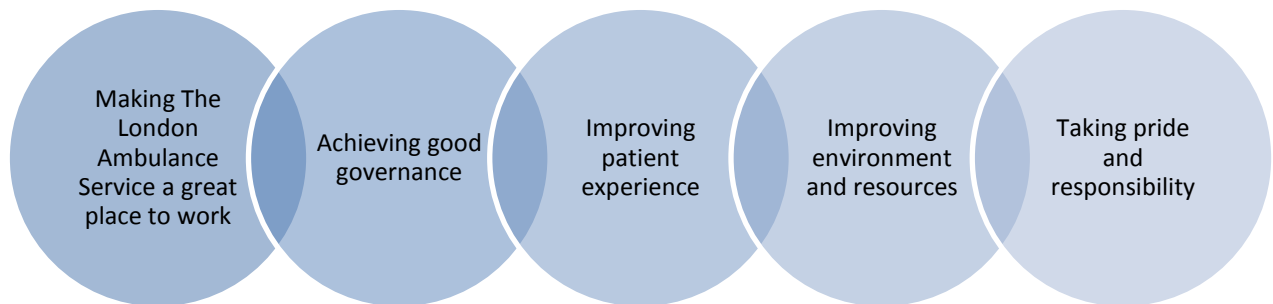
Our Quality Improvement Plan has five work streams:

- Making The London Ambulance Service a great place to work
- Achieving good governance
- Improving the patient experience
- Improving the environment and resources
- Taking pride and responsibility

The following pages summarise the projects for each work stream and how we will measure delivery on each.

Our Quality Improvement Plan – The Five Work Streams

The following pages summarise the projects for each of our five work streams, and how we will measure delivery on each. Our detailed action plan with milestones, key sub-tasks, and lead responsibilities can be found on our website and intranet.



Making The London Ambulance Service a great place to work

Executive Lead – Paul Beal, Director of Human Resources

The CQC said the Trust must:

- *Recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements*
- *Develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.*

The CQC said the Trust should:

- *Review development opportunities for staff*
- *Ensure all staff have sufficient opportunity to complete their mandatory training including personal alerts and control record system*
- *Communicate clearly to all staff the trust's vision and strategy*
- *Increase the visibility and day to day involvement of the trust executive team and board across all departments*
- *Provide NICE cognitive assessment training for frontline ambulance staff.*

- *Review trust equality and diversity and equality of opportunity policies and practices to address perceptions of discrimination and lack of advancement made by trust ethnic minority staff*
- *Ensure all staff receive an annual appraisal.*

We have identified seven key improvement projects under this theme that will collectively deliver our plan to make LAS a great place to work. The Trust has been working intensively to deliver these projects. They are:

- Advert to Action
- Bullying and Harassment
- Training
- Equality and Diversity
- Vision and Strategy
- Supporting staff
- Retention of staff

Advert to Action

- The aim of this project is to deliver the agreed recruitment plans to ensure we have sufficient staffing capacity to meet patient needs and national ambulance targets.
- This project will build on our recruitment success over the last year and includes international recruitment drives, a strengthening of our graduate offer and process, as well as local London recruitment of trainee emergency ambulance crew.
- To work with Health Education England nationally, to ensure that paramedic education and recruitment remains a high national priority.

Bullying and Harassment

- This project builds on phase one of our bullying and harassment action plan and aims to change the culture within the organisation to one that supports and respects individuals and sets realistic targets.
- Through this project we will deliver all staff training programmes, training for bullying and harassment investigators, set key performance targets and time frames for handling investigations, identify what is, and what is not bullying and harassment and an internal communications campaign to raise awareness and understanding.
- To support greater informal and timely resolution to issues this project will explore mediation support to assist managers and staff.

Training

- This project aims to make it easier for staff to complete their mandatory training and offer new e-learning modules. We will roll-out Individual Learning Accounts for non-operational staff that protect time for 'learning activities', and procure a new system to enable increased e-learning.
- Through this project we will redesign the corporate induction programme and the core skills training programme will include subjects such as cognitive and mental health assessment, and safeguarding vulnerable people.

Equality and Diversity

- This project aims to ensure that the Trust is as an equal opportunities employer, and that staff from all backgrounds feel included and part of the workforce. This will include running focus sessions across all staff to gather opportunities for improvement, ensuring equality objectives are embedded within the appraisal process and updating mandatory training for all line managers to include equality and diversity.
- We will also review recruitment processes, particularly in relation to internal promotion opportunities.

Vision and Strategy

- This project will review the Service's values and engage with staff in their development.
- This project will drive the development of a staff charter which will be co-designed with staff
- This project will also deliver improved visibility of the senior leadership across the organisation.

Supporting Staff

- This project will focus on ensuring staff are supported and have opportunities to develop within the Trust. This will include completing appraisals, development of a competency framework, and we will look to enhance our training offer for staff, including the use of e-learning. These, along with a training needs analysis, will support the delivery of an annual training plan.

Retention of Staff

- This project will focus on improving how we recognise and value our staff through strengthened staff engagement to make our organisation a better place to work. We have already developed a staff retention strategy that has been in place throughout 2015/16, and we will be further strengthening this as we move into 2016/17. As part of this project, we will design a London Package for staff to encourage them to stay with the Service. This package will focus on two areas, the banding of paramedics and non-pay benefits for all staff.

We will know that we have been successful when...

We will measure success against the following indicators:



- Reduced staff turnover and sickness absence rates
- Recruiting to 3,169 WTE frontline establishment
- Improved statutory and mandatory training rates.
- The number of Trainee Ambulance Crew staff working towards formal paramedic qualifications
- Improved feedback scores through the staff opinion survey on bullying and harassment
- Improved annual appraisal completion rate
- Increase number of BME staff within the Service

Achieving good governance

Executive Lead: Sandra Adams, Director of Corporate Affairs

The CQC said the Trust must:

- *Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.*

The CQC said the Trust should:

- *Review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting investigation learning and feedback to the Trust and frontline staff*
- *Review and improve trust incident reporting data*
- *Address under reporting of incidents including the perceived pressure in some departments not to report some incidents*
- *Set up learning to ensure all staff understand Duty of Candour and their responsibilities under it*
- *Review staff rotas to include time for meal breaks, and administrative time for example for incident reporting*
- *Develop a long term strategy for the EOCs*
- *Ensure better public and staff communication on how to make a complaint including provision of information in emergency and non-emergency ambulances.*

Projects and work in progress to make improvements

We have identified six key improvement projects under this theme that will collectively deliver our plan to improve quality governance. The Trust has already been working intensively to deliver these projects. They are:

- Risk management

- Capability and capacity of the health, safety and risk function
- Improve incident reporting
- Duty of candour
- Operational planning
- Listening to patients

Risk management

- This project will focus on improving the system of governance and risk management across the Trust, and has already completed a number of key milestones:
 - A risk register review was carried out by the Risk and Audit Manager in conjunction with risk 'owners' during October 2015.
 - The risk management policy is in the process of being reviewed and will be signed off by the Trust Board by March 2016.
 - A programme of risk management training was implemented in November 2015 to provide operational managers with more detail on managing risk, Trust processes and escalation procedures.
 - All managers will have been trained in risk management by March 2016
- Further milestones for the project include a strategic risk review, completing the training programme for all operational and corporate staff and establishing a Risk and Assurance Committee to report into the Executive Leadership Team (ELT).

Capability and capacity of the health, safety and risk function

- This project will focus on ensuring the Trust's capability and capacity to deliver the required risk management and governance activities is sufficient, and is providing the right level of support to managers across the organisation. The review has commenced and will report back with recommendations by March 2016.

Improve incident reporting

- The aim of this project is to improve incident reporting from front line staff, and ensure that clinical incidents as well as health and safety incidents are reported.
- This project will also ensure the smooth implementation of *Datix Web*, and other ways to simplify and increase incident reporting.
- A review has been completed to assess the current incident reporting awareness across the Trust, and a number of user friendly tools have been introduced for staff, with further plans to consider a 24 hour helpline and other engagement tools for staff.

Duty of Candour

- This project will focus on ensuring staff understand their role in duty of candour, and feel confident in applying this. An additional training module will be built into the core skills training programme for 2016/17, having been successfully piloted with staff in December 2015.
- This project will also ensure that staff leading serious incidents investigations are trained in the Duty of Candour.

Operational planning

- This project will review the operational plans for the Trust, to ensure that sufficient time is built into rotas to complete administrative tasks, training and supervision, and allow staff to have appropriate rest breaks. This project will also look over the longer term to ensure we are providing the best service we can that meets the needs of London's population and the changing demographic needs.
- This project will also focus on developing long term strategies for teams where this does not currently exist, to ensure this is aligned to the Trust strategy. This

includes the development of a strategy for the Emergency Operations Centre (EOC).

Listening to patients

- The project will focus on ensuring patients have access to the right information so they know how to feedback complaints or compliments about our Service. The project will also establish systems to gain feedback on our complaints process to make sure this is clear and easy to use. We will review how complaints feedback is fed into Service committees so that we learn from those experiences.

We will know that we have been successful when...

We will measure success against the following indicators:

- Audits shows monthly updates to all risk registers
- Increased numbers of incidents reported
- Decrease in rates for incidents resulting in injury to staff and patients
- There is not a backlog of incidents waiting to be inputted
- An increase in the number of staff able to take a rest break and time to complete non-patient facing tasks
- Improved staff satisfaction surveys
- Improved patient experience feedback
- Improved response time to complaints

Improving patient experience

Executive Lead: Zoë Packman, Director of Nursing

The CQC said the Trust should:

- *Review and improve patient waiting times for Patient Transport Service (PTS) patients*
- *Ensure PTS booking procedures account for the needs of palliative care patients*
- *Develop operational plans to respond to the growing bariatric population in London*
- *Review operational guidelines for managing patients with mental health issues and communicate these to staff*
- *Review patient handover recording systems to be more time efficient.*

Projects and work in progress to make improvements

We have identified three key improvement projects under this theme that will collectively improve the experience of patients in our care. The Trust is committed to delivering these projects. They are:

- Patient Transport Service
- Meeting people's needs
- Response times

Patient Transport Service

- This project will look at improving the performance of Patient Transport Services, to ensure that all patients receive a timely service. This will include the development, trial and implementation of pan-London process for pre-booking

and to ensure that consistent service is provided across the capital. The needs of palliative care patients will receive particular attention.

Meeting people's needs

- We will review our current policies to support an increase in the number of bariatric patients. We will re-assess whether the plans to develop our fleet of vehicles in the future are robust enough for the needs of this group of patients.
- We will update our guidance on managing people with mental health problems and ensure that front line staff receive sufficient skills training to meet the needs of this patient population.

Response times

- One of the most significant challenges we face to providing safe, sustainable care is the high number of patients who are delayed in handover to acute hospitals. We will continue to work with NHS England to address handover times at hospitals and will provide relevant information concerning delays/issues about handover times

We will know that we have been successful when...

We will measure success against the following indicators:

- Reduction in PTS patient waiting times
- Improved Friends and family test results for PTS
- Quicker hospital handover times
- Positive experiences reported by Mental Health Focus group

Improving environment and resources

Executive lead: Andrew Grimshaw, Director of Finance and Performance

The CQC found that the Trust must:

- *Recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification*

The CQC found that the Trust should:

- *Improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.*
- *Ensure full compliance with bare below the elbow requirements.*
- *Ensure adequate and ready provision of protective clothing for all ambulance crews.*
- *Review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.*
- *Improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.*
- *Improve blanket exchange system pan London to prevent re-use of blankets before cleaning.*
- *Review maintenance of ambulances to ensure all are fully operational including heating etc.*
- *Review arrangements in the event of ambulances becoming faulty at weekends.*
- *Ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.*
- *Ensure sufficient time for vehicle crews to undertake their daily vehicle checks.*
- *Ensure equal provision of ambulance equipment across shifts*

- *Increase training to address gaps identified in the overall skill, training and competence of HART Paramedics*

Projects and work in progress to make improvements

We have identified five key improvement projects that will collectively deliver our plan to improve the environment and equipment for both patients and staff:

- Fleet and vehicle preparation
- Information, management and technology
- Infection, prevention and control
- Facilities and estates
- Resilience function

Fleet and Vehicle Preparation

- This project will develop a fleet strategy which will inform future vehicle requirements. This will inform the development of a strategic outline case for the period from 2017/18 to 2022/23 which will cover the number of vehicles required, the type of vehicles, the mode of procurement and delivery of maintenance.
- In the short term, this project will review the current contract in regards to vehicle preparation and equipment maintenance.

Information Management and Technology

- We will review the current provision of IT across the Service but particularly for front line staff and develop a long term strategy to support service delivery. This will include an options appraisal of hand held and vehicle devices for accessing and recording information, improving communication with our mobile staff who are adept at using information in this way.

Infection prevention and control

- This project will focus on improving infection, prevention and control across the Trust. This will include a review of current guidance on bare-below-the-elbow, protective clothing, and local monitoring for infection control.

Facilities and Estates

- This project will focus on urgently reviewing all stations to understand the scope of works required to achieve infection control standards, and review cleaning contracts to meet requirements
- The project will also consider how we make our vehicles ready for use, where responsibilities sit for fleet and equipment
- The project will see the development of a fleet strategy and the purchasing of new vehicles
- The project will also address issues with ambulance vehicle blankets.

Resilience Functions

- This project will lead the improvement of our HART service so that it meets the requirement of the national specification
- This project will ensure that all HART staff are trained to national requirements.

We will know that we have been successful when...

We will measure success against the following indicators:

- Improved compliance with vehicle cleaning standards
- Improved compliance with vehicle equipping standards
- Revised blanket system in place
- Reduced out of service vehicle hours



- Long term strategy in place to provide suitable vehicles
- Improved compliance against the national HART specification
- Improved compliance of “bare-below-the-elbow”
- Revise protective clothing pack in place for staff
- Improve compliance with station cleanliness measures
- Improved results of infection control audits
- 84 wte HART staff employed.

Taking pride and responsibility

Executive lead: Fenella Wrigley, Interim Medical Director

The CQC said the Trust must:

- *Improve medicines management including:*
 - *Review the use of PGDs to support safe and consistent medicines use.*
 - *Formally appoint and name a board director responsible for overseeing medical errors*
 - *Review the system of code access arrangements for medicines packs to improve security*
 - *Set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients*
 - *Set up control systems for the issue and safekeeping of medical gas cylinders.*

The CQC said the Trust should:

- *Improve training for staff on Mental Capacity Act assessment*
- *Ensure all staff understand and can explain what situations need to be reported as safeguarding*
- *Set up a system of regular clinical supervision for paramedic and other clinical staff*

Projects and work in progress to make improvements

We have identified four key improvement projects under this theme that will underpin excellent clinical practice across the organisation. The Trust has been working intensively to deliver these projects.

- Clinical supervision

- Delivery the Mental Capacity Act and supporting patients with Mental Health issues
- Medicines Management
- Safeguarding

Clinical supervision

- This project will ensure that a system of regular clinical supervision is in place for clinical staff, to make sure that they have workplace reviews, feedback and support.

Delivering the Mental Capacity Act and supporting patients with mental health issues

- This project will strengthen the training we provide to staff on the Mental Capacity Act and put in place a support network for staff to ensure they are confident in carrying out mental capacity assessments and able to seek clarification and guidance easily where required.

Medicines Management

- This project will review medicines management governance arrangements and ensure that the Board receives robust assurance on medicines management, it will ensure that individual responsibility for medicines management is clear, and that staff take personal responsibility for the security of medicines. The project will consider the medicines management facilities at our sites and how these can be strengthened.
- The project will also seek to clarify national policy on Patient Group Directives for oral Morphine and rectal Diazepam in partnership with the Trust Development Authority, the CQC and the national pharmacy lead.

Safeguarding

- This project will focus on ensuring all staff receive the appropriate level of safeguarding training and will also look to strengthen safeguarding links with safeguarding boards, social services and other relevant organisations. The project will also guide the implementation of safeguarding supervision for staff.

We will know that we have been successful when...

We will measure success against the following indicators:

- A programme of clinical audit which tests the points raised by the CQC and audit findings which demonstrate continuous improvement.
- Increase mandatory training compliance rate
- Spot checks on compliance with the medicines management policy
- Improved compliance with drug pack forms
- Improvement in clinical practice indicators
- Unannounced spot-checks highlight high level of compliance with control and security of medical gases
- Improvement in safeguarding key indicators, including numbers of staff trained in safeguarding
- Increased appraisal and personal development plan completion rates

How we will deliver our Quality Improvement Programme

For these detailed projects to deliver there are five critical enablers:

- Staff engagement
- Strong programme governance
- Visible leadership
- Our partnership with Defence Medical Services
- Outcome of the 2016/17 contracting round

Staff engagement

To be successful, we need all our staff to understand and own our improvement journey. We will continue to engage our staff so that everyone clearly understands what our improvement plan sets out to achieve and the actions we are taking to get there.

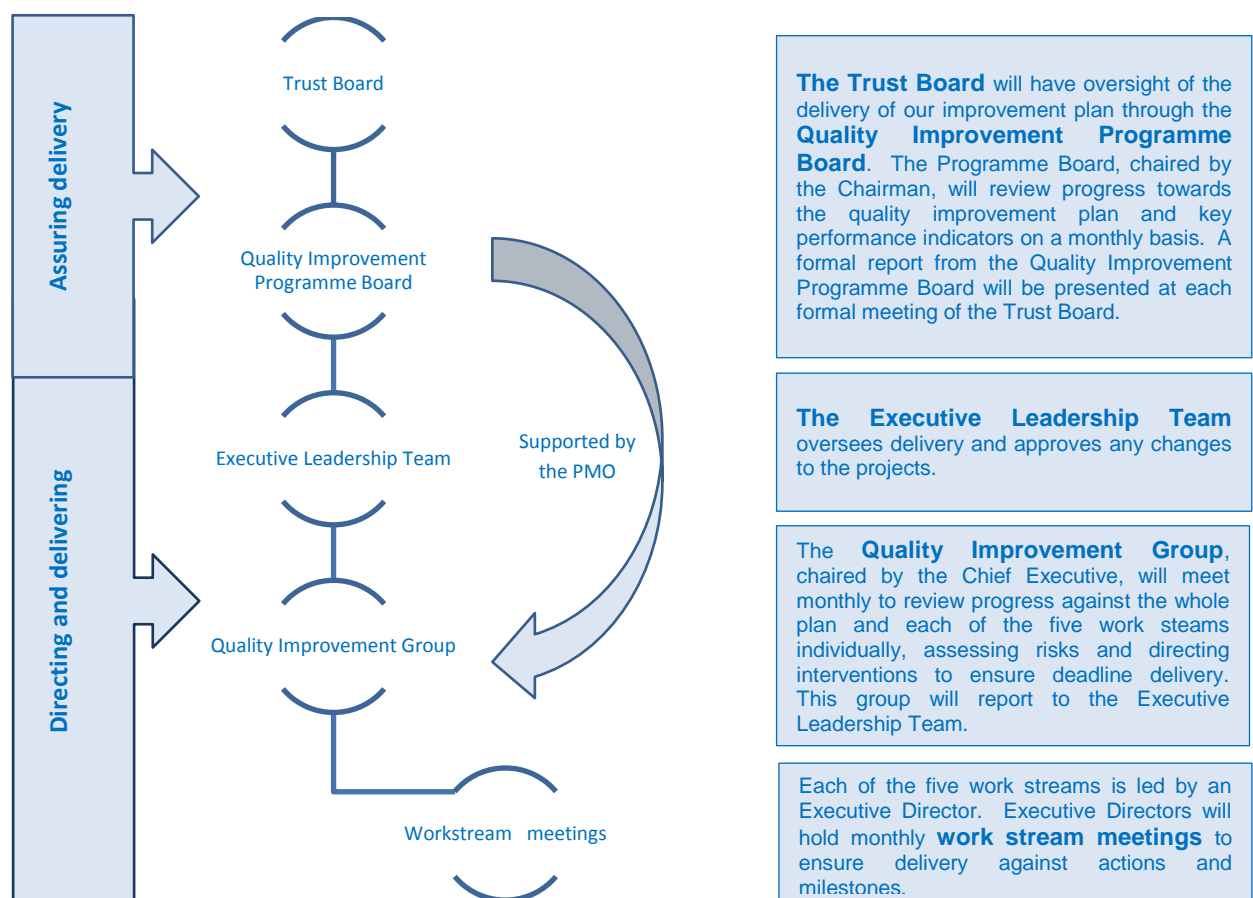
The staff road shows throughout October 2015 gave around 900 staff the opportunity to meet members of the leadership team and hear about the Trust's strategy, the vision for the future, organisational values, how the trust is tackling bullying and harassment, recruitment and the Chief Executive's commitments to staff.

We will hold local sector/departmental sessions to develop local implementation plans so that each part of the Service delivers towards our improvements. Key roles will have "action cards" to ensure that individuals are clear on what the service needs them to do. We will work closely with our managers to support them and their local teams to improve the working environment and to encourage engagement and involvement.

We will continue to update our staff, partners and other stakeholders on progress so that everyone is sighted on both our achievements and the work we still need to do.

Strong Programme Governance

We have established a clear programme of delivery, accountability and governance, led by the Director of Transformation and Strategy, and supported by a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our quality improvement plan. The diagram below identifies how the programme will be governed.



A report detailing performance against our plan will be submitted to the Clinical Quality Review Group (CQRG), chaired by the nominated quality lead from London's Clinical Commissioning Groups, as well as the Regional Oversight Group jointly chaired by the NHS Trust Development Authority (NHS Improvement) and NHS England (London).

Programme Management Office (PMO)

The PMO will:

- Closely monitor the progress of our plan and ensure that this progress along with issues and risks are reported and managed
- Hold the baseline data, delivery dates and target trajectories so that can progress can be effectively measured
- Capture any changes to planned delivery and ensure they are authorised by the Executive Leadership Team.

Specifically the PMO will track progress against:

1. Delivery

We have developed detailed action / milestone plans for each of our improvement areas. Each improvement action has a nominated lead Executive Director and a local owner who together will take accountability for the delivery of the milestone. Progress against milestones will be reviewed on a monthly basis at the work stream meetings and the Quality Improvement Group.

2. Performance metrics

In addition to key national standards, we have developed a set of measures to determine whether our improvement projects are succeeding. These measures will enable us to track progress, ensure delivery of the planned improvements and demonstrate success.

Where performance is not in line with the plan, the local owner will provide exception reports and change requests with clear remedial actions and a delivery impact assessment for approval by Executive Leadership Team.

Visible leadership

The Executive Leadership Team recognises that it needs to be more visible across the organisation and able to demonstrate that it is engaging and listening to staff. The clinical directors all carry out regular clinical shifts, as do members of their teams. The Chief Executive is a doctor and also undertakes regular clinical shifts. They and their deputies participate in clinical on-call and are available to provide clinical leadership and support to our staff.

The non-clinical executive directors undertake observational shifts with front line and control room staff and regular meetings with their management teams and wider groups of staff.

A programme has been developed and will be implemented in February 2016, to assign each executive director to a sector or support service. This will enable each director to build an understanding of the sector and support services and the issues being faced, as well as recognising the good practice and achievements that exist.

The Chairman and Non-Executive Directors also undertake observational shifts and visits to meet and talk to members of staff. In October 2015, we commenced a programme of Board meetings held at other Trust sites. This enables Board members to visit other sites and to meet local teams in a more informal setting. Staff are also invited to present local initiatives and share their experiences at these Board meeting.

Our partnership with Defence Medical Services

We recognise that we have a great deal to do, and to learn. We can't do this alone.

We are very fortunate and excited to be working with Defence Medical Services, who have experience of leading teams to deliver improvements in difficult and adverse



conditions. For example, they set up the Hospital in Camp Bastion, Afghanistan, that dealt with large volumes of patients with complex injuries. Their development of new processes and a new management approach motivated teams to deliver clinical and workplace improvements that led to better patient outcomes. We are looking forward to co-designing a leadership programme with them, for the London Ambulance Service, during January and February 2016, to be rolled out immediately.

The outcome of the 2016/17 contracting round

We work in close partnership with London's 32 CCGs who have supported the development of The London Ambulance Service over the last two years.

The resource implications of this plan will be discussed in detail with commissioners as part of the year's contracting round. The detailed actions within this plan may therefore, be subject to change, and are dependent upon financial support from CCGs.

Working in partnership to ensure delivery

At its heart our Quality Improvement Plan is about delivering better care for patients and making The London Ambulance Service a better place to work for our staff. In order to achieve this, we need to fundamentally transform the Service. We are clear that we cannot deliver our plan without the support and co-operation of our staff, patients and stakeholders. This quality improvement plan will make every part of our organisation stronger but there must be an acceptance that change and transformation on this scale will not happen over-night.

Trade Union Colleagues

Our trade union colleagues are critical to our success. We acknowledge we need to build better and closer relationships with them. We need to make a fresh start and co-design new arrangements for partnership working so that together, we get back to being the best ambulance service in the UK.

System Partners

At the CQC Quality Summit for The London Ambulance Service, we were joined by a number of our partners across London. We were struck by the support for the Service across the Capital. It was clear that everyone at the summit wanted The London Ambulance Service to improve and succeed, and to help us do this a number of commitments were made by key partners. The commitments organisations made included:

NHS England (London) and lead CCG Commissioners will support us:

- To improve access to urgent care centres
- To work with challenged providers to drive actions to support timely hospital handovers.
- To modernise our estate and information technology
- To develop a “London Package” to help retain our staff
- To develop a staff charter to outline what people can expect as an LAS employee and what is expected of an LAS employee.

Health Education England has supported our aim to develop a leadership arm of The London Ambulance Academy and has agreed to share training advice and learning resources.

We are grateful to those people and organisations who invested their time to help us shape our Quality Improvement Plan.

Clinical Commissioning Groups

We work in close partnership with London's 32 CCGs who have supported the development of The London Ambulance Service over the last two years.

The resource implications of this plan will be discussed in detail with commissioners as part of the year's contracting round. The detailed actions within this plan may, therefore, be subject to change and are dependent upon financial support from CCGs.

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HEALTH AND WELLBEING BOARD

8 March 2016

Title: Health and Wellbeing Outcomes Framework Performance Report – Quarter 3 (2015/16)	
Report of the Director of Public Health	
Open Report	For Decision
Wards Affected: ALL	Key Decision: NO
Report Author: Danielle Lawrence, Public Health Analyst Mark Tyrie, Senior Public Health Analyst Dr Fiona Wright, Consultant in Public Health	Contact Details: Tel: 020 8227 5943 Email: danielle.lawrence2@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	
Summary: The quarter 3 performance report provides an update on health and wellbeing in Barking and Dagenham. It reviews performance for the quarter, highlighting areas that have improved, and areas that require improvement. The report is broken down into the following sub-headings: <ol style="list-style-type: none"> 1. Performance Summary 2. Background / Introduction 3. Primary Care 4. Secondary Care 5. Mental Health 6. Adult Social Care 7. Children’s Care 8. Public Health 	
Recommendation(s) Members of the Board are recommended to: <ul style="list-style-type: none"> • Review the overarching dashboard, and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit. • Note the detail provided on specific indicators, and to raise any questions on remedial actions or actions being taken to sustain good performance. • Note the areas where new data is available and the implications of this data; specifically, children and young people accessing tier 3/4 Child and Adolescent 	

Mental Health Services, annual health check of looked after children, chlamydia screening, smoking quitters, breast screening, chlamydia screening, NHS Health Check, permanent admissions of older people to residential and nursing care homes, the percentage of people receiving care and support in the home via a direct payment, unplanned hospitalisation for chronic ambulatory care sensitive conditions, delayed transfers of care and Care Quality Commission inspections.

Reason(s)

The dashboard indicators were chosen to represent the wide remit of the Board, whilst remaining a manageable number of indicators. It is, therefore, important 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. When areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

1. Performance Summary

Section 1 is a summary. Further information and detail on the actions implemented to improve performance can be found in the main report.

Primary Care

Please see **section 3** for detailed information.

- 1.1 The primary care transformation strategy is currently being drafted and will be submitted to the March Governing Body.
- 1.2 During this quarter, King Edwards Medical Centre was inspected by the Care Quality Commission (CQC), and was rated 'good'.

Secondary Care

Please see **section 4** for detailed information.

- 1.3 A&E performance remained below the national threshold this quarter. However, improvements continue to be made at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) following its CQC rating of 'requires improvement' in July 2015.
- 1.4 The number of non-elective admissions at BHRUT decreased in Q3 between October and November, although numbers were still higher than the same month in 2014. Figures for December were not available for inclusion due to a time lag in data availability.

Mental Health

Please see **section 5** for detailed information.

- 1.5 The number of children and young people accessing Child and Adolescent Mental Health Services (CAMHS) increased in Q3.
- 1.6 The proportion of clients on Care Programme Approach (CPA) who have received a review within the last 12 months is exceeding the target.
- 1.7 Delayed transfers of care (DTC) remained above threshold throughout the quarter. An action plan is in place to mitigate against further poor performance.

Adult Social Care

Please see **section 6** for detailed information.

- 1.8 There was a slight increase in DTC from hospital this quarter. However, there was a decrease in DTC due to social care.
- 1.9 The number of permanent admissions to residential and nursing care homes increased this quarter. It is unlikely that the annual Better Care Fund target will be met this financial year. An action plan is in place to improve performance.
- 1.10 Injuries due to falls in people aged 65 and over improved further in 2014/15.
- 1.11 Of the 4 providers inspected by the CQC this quarter, 1 received a 'good' rating; however, 3 were rated 'inadequate'. CQC action plans are in place for improvements, and Quality Assurance is closely monitoring and supporting the providers to meet the CQC action plan requirements.

Children's Care

Please see **section 7** for detailed information.

- 1.12 The percentage of looked after children (LAC) with an up to date health check increased this quarter. A performance improvement action plan has been demonstrated.

Public Health

Please see **section 8** for detailed information.

- 1.13 The number of four week quitters in the borough did not meet the target this quarter. Public Health continues to implement a project plan to improve smoking cessation performance. A service review is near completion.
- 1.14 There was a decrease in the number of positive chlamydia screening results in Q3, and performance fell short of the quarterly target. An action plan is in place to improve performance.
- 1.15 The percentage of the eligible population receiving a NHS Health Check increased this quarter. Performance continues to be closely monitored.

2. Background / Introduction

- 2.1 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.

- 2.2 The indicators chosen include those which show performance of the whole health and social care system, and include selected indicators from the Systems Resilience Group's dashboard.
- 2.3 The indicators contained within the report have been rated according to their performance; red indicates poor performance, green indicates good performance and amber shows that performance is similar to expected levels. The indicators are measured against targets, and national and regional averages.
- 2.4 **A dashboard summary of performance in Q3 (October – December 2015) against the indicators selected for the Board can be found in Appendix A.** The most recently available data is presented. For some indicators data is only reviewed annually. For others there are gaps due to time lag or limitations in data availability.
- 2.5 The following indicators have not been reported on because there is no new data available. These indicators are:
- (i) Immunisation uptake of measles, mumps and rubella vaccine, and diphtheria, tetanus and pertussis vaccine for 5 year olds
 - (ii) Childhood obesity
 - (iii) Under 18 conception rate
 - (iv) Cervical screening
 - (v) Proportion of older people still at home 91 days after discharge from hospital
 - (vi) Emergency readmissions within 30 days of discharge from hospital, and
 - (vii) Unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- 2.6 At the last report Barking and Dagenham was performing below the national average on all of these indicators.

3. Primary Care

Primary Care Transformation

- 3.1 Work on the primary care transformation strategy continues to progress. Substantial further engagement has been undertaken, including facilitated discussions at locality meetings and one-to-one discussions with chairs and clinical leads for primary care. The perspectives and insight gained from this are being used as inputs into the primary care vision, objectives and transformation plans, the workforce development strategy and the development of a financial model.
- 3.2 Feedback was received from NHS England during the primary care stock take meeting, and emerging themes and discussion points were taken away from the Joint Executive Team meeting. Both are being taken into consideration in the drafting of a written primary care transformation strategy, which is currently underway, for submission to the March Governing Body.

CQC Inspections

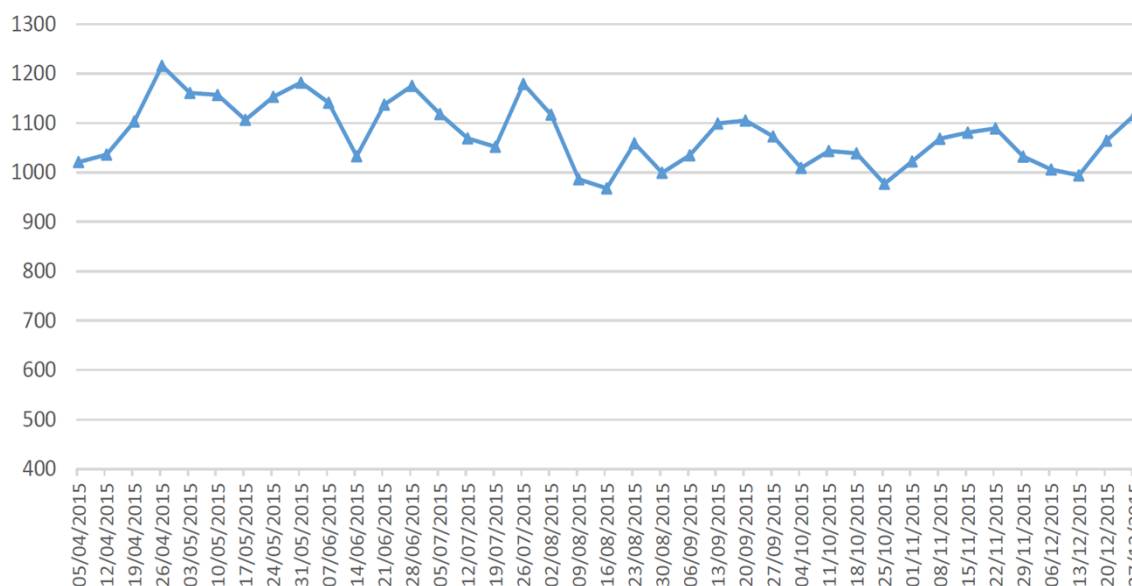
- 3.3 An overview of General Practice CQC inspection reports published during the third quarter of 2015/16 can be found in Appendix B. During this period 1 report was published on a local organisation.
- 3.4 **King Edwards Medical Centre was rated 'good'** during the CQC inspection on 7 October 2015. Key findings from this inspection were that risks were assessed and managed well, patients were treated with compassion and involved in their care, and there was a clear leadership structure in place. Please see Appendix B for further information.

4. Secondary Care

Urgent Care

- 4.1 A&E performance for patients waiting less than four hours from arrival to admission, transfer or discharge remained below the national standard this quarter. The Trust's overall performance began the quarter at 90.2%, fell to 85.3% in November and remained fairly static at 85.0% in December. In Q3 there were no weeks that achieved the national standard of 95%. Overall performance this quarter was 86.5%. This is a deterioration on Q2 performance (92.3%). However, is an improvement on Q3 2014/15 performance of 80.5%. This indicator is RAG rated amber.
- 4.2 BHR Clinical Commissioning Groups (CCGs) non-elective admissions at BHRUT decreased by 155 (3.8%), from 4,086 in October to 3,931 in November. Figures for December were not available for inclusion due to a time lag in figures being published. NHS Barking and Dagenham CCG had a decrease of 123 (10.1%) admissions, from 1,232 in October to 1,109 in November. In comparison with November 2014, November 2015 non-elective admissions were 6.5% higher (there were 1,041 non-elective admissions in November 2014). This indicator is RAG rated amber.

Figure 1: BHRUT Non-Elective Admissions 2015-16



- 4.3 BHRUT had previously been providing secondary uses services (SUS) data relating to ambulatory care activity which both the Trust and CCG agreed had data incorrectly coded to non-elective activity. Work is ongoing to amend the Trust's SUS returns to reflect the correct coding.
- 4.4 BHRUT are also continuing to track patients to identify where the demand in the system is coming from. The Adastra data system will help identify whether the cohort of patients utilising the GP appointments are the same that are attending A&E or are a new cohort of patients.
- 4.5 **Overall, DTOC performance remained within target this quarter.** The lower DTOC threshold target is 20, and the upper threshold limit is 40. At the start of the quarter the weekly average was 10. This increased to 14 in November, and remained static in December. Although, one week in December did breach the lower limit, with the week ending 03 December 2015 having an average of 22 DTOC. **This indicator is RAG rated green.**

BHRUT failed to meet national standards for Referral-to-treatment (RTT)

- 4.6 In December 2013, the Trust identified significant RTT issues following the implementation of its upgrade to a new operating system, including internal system and capacity issues that affected RTT performance. As a consequence the Trust suspended national reporting on RTT performance.
- 4.7 Backlog on all incomplete pathways grew in October 2015. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. The admitted backlog rose to 1,498 at the end of the last week of October. Within the constraints of patient choice, the plan is to outsource treatments considering clinical urgency and treating patients in chronological order. The non-admitted backlog rose to 12,392 at the end of October and stood at 12,662 for the week ending 23/11/2015.

- 4.8 The resolution of the RTT data quality issues and the need to reduce the admitted and non-admitted backlogs has been given high priority within the Trust. A recovery plan has been agreed, and it is anticipated that the earliest recovery of the standard will be March 2017. However, there is a substantial volume of patients who have already breached their 18 week wait period. A system director for RTT has been appointed to lead the RTT recovery programme from January 2016.

CQC Inspections

- 4.9 **BHRUT remains in special measures, but improvements continue to be made.** Examples of recent performance improvement highlights at BHRUT now follow. Patient risk assessments are being regularly undertaken on each ward and there is consistent performance above the 80% target. The assessments focus on many areas. These include a Nursing Documentation Audit, Venous Thrombosis Assessment and National Early Warning Score completion.
- 4.10 80% of the Trusts 'must do' actions set by the CQC within the Effective domain have been signed off. In addition, there has been a month-on-month increase in the number of timely discharges. A permanent dietician also joined the Intensive Care Unit (ITU) in December, replacing the temporary role.
- 4.11 Dementia Feeding Buddies have been recruited and trained to provide support to nursing staff on the ward during patient meal times, and also make feeding times more of a social activity for patients. Additionally, a passport for children with learning difficulties has been introduced on Children's wards, giving staff access to the young person's likes, dislikes and interests.
- 4.12 A new system which ensures that all babies delivered at BHRUT hospitals are discharged with their NHS number has been introduced. Furthermore, the refurbishment of the Outpatients' department at King George Hospital has commenced, making the department more comfortable for patients. Weekly Patient Safety Summits have been set up at both hospital sites, which provides a safe and supportive environment where recent serious incidents are investigated quickly.
- 4.13 Following the CQC rating of 'requires improvement', **a range of quality improvement measures continue to be implemented for maternity services at Homerton Hospital.** Daily cleanliness checks have been implemented, and audits are being carried out to ensure staff observations on obstetric patients are consistently converted into a risk score. Alongside this, a Divisional Operational Director has been appointed to oversee the timely investigation of incidents. Maternity Services continue to work closely with local commissioners to ensure that the necessary changes and improvements are made. Overall, the hospital continues to be rated 'good' overall despite the improvements required in maternity services.

5. Mental Health

CAMHS

- 5.1 **The number of children and young people accessing CAMHS tiers 3 and 4 increased** from 490 in Q2 to 526 in Q3. However, this quarter's performance is a

reduction on the Q3 2014/15 figure of 635. **This indicator has not been given a RAG rating** as there is no target associated with this indicator.

- 5.2 CAMHS caseload review has been undertaken to ensure suitable cases are held and have also discharged/signposted inappropriate long term cases. Triage function has been improved and is providing a more robust and effective screen process and this has ensured the delivery of our referral criteria more effectively and we are offering increased levels of signposting and co working within the wider MDT to reduce the complexity of needs. This is delivered via a weekly MDT meeting and the availability of joint assessments for children and advice and guidance to other health staff.
- 5.3 **DTOC remained above the threshold throughout Q3.** This indicator counts the number of occupied bed days lost due to DTOC. Good performance in this indicator would be a DTOC figure of less than 7.5%. In October, DTOC was 12.2%. This figure rose to 15.4% in November, before falling to 12.4% in December. **This indicator is therefore RAG rated red.**
- 5.4 DTOC poses safeguarding and deprivation of liberty safeguards (DoLS) risks to patients who are not moved from inpatient care in a timely manner. The DoLS are part of the Mental Capacity Act 2005, and aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
- 5.5 The current restriction on placements as agreed with the London Borough of Barking and Dagenham (LBBD) has been altered as of January 2016, to three service users out and two in, with the aim of reducing DTOC to an acceptable level.
- 5.6 To support this, production of a weekly DTOC list, with early identification, has been implemented. Weekly bed management meetings are also taking place. Further discussions on DTOC continue to take place during the Section 75 executive steering group.

Care Programme Approach (CPA)

- 5.7 The proportion of **clients on CPA who have received a review within the last 12 months is exceeding the target.** North East London NHS Foundation Trust (NELFT) policy states that CPA reviews must be completed at least every 6 months and be recorded on the Clinical Records Management System (RiO) by the Care-Co-ordinator. The target for 2015/16 is 97%.
- 5.8 At the start of the quarter performance in this indicator was 98.1%. In November this fell slightly to 97.6%, before rising to 98.8% in December. Therefore this service is exceeding targets set in reviewing clients on time. **This indicator is RAG rated green.**
- 5.9 **The number of carers offered carers' assessments is also on target.** This indicator reports the percentage of carers, who have been identified on RiO as caring for a service user on the CPA, that have been offered a Carers' Assessment. Carers' are legally entitled to be offered an assessment of their needs and this enables appropriate resources to be provided. The target for 2015/16 is 80%.

- 5.10 At the start of the quarter, 80.8% of carers had been offered an assessment. Performance in this indicator has remained fairly static since, with 81.0% in November, and was 81.1% in December. This service continues to assess identified carers and signpost them to relevant services where necessary. **This indicator is RAG rated green.**

IAPT

- 5.11 There is no update available on IAPT since the last Health and Wellbeing Board performance report due to a time lag in figures being published.

6. Adult Social Care

DTOC

- 6.1 This is a measure that reflects both the overall number of DTOC, and the number of these delays that are attributable to social care services.
- 6.2 **There was a slight increase in DTOC from hospital**, from 7.4 per 100,000 population in Q2 2015/16 to 7.7 in Q3. This figure is below the England average of 9.7, but exceeds the London average of 6.9.
- 6.3 In contrast, there was a **slight decrease in DTOC due to social care**, which fell from 4.55 per 100,000 in Q2 2015/16 to 4.1 in Q3. This figure brings the borough above both the England and London averages of 2.3 and 3.1 respectively.
- 6.4 Newham General Hospital (NGH) reported 7.74% of the total Social Care delays without following due process. The Joint Assessment and Discharge (JAD) manager met with NGH in August 2015 to agree a sign off process but this was not honoured. There has been a change in management at NGH in relation to sign offs and a meeting with the new manager has been arranged.
- 6.5 10.14% of all DTOC reported this year have been attributed and verified by the JAD as Social Care delays.

Health Checks for people with Learning Disabilities

- 6.6 Officers in the CCG, CLDT and LA have met to ensure the actions agreed are being implemented. It has been agreed that we will continue to offer support to GPs as they are requested however the initial focus will be on the GPs that have the greatest number of patients with a learning disability registered to the practice. The practice Improvement lead, Lead Nurse and Commissioner will continue to attend the PTI forums in order to support the surgery needs on health check planning and developing health action plans.
- 6.7 The CLDT has requested from each surgery the details of each of their learning disability register. To date 10 surgeries have returned their register. The health facilitation team has begun to validate the learning registers from the first 10 submission. The original number of health checks was 195 with 132 having a health action plan. The current data is now 315 patient with a health check and 217 with a health action plan.

Social Care Admissions

- 6.8 The number of permanent admissions to residential and nursing care homes is a good measure of the effectiveness of care and support in delaying dependency on care and support services. Performance in this indicator for the year to date, as at the end of Q3, was 625.35 per 100,000 population (123 admissions). At the same point last year, the figure was 614.9 per 100,000. The annual Better Care Fund target for this indicator is 635.93 per 100,000 population, where good performance would not exceed this target. Therefore, it is highly unlikely that this annual target will be met. An action plan is in place to improve performance. **This indicator is RAG rated red.**
- 6.9 The percentage of people receiving care and support in the home via a direct payment decreased from 75.1% in Q2 to 74.3% in Q3. This is a decrease on the same period last year, when the figure was 76.2%. The target for this indicator is a year on year increase in the number of clients receiving direct payments.
- 6.10 This indicator had shown a consistent improvement from 49.1% in March 2012 to 75.0% in July 2015. However, due to the circumstances of a minority of service users, some remain on a managed personal budget. Where appropriate, work is ongoing to move service users onto a direct payment.
- 6.11 **Injuries due to falls in people aged 65 and over improved further in 2014/15.** This is the most recent data available for this indicator. The rate of injuries due to falls in people aged 65 and over fell from 2,027 per 100,000 population in 2013/14 to 1,656 in 2014/15. As a result, the borough's performance is better than the national average of 2,125. **This indicator is RAG rated green.**
- 6.12 Falls prevention is a high priority for LBBB, with two indicators relating to it being used as performance metrics for the Better Care Fund ('Emergency admissions to hospital, all ages' and 'Injuries due to falls in people aged 65 and over'). As such, it has been one of the focuses of the Health and Adult Services Select Committee in 2015/16, as well as being the focus of a number of schemes from providers across the health system.
- 6.13 Some of the schemes being delivered by LBBB that are helping to contribute to the continued decrease in falls include the Handy Person Support Service, Whole Body Therapy, and work by the Occupational Therapy and Sensory Service to reduce environmental hazards. These all feed into the council's wider falls prevention strategy.
- 6.14 In addition, falls prevention has been made a high priority within BHRUT. This has led to the appointment of a consultant Orthogeriatrician with falls responsibilities, and increased provision for falls prevention measures such as non-slip socks, lower beds and falls symbols magnets for patients where appropriate. This has helped result in BHRUT having a rate that is approaching half the national average for falls per 1,000 bed days in 2015/16, continuing similar trends observed in 2014/15.
- 6.15 Work by NELFT in partnership with the London Ambulance Service has also contributed, with their K466 emergency car scheme (which attends emergency calls from patients aged 60 years and over) helping to reduce hospital admissions and to make patients feel more safe.

CQC Inspections

- 6.16 **Appendix B contains an overview of CQC inspection reports** published during Q3 2015/16, including those relating to social care providers in the borough, or those who provide services to our residents. During this period 4 reports were published on local organisations. Of the 4 providers inspected, **1 met the requirement for an overall rating of 'good'; the remaining 3 providers were rated 'requires improvement' and are detailed below.**
- 6.17 **Alexander Court rated 'requires improvement'**. Alexander Court has 1 residential and 4 nursing units and is registered to care for older people with dementia, physical disabilities, recovering from injury or illness and provides both residential and nursing care. There has recently been a change of ownership of the home from Lifestyle Care to Orchard Care Homes Ltd.
- 6.18 The CQC identified several areas of concern during their inspection, including staff training, inadequate infection control processes, record keeping not being robust enough, resident preferences on occasion not being taken into account, and residents not feeling cared for by some members of staff. There have been regular meetings with the management of the home and monitoring visits taking place because of concerns raised to adult social care through social work and quality assurance staff. LBBB currently have 36 clients placed in the home, all of whom have been reviewed and found to be safe and cared for. Orchard Care homes in December, after discussion with LBBB staff and as a result of the CQC rating, decided to suspend placements to the home so that they could address issues, produce a sustainability plan for all concerns to be addressed and monitored by their management, CQC and Quality Assurance.
- 6.19 **Harp House rated 'requires improvement'**. Harp House is an extra care scheme; the building is owned and run by Hanover Trust with the onsite homecare being delivered by Triangle Community Services under contract. Harp House has 37 flats, 31 of which are occupied by LBBB clients receiving homecare in their own homes. There are 3 other schemes in the borough which operate in this way, Colin Pond Court, Darcy House and Fred Tibble Court with on site homecare being provided by Triangle. The 4 schemes are contract monitored on a quarterly basis with unannounced visits by LBBB Quality Assurance staff in between.
- 6.20 During their inspection in October 2015, the CQC found that the service did not meet all the requirements on 2 domains, 'Safe' and 'Well Led'. On the release of the rating in November 2015, Quality Assurance reviewed the serious incident log book and has worked with the provider to ensure that robust reporting practices are adhered to throughout all of the schemes; improvements have already been made. Quality Assurance are also supporting the provider to meet the outstanding requirements of the CQC action plan. The 31 clients have been reviewed and found to be safe and happy living at Harp House. No complaints were made about staff or the standard of care they receive, all clients found Harp House a pleasant and sociable place to live, and many commented on the friendliness of staff and their willingness to assist residents of the home.
- 6.21 **Chosen Services rated 'requires improvement'**. Chosen services is a homecare provider providing services for adults of all ages. This agency operates within the

borough and currently provides homecare services to 2 of our clients. Both clients have been contacted and are satisfied and happy with the service they receive and the carers supplied and have no wish to change provider at present, which we respect as their choice is in keeping with the principles of personalisation. We have recently been through a tender process to achieve a Homecare Provider Framework for homecare agencies which meet all our requirements for operating in the Borough including long term sustainability. Chosen Care did not meet requirements, therefore will not appear on this list. Those clients who receive a personal budget will have access and be encouraged to use the agencies on the Homecare Provider Framework, which have been through a robust process to ensure quality. However, will continue to have choice over who they want to provide their care. As a result, agencies outside of the framework could be used.

7. Children's Care

Immunisation

- 7.1 There is no update available on the uptake of DTaP/IPV and MMR2 vaccinations at five years old since the last Health and Wellbeing Board performance report due to a time lag in figures being published.

Annual Health Checks of Looked After Children (LAC)

- 7.2 **Performance improved in Q3.** The percentage of LAC with an up to date health check increased slightly from 72.0% in Q2 2015/16 to 73.2% in Q3. However, this level of performance is a decrease on performance in Q3 2014/15, when 76.4% of LAC had an up to date health check. In previous years, performance in this indicator has improved significantly towards the end of the year; therefore, if performance follows this trend there is expected to be a large increase in performance in Q4.
- 7.3 LAC Services are awaiting the return of completed health check forms from the LAC nurse. The LAC nurse co-ordinates the responses from the other health professionals who have undertaken the health assessments (health visitors and school nurses). Once these are received they will be logged onto the Integrated Children's System. It is expected that the performance of annual health checks for LAC will improve to around 90% by the end of the year (compared to the national average of 84.3%). **This indicator is RAG rated amber.**
- 7.4 **An action plan is in place to improve performance.** This indicator is being jointly addressed by Children's Services and NELFT and has been discussed at the safeguarding board. In line with the action plan, meetings between Health Commissioners and Providers, including CAMHS, are taking place on a monthly basis to look at improvement strategies and to track performance.
- 7.5 In addition, a performance spreadsheet is being sent on a weekly basis to all social care teams and their managers to highlight individuals with missing paperwork. The timeliness and quality of returned forms is also being tracked, as a delay in the return of some reports following medical completion and quality issues have previously been highlighted.

8. Public Health

Smoking Quitters

- 8.1 **The target for the number of four-week smoking quitters was not met this quarter.** The four-week smoking quitter indicator measures the number of individuals who have successfully quit for four weeks.

Table 1: Number of smoking quitters by provider type

	Q1	Q2	Q3	Total Achieved to date	Annual Target
Referrals	173	214	484	871	TBC
GP	32	23	20	75	2,000
Pharmacy	72	51	60	183	
Tier 3	17	15	45	77	1,000
Total	121	89	125	335	3,000
Target	750	750	750	2,250	

- 8.2 In total, there were 125 quitters across tier 2 and 3 services in Q3, which is 40.4% higher than the number of quitters in Q2 (89 quitters).
- 8.3 There has been an upturn in the number of referrals to the stop smoking service so far this financial year.
- 8.4 In comparison to Q2 figures, the number of GP quits decreased slightly. Whilst there were increases in Pharmacy (17.6% increase) and tier 3 (200% increase) quit figures.
- 8.5 To achieve this year's annual target of 3,000, an average of 750 quitters would be required each quarter. This quarter's figure falls significantly short of this target. As a result, this indicator has been RAG rated red.
- 8.6 Women smoking during pregnancy are being targeted via the babyClear programme. Barking and Dagenham was successful in obtaining 36% co-funding from Public Health England to implement a full baby Clear programme, which offers a standardised approach to identifying pregnant smokers with the ambition of reducing smoking at the time of pregnancy to <10% in Barking and Dagenham by October 2018, and referral to smoking cessation services. In August and September 2015, all midwives at Queens and King George's Hospitals were trained to undertake CO monitor readings and provide smoking cessation advice to pregnant women. Nicotine replacement therapy is also available on all maternity wards. From September to December 2015, 273 women reported that they were smoking at their first maternity booking appointment, with 193 (71%) requesting support to stop smoking.

- 8.7 Public Health continues to implement a project plan to improve smoking cessation performance in the borough. This plan aims to increase uptake in both tier 2 and tier 3 services by implementing proactive measures to identify and support GPs with the highest number of registered smokers and unplanned hospital admissions for chronic obstructive pulmonary disease (COPD), as well as targeted approaches for high-risk groups including young people, pregnant women, routine and manual workers and those with mental health problems.
- 8.8 In line with this plan, all providers in the borough with smoking activity (29 pharmacies and 11 GPs) have been contacted, and over the last 4 months have been visited by Public Health. Action plans to improve performance have been developed and agreed with each individual provider, and areas of underperformance are addressed in subsequent visits. The next few months will focus on engaging providers to sign up to the 2016/17 contract and arranging initial performance meetings for this period.
- 8.9 Leisure services started delivering Tier 3 smoking cessation services from 1 October 2015. Six advisors have been recruited to operate the telephone helpline and coordinate community-based smoking cessation activities. The number of community venues offering face-to-face support to quitters will be increased by March 2016, with the advisors being based in Barking Learning Centre, tenancy support services, mental health and other community venues. This includes delivery of peer-led support groups via the Community Health Champions, local faith/community leaders and voluntary organisations. This should help increase take up of smoking cessation services, particularly amongst groups that are known to have a higher smoking prevalence.
- 8.10 To target smokers accessing services at BHRUT, from July 2015 the Trust has provided a stop smoking advisor who is available to offer up to 21-hours' support per week across both the King George and Queen's hospital sites and make referrals to specialist stop smoking services.
- 8.11 Preventing people from smoking has been identified as a priority by the Health and Wellbeing Board. Local health promotion campaigns will focus on preventing initiation of smoking by young people and vulnerable adults. While schools fund prevention initiatives as part of the PHSE curriculum, Barking and Dagenham will continue to invest in prevention via tobacco control initiatives and towards marketing as well as the other investment across the Council in environmental protection and schools as part of the Healthy Schools bronze award programme. The entry criteria into tier 3 services has also been widened to a lower age limit (from 18 years to 12 years) in order to provide specialist support to young smokers.
- 8.12 The Tobacco Alliance is collaborating to refresh the local smoking strategy (including actions to reduce the import and local distribution of illegal cigarettes) and development of smoke-free policies (in vehicles, homes, work places and public places). A tobacco control coordinator was recruited in January 2016 to oversee the delivery of the local tobacco control strategy action plan.
- 8.13 In addition to the above, the smoking cessation service review is near completion, and future local marketing and communications campaigns are being mapped to align with national campaigns.

NHS Health Check

- 8.14 This indicator is formed of two parts; Part I: The percentage of completed health checks for the eligible population (aged between 40 and 74 and not already diagnosed with a long term condition), and Part II: The uptake of health checks for those invited. This is a mandatory indicator for local authorities.

Table 2: NHS Health Check – Part I: Completed health checks for the eligible population

	Q1	Q2	Q3	Year-to-date	Annual Target
2015/16	2.5%	2.9%	3.1%	8.5%	15%
Target	3.75%	3.75%	3.75%	11.25%	

- 8.15 **The percentage of completed health checks for the eligible population (Part I) improved in Q3**, from 2.9% (1,251 completed health checks) in Q2, to 3.1% in Q3 (1,376 completed health checks). However, this is a reduction on Q3 2014/15 performance, when 4.4% (1,644 completed health checks) of the eligible population received an NHS Health Check.
- 8.16 To meet the national annual target, performance needs to average 3.75% each quarter. This quarter's performance does not meet this target. **The year-to-date percentage of completed health checks for the eligible population is 8.5% against the target of 11.25%**. This will make meeting the annual target challenging. **Performance in this part of the indicator has therefore been RAG rated red.**

Table 3: NHS Health Check – Part II: Uptake of health checks for those invited

	Q1	Q2	Q3	Year-to-date	Annual Target
2015/16	69%	70%	61%	66%	75%
Target	75%	75%	75%	75%	

- 8.17 **The uptake of health checks for those invited (Part II) decreased in Q3**. There was an uptake rate of 61% in Q3. This is a decrease on the Q2 rate of 70%, and is also lower than Q3 2014/15, when uptake was 66%.
- 8.18 To meet the national annual target, the uptake of health checks for those invited needs to maintain an average rate of 75%. This quarter's performance does not meet this target. **Furthermore, the year-to-date uptake of invites is 66% against a target of 75%**. This will make meeting the annual target challenging. **Performance in this part of the indicator has therefore been RAG rated amber.**
- 8.19 **An action plan is in place to facilitate improved performance**. As part of this, LBBD Public Health presented a case for purchase of Point of Care Testing (POCT) machines from Alere Ltd. The implementation of POCT across the 36 participating

GPs began in January 2015 and is ongoing. To date, 16 GP surgeries have taken up the offer of a machine and 3 GP surgeries have declined the offer.

- 8.20 POCT is a minimally invasive method of testing blood lipids, which is expected to improve the uptake of the NHS health check. Other benefits include:
- minimisation of health check turnaround time, with results available within a minute or two of analysis;
 - elimination of time delays as analysis and results are completed within one visit; and
 - greater convenience for both the staff conducting the check and the patient receiving it, as there is no longer a need for multiple visits.
- 8.21 Quarterly updates, with a performance dashboard including achievement to date, will be forwarded to all service providers this quarter and an audit of the completeness of eligible health checks is taking place for quality purposes.
- 8.22 In addition to the above, ongoing contract management and service improvement is taking place with a view to achieving the target in Q4.

Breast Screening

- 8.23 The breast screening indicator is a measure of the percentage of women screened adequately within the previous 3 years on 31st March.
- 8.24 **The percentage of women breast screened fell by 6.9%**, from 71.2% in 2013/14 to 64.3% in 2014/15. This brings performance to below both the national (75.4%) and regional (68.3%) averages. In addition, performance was 5.7% below the NHS Cancer Screening Programmes' minimum standard of 70%. **As a result, this indicator has been RAG rated amber.**
- 8.25 **Nationally, promotional campaigns are being implemented to raise awareness and improve coverage.** Other initiatives to improve cancer screening include the development of projects that will improve awareness of the signs and symptoms of cancer, particularly in those from lower-socioeconomic groups, those who are younger and those from ethnic minorities. This is in line with the National Cancer Equalities Initiative.

Chlamydia Screening

- 8.26 The chlamydia screening indicator is a measure of the number of positive tests from the screening process in young adults aged 16-24 years, compared with the expected numbers of positive tests.
- 8.27 **The number of positive Chlamydia screening results decreased this quarter**, from 130 in 2015/16 Q2 to 125 in Q3. To achieve this year's annual target of 596 positive tests, an average of 149 positives would be required each quarter. This quarter's result falls short of this target by 24. In the year-to-date there have been 374 positives against the target of 441. **As a result, this indicator continues to be RAG rated red.**

- 8.28 **An action plan is being implemented to encourage improvement in performance.** In line with this, the Chlamydia screening programme provider continues to support the 17 pharmacies and 36 general practices which are signed up to the Local Enhanced Services (LES) contract.
- 8.29 Providers have been contacted on a regular basis, and monthly performance figures are being sent to each provider to allow them to keep track of their progress and to encourage greater activity. Since this was introduced, many sites have requested training or increased their screening activity as a result of receiving poor performance figures.
- 8.30 Work has also been carried out to address the number of invalid screens on a case-by-case basis, working directly with practice managers via email and phone. This has led to a reduction in the number of invalid screens over the financial year so far.
- 8.31 8 new pharmacies signed up to join the LES in Q2. Follow-up training sessions were held in January for these new pharmacies. This is expected to lead to greater takeup of testing and a higher number of positives.

Conception rate in under 18 year olds

- 8.32 There is no update is available on under 18 conception rates since the last Health and Wellbeing Board performance report due to a time lag in figures being published.

9. Mandatory implications

Joint Strategic Needs Assessment

- 9.1 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.

Health and Wellbeing Strategy

- 9.2 The Health and Wellbeing 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 Health and Wellbeing Strategy, and reflect core priorities.

Integration

- 9.3 The indicators chosen include those which identify performance of the whole health and social care system, including in particular indicators selected from the Systems Resilience Group's dashboard.

Legal

Implications completed by: Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services There are no legal implications for the following reasons:

- 9.4 The report highlights how the various bodies have met specific targets such as the performance indicators: whether they have or have not been met in relation to the indicators for London and England, and how the authority is measuring up against the National average.

Financial

Implications completed by: Roger Hampson Group Manager, Finance

- 9.5 There are no financial implications directly arising from this report.

10. List of Appendices

Appendix A: Performance Dashboard

Appendix B: CQC Inspections Quarter 3 2015/16

APPENDIX A

Key

Appendix A: Indicators for HWBB - 2015/16 Q3

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional 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	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
1 - Children																	
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	83.4%	82.8%	83.3%	80.9%	86.2%	85.1%	84.4%	83.8%	..			↘	R	87.9%	79.8%	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 Q4 data is not yet published																	
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	82.3%	82.2%	82.2%	78.8%	83.4%	82.7%	81.0%	81.2%	..			↗	R	87.9%	80.5%	2	PHOF
Year end figures not yet published. 2014/15 Q4 data not yet published.																	
Prevalence of children in reception year that are obese or overweight	26.6%					27.5%						↗	R	21.9%	22.2%	3	PHOF
Prevalence of children in year 6 that are obese or overweight	42.4%					40.6%						↘	R	33.2%	37.2%	4	PHOF
Number of children and young people accessing Tier 3/4 CAMHS services	1,053	528	546	635	563	1,217	585	490	526			↗	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	93.4%	86.5%	73.0%	76.4%	91.8%	91.8%	82.0%	72.0%	73.8%			↗	A	84.3% (2014/15 annual)	88.1% (2014/15 annual)	6	HWBB OF
2 - Adolescence																	
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	42.4	31.0	20.5	..	..	..	..	..	..			↘	R	21.9	20.4	7	PHOF
Number of positive Chlamydia screening results	511	141	141	127	132	541	118	130	125			↘	R			8	HWBB OF

Key

Appendix A: Indicators for HWBB - 2015/16 Q3

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PHOF	Public Health Outcomes Framework
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BCF	Better Care Fund

Title	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
3 - Adults																	
Number of four week smoking quitters	1,174	142	162	139	200	643	121	89	125			↗	R			9	HWBB OF
Please note that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.																	
Cervical Screening - Coverage of women aged 25 -64 years	72.4%					70.1%						↘	A	73.5%	68.4%	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	11.4%	2.6%	4.2%	4.4%	4.8%	16.3%	2.5%	2.9%	3.1%			↗	R	9.6%	11.6%	11	PHOF
Please note that annual figures, and London and England figures, are a cumulative figure accounting for all four previous quarters.																	
4 - Older Adults																	
Breast Screening - Coverage of women aged 53-70 years	71.2%					64.3%						↘	A	75.4%	68.3%	12	PHOF
Percentage of women whose last test was less than three years ago.																	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	696.8	240.8	425.3	614.9	936.58	936.58	188.24	401.91	625.35			↗	A	668.4	463.9	13	BCF/ASCOF
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	88.3%					67.2%						↘	R	82.1%	85.3%	14	BCF/ASCOF
Injuries due to falls for people aged 65 and over	2027.0					1656.0						↘	G	2125.0	2253.0	15	BCF/PHOF
Directly age-sex standardised rate per 100,000 population over 65 years.																	

* Data from 2011/12

Key

Appendix A: Indicators for HWBB - 2015/16 Q3

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
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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	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
5 - Across the Lifecourse																	
The percentage of people receiving care and support in the home via a direct payment	73.4%	74.7%	75.2%	76.2%	76.7%	75.7%	76.6%	75.1%	74.3%			↘	A	62.1%	67.4%	16	ASCOF
Delayed transfers of care from hospital	5.5	4.2	4.7	5.4	5.4	4.9	7.2	7.4	7.7			↗	A	9.7	6.9	17	ASCOF
Delayed transfers due to social care	1.1	2.22	1.73	2.91	2.2	2.25	2.63	4.55	4.1			↘	A	3.1	2.3	18	ASCOF
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 (type all)	88.8%	85.6%	86.4%	80.5%	88.8%	..	93.4%	92.3%	86.5%			↘	A	94.2%		20	HWBB OF
BHRUT Figure. 2014/15 annual figure not available.																	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1,059.4					1,053.6						↘	R	809.0		21	HWBB OF

* Data from 2011/12

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Appendix B

Provider Name	Location	Weblinks	Location Org Type	Report Date	Inspection Date	Rating
King Edwards Medical Centre	1 King Edwards Road	http://www.cqc.org.uk/location/1-583969135	GP	12/11/15	07/10/15	Good
Liberty Centre UK	Liberty Centre Dagenham	http://www.cqc.org.uk/directory/1-160181244	Social Care Org	30/10/15	15-17/09/15	Good
Orchard Care Homes Ltd	Alexander Court	http://www.cqc.org.uk/directory/1-312323157	Social Care Org	20/10/15	28-29/05/15	Requires Improvement
<p>Orchard Care Homes Ltd Comments / Summary</p> <p>Safe: Inadequate Infection control not adequate. Premises found to be dilapidated in areas and in need of renovation. Staffing levels were found to be unacceptable.</p> <p>Effective: Requires Improvement Staff training is not consistent or adequate.</p> <p>Caring: Requires Improvement People did not always feel cared for by some of the staff.</p> <p>Responsive: Requires Improvement Peoples preferences were not always taken into account.</p> <p>Well Led: Requires Improvement Record keeping inadequate. Inability to identify their own issues and resolve them.</p> <p>Action: The provider suspended placements to the home in order to deal with issues and make satisfactory improvements in accordance with the expectations of CQC and LBBB. The provider has now met these and is accepting placements, however monitoring by us has increased and we are working with the provider to support sustaining the continuous improvements that need to be made in the home.</p>						
Triangle Community Services Ltd	Harp House	http://www.cqc.org.uk/directory/1-189037034	Social Care Org	30/11/15	14/10/15	Required Improvement
<p>Triangle Community Services Ltd Comments / Summary</p> <p>Safe: Requires Improvement No comprehensive risk assessments carried out. Failure to notify CQC of abuse allegations.</p>						

Appendix B

Provider Name	Location	Weblinks	Location Org Type	Report Date	Inspection Date	Rating
<p>Effective: Good Caring: Good Responsive: Good Well Led: Requires Improvement</p> <p>Own quality assurance systems are inadequate. Service manager not registered with CQC.</p> <p>Action: LBBDD have increased their monitoring and supporting the provider to meet the requirements of the CQC action plan. LBBDD are also monitoring serious incident notifications to ensure that they are being forwarded to CQC as per regulations.</p>						
Chosen Services	Homecare Provider all ages	http://www.cqc.org.uk/directory/1-228962162	Social Care Org	03/11/15	29-30/09/15	Requires Improvement
<p>Chosen Services Comments / Summary</p> <p>Safe: Requires Improvement Inadequate risk assessments. Issues with recording medicine assistance.</p> <p>Effective: Requires Improvement Issues with consistency and updating of staff training.</p> <p>Caring: Good</p> <p>Responsive: Requires Improvement Care Plans not person centered.</p> <p>Well Led: Requires Improvement Not adequately identifying deficiencies in systems including not identifying risk assessing and care planning was below standard.</p> <p>Action: Telephone spot checks carried out with 2 clients receiving services from this provider. Both are happy with the service and the carers, they have no wish to change provider at this time.</p> <p>We will continue to monitor and ensure both clients are receiving a quality service, they are aware that they can change to a different provider at any time if dissatisfied.</p>						

HEALTH AND WELLBEING BOARD

8 March 2016

Title:	Devolution through an Accountable Care Organisation in Barking & Dagenham, Havering, and Redbridge	
Report of the Cabinet Member for Adult Social Care and Health		
Open Report	For Information	
Wards Affected: ALL	Key Decision: NO	
Report Author: Mark Tyson, Group Manager, Integration & Commissioning	Contact Details: Tel: 020 8227 2875 E-mail: mark.tyson@lbbd.gov.uk	
Sponsor: Anne Bristow, Strategic Director, Integration & Service Development, and Deputy Chief Executive		
Summary: Further to previous updates, this report summarises the current position with respect to the development of the business case to determine whether or not an Accountable Care Organisation is a viable form for future integrated health and social care delivery across Barking & Dagenham, Havering & Redbridge. This follows the announcement by the Chancellor on 15 December of a devolution pilot for Barking & Dagenham, Havering and Redbridge for health and social care. The update is provided for Board members' information and comment.		
Recommendation(s) Members of the Health and Wellbeing Board are recommended to note the update provided with this report, and to provide comments on the approach being taken.		
Reason(s): The approach to devolution through an Accountable Care Organisation would be a very significant change to how health and social care services are planned and delivered across Barking & Dagenham, Havering and Redbridge. The development of the business case on which these decisions can be made is a substantial programme, and through this and the planned on-going reporting to the Board, Board members are invited to contribute to shaping the developing business case.		

1. Background

- 1.1 This report follows reports to the Health & Wellbeing Board on 26 January 2016, 8 December 2015 and 20 October 2015, which set out the background to the development of a business case which would seek to establish whether an Accountable Care Organisation could strengthen or accelerate improvements in health and social care services in Barking & Dagenham, Havering and Redbridge (BHR).
- 1.2 The programme that has been established to develop this business case includes contributions from all eight statutory partners (the three councils, three Clinical Commissioning Groups, NELFT and Barking, Havering & Redbridge University Hospitals NHS Trust). It is aiming to establish a shared vision for the future of health and social care, including shaping the BHR contributions to the wider North East London Sustainability & Transformation Plan, required by NHS England by June 2016.
- 1.3 The business case will follow formally in July 2016, with the intention of the statutory organisations taking formal decisions on whether to proceed with an accountable care organisation from September onwards.

2. Update on progress

Governance for the development of the ACO business case

- 2.1 The first formal meeting of the Democratic & Clinical Oversight Group took place on 18 February 2016. All organisations were represented. Barking & Dagenham Council was represented by Cllr Darren Rodwell and Cllr Maureen Worby, and the Clinical Commissioning Group was represented by Dr Waseem Mohi, with officers also in attendance. Cllr Rodwell was chosen as the chair for the Group, which then signed off Terms of Reference and received updates on programme structure and approach. The Oversight Group were keen to ensure that the original ambition of the ACO/devolution proposals was kept firmly in view and therefore, before any detail on risks and governance was considered, they requested a workshop at which the scope, opportunities and ambition could be explored and shared between the participants. This was scheduled for 3 March.
- 2.2 A follow-up workshop on 17 March will be supported by external legal advice and will enable the DCOG to get a more detailed perspective on the risks, challenges and organisational forms involved in accountable care approaches.

Programme update

- 2.3 **Population health:** Packages of analytical work have been scoped and initiated, to report back in the timeline required for senior decision-makers to take the judgments necessary to be able to assemble the business case by the summer. Resources to undertake this have been scoped and secured. UCL Partners are working on shaping the future engagement of academia with local health and social

care planning and research, and this is linked to future proposals on analytical capacity.

- 2.4 **Clinically and professionally led service redesign:** this work stream has established a series of workshops which aim to engage clinicians and professional leaders from the eight organisations in discussing the added value an ACO could potentially bring to existing transformation activity. These are focused around urgent and emergency care, mental health, and falls and frailty. Two local authority led sessions will further look to align adult social care strategy and transformation plans across the three local authorities, and scope the impact on wider determinants of health, principally employment, skills, welfare and housing. Children's services discussions continue at 1:1 level within the boroughs, and the Children's Trust in Barking & Dagenham discussed an update at its meeting on 23 February 2016.
- 2.5 **Finance:** The Finance work stream has commissioned external support to ensure that the analysis has independent verification, is concluded at the required pace, and is robust in presenting the current budget gap across all of the partners and the opportunities for an accountable care organisation to help bridge the gaps whilst improving health outcomes for residents. Early setup for this commissioned piece of work will ensure that the other work streams, and all constituent partners, have opportunity to shape how it makes best use of existing analysis and has the best 'fit' to what is required in the business case.

Communications and Engagement

- 2.6 IpsosMORI are being commissioned to undertake engagement activity across the three boroughs to shape the understanding of health challenges, experience of using services, and the opportunities to improve services as seen from the perspective of residents and patients. These will be done in varying levels of detail, from journey mapping people's experience of complex care through to a higher-level telephone survey drawing out the experiences and opinions of 1,000 people per borough.
- 2.7 A communication plan has been drafted and is being developed jointly with communications leads from all constituent organisations. This will include staff messaging and feedback as well as wider public communications. The website of the Integrated Care Coalition – at www.bhrpartnership.org.uk – is also now live and contains a developing information base about a range of activity to develop health and social care services and strategy across BHR, including the ACO development.
- 2.8 To aid discussion about the background to the ACO development, an infographic has been developed and has been 'tweeted' in parts, via the Integrated Care Coalition's Twitter account [@bhrpartnership](https://twitter.com/bhrpartnership). It is attached at appendix A for Board members' information.
- 2.9 There are a range of briefing and exploratory discussions being undertaken by programme participants to explore specific links to other agendas. In terms of regulation, the developments in BHR are being played into wider background

discussions with regulators about how the development of devolved and accountable care systems might impact on regulation.

3. Next steps

3.1 Between now and the next Board meeting, priorities include:

- Workshops for the Democratic and Clinical Oversight Group to re-establish and refine the scope, ambition and strategy;
- Running, or setting up, the workshops with practitioners and other programme leads to establish links to the transformation programmes already underway, and then to capture the products for the business case;
- Initiating the finance analytical work, and completing the first phase of high-level analysis of cross-system financial gap;
- Undertaking the population-level health analysis and shaping the first cut of priorities for the ACO to impact upon;
- Initiate the telephone survey of 3,000 residents to understand their experience of health and social care and their views on where things could be improved.

HEALTH AND WELLBEING BOARD
PROCUREMENT STRATEGY REPORT

8 March 2016

Title: Contract – Procurement of Healthy Child Programme 5-19 (School Nursing and National Child Measurement Programme)	
Report of the Cabinet Member for Adult Social Care and Health	
Open Report	For Decision
Wards Affected: All	Key Decision: Yes
Report Author: Matthew Cole Director of Public Health, London Borough of Barking and Dagenham	Contact Details: Tel: 020 8227 3657 E-mail: matthew.cole@lbbd.gov.uk
Accountable Divisional Director: Matthew Cole	
Accountable Director: Anne Bristow, Strategic Director Service Development and Improvement and Deputy Chief Executive	
Summary:	
<p>Responsibility for the commissioning of the Healthy Child Programme 5-19 (School Nursing and National Child Measurement Programme Services) was transferred to the Council on 1 April 2013. The service offers school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion, as well as tailored support for children and families. The National Child Measurement Programme (NCMP) is a mandated public health programme for the Council.</p> <p>The Healthy Child Programme (HCP) 5-19 contract is currently provided by North East London NHS Foundation Trust (NELFT). The contract commenced on 1 April 2013 for a duration of 17 months with a further 19 months extension agreed by the Health and Wellbeing Board on the 29 July 2014. A 6 months contract award to NELFT was approved by the Board on 26 January 2016 from 1 April until 30 September 2016 to maintain service continuity while a new service is being procured. The service contract will expire on 30 September 2016 with no option for extension.</p> <p>The commissioning of HCP 0-5 (Health Visiting and Family Nurse Partnership Programme) services transferred from NHS England and became the responsibility of the Council in October 2015. This gives the Council the opportunity to join up the commissioning of the 0-5 and 5-19 HCPs as a fully integrated 0-19 HCP. A service review currently being undertaken will make recommendations with options appraisal for the integration of the 0-5 and 5-19 HCPs. These will feed into a more detailed procurement strategy to be presented to the Board at a later date.</p>	

The integration of the 0–19 HCP is expected to deliver both financial and operational efficiencies to the Council, a more streamlined service and better outcomes for children, young people and families. It will allow the introduction of a new service delivery model for specialist Community Public Health Nursing Service to be more focused on improving health and wellbeing outcome, and provides an opportunity for a joined up approach and improved seamless pathway for children, young people and families where health and wellbeing issues are assessed, identified and when necessary supportive interventions implemented. It will provide an opportunity to develop effective partnerships with local services advocating and delivering change to support improvements in services for children’s health and well being.

This report seeks approval for the Council to proceed with the procurement of a contract for the provision of the HCP 5-19 service, via an open tender process. The new service contract will be awarded to the successful provider from 1 October 2016 until 30 September 2017 with the option for the Council to extend the contract for a further one year period.

Recommendation(s)

It is recommended that the Board gives:

- (i) Approval for the Council to proceed with the procurement of a contract for the provision of the Healthy Child Programme 5-19, via an open tender process, in accordance with the strategy set out in this report; and
- (ii) Delegated Authority to the Strategic Director Service Development and Improvement and Deputy Chief Executive, in consultation with the Director of Public Health, Corporate Director of Children’s Services, Strategic Director Finance and Investment, and the Director of Law and Governance, to award the contract to the successful bidder in accordance with the strategy set out in this report

Reason(s)

- To comply with the Council’s Contract Rules and EU Legislation and ensure continued service provision beyond contract end date of 30 September 2016
- To align the end date of the contract with the 0-5 HCP, in order for the Council to procure both services together.

1. Introduction and Background

- 1.1 The Healthy Child Programme¹ (HCP) is an evidenced-based early intervention and prevention public health programme for children and families. It sets out the recommended framework of services for children and young people aged 0 -19 years (including during pregnancy) to promote optimal health and wellbeing, prevent ill health and provide early intervention when required.
- 1.2 Effective implementation of the programme improves a range of public health outcomes including improved sexual health, reduced numbers of teenage pregnancies, healthy diet and exercise, improved educational outcomes, smoking prevention and cessation, substance misuse prevention, and awareness and improved emotional health and wellbeing.
- 1.3 Responsibility for the commissioning of HCP 5-19 (School Nursing and NCMP) service was transferred to the Council on 1 April 2013. The service delivered by School Nurses, offers school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion, as well as tailored support for children and families. NCMP is a mandated public health programme for the Council.
- 1.4 The Healthy Child Programme (HCP) 5-19 contract is currently provided by North East London NHS Foundation Trust (NELFT). The contract commenced on 1 April 2013 for duration of 17 months with a further 19 months extension agreed by the Health and Wellbeing Board on the 29 July 2014. A 6 months contract award to NELFT was approved by the Board on 26 January 2016 from 1 April until 30 September 2016 to maintain service continuity while a new service is being procured. The service contract will expire on 30 September 2016 with no option for extension.

Service Re-configuration

- 1.5 The commissioning of HCP 0-5 (Health Visiting and Family Nurse Partnership Programmes) service transferred from NHS England and became the responsibility of the Council in October 2015. Health Visitors and Family Nurses lead the implementation of the service in partnership with other health and social care colleagues.
- 1.6 The transfer of the commissioning responsibilities provides the Local Authority the opportunity to join up the commissioning of the 0-5 and 5-19 HCPs as a fully integrated 0-19 HCP.
- 1.7 The integration of the 0–19 HCP is expected to deliver both financial and operational efficiencies to the Council, a more streamlined service and better outcomes for children, young people and families. It will allow the introduction of a new commissioned service delivery model for specialist Community Public Health Nursing Service to be more focused on improving health and wellbeing outcome,

1

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf.

and provides an opportunity for a joined up approach and improved seamless pathway for children, young people and families where health and wellbeing issues are assessed, identified and when necessary supportive interventions implemented. It will provide an opportunity to develop effective partnerships with local services advocating and delivering change to support improvements in services for children's health and well being.

- 1.8 A 0-19 project steering group was established in October 2015 to steer the transformation process over the next 12 months and devise a market development strategy that describes the approach the Council will adopt in the analysis and management of the early years health and care system in the borough. The work of this group is still on-going and the recommendations with an options appraisal which considers the various options for integration will feed into a more detailed procurement strategy to be presented to the board at a later date.
- 1.9 While the service review and remodelling is being carried out, the Council needs to ensure continuous service provision of the healthy Child Programme 5-19 service to local children and families. In addition, NCMP is a mandated public health programme for the Council. It has, therefore, been agreed that the Council will proceed with the procurement of a contract for the provision of the HCP 5-19 service via an open tender process.
- 1.10 The new service contract will be awarded to the successful provider from 1 October 2016 until 30 September 2017 with the option for the Council to extend the contract for a further one year period. This will provide the flexibility to tie in with the 0-5 HCP and procure as an integrated 0-19 HCP.

2. Proposed Procurement Strategy

2.1 Outline specification of the works, goods or services being procured.

The core elements delivered by the Healthy Child Programme 5-19 are;

Universal	Progressive/ Universal Plus and Partnership Plus	Enhanced elements
Three universal health reviews	Participation in Common Assessment Framework process where related to direct case load	Health absenteeism support
National child measurement programme, including parental feedback	Participation in Targeted Mental Health in Schools (TaMHS) process where related to direct case load	Tier 2 child weight management
Support for schools to develop health related policies, e.g. pupil medicine management	Participation in safeguarding and child protection procedures where related to direct case load	Additional drop-in school based sessions beyond universal provision
Regular access for children, young	Tier 1 child weight management advice and	Additional input to school curriculum/assembly health

people and educational professionals to professional health advice and support in school and community youth settings.	signposting	related sessions beyond universal provision
Access, for secondary school children, to sexual and reproductive health advice and guidance and, where school SRE policies allow, access to condoms where appropriate	Support to school in signposting and accessing SEN related health services	
Access, for secondary school children, to Level One smoking cessation advice and support where needed.	Support and signposting to services for specific groups of vulnerable young people: <ul style="list-style-type: none"> • Young carers • Children living with chronic diseases e.g. sickle cell disease, diabetes • Lesbian, gay, bisexual and trans identifying youth • Young mothers in education • Youth offenders in education 	
	Signposting of support for vulnerable parents	

2.2 Estimated Contract Value, including the value of any uplift or extension period.

Based on current spend, the indicative cost of the service will be £2,400,000 (£1,200,000 per annum). The cost of this service will be met from the Public Health Grant.

2.3 Duration of the contract, including any options for extension.

Two years (1 year with the option to extend for a further 1 year period).

2.4. Is the contract subject to the (EU) Public Contracts Regulations 2015? If yes and the contract is for services, is it subject to the light touch regime?

Yes, the service being procured falls within the description of services covered by the Light Touch Regime under the Public Contracts Regulations 2015. Because the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations

2.5. Recommended procurement procedure and reasons for the recommendation.

The recommended procurement route is a competitive open tender procedure; the tender opportunity will be advertised on the OJEU, Contracts Finder and the Council's website. The process will widen the competition and ensure the Council gets best value for money for this service.

Reasons

To comply with the Council's Contract Rules and EU Legislation and ensure continued service provision beyond the end date of the interim contract, which is 30th September 2016.

2.6. The contract delivery methodology and documentation to be adopted.

The contract will be provided by one provider and the Public Health Services Contract 2015 with LBBB amendments is the form of contract to be used. The contract will have a break clause allowing notice to be given by either party for termination. This allows increased flexibility should a significant change in service provision be required.

A range of services will be delivered by a specialist workforce of healthcare professionals working with children, young people and their families in local schools and community settings on both a group and individual basis to support children and young people to remain healthy and to ensure that their health needs are met.

Services are to be provided to Barking and Dagenham residents only; the service specification will highlight respective service eligibility criteria

The procurement timetable is as follows:

Activities/ Tasks	Date
Issue PIN for Expression of Interests	2 February 2016
Prepare Tender Documents (Conditions, Specification, ITT, TUPE etc)	By 25 March 2016
Issue contract notice /ITT	31 March 2016
Deadline for clarifications	28 April 2016

Return Tenders	5 May 2016
Tender Evaluation	9-20 May 2016
Prepare award report/ get approval	23 May - 3 June 2016
Provisional Award (notify successful/ unsuccessful Tenderer's)	6 June 2016
Standstill Period	7-17 June 2016
Final award	20 June 2016
Mobilisation including potential TUPE transfers	21 June - 30 September 2016
Contract commencement	1 October 2016

2.7. Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract.

Effective implementation of the service improves a range of public health outcomes including improved sexual health, reduced numbers of teenage pregnancies, healthy diet and exercise, improved educational outcomes, smoking prevention and cessation, alcohol and substance use prevention and awareness and improved emotional health and wellbeing.

In the longer term, the benefit of aligning the procurement of both services into an integrated 0-19 service is expected to deliver both financial and operational efficiencies, a more streamlined service and better outcomes for children, young people and families.

2.8. Criteria against which the tenderers are to be selected and contract is to be awarded.

The Contract will be awarded on the basis of the most economically advantageous tender with a split of 70% price and 30% quality. Price will be assessed based on contract prices based on current volume provided by providers and quality will be assessed according to provider's responses to the method statement questions.

2.9. How the procurement will address and implement the Council's Social Value policies.

The Council's social value responsibilities are taken through its vision: One borough; One community; London's growth opportunity. The procurement of the service will seek to achieve health and well-being outcomes for children and young people and provide additional value to the local community including schools.

The Council will work with the provider to seek to identify local opportunities for apprenticeships, training and recruitment for Barking and Dagenham residents.

3. Options Appraisal

Option 1: Do Nothing

This option is not viable because the Council is required to deliver statutory duties for children, young people and families through the Healthy Child Programme 5-19 service. In addition, NCMP which is an element of the programme is a mandated public health programme for the Local Authority. If the service ceases, access to health and social services for children, young people and families in the borough would be lost, and this would have a detrimental impact on their health, social and educational outcomes. There is also a reputational and financial risk to the authority by the potential failure to perform its statutory duty to deliver public health services for children 5-19 years.

Option 2: Undertake a competitive process to procure an Integrated 0-19 Healthy Child Programme and award a full contract (3-4 years)

This option was considered but rejected at this time due to the delay with the completion of the service reviews. Also, the Council has a two-year contract from 1 October 2015 with an option to extend for up to 12 months for the Healthy Child 0-5 programme; therefore the new 5-19 contract will be awarded to align the end date of the two contracts, in order for the Council to procure both services together.

Option 3: Undertake a competitive process and award the contract for a short period (preferred option)

Advantage:

1. Ensure service continuity after current contract end date
2. Allow completion of the review of early year's services and development of an integrated model that ensure the service best meets the needs of children, young people and families in the borough.
3. The Council is able to fulfil its legal obligation to its residents
4. The Council will comply with the Public Contracts Regulations 2015

4. Waiver

N/A

5 Equalities and other Customer Impact

The award of the contract will provide a model of service delivery to all children and young people (including vulnerable) and their families in Barking and Dagenham through a community and universal offer. This service supports the work of the public health team in challenging some of the inequalities in health outcomes for children and young people and their families in Barking and Dagenham through joint working with schools, teachers, and communities to improve health.

6. Other Considerations and Implications

6.1 Risk and Risk Management

Risk	Likelihood	Impact	Risk Category	Mitigation
Delay to/ failed procurement process	Medium	Medium	Medium	Set and follow a realistic timetable. Council to negotiate new contract with current provider
TUPE prevents providers from tendering for service	Medium	Medium	Medium	Gather TUPE information early in project; get expert advice from legal services. Make information clear in ITT documents. Negotiate new contract with current provider as contingency plan for no tenders received
No tender received, leading to increased service cost by current provider	Medium	High	High	Clear service budget identified and negotiated with current provider
Contract award decision challenged by unsuccessful provider(s)	Low	Low	Low	Procure contract in line with Council's contract rules and ensure OJEU process followed. Liaise with legal and corporate procurement departments at all stages and ensure documentation is kept.
Provider fail to meet contractual obligations	Low	High	Medium	Clear set of outcomes set out in service specification and agreed with provider. Robust and regular performance monitoring procedures, performance indicators and consequences of failure to meet them set out in service contract.

6.2 **TUPE, other staffing and trade union implications.**

Eligible staff currently employed in the service will, in the event of change in service provision, transfer their employment to the new provider under the Transfer of Undertakings (Protection of Employment) Regulations 2014.

6.3 **Safeguarding Children**

The provision of this service would improve the wellbeing of children in the borough and reduce inequalities. The Council would ensure that the provider has in place the necessary safeguarding protocols, in line with Council Policy and applies the Frazier Guidelines and Gillick Competency where a young person is under 16.

6.4 **Health Issues**

The proposal is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy. The award of the contract should further enhance the quality and access of services, as well as user and patient experiences. The proposal will have a positive effect on our local community.

6.5 **Crime and Disorder Issues**

N/A

6.6 **Property / Asset Issues**

N/A

7. **Corporate Procurement**

Implications completed by: Adebimpe Winjobi, Category Manager

7.1 The service being procured falls within the description of services covered by the Light Touch Regime under the Public Contracts Regulations 2015. As the estimated value of the contract is higher than the set threshold (currently EUR 750,000), it needs to be opened up to competition and be advertised in the Official Journal of the European Union (OJEU) as required by the Regulations.

7.2 In keeping with the EU procurement principles, it is imperative that the contract is tendered in a competitive way and that the process undertaken is transparent, non-discriminatory and ensures the equal treatment of bidders. The proposed procurement route to tender this service via EU Open Procedure will widen the competition, as market research demonstrates that there are not many providers currently able to provide this service. This procurement route will provide best competition to get best value for money for the Council and will be compliant with the Council's Contract Rules and EU Regulations.

7.3 Corporate procurement will provide the required support to public health throughout the entire process.

8. Financial Implications

Implications completed by: Richard Tyler, Interim Group Manager, Finance

- 8.1 The contract for the provision of this service is £1.2m per annum and the Public Health Grant has allocated an annual budget of £1.2m to fund this.
- 8.2 There are no additional cost pressures expected to the Council in addition to the agreed contract value.

9. Legal Implications

Implications completed by: Daniel Toohey (Principal Corporate Solicitor, Law and Governance)

- 9.1 This report is seeking approval to procure a contract for the provision of the Healthy Child Programme for children aged 5 to 19. The nature of this contract falls within the description of the Social, Health and Education services under the Light Touch Regime (LTR).
- 9.2 As the estimated value of this contract is above the LTR threshold (currently EUR750,000) it is not exempt from an EU wide tender exercise. Nevertheless, it qualifies for a less stringent procurement process in accordance with the Light Touch Rules provided for under the Public Contracts Regulations 2015 (PCR 2015). It must also comply with a number of mandatory requirements including OJEU advertising, compliance with Treaty principles of transparency and equal treatment, and a procurement process in conformance with the information provided in the OJEU advert.
- 9.3 This report sets out the procurement strategy for this service contract and states that it will be advertised in the OJEU in accordance with the PCR 2015. The report also gives details of the procurement procedure, evaluation criteria, award criteria and the timetable for the procurement exercise. All the above show evidence of a fair tender exercise, in accordance with the PCR 2015, which must be adhered to in compliance with the PCR 2015.
- 9.4 The Law and Governance Team is available to provide assistance with the drafting and execution of the contract for this service.

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HEALTH AND WELLBEING BOARD

8 MARCH 2016

Title:	Systems Resilience Group Update		
Report of the Systems Resilience Group			
Open Report		For Information	
Wards Affected: ALL		Key Decision: NO	
Report Author: Andrew Hagger, Health and Social Care Integration Manager, LBBD		Contact Details: Tel: 020 8227 5071 E-mail: Andrew.Hagger@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 Systems Resilience Group. This report provides an update on the Systems Resilience Group meeting held on 1 February 2016 as set out in Appendix A attached.			
Recommendation(s) The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> • Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the Systems Resilience Group. 			
Reason(s): There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.			

1 Mandatory Implications

1.1 Joint Strategic Needs Assessment

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

1.2 Health and Wellbeing Strategy

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

1.3 Integration

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

1.4 Financial Implications

The Systems Resilience Group 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 Systems Resilience Group.

1.6 Risk Management

Urgent and emergency care risks are already reported in the risk register and group 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 group 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

System Resilience Group Briefings:

Appendix A: 1 February 2016

System Resilience Group (SRG) Briefing	Meeting dated – 1 February 2016
	Venue – Boardroom A, Becketts House, Ilford
Summary of paper	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Officer, BHR CCGs) and attended by members as per the Terms of Reference.

Agenda	Areas/issues discussed
Planned Care	Members were updated on the RTT and Cancer improvement plans. The Trust advised that they have appointed a Programme director to work across the system to increase management capacity for RTT. Further update to come back to the next meeting.
Performance reporting	Key areas from the dashboard were highlighted.
Trust Improvement Plan	Members received a brief update on the latest developments of the Trust Improvement Plan.
Plan for 2015/16	Members received an update on progress of key areas of the 2015/16 plan.
Strategic Development	Members noted the latest position of the Urgent and Emergency Care Vanguard .
Next meeting:	29th February 2016 1pm – 3pm Boardroom, Trust HQ, Queens Hospital, Rom Valley Way, Romford, RM7 0AG

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HEALTH AND WELLBEING BOARD

8 March 2016

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: Andrew Hagger, Health and Social Care Integration Manager	Contact Details: Tel: 020 8227 5071 Email: Andrew.Hagger@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 talk about a new logo for the Health and Wellbeing Board, the success of CCG's Great Staying Healthy event drop as well as an update on the urgent and emergency care vanguard. 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*

A new logo for the Health and Wellbeing Board

As Chair of the Health and Wellbeing Board I am pleased to share with you the new logo for the Barking and Dagenham Health and Wellbeing Board.



Barking and Dagenham Health and Wellbeing Board

The desire for a new logo and 'branding' has been discussed previously by some Board members as well as the Executive Planning Group that supports the Board. It was felt that there needed to be a distinctive identity for the Board so it did not feel solely like a council committee, but like a true partnership board that has a system leadership role and makes decisions on priorities and strategies for the whole area.

The logo shows the diverse range of people that the Health and Wellbeing Board can impact on through our efforts to improve the health and social care system in Barking and Dagenham and beyond. The colour scheme reflects the colours of our partners on the Health and Wellbeing Board.

I hope you'll agree that it looks great. You will be seeing more of the new logo and colours as it and they are used on agendas for future meetings, in the newly revamped Health and Wellbeing Board newsletter and on our twitter feed [@BarDagHWBB](https://twitter.com/BarDagHWBB)

The Great Staying Health Stakeholder Event

On Tuesday 16th February, Barking and Dagenham CCG held an engagement event, hosted by Healthwatch. The event aimed to engage patients and the public about the CCG's commissioning priorities for 2016/17, with an emphasis on getting the views of people who might not otherwise come to a stakeholder engagement event.



The event took place in Relish Café in Barking Town Square and in the atrium of the Barking Learning Centre.

Drinks and healthy snacks were provided on the day (including a few not so healthy cakes!), which were appreciated by all those who stopped by.

There were a number of zones in Relish for people to get more information from, including Healthy families, Make a change, Beating the blues and Navigating the NHS.

The Barking Learning Centre atrium featured the current stroke consultation, information on bowel screening, the British Heart Foundation, information online via the care and Support Hub as

as well as how to get involved with the Patient Engagement Forum, Healthwatch and the CVS.

On behalf of the Board I would like to thank all those who took part, either by attending and discussing health issues and what they think of health services in the area or through helping to organise and put on the event. Staff of both Relish and the Barking Learning Centre helped, while CCG and local authority staff were involved in the organisation and delivery of the event. Special mention should go to our local Health Champions, who were involved in the planning of the event and who, alongside CCG staff, went out into Barking Market on a cold February afternoon to talk to people about the event and encourage them to stop in.



News from NHS England

Mental Health Taskforce Report

Formed in March 2015, the independent Mental Health Taskforce brought together health and care leaders, people using services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England. This national strategy, which covers care and support for all ages, was published in February 2016.

The report highlights that one in four adults experiences at least one diagnosable mental health problem in any given year and that mental health problems represent the largest single cause of disability in the UK. Challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years. The report outlines that increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS.

The report sets out 3 priorities for the NHS to be delivered by 2020/21. These link to the priorities set out in the Five Year Forward View. The priorities are:

- A 7 day NHS providing right care, right time, right quality
- An integrated mental and physical health approach
- Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens

The report emphasises that people facing a crisis should have access to mental health care 7 days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. Better access to support was one of the top priorities identified by people in the taskforce's engagement work.

Part of making physical and mental health care equally important identified in the report is making sure that someone with a disability or health problem won't just have that treated, they will also be offered advice and help so their recovery is as smooth as possible. Engagement work carried out by the taskforce found that mental health support should be made easily available across the NHS and that services should be integrated so that, for example, physical health checks and smoking cessation programmes could be made available for everyone with a severe mental illness.

Prevention was also identified as a key way of creating lasting change. Promoting good mental health and preventing poor mental health includes prevention at key moments in life as well as creating mentally healthy communities and building a better future:

The report identifies that over the next five years additional funding should allow NHS England to expand access to effective interventions. The priority areas identified require an additional £1 billion investment, which will contribute to plugging critical gaps the NHS is currently unable to provide. The expectation is that savings and efficiencies generated by improved mental health care and through new models of care will be re-invested in mental health services.

News from NHS England continued...

NHS hit first target on climate change

A report from the Sustainable Development Unit for NHS England and Public Health England showed the NHS has reduced its carbon emissions by 11% between 2007 and 2015 – exceeding the 10% target set in 2009. This is despite health and care activity increasing by 18% since 2007.

Multiple factors have contributed to the reduction. Carbon emissions in relation to procurement have reduced by 16% – a large part of this is due to improvements in the footprint of pharmaceuticals (through both carbon intensity of products and spend reductions). In addition energy emissions have reduced by 4% and travel by 5%. These improvements offer more than just environmental benefits, they also represent significant cost savings and health benefits.

Improvements in building energy use and staff behaviour change programmes have contributed energy savings of £25m in the last year. Transport reductions represent a fall in the health sector's contribution to air pollution in local communities, which improves public health and reduces the need for the NHS to treat preventable illnesses.

Urgent and Emergency Care Vanguard

Work has finished on the submission of the Value Proposition 2 (the business case) for the Urgent and Emergency Care Vanguard. Having secured £1.31m for the rest of 2015/16 to start work, the bid is asking for further funds to carry out transformation work to the Urgent and Emergency system in 2016/17. This builds on the click, call, come in model that was set out in the earlier submission and includes enhancements around the front door at Queens A&E, establishing a professional hub to link in with 111 and a Programme Management Office team to deliver the Vanguard programme. Local authorities have requested funds to support mapping services, investment in voluntary sector services (including a sitting service to take people home so they are not admitted to A&E), investment for service providers (including training for providers on the new UEC system) as well as enhanced care packages and assistive technology to prevent admissions to A&E. The Vanguard national team have indicated that there won't be any news on this until the middle of March.

The Urgent and Emergency Care Vanguard team attended the Vanguard Quarterly Forum on 25 February, which provided an opportunity to hear from the national team supporting the Vanguards across England and to discuss approaches with other Urgent and Emergency Care Vanguards. The team took inspiration from a talk by Don Berwick, who helped implement the Affordable Care Act (commonly known as Obamacare), on overcoming obstacles in implementing large scale change. The team also heard from the Cambridge and Peterborough Vanguard team about the mental health place of safety that they are about to open, which is being run by the voluntary sector and has been co-designed by service users. The North East Vanguard team explained their new approach to live data, called Flightdeck, which provides real time information on bed availability, how busy services are and what ambulances are currently en route to hospitals, allowing for better resource management and also analysis of long term trends.

Health and Wellbeing Board Meeting Dates

Tuesday 26 April 2016, Tuesday 14 June 2016, Tuesday 26 July 2016, Tuesday 27 September 2016, Tuesday 22 November 2016.

All meetings start at 6pm and are held in the conference room of the Barking Learning Centre.

HEALTH AND WELLBEING BOARD**8 March 2016**

Title:	Forward Plan		
Report of the Chief Executive			
Open	For Comment		
Wards Affected: NONE	Key Decision: NO		
Report Authors: Tina Robinson, Democratic Services, Law and Governance	Contact Details: Telephone: 020 8227 3285 E-mail: tina.robinson@lbbd.gov.uk		
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board			
Summary: The Forward Plan lists all known business items for meetings scheduled for the coming year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that information on future key decisions is published at least 28 days before the meeting. This enables local people and partners to know what discussions and decisions will be taken at future Health and Wellbeing Board meetings. Attached at Appendix A is the next draft edition of the Forward Plan for the Health and Wellbeing Board. The draft contains details of future agenda items that have been advised to Democratic Services at the time of the agenda's publication.			
Recommendation(s) The Health and Wellbeing Board is asked to: a) Note the draft Health and Wellbeing Board Forward Plan and that partners need to advice Democratic Services of any issues or decisions that may be required, in order that the details can be listed publicly in the Board's Forward Plan at least 28 days before the next 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) Note that the next issue of the Forward Plan will be published on 24 March 2016. Any changes or additions to the next issue should be provided before 6.00 p.m. on 21 March.			

Public Background Papers Used in the Preparation of the Report:

None

List of Appendices**Appendix A** – Draft Forward Plan

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HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT April 2016 Edition

Publication Date: Due on 24 March 2016

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at <http://modern.gov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0>. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

- (i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
- (ii) Those that involve 'significant' spending or savings
- (iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk).

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to <http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories> and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2015 / 2016 Council year, in accordance with the statutory 28-day publication period:

Edition	Publication date
March 2016 edition	9 February 2016
April 2016 edition	29 March 2016
June 2016 edition	17 May 2016

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to <http://modern.gov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0> or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk).

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
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Health and Wellbeing Board: 26.4.16	Barking and Dagenham Sport and Physical Activity Strategy : Community The Board will be asked to approve a new Sport and Physical Activity Strategy aimed at increasing Borough residents' participation in physical activity to improve the health of local residents. The Strategy will also set out plans to help the Council, its partners and local sports clubs to raise funds to support improvements in service delivery as well as enable a joined up approach that will encourage participation levels. <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Paul Hogan, Divisional Director of Culture and Sport (Tel: 020 8227 3576) (paul.hogan@lbbd.gov.uk)
Health and Wellbeing Board: 14.6.16	Substance Misuse Strategy The Board will be asked to agree the Substance Misuse Strategy. <ul style="list-style-type: none"> • Wards Directly Affected: All Wards 	Open	Glynis Rogers, Lead Divisional Director, Adult & Community Services (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)

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, Strategic Director for Service Development and Integration and Deputy Chief Executive
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)
Dr Nadeem Moghal, Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Chief Superintendent Sultan Taylor, Borough Commander (Metropolitan Police)
John Atherton, Head of Assurance (NHS England) (non-voting Board Member)