Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 14 June 2016 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 6 June 2016

Chris Naylor
Chief Executive

Contact Officer: Tina Robinson
Tel. 020 8227 3285
E-mail: tina.robinson@lbbd.gov.uk

Membership

Cllr Maureen Worby (Chair)	(LBBD) Cabinet Member for Social Care and Health Integration
Dr Waseem Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Cllr Sade Bright	(LBBD) Cabinet Member for Equalities and Cohesion
Cllr Laila Butt	(LBBD) Cabinet Member for Enforcement and Community Safety
Cllr Evelyn Carpenter	(LBBD) Cabinet Member for Educational Attainment and School Improvement
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) Director of Public Health
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr Jagan 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)
Sean Wilson	(Metropolitan Police, Interim Borough Commander)
Vacant (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 April 2016 (Pages 3 - 16)**

BUSINESS ITEMS

4. **Reducing the Risk of Fire for Vulnerable People (Pages 17 - 56)**

5. **Update on North East London Sustainability and Transformation Plan (NEL STP) (Pages 57 - 66)**

6. **'We all have a part to play' - Public Consultation (Pages 67 - 104)**

7. **Urgent and Emergency Care (UEC) Transformation (Pages 105 - 110)**

8. **Substance Misuse Strategy 2016-2020 (Pages 111 - 126)**

9. **Health and Wellbeing Outcomes Framework Report - Outturn 2015/16 (Pages 127 - 153)**

10. **Director of Public Health Annual Report 2015/16 (Pages 155 - 214)**

STANDING ITEMS

11. **Systems Resilience Group - Update (Pages 215 - 217)**

12. **Sub-Group Reports (Pages 219 - 226)**

13. **Chair's Report (Pages 227 - 231)**

14. **Forward Plan (Pages 233 - 242)**

15. **Any other public items which the Chair decides are urgent**

16. **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.***

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

(i)

(ii)

This page is intentionally left blank

London Borough of Barking & Dagenham
lbbd.gov.uk

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

This page is intentionally left blank

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 26 April 2016
(6:00 - 9:01 pm)

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

Also Present: Cllr Eileen Keller, Terry Williamson and Matthew Hopkins

Apologies: Dr Waseem Mohi, John Atherton, Dr Nadeem Moghal, Jacqui Van Rossum and Sarah Baker,

86. Extension of the Meeting

At 8.00 p.m. the Chair moved that the meeting be extended by half an hour, this was seconded by Cllr Carpenter and agreed by all present. At 8.30 p.m. the Chair moved that the meeting be extended by a further half an hour, this was seconded by Helen Jenner and agreed by all present.

87. Declaration of Members' Interests

There were no declarations of interest.

88. Minutes - 8 March 2016

The minutes of the meeting held on 8 March 2016 were confirmed as correct.

89. Draft Primary Care Transformation Strategy

Sharon Morrow, Barking and Dagenham Clinical Commissioning Group (CCG) Chief Operating Officer presented the report and explained that the CCG's Draft Primary Care Transformation Strategy, which was attached to the report, had been developed in response to a number of drivers for change, such as the NHS Five Year Forward View and the challenges of changing demographics, the increasing number of patients with long-term and multiple-long-term conditions and the number of GP practices that were saying their workload would be unsustainable.

Sharon explained that the emerging vision was of Primary Care led locality based services, which would be supported by other medical professional services such as pharmacies. The CCG felt the integrated services would provide personalised, responsive, timely and accessible care that was both patient centred and co-ordinated, which would improve benefits for patients. It would ensure that patients received a standard offer across all practices. The Strategy would also encourage partnership working between GPs and would drive a better use of IT. The King's Fund framework would be used to develop place based care in Barking and Dagenham. Sharon drew the Board's attention to the timescale and the next steps set out in the report.

Dr John, Clinical Director Barking and Dagenham CCG, commented that the

current GP model would not be sustainable and this vision was trying to improve longstanding problems and to improve patient outcomes. The strategy would encourage partnership working, including with local authorities to integrate health and social care. There was also the added pressure of the number of GPs retiring in the area and across London and the South generally.

The Board raised a number of issues, including:

- Other Factors – Health and care provision alone was not the answer and other social impacts, such as jobs and quality housing all have an impact on long-term health outcomes. Matthew Cole, Director of Public Health agreed to provide some wording on this issue to the CCG.

- Delivery and Funding - How would this Strategy be aligned with other issues, such as the Better Care Fund and how would delivery be achieved? How would it be resourced, bearing in mind the £400m funding gap that exists across the BHR health and social care system?

  Ambition 2020 and any proposals emanating from that would impact on social care services will be delivered in the future. This had not been taken into account.

  Preventative Health measures and better lifestyle choices may not have an impact for many years to come. As a result there were still pressures that needed to be met both now and in the short to medium future.

- Document Accuracy - The details in the document also needed to be accurate, for example one GP mentioned in it had already retired a few months ago.

- Staffing Levels - LBBD was second from bottom for GP staff numbers per 1,000 population. Why was Barking and Dagenham so low in the rating and why were other boroughs better staffed when they had less health issues?

  There are recruitment issues across a whole range of health professionals in this area, which included GPs, Health Visitors, Physiotherapists and Dentists etc. Difficulty in recruitment of qualified professionals was not unique to GPs, for example children's social workers were difficult to recruit and also under pressure because of demand.

- GP Referrals to Outpatients - The number of GP referrals to outpatients was significantly higher at 426 per 1,000 than the London Average or 312. The range across practices locally of 320 to 680 per 1,000 was unlikely to be as a result of population factors alone. This needed to be further explored rather than just being anecdotal evidence.

- Growth Borough - LBBD was a growth borough and the population would be increasing. How were the CCG and GP services going to deal with that increase when Riverside Ward still had no GP Surgery?

- Seven Day Primary Care Service - If a seven day Primary Care Service was to be available, how were GPs going to be able to cope with the extra workload?

- Leadership of Local Health – What input would be provided both from and to other health professionals, for example collaboration between GPs and dentists?

- Data and Statistics – Data was being used to drive the LBBD's Ambition 2020 vision and decisions but there appears to be a lack of data to support the proposals and strategy.

- Implementation - Concern in regard to the implementation dates and felt that this was a little premature and was not as holistic as it should be.

Sharon Morrow responded:

- In relation to the funding issue, the rationale was that if patients have access to wider primary care services there would be less demand for more costly hospital care services.

- The CCG were aware that there were difficulties in recruiting GPs to this area and action was being taken to make it a more attractive option for them to choose to work here.

- The graphs and data were primarily to illustrate some of the variation in health measures that CCG monitor. As the Primary Care localities were progressed then the specific demographics and needs for an area would be addressed through the locality structure.

- The CCG have already attended planning meetings in regards to Barking Riverside and were looking at recruiting GPs and other health professionals for the area as it grows.

- It would be unlikely and impractical for all GPs to open and provide a 7 day service. The expectation is that weekend service would be provided through hubs.

- In regards to leadership, the proposed model recognises that GPs are the gate-keepers for healthcare services and community services are organised around their registered lists. The Localities discussions were being held through HCO/ACO to see how GP practices could work together and provide integrated services.

- Performance management and monitoring would be undertaken and achievement levels would become part of the contract.

Anne Bristow, LBBD Strategic Director of Service Development and Integration, advised that the work around the Accountable Care Organisation (ACO) Business Case was looking at what a locality structure might consist of and at this point in time there had been no decision as to whether these would be led by GPs.

The Chair commented that she had repeatedly pointed out that a one size fits all approach does not work in LBBD and she was disappointed about the lack of consultation. Whilst the Council had signed up to Integrated Care that does not mean it just will hand over services without being absolutely certain those services

would be improved and delivered for individuals. The Council could not sign up to supporting the Strategy as it currently stands.

Dr John advised he had visited LB Tower Hamlets Locality model, which had turned their diabetes service around and it was now one of the best in England. In his view the Strategy would involve a lot of work to co-ordinate health professionals but it could be achieved. Dr John said that he felt that the locality groups would have the same outlook and aims and this would improve patient outcomes. The Locality model was not just about GPs but a hub of shared providers. GPs were currently swamped and something needed to be done in the near future to stop the system deteriorating into crisis.

The CCG indicated that doctors do work collaboratively with dentists and the locality model would make it easier for this to happen.

Helen Jenner, LBBD Director of Children's Services, said that a strategy needs to identify what needs to change but that this does not come out clearly in this Strategy and it was also not clear what it was aiming for within the structures. This Strategy had not been seen by most Board Partners before nor had there been any discussions on the principles and aims but the Strategy had now progressed to the point of a structure. This was a concern as discussion and consultation with Partners should have occurred long before this point.

Conor Burke, Accountable Officer, Barking and Dagenham CCG, advised that there had been little change in Primary Care in the NHS in 68 years. The NHS had to change to address the shifts in the healthcare market and demographics. This was a provider strategy and its aim is for those providers to deliver a more efficient service and it also deals with some of the problems of multi-provider care. Locality models were about how GPs deliver the provision between themselves and it could be a delivery vehicle for the Accountable Care Organisation (ACO). The GPs had recognised that they need to reorganise and reform and this could converge with the ACO business case as that moved forward

The Chair welcomed the clarification and whilst noting Dr John's understanding of the Locality model and the CCG view that it would improve service and patient outcomes, she and her colleagues were rather cynical that North East London was being dealt with as one area. The Chair commented that the Draft Primary Care Transformation Strategy was clearly not new but it had not been talked about before and the Board were not happy with it being foisted upon it. LBBD Board Members wanted the best model for LBBD residents and not the best model for other NE London boroughs.

The LBBD Board Members felt that they could not support this Strategy at the present time and that it required further consultation and consideration of the impact on services, Ambition 2020 and ACO changes.

The Board:

(i) Reviewed the contents of the Primary Care Transformation Strategy and in view of the lack of earlier consultation and the issues raised at the Board agreed that further consultation and work needed to be undertaken before the Board could support the strategy and requested a further report on this issue for further consideration by the Board in due course.

90. Better Care Fund 2016/17

Sharon Morrow and Andrew Hagger, LBBD Health & Social Care Integration Manager jointly presented the report and explained that in December 2015 there had been a report to the Board with details of the progress the BCF had made in 2015, which gave details of performance against agreed metrics, delivery of the agreed schemes and actions being taken to address underperformance. This was then followed by the end of year report in March 2016 that assessed performance and provided an outline of the plans and timescale for developing the 2016/17 BCF Plans. The report and its attachments before the Board now provided both an overview and detailed plans for submission to NHS England.

Sharon explained that issues such as the reduction of non-elective admission and permanent admissions into residential / nursing placements had been taken on board. In regard to delayed transfers of care, the aim was to achieve a 2% reduction in 2016/17. Andrew advised that BCF schemes in the 2015/16 plan had been amalgamated to make them more cohesive and the themes and metrics for these were set out in Appendix B to the report.

Contributions would be in the order of £7.5m from LBBD and £13.2m from the CCG. It was also anticipated that a Section 75 Agreement would be in place by June 2016.

Cllr Carpenter, LBBD Cabinet Member for Education and Schools, drew attention to the funding allocation in section 4 of the report and the 170 admissions target in section 3 of the report and the risk to this not being achieved when we had both an ageing population growth and increasing budget pressures. Anne Bristow advised that there was indeed a risk if the older population grows significantly and also because the borough had a high level of non self funders. The usual rate for residential care settings had been increase by £100 a week, which would should help keep individuals in the community, which is generally a better setting for them. It was noted that the pooled budget had already been committed in existing services and there was not any new funding allocated. Cllr Carpenter commented that the £105,000 was a very modest amount allocated to end of life care. Sharon Morrow advised that this did not reflect total end of life spend and details of the spend would be provided direct to Cllr Carpenter.

Healthwatch advised that they would be able to monitor the patient and service user impact across a range of issues and ascertain if patients had discerned any improvement in services.

The Board:

(i) Endorsed the Better Care Fund plan, budget for 2016-17 and activity and Delegated Authority to the Strategic Director, Service Development and Integration and the Accountable Officer for the BHR CCGs, to agree and submit to NHS England the Plan as set out in Appendix A of the report, subject to the adjustments advised at the Board; and

(ii) Delegated authority to the Strategic Director, Service Development and Integration, to extend the Section 75 agreement for the Better Care Fund, with amendments in line with the report, and in consultation with the

Director of Law and Governance and the Strategic Director Finance and Investment.

91. Referral to Treatment

Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust, introduced the report and led the presentation, supported by Clare Burns, BHRUHT Programme Director for Demand Management. Matthew explained that the NHS Constitution gave patients the right to access services within 18 weeks following a GP Referral. It became apparent in 2014 that in BHRUT this was not being achieved and due to the lack of confidence in the reliability of the data BHRUT had suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014.

The Patient Administration System (PAS) computer system had been updated in December 2013. There appeared to have been both a misunderstanding and mismanagement of the data within the Trust over a number of years, for which the Trust was now apologising.

NHS England had subsequently tasked BHRUT and Barking Havering and Redbridge CCGs to develop a recovery plan and to report regularly to the NHSE / TDA to provide the necessary assurance that changes were happening. Despite the data not being assured in March 2016, BHRUT Board Papers stated that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway, which had led to significant national publicity. Independent auditors had now been appointed to verify the data and patient numbers but the exact numbers were still being verified. The only positive resulting from this problem was that the data deficiencies had allowed an opportunity to investigate where there were gaps between patient demand and capacity of services.

Since March the number of people waiting 52 weeks had reduced to around 800. NHS London had also written to BHR CCGs outlining their concern.

Matthew explained that 95% of patients should have had their procedures / diagnoses within 18 weeks of GP referral. For an organisation the size of BHRUT it would be expected that there would be around 30,000 people on the process / waiting list at any one time. The Trust had 58,000 people on the waiting list. In the past year the Trust had delivered an additional 1,200 operations and 30,000 extra outpatient appointments but there was still a large number of people waiting over 18 weeks. Matthew added that the Junior Doctors strike action had resulted in 4,000 appointments being cancelled on 26 April alone.

The aim now was to achieve compliance with the NHS Constitution standards by March 2017. To achieve that BHRUT were now looking towards other providers across the region, however, some people have indicated that they would prefer to wait longer to stay local. BHRUT had a programme of improvement for the data accuracy and to deal with the backlog of patients waiting for appointments or treatment.

Clare Burns explained that work now needed to be undertaken to provide services locally to resolve demand at the hospitals. As patients do not seem to want to travel for treatment, this would include alternative routes to treatment, such as a

community dermatologist service in LBBD. Clare added that LBBD referrals were often to orthopaedic and surgery when that was not always the answer and alternatives such as physiotherapy and living with the pain for a short while may be the answer. GPs should not stop referring patients, but should have other options in place, which may have more rapid results for patients.

Consultant auditors were checking for clinical harm, that correct governance and robust process were in place, demand and capacity issues and were also undertaking a modelling review.

The Chair said that she felt that it was not a credible statement to say that people would want to wait longer to be seen within the Trust than to travel to another provider and asked where the evidence was supporting this, for example how had people been approached and how many had been contacted, how long had they been told they might have to wait, had they been told they could go elsewhere? Matthew agreed to provide the evidence to the Board in due course.

The Board asked Matthew what was going to happen to reduce the number of people still waiting. Matthew advised that extra work had already been undertaken which had resulted in the delivery of 1,200 extra operations and they had also provided funding to resolve the computer / data issues.

The Board was concerned that the Trust had suspended reporting but had not advised the Board of the difficulties for 18 months. The Board felt that selected reporting of poor performance was unacceptable. Matthew responded that as an organisation it was felt that it was wrong to continue reporting faulty and erroneous data and that before they started reporting again the data must be correct, robust and credible. The Department of Health had provided a support team in September 2015 to review the BHRUT data and consultants, Ernest and Young, had now been engaged to undertake a full review and checks.

The Board was disbelieving of the claim that there had been no clinical harm to the individuals that had been waiting up to 52 weeks or more for treatment and that there could also be psychological harm caused by the stress of waiting and the delay in treatments. Matthew advised that a clinical harm review had been undertaken and there were only two patients with moderate to severe clinical harm from the wait. Clare Burns advised that one of those was a patient with increased problems with a shoulder.

The Chair commented that this situation had not been considered or reported to the Council's health scrutiny committee, known as the Health and Adult Services Select Committee (HASSC), and suggested to Councillor Keller, Chair of HASSC, that the issue of the Referral to Treatment was added to its Scrutiny Work Programme for further investigation as a matter of priority.

Councillor Butt, LBBD Cabinet Member for Crime and Enforcement, was concerned that both the document and presentation referred to 'waiters' and asked that BHRUT not use the term 'waiters' in their future reports and suggested that 'patients' or 'people' was more appropriate.

Councillor Turner, LBBD Cabinet Member for Children's Social Care, reminded the Board of the legal duty of candour and asked Matthew to whom they had reported

the suspension of reporting data. Matthew advised that the Department of Health had been advised as soon as it became apparent that there was a significant issue.

Cllr Turner asked if anybody within BHRUT had been held accountable for the failures. Matthew responded that there had been a systemic lack of capacity in dealing with the problem over many years, as well as incompetency, rather than a wilful misreporting of data. As a result appropriate disciplinary action had been taken but he was not prepared to share what that was with the Board as it was personal information.

Councillor Turner asked who would be the named individual responsible for ensuring the data issues were sorted and the time people were waiting was resolved. Matthew explained that BHRUT and BHR CCG had developed a refreshed Referral to Treatment recovery plan to more effectively tackle the issue of long patient waits and provide the necessary assurance to all stakeholders. The refreshed recovery plan was being reviewed by NHS England and NHS Improvement (formerly TDA) and consultants were also verifying the data. However, as Chief Executive and Accountable Officer he accepted that he was responsible for ensuring the data issue was resolved and patients waiting times were reduced.

Conor Burke, Accountable Officer, Barking and Dagenham CCG, advised that he had just received details on the patients waiting and this would be shared with GPs so that they could look at the individual cases and make the appropriate contact.

The Board:

(i) Noted that the Barking, Havering and Redbridge Clinical Commissioning Groups and Barking, Havering and Redbridge University Hospitals NHS Trust had developed a refreshed Referral to Treatment recovery plan to more effectively tackle the issue of long patient waits that sought to offer necessary assurance to all stakeholders, including patients and the public;

(ii) Noted the recovery plan was being reviewed by NHS England and NHS Improvement (formerly NTDA) and external consultants had been engaged by BHRUT to independently verify the data accuracy and assist BHRUT in the resolution of the problem;

(iii) The Board also wished to place on record its serious concern in regard to:

(a) The decision of BHRUT to ‘not report’ nor advise the Board of the problem over the last 18 months;

(b) The apparent lack of urgency at BHRUT in regard to resolving the problem at an earlier point in time;

(c) The significant number of patients who were waiting more than the 18 weeks referral to treatment target, set out in the NHS Constitution, with some patients still waiting for over 52 weeks;

(d) The potential deterioration in patients’ conditions and the

physiological and social harm that may be caused to patients by the delays;

(iv) Requested that the Board be provided with regular performance updates on this issue, including:

- Details of the action being taken by BHRUT to reduce patient wait times;
- The performance achieved in the previous quarter;
- The projected trajectory rates to achieving the 18 week referral to treatment target across all specialities;
- The numbers of patients in each specialist area and how many of those patients were Barking and Dagenham residents;
- Evidence to substantiate the anecdotal claim by BHRUT that patients were prepared to wait longer to be seen within BHRUT rather than being treated by other providers;

(v) Requested that BHRUT do not use the term 'waiters' in their future reports and suggested that 'patients' or 'people' was more appropriate; and

(vi) Recommended that the LBBD Health and Adult Services Select Committee include the issue of the Referral to Treatment in its Scrutiny Work Programme for further investigation as a matter of priority.

92. London Ambulance Service NHS Trust Improvement Plan

Terry Williamson, Stakeholder Engagement Manager, London Ambulance Service (LAS), presented the report and updated progress on the Improvement Plan. The Improvement Plan had been out into place following the inspection by the care Quality Commission (CGC) in June 2015 which had rated the services as "inadequate".

Terry gave the background to the service and the Improvement Plan, which provided the details of the LAS intention to provide a better service to patients and a better place to work and the work plans to achieve those required improvements. The details were set out in the report but particular attention was drawn to:

- Approximately 200 operational staff cover vehicles deployed in the North East London, which included stations in Dagenham, Ilford, Hornchurch, and Romford and there were also supporting resources from Newham, Hackney and Waltham Forest. The prioritisation of 999 calls was undertaken at the Emergency Operations Centres at Waterloo and Bow.

- Culture change workshops had been held on bullying and harassment.

- Recruitment of Paramedics was being undertaken across the world and the services had been particularly successful in attracting staff from Australia; some of whom would be starting work at the end of March 2016.

- An innovative 'elderly fallers' provision had been set up in partnership with NELFT. This provided an appropriate care pathway for these patients that prevented attendance at hospital.

- The Quality Improvement Plan wouldl involve all staff in all its work streams, which would include an investigation into pathways to treatment at Urgent Care Centres etc and identifying what issues may be stopping staff from using them.

- For the year-to-date, the demand for the service (calls) in Baking and Dagenham had increased by 4.7%. The North East London sector was currently the third highest performing area across the whole LAS area. However, the target for Category A calls nationally was 75% attendance within 8 minutes and whilst this was not achieved by many national services, the LAS was only achieving 58.3% and wished to improve on this.

In response to a question from Cllr Butt, Terry advised that the performance data in section 2.2 of the report were response times for Category A (life threatening) calls, for which the response time to arrive at the patient was 8 minutes. Abbey Ward had the highest level of Category A calls. Sean Wilson, Interim Borough Commander, Metropolitan Police, advised that Abbey was also their highest calls area for violence. It was noted that the call status would not be downgraded if on arrival it transpired the patient did not be life threatening condition. Terry advised that he would provide the necessary data to enable it to be mapped if it may result in some partnership innovation.

Cllr Turner advised that he had seen the data and added that he was pleased to see the LAS engagement with the Board.

Sean Wilson advised that there was some joint working initiatives being trialled with other 999 services, for example LAS are intending to use Havering Fire Brigade on a safe stand-by point for staff.

The Board:

(i) Noted the London Ambulance Services (LAS) NHS Trust Improvement Plan and progress made to date;

(ii) Noted the potential for joint working with the other emergency services and partners to improve service delivery; and

(iii) Was pleased to see the LAS at the Board and would welcome their regular attendance.

93. Care City Programme Update

Helen Oliver, Managing Director Care City, presented the report on the progress made by Care City, which included its formal launch two months earlier, the confirmation of NHS Innovation Test Bed, Barking Riverside designation as a NHS Healthy New Town site and collaborations with national and international groups.

Helen also drew the Board's attention to the innovation work stream, which included investment achievements of £1.8m to test nine IT devices, Activity 2 Exchange innovation with stakeholders, the research and education work streams, which included improvements to cross community skills and capacity, the details of which were set out in the report and presentation.

The Board were pleased to see the innovative use and testing of IT that would

enable people to look after themselves whilst they were still being safeguarded.

The Chair encouraged people to visit Care City to see the work that was going on there.

The Board

(i) Noted the work that had been undertaken following the launch of Care City in January 2016 and the evolving programmes of work which were being developed.

94. Public Health Programme Board Strategic Delivery Plan Update

Matthew Cole, presented the report and explained that the Public Health Programme Board and its sub-committee the Health Protection Committee had oversight responsibility on the national programme for immunisation and screening and how the screening tests helped to identify those at higher risk of a health problem: which in turn would enable early intervention to reduces mortality, morbidity and the economic cost of life-long treatment and support from health education and social services.

Matthew reminded the Board that further actions to improve performance in Antenatal Newborn Screening Programme at both BHRUT and Barts Health NHS Trust in regards to foetal anomaly, Sickle Cell, Thalassaemia and newborn bloodspot screening, and infant physical examination.

Matthew pointed out the performance of other non-cancer screening for abdominal aortic aneurysm and diabetic retinopathy were performing well. However, the uptake of child immunisation at two and five years and the seasonal flu vaccination were still areas that needed to improved performance. The area that was showing a 'R.A.G' red rating was the uptake rates for cancer screening which was below both the London and England average within the last three years.

The Board was surprised to hear that there was a worldwide shortage of BCG vaccinations and UK stocks were almost totally depleted and reminded Public Health England that the duty of candour applied to them also.

NELFT advised that they only had BCG vaccine stocks for a couple of weeks maximum and as there were no further scheduled deliveries of the vaccine they were trying to ascertain when supplies would be forthcoming. NELFT advised it had suspended accepting new BCG vaccination patients and were only immunising those already booked into the BCG clinics and they would also shortly be suspending the universal neonatal BCG programme. With no vaccinations at birth or at the clinics being undertaken there would be an increasing backlog of individuals that would need to be followed up.

Helen Jenner said she was concerned about the loss of 'herd protection' levels for children and asked what would happen if there was an Tuberculosis incident in a local school as the protocol currently was to immunise all children in contact within the school. NELFT advised that they had been told there was a small amount of BCG vaccine held nationally for emergency, but not for a local emergency such as Helen had described.

The Board were very concerned about the lack of BCG vaccination supplies nationally and the number of high risk adults and children who were not being vaccinated.

The Board was also concerned about the need for a proactive plan to urgently obtain BCG vaccination supplies and the apparent failure of the national and London resilience plans in regards to this and any further vaccination supply shortages.

In response to a question about the Measles outbreak, Public Health England advised that there were 64 confirmed cases across London and these were mainly in young adults.

Cllr Turner raised the issue of early testing in pregnancy for Sickle Cell and was advised that BHRUT expected 49.3% of women to have been tested before 10 weeks gestation. The Board noted the pathway for testing and other options and that overall testing uptake of those at risk was over 99%.

The Board

(i) Noted the report;

(ii) Requested that Health and Social Care Commissioners provide performance updates as part of the Board's quarterly performance report on the measures being taken to prevent Health Care Associated Infections within both the hospital and community settings.

(iii) Requested that Public Health England to provide a quarterly performance report on the actions to improve coverage figures for immunisation and antenatal screening, including the sickle cell testing rates for at risk expectant mothers by 10 weeks gestation;

(iv) Requested that the NHS agreed clear arrangements to manage babies moving into the area without full newborn screening;

(v) Requested NHS England provide details to the Strategic Director, Service Development and Integration, within seven working days, of a proactive plan to urgently obtain BCG vaccination supplies and details of the national and London resilience plans in regards to this and any further vaccination supply shortages;

(vi) Reminded partners that Breast Screening provision locally had been raised previously and still need to be included.

95. Contracts: Procurement and Commissioning Plans 2016/17

The Board received the report from Matthew Cole, which set out the Council's commissioning plans around Public Health and Adult Social Care for 2016/17, which included information on contracts over £500,000 in value that were due to expire during 2016/17 financial year.

The report also provided information on how the plans would meet with the Joint Health and Wellbeing Strategy, Partners' commissioning intentions and Legislative

requirements including the Care Act 2014 and Children's Act 2014,

The Board:

(i) Noted the proposed procurement and commissioning plans for 2016/17, including the list of list of contracts over £500,000 that were set to expire during the financial year.

96. 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 29 February and 30 March 2016.

The Board noted the work that was ongoing in regards to the BHRUT Trust and its Improvement Plan, including performance over the Easter period and the front and back door service of Accident and Emergency, influenza uptake, neuro-rehabilitation, Referral to Treatment and Cancer Improvement Plan, the latest position on the Urgent and Emergency Care Vanguard and the governance and delivery arrangements for the SRG.

97. Sub-Group Reports

The Board noted the reports on the work of the:

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

98. Chair's Report

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

- **Sustainability and Transformation Plans (STP)**
  There were now 44 STP areas across England and LBBD was in the North East London STP, which also included Havering, Redbridge, Waltham Forest, Newham, Tower Hamlets, City and Hackney.

  The full Sustainability and Transformation Plans were due for submission at the end of June 2016 and a draft version of the STP would be presented at the next Board meeting.

- **Health and Wellbeing Bard Development Session**
  The Session would be held on 19 May 2016, Care City, Barking.

- **Women's Empowerment Month**

  - Women's Empowerment Awards 2016 and events held in March.

  - The Adoption of the Gender Equality Charter by the Council.

- **News from NHS England:**

  - Resources to support early detection and secondary prevention in primary care. The CVD Primary Care Intelligence Packs had been launched by the National Cardiovascular Intelligence Network (NCVIN).

  – New whistle-blowing guidance for primary care.

99. Forward Plan

The Board noted the draft June edition of the Forward Plan.

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**Reducing the Risk of Fire for Vulnerable People in Barking & Dagenham**
Report of the Borough Commander, London Fire Bridgade	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Mark Tyson Commissioning Director, Adults' Care & Support	**Contact Details:** Tel: 020 8227 2875 E-mail: mark.tyson@lbbd.gov.uk

Sponsor:

Anne Bristow, Strategic Director, Service Development & Integration, London Borough of Barking & Dagenham

Summary:

The London Fire Brigade, as part of its work on prevention of fires, has been actively involved in promoting improvements to the support provided to vulnerable people at heightened risk of fire. The Board will receive a presentation from the LFB Borough Commander, Steve Norman, which sets out the context, drawn from incidents of fire that have occurred, coroners' reports and recent changes to fire safety standards.

He makes some recommendations for improvements, many of which are already being acted upon. The Board is therefore invited to review and comment on the actions being taken. In doing so, the Board may wish to note that one strand of the Better Care Fund plan, approved at the last Board meeting, concerns equipment and adaptations and may be a useful avenue for the work proposed around telecare and its role in fire prevention and response.

Recommendation(s)

The Barking and Dagenham Health and Wellbeing Board is recommended to consider the information provided and note the proposed work to investigate the potential improvements identified by Mr Norman for the prevention of fires for vulnerable people.

Reason(s)

Vulnerable people can be at heightened risk of a fire occurring, and in the event of a fire can also be at greater risk of serious harm. Appropriate prevention measures are therefore important in response.

This page is intentionally left blank

Home Fire Safety Risk Referral Matrix

LONDON FIRE BRIGADE

Risk	Fire risk factors	Control measures to be taken by LFB crews to mitigate immediate risk	Actions for consideration by Care Providers to mitigate medium and long term risk
High Risk A	As in High Risk B. • Adult social care review outcome is to move resident to care home or warden assisted sheltered accommodation due to severity of fire risk. • Resident refuses to be re-housed.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Refer to LA via Serious Outstanding Risk (SOR) process for case management and provision of specialist fire alarms/equipment. • Consider other control measures such as fire retardant bedding and safer ashtrays.	• Consider fitting domestic Automatic Fire Suppression System (AFSS) e.g. sprinklers. • Minimum of BS5839 part 6 Grade F LD2 fire detection and alarm system, interlinked. • Fire alarm to be monitored by a Telecare (social alarm) monitoring centre. • Consider other control measures such as fire retardant bedding and safer ashtrays.
High Risk B	• Inability of resident to react to fire or smoke alarm actuating due to mobility difficulties or decision making difficulties, Dementia, hoarding (level 5 or above). • Signs of high fire risk such as careless disposal of cigarettes, signs of cooking being left on or other high risk of fire.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Refer to LA via Serous Outstanding Risk process (SOR) for case management and provision of specialist fire alarms/equipment. • Consider other control measures such as fire retardant bedding and safer ashtrays.	• Consider fitting domestic Automatic Fire Suppression System (AFSS) e.g. sprinklers. • Care/housing review. • Minimum of BS5839 part 6 Grade F LD2 fire detection and alarm system, interlinked. • Fire alarm to be monitored by a Telecare (social alarm) monitoring centre. • Consider other control measures such as fire retardant bedding and safer ashtrays.
Medium Risk A	• Medium to high fire risk and evidence of fire risk behaviours such as careless disposal of cigarettes, signs of cooking being left on or other high risk of fire but resident is able to respond to fire alarm and leave the premises.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Refer to LA via Serious Outstanding Risk process (SOR) for case management and provision of specialist fire alarms/equipment and consider other control measures such as fire retardant bedding and safer ashtrays.	• Minimum BS5839 part 6 Grade F LD2 fire detection and alarm system including smoke and heat detection, interlinked. • Consider other control measures such as fire retardant bedding and safer ashtrays.
Above this black line – refer as Serious Outstanding Risk.			
Medium Risk B	• One or more fire risk factors with no evidence of fire risk behaviours (see above). • No working smoke alarms or one smoke alarm in escape route (hall).	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Where more than one detector is required (existing or by LFB) recommend that they should be interlinked.	No further action required.
Low Risk A	• No fire risk factors (see reverse). • No smoke alarms.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Where more than one detector is installed (existing or by LFB), recommend that they should be interlinked.	No further action required.
Low Risk B	• Smoke alarm fitted correctly in hall/landing at each level of the dwelling and interlinked. • No fire risk factors (see reverse).	• Full HFSV giving lifestyle advice to reduce risk.	No further action required.

GUIDANCE NOTES

- **This referral matrix is a guide only and all factors should be considered in each case.**
- Advice on prevention of fire specific to the individual's circumstances should always be given.
- In all cases where welfare concerns are identified the case should be referred via the Serious Outstanding Risk process.
- Where more than one detector is already installed check that they are working and recommend that they should be interlinked.
- For all cases where we fit more than one of our standard single-point smoke detectors, we must inform the resident that interlinked smoke detection should be fitted and why.
- Above the black line refer as Serious Outstanding Risk. The HFSV and installation of alarms has not reduced the risk of fire to the resident sufficiently. Tick the Serious Outstanding Risk box on HFSV database record and initiate discussion with the Station Manager on possible solutions.
- Examples of infirmity that could effect the ability to respond or escape may include;
  - Mental health e.g. Dementia, confusion, Alzheimer's disease.
  - Physical health e.g. use of a walking stick, frame or wheelchair, Chronic Obstructive Pulmonary Disease (COPD), stroke, Parkinson's disease, heart disease, speech impediment.

FIRE RISK FACTORS

- Previous fires.
- Burns on carpets, furniture or clothes.
- Evidence of unsafe candle use.
- Poor quality/damaged wiring.
- History of falls.
- Dementia.
- Evidence of mobility difficulties.
- Hoarding disorder.
- Decision making difficulties.
- Carelessness with smoking and smoking materials.
- Careless with cooking practices.
- Alcohol/drug use.
- Home oxygen user.
- Sensory impairment (hard of hearing/deaf)?
- Unsafe use of electrical equipment – overloaded sockets/ extension leads, unsafe use of portable heaters i.e. too close to combustible materials.

WELFARE RISK FACTORS

- No heating and/or lighting.
- No food.
- Vermin infestation.
- Neglect of property.
- Broken windows.
- Hoarding.

EXTRACTS FROM BS5839 PART 6

relating to grade and category of system for domestic fire alarms.

(This should not be read out of context of the whole standard) If any party is instructed to design a fire detection and fire alarm system for a dwelling (e.g. by means of a purchase or tender specification), the instruction should include a clear reference to the Grade and category of system required.

Grade D: A system of one or more mains-powered smoke alarms, each with an integral standby supply. (The system may, in addition, incorporate one or more mains-powered heat alarms, each with an integral standby supply).

Grade E: A system of one or more mains-powered smoke alarms with no standby supply. (The system may, in addition, incorporate one or more heat alarms, with or without standby supplies).

Grade F: A system of one or more battery-powered smoke alarms. (The system may, in addition, also incorporate one or more battery-powered heat alarms.) In the case of Grade D, Grade E and Grade F systems, where more than one smoke alarm is installed the smoke alarms normally need to be interlinked. Any heat alarms also need to be interlinked with the smoke alarms.

Category LD1: A system installed throughout the dwelling, incorporating detectors in all circulation spaces that form part of the escape routes from the dwelling, and in all rooms and areas in which fire might start, other than toilets, bathrooms and shower rooms.

Category LD2: A system incorporating detectors in all circulation spaces that form part of the escape routes from the dwelling, and in all rooms or areas that present a high fire risk to occupants (see Clause 4).

Category LD3: A system incorporating detectors in all circulation spaces that form part of the escape routes from the dwelling.

NOTE: Whilst designed for London Fire brigade staff, this matrix is available for use by all parties involved in the care and protection of vulnerable people as a guide to reducing the risk of death or injury from fire through consistent and appropriate risk control measures.

LONDON FIRE BRIGADE

Reducing the Risk of Fire For Vulnerable People in LBBD

London Fire Brigade

Sheltered Accommodation

Irene - Surrey Coroner's Court 9th May 2014 – HM Coroner Richard Travers highlighted the delay in the monitoring centre passing information to the Fire & Rescue Service. In addition there was a delay in the monitoring centre being alerted to the fire due to the fire detection coverage within the flat being limited.

Independent living – hospital release

James: Age 71, COPD (lung disorder) and a Heart condition, heavy smoker. Living alone and had been released from hospital 2 days prior to fire, Care package. Smoke alarms – no monitoring.

Supported Independent Living

James: Age 90, Alzheimer's, arthritis of the spine and prostrate cancer, bedridden and lives in one room of the house, hospital care bed with an air support mattress, care package, four visits a day, Smoke detection, Telecare delay.

Supported Independent Living

Corinna - Age 81, smoker – our own review expressed concerns at the fire detection coverage delaying the call to the monitoring centre and that the guidance given to Corinna by the call centre staff. In addition the monitoring centre failed to pass critical information on the fire and the location of Corinna to the Fire & Rescue Service and gave inappropriate fire survival advice.

‘Extra care’ Sheltered Accommodation

Michael: Age 57, wheelchair, MS, smoker, scorch marks to clothing, floor and furniture, moved into extra care following family concerns over his ability to look after himself at home, four care visits a day from on site staff, door left unlocked for staff to respond to him, history of LAS attendance for falls.

Recommendation from SFSO

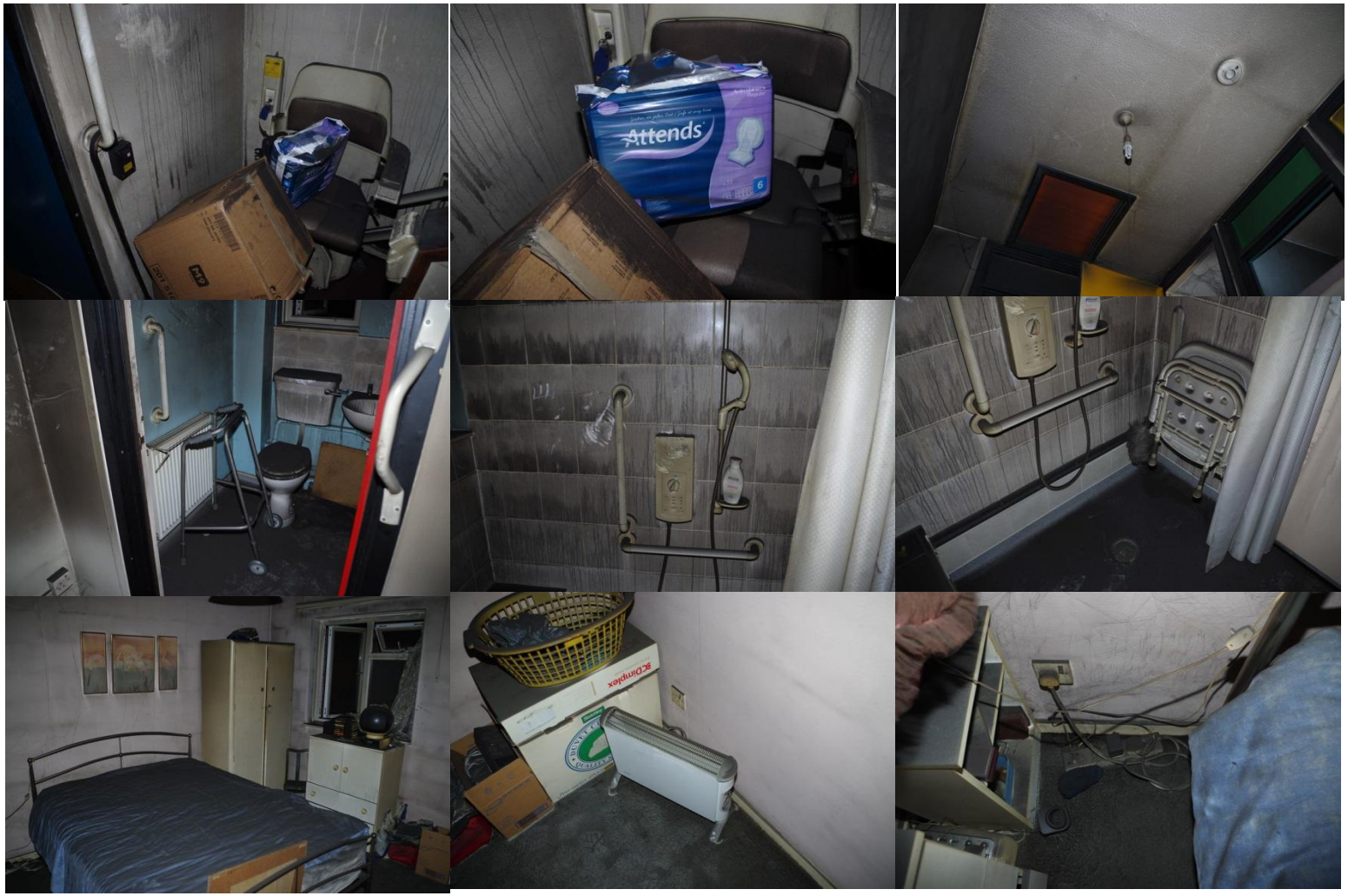
LFB FSR should find that the premises fire risk assessment was not suitable and sufficient as it did not consider the fire hazard associated with the resident's smoking habit in combination with behaviours which led to a high likelihood that a fire would start and the consequences of the fire would be death or serious injury to the resident or other relevant person in the premises. Appropriate control measures for the risk were not put in place either as an individual plan or as part of the premises fire risk assessment. Additional smoke detection, automatic suppression systems or management of fire retardant materials were not considered.

LFB
LONDON FIRE BRIGADE

Supported Independent Living

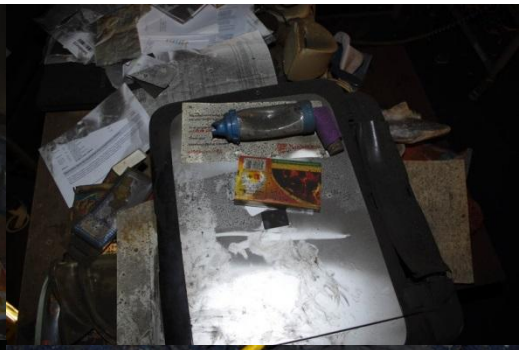
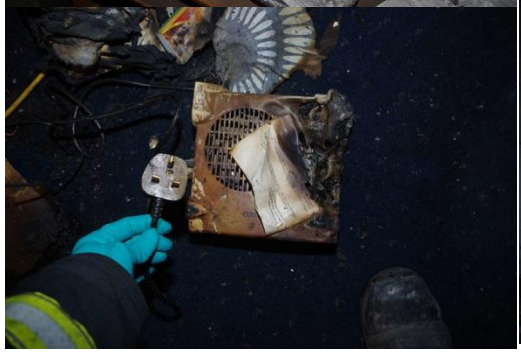
Mr Smith: Age 63, hospital bed with air flow mattress, wheelchair, MS, smoker, care notes cigarette burn to shoulder, previous fire (candle), four care visits a day, medication.

LFB
LONDON FIRE BRIGADE



LFB
LONDON FIRE BRIGADE

LFB
LONDON FIRE BRIGADE

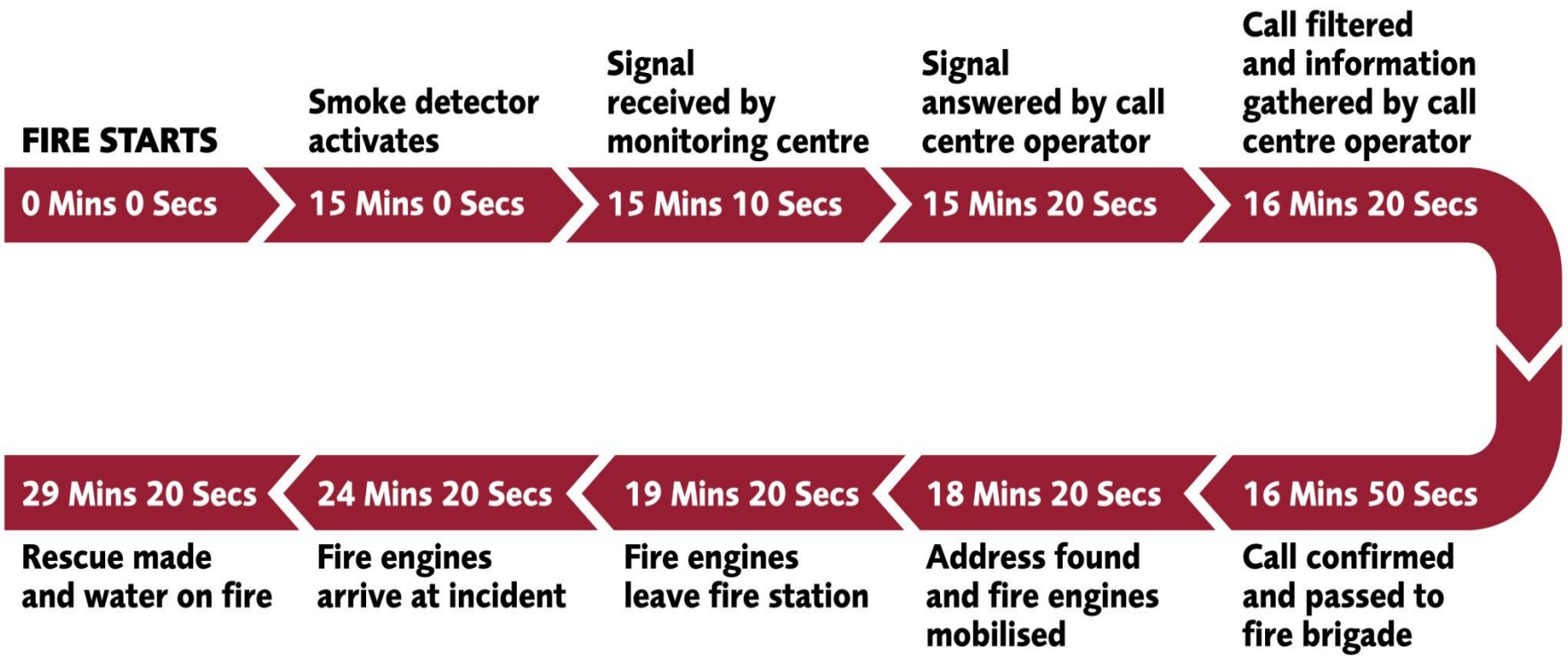
LFB
LONDON FIRE BRIGADE

LONDON FIRE BRIGADE

Aims :

- To improve Prevention and Protection from fire for the vulnerable person.
- To ensure early detection of fire in the room of origin.
- To ensure reliable communication between the fire alarm system and the monitoring centre.
- To improve the interface between the Remote Monitoring Centre and LFB.
- To ensure that a person trapped by fire receives Fire Survival Guidance

Time Line:



LFB
LONDON FIRE BRIGADE

LONDON FIRE BRIGADE

What has changed in BS5839 Part 6 ?

Scope

This part of BS 5839 gives recommendations for the planning, design, installation, commissioning and maintenance of fire detection and fire alarm systems in domestic premises that are:

…… **c) sheltered housing, including both the dwelling units and the common areas.**

The recommendations apply to both **new and existing** domestic premises. The recommendations of this part of BS 5839 may also be applied to the **fire detection components of combined domestic fire alarm systems or fire and social alarm systems**.

LONDON FIRE BRIGADE

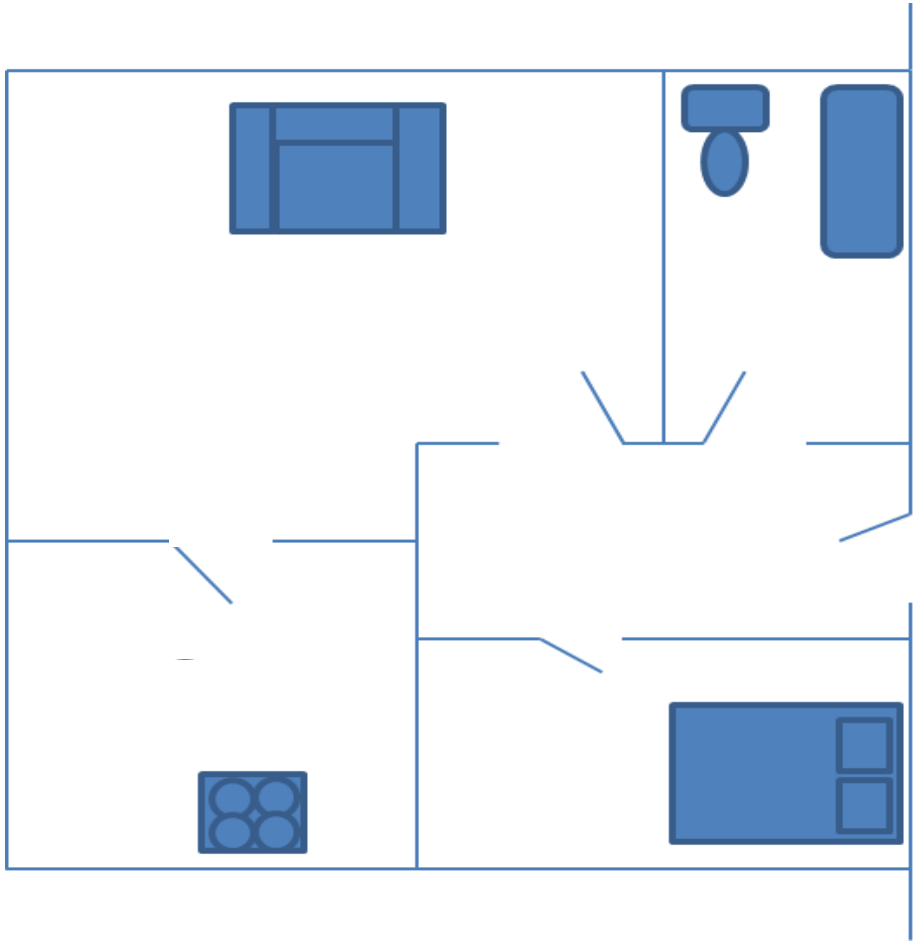
What has changed in BS5839 Part 6 ?

- If a Grade F system is installed by a professional installer (e.g. an electrical contractor), **a certificate confirming compliance of the system with this standard, or identifying any variations from these recommendations should be issued to the user.**
- The level of protection afforded to occupants needs to be related to the fire risk:

  Category LD2: a system incorporating detectors in all circulation spaces that form part of the **escape routes from the premises, and in all specified rooms or areas that present a high fire risk to occupants.**

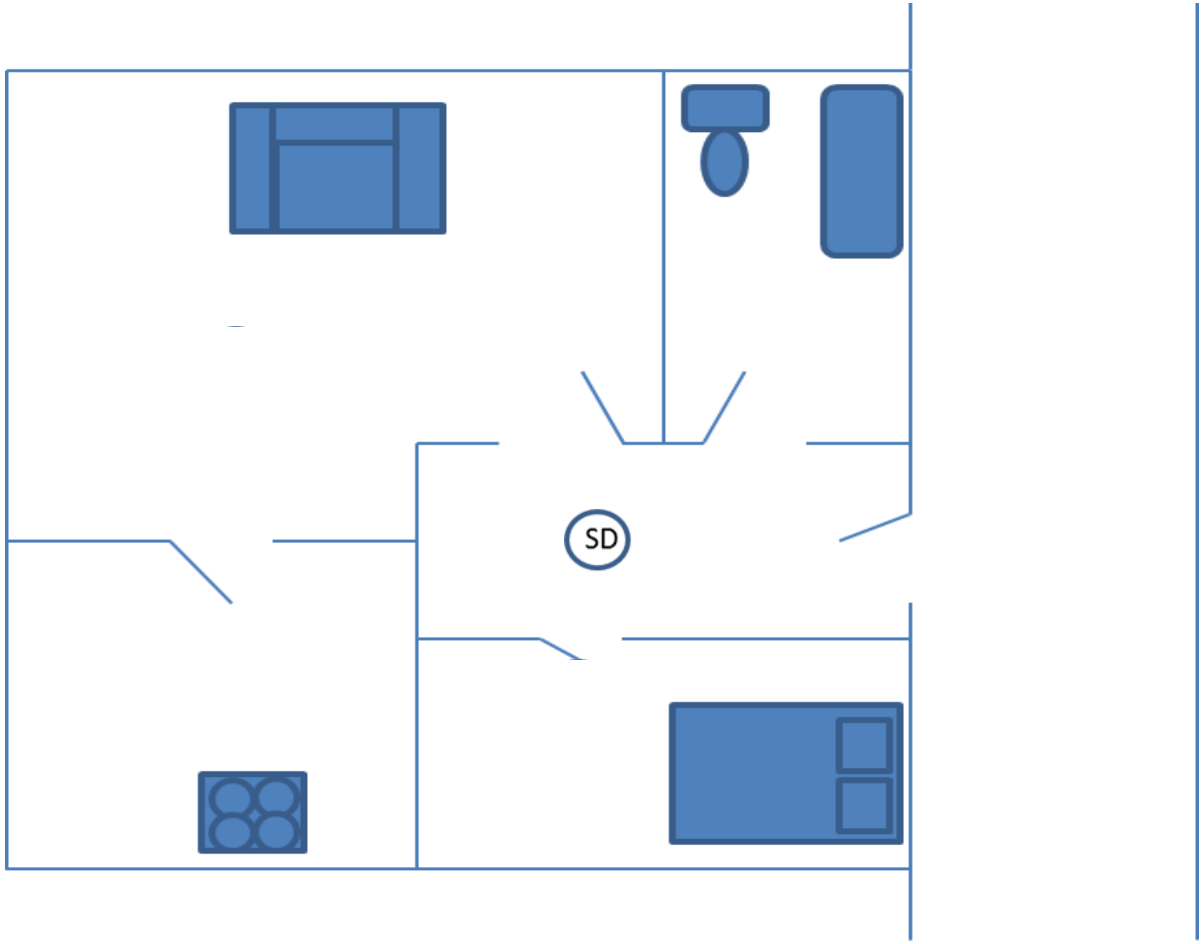
Independent Living or Single Private Accommodation

- 35 Yrs Old
- Non- Smoker
- Able bodied



LFB
LONDON FIRE BRIGADE

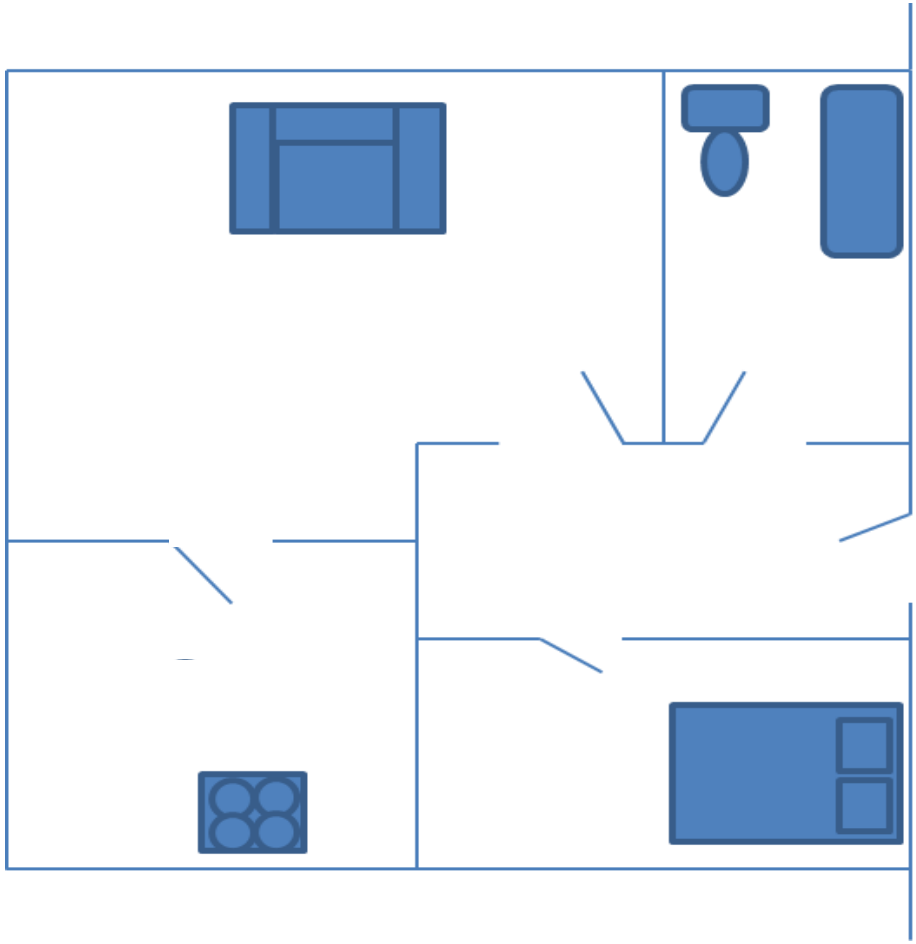
Independent Living or Single Private Accommodation (BS5839 Part 6 Grade ? LD3)



LFB
LONDON FIRE BRIGADE

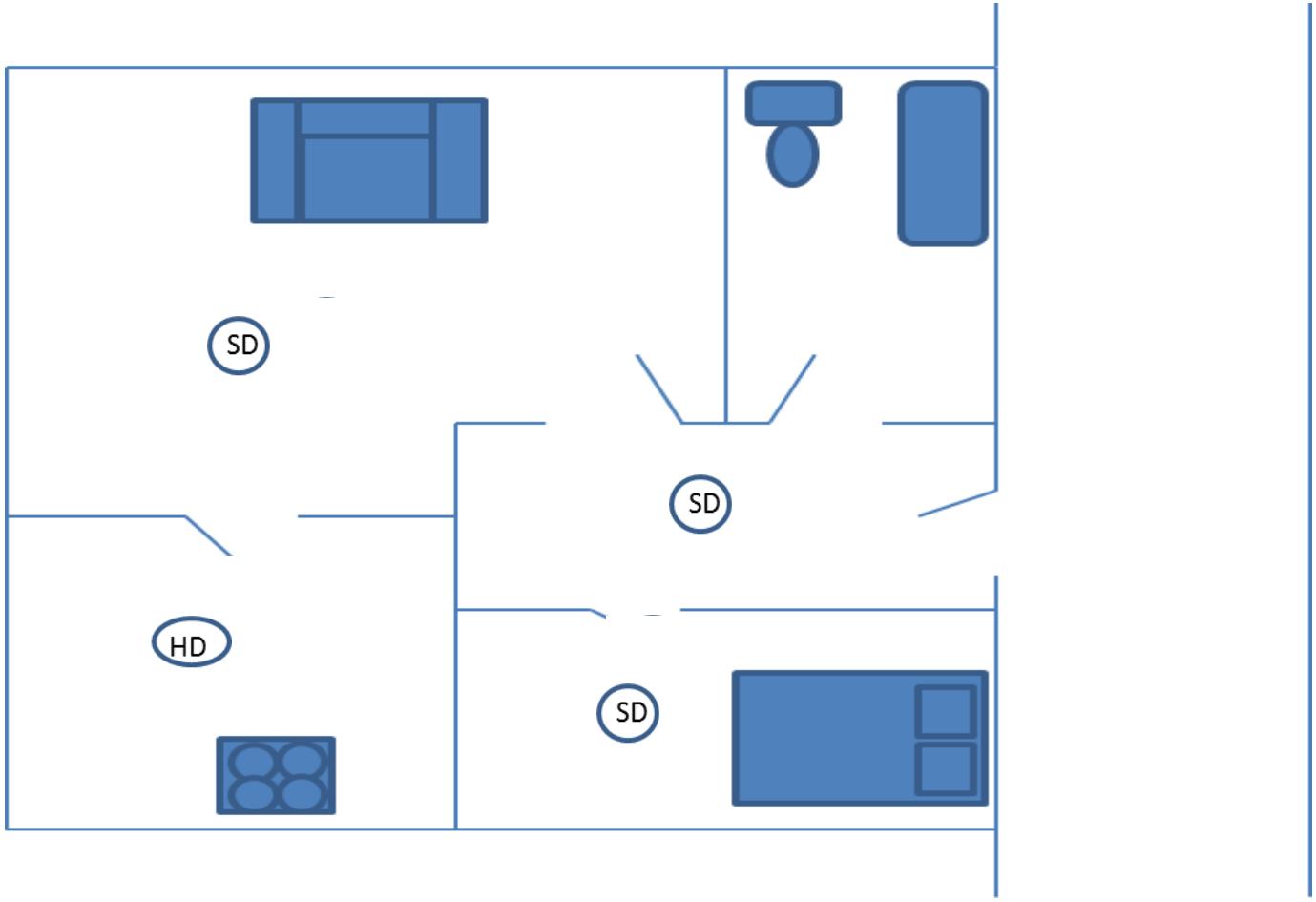
Supported Independent Living or Sheltered Accommodation

- 76 Yrs Old
- Smoker
- Hearing Impaired



LFB
LONDON FIRE BRIGADE

Supported Independent Living or Sheltered Accommodation BS5839 Grade ? LD2 / 1



LFB
LONDON FIRE BRIGADE

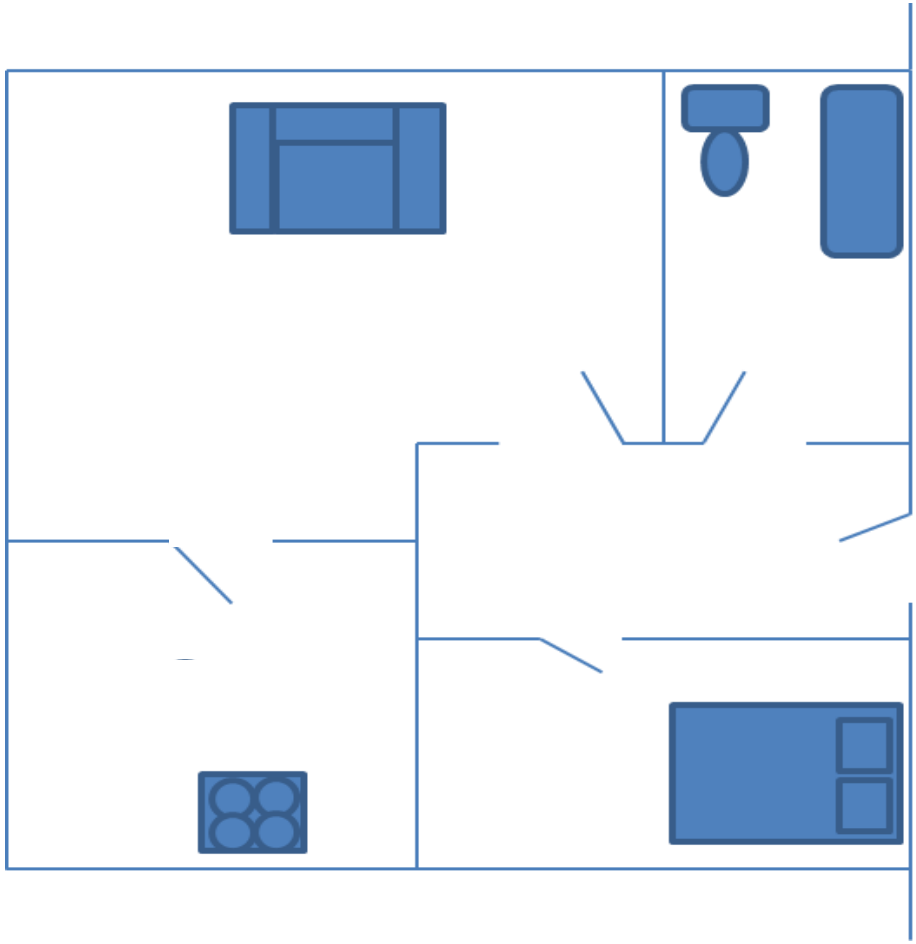
LONDON FIRE BRIGADE

What has changed in BS5839 Part 6 ?

- …..all smoke alarms and heat alarms (if provided) in Grades D, E and F systems **should be interlinked**, such that, when fire is detected by any smoke alarm or heat alarm, an audible fire alarm warning is given by all smoke alarms and heat alarms (if provided) in the premises.

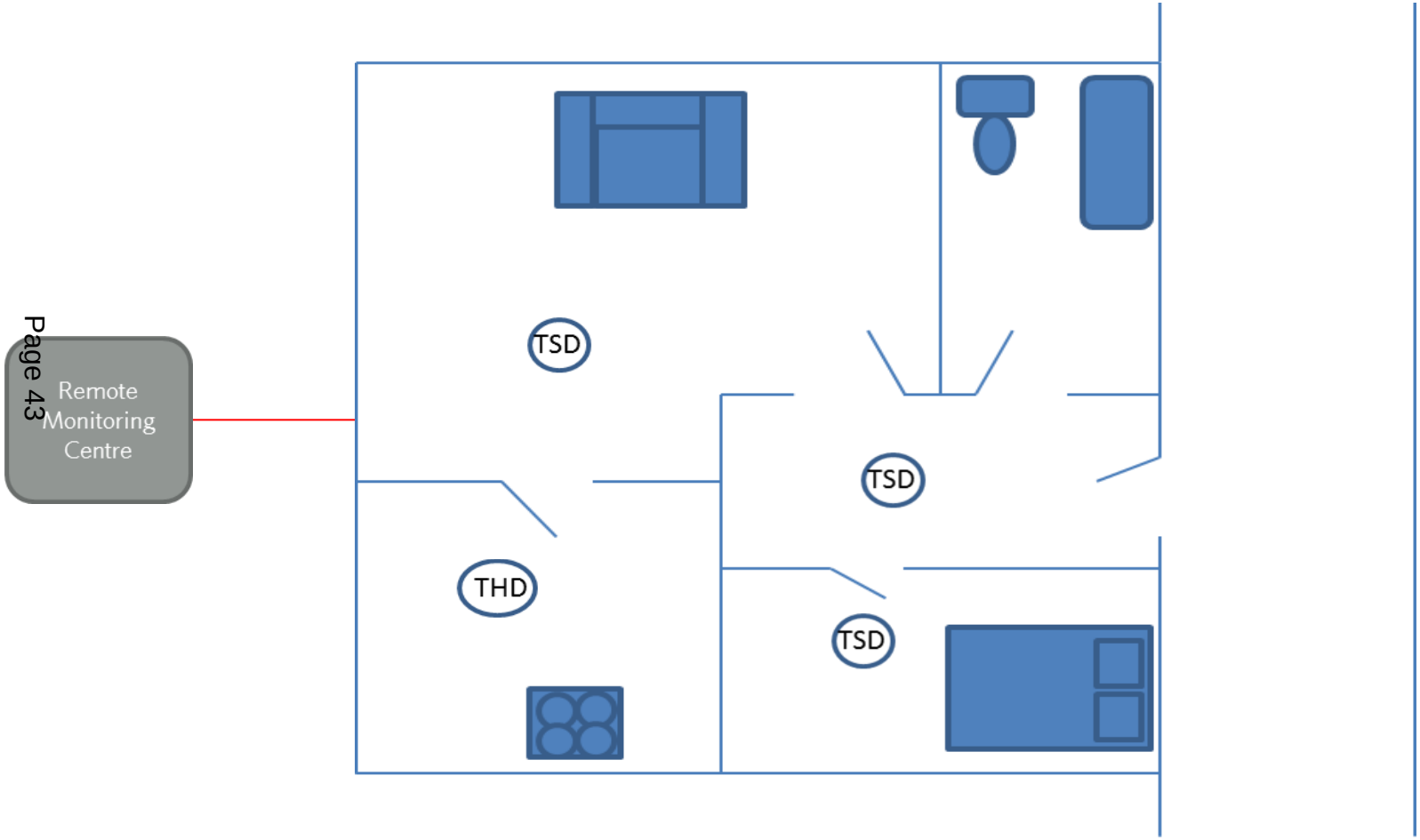
Supported Independent Living or Sheltered Accommodation

- 76 Yrs Old
- Smoker
- Hearing Impaired
- Mobility Impaired
- Dementia



LFB
LONDON FIRE BRIGADE

Supported Independent Living Sheltered Accommodation (BS5839 Part 6 Grade ? LD2)



LFB
LONDON FIRE BRIGADE

LONDON FIRE BRIGADE

What has changed in BS5839 Part 6 ?

- **If the risk to occupants from fire in any part of the premises is deemed to be high**, a Category LD2 or Category LD1 system is always appropriate. For example, a Category LD2 or Category LD1 system needs to be considered if the occupants suffer from **any disability (mental or physical) that could delay their escape from fire.** If it is intended to protect reliably any occupant in the room where a fire originates, a suitable Category LD2, or a Category LD1, system needs to be provided.

LONDON FIRE BRIGADE

What has changed in BS5839 Part 6 ?

- **Addressable fire detection and fire alarm systems are recommended for sheltered housing** in which detectors within dwellings are connected to the fire alarm system in the common parts.
- In Category LD systems, provision of **facilities for automatic transmission of fire alarm signals to the fire and rescue serv**ice should be considered under the following circumstances:

  i) if the occupants are **mobility impaired** to a degree that would be likely to result in high risk in the event of fire; or

  ii) if the occupants suffer from **a disability (e.g. speech impairment) that would preclude communication by telephone with the fire and rescue service.**

Prevention Through Risk Assessment:

Home Fire Safety Risk Referral Matrix

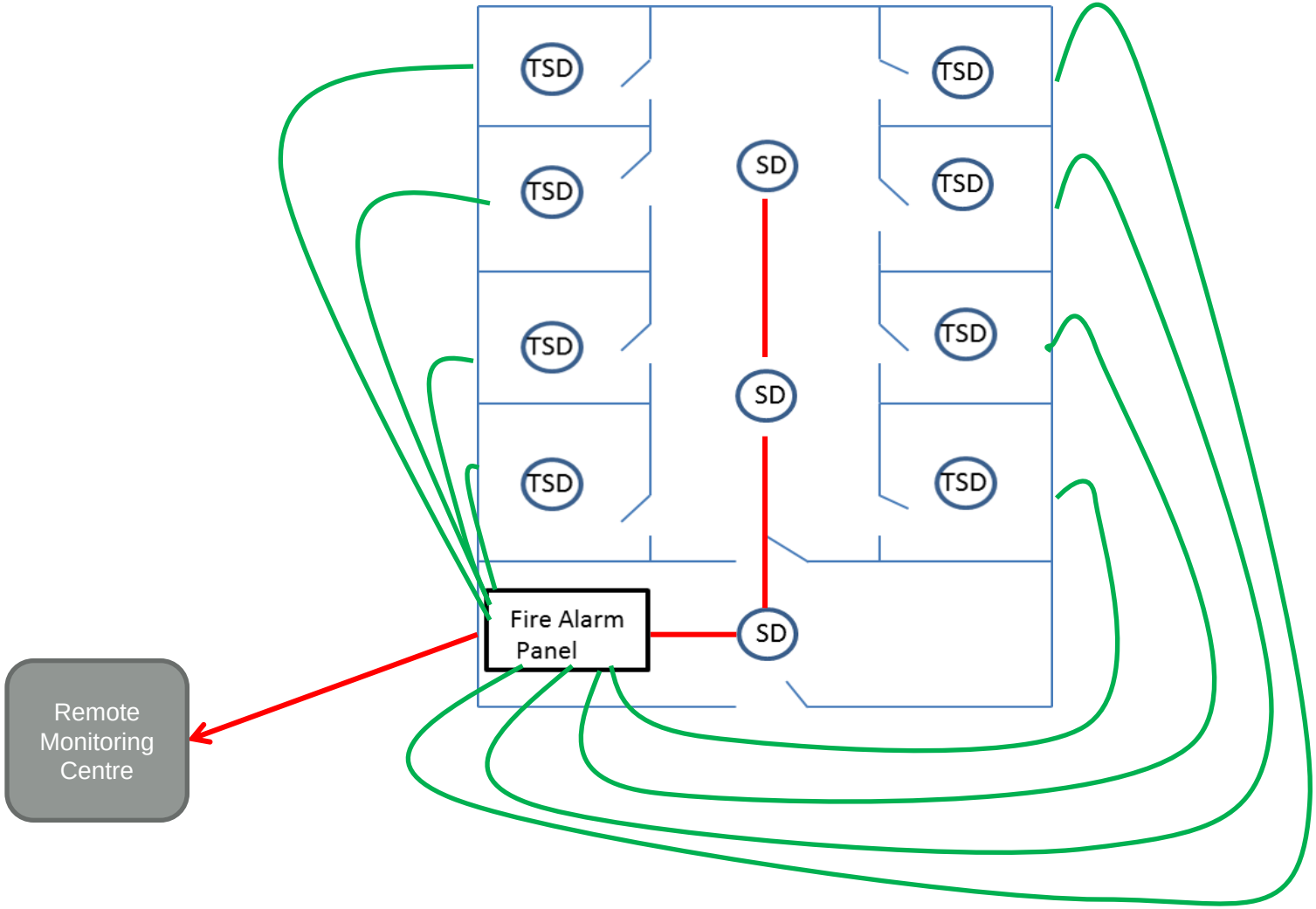
LFB LONDON FIRE BRIGADE

Risk	Fire risk factors	Control measures to be taken by LFB crews to mitigate immediate risk	Actions for consideration by Care Providers to mitigate medium and long term risk
High Risk A	As in High Risk B. • Adult social care review outcome is to move resident to care home or warden assisted sheltered accommodation due to severity of fire risk. • Resident refuses to be re-housed.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Refer to LA via Serious Outstanding Risk (SOR) process for case management and provision of specialist fire alarms/equipment. • Consider other control measures such as fire retardant bedding and safer ashtrays.	• Consider fitting domestic Automatic Fire Suppression System (AFSS) e.g. sprinklers. • Minimum of BS5839 part 6 Grade F LD2 fire detection and alarm system, interlinked. • Fire alarm to be monitored by a Telecare (social alarm) monitoring centre. • Consider other control measures such as fire retardant bedding and safer ashtrays.
High Risk B	• Inability of resident to react to fire or smoke alarm actuating due to mobility difficulties or decision making difficulties, Dementia, hoarding (level 5 or above). • Signs of high fire risk such as careless disposal of cigarettes, signs of cooking being left on or other high risk of fire.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Refer to LA via Serous Outstanding Risk process (SOR) for case management and provision of specialist fire alarms/equipment. • Consider other control measures such as fire retardant bedding and safer ashtrays.	• Consider fitting domestic Automatic Fire Suppression System (AFSS) e.g. sprinklers. • Care/housing review. • Minimum of BS5839 part 6 Grade F LD2 fire detection and alarm system, interlinked. • Fire alarm to be monitored by a Telecare (social alarm) monitoring centre. • Consider other control measures such as fire retardant bedding and safer ashtrays.
Medium Risk A	• Medium to high fire risk and evidence of fire risk behaviours such as careless disposal of cigarettes, signs of cooking being left on or other high risk of fire but resident is able to respond to fire alarm and leave the premises.	• Full HFSV. • Fit single point smoke detection in escape route (hall) and areas of risk. • Refer to LA via Serious Outstanding Risk process (SOR) for case management and provision of specialist fire alarms/ equipment and consider other control measures such as fire retardant bedding and safer ashtrays.	• Minimum BS5839 part 6 Grade F LD2 fire detection and alarm system including smoke and heat detection, interlinked. • Consider other control measures such as fire retardant bedding and safer ashtrays.

Above this black line – refer as Serious Outstanding Risk.

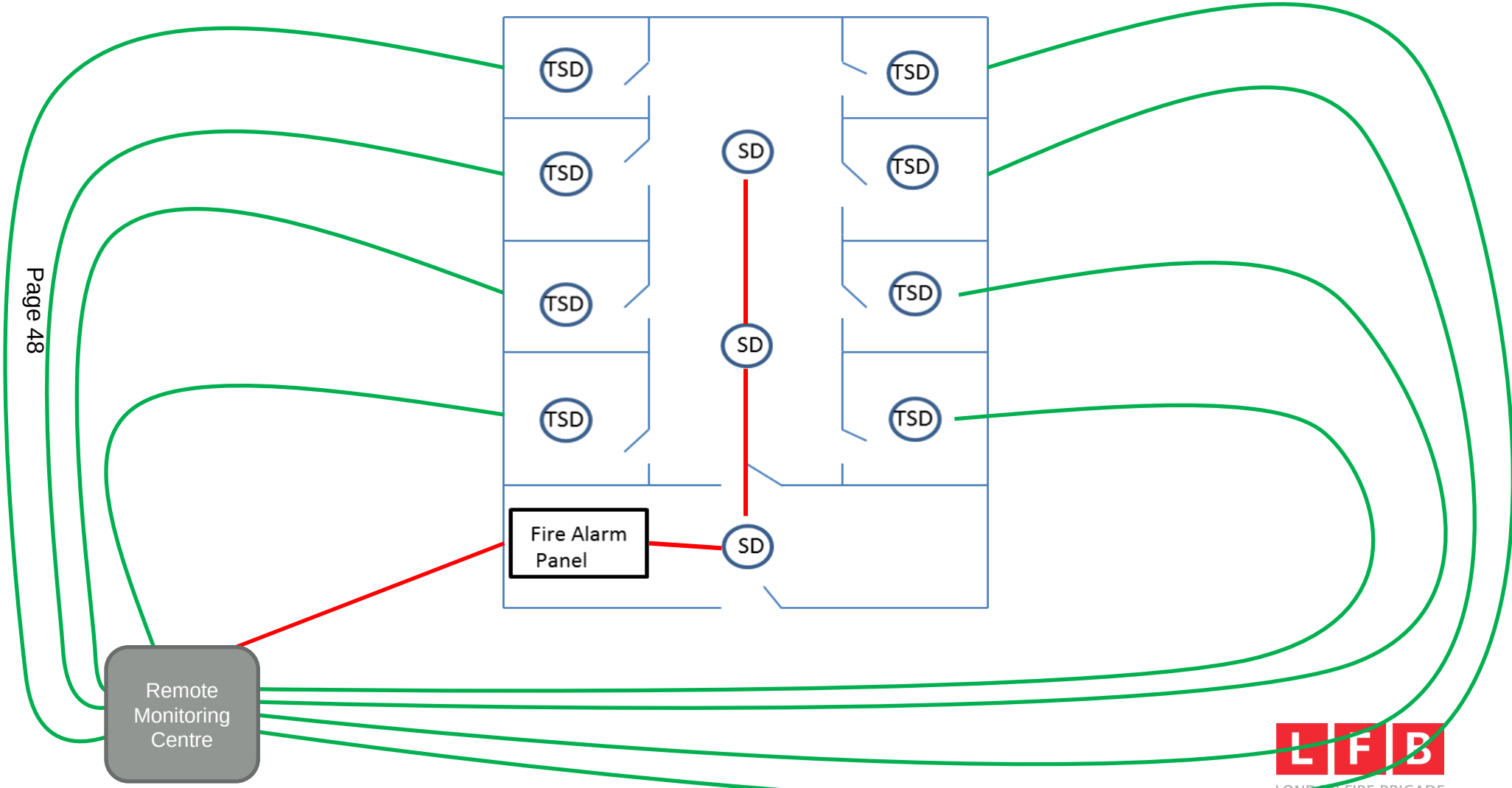
LFB LONDON FIRE BRIGADE

Sheltered Accommodation



LFB
LONDON FIRE BRIGADE

Sheltered Accommodation



LFB
LONDON FIRE BRIGADE

LONDON FIRE BRIGADE

What has changed in BS5839 Part 6 ?

- If the fire detection and fire alarm system is integrated with the social alarm system (or any other alarm system, such as an intruder alarm system), and both systems share a single communications link to an alarm receiving centre, it is important to ensure that **fire alarm signals can be distinguished from other alarm signals** at the ARC.
- **If automatic transmission of fire signals to the fire and rescue service is essential, the reliability of the transmission system needs to be subject to consideration.**

LONDON FIRE BRIGADE

What has changed in BS5839 Part 6 ?

- In sheltered housing, fire alarm signals transmitted to an alarm receiving centre via a social alarm system **cannot be delayed by other alarm signals originating from the premises of fire origin or elsewhere.**
- In the case of sheltered housing, fire alarm signals from dwelling units should, at any site monitoring facility provided for use by a warden or any ARC, **be clearly distinguishable from other alarm signals** that can be relayed from the dwellings, and distinguishable from alarm signals from any other dwelling units.

Economic cost of fire – 2008

(Source: DCLG)

Table 11: Estimates for average costs by building type and region

Region	North East	North West	Yorkshire & The Humber	East Midlands	West Midlands	East of England	South East	South West	London	ENGLAND
Fires in buildings										
Total domestic	£34,634	£47,202	£47,197	£46,343	£41,293	£42,902	£41,269	£44,216	£48,092	**£44,523**
Total commercial	£81,021	£81,104	£73,623	£86,247	£72,135	£72,640	£78,204	£74,996	£69,207	**£75,881**
Public sector	£74,019	£65,694	£66,242	£59,703	£56,787	£62,706	£65,992	£64,733	£62,301	**£63,853**
Total non buildings fires	£5,582	£5,969	£5,618	£6,539	£6,704	£7,027	£7,136	£8,439	£6,078	**£6,412**

Total average cost does not include anticipation. Breakdown of anticipation costs by building types requires detailed breakdown of building stock data. This level of building stock data is not currently publicly available.

Non building fires costs do not include costs related to property damage as this data is not reported on or disaggregated in Association of British Insurers data.

Includes the average cost of arson

LFB
LONDON FIRE BRIGADE

In Summary

- To improve Prevention and Protection from fire for the vulnerable person.
  - We need to ensure the initial assessments and reviews of assessment are include the assessment and control fire risk
- To ensure early detection of fire in the room of origin.
  - We need to ensure that all vulnerable people with medium to high fire risks have Grade F LD2 fire detection and where they cannot respond to a fire or fire alarm they need to be remotely monitored.

LFB
LONDON FIRE BRIGADE

In Summary

- **To ensure reliable communication between the fire alarm system and the monitoring centre.**
  - The critical communication path should be part of the premises and individual fire risk assessment
- **To improve the interface between the Remote Monitoring Centre and LFB.**
  - Monitoring centres should adopt the best practice in BS 8591 and have agreed the correct protocol in the form of an MOU to pass calls to London Fire Brigade
- **To ensure that a person trapped by fire receives Fire Survival Guidance**
  - Monitoring centre staff should be trained in giving Fire Survival Guidance or have the technical ability to pass the call to the LFB so that FSG can be given by LFB control officers

LFB
LONDON FIRE BRIGADE

Actions:

- To identify vulnerable people who are at risk from fire in LBBD and direct resources at the risk:
  - Those currently monitored people with Telecare
  - Referrals from carers, social care, police etc.
- To engage with Barking & Dagenham Carers to provide fire safety awareness education.
- To engage with LBBD Housing to ensure that Fire Safety Order risk assessments for current residential accommodation are reviewed.
- To engage with adult social care workers to ensure the initial assessments and reviews of assessment include the assessment and control fire risk.

LFB
LONDON FIRE BRIGADE

Actions:

- To ensure that Barking and Dagenham Telecare monitoring is trained in monitoring fire and adopts BS8591 standards.
- To carry out HFSVs in all sheltered accommodation dwellings in LBBD over a two year period.
- To develop an emergency Telecare installation through LBBD IRU and/or London Fire Brigade.
- To ensure that the referral process to the LFB for a person at risk from fire is widely understood. #
- To ensure LBBD CSP and H&WB understand the issues
- To raise awareness of these issues at pan-London H&WBs

LFB
LONDON FIRE BRIGADE

- Any Questions?

LFB
LONDON FIRE BRIGADE

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**Update on North East London Sustainability and Transformation Plan (NEL STP)**
Report of the Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Helena Pugh Local Authority Engagement Lead, NEL STP, Tower Hamlets, CCG	**Contact Details:** NEL STP office: Tel: 020 3816 3813 E-mail: nel.stp@towerhamletsccg.nhs.uk
Sponsor: Conor Burke, Accountable Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups	

Summary:

This report provides an update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP). While the mandate for the STP development and sign off lies with health partners, local authorities are integral to its development, and have an important role to play in ensuring its success.

Appendix A provides an update on the plan's development including the draft vision, priorities and enablers which have been identified to support the work of the STP. (This information has been circulated to the eight local authority areas in NEL.) As part of the STP development, several workshops are being held with key stakeholders to ensure their perspectives are reflected and woven into the STP.

A draft 'checkpoint' STP will be submitted to NHS England on 30 June 2016, and further work will continue beyond this to develop the plan in more detail. Additional updates will be presented to the Board as they become available.

For Barking & Dagenham, Havering and Redbridge, the detail of the local contribution to the Sustainability & Transformation Plan for north east London will be the propositions developed through our established programme to develop a business case for an Accountable Care Organisation.

Recommendation(s)

The Barking and Dagenham Health and Wellbeing Board is recommended to:

(i) Discuss the approach set out in Appendix A covering the vision, draft priorities and enablers which have been identified to support the work

(ii) Provide feedback to the NEL STP Team

No formal decisions are required arising from this report.

Reason(s)

The NEL STP Board is developing a plan as stipulated by the NHS England guidance. The plan will reflect the work that has been initiated as part of the local devolution bid approved in December 2015, and which is being taken forward through the local programme to develop a business case for an Accountable Care Organisation.

1 Introduction and Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs) for accelerating the implementation of the NHS Five Year Forward View (5YFV). England has been divided into 44 areas (known as footprints); Barking and Dagenham is part of the north east London footprint. STPs are place-based, five year plans built around the needs of local populations.

1.2 Further guidance was issued on 19 May which sets out details of the requirements for 30 June. The guidance states that the draft STP will be seen as a 'checkpoint' and does not have to be formally signed off prior to submission; it will form the basis of a local conversation with NHS England in July. Further work will continue beyond this to develop the plan in more detail.

1.3 For Barking & Dagenham, the work to develop the detail underpinning the STP is being taken forward jointly with Havering and Redbridge through the work to develop the business case for an Accountable Care Organisation[1]. The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, will be reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

2 Proposal and issues

2.1 Appendix A provides an update on the progress towards developing the NEL STP, covering the draft vision, priorities and enablers which have been identified to support the work.

[1] For further details on the Accountable Care Organisation proposition and its background, refer to Board papers for 20 October 2015 (minute 33), 8 December 2015 (minute 51), 26 January 2016 (minute 68), 8 March 2016 (minute 81).

2.2 In terms of shaping local work, and informing the development both of the NEL STP and the ACO business case, there has been significant activity to bring a range of perspectives and priorities into an emerging overall strategy. These have included:

- Workshops for clinicians to develop the priorities for clinical improvement;
- Local authority workshops that have sought to expand a wider vision for population health improvement and links between health impact, worklessness, welfare and housing;
- Substantial work to ensure a developed locality model that can form the basis for the future operating model for accountable care across Barking & Dagenham, Havering and Redbridge;
- Two voluntary sector workshops to expand the range of voices informing the development of the potential ACO proposition;
- Regular meetings of senior finance representatives of the constituent organisations, facilitated by PwC, in order to ensure that the emerging financial model is robust, both in terms of the challenge and the activities that can close the gap.

2.3 A telephone survey of 1,000 people from each of the three boroughs has been completed and the first cut of the results are being reviewed to see how they shape and refine the vision for local health and social care services. Additionally, a staff survey received 746 responses, by far the highest number of respondents (around a third of the total) being from Barking & Dagenham Council. Again, this is providing useful information to guide thinking about the future model of services.

2.4 In governance terms, the development of the business case and the content to contribute to the NEL STP is overseen by the Democratic and Clinical Oversight Group, which has been meeting with a fortnightly frequency to take regular update reports and to shape the emerging propositions. It is chaired by the Leader of Barking & Dagenham Council, Cllr Darren Rodwell, with the Health & Wellbeing Board Chair, Cllr Maureen Worby as a member, together with non-executives, medical directors and CCG clinical directors. The practical work is overseen on their behalf by the Accountable Care Organisation Executive Group and a Steering Group of officers, which has lately been expanded to include PwC who are leading the financial modelling. In mid-June, the product of the various workstreams will be brought together into an overall account of how the system will function under the any accountable care arrangements.

2.5 The Board is reminded that the decisions on any formal organisational arrangements surrounding the Accountable Care Organisation will be taken through the appropriate statutory governance mechanisms in place for all constituent organisations, and none of the collaborative arrangements in place are designed to replace this requirement.

3 Mandatory Implications

Joint Strategic Needs Assessment

3.1 A recent public health profile of north east London (March 2016) is being used to help us understand the health and wellbeing, care and quality and the financial challenges locally.

Health and Wellbeing Strategy

3.2 The NEL STP links well with the Barking and Dagenham Health and Wellbeing Strategy 2015-18 which identifies three important stages of life: starting well, living well and aging well. These are included in the draft one page summary at the back of Appendix A. Many of the emerging themes of the STP are covered in B&D HWBB strategy including prevention; care and support; and improvement and integration.

Integration

3.3 The STP will act as an 'umbrella' plan for change: holding underneath it a number of different specific local plans to address certain challenges. It will build on existing local transformation programmes and support their implementation. These are include the Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation).

Financial Implications

Completed by: Helena Pugh, Local Authority Engagement Lead, NEL STP

3.4 The NEL STP will include activities to address current financial challenges.

Legal Implications

Completed by: Helena Pugh, Local Authority Engagement Lead, NEL STP

3.5 The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

Risk Management

3.6 Risk management arrangements are being put in place by the north east London STP Board as part of planning for the STP; the board will be considering any risks on an on-going basis, will nominate officers responsible for identifying and carrying out mitigating actions.

Patient / Service User Impact

3.7 The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

3.8 In addition, we are taking account of recent public engagement on the transformation programmes outlined above and where relevant the outputs are being fed into the STP process; this will ensure that the views of residents from each local authority area are incorporated into the draft submission. In addition, a specific session was held for Healthwatch and patient engagement forum chairs to discuss the STP and how they would like to be engaged.

Public Background Papers Used in the Preparation of the Report:

- NHS Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/
- Guidance on submission of Sustainability and Transformation Plans https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf

List of Appendices:

Appendix A: Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan

This page is intentionally left blank

APPENDIX A

Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan

Closing the gaps: working together to deliver improved health and care for the people of north east London

Update for Health and Wellbeing Boards
2 June 2016

Background

Across north east London, the health and care system - clinical commissioning groups (CCGs), providers and local authorities are working together to produce a Sustainability and Transformation Plan (STP). This will set out how the NHS Five Year Forward View will be delivered: how local health and care services will transform and become sustainable, built around the needs of local people. The plan will describe how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

The STP will act as an 'umbrella' plan for change: holding underneath it a number of different specific local plans, to address certain challenges. Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards. It will build on existing local transformation programmes and support their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The STP is also supporting the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

Additional guidance was issued on 19 May which sets out further details of the requirements for 30 June. **The guidance states that the draft STP will be seen as a 'checkpoint' and does not have to be formally signed off prior to submission**; it will form the basis of a local conversation with NHS England in July.

Developing the submission

A NEL STP Board and Partnership Steering Group meet regularly and are attended by both health and local authority colleagues. A meeting is scheduled for local authority chief executives and updates are being shared at each health and wellbeing board.

The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

In addition, we are taking account of recent public engagement on the transformation programmes outlined above and where relevant the outputs are being fed into the STP process; this will ensure that the views of residents from each local authority area are incorporated into the draft submission. In addition, a specific session was held for Healthwatch and patient engagement forum chairs to discuss the STP and how they would like to be engaged.

Barking and Dagenham involvement in the development of the STP
Barking and Dagenham health and social care colleagues are actively engaged in the development of the STP including Conor Burke (Accountable Officer for Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups) and Mathew Hopkins (Chief Executive, BHRUT), and John Brouder (Chief Executive, NELFT) who are core members of the STP leadership team and members of the STP Board.

- Conor Burke is the senior responsible officer overseeing the development of the urgent care and transformation workstreams
- There is Barking and Dagenham LA, CCG and provider representation in portfolio workshops, system leadership events (held and planned)
- A session was held with Healthwatch and Patient Engagement Forum Chairs
- Face to face meetings have been held with the Mark Tyson, Commissioning Director, Adults' Care & Support and Andrew Haggar, Health & Social Care Integration Manager

Following Cheryl Coppell's retirement, Martin Esom (Chief Executive, LB Waltham Forest) is now the Local Authority executive lead supporting the development of the NEL STP.

Our draft vision and draft priorities
Throughout May the STP team has been holding a series of meetings and workshops with key stakeholders including providers, on a variety of topics including prevention, workforce, estates, technology and specialised commissioning. Key priorities raised will be included in the June submission.

Our draft vision

- To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.

- To develop new models of care to achieve better outcomes for all; focussed on prevention and out of hospital care.

- To work in partnership to commission, contract and deliver services efficiently and safely.

Emerging priorities
Based on the recent assessment of our health and wellbeing (Public Health Profile of NEL, March 2016), care and quality and the financial challenges we know that in order to create a better future for the NHS, and for local people to live long and healthy lives, we must make significant changes to how local people live, access care, and how care is delivered. Some of our initiatives will be delivered at local level, some at borough level, some across boroughs and others at NEL level.

For NEL the key emerging areas of focus which we think will be key to addressing our health and wellbeing, care and quality and financial challenges are:

Transformation: focussing on prevention and better care to ensure local people can start well, live well and age well. This will include: whole system prevention and early help; urgent care and mental health. We also see community resilience as having an essential part to play: looking at wider determinants of health (e.g. work, housing, education), to make sure residents have an improved quality of life and confidence to embrace a model of self-care in managing their health and care needs.

Productivity: ensuring our providers and local authorities operate in the most effective efficient way possible to deliver value, considering shared opportunities for development.

Infrastructure: considering the best use of our estates across the system.

Specialised services: establishing sustainable specialised services for NEL, both for residents and those accessing services in NEL.

We have identified the following **enablers** to support our work:

- **Workforce**: recruitment and retention of a high calibre workforce, including making NEL a destination where people want to live and work, ensuring our workforce is effectively equipped to support delivery of new care models, caring for the workforce and reduction in use of bank/agency staff.
- **Communications and engagement:** ensuring stakeholders, including local people, understand and support the need to deliver the Five Year Forward View.
- **Technology:** considering the best use of technology to support and enable people to most effectively manage their own health, care and support, and to ensure a technology infrastructure which supports delivery of new care models.
- **Finance:** access and use of non-recurrent fund to support delivery of the plan, delivering financial sustainability across NEL.

These initial discussions have led us to produce a draft summary of what will be included in the submission (see attached). We welcome the HWBB's views on the following questions:

- Does the vision capture what we need to achieve?
- Have we identified the right priorities?
- How can we continue to work with you as we develop the STP?

Next steps
A meeting for local authority chief executives will take place in June.

The draft of the submission will be shared with NEL STP Board members for review and comment in the second week of June and the draft 'checkpoint' STP will be submitted to NHS England on 30 June. Further work will continue beyond this to develop the plan in more detail and engage with partners on it.

For more information: www.towerhamletsccg.nhs.uk/nelstp or nel.stp@towerhamletsccg.nhs.uk

DRAFT One Page Summary

Vision:

- To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.
- To develop new models of care to achieve better outcomes for all; focused on prevention and out of hospital care.
- To work in partnership to commission, contract and deliver services efficiently and safely.

	Prevent ill health and improve wellbeing	Better Care	Productivity	Specialised Services	Enablers for change
High level priorities	• **Reduce prevalence** • **Deliver wider health benefits** • **Support health & well being strategies of our boroughs**	• **Increase independence and deliver better outcomes** • **Reduce bed-base activity to enable growing population** • **Transform care pathways to reduce acute demand** • **Multi-disciplinary working in community hubs/localities**	• **Reduce unit cost** • **Implement new ways of delivery *within and between* providers** • **Ensure effective and efficient use for every pound of health & social care**	• **Optimise specialised services** • **Ensure effective whole pathway with patient at centre**	• **Enable transformation and change**
Content summary	**A. Starting well** to embed healthy lifestyles from birth onwards **B. Living well** to support prevention – obesity, alcohol, smoking, exercise, mental health **C. Ageing well** to keep older people healthier and independent for longer **D. Identify ill health & take early action** e.g. screening programmes, health checks, diabetes prevention **E. Nuturing a social movement for change** to encourage people to support each other **F. Wider changes** to improve the lives and prospects of the population – housing, employment **G. Personal responsibility**, all engaged and empowered to take control of their health	**A. Self-Care** to better manage health conditions and minor ailments **B. Transform primary care** – coordinated, proactive and accessible **C. Supporting children & young people** to live healthy lives **D. Coordinated and consistent urgent and emergency care** **E. Reduce admissions** to hospitals and care homes, and improve discharge, reablement and supporting independence to keep people at home **F. Strong sustainable hospitals** - optimising elective care, ambulatory care, maternity **G. Transform patient pathway** and outpatients, incl **cancer** **H. Mental health** strategy for NEL, delivering parity of esteem **I. Learning disability** care **J. End of life care** to support people to die in the way they wish	A. Standardise and consolidate business support services B. Consolidate clinical support services C. Hospital productivity - Length of stay - Theatre utilisation D. Pharmacy & medicines optimisation E. Workforce, tackling bank and agency challenge F. Capitalise on estates utilisation G. PFI affordability H. Capitalise on our collective buying power	**A. Realise benefits** of world class cancer and cardiac provision **B. Work collaboratively** to manage, commission and deliver specialised services **C. Transformation** programme for specialised services in North East London	**A. Infrastructure/estates optimisation** across NEL for future needs **B. Sustainable workforce** to deliver the strategy **C. Technology** to support full interoperability and move to paper-free services, shared digital health records, e-consultations and other digital services, advanced analytics to support population health **D. Finance** including payment methods to support delivery of system outcomes **E. New models of care delivery** / provider reform **F. Organisational development** to support new delivery models **G. Communications and engagement** **H. Equalities**

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**'We all have a part to play' – Public consultation**
Report of the Programme Director, Ambition 2020	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Paul Pugh, Strategy Unit	**Contact Details:** Paul.pugh@lbbd.gov.uk:
Sponsor: Anne Bristow, Strategic Director, Service Development and Integration	

Summary:

In April the Cabinet agreed to public consultation on proposals to re-shape the council, and the way in which council services are provided, through the Ambition 2020 programme. It proposes moving away from an organisation which is designed around professional service silos, to one that is designed around what we need to achieve for those who live or work in our borough – with clear long term goals, higher standards and performance, and structures that will allow our workforce and others to deliver the best possible service.

Recommendation(s)

The Health and Wellbeing Board is invited to offer any comments on the proposals in the consultation document.

Reason(s)

The public consultation period lasts until 16 June. The Cabinet will consider the responses to consultation and next steps at its meeting on 19 July.

1 Introduction and Background

1.1 In April 2016 the Council published proposals to re-shape the council, and the way in which council services are provided, through the Ambition 2020 programme. It proposes moving away from an organisation which is designed around professional service silos, to one that is designed around what we need to achieve for those who live or work in our borough – with clear long term goals, higher standards and performance, and structures that will allow our workforce and others to deliver the best possible service.

1.2 The primary purpose of the document is to consult the public about proposed changes to the way in which council services are managed and delivered.

2 Proposal and issues

2.1 The attached consultation document sets out the challenges which the Council faces and the case for change, the Council's response to findings of the independent Growth Commission, and the proposals in the 'Ambition 2020' programme for transforming how the Council works.

2.2 Pages 20-24 of the consultation document summarise the proposals for how the Council should provide its people-focused services.

3 Implications

3.1 These were set out in the 19 April report to the Cabinet.

Public Background Papers Used in the Preparation of the Report:

- Cabinet paper, 19 April 2016, 'Council's Response to the Growth Commission and Ambition 2020'

List of Appendices: 'We all have a part to play' – Public consultation document

“We all have a part to play”

One borough; One community; London’s growth opportunity

Transforming our borough and transforming how our council works

Our proposals for consultation

Ambition2020
Barking&Dagenham

London Borough of
Barking&Dagenham
lbbd.gov.uk

“We all have a part to play”

Foreword – Leader of the Council

This plan sets out our proposals for transforming our borough, and for transforming how our council works.

We are at a key moment in our borough's history. We have a long and proud record of providing public services for the local community including good quality housing, schools and care for people from the cradle to the grave. At the same time, we have already sustained the deepest cuts in government support in the last few years, and further government cuts mean that we will face a shortfall of £63 million, a third of our remaining budget, by 2020.

We face a simple choice: we can do nothing and continue to cut services, or we can find new ways of delivering them. That is our challenge.

We also find ourselves in a unique position as London's growth opportunity over the next few years. This means more development and rising house prices. Again we face a choice: if we do nothing, the borough will continue to grow. However, there is no guarantee this will benefit local residents; that we will have enough schools, or that jobs will be created for the future. We see the Council's role as harnessing the borough's potential for the benefit of all, where no one is left behind.

Our ambition is to make Barking and Dagenham a stronger, more prosperous place to live in the coming years with opportunity for all.

To achieve our ambition we need to change the way the Council is run. We need to be less traditional and more efficient, and spend money wisely. We are making progress: for example, we are saving £1 million in management costs. But to achieve £63 million savings over the next four years, we also need to reach a new agreement with the local community. We need to increase the opportunities for them to have their say; we need to do more to work in partnership with community and voluntary organisations to provide services; and we need to enable residents to become less reliant on us.

In a way, this is nothing new. When the Becontree estate in Dagenham was first built nearly 100 years ago, you had to be in work to get a council house and there was a clear understanding between the Council and the community about what they could expect from each other.

Today the Council faces huge financial challenges, but we have the opportunity of a lifetime to remake the borough according to our principles and in the image of our founders. Our task is to deliver a place for everyone and where everyone has a place in the next 100 years. We can do nothing and wish for a past that will never return, or we can seize the future before us.

This demands a different kind of leadership and a different kind of council. Our plan shows how we propose to achieve this. And it starts here. We want to start as we intend to continue. We want to give everyone an opportunity to tell us what they think before we make our decisions in the summer.

Councillor Darren Rodwell,
Leader of Barking and Dagenham Council

“We all have a part to play”

Summary

We have a record of achievement over the last few years. So we have strong foundations to build on.

But we can't stand still – our borough has changed and is changing – we have to respond.

We are not where we could and should be – in areas such as employment, skills, educational attainment, or health, our performance is well below London averages – and our residents tell us they have higher expectations.

We have already shown that we can do more with less, but austerity is set to continue, and by 2020 we will be spending half of what we had in 2010.

At the same time the borough has huge potential – there is a great prize if we can realise our ambition to be London's growth opportunity.

In summer 2015 we began two major pieces of work – one internal (Ambition 2020, looking at how the Council works) and one independent (the Growth Commission, looking at the potential for economic growth).

This report sets out the next steps in achieving our growth vision, and our response to the report of the independent Growth Commission, which was published in February. We welcome the principles and key actions recommended by the Commission.

It explains our proposals for re-shaping the Council, and how we will provide our services. We will combine the enduring core values of the public sector, with the community involvement and flexibility of the voluntary sector, and the commercial-mindedness of the private sector.

Our context and vision demand an organisation that is designed to enable the contribution of others as well as deliver services ourselves. That means moving away from an organisation which is designed around professional service silos, to one that is designed around what we need to achieve for those who live or work in our borough – with clear long-term goals, higher standards and performance, and structures that allow our workforce and others to deliver the best possible service.

We want the views of residents, our partners, those who do business in the borough, and others who would be affected by those proposals before we decide whether to go ahead. Please let us have your views by Thursday 16 June 2016.

“We all have a part to play”

Building on success

The starting point for our proposals is a record of substantial achievements over the last few years – we are building on success.

We are a place with vision, ambition, and a lot to be proud of.

A strong commitment to economic growth and increasing prosperity

- Over £640m of committed inward investment to deliver new homes of mixed tenure to meet the needs of all residents and new business development
- Over 1500 more active businesses in the borough than in 2010
- New cultural quarter providing opportunities for creative businesses
- £7.4m funding from the Green Investment Bank to replace all our street lights

A strong commitment to providing decent affordable homes including council housing

- £200m for building up to 1000 new council homes over the next 10 years
- £350m over 10 years to improve our council housing stock
- First council in the UK to introduce a 'right to invest' shared ownership scheme which will protect council tenants by giving them the opportunity to purchase a share of between 25% and 70% of their property.
- Over 1000 new homes built since 2014
- Barking and Dagenham Reside offering quality affordable housing to local people

A strong commitment to families and our children

- 100% of children's centres assessed as good or outstanding
- GCSE attainment improved by 56% since 2005
- Public/private/voluntary sector partnership agreed to set up new Youth Zone to give young people affordable access to sports, arts, music and employability advice and mentoring

A strong commitment to building pride and a sense of community around 'one borough'

- First UK council to adopt a Gender Equality Charter as part of our commitment to social justice and opportunity for all
- First Women's Empowerment Month
- First UK council to introduce a dog DNA scheme encouraging greater social responsibility and pride in the borough

“We all have a part to play”

A strong commitment to health and wellbeing

- Partners in the London pilot Accountable Care Organisation, pioneering a new approach to health and social care
- Founding partner in ‘Care City’ developing innovation in health and care
- ‘Healthy new town’ status for Barking Riverside
- Over 90% of schools in the borough participating in the Healthy Schools programme
- Priority neighbourhood crime down by 20% since 2012
- Reported incidents of anti-social behaviour down by 18% since 2014

A strong commitment to civic purpose

- Over 100,000 people attended our 70 events to celebrate 50 years of the borough, including visit by HM the Queen
- The first Young Mayor for the borough in 2015

We also have a track record of delivering our services against a background of reductions in government grant and rising demand. Between 2010/11 and 2015/16 we have implemented over £100 million in savings.

The independent Growth Commission, whose report was published in February 2016, concluded that the borough:

‘has the ambition and the political will to become an inclusive, prosperous and resilient place, in which all communities have the opportunity to fulfil their potential.’

Why do we need to change?

Our people

Over the last 15 years Barking and Dagenham has become one of the fastest- changing communities in Britain.

This is in contrast to the post-war years when the borough was predominantly made up of traditional white working-class East End families with a close knit sense of community

Change is everywhere, but the Council remains committed to ensuring equality of opportunity for all and establishing a 'one borough' sense of community.

The population of Barking and Dagenham rose from 164,000 in 2001 to 186,000 in 2011, and an estimated 198,000 in 2014.

Population growth is set to continue. National statistics forecast a population of 220,000 by 2020, and up to 275,000 by 2037.

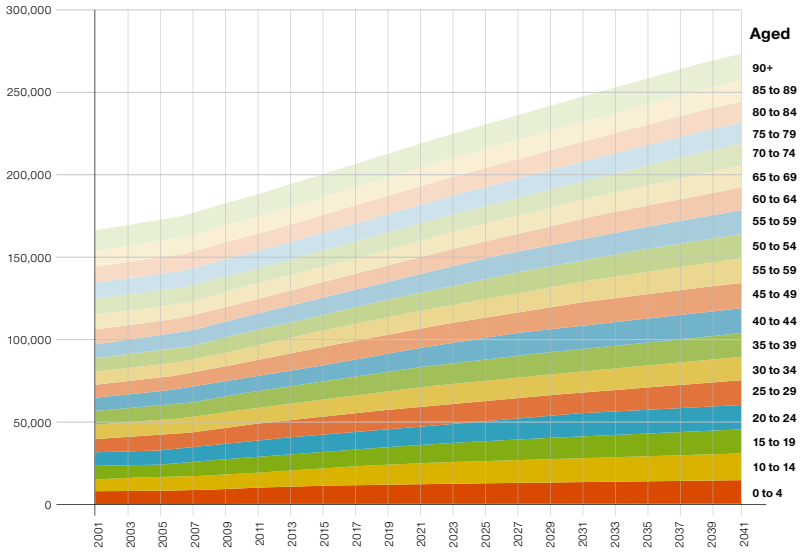
The population is much more diverse than 15 years ago – since 2001 the proportion of the population from minority ethnic backgrounds has increased from 15% to 50%. That proportion is projected to increase to 62% over the next 25 years.

Like other London boroughs, there is also rapid movement of people: between 2012 and 2014 approximately 50,000 new residents came to the borough, and roughly the same number left, meaning that the 'turnover' was almost a quarter of the total population.

The age profile of the population is also changing. Between the last two national censuses, the 0 – 4 year old age group grew significantly. More recent data show that the rate of increase in the very young has slowed, with the largest increases now in primary school ages. At the same time, the borough has the fourth highest proportion of people aged 10 to 19 in the country and has seen an increase in the 20 to 29 age group of just under a quarter.

“We all have a part to play”

Population increase (2001-2041)

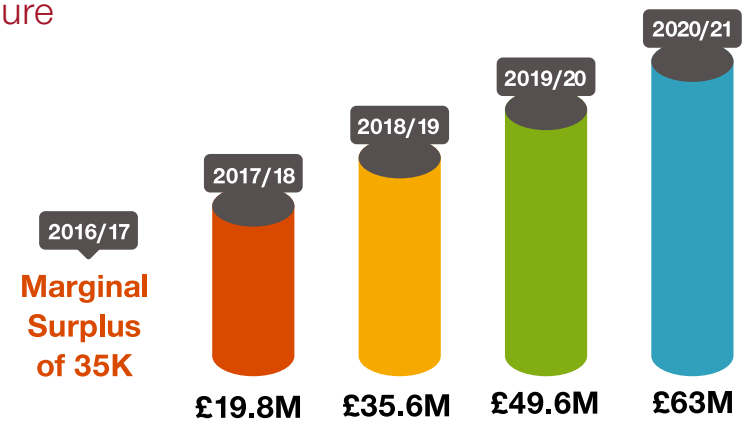


Financial pressures

Those changes have increased demand for services, adding to the huge financial challenge. Demand for services will continue to increase as the population changes and increases – but the reductions in funding imposed by central government will make it impossible to meet those demands. Without a change in approach, we would not be able to meet the most basic needs of our residents.

By 2020 the cuts in funding mean that the Council will have roughly half the amount of money that we had to spend in 2010. At the same time, the pressures caused by the growing population and more complex needs mean that we will need an additional £50 million to meet rising demands. Overall we estimate that, if we did nothing, there would be a shortfall in our budget of £63 million by 2020/21.

Budget pressure



National policy changes

The Government is also implementing reforms in national policy and legislation that will have a major impact on council services, residents and local businesses. They include:

- Reform of the housing and planning systems.
- Welfare reform, including a reduction in the cap in household benefits, and a freeze on working age benefits.
- Reform of adult social care, and health and social care integration.
- Promoting 'devolution deals' at regional or sub-regional levels.
- Proposals for all schools to become academies.

Those changes will have a major impact on many of the traditional approaches of the Council and the services people are accustomed to receiving.

The combined impacts of austerity, population change and government policy mean that we can no longer afford to meet the needs of our residents by spending more money on the kinds of services we currently provide. Instead we need to re-focus what we do so that we identify the root cause of need and tackle it, so that people have a better chance of living more independently. Our job must be to build resilience so that people are better able to help themselves.

Impacts of housing & welfare reform

New housing legislation includes:

- Mandatory powers to require council tenants with a household income of more than £40,000 to pay market rent.
- Provisions to extend the Right to Buy (RTB) to registered housing providers.
- Forced sale of high value council homes.
- Duty on councils to promote the supply of Starter Homes.

Welfare reforms include a freeze to Local Housing Allowance and a reduction in the household benefit cap, and an enforced 1% rent reduction in council housing.

These reforms together will mean that affordable housing supply will fall, private sector rents will remain high and the council will see its own stock of good quality, well managed social rent homes decline. Without a new approach, there will be a rise in homelessness, rent arrears and repossessions.

Expectations and Outcomes

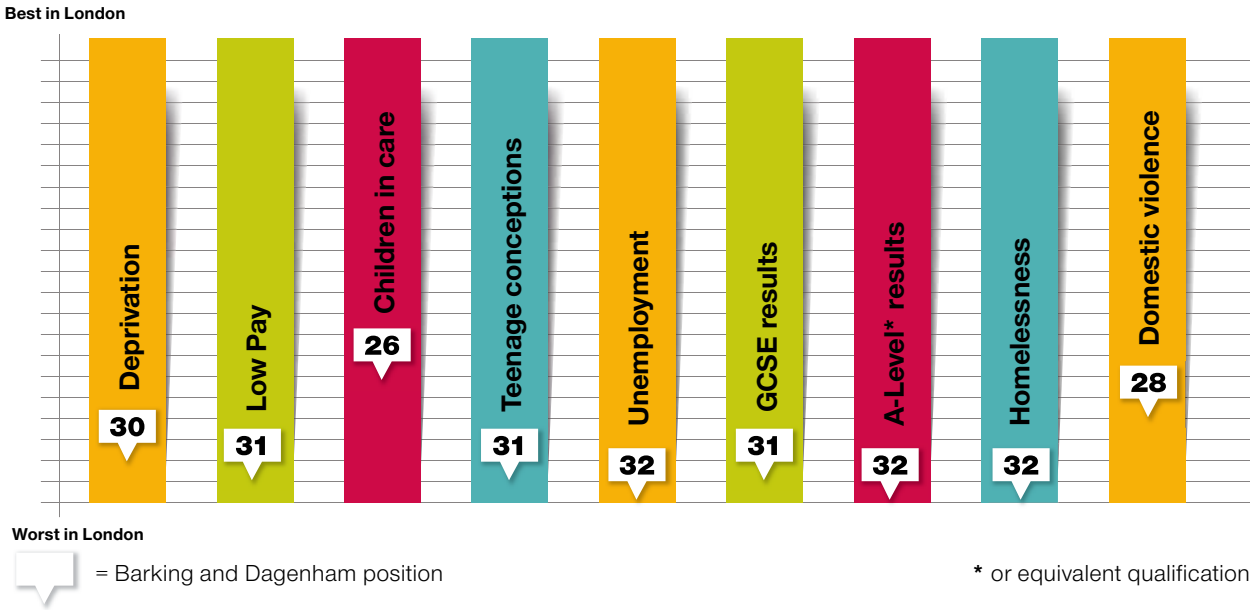
We also need to change because what we have done in the past is not good enough in meeting what our residents need and expect.

In the recent residents survey 70% of our residents said that they were satisfied with the area, compared to 86% for London residents generally. Only 53% said that the Council listens to, or acts on, the concerns of local residents. Lack of confidence in council services undermines the trust of local people.

Our residents are at the bottom of too many London league tables. People in our borough die earlier, have poorer health, and lower levels of education and skills than in most other London boroughs. Too many are insufficiently skilled, too many are in low paid work, too many struggle to find suitable accommodation to live in.

On many measures of health and well-being, our residents have significantly worse health outcomes than national averages – including lower life expectancy, and higher rates of obesity, diabetes, and smoking prevalence.

How did Barking and Dagenham compare to other London boroughs in 2015?



The prize of economic growth

The unprecedented challenge caused by the financial pressures, social and demographic change, and the policy priorities of the current government are not unique to our borough. But unlike most other areas, we have a once in a lifetime opportunity to secure the benefits of huge economic growth for our residents, so that no-one is left behind.

No other part of Greater London has the potential to play the role that Barking and Dagenham does in the expansion of London's economy. But we recognise that the borough is not yet ready for the scale of change this will mean. There is much work to do to prepare for this future if growth is going to be inclusive and sustainable, making the borough a better place for all our residents.

Over the next 20 years, we have the potential for over 35,000 new homes and over 10,000 new jobs in the borough. We can stand by and watch things happen, seeing inequalities increase and the weakest driven out of the borough – or we can shape the future so that the whole community benefits and prospers.

Our response to the challenges

In summer 2015, the leadership of the Council launched two major pieces of work:

- A panel of independent experts – the Growth Commission - to review the Council's ambition to be London's growth opportunity, and to recommend how to maximise the contribution of the Borough and our people to the London economy. Their report was published in February.
- We set up our 'Ambition 2020' programme within the Council to re-examine every aspect of what the council does and how we are organised.

This plan sets out:

- What we will do to realise for our residents the benefits of economic growth – and our response to the recommendations of the Growth Commission.
- How we propose to transform how the Council operates.

Transforming our borough – London's growth opportunity

The findings of the independent Growth Commission will help us to establish a blueprint for transforming the borough over the next 20 years and beyond. We have already seen early benefits from the Commission's work by securing one of 11 new London Housing Zones.

The Growth Commission recommended that ten key steps were essential for realising our vision.

We have already agreed those recommendations and are in the process of implementing the 10 key steps.

Building on what the Commission proposed, we commit ourselves to a set of principles.

We will:

- Develop with partners a 20-year vision for the borough, backed by a series of measurable goals.
- Support the renewal of civic culture through much more active involvement of the local people and communities, organised and empowered to support and challenge the public and private sectors.
- Develop the housing offer in the borough to reflect London's diversity - including social housing for rent, affordable sub-market stock, a well-regulated private rented sector and a very substantially increased stock of owner-occupied housing.
- Increase a vibrant local business community providing a home for local entrepreneurs and businesses, large and small from around the world.
- Leave no-one behind, ensuring that everyone has the opportunity to fulfil their potential and benefit from the borough's growth.
- Ensure that the local community and business, as well as the Council and other public sector organisations, each play an appropriate leading role.
- Benchmark everything the Council does against the excellence that is part of the best of the Borough's history in housing and manufacturing.
- Take decisions based on the very best available evidence.

Over the next 12 months, we will lead the development of the 'Barking and Dagenham Manifesto', which will set out what the borough needs from its London and national partners, with a programme to develop those proposals and a sustained commitment to seeing them delivered on the ground.

As part of our 'Ambition 2020' programme to transform the Council, we propose to set up a borough-wide regeneration vehicle as recommended by the Commission. That would bring together the expertise of the Council, other statutory partners, and the private sector in a new Council-owned company to manage the delivery of the borough's housing and regeneration plans.

We will ensure that our progress in implementing these, and the other recommendations, is reviewed and reported publicly on an annual basis. Once agreed, the key targets in the Borough Manifesto will provide the framework for managing our performance and the accountability of others for achieving them.

The Commission's recommendations about each specific area of the borough will be considered as part of the local planning processes. We will not, however, be taking any further action on their proposal to consider a large scale voluntary transfer (LVST) of the council's housing stock. We do not consider that it would be financially beneficial at this stage; and we believe that the management of our council housing stock can be better achieved by a different approach - which we are proposing as part of our plans to transform the council - 'My Place'. We also do not agree with their recommendation to pause the development of Barking Riverside when we should be looking to accelerate it to boost numbers of new homes.

We will be engaging local schools and other partners in considering the Commission's recommendations about supporting people through early years, educational attainment, and skills development. We will formulate our action plans in the light of that engagement. Given the current government proposals on schools' funding and status, we will need time to work with our education partners on the right targets and priorities. But we are clear that closing the gap with London and exceeding the average is an essential ambition for our children and young people.

We believe that the residents should also reap the benefits of economic growth by seeing the profits from investment being re-invested in our public services. The Council will develop a capital investment programme of our own.

This will involve the identification of potential investment opportunities in both residential and commercial properties. Our aspiration is to invest as far as possible inside the borough to act as a boost to regeneration and economic development. Investments will be sought outside the borough if they provide an appropriate level of return.

In addition to the 10-year plans which we already have to invest £200 million in new council homes and £350 million in maintaining our stock, we propose to invest at least £100m over the next 5 years, with a target net rate of return of 5%. That will generate an annual net income for the Council of £5 million by 2020/21.

Transforming our Council – 'Ambition 2020'

Our 'Ambition 2020' programme began in summer 2015, designed to create a sustainable organisation that can live within its means; tackle the challenges the borough faces; respond to the Growth Commission findings and deliver our Council's vision.

The starting point was the challenge of finding £63 million in savings over the next 4 years, on top of the £90 million savings which we have had to find since 2010.

Traditionally, local authorities reduce spending by department. We managed to do that between 2010 and 2014. But we cannot continue to do that. Other local authorities also outsource or privatise services and dramatically reduce the size of the workforce. We have no desire to take those paths.

Our approach

Our Council will combine the enduring core values of the public sector, with the community involvement and flexibility of the voluntary sector, and the commercial-mindedness of the private sector

Our fundamental values of public service, integrity, and social justice will continue to underpin everything the Council does. But we need the full involvement of local people to build relationships of trust, and the flexibility to respond in ways which help to break the cycle of dependence. And we have to be more commercially-minded and entrepreneurial so that our services can be financially self-sufficient wherever possible.

In short, we must transform our organisation to work in a very different way.

Our own staff told us that our traditional incremental, salami-slicing method of budgeting and cost reduction would not work. Over the year, we involved hundreds of our staff through workshops, briefings and focus groups. They encouraged us to be bold, and they urged us to redefine what the local authority is for and what it can do.

Ambition2020
Barking&Dagenham

That echoed the conclusions of a peer review of the Council's effectiveness carried out by the Local Government Association in 2014. The review concluded that:

'Only by genuinely revising what it does and how it operates can the council seek to address the financial, social and economic challenges being faced. It is also vital to get the council's core services and delivery right.'

Our Council of the future will need to excel at five things:

- Providing consistently outstanding customer service – we need to improve how customers get access to information and services and find innovative ways to enhance the customer experience and build trust whilst reducing demand and therefore cost.

- Shaping a place that people choose to live in – That means creating and maintaining areas that are attractive and affordable. That includes excellent schools, a safe and clean environment, culture and leisure facilities, and heritage.

- Being commercially minded and financially self-sufficient – Making our Council commercially astute, with the capability to innovate and to maximise income, and a constant drive to improve our efficiency and productivity.

- Building public engagement, greater responsibility and civic pride – this includes a focus on clean streets and enforcement, holding private sector landlords to account for the condition of property they own, and running a wide and varied Council events programme promoting a sense of community and attracting people to the borough.

- Reducing service demand – A coordinated approach to reducing demand through early and effective intervention including key services such as social care, housing and integrated health.

In developing our proposals, we have been clear that the Council should remain a fair employer, able to attract and retain high calibre staff. We will work closely with the trades unions, seeking to avoid compulsory redundancies.

We also reject the approach of wholesale outsourcing or privatisation of services, where the benefits and profits are realised by the private shareholders.

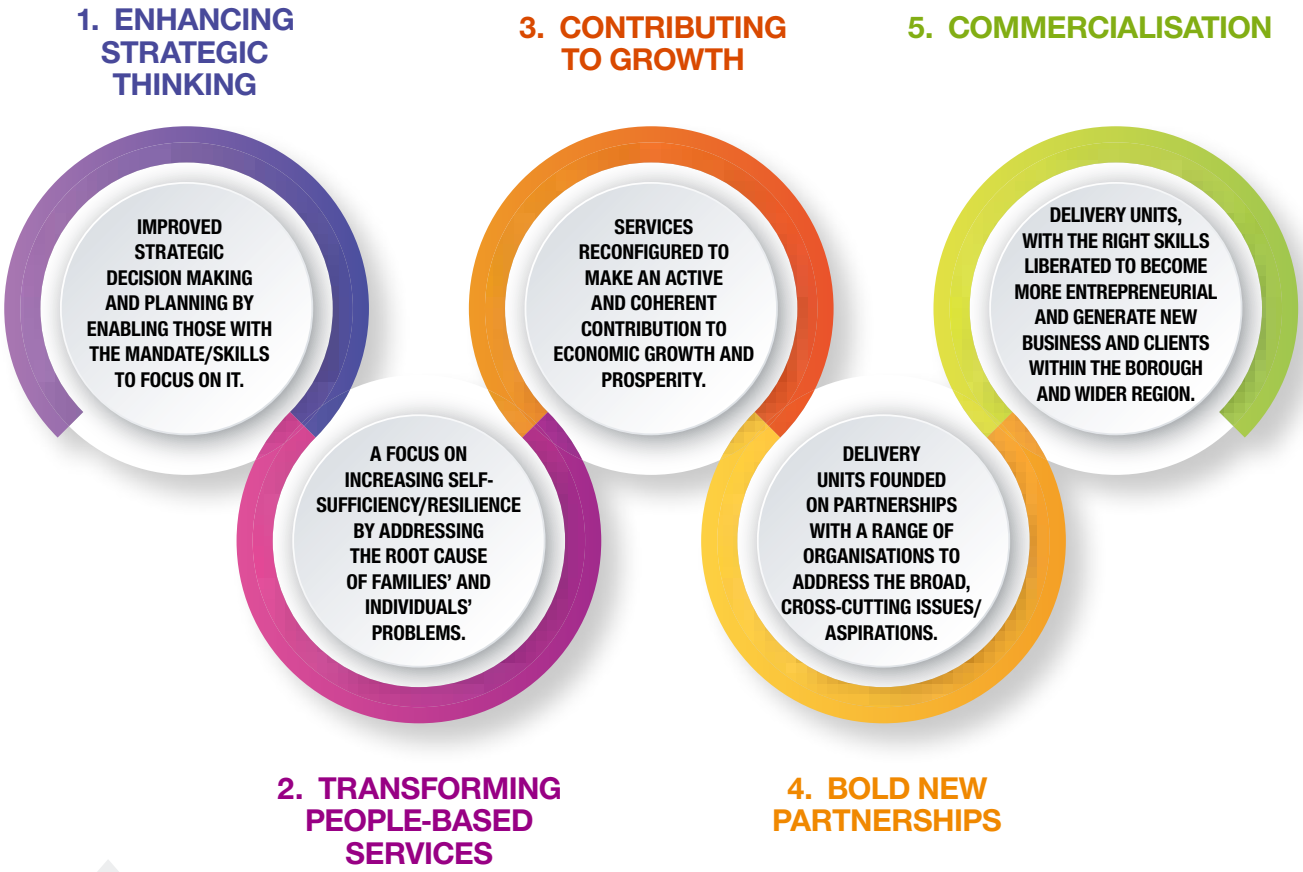
“We all have a part to play”

Our organisation

We propose to establish a new operating model for the Council, moving away from an organisation which is designed around professional service silos, to one that is designed around what we need to achieve for our residents.

As the Local Government Association review identified:

> **‘The council needs to make a massive shift in relation to how it corporately uses resident insight, lobbying/public affairs, community engagement, internal and external communications and performance management to deliver the vision and priorities. They aren’t at the level they should be. Moving forward, the organisation needs to have different, and much more demanding, expectations of what is delivered through the ‘corporate core’ and these functions.’**



We have already established a new Strategic Leadership Team within the Council. That team will be responsible for supporting Members to develop the long-term goals which will be captured in the 'Borough Manifesto'. They will then articulate these into 5-year strategy and commissioning plans that will include detailed evidence and clear targets and measures.
These plans will in turn drive the determination of contracts or service agreements, ensuring that delivery is focused on the achievement of the Council's goals. Finally, annual service plans will be agreed so that performance can be managed day-to-day.

The Strategic Directors will be accountable for delivery of the key goals, and for ensuring that all the statutory duties of the Council are met. This will entail a new approach to leadership and accountability which can work with a 'mixed economy' of service provision – whether directly by the Council, working with partners, or by others who are commissioned or contracted to provide services.

For example, we know that raising educational attainment will be essential to give our young people the best chance of getting access to higher education and improving their career prospects. The Council does not run schools directly – and current government proposals would make all schools become academies - but it is the Council's role to set overall goals for education and support for children and young people, to commission the right provision from schools and others, and to hold them to account for performance.

In order to work in that way, where the Council is not the main provider of all services, the Council has to become much stronger in developing strategy, setting clear and measurable objectives to support the strategy, and commissioning services. The Council's existing departmental and corporate strategy and policy departments will be supplemented with some new capacity to ensure that our policy and planning are based on good evidence, sound analysis, customer insight and intelligence.

The corporate 'core' will also provide support functions such as HR, Finance and IT and will own the Council's main customer access channels. We estimate that the changes to the structure and operation of the Council, as set out below, together with improving efficiency in our transactional support services will enable us to make £5 million of back-office savings by 2020/21.

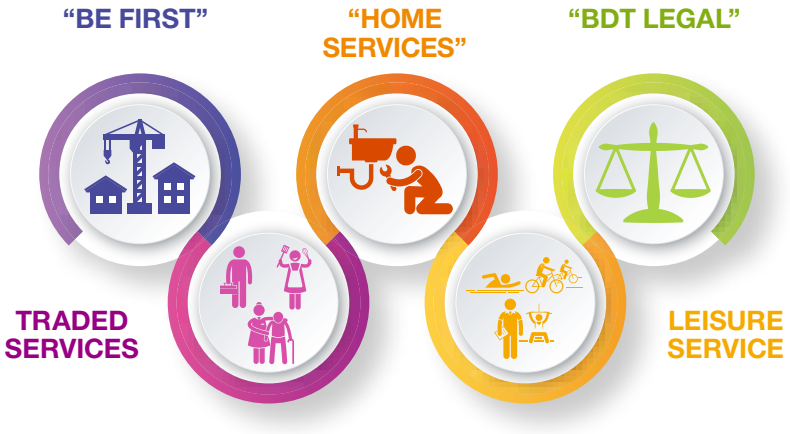
“We all have a part to play”

How we will provide our services

We will no longer have separate functional departments or directorates. We will shape our organisation around the needs of people, the place, and our goals.

The delivery of services will be undertaken by a range of ‘Service Delivery Blocks’. Some of them we propose should be in-house, and some should be at arm’s length, so that they are able to generate the income to become self-funding and to re-invest.

Arm’s length service delivery blocks



In-house service delivery blocks

Supporting people

As the core of our people-focused services, we propose to establish **'Community Solutions'** to identify and resolve the root cause of an individual's or family's problems.

We intend to move from separate departments to coordinated and integrated services for residents who need help. Current services often work in functional silos, tackling single issues and failing to address the underlying reasons why the person may be looking for help. The combination of rising demands and financial pressures mean that we have to re-think our approach. In future, we propose a single service for those who believe that they need help - whether that concerns housing, welfare, employment, social care, or other issues.

The purpose of the service will be early resolution and problem-solving to help residents to become more self-sufficient and resilient. It will tackle the multiple needs of households in a joined-up way and at an early stage. It will comprise multi-disciplinary and multi-agency teams that will collaborate closely with the voluntary and community sector and others to deliver early intervention and preventative support.

The detailed design of the service is at an early stage, but we envisage that it would provide:

- Universal self-service and voluntary and community provision – such as online directories of services available from both the council and voluntary organisations; online self-assessment and signposting; a user-friendly tool that helps residents and front line staff identify needs and understand available support; and front-line staff – in the Council, from partner organisations, from voluntary organisations and community champions - trained to recognise a wider range of needs, provide low-level support and signpost to the available services. Most people should be able to resolve their issues at this point.

- Support for households who are experiencing difficulties – a range of services maximising opportunities for early resolution and increasing independence; with some outreach services aimed at those who are identified to be "at risk".

- Targeted support for those who need it to tackle multiple issues – for eligible households a 'Community Solutions' case co-ordinator will coordinate services around the individual or household to tackle underlying issues.

"COMMUNITY SOLUTIONS"

“We all have a part to play”

This service is the engine room of our vision to see our residents benefit from growth. It will be driven by an ethos of resilience and self-help. For most adults of working age the route out of poverty is employment. The service will therefore have a strong orientation to helping individuals to obtain work or to develop skills to obtain better-paid jobs.

Current council services that would form part of the **‘Community Solutions’** service include:

- Housing allocations and determination of housing need
- Parts of adult social care providing advice and information
- Integrated youth services
- Children’s early intervention; family support; Early Years and Childcare
- Employment and skills and jobs brokerage
- Financial support, revenue and benefits advice
- Parts of community safety services including dealing with anti-social behaviour
- Housing advice and preventing homelessness
- Libraries

We anticipate £6.6 million savings from ‘Community Solutions’ by 2020/21, £4.5 million through reduction in future demand, and £2.1 million through reduction in staffing and related changes.

Under the banner of **'Care and Support'** we propose to bring together the cluster of services for those individuals or families who either need our continuing support or require an intervention to safeguard those who are at risk.

There will be a re-designed adult social care service; a re-designed children's social care service; and a new disability service. The pressures of demand and financial constraints mean that current arrangements are not affordable. We should also do more for those needing care and support to improve the quality of services and the outcomes. Our aim is to enable and support more adults to live in their own homes for longer, and more children and young people to live at home with their families.

We aim to offer more choice and options for service users – children, young people and adults. We will see reduced overlap and duplication of tasks between professionals. Making sure all social work processes are streamlined and effective will ensure that children, young people and families are not involved in unnecessary and costly bureaucratic processes. There should be more access to skilled social workers and other professionals who will be able to offer a range of tools, techniques and services which will make a difference.

For both adults and children, services will be smaller, more responsive and user focused. Social workers will have more contact with services users and carers. Social work teams will include a mix of staff to ensure best use is made of skilled social worker time which is in short supply. A modern electronic record system and use of up to date technology to support mobile working will give social workers more time for direct work with children, young people and adults. There will be a range of service providers and a variety of different types of provider.

We propose that there should be a single disability service for those with life-long disabilities. Services to children and adults are currently delivered separately, with significant differences in approach between services which in part reflects the differing legal positions but which are often experienced as difficult and confusing by individuals. Integration will deliver a more seamless service and better 'life course' planning. In particular, the transition from children to adult services will be easier to plan and easier for parents and young people to navigate. Where possible, we will seek to bring together health and social care services in a way which promotes independence, reduces gaps and overlaps and delivers savings by reducing demand and through economies of scale. Older people's services will cover disabilities brought about as part of the ageing process.

We anticipate £11.8 million savings from 'Care and Support' by 2020/21 - £2 million of reduction in anticipated future demand, £4.5 million of other savings (changes to service models, contracts/providers), and £4.9 million of workforce-related savings.

"CARE & SUPPORT"

“We all have a part to play”

Access for customers for council services will be through a single digital platform that will enable seamless on-line, phone and face-to-face contact.

At present, the ways in which people contact the council are fragmented, and inefficient, and often frustrating for customers. There are multiple contact channels, and the service is inconsistent and does not always lead to a swift resolution. Customers can be asked for the same information on multiple occasions depending on which service they contact or may be required to speak to multiple members of staff to have their query resolved.

A new customer access strategy will ensure consistency across all services and contact channels with the overall aim to make our Council **“Digital by Design”.** We will ensure that people will no longer be asked for the same information multiple times and can access live updates about their own requests. Customers will be kept informed of events and changes to services that are relevant to them, and they will receive progress of their contacts in a way they prefer, without having to chase.

For those who require additional support there will be online help (using web chat), a telephone service (using the contact centre) and locations across the borough where there will be staff who can provide immediate assistance or where appointments can be made to meet face to face with specialist officers. We will also aim to ensure that residents are connected to partners or community organisations where this is most appropriate.

We anticipate £5.7 million savings by 2020/21 through streamlined processes, reduced demand, and reductions to the workforce.

We propose to create a revitalised and consolidated **Enforcement** service to promote civic pride and to shift the behaviour of those who act irresponsibly or without due regard for others.

The service will bring together all those council functions which are involved in enforcement and regulation. Current services are fragmented across a dozen different functions. Our aim is to provide a better service to residents, and to make the service and its employees more productive and effective.

We propose to develop an intelligence-led, highly visible enforcement service in the borough, which is located where it will have the greatest impact. It will be able to respond to emerging high-profile issues swiftly. We expect it to ensure that the enforcement service is self-funding and provides value for money. This includes the functions in relation to private sector landlords.

The service is an important part of our response to residents' concerns about crime and anti-social behaviour and will complement our work to design out crime as we develop parts of the borough, the role of the 'My Place' service, and the work of our 'Community Solutions' service.

Enforcement and regulatory functions should be delivered in a consistent manner which sets an acceptable standard of behaviour, where those who live, work and visit the borough have pride in the place. People should be able to report issues for all these services online/by phone easily and to get feedback on what has happened. We also want the local community and businesses to play their part in improving standards within the public realm.

We anticipate £2.9 million of savings by 2020/21, primarily from increased income, with some workforce changes.

ENFORCEMENT

Shaping places

'My Place' will be an innovative new service designed to maintain the Council's assets and to support a broader approach to place management that will benefit the whole community.

Over the last decade there has been significant growth in the private rented sector. Owner occupation has fallen in the last fifteen years to 44% - the lowest level of owner occupation in London. Over the same period there has been a substantial growth in the private rented sector to around 16,500 tenancies. The estates and streets of our borough are becoming more diverse in terms of tenure with a varied mix of council tenants, private rented sector, 'Right to Buy' homes, owner occupiers, and shared ownership, all of which could be found on one road. That mix will continue to change with large amounts of private investment coming into the borough.

Increasing diversity in the housing mix has made our current tenancy management model inefficient and redundant. 'My Place' will be a new service that will become a local managing agent and handle all resident affairs relating to property. It will include tenancy management and property management for our own stock. It will also allow the council to provide management services in the open market for landlords and developers that operate in the borough and charge for this service.

It will act as the commissioner for services which maintain public spaces, using the best placed provider. We anticipate £600,000 additional income by 2020/21 from managing agent services and lettings agency income. 'My Place' will drive local environmental improvements by commissioning and performance managing the Council's **refuse and street cleansing services.**

We propose that both those services should be retained as in-house services; but significant improvements in the efficiency of both services can be achieved. We have the highest volume of waste per household in London. The current waste service is focused on collection rather than preventing waste creation, which should be its core aim. Due to the cost per tonne for disposal and high staffing costs this service is expensive to run. We will improve public education and enforcement to reduce waste volumes and disposal costs.

We anticipate £1.2 million savings by 2020/21 from workforce related savings and waste volume reduction. We propose to establish a new service designed to breathe life back into the Borough's flagship parks and open spaces with a particular emphasis on exploiting their commercial potential for the benefit of all users.

We are a green borough with some 32% of land being parks and green spaces. We have 25 **parks and open spaces,** but the quality of many of these is poor. The Council has attracted some inward investment to parks, but significant further inward investment is needed for the basics of maintenance and safety, and to reverse the gradually increasing dilapidation.

Our ambition is to see our parks and open spaces as assets that help deliver our growth ambition. We are seeking to become a destination of choice and it is vital that the public realm looks the best it possibly can. A high quality park can add up to 25% to the value of properties bordering high quality and attractive green spaces and making regeneration schemes work. We intend to run a public competition to generate the best ideas that will make turn our parks into attractive destinations.

We anticipate £0.6 million of additional income by 2020/21, and £0.6 million savings from workforce and operational changes.

We propose also to retain the **Heritage Service** in-house with a vigorous mission to promote the borough's past and its connection to the present and future. We will implement an improvement programme to increase visitor numbers, income and volunteering whilst reducing operational costs. The scope of the service will include - Valence House Museum (including the Archive & Local Studies Library) and Eastbury Manor House – together with any new heritage assets that may be developed. It will continue to source external funding opportunities wherever possible. However, there will be a concerted effort to drive up visitor numbers and maximise commercial opportunities.

We anticipate that better promotion of the heritage attractions in the borough will boost its reputation as a place to live and visit. This will generate an additional income of £80,000 by 2020/21.

PARKS, OPEN SPACES & CEMETERIES

HERITAGE

Growth and investment

Achieving our vision will mean leading and accelerating the transformation of our borough's redevelopment and regeneration. We have embraced opportunities as they have become available and pioneered initiatives such as 'Reside'. However, realising our full potential will require a step change in capacity and in our capability to engage with the market of potential investors, to generate commercial opportunities and initiatives that will trigger government reward mechanisms.

We propose to establish **'Be First',** a new commercial growth and regeneration company charged with accelerating the pace and scale of economic, infrastructure and housing development in the borough in line with the Council's vision and 20 year goals. We propose that this is a commercially dynamic social enterprise, owned by the Council. That will ensure that any profits generated are returned to the Council.

Locating those functions in an arm's length body will allow more operational freedom to engage with the market place. "Be First" will be able to attract necessary talent to carry out its mission and the concentration of skills will lead to rapid and effective decision-making that will allow the Council to shape the environment in favour of its residents.

The new company will lead the identification of investment opportunities for the Council to pursue as a commercial investor in its own right. Many of these investments - in property, for example - will then be managed by the new proposed "My Place" service.

We anticipate that 'Be First' will generate £6 million in net benefits by 2020/21 through additional income.

"BE FIRST"

We propose to set up three other council-owned social enterprises. Putting these services on a new footing would enable them to create additional levels of income and generate new business.

'Home Services' will be a revitalised repairs and maintenance service contracted by the Council to maintain and repair the Council's own portfolio of properties. It will comprise all the services currently within the Council's direct labour organisation (DLO). The aim is to create a service that could trade, in particular offering a service to local landlords, providing the opportunity for the service to generate additional income by broadening its customer base. We propose that this is a social enterprise, owned by the Council, supported initially by external commercial expertise.

We anticipate that 'Home Services' will generate £1.7 million savings by 2020/21, primarily in workforce savings, with some additional income from trading activity.

BDT Legal will be a council trading subsidiary with Thurrock Council, to provide legal services to councils, other public sector organisations and charities. We propose that this is a local authority traded company. This will build on the success of the current traded activity of the shared legal team.

We anticipate that BDT Legal will generate £550,000 additional income annually by 2020/21 for both councils.

Traded Services will be a social enterprise, owned by the Council, that offers a range of support functions initially to the family of schools in the borough and to schools in other locations but could also explore wider markets. We will explore with schools the extent to which they want to be partners in this venture.

We anticipate £260,000 additional annual income from traded services by 2020/21.

For all these services, we consider that the proposed new model offers the best option to improve the delivery of services and to protect jobs. All these services must be able to maximise income, and we want the benefits of that income to support the delivery of public services, not private profit. Retention of those services within conventional council management arrangements would limit their flexibility to operate commercially. Outsourcing or privatisation would see the benefits going to shareholders, not local residents.

"HOME SERVICES"

"BDT LEGAL"

TRADED SERVICES

“We all have a part to play”

The **leisure service** is the only council-run service where we propose to transfer the management and operation of the service outside council ownership to a ‘not-for-profit’ operator. We propose to invite bids to operate the service. The Council would retain ownership of the assets and lease the facilities to the operator for the contract term.

There is a well-developed market of “not for profit” operators who can be expected to bid for the contract. We anticipate that there will be considerable efficiencies to be gained by transferring to an established operator, which will have lower overhead costs, greater experience and capacity to market the service and generate new business and income.

We anticipate £1.2 million net annual benefits by 2020/21.

LEISURE SERVICE

What does this mean for our workforce?

Our proposals safeguard jobs. Of the current workforce – which is approximately 3500 full-time equivalent posts – about 1000 posts would transfer into the proposed wholly owned social enterprises or not-for-profit operators and contribute to new income generation. If our proposed, more commercial delivery organisations are successful, those jobs can be protected.

Some reduction in the overall size of the workforce will be necessary, and we estimate that, as a result of the proposed reforms and savings, the size of the workforce will reduce by about 550 'full time equivalent' (FTE) posts. The values that underpin public service and which are recognised by the council workforce will not change. However, getting the most from limited resources will mean adopting new ways of working and ways of managing that are closer to the private sector than traditional local government practice.

Continual change will be part of the future and our workforce will need to be flexible enough to respond positively to that challenge. This will mean using organisational change as an opportunity to develop and grow the skills and capabilities of our people. In part, this will be achieved as a result of providing the right tools to do the job and, in particular, a comprehensive programme of learning and other development opportunities in line with the requirements of the new models of delivery.

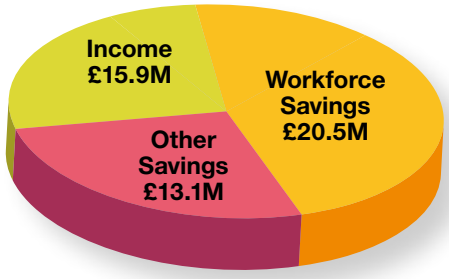
We will have high expectations of our staff, with challenging targets for performance and productivity. Good performance will be recognised and rewarded, and poor performance will be tackled quickly.

Bridging the financial gap

If the proposals set out here are agreed and delivered, we estimate that the budget gap will be reduced from £63 million to £13.5 million. This programme of transformation should deliver £49.5 million of savings each year by 2020/21, including nearly £16 million in additional income. During that period we will aim to secure further savings through better integration of health and social care services – by exploring pioneering options such as an Accountable Care Organisation - and further opportunities to generate income.

We are confident that the proposed model gives us the best chance to manage the financial pressures, secure improved outcomes, and to realise the benefits of economic growth.

Financial benefit after ongoing cost profile per category



Next steps

We are at the start of a five-year programme of transformation. We will now press ahead with the changes which will improve the efficiency of the services which we are intending to retain in house.

We are consulting residents, partners, businesses and our staff now on those proposals which would entail a major restructuring of council services or creation of new arm’s length bodies.

A set of questions for consultation is at **www.lbbd.gov.uk/consult**
‘Transforming our borough and transforming how our council works’
We are seeking responses by Thursday 16 June 2016.

We expect to consider the responses to consultation, and then to take firm decisions in July 2016.

Technical note – Data sources

This note summarises the data sources for the statistical information and comparisons.

Deprivation: English Indices of Deprivation 2015 (Rank of Average score)

The Indices of Deprivation is produced by the Department for Communities and Local Government. The most recent version was published in 2015.

Relative levels of deprivation across England are measured over a range of indicators, including:

- Income Deprivation
- Employment Deprivation
- Education, Skills and Training Deprivation
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment Deprivation

These measures are combined into one overall score (Index of Multiple deprivation) and this score is then ranked for each local authority in England.

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Low Pay: (Annual Survey of Hours and Earnings 2015 [provisional]: Annual pay by place of residence – All)

The information for this indicator is derived from the Annual Survey of Hours and Earnings (ASHE) which is conducted annually by the Office for National Statistics (ONS). The measure used here is the average annual salary by a person's place of residence (and includes part time and full time work).

http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/2015provisionalresults

Children in Care: (LA looked after children 2015, DfE, 2015, Table: SFR34:LAA1)

This measure is produced by the Department for Education (DfE) and shows the number of looked after children (including adoptions) per 10,000 children aged under 18 years. The figure used is for year ending 2015.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483716/SFR34_2015_Local_Authority_Tables.xlsx

Teenage Conceptions: (Office for National Statistics: Vital Statistics: June Quarter 2015)
This measure is produced by the Office for national Statistics on a quarterly basis and is the rate of conceptions per 1000 women aged 15 to 17 years for each local authority.

http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/datasets/quarterlyconceptionstowomenagedunder18englandandwales

Rate of Unemployment: (Annual Population Survey – ONS, 2015)
This measure of unemployment is derived from the Annual Population Survey (APS), which is conducted by the Office for National Statistics.

The rate is based on the number of people unemployed as a proportion of the economically active population in a local authority.

https://www.nomisweb.co.uk/reports/lmp/la/1946157260/report.aspx

GCSE results: (% of KS4 pupils attaining 5+ GCSEs inc. English and Maths 2015 – Department for Education - DfE)
This measure is produced by the Department for Education showing the percentage of pupils at Key Stage 4 achieving 5 or more GCSEs (including English and mathematics). It relates to the 2015 academic year.

https://www.gov.uk/government/statistics/provisional-gcse-and-equivalent-results-in-england-2014-to-2015

Level 3 results: (Percentage of students achieving at least 2 substantial level 3 qualifications DfE (provisional) 2014/2015)
This measure of educational attainment is produced by the Department for education and gives the percentage of students achieving at least 2 substantial level 3 qualifications (which are A levels or their equivalent) by local authority

https://www.gov.uk/government/statistics/a-level-and-other-level-3-results-2014-to-2015-revised

Domestic Violence: (MOPAC: 2015)
This measure shows the proportion of domestic abuse victims subject to repeat incidents and is compiled by The Mayor's Office for Policing and Crime (MOPAC)

https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-research/crime/domestic-and-sexual

Publication reference number: MC7851
Date: April 2016

Cover images:
'The Colour of Time' at the One Borough Show in Parsloes Park
©Mike Attridge Pictureplus for Creative Barking and Dagenham (2015)

An aerial photo of Dagenham

A view from Barking Town Square

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**Urgent and Emergency Care transformation programme**
Report of the Programme Director for the Urgent and Emergency Care transformation programme	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Alan Steward, UEC Programme Director, BHR CCGs	**Contact Details:** Tel: 020 3182 3403 E-mail: alansteward@nhs.net
Sponsor: Conor Burke, Chief Accountable Officer, BHR CCGs	

Summary:

The Barking and Dagenham, Havering and Redbridge (BHR) urgent and emergency care (UEC) vision seeks to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for the 750,000 residents across the BHR health economy - the most challenged health economy in the country. The System Resilience Group (SRG) believes there is a need to do things differently and evidence suggests that patients are confused by the many and various urgent and emergency care services available to them - A&E, walk-in centre, urgent care centre (UCC), GPs, pharmacists, out of hours services etc.

The UEC programme has been re-structured with our system partners working together to create a programme which will deliver improvement to all areas of the UEC pathway including local NHS Operating Plan commitments (performance and activity) for 2016/17. This aligns and builds on the Better Care Fund, local NHS QIPP (Quality Improvement Productivity and Prevention) plans and the UEC vanguard programme.

Recommendation(s)

Members of the Health and Wellbeing Board are recommended to note the progress of the Urgent and Emergency Care transformation programme.

Reason(s)

Barking and Dagenham, Havering and Redbridge residents live in one of the most challenged health and social care economies in the country when it comes to the quality of services and the finances available to deliver them.

NHS and local authority partners across Barking and Dagenham, Havering and Redbridge (BHR) are working together on transformation of the urgent and emergency care services in our area through the Systems Resilience Group (SRG).

1 Introduction and Background

1.1 Urgent and emergency care has been a key challenge for our health economy for many years with a background that includes:

- A complex urgent care system with duplication and fragmentation across services
- Challenged health economies and challenged acute trusts
- Key national standards and targets, particularly in accident and emergency, not being met

1.2 A BHR urgent care conference was held on 1 July 2015. The purpose was to gather views on how we can transform urgent care services over the next 2-5 years. Soon after the BHR urgent care conference, an opportunity to bid to become an urgent and emergency care "Vanguard" site was announced.

1.3 The BHR System Resilience Group (SRG) was successful in its application to become a national urgent and emergency care Vanguard. The outcomes of the Keogh Review, led to a nationally agreed model for UEC. This meant our priority was to accelerate the implementation of those measures.

1.4 These are:

- Delivery of Integrated Urgent Care (IUC) – the national enhancements to NHS 111. Will include an enhanced clinical hub to support NHS 111 and shared care plans
- New payment models for providers
- Testing of new system measures - to move focus away from the 4hr A&E standard
- The economic evaluation of channel shifts
- Setting up effective urgent and emergency care networks
- Designation of UEC services
- Ambulance response times

2 Developing our Urgent and Emergency Care Programme for 2017

2.1 The UEC programme builds on and aligns with the vanguard programme, Better Care Fund plans and brings planned activity reductions into a single programme that will deliver improvement to all areas of the UEC pathway and deliver local Operating Plan commitments. It is a system programme, involving BHRUT, NELFT, PELC and the local authority colleagues in the three boroughs.

2.2 Operating Plan commitments are:

- To deliver 91.5% on the national 4 hour A&E wait standard by March 2016
- Activity reductions of 4,296 A&E attendances and 2,150 non-elective admissions

2.3 The trajectory for delivering 91.5% on the 4 hour wait standard by March 2016 is as follows:

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
77%	80%	82.00%	84.00%	86.00%	90.00%	90.00%	90.00%	90.00%	91.5%	91.5%	91.5%

2.4 The UEC service model is organised into five service delivery workstreams:

- Integrated urgent care (IUC)
- Out of hospital
- Hospital front door
- In hospital
- Hospital back door

2.5 These are supported by five enabling workstreams:

- Communication and engagement
- Technology
- Finance and activity
- Workforce
- Governance and project management

2.6 Each of the service delivery workstreams oversees a number of projects aimed at reducing attendances and admissions. The workstreams each have a system management lead, with clinical leads also being identified for each workstream:

2.7 Each project within the UEC programme will deliver improvements to performance. The planned activity reductions are as follows:

Scheme	Impact	
	A&E (atts)[1]	NEL[2] (adm)
Enhanced mental health (MH) liaison for children and young people (24/7 Interact)	30	2
Enhanced UCC (Queens)	1,165	93
Professional hub & expansion of call centre capacity for 111	784	78
Acute Care Improvements (Ambulatory Care & Hot Clinics)	469	487
Care in the community enhancements: Rapid response, in-reach and social care	119	10
Software and configuration	231	159
Integrated Case Management (ICM)	565	565
Falls (includes Falls with and without Fracture)	118	94

[1] Number of people who attended A&E (BHRUT)
[2] Non Elective Care – unplanned admissions from A&E (BHRUT)

End of Life Care (EOLC)	52	52
Care Homes	390	312
Chronic Kidney Disease/ Acute Kidney Injury (CKD/AKI)	373	298
Total	**4,296**	**2,150**

2.8 The key national service delivery priority is integrated urgent care. Under this scheme, our plans will increase the level of professionals available via NHS 111. This will mean professionals in the community (e.g. GPs, care home staff, paramedics) can seek additional advice to resolve more cases or divert patients to more appropriate healthcare settings than A&E. This will also be available to people calling 111.

2.9 This is important because high levels of people seek advice from healthcare professionals before attending A&E. This has been demonstrated in two recent surveys undertaken in BHR - audits undertaken at Queen's Hospital as part of the Healthy London Partnership UEC behavioural insights survey (50%) and a local research survey undertaken as part of the UEC vanguard programme (61% of those seeking advice before attending A&E).

3 Consultation and Engagement

3.1 BHR has a commitment to co-design throughout the UEC programme, building on the work started at the UEC conference in July 2015.

3.2 The UEC co-design stakeholder group agreed that first step to the UEC programme should be large-scale local research to provide sound evidence of local understanding, awareness and drivers for UEC services.

3.3 A significant research study (co-designed with Healthwatch) was conducted in March 2016 to survey the local population on our urgent and emergency care services. This involved telephone interviews with 3,000 people, and 900+ face to face interviews and 10 focus groups.

3.4 This culminated in a successful stakeholder co-design workshop to discuss the findings, identify gaps and propose next steps for our programme.

3.5 Research findings are being used to inform care model co-design and will inform our co-design and engagement programme for 16/17. Key findings from the research are:

- overall the highest UEC usage is of primary care, then pharmacy followed by A&E
- there is a high awareness of current UEC services
- of those attending A&E
  - 39% sought no advice before attending A&E
  - 37% had seen their GP with the same issue
  - 26% had been to A&E before with same issue
- 41% of parents surveyed had attended A&E at least once in the last six months, non-parents 27% and of those aged over 65, this was 21%

3.6 We are aligning the outcomes of the research with our detailed analysis of current attendances and admissions to refine the delivery plans within the programme. This will include a workshop with all stakeholders to consider the latest data and the implications for our delivery plans.

4 Improving our current performance

4.1 A&E performance at BHRUT has not achieved the national standard (95%) since August 2015 and for March 2016, it dropped to 75.6%. In April 2016, weekly performance has averaged 81.38% (unvalidated).

4.2 This fragile and below standard performance is driven by the following key issues:

- Surge in A&E attendances compared to prior year both "walk-in" and ambulance conveyance
- Emergency department staffing shortages, in particular low proportion of medical rotas that are filled
- Poor performance during night shifts, related to access to access to senior decision making and surges of patients during the evening and night
- Reduced throughput in the Queen's Urgent Care Centre (UCC)
- Multiple service at the front door of A&E that can be confusing to patients

4.3 Following a detailed review of attendance and admission data at its April meeting, the Systems Resilience Group agreed to hold a summit to address these issues and stabilise performance with the aim of ensuring that any actions have an impact on performance by the start of July 2016.

4.4 The summit was chaired by the SRG Chair (Conor Burke) and agreed the following actions:

Service delivery workstream	Quarter one actions	Lead
NHS111	Implement / extend the planned pilot to re-triage NHS 111 ED dispositions	Yemisi Osho (PELC)
Front door	Move streaming and triage to the UCC front door and extend the capacity (with GPs and ENPs) to allow more time with individual people and extend to midnight / 1am. Enhance UCC staffing and integrate	Sheraz Younas (GP Federation) and Mairead McCormick (BHRUT)
	UCC – integrate UCC with Majors Light to provide an integrated non-admitted service	Sheraz Younas and Mairead McCormick

This plan was signed off at the SRG on 4 May 2016

5 Resources and investment

5.1 As a Vanguard programme, in addition to practical support offered by the national teams, BHR also has access to the national Transformation Fund. We are awaiting

confirmation of our national resource bid for 2016/17 and any conditions attached and this will be tabled at the next SRG Board meeting. As part of the Vanguard programme, we are also required to adopt and test a new contracting/ pathway payment mechanism as supported by NHSI (NHS Improvement). This will be aligned to the developing work around the Accountable Care Organisation (ACO).

6 Equalities

6.1 An equalities impact assessment has not been undertaken, but this will be a key element of the testing of the new service model. The brief for the research study required BMG Research and Healthwatch to ensure participants were statistically representative of the communities that live in each borough in line with the latest demographic information.

7 Risk

7.1 We will be developing full risk logs and assessments as part of this programme. This will include risks around finance, clinical and resident engagement, and programme delivery

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**Substance Misuse Strategy 2016-20**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** Yes
Report Author: Sonia Drozd Drug Strategy Manager, LBBD	**Contact Details:** Tel: 020 8227 5455 E-mail: Sonia.drozd@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, LBBD	

Summary:

The four year Substance Misuse Strategy 2016-20 has been presented at the Substance Misuse Strategy Board and the Community Safety Partnership meeting for consultation, and their comments have been incorporated.

The Strategy is now being presented to the Health and Wellbeing Board, who are invited to comment further and to recommend the Strategy for final approval from Cabinet.

Recommendation(s)

The Health and Wellbeing Board is invited to:

(i) Comment on the strategy;

(ii) Recommend to Cabinet the adoption of the strategy subject to any amendments requested; and

(iii) Recommend that partner organisations also take the steps necessary to formally adopt the strategy through their organisational arrangements.

Reason(s)

The Strategy sets out a broad range of actions designed to improve public health, encourage social responsibility, reduce demand on public services and enhance community safety. Delivery of the strategy's aims would support the Council's priority of enabling social responsibility, through improving access to healthcare, protecting the vulnerable, and encouraging people to take responsibility for their health and wellbeing. It would also contribute to the Council's commitment to borough growth by supporting those with substance misuse problems into employment.

1 Introduction and Background

1.1 It is necessary to have a Substance Misuse Strategy in order to tackle the impact that drugs and alcohol have on the Borough and to reduce the harm they cause.

1.2 The Strategy is also necessary to strengthen and build upon existing partnership working with criminal justice colleagues, in order to identify those individuals who use drugs and alcohol problematically and ensure that they are offered the most appropriate therapeutic interventions.

1.3 Drug and alcohol treatment provision have been designed to ensure that people do not re-present to services. More emphasis has been placed on offering interventions to those who have stabilised in treatment and are now ready to re-integrate into society.

1.4 A greater focus on early intervention will be embedded in the action plan. Many individuals who misuse substances do so as a way of coping with traumatic events in their lives. More therapeutic work needs to take place for children with parents who misuse substances, and for those that have witnessed or experienced trauma such as abuse or violence.

1.5 The Substance Misuse Strategy has been presented at the Substance Misuse Strategy Board and Community Safety Partnership Board for consultation. Following Health & Wellbeing Board approval, it will be presented to Cabinet for adoption on behalf of the Council. This recognises the cross-cutting nature of substance misuse issues and the impact that they have on the borough's growth potential, with a corresponding need for wide sign-up from across the Council.

2 Proposal and issues

2.1 The purpose of the Strategy is to ensure that investment in substance misuse education and treatment continues in order for provision to be the most effective and relevant it can be.

2.2 The action plan, which will dictate future work in this area, will be agreed at the appropriate Sub Group of the Community Safety Partnership to be held July 2016.

3 Mandatory Implications

Joint Strategic Needs Assessment

The strategy compliments the identification of need and the priorities for future action described in the JSNA, specifically section 7.11 Substance Misuse. In the refresh paper presented to the Board at its October 2014 meeting, a number of recommendations were made which are in part addressed by the proposals in this strategy. These include improvements in mental health services, for both children and adults, increasing support for those with health conditions (which would include addiction) into employment, and further work to encourage people to make lifestyle changes that can positively impact on their health.

Health and Wellbeing Strategy

3.1 The strategy supports priorities from the Health and Wellbeing Strategy by proposing work which will cause fewer adolescents and adults to problematically use substances.

Integration

3.2 The strategy maintains, and reaffirms, the integrated approach to commissioning and planning of drug and alcohol support, as well as continuing to bring together approaches to offender management and treatment options. It also sets out aims around bringing together sources of intelligence which will enable joint decision-making around substance misuse interventions, based on wide-ranging evidence.

Financial Implications

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

3.3 The strategy set out by the Substance Misuse Strategy team would be delivered using funding received from the public health grant and London Crime Prevention funding received from Mayor's Office for Policing and Crime.

3.4 The funding allocation from the Mayor's Office for Policing and Crime is £110,000 for the 2016/17 financial year. This is however the last year of the London Crime Prevention funding. Year on year the funding will be reviewed as this may fluctuate if cuts are required or if any of the grants cease. Any major variation in the funding may impact on the delivery of the strategy. Funding streams will be regularly reviewed to minimise this risk.

3.5 This strategy is a is a health priority and so any costs will be contained within the overall Public Health grant allocation

Legal Implications

3.6 There are no legal implications with regards to this report.

Completed by Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services

Risk Management

3.7 Through approaches to service commissioning, there are mechanisms for ensuring that the risks around individuals who use substances are managed, jointly as necessary with the systems in place for offender management.

3.8 In terms of the delivery of the Strategy and its action plan which is to follow, the Substance Misuse Strategy Board will have in place a risk management system to ensure that delivery remains on track and remedial action can be taken as necessary.

Patient / Service User Impact

3.9 As the strategy itself notes,

Our local treatment services have also seen an upward trend in the proportion of individuals who have completed treatment successfully over the last three years as a proportion of those in treatment. The number of people who then relapse and return to treatment is reducing.

3.10 The range of actions in the strategy are designed to continue this trajectory and to see improvements in the support provided to service users.

4 Non-mandatory Implications

Crime and Disorder

4.1 Substance misuse impacts on many areas of crime and disorder including anti social behaviour and offending behaviour. These implications have been extensively reviewed by the Community Safety Partnership in their approval of the Strategy.

Safeguarding

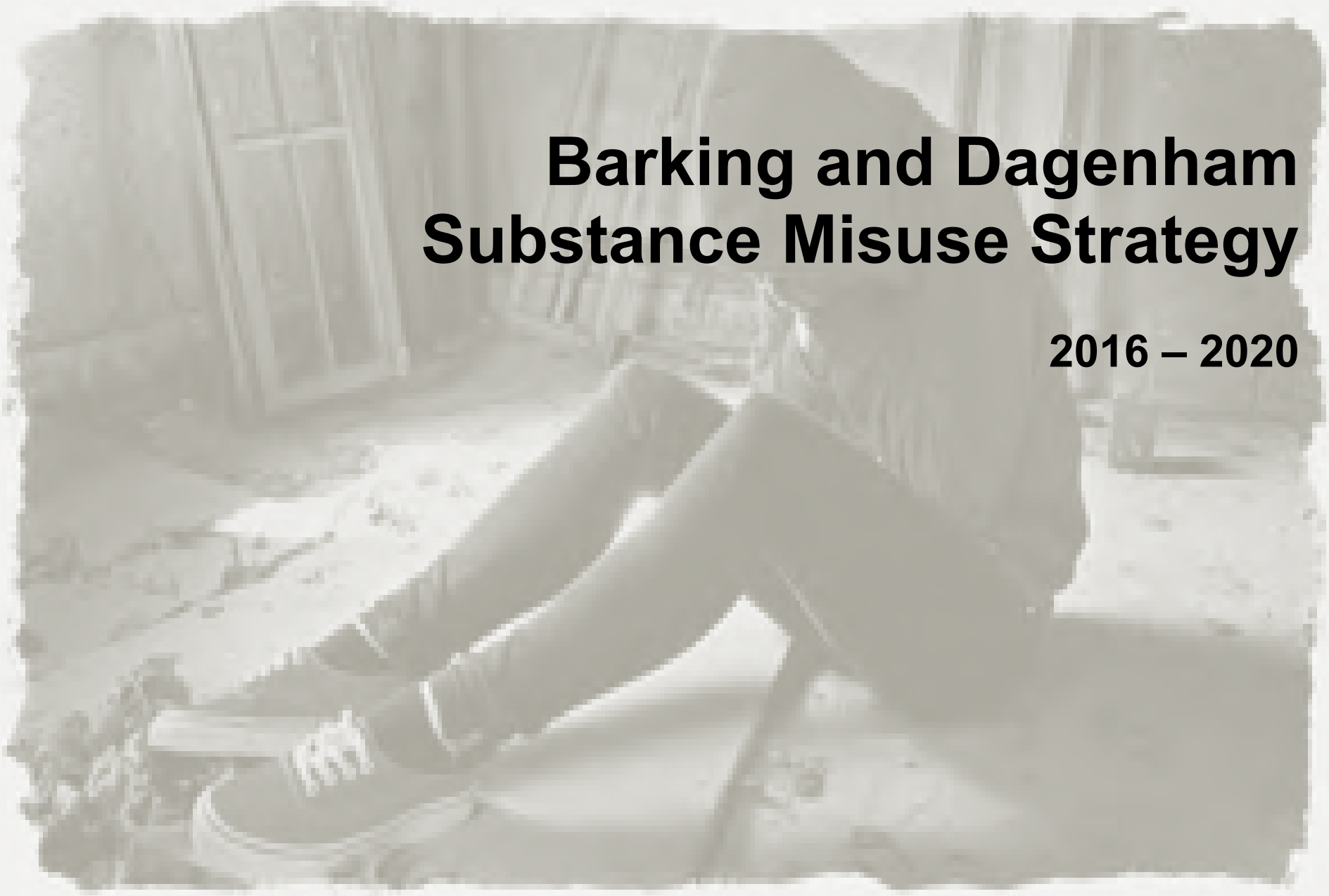
4.2 Substance use presents a range of behaviours that pose a risk to the individuals themselves and others around them, and can give rise to a range of safeguarding concerns, including domestic violence. The borough's systems for reporting and investigating both adult and child safeguarding concerns have established links to drug and alcohol services, and the Strategy recognises the need for commissioning interventions to continue to foster these links, and provide training for those involved in safeguarding.

Public Background Papers Used in the Preparation of the Report:

- National 10 year Drug Strategy

List of Appendices:

Appendix A Barking and Dagenham Substance Misuse Strategy, 2016 – 2020



Barking and Dagenham Substance Misuse Strategy

2016 – 2020

Contents

	SECTION
Foreword	1
Introduction	2
Vision	3
Aims	4
Objectives	5
Links to other strategies and plans	6
Governance	7
National Context	8
Local Context	9
Performance	10
Key Deliverables	11

Foreword 1

In Barking and Dagenham we understand the impact substance misuse has on an individual and the wider community and we are committed to ensuring that this is a priority for us. We have continued to invest in our substance misuse treatments services and have developed strong partnerships to address the wider impact on the community. As a partnership, we understand that having an addiction to a substance, whether it is alcohol, illegal drugs or prescribed medication is not a lifestyle choice and there are many contributing factors.

We are committed to ensuring that individuals who have become addicted, have opportunities to receive the treatment and support they need to enable them to become healthy and reach their full potential in life.

We are also committed to addressing the impact substance misuse has on the wider community through education and enforcement. For example, over the last 2 years we have ensured that all school pupils have been given age appropriate information about drugs and alcohol which dispels myths that may make experimenting with substances, including so called legal highs, attractive. The Council has also introduced and enforced Public Spaces Protection Orders regarding drinking alcohol in public areas and are seeking to do the same for the use of nitrous oxide (laughing gas). We want residents and visitors of Barking and Dagenham to feel safe when walking around the borough, and will not tolerate the few individuals who cause anti-social behaviour by using substances in public.

Through partnership working between the Local Authority, Public Health Services, Metropolitan Police, National Probation Service, Community Rehabilitation Company (CRC), Job Centre Plus, Council for Voluntary Services (CVS) and drug and alcohol service providers we are confident we will significantly and positively change the landscape of substance misuse within Barking and Dagenham.

Cllr Maureen Worby, Cabinet Member for Adult Social Care and Health

Cllr Laila Butt, Cabinet Member for Crime and Enforcement

Introduction 2

The London Borough of Barking and Dagenham is located at the heart of the Thames Gateway and has a vibrant community and significant investment opportunities alongside complex challenges.

Barking and Dagenham has seen a significant overall population increase of 13.4% to 185,911 (2011 Census), which equated to 22,000 more people living in the borough since 2001.

The 2014 mid-year population estimate was 198,294 and is projected to rise to 229,300 in 2022. This is a 20.3% increase and is the second largest in England after Tower Hamlets.

As a borough with a growing and diverse community with complex needs at a time of reducing resources, we face challenges in the future. However, the borough has developed excellent partnership working arrangements which enable resources to be shared to achieve the best outcomes for our community.

The Substance Misuse Strategy sets out our vision for improving the health and wellbeing of residents and reducing the impact of substance misuse on the wider community by 2020.

This Strategy identifies a number of objectives which will underpin commissioning plans and other agreements, to work in partnership, in order to make the greatest impact across the health and criminal justice system.

It also sets out how we will work together to deliver the agreed objectives over the next 4 years, whilst considering the changing political and financial environment that organisations are working in.

The Substance Misuse Strategy is the mechanism by which our Community Safety Partnership and Health and Wellbeing Board will address the identified objectives. The Strategy will be supported by a Delivery Plan which will be reviewed quarterly at the Substance Misuse Strategy Board.

Vision 3

To work in partnership to reduce the harm to individuals and the community caused by substance misuse.

Aims 4

- Improve public health
- Encourage social responsibility to reduce demand on public services
- Enhance community safety

Objectives 5

To achieve this Vision the key objectives of the Barking and Dagenham Substance Misuse Strategy are;

- Reduce the harmful impact of substance misuse on the wider community
- Ensure everyone can access good quality healthcare when they need it and continue to enable access to effective treatment and promote sustained recovery
- Enable social responsibility by supporting residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe

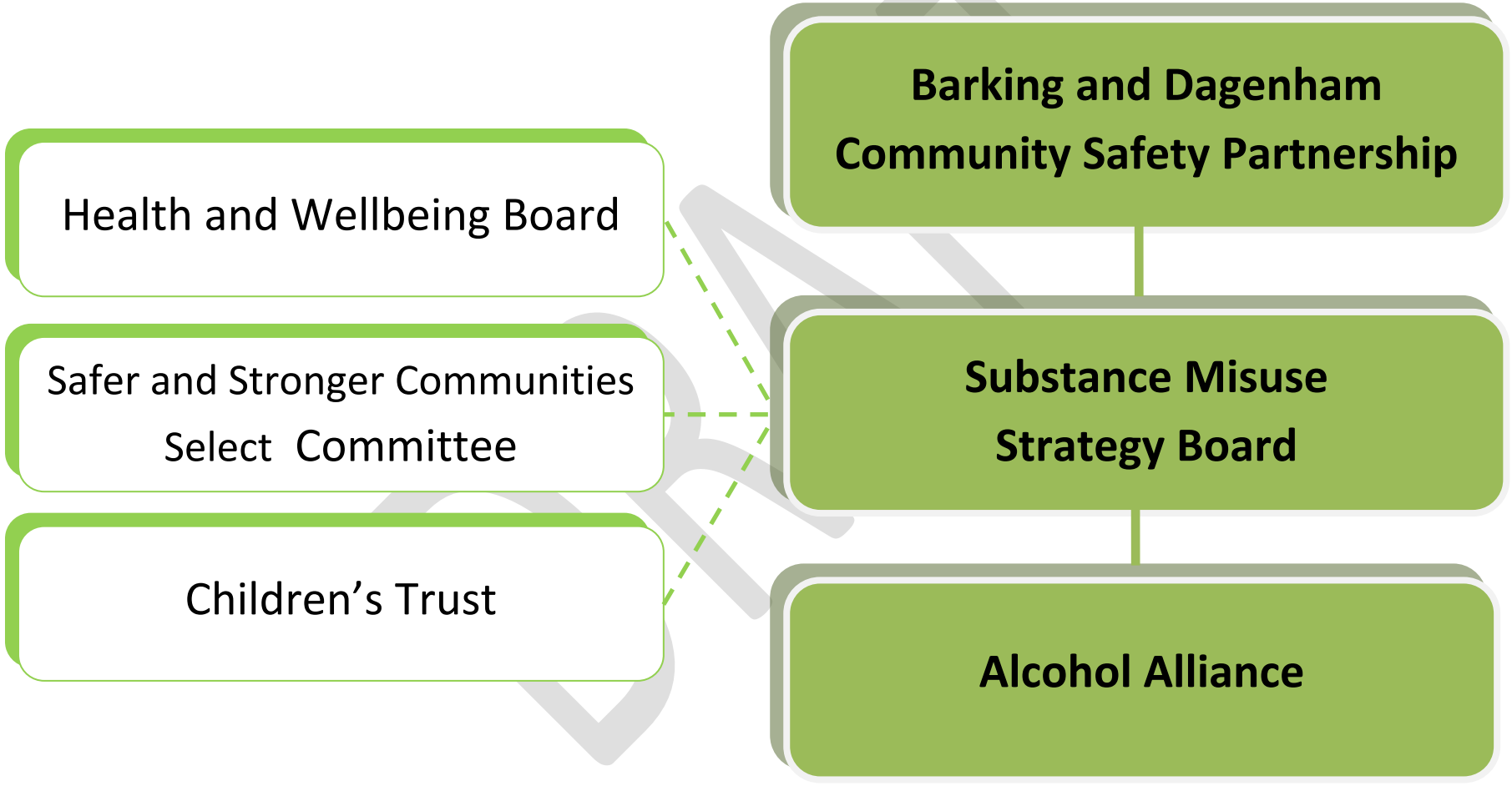
Links to other strategies and plans 6

There are a number of national, regional, and local documents that have influenced the development of Barking and Dagenham's Substance Misuse Strategy. These are identified as follows:

National Policy and Strategy Documents	Regional Policies, Strategies and Plans	Local Policies, Strategies and Practices
National Drug Strategy (being developed) Outcome Frameworks for NHS, Public Health and Social Care	Police and Crime Plan 2013-17 Public Health England Joint Strategic Needs Assessment	Ambition 2020 Community Safety Plan 2014-2017 Community Safety Strategic Assessment Corporate Delivery Plan 2015-2016 2016-2017 Domestic Abuse Strategy 2015 Growth Strategy 2013-2023 Health and Wellbeing Strategy 2015-2018 Licensing Policy (LBBD) Housing Strategy 2012-2017 Local Area Plan Local Joint Strategic Needs Assessment London Borough of Barking and Dagenham Education Strategy 2014 to 2017

Governance

7



National Context 8

The Government put together a National Drug Strategy[1] in 2010 to tackle the issues of substance misuse across the Country. They advise that the most effective strategy is one that will meet local need and that services commissioned are in line with best practice
This strategy attempts to tackle local issues in line with the Governments National Drug Strategy, therefore the themes will be the same: Reduce Demand, Restrict Supply and Building Recovery in Communities.

Reducing Demand – creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop. This is key to reducing the huge societal costs, particularly the lost ambition and potential of young drug users. The UK demand for illicit drugs is contributing directly to bloodshed, corruption and instability in source and transit countries, which we have a shared international responsibility to tackle;

Restricting Supply – drugs cost the UK £15.4[2] billion each year. We must make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks;

Building Recovery in Communities - this Government will work with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and will offer a route out of dependence by putting the goal of recovery at the heart of all that we do. We will build on the huge investment that has been made in treatment to ensure more people are tackling their dependency and recovering fully. Approximately 400,000 benefit claimants (around 8% of all working age benefit claimants) in England are dependent on drugs or alcohol and generate benefit expenditure costs of approximately £1.6 billion per year[3][2]. If these individuals are supported to recover and contribute to society, the change could be huge.

The latest findings from Public Health England indicate that each drug user not in treatment costs society £26,074. The findings also show that every £63 invested in drug treatment prevents a crime. Every **£1 spent on drug treatment saves £3.85** to society. NICE estimates the costs to society generated by each injecting drug user add up to £480,000 over their lifetime.

Furthermore, Public Health England Alcohol and Drug team (using Home Office data) estimate the borough saves **£9,017 per year per person** who is engaged in structured treatment. During 2014/15 there were 879 individuals engaged in structured drug treatment in Barking and Dagenham, therefore the total saving was estimated to be **£7,925,943**. It is crucial to ensure as many drug users as possible are engaged in treatment for their own benefit and the benefit of the residents of Barking and Dagenham.

[1] http://www.homeoffice.gov.uk/drugs/drug-strategy-2010

[2] Gordon, L., Tinsley, L., Godfrey, C. and Parrott, S. (2006) The economic and social costs of Class A drug use in England and Wales, 2003/04, In Singleton, N., Murray, R. and Tinsley, L. (eds) 'Measuring different aspects of problem drug use: methodological developments.' Home Office Online Report 16/06

[3] Hay, G. and Bauld, L. (2008) Population estimates of problematic drug users in England who access DWP benefits: a feasibility study. DWP Working Paper No. 46. Department for Work and Pensions; and Hay, G. and Bauld, L. (forthcoming in 2010) Population estimates of alcohol misusers who access DWP benefits. DWP Working Paper.No. 94. Department for Work and Pensions

Local Context 9

In Barking and Dagenham it is estimated that there are currently over 1,000 individuals who use opiates and/or cocaine[4] and over 7,000 people using cannabis according to the National Crime Survey for England and Wales[5] and 2011 census population figures.

In addition it is estimated that about one in five of the adult population of Barking and Dagenham are hazardous alcohol drinkers, with nearly 6,000 of them drinking sufficient amounts to be harmful to their health[6].

Work is underway to identify the prevalence of New Psychoactive Substances, also known as legal highs, in Barking and Dagenham. However, it is known that Nitrous Oxide (laughing gas) and Spice (synthetic cannabis) are the main substances used by young people that engage with the young people's drug project. The decision to illegalise New Psychoactive Substances has not yet been made by Government. The changes in legislation will be reflected in the delivery plan of the strategy.

The borough has also set up an addiction to medicine treatment pathway to support those individuals who are either prescribed pain killers or purchase them over the counter and have subsequently become dependent on them.

It is important to note that not everyone that uses substances, whether legal or illicit will use them problematically or abuse them. However, we need to establish why people use drugs and alcohol and what we can do in order to prevent the next generation of substance abusers.

A key area of work has been around education, to ensure that individuals are informed as much as possible with the known facts about substances so they can make an educated choice. We currently provide substance misuse workshops in all secondary schools in the borough and have commissioned a provider to work with PSHE leads to ensure that teachers have the most up to date and relevant tools to deal with substance misuse issues.

The Substance Misuse Strategy Board is keen to ensure that treatment provision recognises that there are many elements to an individual's recovery journey. Whilst individuals may receive a variety of tailored interventions where there is a demonstrable need, this should be within a wider context of recovery planning from the outset.

Our local treatment services have also seen an upward trend in the proportion of individuals who have completed treatment successfully over the last three years as a proportion of those in treatment. The number of people who then relapse and return to treatment is reducing.

Addictions to substances is also a key contributor to many other crimes, including domestic abuse which, due to its prevalence, is a priority in Barking and Dagenham. The Substance Misuse Strategy Board is keen to ensure that addressing harmful use of substances remains a cross cutting priority on the agenda for the Community Safety Partnership and Health and Wellbeing Board.

[4] Source: Public Health England 2011/12 prevalence estimates for Opiate and Crack users, 2014: http://www.nta.nhs.uk/facts-prevalence.aspx

[5] http://www.crimesurvey.co.uk/index.html

[6] http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756

Performance 10

Public Health Outcome Framework: Indicator 2.15 -

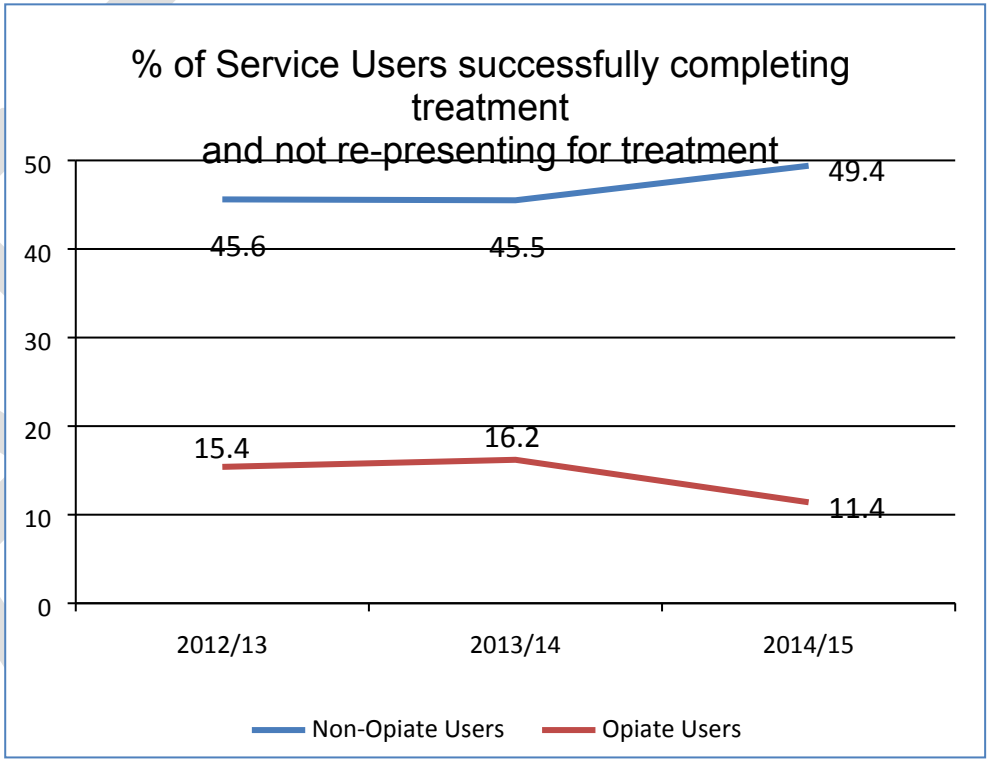
Successful Completion of Drug Treatment

Definition

The number and proportion of clients in treatment in the latest 12 months who successfully completed treatment and who did not then re-present to treatment again within six months, reported separately for opiate and non-opiate clients.[7]

The graph highlights performance in Barking and Dagenham in the last three years. There has been an increase of those individuals that used non opiate drugs, with almost half successfully completing treatment and not returning to Substance Misuse services.

Despite the decline in the number of people using opiates that successfully completed and not returned to Substance Misuse services, Barking and Dagenham are still one of the highest performing boroughs compared with boroughs clustered similar to ours.



[7] Successful Completions and Re-Presentations: Partnership Report, Guidance Document 2014/15

Key Deliverables 11

Reduce the harmful impact of substance misuse on the wider community

- To provide training and support to enforcement services to improve compliance with the Designated Public Place Order, also known as Controlled Drinking Zone and Public Spaces Protection Orders.
- Review alcohol licensing enforcement by the Council and Police to ensure all available resources are being used effectively and efficiently.

Ensure everyone can access good quality healthcare when they need it and continue to enable access to effective treatment and promote sustained recovery

- To commission drug and alcohol services to support adults and young people to provide education and information and support people with problematic substance use to achieve a better quality of life.
- Increase the number of OCUs accessing treatment and being discharged from treatment free from drug dependency
- Improve treatment coverage of non OCUs, as measured by numbers successfully engaged in treatment and re-presentation rates

Enable social responsibility by supporting residents to take responsibility for themselves, their homes and their community

- To work in partnership with retailers and licensees to promote the Drink Aware campaign and reduce opportunities for alcohol misuse.
- Using intelligence from sources such as CCTV, Neighbourhood Watch and service users disrupt drug supply routes into the borough through targeted partnership activity.
- Provide intensive, bespoke support to Troubled Families, and other families with multiple complex needs to reduce the number of families who have drug and alcohol related issues

Protect the most vulnerable, keeping adults and children healthy and safe

- To develop the programme around drug and alcohol education to be available to all schools to enable them to achieve the Healthy Schools Award.
- To work in partnership with GP's to support individuals who are addicted to prescribed medication.
- Identify high-risk population and offer them Identification and Brief Advice (IBAs) for alcohol harm reduction.
- Consider good practice from other areas in relation to early intervention and action.

HEALTH AND WELLBEING BOARD

14 June 2016

Title: Health and Wellbeing Outcomes Framework Performance Report – Quarter 4 (2015/16)	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision: NO**
Report Author: Michael Sinclair, Public Health Analyst Sandeep Prashar, Interim Head of Public Health Intelligence Dr Fiona Wright, Consultant in Public Health	**Contact Details:** Tel: 020 8227 5431 Email: michael.sinclair@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

The quarter 4 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:

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:

- 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, the percentage of people receiving care and support in the home via a direct payment, 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 was submitted to the March Governing Body. The Governing Body reviewed a high-level draft of this strategy and agreed a programme of stakeholder engagement to review and refine the strategy proposals so that the strategy could be finalised.

1.2. During this quarter, Becontree Medical Centre was inspected by the Care Quality Commission (CQC), and was rated 'requires improvement'.

1.3. During this quarter, Dr R Chibber's Practice was inspected by the CQC, and was rated 'good'.

Secondary Care

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

1.4. 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.

1.5. BHRUT are failing to meet several of the national standards required in the Operating Framework. There are action plans in place to recover the standards for A&E, Referral to Treatment (RTT), cancer and diagnostics.

1.6. The number of non-elective admissions at BHRUT decreased in Q4. The Barking and Dagenham CCG had an increase in number of admissions from February to March.

Mental Health

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

1.7. The number of children and young people accessing Child and Adolescent Mental Health Services (CAMHS) increased in Q4.

1.8. The proportion of clients on Care Programme Approach (CPA) who have received a review within the last 12 months is exceeding the target.

1.9. Delayed transfers of care (DTOC) 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.

1.10. There was a slight increase in DTOC from hospital this quarter. However, there was a decrease in DTOC due to social care.

1.11. Injuries due to falls in people aged 65 and over improved further in 2014/15 compared to 2013/14.

1.12. Of the 4 providers inspected by the CQC this quarter, 1 received a 'good' rating; however, 2 were rated 'requires improvement'. 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.

1.13. 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.

1.14. 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 now complete and recommendations are under discussion.

1.15. There was a decrease in the number of positive chlamydia screening results in Q4, and performance fell short of the quarterly target.

1.16. The percentage of the eligible population receiving a NHS Health Check slightly decreased 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 Q4 (January – March 2016) 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) Childhood obesity
(ii) Cervical screening
(iii) Proportion of older people still at home 91 days after discharge from hospital
(iv) Emergency readmissions within 30 days of discharge from hospital, and
(v) 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 taken into consideration in the drafting of a written primary care transformation strategy, which was submitted to the March Governing Body. The Governing Body reviewed a high-level draft of this strategy and agreed a programme of stakeholder engagement to review and refine the strategy proposals so that the strategy could be finalised.

CQC Inspections

3.3. An overview of General Practice CQC inspection reports published during the fourth quarter of 2015/16 can be found in Appendix B. During this period 4 reports were published on local organisations.

3.4. Goodmayes Medical Centre was rated as 'requires improvement' in a recent CQC inspection in October 2015.

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 83.3%, fell to 80.4% in February and remained fairly static at 75.6% in March. In Q4 there were no months that achieved the national standard of 95%. Overall performance this quarter was 79.8%. This is a deterioration on Q3 performance (86.5%). However, is similar to the Q4 2014/15 performance of 88.8%. **This indicator is RAG rated amber**.

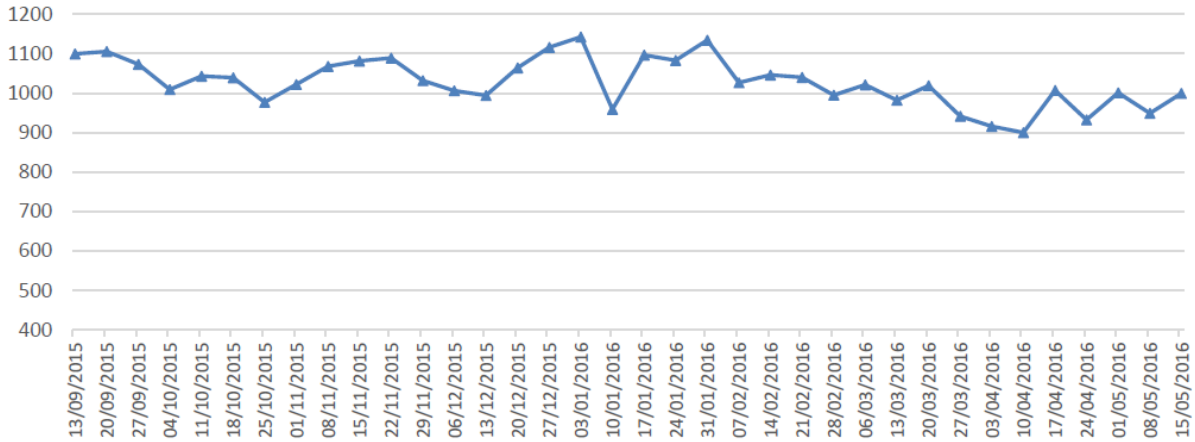
4.2. The un-validated March performance for BHRUT is 75.6% with a full year un-validated position of 87.83%; deterioration has been seen throughout Quarter Four with significant issues at both sites but particularly at Queen's Hospital. Site performance in March was 82.1% (un-validated) at King George Hospital and 71.27% at Queen'-s Hospital.

4.3. A&E performance continues to be impacted by high attendances reported in January and February continuing through March; an increase of 18.7% has been recorded compared to 2014/15 for these months.

4.4. A review of demand for A&E and urgent care services has been undertaken which has not identified a specific trend in increased activity compared to 2014/15 by age cohort or condition.

4.5. **BHR Clinical Commissioning Groups (CCGs) non-elective admissions at BHRUT.** The total numbers of BHR CCGs non-elective admissions at BHRUT in March 2016 (3,966) are 2% (65) lower than they were in the same month in 2015 (4,031) Barking and Dagenham – 0.36% increase March 2016 (1,129) compared to March 2015 (1,125). **This indicator is RAG rated red.**

Figure 1: BHRUT Non-Elective Admissions 2015-16



4.6. **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 16. This remained at 16 in February, and increased slightly to 17 in March. 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.**

4.7. There were two weeks during quarter 4 where the DTOC lower threshold was breached.

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

4.8. 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.

4.9. As a consequence the Trust suspended national reporting on RTT performance this remains true as of May 2016.

4.10. The NHS Constitution gives patients the right to access services within 18 weeks following a GP referral. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) which runs King George and Queen's Hospitals, suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014 due to a lack of confidence in the ability of the Trust to reliably report the numbers of patients waiting.

4.11. BHR CCGs and BHRUT were subsequently tasked by NHS England (NHSE) and the Trust Development Agency (TDA), now NHS Improvement (NHSI), to develop and deliver an RTT recovery and improvement plan. The full extent of the RTT challenge has evolved more recently through the development of the recovery plan which has a parallel focused requirement of limiting inflowing planned care demand to the Trust.

4.12. Despite BHRUT data quality not being assured, its March 2016 Board papers stated that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. This led to considerable national publicity. Clearly this is a major issue for commissioners and commissioners have made it very clear to BHRUT that it is unacceptable for patients to wait this long for the treatment that they need.

4.13. Ernst & Young (EY) have been commissioned to support the RTT turnaround work and the first phase of their work has specifically focused on system governance, clinical harm review, data validation and demand and capacity planning.

CQC Inspections

4.14. **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.

4.15. BHRUT are failing to meet several of the national standards required in the Operating Framework. Commissioners continue to actively manage performance through a number of forums held on a weekly basis and as a consequence Contract Performance Notices have been served. There are action plans in place to recover the standards for A&E, Referral to Treatment (RTT), cancer and Diagnostics. The Trust is held to account on actions required with associated penalties enforced in accordance within the contract.

4.16. Poor performance at both acute trusts (BHRUT and Barts) has led to them being placed in special measures. National reporting of 18 weeks has been suspended for both trusts.

5. Mental Health

CAMHS

5.1. **The number of children and young people accessing CAMHS tiers 3 and 4 increased** from 526 in Q3 to 539 in Q4. However, this quarter's performance is a reduction on the Q4 2014/15 figure of 563. **This indicator has not been given a RAG rating** as there is no target associated with this indicator.

5.2. **DTOC remained above the threshold throughout Q4**. 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 January, DTOC was 13.54%. This figure rose to 24.40% in February, before falling to 15.57% in March 2016. **This indicator is therefore RAG rated red.**

5.3. 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.

5.4. The current restriction on placements as agreed with the London Borough of Barking and Dagenham (LBBD) has been lifted with further investment in the service aim at reducing DTOC to an acceptable level.

5.5. 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.

5.6. Following a Board decision, Goodmayes Hospital's Brookside mental health unit has closed. This unit provides tier 4 services to CAMHS. The situation has presented an opportunity to redesign the tier 4 provision and the NELFT, B&D CCG and NHS England team are in dialogue to look at this. . The decision to close the unit temporarily affected one Barking and Dagenham resident who has been relocated to an appropriate in-patient unit.

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 98.3%. In February this fell to 96.8%, before rising to 97.1% in March. The 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 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. Performance in this indicator has remained fairly static with a drop below the target for the first time in January 2016 at 76.95%. Remedial work was undertaken by the service to ensure all carers we offered an assessment and recorded. This resulted in improvement in February and March 2016 of 79.62% and 81.37% respectively. This service continues to assess identified carers and signpost them to relevant services where necessary. **This indicator is RAG rated green.**

Improving Access to Psychological Therapies (IAPT)

5.11. NHS Barking and Dagenham CCG is required to deliver two mental health standards related to IAPT; 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%.

Table 1: Performance against IAPT access target Q4 2015/16, Barking and Dagenham and neighbouring boroughs

	HSCIC published figures	Target
NHS Barking and Dagenham CCG	4.24%	3.75%
NHS Havering CCG	3.91%	3.75%
NHS Redbridge CCG	3.16%	3.75%

5.12. Quarter 4 HSCIC figures are provisional.

5.13. It should be noted that the B&D IAPT service has achieved the quarterly IAPT target for the first time this year during Q3 and Q4 provisional figures are also showing that same trend.

5.14. As of the 1 April 2016 CCGs are expected to deliver, in addition to access and recovery standards, a waiting time standard for IAPT. This standard will mean that 75% of people referred to IAPT are treated within six weeks of referral and 95% will be treated within 18 weeks of referral.

5.15. Barking and Dagenham, Havering and Redbridge CCGs have contracted with NELFT to provide the IAPT service and have agreed additional investment to ensure that the capacity is in place to deliver these new targets.

5.16. Delivery of the IAPT access and recovery standards was a component of the CCG operating plan in 2015/16 and continues to be so in 2016/17 in addition to the new standards. BHR CCGs have historically been some of the few in London not attaining the required access targets.

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. DTOC from hospital have remained static at 7.7 per 100,000 population since Q3 of 2015/16. This figure is below the England average of 9.7 but exceeds the London average of 6.9.

6.3. DTOC attributable to social care have declined slightly from 4.1 per 100,000 in Q3 2015/16 to 3.8 in Q4. The borough is now below the England average of 5.3.

Health Checks for people with Learning Disabilities

6.4. Officers in the CCG, CLDT and LA have continued to support GPs to ensure the actions agreed are being implemented. The practice Improvement lead, Lead Nurse and Commissioner continue to attend the PTI forums in order to support the surgery needs on heath check planning and developing health action plans.

6.5. The CLDT continues to validate the details of each of their learning disability register. To date 22 of the 39 surgeries have returned their register for validation. The validation process has identified patients who were previously not known to the CLDT and clarified patients that should be removed from the Learning Disability register. There has been a 120% increase on the number of health checks since January 2016. The previous percentage was 25% it is now reporting 56%.

6.6. CLDT has also begun to facilitate training sessions with providers and service users on the need for, and process of, a health check. This will empower service users to expect a health check routinely when visiting their GP. The issue and importance of health checks are also discussed at the Learning Disability Partnership Board and the 3 sub-group forum that represent Service users, Carers and Providers.

Social Care Admissions

6.7. 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 as at the end of Q4 is 910.0 per 100,000 population (179 admissions). The annual Better Care Fund target for this indicator is 635.93 per 100,000 population so the target has been exceeded considerably. An action plan is in place to improve performance. **This indicator is RAG rated red.**

6.8. The percentage of people receiving care and support in the home via a direct payment decreased from 74.3% in Q3 to 73.2 in Q4. This is also a decrease on the same period last year, when the figure was 76.7%. The target for this indicator is a year on year increase in the number of clients receiving direct payments.

6.9. In keeping with the principles of personalisation service users can choose how they receive services and some prefer to remain on a managed personal budget, due to their circumstances. Where appropriate, work is ongoing to move service users onto a direct payment.

6.10. **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.**

6.11. Falls prevention is a high priority for LBBD, 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.

6.12. Some of the schemes being delivered by LBBD 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.

6.13. 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.

6.14. 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

6.15. **Appendix B contains an overview of CQC inspection reports** published during Q4 2015/16, including those relating to social care providers in the borough, or those who provide services to our residents.

During this period 7 reports were published on local organisations. Of the 4 providers inspected, **3 met the requirement for an overall rating of 'good'; the remaining 4 providers were rated 'requires improvement' and are detailed below.**

6.16. **Darcy House rated 'requires improvement'.** Darcy House is one of 4 extra care schemes operated by Triangle Community Services. Quality Assurance regularly monitors all the schemes and meets with management of both Triangle and the building. We have increased monitoring to ensure that the CQC action plan for improvements is being adhered to.

6.17. **Elora House rated 'requires improvement'.** This home caters for learning disabled people from 18 to 64. There are currently no LBBD services users in this home. After the publication of the CQC report we increased our quality assurance monitoring and also liaised with placing authorities on our findings. The home has made improvements and is working with the CQC action plan.

6.18. **Rupaal Care and Training rated 'requires improvement'**. This is a homecare provider and we currently do not have any service users placed with them on managed personal budgets; however, there may be people using their personal budgets to purchase care from them. We have not had any complaints or safeguarding concerns raised about this provider, however we monitor them as part of our quality assurance framework and they are working to make the required improvements.

6.19. **Br3akfree rated 'requires improvement'.** Br3akfree provides homecare to people with a learning disability. We currently have no service users getting a managed personal budget receiving services from them; however those service users who have a personal budget are free to buy services from a provider of their choice. Br3akfree are part of our quality assurance quarterly monitoring process and we are monitoring their progress with improvements as part of the CQC action plan.

7. Children's Care

Immunisation

7.1. The quarter 3 data available on the uptake of DTaP/IPV (84.1%), year to date, and MMR2 (85.3%) vaccinations, year to date, at five years shows that Barking and Dagenham are performing above the London average, 76.5% and 77.6% respectively; however below the England average, 87.4% and 87.6% respectively. **As a result, this indicator is RAG rated as amber.**

Annual Health Checks of Looked After Children (LAC)

7.2. **Performance improved in Q4.** 2015/16 outturn for looked after children health checks is good with the year end position exceeding national levels, despite concern about mid-year figures. The percentage of looked after children in care for a year or more with an up to date health check increased to 94% compared to 74% in Q3.

7.3. Our end of year performance is 1% better than last year and RAG rated as green as the local target was exceeded and performance remains above national and London averages. **This indicator is RAG rated green.**

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 2: Number of smoking quitters by provider type

	Q1	Q2	Q3	Q4	Total Achieved to date	Annual Target
Referrals	173	214	484	405	**1,276**	TBC
GP	32	23	22	43	**120**	2,000
Pharmacy	72	50	64	94	**281**	
Tier 3	17	15	45	74	**151**	1,000
Total	**121**	**88**	**131**	**211**	**551**	3,000
Target	**750**	**750**	**750**	**750**	**3,000**	

8.2. **In total, there were 211 quitters across tier 2 and 3 services in Q4, which is 61.1% higher than the number of quitters in Q3 (131 quitters) and the highest quarter for 2015/16**.

8.3. There has been a 16% decrease in the number of referrals to the stop smoking service so far between quarter 3 and quarter 4. The quarter 3 figures were high due to stop smoking week activities.

8.4. In comparison to Q3 figures, the number of GP quits has almost doubled. Whilst there were increases in Pharmacy (46.9% increase) and tier 3 (64.4% 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. In total, there were 211 quitters across tier 2 and 3 services in Q4, which is a significant improvement on the previous three quarters and is testament firstly to the work of the then primary care engagement officer who had invested time in visiting and building relationships with Providers over several months. Secondly, a pilot support process was undertaken with Quit Manager to help clean up data and

make telephone follow-ups to non-respondents in order to encourage would be quitters back into the service.

8.7. Going forward for 16/17 PH will continue to support Providers to maintain a quality service, monitor smoking quits on a monthly basis and implement initiatives that will drive smokers into the services.eg mail shots to smokers on practice registers and target high risk groups.

8.8. This indicator has continued to be RAG rated red as it is clearly too great a challenge to achieve the 3000 quits target. Going forward for 16/17 a more realistic target will be set, that will still represent a stretch, but should be achievable. Robust monthly monitoring and detailed action plans will be followed to support the achievement of this target.

8.9. 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 babyClear 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.

8.10. The Tobacco Control Coordinator has produced an action plan document for the Tobacco Alliance to work from in order to achieve the goals set out in the Tobacco Control strategy, The Action plan is in the final phase of allocating tasks and budgets to relevant leads & service managers to undertake specific tasks. Including the smokefree homes programme.

NHS Health Check

8.11. 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 3: NHS Health Check – Part I: Completed health checks for the eligible population

	Q1	Q2	Q3	Q4	Year-to-date	Annual Target
2015/16	2.5%	2.9%	3.2%	**3.1%**	**11.7%**	15%
Target	3.75%	3.75%	3.75%	3.75%	15%	

8.12. **The percentage of completed health checks for the eligible population (Part I) reduced slightly in Q4,** from 3.2% (1,387 completed health checks) in Q3, to 3.1% in Q4 (1,359 completed health checks). This is a reduction on Q4 2014/15 performance, when 1,649 members of the eligible population received an NHS Health Check. The uptake percentage cannot be compared as the base population numbers were changed in 2015/16.

8.13. 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 11.7% against the target of 15.0%.** This will make meeting the annual target challenging. **Performance in this part of the indicator has therefore been RAG rated amber.**

Table 4: NHS Health Check – Part II: Uptake of health checks for those invited

	Q1	Q2	Q3	Q4	End of Year	Annual Target
2015/16	69%	70%	60%	67%	66%	75%
Target	75%	75%	75%	75%	75%	

8.14. **The uptake of health checks for those invited (Part II) increased in Q4.** There was an uptake rate of 67% in Q4. This is an increase on the Q3 rate of 60%, and is also higher than Q4 2014/15, when uptake was 66%.

8.15. 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.**

8.16. **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.

8.17. 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:

(i) minimisation of health check turnaround time, with results available within a minute or two of analysis;

(ii) elimination of time delays as analysis and results are completed within one visit; and

(iii) greater convenience for both the staff conducting the check and the patient receiving it, as there is no longer a need for multiple visits.

8.18. 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.

Breast Screening

8.19. The breast screening indicator is a measure of the percentage of women screened adequately within the previous 3 years on 31 March.

8.20. **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.**

8.21. **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

8.22. 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.

8.23. **The number of positive chlamydia screening results decreased this quarter,** from 125 in 2015/16 Q3 to 120 in Q4. This year's annual target of 596 positive tests has not been met, with a total of 493 at year end. The year end result falls short of this target by 103. As a result, **this indicator continues to be RAG rated red.**

Conception rate in under 18 year olds

8.24. The 2014/15 end of year under 18 conception rate per 1,000 population shows that there has been a 30.9% decrease from 42.4 in 2013/14 to 29.3 in 2014/15.

8.25. The chlamydia screening service provided by the Terrance Higgins Trust has now been decommissioned and cased on 31 March 2016. Mandatory screening functions (reporting to the national database and screening diagnostics) have now transferred to primary care.

9. Mandatory Implications

9.1. **Joint Strategic Needs Assessment**

The Joint Strategic Needs Assessment provides an overview of the health and care needs of the local population, against which the Health and Wellbeing Board sets its priority actions for the coming years. By ensuring regular performance monitoring, the Health and Wellbeing Board can track progress against the health priorities of the JSNA, the impact of which should be visible in the annual refreshes of the JSNA. The JSNA 2016 refresh is underway and will be completed by September 2016.

9.2. **Health and Wellbeing Strategy**

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.

9.3. **Integration**

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

9.4. **Legal**

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

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.

9.5. **Financial**

Implications completed by: Roger Hampson Group Manager, Finance (carried over from previous performance reporting)

There are no financial implications directly arising from this report.

10. List of Appendices

Appendix A: Performance Dashboard

Appendix B: CQC Inspections Quarter 4 2015/16

Key

Appendix A: Indicators for HWBB - 2015/16 Q4

	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: England Average	BENCHMARKING: London Average	HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4							
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%	84.0%			↗	A	87.4%	76.5%	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. Q4 2015/16 data has 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%	93.8%			↗	A	87.6%	77.6%	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	539	1,114	↘	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%	94.2%	94.2%	↗	G	87.7%	89.9%	6	HWBB OF
2 - Adolescence																	
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	42.4	31.0	20.5	37.1	28.6	29.3	..	..	..			↘	R	21.8	18.8	7	PHOF
Number of positive Chlamydia screening results	511	141	141	127	132	541	118	130	125	120	493	↘	R			8	HWBB OF

Appendix A: Indicators for HWBB - 2015/16 Q4

Key	
	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		
3 - Adults																	
Number of four week smoking quitters	1,174	142	162	139	200	643	121	89	131	211	551	↗	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%	3.2%	3.1%	11.7%	↘	A	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. Please note base eligible population changed from 2014/15 and 2015/16.																	
4 - Older Adults																	
Breast Screening - Coverage of women aged 53-70 years	71.2%					64.3%						↘	A	75.4%	68.3%	12	HSCIC
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	910	910	↗	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 standarised rate per 100,000 poulation over 65 years.																	

Key

Appendix A: Indicators for HWBB - 2015/16 Q4

	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

														BENCHMARKING			
Title	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	England Average	London Average	HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4							
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%	73.2%	74.8%	↘	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	7.7	7.5	↗	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	3.8	3.77	↘	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%	79.8%	88.0%	↘	A	94.2%		20	HWBB OF
BHRUT Figure. March 2016 figure is unvalidated.																	
Unplanned hospitalisation for chronic ambulatory care sensititve conditions	1,059.4	220.6	239.0	304.0	252.1	1,015.8						↘	R	807.4	723.3	21	HSCIC

This page is intentionally left blank

Appendix B

Provider Name	Location	Weblinks	Location Org Type	Report Date	Inspection Date	Rating
Dr R Chibber's Practice (also known as Dr Gupta & Partner)	7 Salisbury Avenue, Barking,	http://www.cqc.org.uk/location/1-538798433/reports	GP	10/3/2016	15/1/2016	**Good**
Dr BK Jaiswal's Practice (Julia Engwell Health Centre)	Woodward Road	https://www.cqc.org.uk/location/1-582326413	GP	28/1/2016	20/4/2016	**Good**
Dr AK & S Shah (Goodmayes Medical Centre)	4 Eastwood Rd , Goodmayes	http://www.cqc.org.uk/location/1-568506944	GP	9/5/2016	9/10/2015	**Requires Improvement**

Dr AK & S Shah – CQC Inspection area ratings

Safe: Requires improvement

Effective: Good

Caring: Good:

Responsive: Requires improvement

Well-led: Good

Checks on specific services

Older people: Requires improvement

People with long term conditions: Requires improvement

Families, children and young people: Requires improvement

Working age people (including those recently retired and students): Requires improvement

People whose circumstances may make them vulnerable: Requires improvement

People experiencing poor mental health (including people with dementia): Requires improvement

Appendix B

Provider Name	Location	Weblinks	Location Org Type	Report Date	Inspection Date	Rating
Dr Asma Moghal (Becontree Medical Centre)	RM8 3HP	http://www.cqc.org.uk/sites/default/files/new_reports/AAAF0958.pdf	GP	27/5/2016	11/3/2016	**Requires Improvement**
Dr Asma Moghal - CQC inspection area ratings Safe: Requires improvement Effective: Requires improvement Caring: Good Responsive: Requires improvement Well-led: **Inadequate** **CQC Inspections and ratings of specific services** Older people: **Inadequate** People with long term conditions: Requires improvement Families, children and young people: Requires improvement Working age people (including those recently retired and students): Requires improvement People whose circumstances may make them vulnerable: Requires improvement People experiencing poor mental health (including people with dementia): Requires improvement						
Aspire Dental Care Limited	1-3 Dewey Road, Dagenham,	http://www.cqc.org.uk/location/1-1788549875	Dental Surgery	17/3/2016	12/2/2016	**No action required**
North East London NHS Foundation Trust	Goodmayes Hospital,	https://www.cqc.org.uk/provider/RAT/reports	Provider	26/1/2016	Dec 2014 followed by 20/10/2015	
This inspection found: Staff prescribed and managed anti-psychotic and sedative medicines safely. Staff followed trust procedures to ensure they protected patients from the risk of over-						

Appendix B

		sedation. Staff carried out appropriate checks on the physical health of patients. Staff knew how to access emergency equipment, such as ligature equipment, in an emergency. Staff had developed individual plans to manage risks to the health and safety of each patient. Activities were available to patients on Titian and Ogura wards. Patients on both wards were able to access information about how to complain and advocates visited the wards. **However:** Staff did not always explain in the notes of community meetings how they would address the complaints and concerns patients had raised. Whilst staff appropriately observed patients assessed as being at risk, we identified a number of ligature points on Titian ward. The trust had not completed a risk assessment to identify all the ligature points on the ward and the trust did not have an action plan or schedule of works that explained how the trust would address these risks. Staff had not appropriately assessed or managed potential ligature risks associated with the use of plastic bin bags in communal areas of the ward. Patients could not always keep their possessions secure because on Titian ward there was a blanket ban on patients having the key to the locker in their bedroom. Senior managers informed us during the inspection that they would immediately rectify this and patients would receive a key to their locker unless this posed a risk to health and safety.				
Cherry Orchard	1 Richard Ryan Place, Dagenham	https://www.cqc.org.uk/location/1-469602584#accordion-1	Care homes	11/5/2016	10/2/2016	**Good**
Outlook Care	Maplestead Road	https://www.cqc.org.uk/location/1-124583683	Care home	8/4/2016	18/2/2016	**Good**

Appendix B

Provider Name	Location	Weblinks	Location Org Type	Report Date	Inspection Date	Rating	Comments / Summary
Triangle Community Services	Darcy House	http://www.cqc.org.uk/directory/1-1698526332	Social Care Org	06/01/16	02/11/15	**Requires improvement**	After their inspection in November 2015 the CQC rated requirements as: **SAFE: Requires improvement** Failure to notify CQC of safeguarding allegations **Effective: Good** **Caring: Requires Improvement** Staffing levels not sufficient to meet needs and provide respectful care **Responsive: Good** **Well Led: Good** **Action:** CQC action plan in place and LBBD will continue to monitor the provider.
Elora House	Elora House	http://www.cqc.org.uk/directory/1-146917848	Social Care Org	11/01/15	08&15/12/15	**Requires Improvement**	CQC rated requirements after an inspection in December 2015 as: **Safe: Requires Improvement** No comprehensive risk assessments carried out; Staff did not have criminal records checks **Effective: Requires improvement** Staff training not up to date or regular **Caring: Good** **Responsive: Good** **Well Led: Requires**

Appendix B

							Improvement Own quality assurance systems were inadequate **Action:** LBBD Quality Assurance Officer visited the home after the report was released. The provider had made improvements and was working to implement all the action plan requirements within a timeframe set by CQC.
Faircross 102	Faircross 102	http://www.cqc.org.uk/directory/1-1884064402	Social Care Org	12/02/16	30/12/15	**Good**	CQC rated requirements after an inspection in December 2015 as: **Safe: Good** **Effective: Good** **Caring: Good** **Responsive: Good** **Well Led: Good**
George Crouch Centre	George Crouch Centre	http://www.cqc.org.uk/directory/1-448141860	Social Care Org	11/02/16	23&26/10/15	**Good**	CQC rated requirements after an inspection in October 2015 as: **Safe: Requires improvement** Risk assessments were not comprehensive; Medicines not always managed safely **Effective: Good** **Caring: Good** **Responsive: Good** **Well Led: Good**
Rupaal Care and Training	Rupaal Care & Training Ltd	http://www.cqc.org.uk/directory/1-473061854	Social Care Org	19/02/16	21/01/2016	**Requires Improvement**	CQC rated requirements after an inspection in January 2016 as: **Safe: Requires Improvement** Medicines not always administered or monitored safely;

Appendix B

							Staff recruitment procedures were not robust **Effective: Requires Improvement** Lack of staff training and knowledge around the Mental Capacity Act **Caring: Good** **Responsive: Good** **Well Led: Requires Improvement** Poor record management about the running of the service: Own quality assurance systems were inadequate **Action:** LBBD Quality Assurance increased monitoring.
Diversity Health and Social Care Limited	Diversity Health and Social Care Limited	http://www.cqc.org.uk/directory/1-2001163039	Social Care Org	10/03/16	16/02/16	**Good**	CQC rated requirements after an inspection in February 2016 as: **Safe: Good** **Effective: Requires Improvement** Staff had not had formal supervision **Caring: Good** **Responsive: Good** **Well Led: Good**
Br3akfree Limited	Br3akfree Limited	http://www.cqc.org.uk/directory/1-2161237091		07/03/16	05/02/16	**Requires Improvement**	CQC rated requirements after an inspection in October 2015 as: **Safe: Requires Improvement** **Procedures for recruiting staff were not robust** **Effective: Good**

Appendix B

							Caring: Good **Responsive: Good** **Well Led: Requires improvement** Own quality assurance policy and procedures not followed **Action:** LBBD Quality Assurance increased monitoring

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

Date 14 June 2016

Title: DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT	
Open Report	**For Decision**
Wards Affected:	**Key Decision:**
Report Author: **Matthew Cole, Director Public Health**	**Contact Details:** Tel: 0208 227 3657 Email: matthew.cole@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

The Director of Public Health is required to prepare an annual report on the health of the people in the borough. The report is an opportunity to focus attention on issues of concern and opportunities to improve health. As an independent professional report, the aim is not to make recommendations but to challenge others to propose solutions.

The report has been informed by and supports the achievement of the recommendations of Barking and Dagenham's Independent Growth Commission as well as the Council's and the NHS transformation planning. Our health and life chances are inextricably linked. The importance of 'preventing the preventable'; as part of our plans to transform NHS and Council services is never more obvious as a means to improve the health of residents and future generations.

History shows that austerity has sometimes been important for change in health and social systems. My report takes austerity as a catalyst for change as its basis. The Health and Wellbeing Board is well positioned to know about economic determinants of health and that reduction in social care and health budgets create new inefficiencies, and may increase costs and inequalities. Health is wealth and only healthy populations will be engines for dynamic economies and creators of employment.

Focusing on what matters will enable us to begin to realise the opportunities to improve the health of residents and future generations. In Chapter 1, I examine our borough's Life Expectancy and Healthy Life Expectancy where the challenge of increasing numbers of adults with multiple long term conditions account for a high proportion of need and demand for health and care services. There are a number of known interventions which are explored that have a strong evidence-base and cost-effectiveness in preventing and treating these conditions.

I continue this theme in chapter 2, where health status is for many determined by where they live, by their education, employment, the homes they live in, the lifestyle they choose and how they deal with ill health once it has developed. I discuss these in the context of how planners can shape the borough in ways that address health inequalities over the next 15 to 20 years.

Chapter 3 discusses what health outcomes could be considered for health improvement in the context of our demographic change and 5 year commissioning plans. Chapter 4, follows on neatly to explore the opportunities provided by a partnership-based Accountable Care Organisation method, using devolved powers which would deliver better outcomes for our residents.

In the final chapter, I discuss the scope and scale of health protection work by the Council and Public Health England to prevent threats to health emerging, or reducing their impact, driven by the borough's and London's health risks.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note and comment on the observations of the Director of Public Health in his Annual Report.

Reason(s)

A number of the Director of Public Health's specific responsibilities and duties arise directly from Acts of Parliament – mainly the NHS Act 2006 and the Health and Social Care Act 2012 – and related regulations.

The Director of Public Health has a duty to write a report, whereas the authority's duty is to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

APPENDIX 1 - Director of Public Health Annual Report 2015/2016. Focusing on what matters: Opportunities for improving health

Director of Public Health
Annual Report 2015/2016

Focusing on what matters: Opportunities for improving health

50th anniversary
one borough; one community

London Borough of Barking & Dagenham
lbbd.gov.uk

One borough; one community; London's growth opportunity

The Council's vision recognises that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing.

The borough's corporate priorities that support the vision are:

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

Cover picture: Community Food Enterprise providing freshly made fruit juices at the Eastbrookend Country Fair

Contents

Foreword 2

CHAPTER 1

What matters: Changing the fact that both women and men in Barking and Dagenham live shorter lives when compared to London and England 6

How long are people in Barking and Dagenham living? 8
How long are people in Barking and Dagenham living healthy lives? 9
How can we increase Healthy Life Expectancy in Barking and Dagenham? 10
Deprivation in Barking and Dagenham 10
What are the conditions that are causing our poorer Life Expectancy? 11
How many deaths do we need to prevent to bring Barking and Dagenham in line with the London and the national averages? 11
Chronic obstructive pulmonary disease (COPD) 13
Coronary heart disease (CHD) 13
Newborn and infant mortality 14
Taking action to decrease newborn and infant mortality 14
Cancer 14
Why is Barking and Dagenham an outlier? 14
If we are to tackle one-year survival rates, we have to address variation within general practice 15
Routes to diagnosis that have a significant impact on survival rates in Barking and Dagenham 15
Delivering the Forward View: NHS Planning Guidance 2016/17 16

CHAPTER 2

Growing the borough to improve health 18

Addressing social determinants to improve health in the long term 20
The growth agenda 21
Barking Riverside – London's Healthy New Town 22
Employment and skills 23
One borough, one community? 24
Conclusions 26

CHAPTER 3

Commissioning for Population Health 27

The challenge - We need to get to the root cause of problems 28
What is Population Health? 28
Population Health: The role of commissioners 30
Being clear about the outcomes that matter 32
Conclusions 35

CHAPTER 4

New Model of Care: Accountable Care Organisation 36

What is devolution? 38
What does the evidence tell us about the benefits of establishing an ACO? 39
How can we make it work? 40
Conclusions 44

CHAPTER 5

Protecting the health of the local population: focusing on health protection (infectious disease and non infectious environmental hazards) – the future? 45

Background 46
Consultations – "Securing our future" 46
Infectious Disease Cases and Incidents 47
The future? 54
Conclusion 55

Foreword

Matthew Cole
Director of Public Health

View of Barking Town Square from the 50th anniversary celebrations

Welcome to the Director of Public Health Report 2015/16 which coincides with Barking and Dagenham's 50th anniversary of becoming one borough. The next 50 years are going to be defined by how we use the Council's growth agenda and the investment it brings to release the unmet potential in our communities.

Council Leader Councillor Darren Rodwell health assessment by Harmony Health Clinic

Over the next five years we will need to radically redesign public services to address the scale of the financial savings to be made while the borough's population continues to increase. Meanwhile National Government is implementing reforms that will have a major impact on Council services, residents and local businesses. Collectively they present a profound challenge to many of the prevailing policy approaches of the Council and the services people are accustomed to receiving.

Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide. Instead we need to re-focus what we do so that we identify the root cause of need and tackle it so that the individual or family in question have a better chance of living more independently now and in the future. At the heart of the Council's Ambition 2020 transformation programme[1] has to be the opportunity to improve the health of residents and future generations.

As Director of Public Health it's my responsibility to describe and advocate the need to improve health through a lens that's wider than care to the root causes of our poorer Life Expectancy relative to other London boroughs. In my reports of 2013[2] and 2014[3], I identified a number of opportunities where collectively the partners could use their resources to improve health. Better Health for London[4] and the NHS Five Year Forward View[5] acknowledge that the future sustainability of the local health and social care economy hinges on a radical upgrade in prevention that addresses the wider determinants of health such as income and housing; unless we take prevention and public health seriously, this will adversely affect the future health and wellbeing of residents, particularly our young residents, and the sustainability of the public services.

How we radically transform the relationship between our residents and the Council as well as between patients and the NHS will determine the delivery approaches we take where the best outcomes can be delivered at the right cost. The Health and Wellbeing Board recognises that whatever the solutions, it is increasingly clear that the future depends on much closer joint working between our partners both locally and at London level.

1 http://moderngov.barking-dagenham.gov.uk/documents/g8164/Public%20reports%20pack%20Tuesday%2019-Apr-2016%2019.00%20Cabinet.pdf?T=10
2 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
3 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/018583-BD-Annual-Health-Report-2014-WEB.pdf
4 http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission-Better-Health-for-London.pdf
5 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

A young Barking and Dagenham resident pledging to eat an apple everyday as part of the #makeachange campaign

My report gives a professional perspective that informs this approach based on sound epidemiological evidence and objective interpretation taken primarily from our Joint Strategic Needs Assessment 2015[6]. I hope my observations in the following chapters act as a starting point for systematically identifying 'where to look' before 'what to change' and finally 'how to change'.

In 2010, the 2012 Olympic boroughs agreed "that within 20 years the communities who hosted the 2012 Games will have the same social and economic chances as their neighbours across London[7]. A key outcome agreed was narrowing the gap or difference in both female and male Life Expectancy to the London level. Chapter 1 focuses on our borough's Life Expectancy and Healthy Life Expectancy where improvement is noted, however the nature of the problem includes persistent and widening inequalities in health, the challenge of increasing numbers of adults with multiple long term conditions who account for a high proportion of need and demand for health and care services. There are a number of known interventions which are explored that have a strong evidence-base and cost-effectiveness in preventing and treating these conditions.

I continue this theme in chapter 2, where health status is for many determined by where people live, by their education, employment, the homes they live in, the lifestyle they choose and how they deal with ill health once it has developed. The Council established a Growth Commission in 2015[8] to examine the opportunities provided by becoming London's growth opportunity. I discuss these in the context of how planners can shape the borough in ways that address health inequalities over the next 15 to 20 years.

In chapter 3, I examine what health outcomes could be considered for health improvement in the context of a rapidly changing and growing borough population. Left unchecked, and coupled with entrenched social problems, demand for health and

6 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/?loggedin=true
7 http://www.gamesmonitor.org.uk/files/strategic-regeneration-framework-report.pdf
8 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/

Community Games in Barking and Dagenham

care services will soon become unaffordable and unsustainable. This means we need to be clear about what does and doesn't work so that we increasingly focus our efforts on those things that have the most pivotal impact on Life Expectancy and Healthy Life Expectancy.

Chapter 4 follows on neatly to explore the opportunities provided by a partnership-based Accountable Care Organisation (ACO) method, using devolved powers which would deliver better outcomes for our residents. This will require the creation of an ambitious local blueprint for Barking and Dagenham, Havering and Redbridge health and social care system that is place-based, underpinned by multi-year plans that are built around the needs of residents. Can the ACO method evolve our thinking from purely an integrated care focus for transforming care to one that has concern for the broader health of local populations and the impact of the wider determinants of health?

In the final chapter, I discuss the scope and scale of health protection work by the Council and Public Health England to prevent threats to health emerging, or reducing their impact, driven by the borough's and London's health risks. Changes to the health protection system are being planned and this is discussed in respect of our major programmes such as the national immunisation programmes, the provision of health services to diagnose and treat infectious diseases, surveillance and response to incidents and outbreaks.

I hope you find the 2015/16 Report of the Director of Public Health for Barking and Dagenham of interest and value. Comments and feedback are welcome, and should be emailed to matthew.cole@lbbd.gov.uk

Matthew Cole

Director of Public Health

1

What matters:

Changing the fact that both women and men in Barking and Dagenham live shorter lives when compared to London and England.

Kinder Kitchen serve students at Monteagle Primary School as part of a theme day organised by Barking and Dagenham Catering Services. Photo courtesy of the Barking and Dagenham Post

The funding for local government is set to fall significantly over the next five years. By 2020 the cuts in funding mean that the Council will have roughly half the amount of money that it had to spend in 2010. Because of the growing needs of our residents, we estimate that if we did nothing, there would be a shortfall in our budget of £63 million by 2020. Instead of working out how to make cuts, we have concluded that we need to decide how to best spend what we still have available to us each year.

Diversity with the Olympic torch at the 2012 torch relay events in the borough

This reduction in resources requires us to think differently about the services we provide and how we provide them. It's a huge challenge, but one in which tackling health inequalities is a key goal within the Council's Ambition 2020 transformation programme[1]. In short with our partners we want to focus on increasing Healthy Life Expectancy to improve outcomes such as quality of life and to reduce the demand on health and social care services; in turn, reducing the burden of disease in the borough.

This means re-imagining health care delivery and seeking a system that opens up the definition of health from clinical care to one that also encompasses the wider determinants such as income and educational attainment. There is significant evidence that where and how people live, affects their health. Professor Sir Michael Marmot suggests that 80% of health outcomes are determined by wider factors such as lifestyle choices, the physical environment and family and social networks[2]. I address the wider determinants of health in chapter 2. In this chapter I consider the impact of primary and secondary prevention in the context of disease and Life Expectancy.

There is no doubt that people are living longer than they used to twenty years ago[3]. The reality is that people are often living longer with multiple health needs and long term conditions such as cardiovascular disease including hypertension, chronic obstructive pulmonary disease, diabetes and mental health problems. As a society our failure to prevent these conditions, where they are preventable, has meant that the demand on health and social care services is increasing annually. This trend is set to continue as our ageing population increases; however, it is clear that this state of affairs is not sustainable.

1 Ambition 2020, Barking and Dagenham http://lbbdstaff/Marketing/Pages/Ambition2020.aspx
2 http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
3 Barking and Dagenham, Joint Strategic Needs Assessment 2015 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/

How long are people in Barking and Dagenham living?

Both women and men in Barking and Dagenham live shorter lives when compared to London and England. We also know that Life Expectancy in the borough is lower than in any other London borough. Table 1 shows Life Expectancy in Barking and Dagenham and compares this with London and England, Figures 1a and b show the increasing trend in Life Expectancy in the borough for women and men.

Life Expectancy for females in the borough is increasing generally, but fell in 2012-14 from the high point of 2011-13. Baby girls growing up locally are more likely to die around 13 months earlier than the 'average' English girl. This gap has improved by approximately 6 months over the last 10 years; however, compared with the London average, the gap in Life Expectancy of women has widened by approximately 3 months in the last 10 years.

For males, improvements in Life Expectancy at birth have not been as fast as those seen nationally or in London, and the gap has widened over the last ten years. Baby boys living in Barking and Dagenham are likely to die 23 months earlier than the 'average' English boy. The gap between local Life Expectancy and the national rate has widened slightly in the last 10 years, with the gap being 4 months wider than in 2002-04. This is mirrored when compared with the London average, with the gap being two months wider than ten years ago.

Life Expectancy is a prediction of how long a baby born in this area would live if current age and sex death rates apply throughout its life. Life Expectancy for people has increased over the past 10 years in Barking and Dagenham, in London and in England.

Table 1:

Life Expectancy in women and men 2012-14.

Indicator	Period	England	London Region	Barking and Dagenham
Life Expectancy at birth (Male)	2012-2014	79.5	80.3	77.6
Life Expectancy at birth (Female)	2012-2014	83.2	84.2	82.1

Source: PHOF

Figure 1a:

Female Life Expectancy from birth, Barking and Dagenham, London and England, 2002-2004 to 2012-2014.

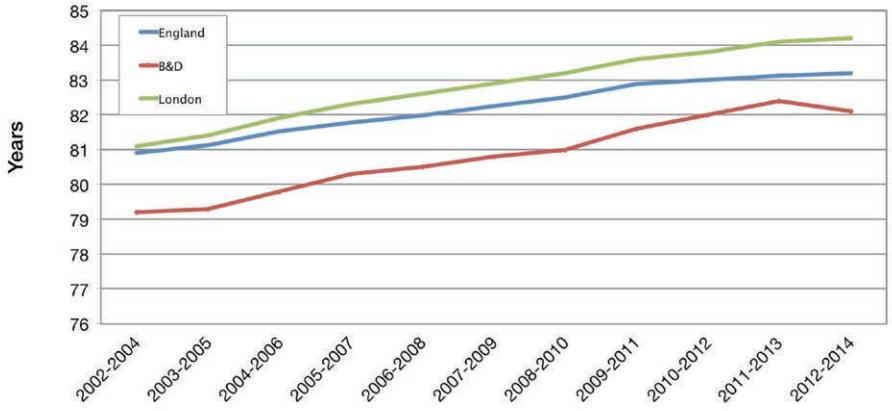
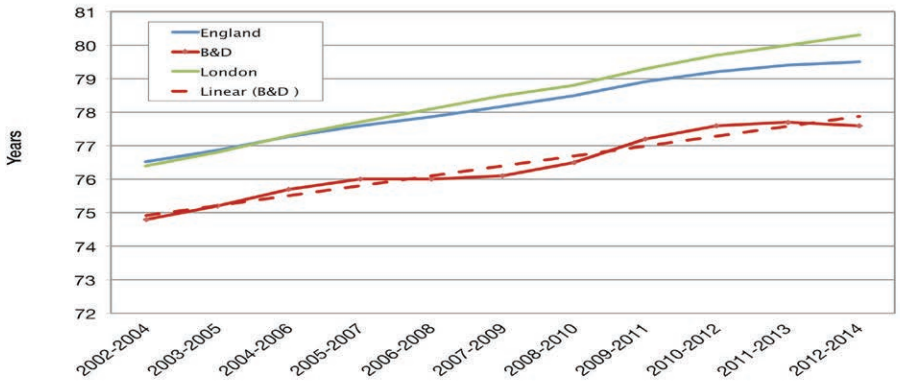


Figure 1b:

Male Life Expectancy from birth, Barking and Dagenham, London and England, 2002-2004 to 2012-2014.



Source: HSCIC/PHOF

How long are people in Barking and Dagenham living healthy lives?

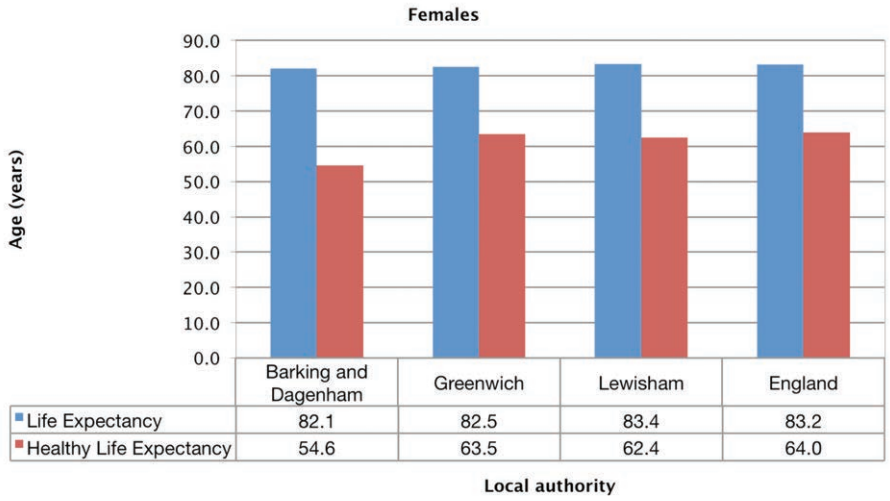
Healthy Life Expectancy in Barking and Dagenham for males is 4 years and for females is almost 7 years lower than the England average, and also is lower than for the most similar statistical neighbours in London (Greenwich and Lewisham). This difference is associated with the number of years' people live with chronic health issues, and often is dependent on health and social care support. Figure 2 compares the Life Expectancy, Healthy Life Expectancy and years with chronic health issues for males and females in Barking and Dagenham, Greenwich, Lewisham and England in 2012-14 (3 year average).

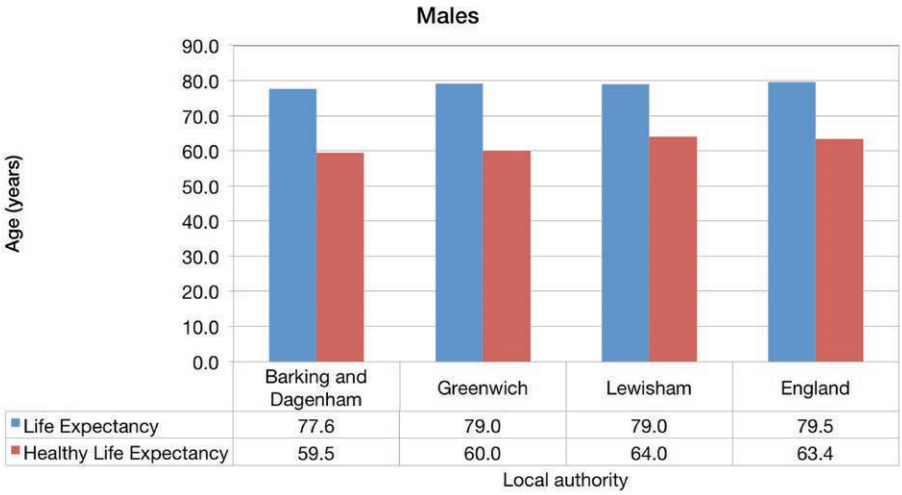
The difference between Life Expectancy and Healthy Life Expectancy shows the years that a person spends in poor health is important because it highlights the years where a person's demands on health and social care are greatest. Our joint Health and Wellbeing Strategy priorities include reducing this gap between Healthy Life Expectancy and Life Expectancy to improve quality of life and reduced demands on the health and care system. Barking and Dagenham has broadly similar figures to our statistical neighbours and England for Life Expectancy, but significantly lower Healthy Life Expectancy for all people, particularly for females.

Healthy Life Expectancy (or disability–free Life Expectancy) is a prediction of the length of time that an individual can expect to live free from a limiting long-standing illness or disability.

Figure 2:

Life Expectancy and Healthy Life Expectancy, Barking and Dagenham, Greenwich, Lewisham and England, 2012-2014 (3 year average).



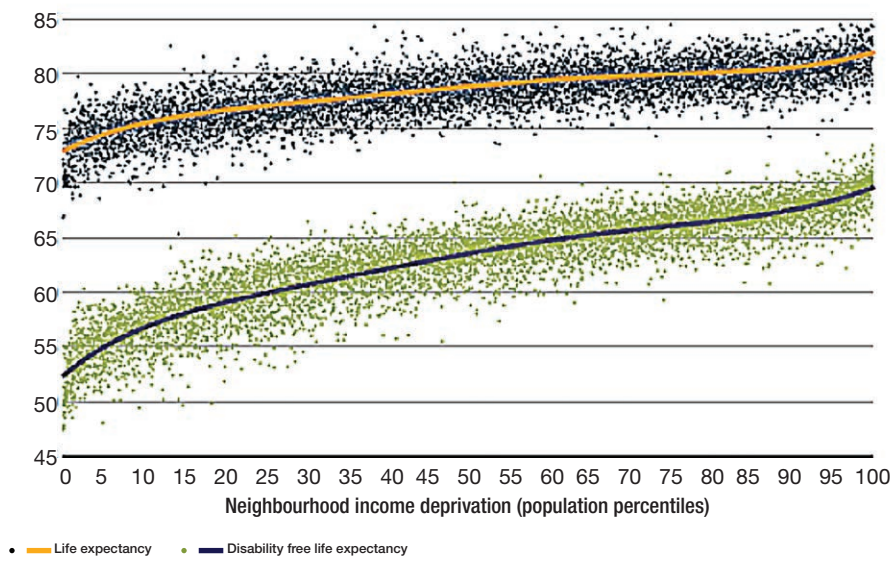


How can we increase Healthy Life Expectancy in Barking and Dagenham?

Fair society, healthy lives, more widely known as 'The Marmot Review' after its author Professor Sir Michael Marmot, has been highly influential in debate on health inequalities policy since its 2010 publication, especially among local authorities and health and wellbeing boards. One of the iconic charts in the review, referred to below as 'the Marmot curve', Figure 3, shows how Life Expectancy and disability-free Life Expectancy (that is, the number of years that we live free from disease) are systematically and consistently related to differences in income deprivation across thousands of small areas in England.

Figure 3:

The Marmot Curve.



Source: Bernstein et al 2010

Note: The original figure was first published in an independent review for government in early 2010, supported by the Fair society, healthy lives team.

Deprivation in Barking and Dagenham

The impact of the factors that affect Life Expectancy and Healthy Life Expectancy on our residents is significant. Barking and Dagenham is the 3rd most deprived borough in London and the 12th most deprived borough in England. This has changed since 2010 when Barking and Dagenham was ranked 7th most deprived borough in London and 22nd most deprived borough in England. It's important to understand that this worsening in rank does not equate to a worsening in deprivation, but rather is a result of a slower relative improvement in the borough than some other London boroughs and local authorities.

Communities like Barking and Dagenham, where residents have low incomes tend to have more ill health and lower Life Expectancy, with more people dying of preventable disease

Young residents of Barking and Dagenham pledging to make a change

before 75 years of age than in less deprived areas. Therefore, delivery of Council plans to achieve priorities will need to target resources to optimise improvements in borough Life Expectancy.

What are the conditions that are causing our poorer Life Expectancy?

More than half of the gap in Life Expectancy and premature death are caused by four conditions: chronic obstructive pulmonary disease (COPD), lung cancer, coronary heart disease and pneumonia. Falls also contribute to mortality in women over 65 and diabetes is one of the causes of coronary heart disease. The commonest causes of premature death (under 75 years old) in men and women are detailed in Table 2 in decreasing order.

Table 2:
Most common causes of ill health and premature death in Barking and Dagenham.

	Men	Women
1	Coronary heart disease	Lung cancer
2	Lung cancer	Breast cancer
3	COPD	Coronary heart disease
4	Stroke	COPD
5	Colorectal cancer	Pneumonia
6	Liver disease	Colorectal cancer

Main Action 1

The London Health Observatory model estimates that around 7,000 people would need to quit annually in Barking and Dagenham to decrease the inequalities gap by around 32% in each sex over 10 years. Of these, it is estimated that 71% (around 5,000 annually) will start smoking again within a year so follow up is required and another quit attempt encouraged.

How many deaths do we need to prevent to bring Barking and Dagenham in line the London and the national averages?

The common feature for all the conditions in Table 2 is that they are caused by smoking and the numbers of smokers in the borough (prevalence). Nationally, 17.2% of people currently die of a condition directly caused by their smoking (Table 3). This proportion will change as the effects of historic smoking prevalence rates work through the life course. In 2014, 218 deaths in Barking and Dagenham were directly attributable to smoking.

Table 3:
Risk percentage population attributable.

Condition	Number of deaths in B&D in 2014	Smoking attributable Percentage, England 2013	Estimated number of deaths in B&D attributable to smoking- 2014
COPD	96	85.3%	82
Lung cancer	93	80.5%	75
CHD	161	13.2%	21
Pneumonia	69	17.9%	12
Total deaths	1,266	17.2%	218

Data source: PCMD and HSCIC – 2013 Statistics on Smoking

In 2009, modelled smoking prevalence in Barking and Dagenham was the highest in London at 32%, and 8th highest in England. By 2013 it was estimated that local prevalence had declined to 23%, still the highest in London, almost 6% higher than the London and 4.5% higher than the national average. In 2014, it was estimated that smoking prevalence had further declined to 21.7% which puts Barking and Dagenham as the fourth highest in London. However, these estimates are based on responses to a national survey and should be treated with caution, particularly in relation to changes and trends. It is, however, clear that smoking is the cause of health problems for many residents in the borough.

In addition, according to research, the majority (two-thirds to three-quarters) of quit attempts are performed without any health service intervention. These have a poorer quit rate than supervised people but this will still be the largest route of quitting in Barking and Dagenham. This is an important route with vaping now being the preferred quit method for the majority of the population in the UK. Modelling would suggest that fewer than 1,000 people quit permanently each year in the borough. The stop smoking service contribution to this would only have been modest – between 140 and 360 people.

To substantially decrease the gap between Barking and Dagenham and the national Life Expectancy rate smoking must be seen as the highest priority. The following are key actions:

i). Increase the stop smoking quitters (at 4 weeks) to at least 2,000 people annually. This quit rate has not been attainable over the past three years in Barking and Dagenham, and in part this is due to the variation in approach in independent practitioners in primary care.

Table 4:

Risk percentage population attributable.

	Estimate of current smoking prevalence	Estimate of number of smokers in B&D if same rate	Numbers needed to quit in B&D to reach same rate as national or regional rates
Barking and Dagenham	21 to 23%	30,100 (28,700 to 31,500)	-
London	17%	23,200	6,900 (5,500 to 8,300)
England	18%	24,600	5,500 (4,100 to 6,900)

Source: PHOF and ONS Population Estimation

Stop Smoking Service with Council Leader Councillor Darren Rodwell, Councillor Saima Ashraf and Councillor Syed Ahammad for No Smoking Day

ii). Catching potential smokers before they start. Education interventions to decrease new starters are effective and the numbers of young people smoking in the borough is low in comparison to national averages.

iii). Creating an environment that makes smoking the hard choice.

iv). Strengthening tobacco enforcement and general education/advertising on how best to quit alone as around 2/3rds of future quitters will not seek any assistance.

v). Training all front line staff to give smoking advice to all smokers.

vi). Increase the extent and diversity of front line staff who can give Level 2 stop smoking advice, so that almost all facilities and staff groups have at least one provider.

Chronic obstructive pulmonary disease (COPD)

There are two main interventions that increase Life Expectancy in COPD. These are:

i). Stopping smoking.

ii). Domiciliary oxygen for those late in the disease.

It is particularly important to identify people with COPD at an early stage in their disease in order to advise on stop smoking techniques and referral for management to give symptomatic relief.

Main Action 2

To eliminate the inequalities gap around 12,000 hypertensives would need to be diagnosed and/or known hypertensives have their blood pressure lowered into the target range over 10 years. It is not just a question of improving blood pressure control as there are only 4,000 people with inadequately controlled blood pressure. Instead, at least 8,000 hypertensives will need to be diagnosed (mainly via the Health Check programme) and the number excluded for not attending or where medication cannot be prescribed, commonly known as exception reported, (820) needs to be reduced substantially. Adequately, treating 1,200 hypertensive's annually would decrease the inequalities gap by around 10% over 10 years.

Coronary heart disease (CHD)

The rate of CHD in Barking and Dagenham is only slightly higher than the national and regional rates. However, this slight elevation results in 11 male deaths and 7 female deaths more than would be expected annually if the local rate was the same as the national rate. The London Health Observatory has performed modelling to show what interventions would have the most effect in reducing cardio vascular disease. These are:

i). Decreasing smoking prevalence:

- In the general population.
- In those at high risk of cardiovascular disease (CVD) or with evidence of the disease. This is likely to include equipping more primary care professionals to deliver stop smoking advice.

ii). Improving blood pressure control:

- Increasing diagnoses of hypertension to raise the prevalence nearer to the expected level.
- Decreasing the number of hypertensives who are excluded from monitoring i.e. exception reported in primary care.
- Improving drug and lifestyle management of hypertension to achieve adequate control.

iii). Controlling cholesterol in those at risk of CVD:

- Assessing all hypertensives for overall vascular risk and commencing a moderate proportion on statins.
- Roll out of the vascular risk assessment project in order to detect more hypertensives and more people at high risk of CVD.

iv). Secondary prevention of CVD:

- This involves maximising the use of drug treatments with a good evidence base.

From a local perspective the work that is required is:

- Detecting more people who have undiagnosed CVD but have not been placed on the primary care registers.
- Decreasing the number of patients with disease who are excluded from performance monitoring i.e. exception reporting in primary care.
- Improving drug and lifestyle management of CVD using well known evidence based approaches. This includes increasing uptake of some of the more 'difficult' treatments like Warfarin in atrial fibrillation and B-blockers in heart failure.

Newborn and infant mortality

There are only a small number of deaths in the first year of life or in the early years but each one causes a disproportionately large decrease in the overall Life Expectancy in the borough. A large proportion of children who die in infancy are born to mothers who have some degree of socio-economic deprivation. Worldwide, the level of infant mortality is more dependent on the educational and economic positions of the mother than the nature and extent of maternity and infant care. Hence, the major inputs into infant mortality include:

i). Collaborative work to increase the wellbeing, education and aspirations of young people, especially women.

ii). Antenatal care aspects especially:

- Stopping smoking.
- Early booking (first trimester) so that maternal or foetal problems can be identified and ameliorated at an early stage.

iii). Delivery and early postnatal care including:

- Promotion and maintenance of breastfeeding.

iv). Care at home including:

- Completion of vaccinations in timely fashion.
- Continuation of breastfeeding to 6 months.

Taking action to decrease newborn and infant mortality

Preventing deaths around birth and in the first year of life are highly effective in decreasing the inequalities gap. Interventions include:

Main Action 3

Each life saved in utero, in the newborn or in the first year of life decreases the Life Expectancy inequalities gap by 0.5% in a single year. Reducing the annual number of deaths to around 17 infants (4.7 per 1,000 births over 3 years) will keep the infant mortality gap to a minimum.

i). Collaborative work to increase the wellbeing, education and aspirations of young people, especially women.

ii). Antenatal aspects especially:

- Stopping smoking.
- Early booking (first trimester) so that maternal or foetal problems can be identified and ameliorated at an early stage.
- Delivery and early postnatal care.
- Promotion and maintenance of breastfeeding.

iii). Care in the first year of life include:

- Completion of vaccinations in timely fashion.
- Continuation of breastfeeding to 6 months.
- Decreasing second hand smoke exposure.

There are very many socio-economic inputs with big effects on infant mortality. They are documented in the next chapter of my report.

Cancer

My aim to improve cancer outcomes demonstrates the need for a radical prevention approach to improve Life Expectancy and Healthy Life Expectancy.

Why is Barking and Dagenham an outlier?

Overall, Barking and Dagenham has the lowest net survival amongst London and West Essex clinical commissioning groups (CCGs), ranking 33 (1 highest, 33 lowest). In part this is due to:

- Low percentage of residents able to recall a symptom of cancer[4].
- Breast cancer screening coverage and uptake is consistently (over the period 2012 -2014) lower than the England average.
- There are 352 cancer deaths per 100,000 people each year. This is higher than the England average.
- Low bowel screening uptake.
- Two-week wait conversion rate. This is the number of referrals from general practice against the number of cancers detected.
- 25% of patients with cancer are diagnosed via emergency care services.
- Significantly lower Healthy Life Expectancy.

In 2009/10, only 31% of residents could recall a lump or swelling as a sign of cancer (68% England, 57% Havering and 50% Redbridge). This meant that we were the 2nd lowest out of 22 CCGs (Primary Care Trusts) in London who were surveyed using the Cancer Awareness Measure. Although one-year net survival index for Barking and Dagenham has increased steadily with 63.9% of those with all newly diagnosed cancers surviving one year or more in 2012 (ONS), it is lower than the London average of 69.7% and the overall England figure of 69.3%.

4 http://www.cancerresearchuk.org/health-professional/prevention-and-awareness/the-cancer-awareness-measures-cam

If we are to tackle one-year survival rates, we have to address variation within general practice.

Table 5 shows the considerable variation in early diagnosis within our general practices. Caution should be used when interpreting 0 as the bottom of the range.

Screening has a huge part to play in addressing one-year survival. About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying each year (Cancer Research, 2013). Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16% (Cochrane Database of Systematic Reviews, 2006). Colorectal cancer (using the faecal occult blood test) screening programme's target is 60% of patients with a definitive screening result, out of those invited. Uptake in Barking and Dagenham is below the England average and the screening programme target.

Routes to diagnosis have a significant impact on survival rates in Barking and Dagenham:

Table 6 identifies all malignant tumours newly diagnosed between 2006 and 2013 as well as selected benign and in-situ tumours. The methodology is consistent with previous work on the routes to diagnosis of cancers. Improved linkage to Hospital Episode Statistics data has helped to reduce the proportion of tumours with an unknown route and provided a better understanding of how other routes originated.

If we examine further the routes of diagnosis and compare against 1-year survival rates in Tables 7 and 8 clear inequalities can be seen.

Table 5:

Indicator	Barking and Dagenham	England	Lowest	Highest
Two-week conversion rate	8.6%	8.4%	0%	22%
Breast screening	68.6%	77%	30%	82.1%
Bowel screening	43.7%	58.8%	28.1%	52.3%

Table6:

	Routes to diagnosis - 2006 to 2013. All tumours (excluding C44)								
	Screen detected	Two week wait	GP referral	Other outpatient	Inpatient elective	Emergency presentation	Death certificate only	Unknown	Number of cases
2006	3%	20%	27%	11%	2%	32%	0%	5%	793
2007	1%	26%	30%	11%	2%	26%	0%	4%	771
2008	8%	24%	30%	9%	2%	26%	0%	2%	852
2009	4%	26%	34%	10%	1%	24%	0%	2%	875
2010	2%	29%	32%	10%	1%	24%	0%	2%	781
2011	8%	28%	27%	11%	1%	22%	0%	3%	809
2012	3%	34%	27%	11%	1%	22%	1%	2%	842
2013	1%	32%	28%	13%	1%	23%	1%	2%	818

Table 7:

Lung Route to Diagnosis - % for those diagnosed between 2006 and 2010, England.

Lung	All routes	Two Week Wait	GP referral	Other Outpa-tient	Inpatient Elective	Emer-gency Presenta-tion	Unknown
Route	-	**24%**	**21%**	**10%**	**2%**	**38%**	**3%**
1-year survival	**29%**	**42%**	**38%**	**42%**	**32%**	**11%**	**23%**

Table 8:

Breast Route to Diagnosis - % for those diagnosed between 2006 and 2010, England.

Lung	All routes	Screen detected	Two Week Wait	GP referral	Other Outpa-tient	Inpatient Elective	Emer-gency Presenta-tion	Unknown
Route	-	**28%**	**43%**	**16%**	**3%**	**0%**	**5%**	**5%**
1-year survival	**96%**	**100%**	**98%**	**96%**	**91%**	**85%**	**50%**	**95%**

Delivering the Forward View: NHS Planning Guidance 2016/17[5]

The guidance describes Ambition 2020 for cancer in respect of the Government's mandate to NHS England 2016/17. Overall the 2020 goal is to deliver the recommendations of the Independent Cancer Taskforce[6], including:

- Significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (up from 69% currently); and
- patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.

The clear priority and deliverables for 2016-17 include:

- Adult smoking rates should fall to 13%.
- 57% of patients should be surviving for 10 years or more.
- 1 year survival should reach 75% for all cancers.
- 95% with a definitive cancer diagnosis within 4 weeks or cancer excluded 50% within 2 weeks.
- 75% bowel screening uptake.
- Achievement of cancer waiting time standards of 2 weeks, 31 days and 62 days.

The Health and Wellbeing Board in its system leadership role will need to focus on the following, if we are going to deliver the 2020 cancer goals:

Prevention

- Supporting a radical prevention approach to improve recall of signs and symptoms.
- Ensuring an active smoking control plan is in place.

Early Diagnosis

- Supporting primary care to reduce variation, improve early diagnosis and 1 year survival.
- Increasing the uptake of effective screening programmes e.g. cervical cancer screening, bowel cancer screening.
- Encouraging the population to present and improving access to primary care.

Survivorship

- As at the end of 2010, around 3,600 people in the borough were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 7,000 by 2030.
- Endorsing a move towards cancer being viewed as a long term condition.
- Encouraging improved, standardised Cancer Care Reviews in primary care.
- Lifestyle schemes are commissioned but currently underutilised.

Mental Health

Equally as important as physical health is mental health and although I have not reviewed the evidence base in this chapter mental health also impacts on Life Expectancy[7]. It's long been known that people with mental health problems tend to live shorter, less healthy lives, than people who are more resilient. In part this is due to the drug and alcohol dependency that people with mental health problems experience, and also due to the impact of drugs used to treat mental health problems.

There is a very large gap in Life Expectancy between people with mental health problems and the general population. A woman born in 2009 is likely to die twelve years early and a man is likely to die sixteen years early. Although suicide has some impact on the Life Expectancy of people with mental health problems, at most 20% of all early deaths are as a result of suicide, all other early deaths are as a result of medical conditions. This is not an acceptable position to be in and the borough has in place plans to improve both adult and children's mental health.

Conclusion

We need to address variation in care offered across the life course. In the cancer example we want to be able to say that our patients are diagnosed faster, have a better chance of survival, a better experience of care and are better informed and supported. The development of new models of care has to reduce variations in care from the front door, primary care providers, through to our hospital and community services.

The evidence base for what works and impacts on Healthy Life Expectancy and Life Expectancy is vast. This is best represented by Figure 4. In a very simple way this diagram shows that social determinants of health, such as housing, can take up to 15 years to impact on health, lifestyle interventions take up to 10 years and clinical interventions take up to 5 years to impact. It is important that all three approaches (A-C) are taken as shown in Figure 4. I examine this in chapter 2.

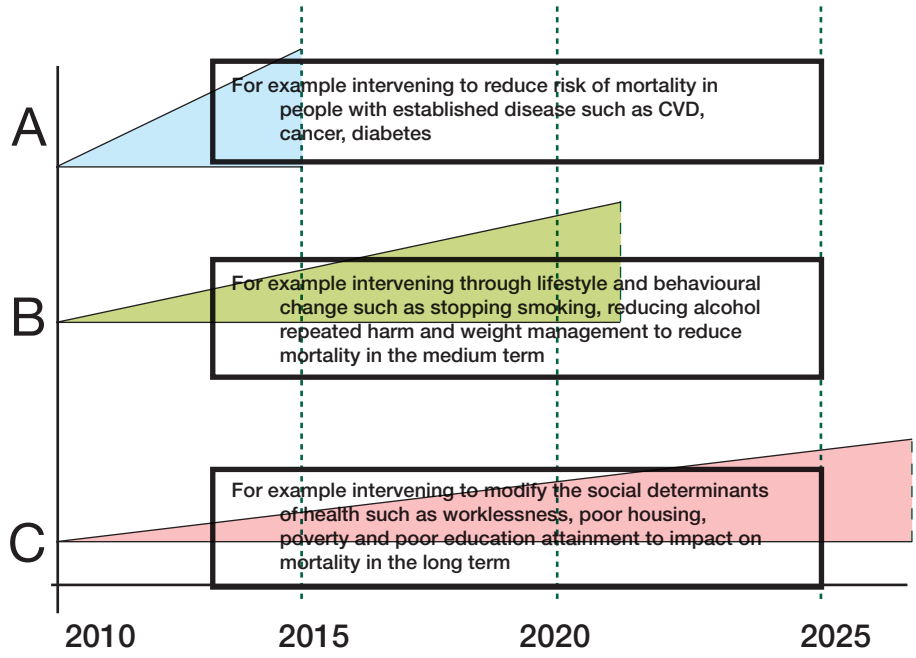
5 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
6 http://www.cancerresearchuk.org/about-us/cancer-taskforce
7 Lawrence, D (2011) Life Expectancy Gap Widens Between Those with Mental Illness and General Population. British Medical Journal. 21 May 2013.

While there are a number of known interventions that have a strong evidence-base and cost-effectiveness in preventing and treating the health conditions that lead to pre-mature death and ill health in respect of intervention design there is no one-size fits all solution that works across all community groups. For this reason, insight into our resident's needs and into the evidence-base is critical to the delivery of successful programmes to achieve good outcomes.

Implementation of the Council's Ambition 2020 programme and The Five Year Forward View both provide the opportunity to integrate approaches to commissioning and take more radical action on prevention. It is essential that we engage communities in developing all our plans and also to implement a combination of individual and societal interventions. These interventions can be universally applied and also targeted to reach those with the greatest need to improve the health of the poorest fastest.

Figure 4:

Health Inequalities, Different Gestation Times for Interventions.



Source: Health Inequalities National Support Team (2009)

Raising awareness of the impact of domestic violence on individuals, families, communities and services. Supporters included Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health, and Chair of the borough's Health and Wellbeing Board

2

Growing the borough to improve health

Barking Riverside new housing opposite lake

In 2015, the Council asked a team of independent experts to form a Barking and Dagenham Growth Commission[1], to review our ambition to be London's growth opportunity and recommend how to maximise the contribution of the borough to the London economy; generating growth in Barking and Dagenham in a way that benefits all residents. Their report was published on 24 February 2016 and included 109 recommendations.

Councillor Evelyn Carpenter Member of the Health and Wellbeing Board and children from Northbury Primary school planting apple and pear trees in Barking Park to encourage healthier eating

The growth agenda gives us a chance to shape the whole borough very differently in the longer term with up to 35,000 new homes and 10,000 additional jobs over the next 20 years. It also brings challenges, in particular maximising the opportunities for improving health and tackling the inequalities. The challenge continuing on from chapter 1 is narrowing the gap in Healthy Life Expectancy in Barking and Dagenham compared to London. The outcome is defined in our joint Health and Wellbeing Strategy[2].

There is substantial scope for improvement in both Life Expectancy and Healthy Life Expectancy. Both aim to narrow the gap between those with poor health status and the population as a whole, a gap that is generally widening. Achievement of narrowing the gap is not only about saving lives overall, but is about ensuring that a higher proportion of the gains are made by those in poorer circumstances. It focuses attention on the distribution of health benefit, rather than simply on overall health outcomes from the provision of programmes and services. Improvements in Life Expectancy will be achieved through the wide range of actions recommended by the Commission.

The latest official Life Expectancy data for 2012-14 shows that Healthy Life Expectancy in Barking and Dagenham is lower than that for London as a whole with Healthy Life Expectancy in the borough being 4.5 years less for males and 9.5 years less for females. Over the next 15 years we need to increase the Healthy Life Expectancy trajectory to achieve the London rate. For illustrative purposes in Tables 1 and 2 the values are based on a linear regression line generated from the three year rolling data based on 2009-11 to 2012-14. Table 1 predicts the current trend in both London and Barking and Dagenham over the next 15 years.

1 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/
2 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-policy-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

Table 2 examines the increased Healthy Life Expectancy trajectory to the London rate. In order for Barking and Dagenham to reduce the Healthy Life Expectancy gap with London and match Healthy Life Expectancy for males and females in 15 years time (2030) there will need to be a 2.4 year improvement in the next five years for males and 10.6 year improvement for females as described below.

This chapter draws on the evidence from the expert Growth Commission and elsewhere. I explore the potential for addressing the social determinants and for reducing inequalities in health for the whole borough.

Addressing social determinants to improve health in the long term

Inequalities in health result from inequalities in society, not simply because of inequalities in healthcare. Lack of access to high quality healthcare can contribute to health inequalities, and universal access is necessary to deal with problems of illness when they arise. But and it is an important but, if the causes of health inequalities are social, economic, cultural and political, then so should be the solutions[3].

A clear understanding of health inequalities is paramount for the development of our Growth policies and interventions that support all our communities in Barking and Dagenham. Many researchers view social position as the fundamental cause of ill health[4]. Using a pathways approach, important influences on population health are presented in the form of an interlocking framework. Factors such as the education system and labour market, and the structure of society, help shape people's lives. An individual's social position, based on for example socioeconomic factors, sex, ethnicity and sexuality, affects their access to resources and relative exposure to health risks. Intermediary factors, including personal behaviour or lifestyle, environmental factors such as poor housing and the provision of health and social care, impact on health outcomes or a person's health and wellbeing.

Social determinants of health and health are inextricably linked. The cost to society, for example, from transport-related poor air quality, ill health and accidents is at least £40 billion per year[5]. Figure 4, chapter 1 shows the different gestation times for interventions (with people with established disease, lifestyle factors or via social determinants) to address health inequalities. The time lag for impact of social determinants is 0-15 years. Whilst the lag might be many years Marmot would argue that the social determinants approach, via housing and employment or environmental factors for example,

Table 1:

Projection of Healthy Life Expectancy linear progression from 3 year rolling averages.

	Males			Females		
	B&D	London	Difference	B&D	London	Difference
2015-17	60.4	64.4	4	51.2	64.3	13.1
2020-22	60.9	66.0	5.1	45.6	64.9	19.3
2025-27	61.5	67.6	6.1	40.0	65.4	25.4
2030-32	62.0	69.2	7.2	34.4	66.0	31.6

Table 2:

Increased Healthy Life Expectancy trajectory to the London rate.

	Males			Females		
	B&D Projected	B&D Target	Difference	B&D Projected	B&D Target	Difference
2015-17	60.4	60.4	-	51.2	51.2	-
2020-22	60.9	63.3	2.4	45.6	56.2	10.6
2025-27	61.5	66.2	4.7	40.0	61.1	21.1
2030-32	62.0	69.2	7.2	34.4	66.0	31.6

3 http://www.bris.ac.uk/poverty/downloads/keyofficialdocuments/Tackling%20HE%2010%20years%20on.pdf

4 http://nwph.net/nwpho/inequalities/health_wealth_ch2_(2).pdf

5 http://www.instituteofhealthequity.org/projects/understanding-the-economics-of-investment-in-the-social-determinants-of-health

has the most impact in the long term at reducing inequalities in health[6]. The Growth Commission supports this approach stating that the focus of the Council and its staff should be on "enabling every resident of the borough to fulfil their potential through the reform and the delivery of services aimed at reducing dependency and increasing employment, skills and growth in every part of the community"[7].

The growth agenda

The Commission has advised the Council to focus on its much wider role of shaping local places. The opportunities to radically improve health lie in promoting economic, social and environmental wellbeing at the local level, for which it is ideally placed to deliver on behalf of residents.

There are 7 growth hubs which are the focus for the next 20 years in the borough[8]. Alongside the capacity for 35,000 new homes and 10,000 additional jobs, developments include transport infrastructure, industrial development (including on the former Ford stamping plant), green energy industries and advanced manufacturing industries, social infrastructure such as schools and health and social care as well as plentiful green and blue spaces including parks, nature reserves and two rivers.

The first of the Barking and Dagenham major growth areas and part of the London Riverside opportunity area is the Barking Riverside development[9]. Figure 1 shows a plan of this area.

Figure 1:

Artist impression of Barking Riverside Development

It is being developed on mainly brownfield, ex–industrial sites. It sits within Thames electoral ward, a ward with some of the worst socio-economic and health outcomes of the borough. There is planning permission for 10,800 new homes by 2031– a new town similar to the size of Windsor. This will be supported by 65,500 square metres of commercial, retail and leisure space that will create an estimated 3,000-3,500 temporary construction jobs and 2,500 new permanent jobs. There will be five new schools, health centres, places of worship and community facilities. Transport developments will also be key, for example the extension of the Barking to Gospel Oak overground line into Barking Riverside. There are plans for extensive new sports facilities, play stations, public open spaces, extensive parkland, nature reserve, green belt and there will be a reconnection of residential areas to 2km of the River Thames as well as other areas of open water (blue spaces). An innovative feature is a Community Interest Company (CIC), ultimately to be predominantly residents that will manage the public realm of Barking Riverside[10]. Work has already started and there are currently nearly 700 units built. This is a mix between private and affordable homes. Schools and green space developments are in place.

6 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235358/
7 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/
8 https://www.lbbd.gov.uk/wp-content/uploads/2014/09/GrowingTheBorough.pdf
9 https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/london-riverside
10 http://moderngov.barking-dagenham.gov.uk/mgOutsideBodyDetails.aspx?ID=543

Barking Riverside – London's Healthy New Town

For Barking Riverside, as a new area on a brownfield site we can plan to get the social determinants of health right from the start. We can develop our housing, the built environment, use of green and blue spaces and economic regeneration to maximise health. This is a powerful opportunity to build a healthy new town. In recognition of this the area has now been designated a Healthy New Town (HNT) – the only one in London and one of 10 in the country. In chapter 4 I also examine this approach in context of the Accountable Care Organisation method.

The HNT affirmation brings access to expertise and some limited funding to rise to the challenge of regenerating the area in a way that improves health. As Barking Riverside will be built as a staged process over a further 15 years we have unique opportunities to work with our partners to evaluate impact and improve upon this as we go along and also to learn from other growth areas in the borough. The HNT proposal identified creation of an "age friendly" built environment and new models of health and social care as key opportunities. The proposal also majored on the use of green and blue spaces, community involvement and social and economic regeneration, including employment and skills, as key issues for Barking Riverside.

Looking in detail at two of these aspects, utilisation of green and blue spaces and the development of employment and skills, we can see how they offer opportunities to improve health through addressing the wider determinants.

Green and blue spaces

Green spaces include parks, gardens, natural and semi-natural urban spaces, green corridors, outdoor sports facilities, community gardens, and landscape around buildings[11]. Blue spaces cover ponds, lakes, canals, rivers, and any other areas of open water.

Why are they important?

Green and blue spaces bring a range of health benefits: the health benefits of green spaces include: space for physical activity (impacting on obesity), improved mental health (for those living in green areas), community cohesion and participation (for example, through a wide range of activities with vulnerable groups). Other impacts include benefits from community gardens in an improved environment, increased opportunities for older people to live independently and potentially reducing food poverty. Whilst there is less evidence for blue spaces[12] they have been shown to improve mental health (psycho restorative effect), and provide opportunity for physical activity and community participation[13].

Opportunities from the green and blue spaces in Barking and Dagenham: green spaces comprise 34% of the borough. Barking Riverside has 2 km of frontage on the River Thames and access to the River Roding. There are sports facilities, open spaces, a nature reserve and green belt.

Inequalities in access and use of green spaces: despite the large amount of green space in the borough we have one of the lowest levels of utilisation in England. There are also parts of the borough with limited green space; in 4 wards more than 50% of the households have inadequate access to nature and green space. Nationally the most affluent 20% of wards have five times the amount of green space as the least affluent 10%. There are also inequities in utilisation by vulnerable groups such as the elderly, disabled and urban deprived.

Potential to improve poor health outcomes in the borough: in Barking and Dagenham we have the highest rate of adult obesity in London and high childhood obesity rates (26.2%) and low levels of physical activity (less than half our adults) compared to London and England[14]. Physical inactivity and obesity are risk factors for major causes of premature mortality in our residents: cancer (lung and colorectal) and cardiovascular disease (heart disease and strokes).

The future pattern of land development will shape the choice and mode of travel for future generations, as well as determine housing location and affordability. Evidence clearly shows that people who live in spread-out, car-dependent neighbourhoods are likely to walk less, weigh more, and suffer from obesity and high blood pressure and consequent diabetes, cardio-vascular and other diseases, compared to people who live in more efficient, higher density communities with access to green space (Ewing et al, 2003a).

11 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
12 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
13 http://www.ecehh.org/research-projects/blue-health/
14 http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

What works?

Reasons given for not using green and blue spaces include poorly maintained spaces, fear of safety, inadequate facilities and lack of transport. Accessible, good quality green spaces increase their utilisation. The evidence suggests that development of new spaces or physical regeneration of old spaces increases utilisation. Few studies demonstrate outcomes or address inequities or uptake by socially excluded groups[15].

A cost effectiveness study showed £23 returned for each £1 spent in the Birmingham "Be Active" programme[16]. There are fewer studies of blue spaces, particularly fresh water, than of green spaces. However, the issues about access and use overlap with green spaces[17]. A new study of the use of blue spaces, "Blue Health", is in development and we are in liaison with the researchers[18].

Parsloes Park, Dagenham

Issues to consider

We have opportunities in our growth areas with plentiful blue and green spaces. A health impact assessment (HIA) of the green and blue spaces of the development built so far on the Barking Riverside site identified some issues for consideration including the role of the CIC in ensuring places are well maintained and actions to maximise wider health benefits such as tobacco free spaces and improved mental health. The HIA highlighted the importance of addressing issues such as transport (linked with active travel), fear of crime and affordability of formal facilities to ensure accessibility[19]. There is a gap in the evidence base regarding uptake by socially excluded groups and impact upon inequalities in use or access of green spaces. We have an opportunity to work with academics to strengthen this research area and help to optimise the health benefits for the development.

Employment and skills

Why is this important?

Addressing the link between employment and skills and health: unemployment impacts on health through lower living standards, also influencing social integration and self-esteem; through increasing distress, anxiety and depression and through impacting upon health behaviours (such as lower rates of physical activity)[20]. The relationship between unemployment and health is cyclical: unemployment leads to poor health and poor health increases the risk of unemployment; the two becoming mutually reinforcing[21].

Evidence suggests one in seven men develop clinical depression within six months of leaving their job. Good work is generally good for wellbeing but this is not necessarily the case for poor quality work. Job stress, job insecurity and lack of job control are strongly

15 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
16 http://www.instituteofhealthequity.org/projects/understanding-the-economics-of-investments-in-the-social-determinants-of-health
17 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
18 http://www.ecehh.org/research-projects/blue-health/
19 Wright F. Retrospective rapid health impact assessment (HIA) of green and blue spaces of Barking Riverside development to date. Barking and Dagenham Council, 2016.
20 http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
21 https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-dame-carol-black-review

related to poor mental and physical health outcomes[22]. Many people who are in paid employment live in poverty. Education and skills provide a route to good quality employment as well as increasing health literacy, reducing the risk of ill health[23] and increasing Life Expectancy.

Providing opportunities for employment and skills in the borough: the borough has a strong history of industry - most notably Ford, which is still a local employer[24]. There are new opportunities within the creative (such as the Ice House Quarter), advanced manufacturing and green energy industries. Developments of the health and social care sector include key worker housing and skills development in the innovative Care City test bed site[25].

High unemployment and low skill levels: unemployment rates are higher than London and England at 13.1% compared to London's 6.5%. More than 10,000 residents have been claiming out of work benefits for more than a year (8.5% of working age) – the third highest in London (6.3%). For full time workers in the borough the median hourly pay is the third lowest in London and one of five are earning less than the £9.20 that is effectively equivalent to the London Living Wage[26]. 42% of our residents of working age are unable to understand and make every day use of health information[27].

Potential to improve poor health outcomes: good quality work and higher educational attainment can reduce the risk of unhealthy lifestyle behaviours and increase Life Expectancy. As discussed in chapter 1 smoking rates in the borough (23.1% of adults) are amongst the highest in London and both Life Expectancy and Healthy Life Expectancy for men and women in the borough is amongst the lowest. Women in our borough spend on average 26.9 years in poor health (difference between Healthy Life expectancy and Life Expectancy).

What works?

For most families' an adequate income is essential to live a healthy life. More widespread adoption of the living wage can reduce the number of working families on low income and improve public health, provided that the increase in wages is not cancelled out by reductions in benefits. Increasing benefit uptake amongst eligible households alongside addressing low wages is also important[28].

We can also improve the health of employees through positive work cultures, development of health promotion initiatives and establishing systems to recognise and manage ill health. Supported employment and job retention schemes, for example for people with mental health problems, are beneficial. Employee wellness programmes have been shown to return between £2 and £10 for each £1 spent[29].

Issues to consider

The Growth Commission proposes bringing in key work opportunities including the Billingsgate fish market[30]. The Greater London Authority runs a Healthy Workplace charter award scheme that recognises good quality employment. The Council could lead the way and encourage partners and businesses to aim to achieve this award alongside implementation of the healthy living wage. Care City is an opportunity for skill development and key worker roles in health and social care.

One borough, one community?

Improving health or reducing inequalities?

The growth of the borough will bring communities into new, mixed tenure houses. Some of these will be more affluent people into a very deprived borough, potentially increasing both wealth and health inequalities. Whilst it may be welcome or necessary to do this for local economic regeneration (especially in a financially tight environment), arguably this presents the biggest challenge for improving health and, with that, reducing health inequalities through the growth agenda.

We know that policies may inadvertently widen health inequalities

22 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
23 http://www.nber.org/digest/mar07/w12352.html
24 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/
25 http://carecity.london/
26 http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/previousReleases
27 http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-80
28 http://www.instituteofhealthequity.org/projects/health-inequalities-and-the-living-wage
29 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
30 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/

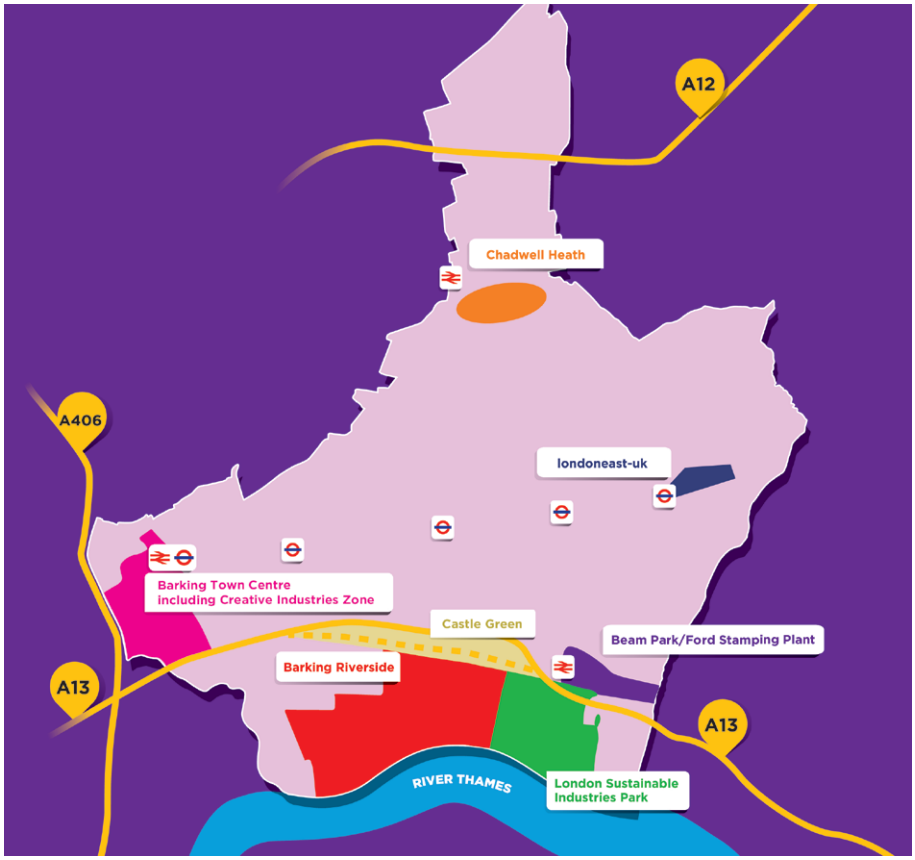
unless we specifically work against this[31]. There are plenty of examples of this such as uptake of screening programmes which are accessed disproportionately by more affluent groups. Even when taking action to address social determinants of health, such as in this regeneration programme, it is important to ensure our policies narrow rather than widen inequalities in health.

Wilson and Pickett[32] explain that more equal societies are healthier societies. Less equal societies have poorer health outcomes, not only for those who are less affluent but for the affluent in those societies. Also strong social capital improves the health of the less advantaged in that community[33].

To achieve a healthy new town, it is important to have community cohesion and social capital. How do we bring old and new communities together so "no one is left behind"? How do we truly develop a growth area and the surrounding areas in the borough to achieve equality of health, social, economic outcomes over the coming years? How do we maximise assets in the borough and in the growth areas so as to ensure that health inequities are narrowed and not widened?

Some approaches and principles

The two examples above give insights into the potential for positive or negative impacts on community cohesion within a society and on inequalities. Inequities in access or utilisation of green spaces or of employment opportunities are seen by socio economic group and by vulnerable groups such as the elderly or disabled.



Barking and Dagenham's growth hubs

Notably much of the research evidence for both examples discusses the impact on health and fails to evidence impact on health inequalities or cost effectiveness. There are examples of good practice but these are often poorly evaluated. Resources for evaluation and health impact assessments of new developments will be important to further develop the evidence base. Local assets, such as the River Thames, as well as new creative or green technology industries are there to be maximised but again we need to be mindful to promote equity of access. For example, we should keep down costs of using formal recreation facilities so as not to exclude low income groups and should skill up lower socio-economic groups to be able to obtain employment.

We can see that health cuts across different social determinants. A health in all policies approach is needed. For example, to maximise the health benefits of green spaces, accessible transport is needed. There are strong recommendations throughout the report of the Growth Commission about the importance of involving communities in planning and delivery of policy in order to address inequalities[34]. The CIC for Barking Riverside is an example of this.

31 https://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report
32 https://www.equalitytrust.org.uk/about-inequality/spirit-level
33 personal communication Dr Tim Huijts, Lecturer in Global Health, Queen Mary's University,2014
34 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview/2

Figure 2 proposes some principles to consider in policy development in order to achieve a reduction in inequalities. These are by no means complete as these issues are complex and challenging and merit further exploration. However, building on the expertise from the Growth Commission we will seek support from experts within the Healthy New Towns network to consider how we can address inequalities and community cohesion to ensure no one is left behind as we grow our borough.

Figure 2:

Key approaches to consider in addressing inequities in the long term.

- **Address social determinants of health.**
- **Utilise local assets.**
- **Take a "health in all policies" approach.**
- **Implement proportionate universalism – mindful of a social gradient in many health outcomes - rather than just focusing on the most vulnerable.**
- **Consider vulnerable groups, such as the mentally ill or people with learning disabilities.**
- **Use health impact assessments and health inequality impact assessments to maximise positive impacts for the disadvantaged.**
- **Put resources into monitoring and evaluation, including of equity.**
- **Involve communities in decisions, planning and delivery.**

Conclusions

The Council and our partners' commitment to reduce inequities and address the root causes of ill health are outlined in our joint Health and Wellbeing Strategy and Local Plan[35]. Although the Growth Commission has refreshed our ambition of shaping a borough where people want to live, work, invest and visit whilst enabling our residents and businesses to achieve their potential, the basic principle has not changed. It is important to recognise the progress made over the last 10 years and look forward towards the next 10 years.

The Commission recommended developing a Borough Manifesto that casts our vision into concrete 20 year goals. These are to be developed in consultation with residents, businesses and partners. Learning from the failure to capitalise on the Olympic legacy, we then stick to it like glue delivering a step-change in regeneration activity in Barking and Dagenham. The Manifesto underpinned by our Local Plan will drive an integrated programme of activity across the borough, taking advantage of our key assets and tackles constraints on growth. As with other interventions, planning solutions need evaluation of their appropriateness, cost and effectiveness, to help avoid future costs associated with ill-health, and wasted expenditure on what may be poorly designed, ineffective prevention approaches.

The 'lost art' of undertaking local health impact assessments, especially around policy and planning will need to be found again. This will involve working with partners on policy aimed at reducing the impact of social disadvantage on health and minimising the influences that the physical and social environment has on health. Good health impact assessments move beyond the purely technical assessment of impacts on outcomes, to include community views. Imposing solutions on the public will be neither welcomed nor sustainable; and what matters to the public is not always what matters to experts. This commitment to improvement is an opportunity not to be missed, but improvements inevitably take time.

35 https://www.lbbd.gov.uk/residents/planning-and-building-control/planning-guidance-and-policies/local-plan-review/one-borough-one-community-one-plan/

3 Commissioning for Population Health

Her Majesty The Queen receiving gifts whilst on her visit to Barking and Dagenham to celebrate the borough's 50th anniversary

In my reports of 2013[1] and 2014[2] I set out that in order to improve our Life Expectancy and Healthy Life Expectancy as described in chapter 1 we needed to look beyond illness to the wider social and public health context, reaching out to high-risk groups and working together to tackle the wider determinants of ill-health. This is essential if the future burden of increasing numbers of people experiencing multi-morbidity and dementia is to be reduced, against a back drop of tighter financial controls and cuts that pose risks to the quality of care.

This chapter explores the means of delivering a radical prevention agenda at the scale needed to deliver the services, transformation and public health programmes required to achieve our joint Health and Wellbeing Strategy outcomes[3].

Council Leader Councillor Darren Rodwell with children at Gascoigne Keep Active Fest

The challenge - We need to get to the root cause of problems

The combined impacts of austerity, socio-economic change and government policy lead us to a more profound conclusion about the need for change in the way we design and deliver services. Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide. Instead we need to re-focus what we do so that we identify the root cause of need and tackle it so that the individual or family in question have a better chance of living more independently now and in the future. Our job becomes one of building resilience so that people are better able to help themselves. Over the next 5 to 15 years we need to work on significantly reducing the demand for our higher cost health, social care and housing services.

Reduction in demand can only be fully achieved by understanding and addressing the underlying causes of our residents' poor Life Expectancy. To achieve this you have to look beyond efficiency and effectiveness of health

1 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
2 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/018583-BD-Annual-Health-Report-2014-WEB.pdf
3 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

and care services as evidence tells us the single most important thing that drives the health of our residents is the wider determinants of health such as education and economic development. We are indeed London's growth opportunity and with that growth comes the prospect of significantly improved lives for our residents now and in the future. But with this comes the challenge to cast our ambitions into concrete long term plans of up to 20 year goals. The science underpinning that is even stronger than the science underpinning healthcare.

To exemplify the point, the Council has examined the potential impact of the Housing and Planning Bill[4] and the Welfare Reform and Work Bill[5] currently going through the parliamentary process:

- 1% Rent reduction: wipes £33M from the Housing Revenue Account over the next 4 years (£450m over the next 30 years). Reduces our ability to build and maintain our social housing stock.
- Pay to stay: Market Rent for households earning over £40K. This will make Council housing unaffordable for many tenants and provide a further impetus for Right to Buy.
- Forced sales of high value council homes: will reduce our stock by up to 800 units over the next 5 years.
- Changes requirement for affordable housing: emphasis is on starter homes (not affordable) and some limited shared ownership. New public investment will not be available for social housing.
- Welfare reform (benefit cap and local housing allowance): expect to see a 100% increase in homelessness applications with a £5m cost to the Council by 2020.

Set against our level of deprivation as measured by the Index of Multiple Deprivation[6] the above will exacerbate housing as a health inequality issue and increase recognition of the importance of decent affordable housing as a prime requisite for health. Poor housing may pose a health risk that is of the same magnitude as smoking (and clearly interrelated) and, on average, greater than that posed by excessive alcohol consumption. The British Medical Association 2003 report Housing and Health[7] drew attention to the vital importance of access to good quality housing for those in poor health.

Better Health for London[8] and the NHS Five Year Forward View[9] acknowledge that the future sustainability of the local health and social care economy hinges on a radical upgrade in prevention that addresses the wider determinants of health such as income and housing. When examining NHS sustainability in particular one should reflect on

the analysis by Dominic Harrison, Director of Public Health, Blackburn with Darwen Borough Council of the recent Public Health England Older Age Mortality Report[10]: "Although variations in life expectancy are multi–faceted one cannot ignore the loss of wider 'community care' emerging because of social isolation and now dangerously exacerbated by cuts to Local Authority Adult Social Care Services: Older adults (the majority of deaths each year), with a number of long term conditions (which will be the majority) when becoming frail will contract routine infections – particularly respiratory-which, if unobserved, undiagnosed and untreated will exacerbate quickly to the point that death is inevitable. Whilst their underlying vulnerability is biomedical, increasing social isolation coupled with the dramatic withdrawal of preventive adult social care services and the voluntary services they often commission which had often provided daily contact are now disappearing".

Dominic Harrison goes on to question whether it is possible to meet all four requirements of the NHS Planning Guidance - contain costs, improve quality, reduce inequalities and improve outcomes within a diminishing resource envelope. In Barking and Dagenham, we too need to acknowledge the risk to health outcomes from the pressure to contain costs in a context of increasing need, and comprehensively assess the impact of our policies against all four criteria.

4 http://services.parliament.uk/bills/2015-16/housingandplanning.html
5 http://services.parliament.uk/bills/2015-16/welfarereformandwork/documents.html
6 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
7 http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/G7L4PYYLM6HGKVT8CXLVJGQBEPBK8K.pdf
8 http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
9 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
10 https://www.gov.uk/government/news/life-expectancy-at-older-ages-is-the-highest-it-s-ever-been

What is Population Health?

The Kings Fund[11] describes population health as more than just access to traditional health and care services, although recognising this plays an important part in determining the health of a population, evidence suggests that this is not as important as lifestyle, the influence of the local environment, and the wider determinants of health. This means that improving population health requires efforts to increase incomes, change behaviours and living conditions across communities. It also means that accountability for population health is spread widely across these communities, not concentrated in single organisations or within the boundaries of traditional health and care services.

For us the scale for the health and social care system is now defined as a population of 750,000 covering the geographical area of the London boroughs of Barking and Dagenham, Havering and Redbridge. This as a minimum requires greater pooling of data and budgets; population segmentation; place-based leadership drawing on skills from different partners and communities based on a shared vision and strategy; shared goals based on analysis of local needs and evidence-based interventions; effective community engagement; and incentives to encourage joint working.

However, using a population level lens to plan cross borough programmes at scale is not a means to an end in addressing the impact of changing demography, lifestyles and health and care needs on facilities and services provided for local people and the role that individuals can take in their health and wellbeing. One size certainly doesn't fit all and there is a clear need in developing different strategies for different population segments, according to needs and level of health risk. In meeting the challenge the Health and Wellbeing Board in its system leadership role over the last 24 months has been setting out what good care and prevention looks like through the refresh of our joint Health and Wellbeing Strategy 2015–2018[12] and delivery plan. The Board recognises that commissioning at scale is an essential part of containing costs and managing demand in the health and care system.

Population Health: The role of commissioners

The history of well-intentioned public health strategies that have promised much but delivered less – dating at least as far back as Prevention and health: everybody's business in 1976 (Department of Health and Social Security 1976)[13] suggests caution in claiming that things will be different this time around. This view has maintained through the decades as traditional commissioning strategy has tended to focus on processes, individual organisations and single inputs of care or lifestyle.

The government published a joint Spending Review and Autumn Statement on 25 November 2015[14] which is a 'game changer' in respect of public sector planning and performance introducing five year commissioning plans. The strategic commissioning focus is now:

- Place based budgets predicated on the scale of natural health and social care economies.
- The role councils play in shaping the local health economy transformation plans.
- A five-year financial settlement.
- The ability and willingness of councils to use new council tax powers to fund social care. Even if councils decide to raise revenue in this way there remains a strong possibility that we could see serial failures of social care providers.
- Improving the quality of health and care sustainably with an 'upgrade in prevention and public health'.

The NHS Planning Guidance 2016/17-2020/21[15] has asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View. Sustainability and Transformation Plans will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

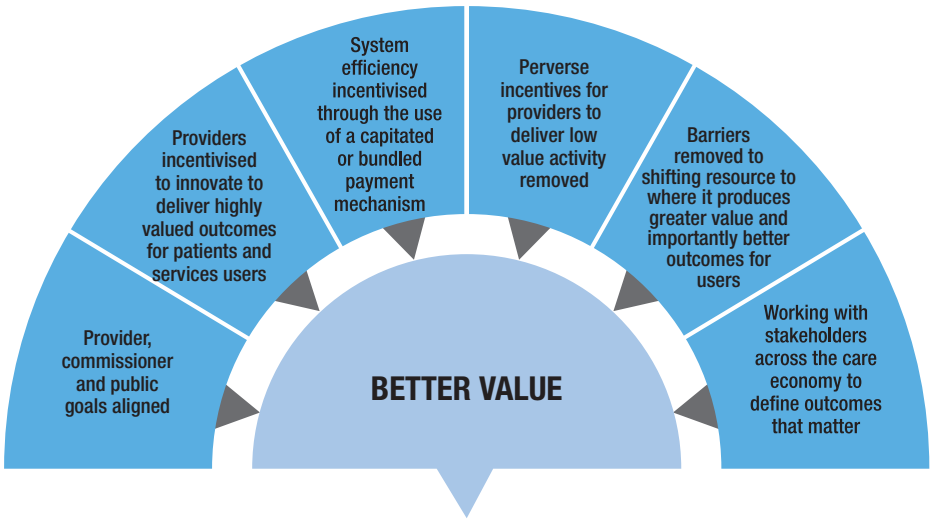
11 http://www.kingsfund.org.uk/publications/population-health-systems
12 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true
13 Prevention and Health, Everybody's Business: A Reassessment of Public and Personal Health. Dept. of Health and Social Security, Majesty's Stationery Office, 1976.
14 https://www.gov.uk/government/topical-events/autumn-statement-and-spending-review-2015
15 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Whatever your view point there is an undeniable opportunity to assess how the prevention opportunities might contribute to the current demand and financial challenges. The analysis will support our Health and Wellbeing Board to identify where improved health outcomes and benefits can be achieved sustainably by working at scale and therefore which part of the system commissions and which particular prevention interventions are invested in.

This will require a fresh approach to commissioning that releases energy and ambition focusing the right conversations and decisions on prevention as an integral part of improving health and care outcomes, identifying the opportunities for co-ordinated and targeted intervention across agencies, and seeking to redeploy resource across the provider landscape. Commissioners will need to focus on what matters, improving population health, helping people to achieve goals, and delivering a quality service. Such a move to system wide outcomes-based commissioning approaches have already been successful in helping transform the delivery of care internationally, but are in their infancy in England. Careful thought is needed to understand how outcomes-based commissioning can be developed locally to enable changes in the way services are delivered.

Figure 1:

How does an outcomes-based approach provide better value?



Source: Outcome Based Commissioning Alliance (OBC Alliance) formed of PwC, Wragge & Co, Cobic and Beacon

In principal the approach:

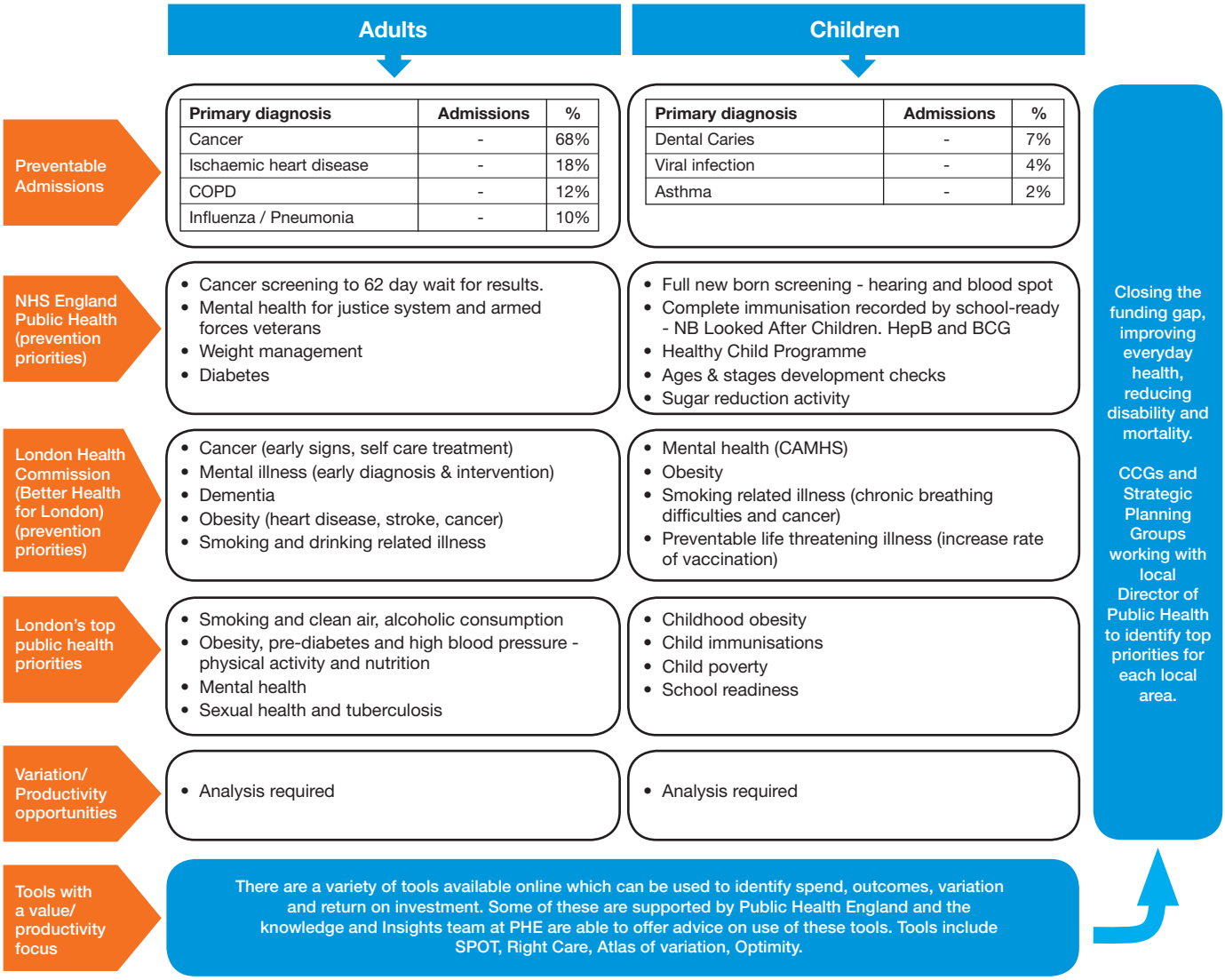
- is a way of paying for health and care services based on rewarding the outcomes that are important to the people using them;
- typically involves the use of a fixed budget for the care of a particular population group, with aligned incentives for care providers to work together to deliver services which meet outcomes; and
- aims to achieve better outcomes through more integrated, person centred services and ultimately provides better value for every pound spent on health and care.

This approach incentivises high-value interventions, shifting resources to community services, a focus on keeping people healthy and in their own homes, and co-ordinated care across settings and systems. The aim (see Figure 1) is to achieve better outcomes through integrated person-centred services and ultimately provide better value for every pound spent on health and care[16]. It also encourages a resident focus on becoming self sufficient and resilient, the experience of using the services, and achieving the outcomes that matter to them.

16 http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Beginning-with-the-end-in-mind.pdf

Figure 2:

Proposed approach to identifying priorities using illustrative figures.



Source: NHS England (London) (2015)

Being clear about the outcomes that matter

The Council, NHS England (London) and NHS Barking and Dagenham Clinical Commissioning Group are refreshing their 5 year plans in 2016 and there is an opportunity to align local strategies for prevention. All acknowledge that the future sustainability of the NHS and social care hinges on a radical upgrade in prevention.

No partner can do everything that's needed by itself, but all acknowledge that collectively all public service partners need to be more activist agents of health-related social change, leading where possible, or advocating when appropriate, a range of new approaches to improving health and wellbeing. The NHS Planning Guidance 2016/17-2020/21[17] specifically calls on the NHS to offer more proactive prevention activities through primary care. Figure 2 from NHS England (London) outlines a draft approach to identifying those priorities that could describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people.

17 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Wheelchair Basketball put on for the Festival of Sport as part of the 50th anniversary celebrations

Is this radical enough or just the usual NHS response that looks to ensure sustainability by developing priorities relevant to the full cycle of health and care, from an initial problem through to recovery? History tells us, we need to be more ambitious when defining outcomes that deliver a real shift in the way we plan and deliver services to achieve a switching focus towards identifying and achieving outcomes over 5 and 15 years that really matter, thus breathing new life into the services we commission.

For the most part this can only be realised in the way we focus our resources in delivering key health outcomes across the life course to enable a fairer distribution of health and wellbeing for our residents. From the Joint Strategic Needs Assessment 2015[18], we know what impacts on the residents' health and Life Expectancy (social, environmental, physical and mental). The joint Health and Wellbeing Strategy[19] sets out how the Council and its partners address the borough's poor Life Expectancy and Healthy Life Expectancy. Informed by this understanding of need the following five outcomes are put forward for discussion for improving both Life Expectancy and Healthy Life Expectancy over the next 5 to 15 years:

Starting Well

- **Childhood:** Children to have a good level of development at age 5 in order that they can participate effectively in school and aspire to become good citizens.
- **Adolescence:** Adolescents, including our most vulnerable, to have a good level of education, indicated by qualifications, in order that they can engage with society and aspire to maximise their potential to grow into healthy, socially and economically active adults.

Living Well

- **Early and established adults:** Adults to have opportunities to earn a good income in order to engage with society and maximise their social and economic potential.

Aging Well

- **Established and older adults:** Established and older adults who develop a long term condition and have unhealthy lifestyles (smoking, poor diet, alcohol and/or inactivity) to be able to maximise opportunities to manage their own health.
- **Older adults:** Older adults who are at the end of their lives to have a choice of where they die.

Once key outcomes are selected, we need to identify a range of indicators that will reflect change in the health of residents. It includes both indicators of the wider determinants of health and indicators of health. This will enable us to measure how education, housing and lifestyle impact on the mental and physical health of our residents.

How could this look for 0-5 year olds?

If we examine an outcome for early years: to enable children to have a good level of development at age 5 in order that they can participate effectively in school and aspire to become good citizens, we can see how this approach can be applied.

Why this is important?

The path to poor health and social outcomes starts before birth, with children in families with multiple risk factors such as debt, substance misuse, poor housing and domestic violence being more likely to experience development and behaviour problems, mental illness, substance misuse, low educational attainment and offending behaviour. Investment in our interventions has to focus on improving early years outcomes in the crucial first five years of life, and identify what matters most in preventing poor children becoming poor adults.

18 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/?loggedin=true
19 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-policy-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

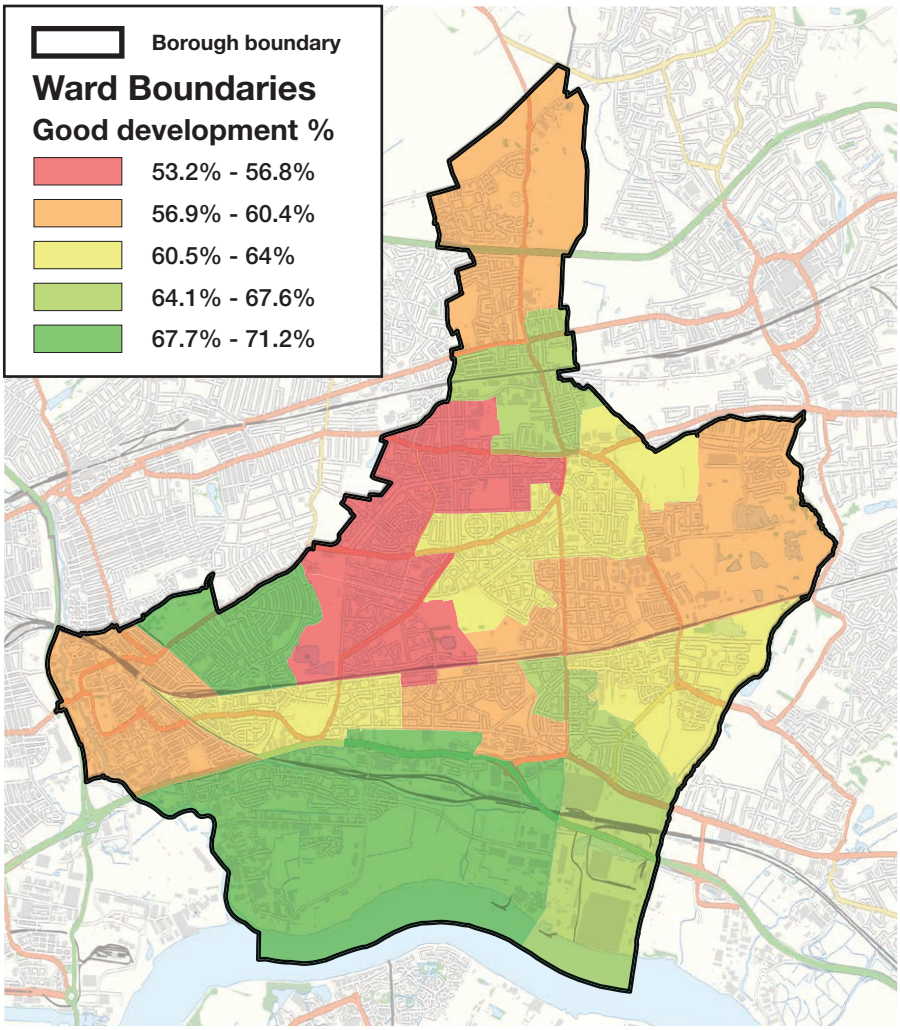
Detailed research has been undertaken to identify the factors that affect child outcomes[20]. As an example, maternal factors have been shown to be particularly influential when the child is 3 years old. In chapter 4 of my 2013 report[21] I examined the evidence and factors influencing child outcomes including living in poverty and having parents who disagree about the upbringing of the child, as well as more obvious factors such as the child having a life-limiting illness and poor general health of the mother. A number of the indicators proposed in the 2013 report are included here.

We want our children to have a good level of development at age 5. What happens during early years, starting in the womb, has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status[22]. Good health supports good development. Figure 3 shows the level of good development in the borough.

In super output areas in the west of the borough children had a less good level of development in 2011/12. This indicates that the greatest need for child help is in this area and hence this area should be targeted.

Figure 3:

Barking and Dagenham heat map of wards percentage of population achieving a good level of development at age 5, 2011/12.



The health economic case?

Public Health England in their report Improving school readiness Creating a better start for Londoners[23] put forward a compelling case to why we should invest. They argue that failing to invest sufficiently in quality early care for those who need it and education short changes taxpayers because the return on investment is greater than many other economic development options:

- Every £1 invested in quality early care and education services saves taxpayers up to £13 in future costs.
- For every £1 spent on early years education £7 has to be spent to have the same impact in adolescence.
- The benefits associated with the introduction of literacy hour have in the UK outstripped the costs by a ratio between 27:1 and 70:1.

For improving self sufficiency and resilience in later life investment in early years interventions targeted at those that need them have been shown to have a higher rate of return per investment than later interventions

20 http://www.chimat.org.uk/preview/evidence
21 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
22 https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
23 https://www.gov.uk/government/publications/improving-school-readiness-creating-a-better-start-for-london

with improved educational outcomes, reduced healthcare costs, reduced anti-social behaviour and increased taxes paid due to higher earnings as adults.

What works for our population?

There is an expectation that there will be whole system reforms both to streamline and to join up local services in order to provide better outcomes for families and reduce costs. This provides an opportunity to promote more effective integration of services locally with a focus on early intervention which will secure better returns on investment. Therefore, the partners are encouraged to work with families in ways that evidence shows to be more effective, such as:

- Joining up local services.
- Dealing with each family's problems as a whole rather than responding to each problem, or person, separately.
- Appointing a single key worker to get to grips with the family's problems and work intensively with them to change their lives for the better over the long term.
- Using a mix of methods that support families and challenge poor behaviour.

There is good evidence that the following interventions support good development:

- Giving priority to pre and postnatal interventions, such as early booking, stop smoking and intensive home-visiting programmes that reduce adverse outcomes of pregnancy and infancy.
- Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet health and social need via outreach to families. This approach is particularly important for 'at risk' families and links closely with our work on community solutions[24]. One example of such a programme is Family and School's Together.
- Providing school based health services and lifestyle programmes to support good development and informed decision making.
- Additionally to improve immunisation uptake[25] a universal approach is needed that supports all children's services to encourage vaccination underpinned by appropriate training and information systems. Again this approach is particularly important for 'at risk' families and links closely with our work on community solutions.

Conclusions

Being clear on the outcomes that matter is the driver for transforming care and innovative prevention approaches. There is established consensus that outcomes based commissioning will expect providers to encompass and work with all the services and functions that contribute to achieving those outcomes. Finding ways to align providers' incentives to outcomes will be crucially important.

This chapter establishes that if we commission for outcomes for what matters, the Growth Commission recommendations and Accountable Care Organisation method in chapters 2 and 4 respectively illustrate the place based approaches to achieving the outcomes. The principles on which the success of the approaches discussed in chapters 2 and 4 include:

- Focusing on the outcomes that matter to improve our borough's Life Expectancy and Healthy Life Expectancy for both females and males, combined with the alignment of incentives and indicators to drive improvement and co-ordination between providers.
- One size doesn't fit all and there is a clear need in developing different strategies for different population segments, according to needs and level of health risk.
- Moving to outcomes based commissioning predicated on longer term contracts will make it easier to focus on prevention and invest in services whose health improvement return may take several years to achieve.
- The need to focus our resources in delivering key health outcomes across the life course to enable a fairer distribution of health and wellbeing for our residents this includes economic benefits in reducing losses from illness associated with health inequalities.

24 https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
25 https://www.nice.org.uk/guidance/ph21 .

4

New Model of Care:

Accountable Care Organisation

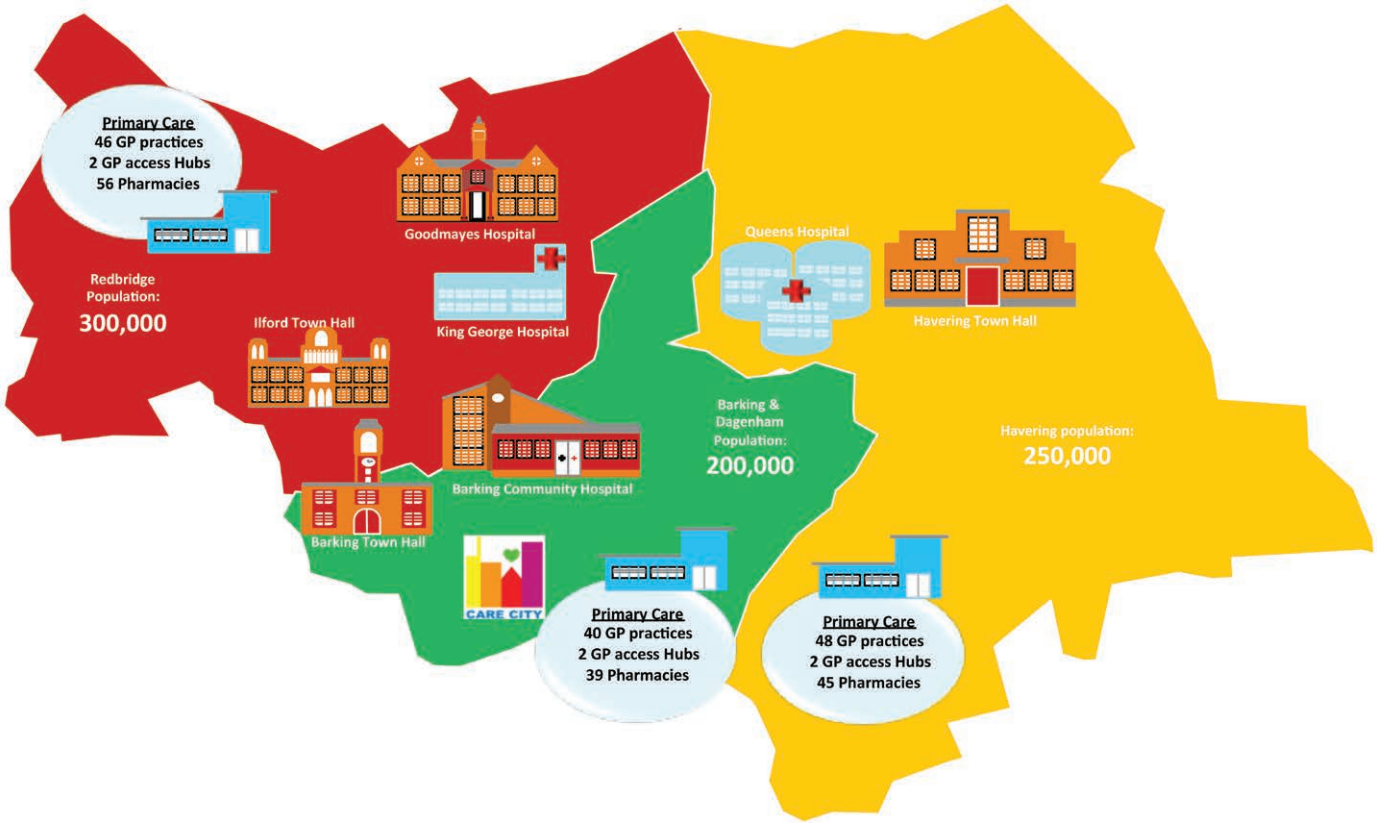
Council Leader Councillor Darren Rodwell, Councillor Laila Butt and staff from Asda raising money for White Ribbon Day as part of the '16 Days of Activism' campaign against domestic violence

In this chapter I continue my interest in transformation with consideration of the new care models programme which was launched by NHS England in January 2015[1].

In my annual reports of 2013[2] and 2014[3] I examined the necessity to identify ways of preventing ill health and moderate demand through integration of services. Our joint Health and Wellbeing Strategy[4] directs us to shape fundamentally more productive services that are integrated and operate as a co-ordinated system. This requirement encompasses primary, community, hospital and social care services and is driven by the need to ensure meeting the needs of the residents goes hand in hand with the provision of services that are of high quality, but are also sustainable and affordable.

The Barking and Dagenham, Havering and Redbridge (BHR) health and social care system (see Figure 1) is recognised nationally as a patch with strong clinical and political leadership. We are now exploring whether a partnership-based Accountable Care Organisation (ACO) method, using devolved powers would deliver better outcomes for our residents while also helping to bridge our funding gap. The ACO method is set out in the NHS Five Year Forward View as one of five transformational models of care, which effectively mean the development of 'place based care' at a local level.

Figure 1:
The Barking and Dagenham, Havering and Redbridge (BHR) health and social care system.



1 https://www.england.nhs.uk/wp-content/uploads/2015/12/acc-uec-support-package.pdf
2 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
3 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/018583-BD-Annual-Health-Report-2014-WEB.pdf
4 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

What is devolution?

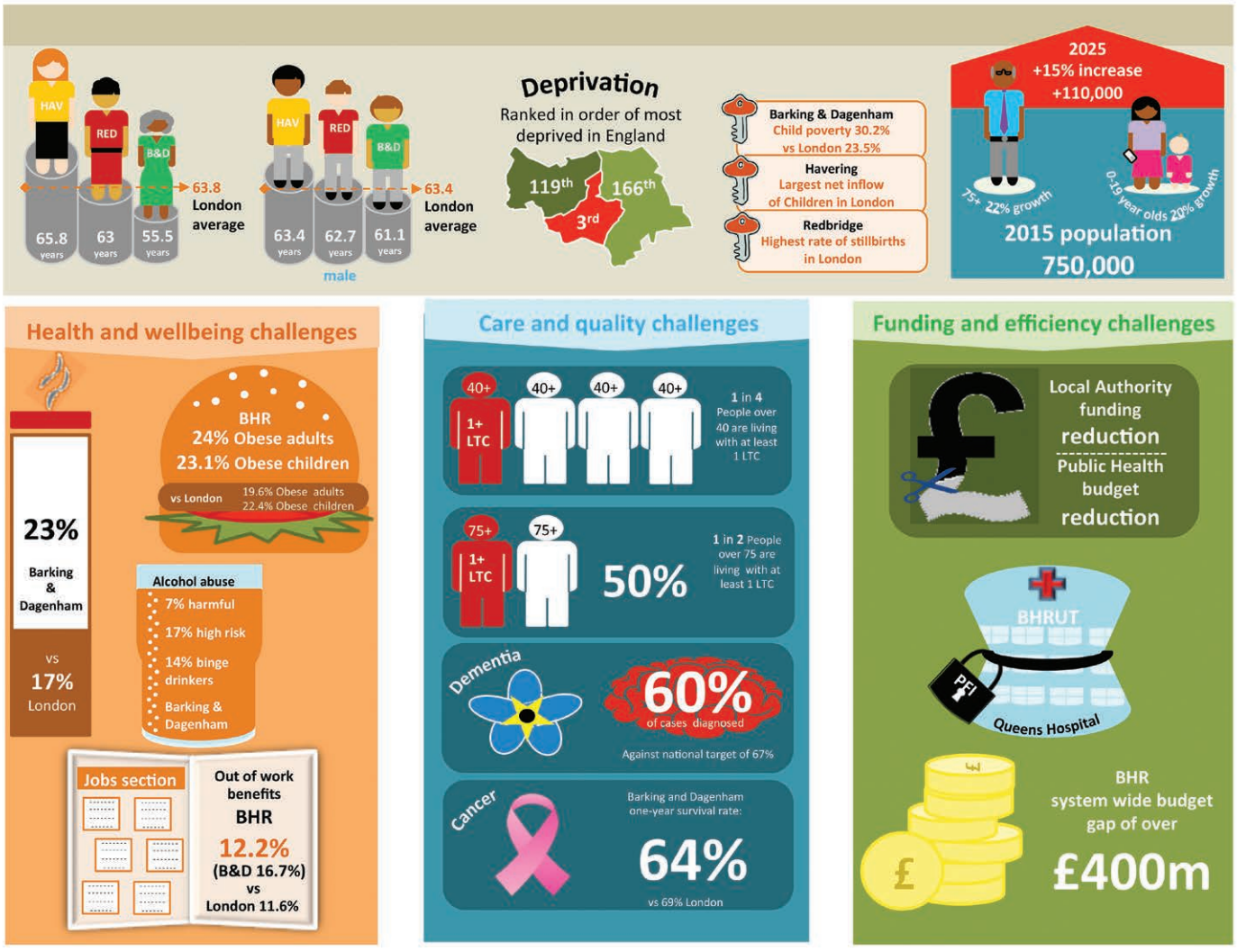
Devolution is: "The transfer or delegation of power to a lower level, especially by central government to local or regional administration". There is an opportunity to use these new powers and resources that are available through the London Health Devolution Agreement[5] to build on what's already working in BHR. With clinicians and elected representatives in the driving seat, we can work to dissolve the barriers between primary care, community services, mental health services, hospital and social care and come together in a stronger partnership for the benefit of our population.

The ACO is the method through which we will explore the potential benefits of devolution to determine whether we can deliver better outcomes and bridge the funding gap. A core goal of the London Health and Care Devolution Pilots is to shift services to prevention and early intervention, both to improve outcomes and reduce pressures on services. A key question in the business planning process is whether the creation of an ACO can unlock a significant shift towards prevention, in line with the Council's aspiration to tackle the root causes of ill health. Any outcomes agreed to address the key system challenges to BHR which are outlined in Figure 2 below, will require focused impact at the scale commensurate with population health gain.

The first full devolution model in England is 'Devo Manc' the new Greater Manchester Combined Authority, which like London, also has an elected mayor and assembly[6]. The evidence suggests that like 'Devo Manc' the ACO method is likely to be more effective if it can be aligned with a range of other public sector reforms to welfare and housing which also increase the emphasis on, and support for, improving quality and reducing costs.

Figure 2:

BHR Health and Social Care key System Challenges.



5 https://www.gov.uk/government/publications/london-health-devolution-agreement/london-health-devolution-agreement

6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/369858/Greater_Manchester_Agreement_i.pdf

What does the evidence tell us about the benefits of establishing an ACO?

The growing interest in new models of service delivery has been driven by a consensus that the existing NHS health care delivery and payment systems are neither effective nor sustainable[7]. The current system, based on volume and intensity, pays more for overuse of referrals to hospitals and undermines efforts to invest money and effort in delivery-system improvements that can sustainably reduce costs.

A review of the international evidence tells us that ACOs are essentially groups of doctors, hospitals, and other care providers, who come together voluntarily into networks to provide co-ordinated high quality care to a defined patient population[8]. The Kings Fund (2015)[9] has found that the ACO method has a number of different potential configurations and that claims about its effectiveness are not yet fully supported by a particularly strong evidence base. However, commentators argue that a real and enduring impact can potentially be achieved if understanding goes beyond the integration of care for patients and service users to explore how they can use their resources to improve the health of the populations they serve. Put simply, it is a case of simple economics; since providers only share in ACO savings when they decrease costs, it will be crucial for ACOs to switch from merely treating sickness to maintaining or improving health, to prevent costly avoidable illness and unnecessary care.

Whilst there are no set structures for ACOs[10], there are some common basic principles, which include:

- Primary care being placed at the heart of all services.
- The development of integrated service models that span across organisational boundaries.
- A provider or group of providers is allocated a fixed budget to manage all health and care needs for a defined population group (capitated payment), patient-linked IT datasets and a culture of continuous improvement/innovation.
- Closer working with local partners including primary care, social care and community services.

An important difference in the England context is the definition of the population group whose health is being managed or improved. Nevertheless, the American ACO method can be applied to English context. When considering the system challenges faced by BHR that are outlined in Figure 2, the NHS can no longer look through the narrow lens of care and needs to embrace its dual role in prevention and lifestyle support as well as developing new models of care. Indeed, changes to the planning framework outlined in the previous chapter now make the ACO an attractive option for delivering the population health benefits that we need to achieve.

A summary of the benefits for improving population health are contained in Box 1 and the challenges in Box 2 below:

Box 1:

The ACO method offers a number of opportunities for improving population health.

- Patients and service users will be at the centre of care, and should be offered increased involvement and engagement in the design, delivery and improvement of services.
- Health and care staff will be better able to keep their patients informed, as well as keep listening to and honouring their choices. This includes proactively contacting individuals to prevent disease in the first place, actively involving patients and their caregivers in setting care goals, and sharing decision-making.
- Provides the ability to better manage and co-ordinate the care of individuals along the full length of clinical and social care pathways. This offers the potential to improve access and reduce the number of care transitions. Improved co-ordination should also lead to patients being treated and supported in a range of different, more appropriate, settings, which should contribute to ensuring greater continuity of care.
- Enhanced sharing of performance data within the network means the best performing partners within the ACO can be identified, and they can then share what they are doing with the other partners in the network. The sharing of patient information and co-ordination of care within the network should improve patient care and also help drive efficiencies, for example by reducing the number of repeated medical tests.
- Proactive management of their defined patient populations, to inform early intervention and prevention. The aim will be to keep people healthy for longer, through an increased focus on primary care and a bias toward early intervention.

7 http://hsr.sagepub.com/content/early/2015/06/16/1355819615590845.abstract
8 http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england
9 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf
10 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf

Box 2:

The ACO method offers a number of challenges for improving population health.

Whilst the ACO concept offers significant opportunities for improving population health, there are also a number of challenges that would need to be overcome to achieve them. These include:

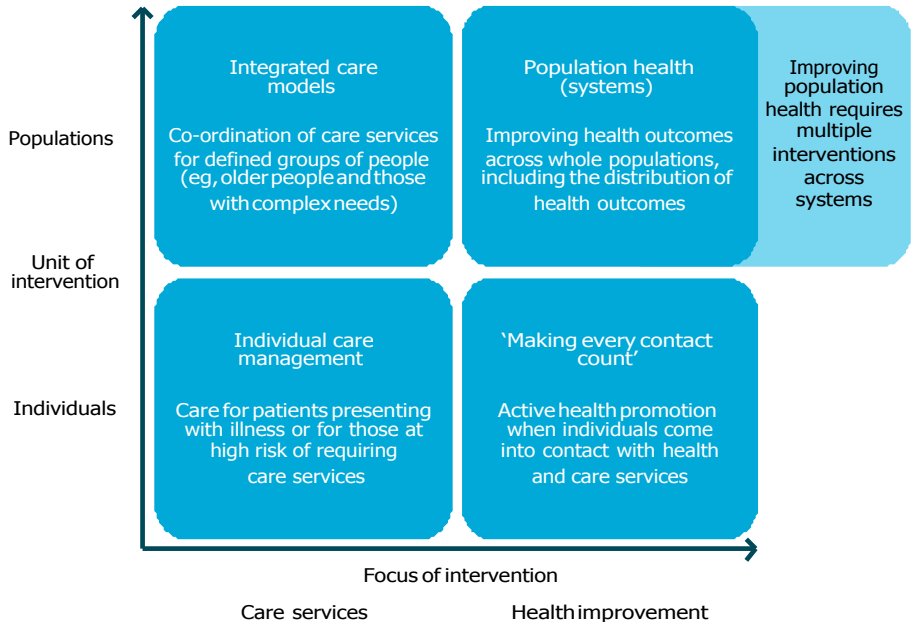
- The formation of seamless provider networks across the BHR system.
- The development of effective mechanisms to share data and information within the BHR Integrated Care Coalition.
- The development of mechanisms for actively engaging patients and their families in their care.
- Overcoming existing institutional barriers. Budgets within the Partner organisations and between the NHS and social services are separate and institutional separation between primary care, hospital care and social care is currently a significant obstacle. Staff employed by these different institutions may work together but they are separated through different cultures, and different terms and conditions.
- The need to develop effective joint commissioning between the partners of the BHR Integrated Care Coalition.
- Striking a balance between delivering standardised care and adopting a flexible personal tailored approach.

How can we make it work?

Firstly:

The Kings Fund set out a challenge to those involved in integrated care and public health to 'join up the dots'. This means that any ACO development must have improving population health at its centre. Figure 3, describes the need to have a wider focus than our traditional approach to integrated care. While interventions focused on individuals and integrating care services for key population groups are important, they must be part of a broader focus on promoting health and reducing health inequalities across whole populations[11]. Therefore, the ACO method will need to be shaped to support the Council's vision as London's growth opportunity as well as addressing the Government's reforms that will have a major impact on Council services, residents and local businesses.

Figure 3: The focus of population health.



11 http://www.kingsfund.org.uk/publications/population-health-systems

Secondly:

Partners within the Coalition must embrace the concept of 'place based care'. This involves organisations moving away from a 'fortress mentality' whereby health and social care organisations each act to secure their individual interests and future. Instead they must establish place-based 'systems of care' in which they collaborate across the BHR health and social care system to address challenges and improve the health of the populations that they serve.

This means that, rather than organising care around disease or organisation, it should be organised around the place in which people live. Consequently, teams should be structured around geographical areas and work as part of the local community in which they operate. This will enable them to tailor the care they provide to local needs and linking to local assets. While there are some current examples of this extending into population health, most of the current initiatives have started with local government (as in the case of the health commissions established in Liverpool and London).

For Barking and Dagenham a real opportunity has emerged as part of the growth agenda, which provides a place based and population health hook for the ACO approach. On 10th March 2016 NHS England chief executive Simon Stevens announced Barking Riverside (10, 800 new homes) as one of the locations of the 10 "healthy new towns". These are communities across England where health and wellbeing will be "designed into" their construction. The programme, runs in conjunction with Public Health England, aims to join up design of the built environment with health and care services. NHS England plans to bring in clinicians, designers and technology experts to shape care provision in each location. Mr Stevens stated: "The much needed push to kick start affordable housing across England creates a golden opportunity for the NHS to help promote health and keep people independent. As these new neighbourhoods and towns are built, we'll kick ourselves if in 10 years' time we look back having missed the opportunity to 'design out' the obesogenic environment, and 'design in' health and wellbeing".

Although, caution should be used when comparing models used in other countries, there is sufficient evidence available to suggest that the 'healthy new town' model can be applied to the England ACO context. The Kings Fund (2015) looks at a number of successful international approaches that have evolved past a pure care based method. Counties Manukau Health, New Zealand provides an interesting case study of how an ACO method can go beyond care to incorporate housing and health as part of its community solution.

Thirdly:

In respect of population health, a planning framework operating at 3 levels within the BHR system may serve to improve outcomes for the diverse populations across the three boroughs:

- The BHR health and care economy level estimated population 750,000. This will involve partner organisations working together across systems to improve health outcomes for defined population groups. Unlike typical approaches to integrated care that focus primarily on groups that are frequent users of health and care services, the aim here is to improve people's health across the whole of the populations that they serve. This population-level lens is used to plan programmes and interventions across a range of different services and sectors to maximise value for money and effectiveness of large blocks of care.
- The Locality model provides care for a defined population, usually 50,000 – 70,000 people. This will involve localities developing different strategies for different segments of the populations that they serve, depending on needs and levels of health risk. By grouping people with similar needs and tailoring services and interventions accordingly, this approach recognises that improving the health of older people and children, or healthy adults and those living with multiple long-term conditions, will require a different set of approaches, and involvement from different system partners to be effective.
- With the locality model there will need to be a neighbourhood level. This is primarily to address inequalities by delivering a range of interventions aimed at improving the health of individuals within the small geographical areas (such as deprived estates). These interventions are many and varied, and involve input from a number of organisations and services. In the Counties Manukau Health case study they include housing support, education programmes, vocational services, employment advice, exercise programmes, smoking cessation services and other lifestyle support, as well as more traditional health and care services like care planning and individual case management for people with complex health and care needs.

Case Study

Counties Manukau, New Zealand

Counties Manukau Health (CMH) is responsible for commissioning health and care services for the whole population of 500,000 people living in South Auckland, and for providing hospital and specialist services in the area.

It works with a range of local and national partners to integrate services and improve the health of the population living in Counties Manukau. This has had a major impact on Council services, residents and local businesses.

As with many other integrated care systems, CMH has worked with local providers to develop locality-based integrated health and care teams that are aligned with networks of general practices and working in partnership with hospital services. Services are tailored to the needs of different population groups within each locality, based on population risk stratification. Services range from primary prevention services and lifestyle support through to active case management for patients with complex health and social care needs, with the emphasis being on supporting people to manage their own health. Each locality is served by a wider social care network to provide help and support to families with complex needs whose living environments are impacting on their health.

An example of this is CMH's Healthy Housing Programme which is a joint initiative between CMH, neighbouring district health boards and Housing New Zealand, (the government-owned social housing provider) which ran from 2001 to 2013. The programme was open to all people living in rented Housing New Zealand accommodation, and focused on:

- Improving access to health and care services;
- reducing the risk of housing-related health issues; and
- identifying social and welfare issues and providing a link to relevant agencies.

After a joint visit and assessment from local health and housing teams, typical interventions included educating families about their health risks, referrals to health and social care services, installing insulation to make houses warmer and drier, modifying houses to meet health and disability needs, and transferring families to alternative houses in cases of overcrowding. These interventions were tailored to the needs of different families and population groups, in particular, the Māori and Pacific Island groups, which are disproportionately affected by poor housing conditions. The programme took a locality-by-locality approach to ensure that every eligible household was reached systematically and to reduce the potential for stigmatisation of families involved in the programme.

Residents taking part in events for Older People's Week

Fourthly:

Local elected councillors and local authority chief officers will need to make some hard choices as they seek to increase the accountability of the health and care services that are provided to their local populations. The ACO method is an opportunity for the Council to think creatively about the powers and democratic representation they can bring to bear. The Nuffield Trust[12] argues that accountability for public services has three, inter-related elements (Brinkenhoff, 2003):

- Accountability for strategic decisions on provision and the allocation of resources, particularly which services are provided and to whom;
- accountability for the quality of services delivered, such as access, clinical quality, safety and outcomes; and
- accountability for the management of resources including value for money, probity and fairness.

All three of these elements are important. Over the next 5 years, for example, it will be crucial for the Health and Wellbeing Board to exert its system leadership role in how services respond to challenges such as:

- Emerging needs, such as addressing the challenge of care for the rapidly rising number of people with dementia and the demographic growth in children;
- how health and care services can be better integrated to provide more seamless care;
- how health and care services can be better integrated with other public services such as employment support, housing and leisure to better prevent ill-health; and
- embedding an ethos of quality across all care, following a number of high-profile failures in recent years.

The Health and Adult Services Select Committee (health scrutiny) also has a strategic role in taking an overview of how well integration of health, public health and social care is working. Relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration and in making recommendations about how it could be improved. Scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system and will have to evolve within a population health system.

12 http://www.nuffieldtrust.org.uk/publications/reconsidering-accountability-integrated-care

Conclusions

The Kings Fund (2014) in their paper Accountable care organisations in the United States and England testing, evaluating and learning what works[13] concludes that the context in which integrated care develops is itself a critical variable, suggesting that a 'made in England' approach is likely to have a greater chance of success than seeking to copy a model that itself remains emergent in the Unites States. Beyond the obvious attraction of a network of providers working under a capitated budget that creates incentives to improve outcomes lies the hard slog of converting concepts into practice. As Burns and Pauly (2012) argue, strategic change of the kind represented by ACOs needs to be carefully implemented, and yet implementation and execution are poorly understood processes.

Key messages which can be drawn to inform discussion include:

- There is neither a 'one-size-fits-all' approach to ACOs nor are ACOs the only solution, yet they provide a potentially viable means to realising the principal aim of using devolved powers to deliver better outcomes for our residents while also helping to bridge our funding gap.
- Review has shown that progress to date has been mixed and there needs to be realism about the hard work and time it will take for this method to demonstrate measurable benefits. While some ACOs in some contexts have slowed the rate of health care spending and delivered improvements in quality of care, other ACOs in other contexts have not done so.

Residents taking part in a class in the Ageing Well programme

- Real and enduring impact can be achieved if the ACO method is aligned with a range of other public sector reforms to welfare and housing. Understanding needs to go beyond the integration of care for patients and service users to using resources to improve the health of the populations of the three boroughs.
- Development of a primary care and localities approach based on populations of 50,000 – 70,000 is helpful. Establishment of a locality structure to enable general practice and wider health and care teams develop as a group of providers, to reward the achievement of better outcomes and to encourage discussion and exploration of solutions within each locality that address the wider determinants of health such as income and housing will increase the chance of success.
- Accountability arrangements are critical to any system. A clear framework needs to be in place for strategic decisions about how services are provided and to whom, the quality of those services and whether the funds available are well spent.

13 http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england

5

Protecting the health of the local population:

focusing on health protection (infectious disease and non-infectious environmental hazards) – the future?

Diabetes UK roadshow in the borough

Background

Local authorities have a key role in protecting the health of their population, both in terms of planning to address threats that are a Local Authority lead responsibility, and in ensuring appropriate responses are undertaken by other agencies when incidents occur, particularly Public Health England (PHE) and NHS England (NHSE).

PHE was formed in 2013 and saw the then Health Protection Units become Health Protection Teams but working closely with Local Authorities. Local teams have detailed plans in place for dealing with infectious and non-infectious environmental hazards. They are responsible for leading and responding to cases and incidents and report to the local Director of Public Health (DPH) who holds the assurance role to the Council. If there is a need for an incident meeting the DPH would be invited.

NHSE responsibilities include commissioning immunisation and screening. This was a change from the work originally undertaken by Primary Care Trusts and at first a difficult transition. The DPH, with their assurance role, found they were no longer responsible for many of the key initiatives such as linking directly with General Practitioners in order to improve vaccination uptake.

The Council have had a Health Protection Committee running before and after the transition in 2013 and this ensured that those responsible for the delivery of health protection were reporting to the DPH at regular meetings. Initially there were a few teething problems as it was difficult to get representation from NHSE who were working across London and were stretched. This was rectified some time later with staff from NHSE being responsible for patches. The Health Protection Committee since has seen regular attendance from the health protection team and the immunisation team but to date no representation from the screening team.

Consultations – "Securing our future"

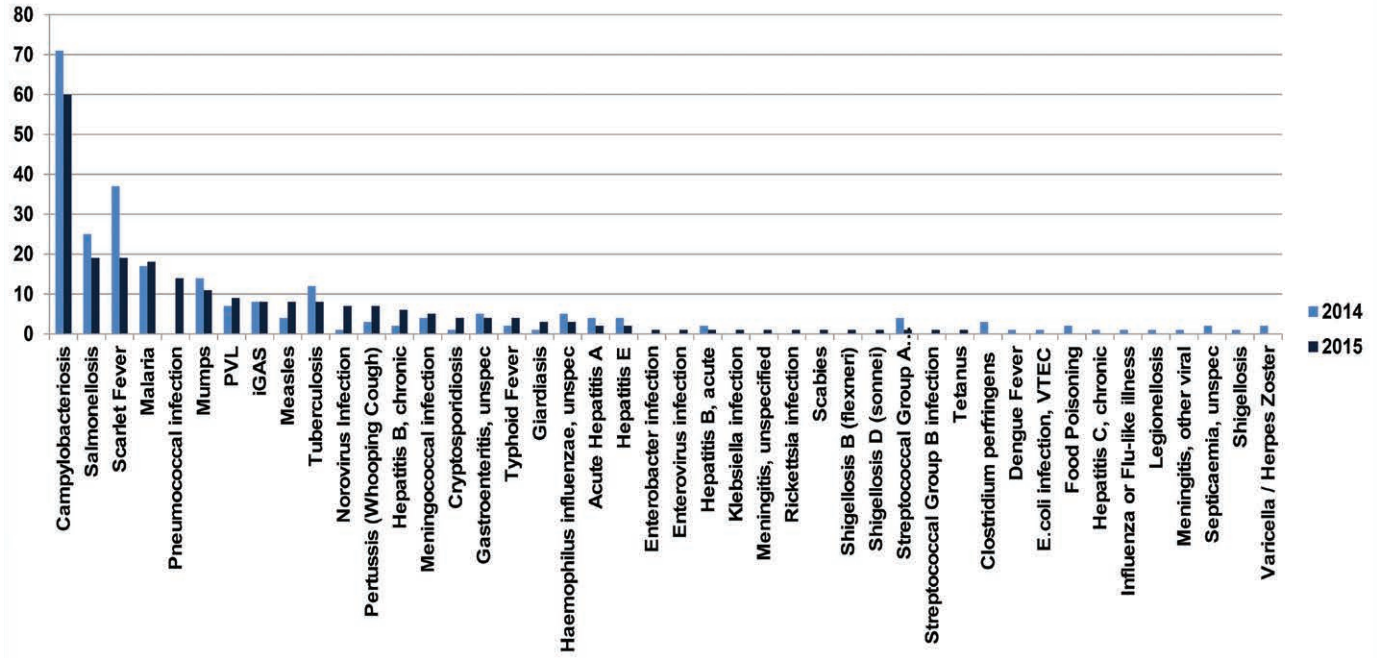
The Council have always had a Consultant in Communicable Disease Control/Consultant in Health Protection who works closely with the DPH and more recently a named health protection practitioner. This has worked extremely well with cross cover for leave and ensures there is always a named person from PHE who can be called in the event of an incident. This can be especially important when there are concerns from the public or media interest.

Several consultations from PHE have been sent to the DPH for comment which are called "Securing our Future" Phases 1 and 2 and are looking at redesigning health protection teams due to cuts in funding. For many parts of the system it isn't broken and doesn't require fixing and the Health Protection Committee recommended that the system stays intact as much as possible with emphasis on improving the model for immunisation and screening.

The main changes seem to be, sadly, some redundancies with fewer Consultants left in London but those still left, working more strategically with boroughs (which has historically always happened in Barking and Dagenham). There appears to be a move to more reactive work for those who are not Consultants. Certainly from the Council's perspective we would want to keep our current links with our named PHE person(s) working in partnership with us and hope that this is not eroded. The danger could be that practitioners would not have the capacity to deal with incidents in depth or attend important local borough meetings due to reactive on call and with less Consultants in London there would be a potential to have too few, spreading them across areas with a lack of capacity to deal with anything strategically in a meaningful way. This report highlights some of the key successes and future challenges in our borough.

Figure 1:

Barking and Dagenham Cases by year reported (2014 & 2015)



Infectious Disease Cases and Incidents

Higher numbers of campylobacter, panton-valentine leukocidin (PVL), pneumococcal, scarlet fever, tuberculosis, hepatitis B, and gastro intestinal infections were reported in 2014/15 compared with 2015. Campylobacter was due to differences in laboratory techniques and there was a national outbreak of scarlet fever. Increases in the other infections are too small to show a significant trend (Figure 1).

In 2015 there were 14 reported outbreaks in the borough mainly related to gastroenteritis outbreaks in care homes, two tuberculosis incidents in workplaces, a hepatitis B incident in a Spa, three cold chain incidents in surgeries, a water incident and a “needlestick” incident in a school.

Tuberculosis (TB)

Following major declines in the incidence of TB during most of the 20th century, the incidence of TB in England increased steadily from the late 1980s to 2005, and has remained at relatively high levels ever since. TB is concentrated in large urban centres, with rates in London, Leicester, Birmingham, Luton, Manchester and Coventry more than three times the national average.

In 2014, 68 cases of TB were notified in residents of Barking and Dagenham, a rate of 34 per 100,000 population. The rate varied across different wards in the borough. Overall in London, there were 2572 TB cases notified and a rate of 34 per 100,000 population. The TB rate in Barking and Dagenham decreased slightly in 2014 but is above the London rate.

In 2014, 9% of non-UK born cases were diagnosed within 2 years of entry to the UK and 18% in 2-5 years. The most common countries of birth for cases in 2014 were the UK, India, Pakistan and Somalia.

Figure 2:

TB rates for North East London residents.

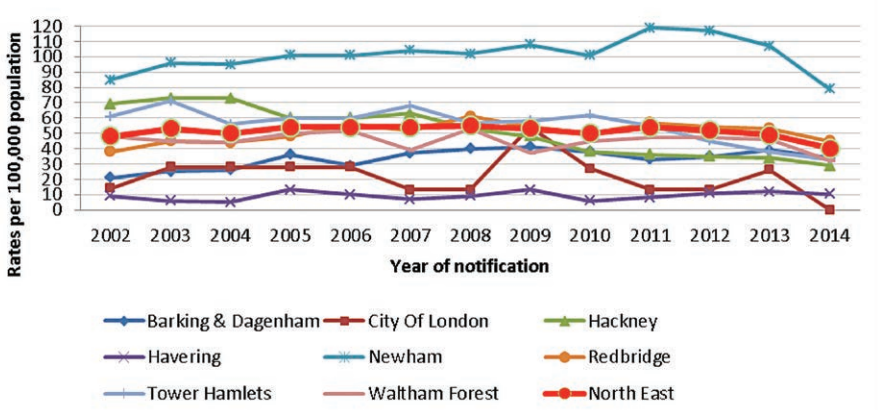
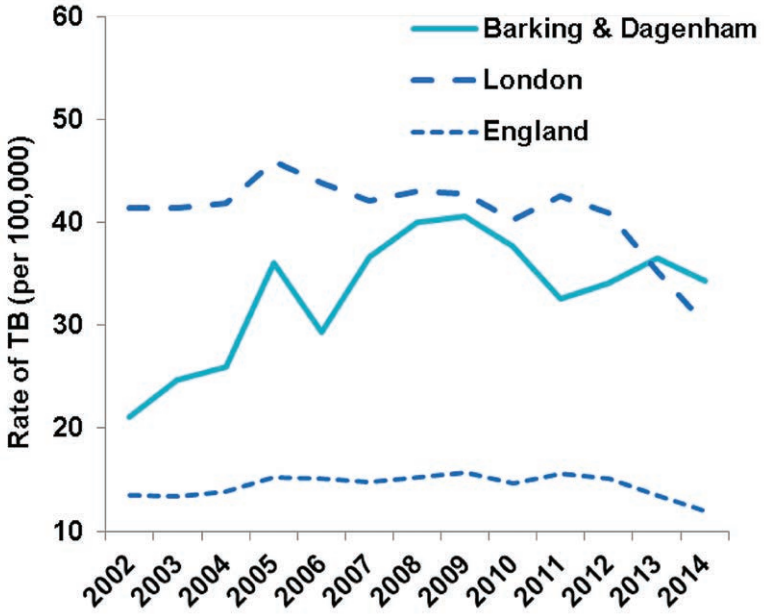


Figure 3:

TB case rates Barking and Dagenham compared with London and England 2002-2014.



A small number of TB cases in the borough were infectious and there were public health implications in two instances, where contact tracing exercises were undertaken in order to offer screening tests to those who were exposed.

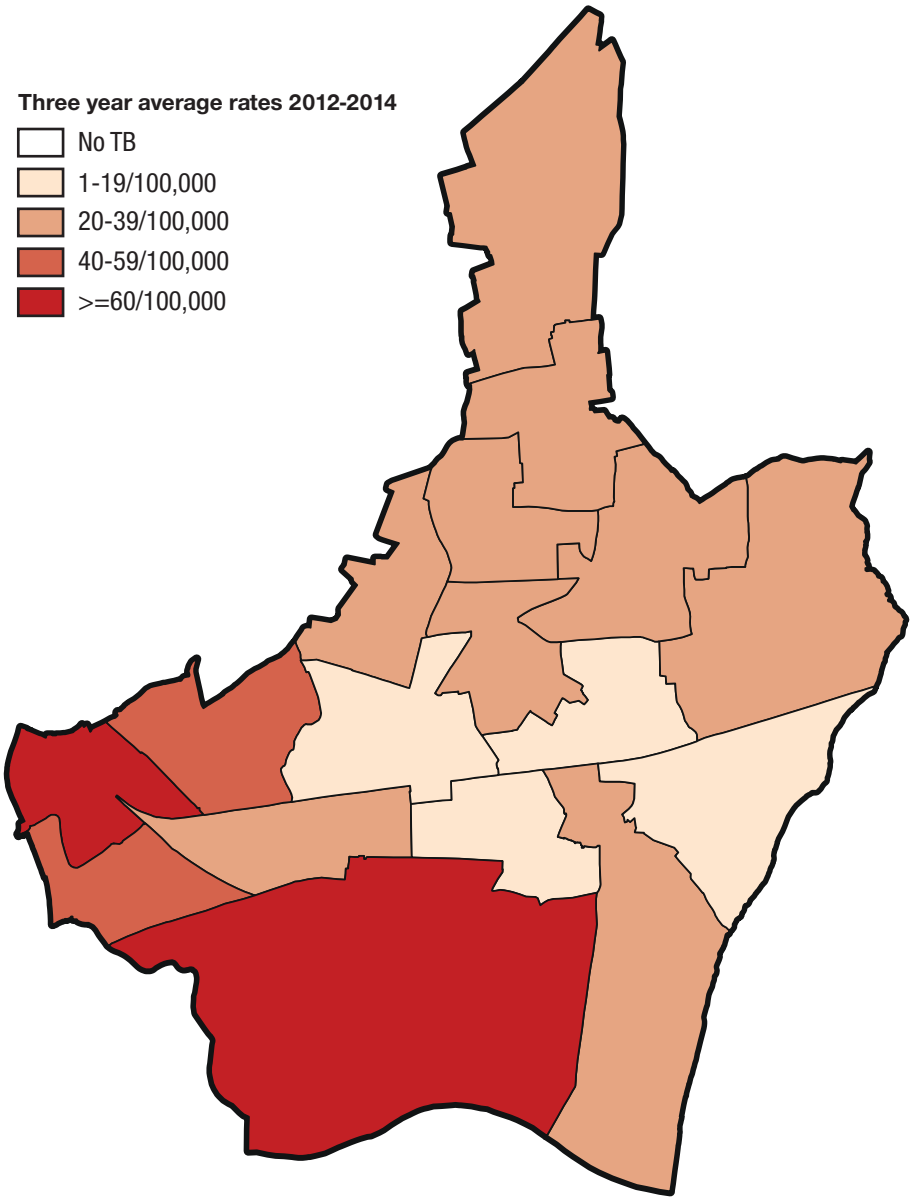
It has been found that it is likely that the majority of TB cases in England are the result of 'reactivation' of latent TB infection. Latent TB is where someone is carrying the bacteria that causes TB but are not infectious or symptomatic with active disease, an asymptomatic phase of TB, which can last for years. For this reason, funding has now become available for latent TB testing in some local authorities (those local authority areas with a TB incidence of ≥20 per 100,000 population or over).

We have had funding approved to carry out Latent TB testing in new migrants as part of the programme being rolled out across England. The testing is for those people who are: aged 16 to 35 years, entered the UK from a high incidence country (≥150/100,000 or Sub Saharan Africa) within the last five years and been previously living in that high incidence country for six months or longer.

The London TB team Extended contact tracing team (LTBEx) are to be disbanded in 2016 and although we have set up a proactive approach by engaging in latent Tuberculosis screening, the LTBEx team have been invaluable in dealing with contact tracing for large tuberculosis incidents. They were able to respond quickly and screen TB contacts on-site (e.g. at schools, workplaces, etc.) to ensure there is no onward transmission. With this function removed, there is a concern over capacity to deal with large scale TB incidents when there is a reduction in staff at a Health Protection Team level.

Figure 4:

Three-year average annual TB incidence rate by ward, 2012-2014.



Vaccination

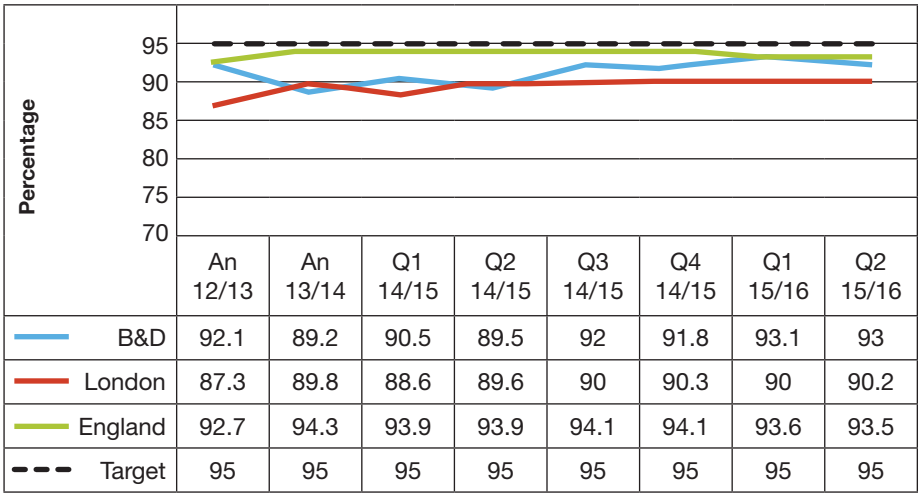
Vaccination continues to have a historical place - on a par with the provision of clean water and improved sanitation - as one of our society's most fundamental tools in the continuing battle for better public health. The borough has, for many years, had lower than average vaccination coverage levels, often markedly so.

The Cover of vaccination evaluated rapidly (COVER) programme evaluates childhood immunisation in England. Quarter 2; July–September 2015 is the latest available data. The borough is below the national target of 95% but achieving above the London average for diphtheria, tetanus, pertussis, pneumococcal, haemophilus influenza type b (DTaP/IPV/Hib) at 12 months with 93% uptake in Q2 15/16 compared to 90.2% for London and is similar to the England average of 93.5%.

Uptake for the 24 month vaccinations is below the national target, with 86.6% uptake for the pneumococcal (PCV) booster and measles, mumps and rubella (MMR1), and 86.4% for the haemophilus influenza type B and meningitis C (Hib/MenC) booster.

Figure 5:

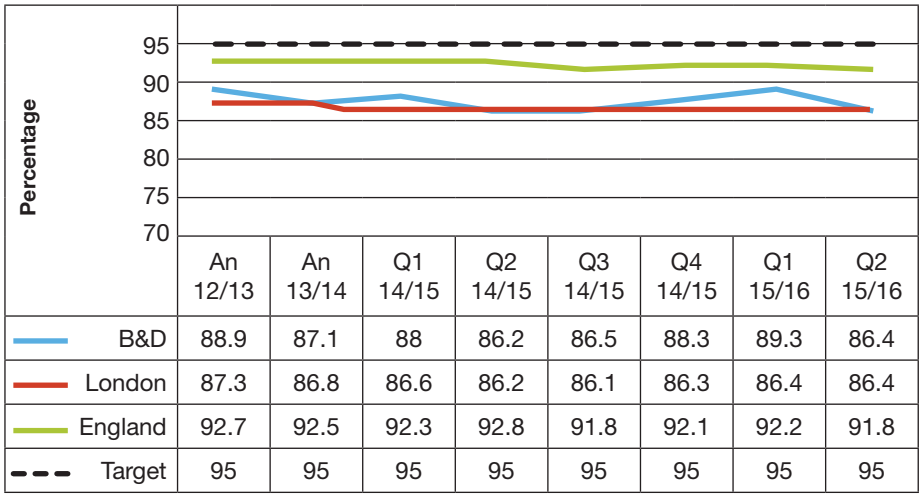
DTaP/IPV/Hib at 12 months.



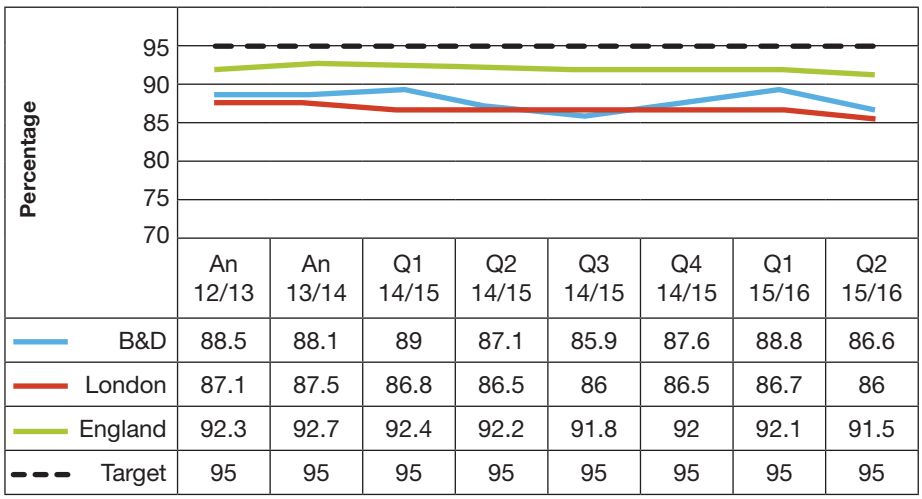
	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	92.1	89.2	90.5	89.5	92	91.8	93.1	93
London	87.3	89.8	88.6	89.6	90	90.3	90	90.2
England	92.7	94.3	93.9	93.9	94.1	94.1	93.6	93.5
Target	95	95	95	95	95	95	95	95

Figure 6:

Hib/MenC and MMR1 at 24 months.



	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	88.9	87.1	88	86.2	86.5	88.3	89.3	86.4
London	87.3	86.8	86.6	86.2	86.1	86.3	86.4	86.4
England	92.7	92.5	92.3	92.8	91.8	92.1	92.2	91.8
Target	95	95	95	95	95	95	95	95



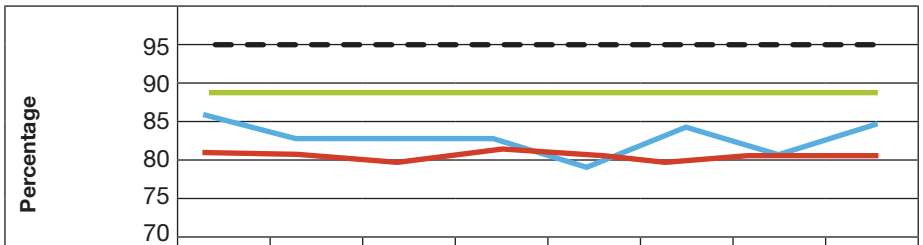
	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	88.5	88.1	89	87.1	85.9	87.6	88.8	86.6
London	87.1	87.5	86.8	86.5	86	86.5	86.7	86
England	92.3	92.7	92.4	92.2	91.8	92	92.1	91.5
Target	95	95	95	95	95	95	95	95

Uptake for the 5 year vaccinations is below the national target at 84.1% for the DTaP/IPV booster, and 83.6% for the MMR2.

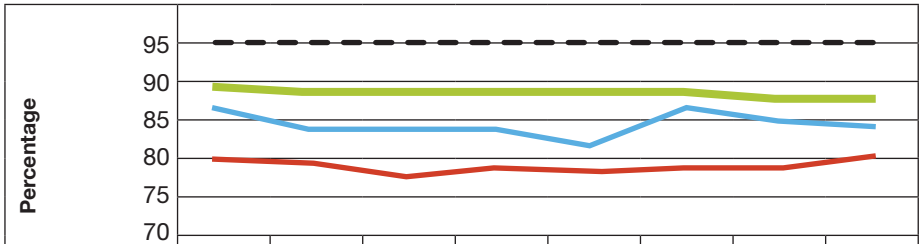
Barking and Dagenham hepatitis B vaccination rates are above the London and England averages.

Figure 7:

MMR2 at 5 years and the DTap/IPV Booster.



	An 12/13 3	An 13/14 4	Q1 14/15 5	Q2 14/15 5	Q3 14/15 5	Q4 14/15 5	Q1 15/16 6	Q2 15/16 6
B&D	85	82.3	82.2	82.2	78.8	83.4	81	83.6
London	80.8	80.7	79.9	80.8	80.5	80.1	80.4	80.5
England	87.7	88.3	88.5	88.5	88.5	88.6	88.5	87.9
Target	95	95	95	95	95	95	95	95



	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	85.9	83.4	82.8	83.3	80.9	86.2	84.4	84.1
London	79.9	79.3	77.3	78.2	78	78.5	78.5	79.8
England	88.9	88.6	88.6	88.6	88.4	88.4	87.7	87.9
Target	95	95	95	95	95	95	95	95

Table 1:

Barking and Dagenham Hepatitis B vaccination programme

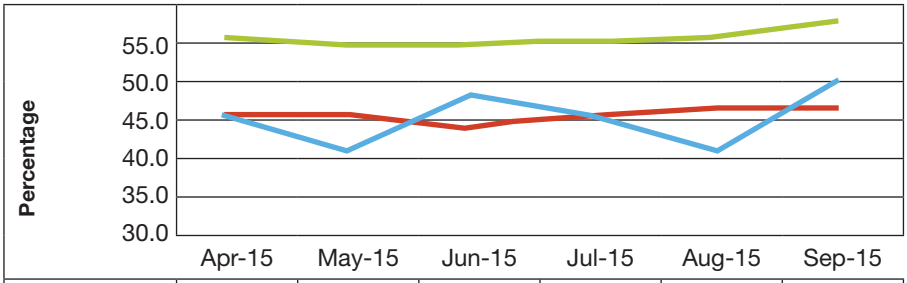
	12 Months			24 Months		
Quarter	**B&D**	**London**	**England**	**B&D**	**London**	**England**
Q1 14/15	100	86.9	83.4	92.3	78.5	72
Q2 14/15	100	92.5	87.3	88.2	87.2	79.4
Q3 14/15	100	84.7	85.4	91.7	75.2	72.1
Q4 14/15	82	83	84	91	79	72
Q1 15/16	86	88	85	80	81	75
Q2 15/16	100	91	87	88	80	72

Pertussis vaccinations in pregnant women:

This programme commenced September 2012 as an interim programme and has been extended until 2019. There is no nationally set target for uptake. Vaccinations are given between weeks 28 and 38 of pregnancy. The borough is performing above the London average but remains below the England average for uptake.

Figure 8:

Pertussis in pregnancy vaccinations.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
B&D	45.7	40.9	48.1	45.9	41.1	50.0
London	46.0	45.8	44.3	45.4	46.8	46.6
England	56.1	55.2	55.1	55.6	56.6	57.7

HPV Vaccination Programme:

Human papilloma virus (HPV) vaccine is offered to girls aged 12-13 years. The vaccine protects against cervical cancer. The borough is achieving above the London average for uptake. England uptake rates for 2014/15 are not currently available.

Shingles Vaccination Programme

The aim of the vaccination programme is to reduce the incidence and severity of shingles in those targeted by the programme. There is no national uptake target set. The borough is currently performing below the London average for shingles uptake, with 44.6% uptake in the 70 year olds, 45.4% in 78 year olds and 48.3% in the 79 year olds.

Stay Well this Winter national campaigning supported locally

Seasonal Flu programme

The seasonal flu programme is an annual programme offering flu vaccinations to people who are more likely to suffer from complications from getting flu. These include people aged over 65 years, people in clinical risk groups, pregnant women, children aged 2, 3 and 4 years and school years 1 and 2. Additionally carers and frontline health care workers can also receive free flu vaccinations. We rolled out the child flu school vaccination programme this academic year, for schools' years 1 and 2, and for children in special needs schools. National targets are set for those aged over 65years and those in clinical risk groups (75%). The borough historically fell below the national targets for flu vaccination uptake.

Table 2:

Seasonal Flu Vaccine uptake amongst GP patients 1 September 2015 to 30 November 2015 (compared to 2014 data)												
Area	over 65s 15/16	over 65s 14/15	clinical risk groups 15/16	clinical risk groups 14/15	Pregnant women 15/15	Pregnant women 14/15	2 Yr olds 15/16	2 Yr olds 14/15	3 Yr olds 15/16	3 Yr olds 14/15	4 Yr olds 15/16	4 Yr olds 14/15
B&D	62	65.8	41.1	48.9	39.3	38.7	19.3	29.5	21.1	29.2	15.5	19.9
London	61	66.9	37.7	46.6	34.3	38.3	20.4	28.4	22.1	30.8	17	22.1
England	66.9	68.5	39.3	44.4	38.3	38.5	29.2	31	30.4	33.1	24.7	26
Target	75	75	75	75	75	75	40	40	40	40	40	40

Increasing immunisation uptake for both children and older people is a priority for the Council, NHSE, local GPs and NHS Trusts. The DPH advises that NHSE provides quarterly performance reports to the Health and Wellbeing Board on the arrangements being put in place to improve performance in achieving the optimum uptake of immunisation programmes by the eligible population of Barking and Dagenham.

The immunisation and screening teams are also going through a period of change and a move to working much more closely with local boroughs, agreeing local plans with the DPH. From the initial difficult start NHSE are moving from patch based groups to having either multiagency immunisation meetings or inclusion in local health protection forums where NHSE will be represented.

Moving to a better reporting structure such as quarterly infectious disease reports and quarterly immunisation cover, representation from PHE and NHSE at the Health Protection Committee will ensure that the DPH can make assurances to the Health and Wellbeing Board.

HealthCare Associated Infection

(Data is for the time period: 2014/15)

Despite significant reductions in incidence, healthcare associated infections (HCAI) continue to be one of the biggest challenges the health and residential care services face. This is because, whilst we are performing much better, the targets we are setting ourselves are becoming ever-more challenging year-on-year, and rightly so. The rate of C. difficile infection for NHS Barking and Dagenham Clinical Commissioning Group in people aged over 2 years was 23.2/100,000 population. Although this is below the England average of 26.3/100,000 population, it is among the higher rates in North East London. This indicates that there is substantial work to be done around antimicrobial use and prevention of C. difficile infection in the community.

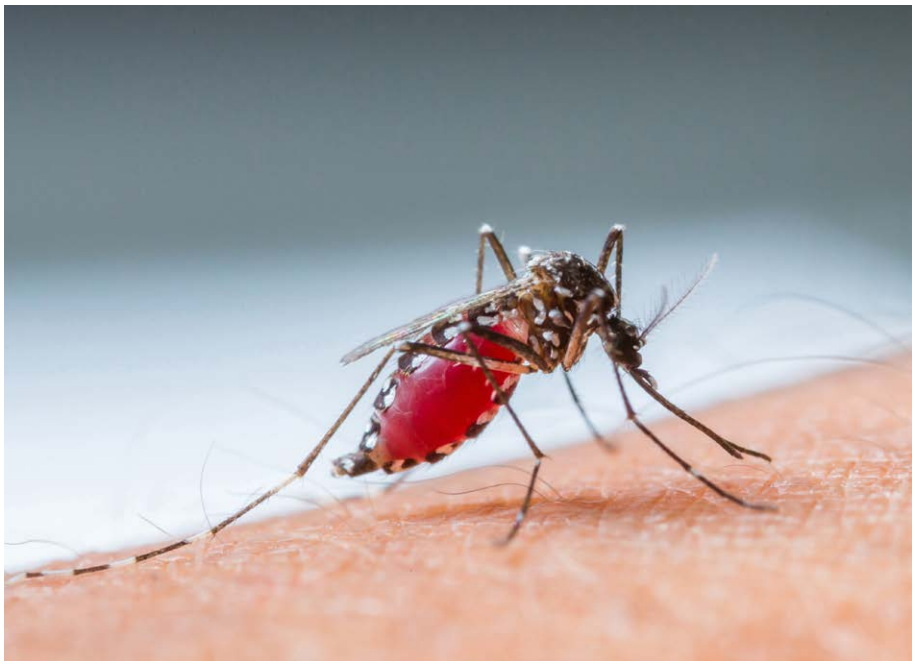
The Barking and Dagenham rate for MRSA bacteraemias for NHS Barking and Dagenham Clinical Commissioning Group was 2/100,000 population; this provides an important indicator of infections in the community population. This is the same as the national average of 2/100,000 population. Work is needed to continue to improve training in the care of intravenous therapy lines (infusion of liquid substances directly into a vein) and catheters in the community to ensure that they are inserted safely and managed properly, so that MRSA bacteraemia can be prevented.

There is work to be done around antimicrobial use and prevention of C. difficile infection in the community; looking at the cause of the infections; education; and ensuring samples are taken appropriately. The infection control team at Barking Havering and Redbridge University Hospitals NHS Trust are already auditing practice and educating staff. The DPH recommends that HCAI prevention through key initiatives. For example, appropriate use of antimicrobials, appropriate insertion and care of invasive devices and lines, and all providers of care being trained in infection prevention and control.

Mind the Gap?

The changes in landscape since 2013 had initially been difficult to work with but through excellent historic working relations and an established health protection forum, the Council are in a strong position despite on-going changes. However, there are gaps emerging from the new systems and these are areas we need to focus on:

- Immunisation and training for practice staff was a gap with ad hoc providers and poor evaluation. PHE have recently trained practice staff on the new immunisation programmes but will there be on-going capacity?
- The Infection Control provision in the community e.g. GP/Dentist training does not directly come under the DPH and we are currently unsure of the capacity, roles and responsibilities. This can be problematic with CQC visits to practices that get reported to the health protection team and the DPH, such as breaches in storage of vaccines leading to a cold chain incident. There also appears to be confusion from practices around the provision of infection control training. There is an infection control team in the community but they do not sit on the Health Protection Committee. This is an area for the Committee to take forward.
- Screening is still an issue that needs to be addressed as there has been no representative at the Health Protection Committee.



The future?

In 2015 an outbreak of Ebola Virus Disease in Sierra Leone showed how easily it is to import an infection due to global travel. PHE had to set up screening teams at major ports. North East & Central Health Protection Team (NECLHPT) were responsible for port health screening at St Pancras International Station. PHE have a national and international horizon scanning team whereby issues can be identified early and worked through with the local authority. In 2015, the Council ran an Ebola workshop with key stakeholders.

Zika virus has been recently reported in the news. Zika is a mosquito-borne infection caused by Zika virus, a member of the genus flavivirus and family Flaviviridae. It was first isolated from a monkey in the Zika forest in Uganda in 1947. Zika virus outbreaks have occurred in areas of Africa, Southeast Asia and the Pacific Islands. In May 2015, the Pan American Health Organisation issued an alert regarding the first confirmed Zika virus in Brazil. The infection causes symptoms such as mild fever, conjunctivitis and headache but has been linked to babies being born with undeveloped brains.

Aedes mosquitoes carry the virus and are found particularly in the above regions. The Aedes mosquito is not present in the UK and is unlikely to establish in the near future as the UK temperature is not consistently high enough for it to breed.

The mosquitoes predominately bite during the day and also around dawn and dusk (as opposed to mosquitoes

that transmit malaria, which bite at night between dusk and dawn). Advice for travellers is to use a good repellent containing N, N-diethylmetatoluamide on exposed skin, together with light cover-up clothing.

Locally the NECLHPT works closely with the Council to ensure any trends or changes in infections are identified and actions implemented. Some of the future priorities are around antimicrobial resistance. When drugs are no longer effective in treating infections caused by micro-organisms, minor surgery and routine operations could become high-risk procedures, leading to increased duration of illness and premature mortality.

The biggest threat to the UK and the borough is still pandemic influenza and through joint working with our partners we have plans in place which are exercised and tested yearly.

Conclusion

The historic links built up over many years have meant that the Council and our partners can safely respond to incidents and outbreaks. The potential of having immunisation links at a local level is welcomed and this same model could be used for screening. There appear to be gaps in service provision, some real and some perhaps due to lack of clarity that need to be addressed via our Health Protection Committee.

The health protection service re-design at PHE needs to ensure career pathways are attractive and maintain the established local links which have driven many excellent initiatives in the borough.

Acknowledgements

Contributors to this report include:

Sue Lloyd Consultant in Public Health – Chapter 1

Sandeep Prashar Head of Health Intelligence – Chapter 1

Dr Fiona Wright Consultant in Public Health – Chapter 2

Vivien Cleary Consultant in Communicable Disease (Public Health England) – Chapter 4

Sofia Saeed, Health Protection Practitioner (Public Health England) – Chapter 4

This report was prepared by:

Pauline Corsan Personal Assistant to Director of Public Health

London Borough of Barking and Dagenham Marketing and Communications Team

Advisors

Dr Benjamin Cole

Val Day

If you need a copy of this document in large print or an alternative format, please contact Barking and Dagenham Direct on 020 8215 3000.

London Borough of Barking and Dagenham
Phone: 020 8215 3000
Fax: 020 8227 3470
E-mail: 3000direct@lbbd.gov.uk

Out-of-hours emergencies only phone: 020 8215 3024

Website: www.lbbd.gov.uk

We have tried to make sure that this information is correct at the time of going to print. However, information may change from time to time.

Publication reference number. MC7854 Date: April 2016

INVESTORS IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

London Borough of Barking & Dagenham
lbbd.gov.uk

HEALTH AND WELLBEING BOARD

14 June 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 meetings held on 4th May 2016.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

- Consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the 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: 4 May 2016

System Resilience Group (SRG) Briefing	Meeting dated – 4 May 2016
	Venue – Bentley Rooms, Imperial Offices
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
SRG Governance and Delivery arrangements	Members were updated on the review of the SRG governance and delivery arrangements being undertaken by Prederi. Final report will be presented at the next meeting.
Performance Update	Key areas from the dashboard were highlighted.
Urgent and Emergency Care Delivery Plan	Members were updated on the latest UEC programme plan and discussed the outcome of the urgent care engagement and research. BHRUT presented the latest UCC strategy document. Discussions took place around the national policy changes and implications to DToC reporting, the discharge standards project and received an update on the discharge to assess pilot.
Planned Care delivery plan	Members were updated on the RTT and Cancer performance position.
BHRUT Improvement Plan	Members noted the latest update on the Trust Improvement Plan.
Next meeting:	Monday 23rd May 2016 1pm - 3pm Committee Room 2, Barking Town Hall

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 June 2016

Title:	**Sub-Group Reports**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: NONE	**Key Decision: NO**
Report Authors: Andrew Hagger, Health and Social Care Integration Manager, LBBD	**Contact Details:** Telephone: 020 8227 5071 E-mail: Andrew.Hagger@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	

Summary:

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

Please note that there is no report for Public Health Programmes Board and Integrated Care Sub Group, as they have not held a meeting since the last Health and Wellbeing Board.

Recommendations:

The Health and Wellbeing Board is asked to:

- Note the contents of sub-group reports set out in the appendices and comment on the items that have been escalated to the Board by the sub-groups.

List of Appendices

- Appendix A: Children & Maternity Group
- Appendix B: Mental Health Sub Group
- Appendix C: Learning Disability Partnership Board

This page is intentionally left blank

Children & Maternity Group

Chair: Sharon Morrow, Chief Operating Officer

Items to be escalated to the Health & Wellbeing Board None
Performance The HWB indicators were reviewed. Key areas for performance improvement were identified obesity, infant mortality, 12 week booking and immunisation.
Meeting Attendance 60%
Action(s) since last report to the Health and Wellbeing Board The Sub-Group reviewed a draft HWB paper on Health support in the community for children with additional needs. The Group felt that the paper needed further development to ensure that it reflected wider commissioning for children with special educational needs and disabilities. Further joint work was in development and deferring the plan to enable the outcome of this work to be shared with HWB would demonstrate a much clearer picture of service provision and issues. The Sub-Group reviewed the final report of the Children and Young People's mental health and wellbeing needs assessment report and recommendations. Various comments were received to enable report to be finalised. Members also reviewed the Group's work plan and took stock of progress particularly in the light of performance against the HWB key indicators.
Action and Priorities for the coming period A Looked After Children's progress report will come to the next meeting along with a report on immunisation and a wider review of maternity indicators and plans to support implementation.

Contact: Dawn Endean, Locality Admin Support

Tel: 020 3644 2378 **Email:** bdccg@barkingdagenhamccg.nhs.uk

This page is intentionally left blank

Mental Health Sub Group

Chair: Melody Williams

Items to be escalated to the Health & Wellbeing Board

None.

Performance

The end of quarter four figures for these indicators are yet to be available.

1. Emotional Wellbeing of Looked after children
2. Number of children and young people accessing Tier 3/4 CAMHS services
3. Improving Access to Psychological Therapies

Meeting Attendance

25th April 2016. Ten out of seventeen attended.

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

(a) MH Sub group oversight of the Child & Adolescent Mental Health Services - Needs Assessment. Needs assessment has been undertaken.

(b) New Dementia Care Pathway for primary care has been developed and cascaded to all GPs across BHR.

(c) Updated work plan. Mental Health Strategy development is underway.

Action and Priorities for the coming period

(a) To consider the most appropriate use of Health Education North Central & East London training monies

(b) Mental Health Strategy to be developed and implemented

(c) Suicide Strategy to be developed to be developed and implemented

Contact: Julie Allen

Tel: 0300 555 1201 ext 65067 **Email:** julie.allen@nelft.nhs.uk

This page is intentionally left blank

Learning Disability Partnership Board

Chair: Bill Brittain, Group Manager, Intensive Support

Items to be escalated to the Health & Wellbeing Board

None.

Performance

The HWB indicators were reviewed together with the action plan that had brought together the various actions to improve services and support for people with learning disabilities. See update on healthchecks, below.

Meeting Attendance

75%

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

a) Glynis Rogers Divisional Director Commissioning and Partnerships has retired from the Council and, therefore, as the Chair of the Learning Disability Partnership Board. Mark Tyson, Commissioning Director, Adults' Care & Support has accepted the role of Chair and will take this up as diaries permit. A small meeting outside of the Board considered ways of structuring its work to maximise engagement alongside ensuring that its routine work was delivered.

b) Sub Group Forums

There has not been a provider forum since the last Health and Wellbeing Board. The next date in June has been booked and will have agenda items including Dysphagia, Quality Assurance and Safeguarding.

c) Health Checks for people with Learning Disabilities:-

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 heath check planning and developing health action plans.

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.

d) The Independent Housing Strategy will be presented to the next LDPB in July.

e) Carers requested that they are formally recognised as JobCentre Plus are requesting that carers are undertaking assessments to work and the caring role is not being recognised and being taken into account. JCP have confirmed attendance at the next LDPB.

f) LDPB have been involved in planning Learning Disability Week. It was agreed by the group that work tasters would be offered by all partners with a view to partner organisations following the good practice of the Borough in job carving. Bill Brittain has said that he will look into job carving two roles in his area. During LD Week, these would be promoted.

Action and Priorities for the coming period

a) Update and review of progress in the implementation of the Learning Disability Strategic Delivery Plan.

b) Employment for people with Learning Disability (4 hours or more): reviewing options for improving local performance.

Contact: Karel Stevens-Lee

Tel: 020 227 2476 **Email:** karel.stevens-lee@lbbd.gov.uk

HEALTH AND WELLBEING BOARD

14 June 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.	

This page is intentionally left blank

In this edition of my Chair's Report, I talk about the recent Health and Wellbeing Board Development Session and Healthwatch being shortlisted for an award at the Healthwatch National Conference. 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

Health and Wellbeing Board Development Session – 19th May

The Health and Wellbeing Board hosted a development session on 19th May, with the aim of informing people about the different transformational change programmes that are either under way or are being developed across the health and social care system in Barking and Dagenham and across the wider Barking and Dagenham, Havering and Redbridge health and social care economy. While all members of the Board of were invited, the session was aimed towards those who work in partner organisations who are contributing to developing these change programmes or may be impacted on by the changes that emerge from them.

The session started with an overview of all the change and transformation programmes currently in progress or being developed, including the Sustainability and Transformation Plan, the Accountable Care Organisation, the Council's recently launched Ambition 2020 programme, the CCG's Transformation plans as well as briefing on Care City and Healthy New Towns. There was then an opportunity for discussion, where groups talked about the linkages between the different programmes as well as some of the issues and challenges that we need to respond to.

In terms of linkages, groups highlighted that many of the programmes identify the need to work closely with the voluntary sector and to support volunteers and that there needs to be consultation with the community to get a balanced view of what people want from their services. There was also discussion about the need for all the programmes to have a shared understanding of the needs of the population, the importance of improving online information and access to services. Prevention runs throughout the programmes as a key way of reducing demand, while there are also shared financial pressures across the system and a shared understanding of the need to increase investment in the borough.

Issues that need to be resolved in order to deliver the transformation programmes included how to redirect people away from hospitals, such as having alternatives to A&E available and making sure people know about them and are encouraged to use them. Improved knowledge and capacity of people to manage their own health effectively was also raised, in particular around better information availability and training for carers. Another issue to be resolved was better use of the information we do have in the development of services, including commissioning services that are filling a gap in provision for our communities.

Prevention was also raised as a key issue, with the need to address the key root causes of poverty and poor life expectancy. This included the promotion of personal responsibility as well as better education for children so they have

better life chances. Those present also discussed how to deliver these significant transformation programmes at the pace that is required and with limited resources.

The afternoon session was a workshop session by the firm Locality Matters, who are carrying out research in Gascoigne ward to see how to build stronger more resilient communities and how communities can play a role in service delivery or demand reduction. The project is testing if statutory providers had a better understanding of the capabilities that exist in their communities they would commission in a different way and if local groups better understood the scale of demand and costs related to health and wellbeing services they would play a different role. The workshop produced some interesting discussions including sustaining community involvement around projects and also how to use information on community capacity to commission better services.

Attendance at the session was great, with 37 attendees including representatives from London Borough of Barking and Dagenham, Barking and Dagenham CCG, NELFT, Healthwatch, London Fire Brigade and Carers of Barking and Dagenham. This contributed to some productive and lively discussions that got to the heart of some of the issues we are facing. I'd like to thank all those who attended for taking the time to participate and to share your knowledge and passion for health and social care in Barking and Dagenham.

Healthwatch success

The shortlist has been unveiled for the 2016 Healthwatch Network Awards, the annual awards that celebrate the difference local Healthwatch across the country have made to health and social care at a local and national level.

Our own Barking and Dagenham Healthwatch nominated for an award in the Community category, which is for the Healthwatch that have brought added value to their local community. The nomination is for their work on the phlebotomy service.

The local Healthwatch shortlisted for 2016 Healthwatch Network Awards were picked from over 120 award entries and the winner of each category will be chosen by a panel of external judges and announced on Thursday 9th June.

2 members of Healthwatch are attending the event in Nottingham and I hope that we can hear about their success at the Board meeting on 14th June.

Congratulations to all the team at Healthwatch and good luck with the award.

healthwatch Barking and Dagenham

News from NHS England

Joint working with fire and rescue services

Fittingly, given the presentation earlier on the agenda from London Fire Brigade, a document has recently been published showing how work by the fire and rescue services can help reduce demand for other services through prevention, including health and social care. This document is called 'Working Together' and the link can be found here.

Fire and rescue services are applying the principles of early intervention and prevention to health-related risk factors, resulting in a reduced demand for the services of others, whilst also continuing to reduce demand for fire and rescue.

A key aim of the NHS Five Year Forward View is to tackle widespread preventable illness and deep-rooted health inequalities through a radical upgrade in prevention and public health. By working with fire and rescue services, health and social care partners, from local authorities to CCGs, can make use of fire and rescue service expertise, experience, existing prevention mechanisms and ability to adapt engagement with those most at risk.

Fire and rescue services are being recognised as partners in the wider health and social care arena and, along with health and social care, are ready to meet the challenge of preventing avoidable illness, isolation and injury.

Opportunities for joint working include:

- Safe and Well visits –a person-centred home visit that expands the scope of previous home checks by focussing on health, as well as fire. It involves the systematic identification of, and response to, health and well-being issues along with fire risk reduction, ensuring people with complex needs and older people get the personalised, integrated care and support they need to live full lives and sustain their independence for longer.

- Children and young people – Working with young people is key to changing behaviours that lead to avoidable illness. Helping young people gain meaningful employment is one of the most effective ways to help them improve the impact of the wider determinants of health.

- Community Risk Intervention – Community Risk Intervention is a new model, building on the Safe and Well visit model and combining an expanded approach to home safety, risk reduction and increased independence with a response on behalf of police and ambulance services to low-priority, high-volume calls.

Health and Wellbeing Board Meeting Dates

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.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

14 June 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 27 June 2016. Any changes or additions to the next issue should be provided before 2.00 p.m. on 21 June.

Public Background Papers Used in the Preparation of the Report:
None

List of Appendices
Appendix A – Draft Forward Plan

This page is intentionally left blank

HEALTH and WELLBEING BOARD FORWARD PLAN

DRAFT July 2016 Edition

Publication Date: Due on 27 June 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://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

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

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

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

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

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

Information included in the Forward Plan

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

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

- the date when the decision is due to be made;

Publicity in connection with Key decisions

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

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

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

Edition	Publication date
June 2016 edition	17 May 2016
July 2016 edition	27 June 2016
Sept 2016 edition	26 August 2016
November 2016 edition	24 October 2016
January 2017 edition	23 December 2016*
March 2017 edition	13 February 2017
May 2017 edition	10 April 2017

Confidential or Exempt Information

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

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

Key to the table

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

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

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

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

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

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 26.7.16	**CAMHS Transformation Plan and Needs Assessment** : Community The report will inform the Board of the CAMHS Transformation Plan which was developed by the Children and Maternity Sub-Group as well as presenting the CAMHS Needs Assessment. The Board will be asked to discuss and note the CAMHS Transformation Plan and to discus and agree the recommendations set out in the CAMHS Needs Assessment. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2378) (Sharon.morrow2@nhs.net)
Health and Wellbeing Board: 26.7.16	Update on Commissioning of Eye Care Services Following consideration of the Health and Adult Services Select Committee's Scrutiny Review on Local Eye Care Services in October 2015, the Board will be presented with an update on actions and changes that have taken place as a result of partners pursuing the recommendations made. • Wards Directly Affected: All Wards	Open	Sharon Morrow, Chief Operating Officer (Tel: 020 3644 2378) (Sharon.morrow2@nhs.net)
Health and Wellbeing Board: 26.7.16	Healthwatch Barking and Dagenham Annual Report 2015/16 Healthwatch Barking & Dagenham is the consumer champion for health and social care services. The annual report pulls together all the work carried out during 2015/16. The Board will be asked to note the Healthwatch Annual Report. • Wards Directly Affected: All Wards	Open	Frances Carroll, Chair, Healthwatch (francarroll@btinternet.com)

Health and Wellbeing Board: 26.7.16	Learning Disability Partnership Board Strategic Delivery Plan Update The report will provide and update of the Learning Disability Partnership Board Strategic Delivery plan, including the strategic frameworks that drive improvements for learning disability services. • Learning Disability Self Assessment Framework Improvement plan • Adults Autism Strategy • Challenging Behaviour Strategy • Carers Strategy The Board will be asked to note the report and discuss any comments within it. • Wards Directly Affected: All Wards	Open	Karel Stevens-lee, Integrated Commissioning Manager (Learning Disabilities), Joint Service (Tel: 0208 227 2476) (karel.stevens-lee@lbbd.gov.uk)
Health and Wellbeing Board: 26.7.16	Children and Maternity Sub-Group Assurance Update The report will provide and update on the work of the Children and Maternity Sub-Group, providing the Board assurance that the Sub-Group is delivering against its strategic objectives. The Board will be asked to note the report and discuss any comments within it. • Wards Directly Affected: All Wards	Open	Karel Stevens-lee, Integrated Commissioning Manager (Learning Disabilities), Joint Service (Tel: 0208 227 2476) (karel.stevens-lee@lbbd.gov.uk)
Health and Wellbeing Board: 27.9.16	**Obesity and Physical Activity Strategy** : Community The Board will be asked to approve the Obesity and Physical Activity Strategy. • Wards Directly Affected: All Wards	Open	Paul Hogan, Commissioning Director, Culture & Recreation (Tel: 020 8227 3576) (paul.hogan@lbbd.gov.uk)

Health and Wellbeing Board: 27.9.16	Joint Strategic Needs Assessment (JSNA) 2016 - Key recommendations The Joint Strategic Needs Assessment is the outline document written with Health and Wellbeing partners to provide information about the services that benefit the health and wellbeing of residents in Barking and Dagenham. The report will present the JSNA and the priorities for commissioning based on the JSNA. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 22.11.16	**Domestic and Sexual Abuse Strategy** : Framework The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy. • Wards Directly Affected: All Wards	Open	Sonia Drozd, Drug Strategy Manager (sonia.drozd@lbbd.gov.uk)
Health and Wellbeing Board: 22.11.16	**Contract: Healthy Child Programme (0-19) - Procurement Strategy** : Financial The contracts for the 0-5 and 5-19 Health Child Programmes (HCP) respectively are due to expire on 30th September 2017. This Board will be asked to approve the procurement strategy for the competitive procurement of these service as an integrated 0-19 HCP and to delegate authority to award a contract to the successful provider. • Wards Directly Affected: All Wards	Open	Christopher Bush, Interim Commissioning Director, Children's Care and Support (Tel: 020 8227 3188) (christopher.bush@lbbd.gov.uk)

APPENDIX 1

Membership of Health and Wellbeing Board:

Councillor Maureen Worby, Cabinet Member for Social Care and Health Integration (Chair)
Councillor Sade Bright, Cabinet Member for Equalities and Cohesion
Councillor Laila Butt, Cabinet Member for Cabinet Member for Enforcement and Community Safety
Councillor Evelyn Carpenter, Cabinet Member for Educational Attainment and School Improvement Councillor Sade Bright, Cabinet Member for Equalities and Cohesion
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)
Sean Wilson, Interim LBBD Borough Commander (Metropolitan Police)
Vacant - (NHS England) (non-voting Board Member)